

# CMS DSH Report and Audit Frequently Asked Questions

## 1. What is the CMS DSH Report?

In accordance with Federal regulation, 42 C.F.R. §447.299(c), Pennsylvania (PA) Medicaid is required to annually submit a report to the Centers for Medicare and Medicaid Services (CMS) for the purpose of determining PA Medicaid's compliance with Section 1923 of the Social Security Act (SSA) relating to disproportionate share hospital (DSH) limits. The regulation requires that the report consist of twenty (20) specific data elements for each PA hospital that received a DSH payment. In addition, the report must undergo an audit as required by 42 C.F.R. Part 455 Subpart D.

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

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

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

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

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

## 3. What does federalizing mean?

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

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

Many PA Medical Assistance (MA) payments consist of both State and Federal funding. Lump-sum MA DSH and supplemental payments are processed by DHS periodically during the fiscal year. Claims payments for General Assistance (GA) patients which are made directly by DHS or by Medicaid Managed Care Organizations (MCOs)<sup>2</sup> are considered to be MA DSH payments.

Please reference the following information from CMS regarding FFP:

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

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

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

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

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

**Process 2:** DHS annually prepares a Medicaid DSH Report as required by Section 1923 of the Social Security Act (42 U.S.C. §1396r-4(j)). This report utilizes financial data pertinent to the year of the report and is based on actual, not estimated, uncompensated care charges (which are converted to costs) and related payments for the particular fiscal year. The prepared DSH report undergoes an independent audit prior to submission to CMS. The DSH report and audit for Medicaid SPRY 2011 were due to CMS by December 31, 2014. Likewise, future report and audit submissions are due to CMS no later than December 31 of the Federal FY ending three years from the Medicaid SPRY under audit.

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

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

<sup>3</sup> 73 FR 77904 and 79 FR 71679-71694

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

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

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

The CMS regulations require the DSH Report to include costs incurred and revenue received by hospitals for out-of-state Medicaid beneficiaries. See 42 C.F.R. §447.299(c). Following CMS protocol, DHS utilizes the Medicaid Management Information System (MMIS) as the source for PA Medicaid Fee-For-Service (FFS) costs and payments. Since DHS's MMIS captures information related solely to PA beneficiaries, DHS is requesting hospitals provide information specific to out-of-state fee-for-service and out-of-state MCO Medicaid beneficiaries.

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

While lines 11 and 12 of FY 2013-2014 Schedule S-7, Part I relate to Self-Pay and Uninsured charges and revenues, the reported amounts may include elements of charity care that do not qualify for inclusion under CMS Guidelines, while charges and revenues related to the underinsured (those with insurance, but no coverage for the specific service received) are permitted, but may not have been reported on the S-7 schedule.

**8. Who is considered uninsured?**

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

**9. What is underinsured?**

CMS' Final Rule published December 3, 2014, 79 FR 71679-71694, provides a detailed explanation of underinsured effective December 31, 2014. In general, if a person does not have insurance coverage for the specific hospital service being provided then the charges for the service should be treated as an uninsured charge and any payment received from the patient (there would be no payment from insurance) should be reported as payment for an uninsured person.

## 10. What is General Assistance (GA)?

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

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

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

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

Depending on the definition used, hospital costs associated with the uninsured may be a subset of a hospital's charity care or may entirely encompass a hospital's charity care program. Regardless of a hospital's definition of charity care, States and hospitals must comply with Federal Medicaid DSH regulation and policy guidance in determining what portion of their specific charity care program costs qualify under the hospital-specific UPL. To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage, hospitals will need to modify their accounting systems to do so. Also, hospitals must ensure that no duplication of such charges exist in their accounting records.<sup>4</sup>

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

If the error pertains to ten (10) or fewer pages, please email the affected page(s) clearly noting the requested changes to [RA-pwdshpymt@pa.gov](mailto:RA-pwdshpymt@pa.gov), Subject: "[Hospital Name] FY 2013-2014 Cost Report Change Request".

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<sup>4</sup> 73 FR 77911

If the changes are extensive, pertaining to more than ten (10) pages, please send an email to [RA-pwdshpymt@pa.gov](mailto:RA-pwdshpymt@pa.gov). **Subject: “[Hospital Name] FY 2013-2014 Cost Report Change Request”** to indicate a forthcoming change request and mail the revised cost report express delivery to the following address.

