Pennsylvania (PA) Medicaid Disproportionate Share Hospital (DSH) Report and Audit
Frequently Asked Questions (FAQ)

1. What is the Medicaid DSH Report?

In accordance with Federal regulation[1], the Department of Human Services (DHS) is required to annually submit a report to the Centers for Medicare and Medicaid Services (CMS) for the purpose of determining if PA MA payments funded through Medicaid comply with Section 1923 of the Social Security Act relating to DSH payment limits ("Medicaid DSH Report"). The Medicaid DSH Report must consist of twenty specific data elements for each PA hospital that received a DSH payment[2]. In addition, the Medicaid DSH Report must undergo an independent certified audit[3].

DHS annually prepares the Medicaid DSH Report as required by Section 1923 of the Social Security Act[4]. The Medicaid DSH Report utilizes Fee-for-Service (FFS) claim and Managed Care Organization (MCO) encounter data submitted to the Medicaid Management Information System (MMIS)[5] in combination with uncompensated care charges and revenues for the Medicaid State Plan Rate Year (SPRY) under review. The audited Medicaid DSH Report is due to CMS no later than December 31 of the Federal Fiscal Year (FFY) ending three years from the Medicaid SPRY under review[6]. For example, the audited Medicaid DSH Report for Medicaid SPRY 2011 was due to CMS by December 31, 2014.

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

No. DHS has submitted audited Medicaid DSH Reports, as required by CMS, for Medicaid SPRYs 2005 through 2018. Findings for Medicaid SPRYs 2005 through 2010 were subject to transition provisions and were given weight only to the extent that they drew into question the reasonableness of states' uncompensated care cost estimates used for calculating of prospective DSH payments for Medicaid SPRY 2011 and thereafter[7].

These Medicaid DSH reports can be accessed on CMS' website at https://www.medicaid.gov/medicaid/finance/dsh/index.html, under the *Annual DSH Reports* heading.

[1] See 42 C.F.R. §447.299(c).
[2] See *id*.
[3] See 42 C.F.R. Part 455 Subpart D.
[4] See 42 U.S.C. §1396r-4(j).
[5] PA's MMIS implementation is PROMISe.
[6] See 42 C.F.R. §455.304(b).
[7] See 42 C.F.R. §455.304(e).

Beginning with Medicaid SPRY 2011, Federal Financial Participation (FFP)[8] was no longer available for DSH expenditures that are found, through the independent certified audit, to exceed the hospital-specific uncompensated care cost limit[9]. The hospital-specific uncompensated care cost limit is also referred to as a hospital's "Upper Payment Limit" or "UPL."

3. **Who performs the audit of the Medicaid DSH Report for PA?**

   Audits for Medicaid SPRYs 2005 through 2011 Medicaid 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 audited hospitals and was therefore eligible to perform the audit.

   DHS contracted Maher Duessel as the independent auditor for the Medicaid SPRYs 2012, 2013, 2014, 2015, 2016, 2017, and 2018 Medicaid DSH Reports.

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

   Historically, hospitals selected for audit have been notified by email directly from the independent auditor. If email communication proves unsuccessful, the independent auditor will follow up with phone calls or via US Mail.

5. **What is DSH UPL? What is the difference between the Medicaid DSH Report and the Prospective DSH UPL process?**

   DSH UPL is a federally-imposed limit on the amount of DSH payments hospitals may receive[10]. A hospital's DSH payments may not exceed the hospital's costs incurred by furnishing services to Medicaid patients and uninsured patients during the year, less other Medicaid revenues, and revenues received from uninsured patients[11].

   DHS reviews each hospital's DSH limit in two separate processes:

   Retrospective DSH UPL Analyses: The Retrospective DSH UPL analyses are derived from the Medicaid DSH Report using actual, experienced charges and related revenues to calculate the actual uncompensated costs in the Medicaid SPRY period under review. DHS annually provides Hospital-Specific Retrospective DSH UPL Analyses to those hospitals determined in the Medicaid DSH Report through the audit to have exceeded their Retrospective DSH UPL.