**USPS**

Department of Human Services  
 Bureau of Fiscal Management | Division  
 of Hospital and Outpatient Rate Setting  
 Commonwealth Tower, 6th Floor  
 P.O. Box 2675  
 Harrisburg, PA 17101

**UPS or FedEx**

Department of Human Services  
 Bureau of Fiscal Management | Division  
 of Hospital and Outpatient Rate Setting  
 Commonwealth Tower, 6th Floor  
 303 Walnut Street  
 Harrisburg, PA 17101

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

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

The table below lists all of the lump-sum DSH payment programs (paid either quarterly or annually) applicable to FY 2013-2014. A record of these payments, including the date and amount disbursed, is provided to hospitals by DHS via Remittance Advice (RA) statement.

Please reference

[http://www.dhs.pa.gov/cs/groups/webcontent/documents/communication/s\\_002926.pdf](http://www.dhs.pa.gov/cs/groups/webcontent/documents/communication/s_002926.pdf), or an explanation about the information provided within an RA statement. To request a duplicate RA or access your RA online, please follow the instructions provided at <http://www.dhs.pa.gov/dhsassets/duplicateraform/index.htm>.

| DSH Payment Program Name        | DSH Payment Program RA Description | FY 2013-14 |
|---------------------------------|------------------------------------|------------|
| Inpatient DSH                   | INP DISPROPORTIONATE SHARE         | X          |
| Community Access Fund (CAF)     | COMMUNITY ACCESS PMTS              | X          |
| Burn DSH                        | BURN CENTER DSH                    | X          |
| Critical Access Hospital (CAH)  | CRITICAL ACCESS DSH                | X          |
| Hospital Enhanced DSH           | HOS ENHANCED DSH                   | X          |
| Small & Sole Community Hospital | SMALL/SOLE COMM HOSP DSH           | X          |
| Act 77 Tobacco DSH              | TOBACCO UNCOMP CARE PYMT           | X          |
|                                 | TOBACCO EXTRORDY PYMT              | X          |
| Trauma DSH                      | TRAUMA LEVEL I & II                | X          |
|                                 | TRAUMA LEVEL III                   | X          |
| Additional Class of DSH         | CLEFT PALATE                       | X          |
|                                 | IMPOVERISHED AREA DSH              | X          |

|                               |                                    |   |
|-------------------------------|------------------------------------|---|
| High Volume                   | DISPROPORTIONATE SHARE/UNSPECIFIED | X |
| Access to Care                | DISPROPORTIONATE SHARE/UNSPECIFIED | X |
| OB/NICU                       | OB/NICU DISPROP SHARE PMTS         | X |
| Psychiatric Medical Education | PSYCH MED ED PAYMT                 | X |
| Academic Medical Center       | ACADEMIC MED CTR DSH PYMT          | X |
|                               | RURAL ACAD MED ED DSH              | X |
|                               | REGIONAL ACAD MED ED               | X |
|                               | ACAD MED DSH, LESS URBAN           | X |
| General Assistance Claimss    | Individual Claim Detail            | X |

#### 14. What is DHS using as the source of the information for the DSH UPL calculation?

The DSH UPL calculation encompasses both Medicaid Title XIX and uninsured costs<sup>6</sup> and revenues. DHS utilizes a variety of sources to obtain data necessary to prepare the DSH report.

##### Title XIX Fee-for-Service Charges and Revenue

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

##### Title XIX Managed Care Charges and Revenue

DHS utilizes the paid claim information from its claims processing records to identify Title XIX managed care charges and revenue.

##### Uninsured Charges and Revenue

For Medicaid DSH UPL calculation purposes, individuals with no source of third party coverage for the hospital services they receive are considered uninsured.<sup>7</sup> This includes self-pay and underinsured individuals as well as GA beneficiaries. As described below, DHS is able to identify a portion of uninsured charges and revenue from its claim processing records (related to GA); however, DHS cannot separately identify the self-pay and underinsured portions of uninsured charges and revenue as described in FAQ #8.

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<sup>5</sup> To determine whether a patient was eligible for the GA program during the specific date of service, please refer to the Eligibility Verification System (EVS). For information related to EVS, see Provider Quick Tip #11, [http://www.dhs.pa.gov/cs/groups/webcontent/documents/communication/s\\_002924.pdf](http://www.dhs.pa.gov/cs/groups/webcontent/documents/communication/s_002924.pdf), refer to section 4.5 of the PROMISE Provider Handbook or call the Eligibility Verification Hot Line at 1-800-766-5387 (Hours of operation: 24 hours a day, 7 days a week Website: <http://www.dhs.pa.gov/provider/promise/>).