[8]For more information on FFP, please reference the following information from CMS: https://www.medicaid.gov/medicaid/finance/.
[9] See 42 C.F.R. §455.304(a)(2).
[10] See 42 U.S.C. §1396r-4(g).
[11] See 73 FR 77904 and 79 FR 71679-71694.

Prospective DSH UPL Analyses: The Hospital-Specific Prospective DSH UPL Analyses are an estimate of uncompensated care costs and related revenues prepared annually by DHS for each disproportionate share hospital. This analysis uses historical utilization and financial data from the most recent Medicaid DSH Report and trends the data forward to estimate uncompensated care costs and related revenues for the current State Fiscal Year (SFY). DHS utilizes the Hospital-Specific Prospective DSH UPL Analyses to limit DSH payments in excess of estimated hospital uncompensated care costs for the SFY under review. Hospitals potentially qualifying to receive DSH payments that are projected to exceed the hospital's Prospective DSH UPL are notified and provided an opportunity to submit additional information to better estimate uncompensated care costs and related revenues for the SFY under review.

6. **How does CMS' December 31, 2018 rescission of FAQs 33 and 34 impact the Medicaid SPRY 2018 Medicaid DSH Report[12]?**

   DHS intends to include third-party payments in calculating the UPL for the Medicaid SPRY 2019 Medicaid DSH Report in accordance with CMS' final rule 82 FR 16114 effective June 2, 2017.[13]

7. **What does "federalizing" mean?**

   Many PA MA payments are jointly funded by the federal and state governments through the Medicaid program. The federal government pays states for a specified percentage of some Medicaid expenditures, referred to as the "Federal Medical Assistance Percentage" (FMAP)[14] or FFP. States may claim FFP in accordance with their CMS-approved Medicaid State Plan[15].

   During each SFY, DHS periodically processes lump-sum DSH and supplemental payments. DSH payments include General Assistance (GA) DSH payments, authorized for FFP through PA's CMS-approved Medicaid State Plan[16], and made directly by DHS or by MCOs.

[12] See https://content.govdelivery.com/accounts/USCMSMEDICAID/bulletins/2258940.
[13] https://www.govinfo.gov/content/pkg/FR-2017-04-03/pdf/2017-06538.pdf
[14] "Financing & Reimbursement | Medicaid.gov." *Financing & Reimbursement | Medicaid.gov*. N.p., n.d. Web. 06 Nov. 2014.
[15] Pennsylvania's Medicaid State Plan is available from DHS Bureau of Policy, Analysis and Planning at: https://www.dhs.pa.gov/docs/Publications/Pages/Medicaid-State-Plan.aspx.
[16] State Plan Amendment (SPA) 4.19A pp. 25-26. Approved by CMS on October 12, 1995. Effective October 30, 1994.

8. What are "hospital services"?

CMS directs that states' approved Medicaid State Plans define which services are "hospital services."[17] PA's Medicaid State Plan classifies hospital services as those services billable by a hospital provider type and contains payment methodology for inpatient hospital services under SPA 4.19A p. 1 and outpatient hospital services under 4.19B p. 3[18]. Hospital service locations are enrolled in MMIS, and MMIS codes FFS claims and MCO encounters submitted for that location by type – both in accordance with these definitions.

9. Which patients are considered "uninsured"?

For Medicaid DSH UPL calculation purposes, patients with no source of third-party coverage for the hospital services they receive are considered "uninsured." Further, non-Medicaid patients covered by PA MA or local governmental programs are also considered uninsured. This includes self-pay and underinsured patients as well as patients covered by GA. For a detailed definition, please refer to CMS's December 3, 2014 Final Rule[19].

10. Which patients are "underinsured"?

CMS' December 3, 2014 Final Rule[20] provides a detailed definition of "underinsured." In general, if a patient does not have insurance coverage for the specific hospital service provided, the charges for the service should be treated as an uninsured charge and any payment received from the patient (there would be no payment from insurance) should be reported as payment for an uninsured person.

11. What is "GA"?

GA is a category of PA MA for persons not eligible under a Medicaid category[21]. For Medicaid DSH UPL calculation purposes, allowable charges associated with GA beneficiaries are considered uninsured charges. Revenues received by hospitals on behalf of those GA beneficiaries are not used to offset costs to determine the Medicaid DSH UPL per CMS regulations[22], except to the extent that DHS later claims FFP on those state expenditures. Please note: Not all revenues relating to GA beneficiaries are used in determining eligibility for FFP. The "GA" MA category and patient population are NOT interchangeable with "GA DSH."

[17] See 73 FR 77903-77952.
[18] State Plan Amendment 4.19B p.3 references the MA Fee Schedule, which is available on DHS' website at: https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/MA-Fee-Schedule.aspx.
[19] See 79 FR 71679-71694.
[20] See *id*.
[21] See 55 Pa. Code §1101.21.
[22] See 42 C.F.R. §447.299(c)(12).

12. What is "GA DSH"?

"GA DSH" is a distinct DSH program under PA's Medicaid State Plan which authorizes FFP for qualified GA expenditures[23]. These federalized payments, received by hospitals and associated with GA beneficiaries, are DSH payments. As with other DSH payments, the GA payments eligible for FFP are reported to CMS according to the Medicaid SPRY in which payments were processed, and not the periods to which data underlying the payments pertains.

Please note: "GA DSH" is a distinct program from the "GA" MA category and patient population. Therefore, "GA DSH" is NOT interchangeable with "GA."

13. How do "GA" and "GA DSH" differ?

GA and GA DSH are separate and distinct programs with different authority and different funding sources. GA DSH payments are based upon GA expenditures, but not all GA expenditures are reflected in GA DSH payments. When GA expenditures qualify for FFP, PA claims the FFP under the authority of the Medicaid State Plan and the state funds and federal matching funds claimed constitute a DSH payment, which DHS must include on the Medicaid DSH Report. GA expenditures that do not qualify for FFP, or for which CMS denies reimbursement, retain their non-DSH character and are counted in the DSH Report as noted in FAQ #9.

14. What information sources does DHS use to compile the Medicaid DSH Report?

The Medicaid DSH Report includes charges[24] and revenues for Medicaid patients[25]. DHS utilizes a variety of data sources to compile the Medicaid DSH Report.

Medicaid FFS and MCO Charges and Revenues (including dual-eligible patients): DHS utilizes paid FFS claim and paid MCO encounter information from MMIS to identify Medicaid charges and revenues.

Please note: all FFS claims and MCO encounters with dates of discharge within the Medicaid SPRY under review are evaluated for inclusion, however only those FFS claims and MCO encounters which qualify as "hospital services" are included in the Medicaid DSH Report[26].

[23] See SPA 4.19A pp. 25-26, *supra*.
[24] Costs are estimated by applying a Cost-to-Charge Ratio (CCR) to charges.
[25] Also referred to as "Title XIX Patients". See 42 U.S.C. 1396 *et. seq.*
[26] See FAQ #8, *supra*.

Uninsured Charges and Revenues: For Medicaid DSH Report purposes, patients with no source of third-party coverage for the hospital services they receive are considered uninsured.[27] This includes self-pay patients, underinsured patients, and GA beneficiary patients. DHS identifies the portion of uninsured charges and revenues that are related to GA from MMIS, however, DHS cannot separately identify the self-pay and underinsured portions of uninsured charges and revenues as described in FAQ #22.

Cost-to-Charge Ratios (CCRs)
DHS will utilize the hospital's Medicare Cost Report to derive cost-center-specific CCRs. DHS will apply these CCRs to charges to estimate costs for Medicaid DSH Report purposes.

Medicare Crosswalk
DHS will utilize the Medicare Crosswalk released with the SFY 2018-2019 Medicaid DSH Report Survey for pricing and aggregating FFS claims and MCO encounters within twenty-two cost centers. Both FFS claims and MCO encounters will be processed through the crosswalk according to hospital-specific cost center CCRs[28].