<sup>6</sup> Costs are estimated by applying a cost-to-charge ratio (CCR) to charges. See FAQ #19 for more information related to CCRs.

<sup>7</sup> 42 C.F.R. 447.299(c)

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

#### Cost-to-Charge Ratios (CCRs)

See FAQ #19.

#### Medicare Crosswalk

DHS will utilize the Medicare Crosswalk released with the FY2013-2014 DSH Survey pricing and aggregating claims within twenty-two (22) cost centers. Both PROMISe Claims Data and MCO Encounters will be processed through the crosswalk according to hospital specific cost center CCRs.

#### **15. If DHS is utilizing paid claims data, how are out-of-state costs incorporated into the DSH UPL report?**

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

#### **16. How is Statewide Quality Care Assessment handled in calculation?**

DHS is requesting that hospitals indicate whether and how much assessment was paid, whether the assessment cost was included in the Medicare Cost Report (MCR), and whether and how much offsetting revenue was reported.

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

**17. How will Assessment costs be treated and allocated to the Medicaid and uninsured patient costs?**

Treatment of the Hospital Assessment(s) remains unchanged. DHS will allocate only the Medicaid and uninsured portion of the Assessment(s), separate from the cost-to-charge ratio calculations.

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

Bad debt is not included in the DSH UPL calculation.

According to CMS,

Bad debt arises when there is non-payment on behalf of an individual who has third party coverage. Section 1923(g)(1) is clear that the hospital-specific uncompensated care limit is calculated based only on costs arising from individuals who are Medicaid eligible or uninsured, not costs arising from individuals who have third party coverage. Thus, while the Medicaid statute does not specifically exclude bad debt from the definition of uncompensated care costs, there is nothing in the statute that would suggest that any costs related to services provided to individuals with third party coverage, including bad debt, are within that definition.<sup>8</sup>

**19. What CCR is used to convert charges to cost?**

For the SPRY14 Medicaid DSH UPL calculation, DHS will utilize the hospital's MCR to derive cost-center-specific cost-to-charge ratios (CCRs). These CCRs will be applied to charges to estimate costs for Medicaid DSH UPL calculation purposes.

**20. Will the Medicare Ratio of Cost to Charges (RCCs) on Worksheet C of the MCR be the basis for the calculation, or will other Worksheets be used to create the RCCs?**

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

**21. How did DHS determine the 22 Cost Centers?**

The 22 cost center groupings are based on Medicare's approach for grouping the cost report cost centers together when using the cost report data to develop relative weights for its CMS DRG system. CMS actually uses even fewer than 22 groupings; however, DHS has expanded the cost centers to reflect Medicaid-specific costs (for example Nursery and Neonate ICU).



**22. How will DHS treat costs not directly captured in the 22 Cost Centers?**

DHS will utilize the Medicare Crosswalk to price claims and encounters. Hospitals will have an opportunity to provide additional information during the 30-day preliminary review period. Navigant Consulting provided Cost Center and Revenue Code groupings (“crosswalks”). DHS will make these crosswalks available on the DHS website.

DHS intends to “add back” what was removed from educational costs (usually residents and interns).

**23. How will DHS calculate the “ungroupable” cost-to-charge ratio (i.e. the 23rd RCC)**

The calculation is as follows:

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

**24. If RCCs are from Worksheet C, how will DHS handle Medical Education Expenses in the DSH UPL calculation?**

See FAQ #20.

**25. If RCCs are from Worksheet C how will DHS develop line items without an RCC (e.g. Room & Board areas, Observation Non-Distinct, Transplant Services, etc.)?**

See FAQ #20.

**26. If DHS is using other Worksheets, which worksheets and how are they used?**

For each Cost Center on Worksheet C Part I, costs from Column 5 are added together with Cost Center specific Medical Education costs from Worksheet B Part I, Column 21 (Intern & Resident Salary & Fringes) and Column 22 (Intern & Resident Program Costs) to determine total costs (including Medical Education). Charges by Cost Center are taken from Worksheet C Part I Column 8. The Cost Centers listed on Worksheet C Part I are consolidated into twenty-two (22) Cost Center categories. Costs and charges in each consolidated Cost Center are subtotaled, then the CCRs for the twenty-two (22) consolidated Cost Centers are calculated by dividing total costs by total charges.

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

CMS requires DHS to use the MCR as the basis for the DSH Audit. While the Reasonable Compensation Equivalent (RCE) is an adjustment to costs applied by Medicare on the A-

8-2, that adjustment is not included in the calculation of RCC factors for the Worksheet C Schedules. Therefore, the DSH Limit calculations will not include any RCE limitations.

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

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

**29. How will DHS use \$0-paid claims/encounters in the cost calculation?**

PROMISe denied claims and MCO denied encounters are not costs to the MA program, as MA did not make payment for the services. The cost of denied claims/encounters may be included as uninsured. Hospitals can submit supplemental listing of denied claims/encounters to DHS during the 30-day preliminary review period. As DHS does not plan to grant extension requests due to this issue, hospitals should begin reviewing their claims for this issue immediately.

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

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

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

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

- The calculated amount of the requested adjustment to MA revenues;
- Supporting documentation which includes:
  - a written explanation of the methodology used to compute the proposed adjustment; and
  - the instances when bundled payments for physician and hospital services are paid by the MCO to the hospital.
- The hospital must make source documentation related to this adjustment available upon request of the Department or the independent auditor.

The hospital should present this adjustment to DHS as part of the 30-day preliminary review period. DHS recommends working on the preparation of this adjustment and supporting documentation now, should a hospital believe this adjustment is reasonable.

**32. How will DHS price uninsured costs provided on the FY2013-2014 DSH Survey?**

DHS will apply a blended CCR to the hospital's reported total uninsured/self-pay costs listed on the FY2013-2014 DSH Survey.

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

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

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

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

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

**35. How will I know whether my hospital will be audited?**

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

**36. Can I request that my hospital be audited?**

Yes. Please contact DHS via email, [RA-pwdshpymt@pa.gov](mailto:RA-pwdshpymt@pa.gov) Subject: "[Hospital Name] FY 2013-2014 Audit Request". DHS will forward your request to the audit firm, but cannot guarantee an audit will occur.

**37. Will DHS be providing hospitals with supporting data and calculations used to prepare the CMS DSH Report?**

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

**NOTE:** the claims data will be presented differently for SPRY 2014. DHS will be grouping hospital charges by cost center, FFS separate from MCO, IP separate from OP, dual

separate from non-dual and GA separate from non-GA. Consistent with past practice, DHS will continue to provide patient ID numbers to facilitate hospitals with referencing claims data.

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

DHS will notify hospitals determined to have excess DSH payments in writing, and via email, after submitting the DSH Report to CMS. The writing will request return of overpaid funds within thirty (30) days of the letter. In addition to the original limited hospital review window referenced in FAQ #22, hospitals determined with excess DSH payments on the final DSH report will have an opportunity to appeal the final determination. Specific appeal rights and procedures are detailed in the notification sent to hospitals requesting repayment.

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

Irrespective of whether hospitals appeal the final determination, repayment of the excess DSH funds is required within thirty (30) calendar days of DHS' written request, detailed in FAQ #23. Failure to remit payment within the stipulated period will result in credit gross adjustments in the amount of the excess DSH funds.

**40. Who can I contact with additional questions?**

Please email additional questions to [RA-pwdshpymt@pa.gov](mailto:RA-pwdshpymt@pa.gov) Subject: “[Hospital Name] FY 2013-2014 Survey Response Additional Question(s)”.

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

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

Section 1923 of the Social Security Act

[http://www.ssa.gov/OP\\_Home/ssact/title19/1923.htm](http://www.ssa.gov/OP_Home/ssact/title19/1923.htm)

December 19, 2008 DSH Audit and Reporting Final Rule

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

April 24, 2009 DSH Audit and Reporting Rule Correcting Amendment

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

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

<https://www.medicare.gov/medicaid/financing-and-reimbursement/downloads/dsh-guidance71709.pdf>

September 18, 2013 Additional DSH Reporting Requirements Rule  
<http://www.gpo.gov/fdsys/pkg/FR-2013-09-18/pdf/2013-22686.pdf>

December 3, 2014 Medicaid Program; Disproportionate Share Hospital Payments—  
Uninsured Definition Final Rule  
<http://www.gpo.gov/fdsys/pkg/FR-2014-12-03/pdf/2014-28424.pdf>

General DSH Audit and Reporting Protocol  
[https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/general\\_dsh\\_audit\\_reporting\\_protocol.pdf](https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/general_dsh_audit_reporting_protocol.pdf)

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

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

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