15. If DHS is utilizing paid FFS claims and paid MCO encounters, how are Out-of-State (OOS) patients incorporated into the Medicaid DSH Report?

DHS utilizes paid FFS claims and MCO encounters from MMIS. The paid FFS claims and MCO encounters do not include OOS charges or revenue. Hospitals must separately provide OOS FFS and OOS MCO inpatient and outpatient charges as recorded within the hospital's accounting records on the SFY 2018-2019 Medicaid DSH Report Survey. Hospitals should report for claims within the period based on the date of discharge. Supporting documentation is not required with the SFY 2018-2019 Medicaid DSH Report Survey submission, however, hospitals should retain supporting documentation for audit purposes.

16. There is an error on my hospital's Medicare Cost Report. How can the error be corrected?

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

17. How will DHS include hospitals that are not required to file Medicare Cost Reports in the Medicaid DSH Report?

DHS will utilize data from the PA Medicaid Cost Report for hospitals that are not required to file Medicare Cost Reports.

[27] See 42 C.F.R. 447.299(c).
[28] Blended CCRs are calculated for hospitals with a Medicare Cost Reporting period that substantially differs from the Medicaid SPRY.

18. There is an error on my hospital's PA Medicaid Cost Report. How can the error be corrected?

Beginning with the Medicaid SPRY 2014 Medicaid DSH Report, CMS required DHS to utilize the Medicare Cost Report as the basis of the Medicaid DSH Report. DHS utilizes the PA Medicaid Cost Report for hospitals that are not required to file a Medicare Cost Report. If these hospitals wish to amend their PA Medicaid Cost Report, the hospital may send an email clearly noting all the requested changes to RA-pwdshpymt@pa.gov, **Subject: "[Hospital Name] SFY 2018-2019 PA Medicaid Cost Report Change Request"**. DHS will review the request and contact the hospital to discuss incorporating the request through the iPACRS system.

19. How do hospitals know the amount of DSH payments they received for a given SFY?

Disproportionate Share Hospitals may receive Medicaid DSH payments via one or more PA MA DSH payment programs. Some individual payments are easily recognized as DSH payments, while others, particularly GA DSH, may be more difficult to recognize as DSH payments.

The table below lists all the DSH payment programs in SFY 2018-2019. DHS provides a record of these payments, including the date and amount disbursed, on weekly Remittance Advice (RA) statements[29].

DSH Payment Program Name	DSH Payment Program RA Description
Inpatient DSH	INP DISPROPORTIONATE SHARE
Community Access Fund (CAF)	COMMUNITY ACCESS PMTS
Burn DSH	BURN CENTER DSH
Critical Access Hospital (CAH)	CRITICAL ACCESS DSH
Hospital Enhanced DSH	HOS ENHANCED DSH
Small & Sole Community Hospital	SMALL/SOLE COMM HOSP DSH
Act 77 Tobacco DSH	TOBACCO UNCOMP CARE PYMT
	TOBACCO EXTRORDY PYMT
Trauma DSH	TRAUMA LEVEL I & II
	TRAUMA LEVEL III
Additional Class of DSH	CLEFT PALATE
	IMPOVERISHED AREA DSH
	LESS URBAN ACCESS DSH
	LOW COMMERCIAL PAYOR RATIO DSH
	PHYSICIAN PRACTICE PLANS DSH
	UNDERSERVED AREA DSH
	ENHANCED ACCESS TO CARE

[29] Please reference https://www.dhs.pa.gov/providers/Quick-Tips/Documents/Qtip%207.pdf for an explanation of the information provided within an RA statement. To request a duplicate RA or access an RA online, please follow the instructions provided at https://www.dhs.pa.gov/providers/FAQs/Pages/Checks-Payment-Remittance-FAQ.aspx.

	HIGH VOLUME MA DSH
OB/NICU	OB/NICU DISPROP SHARE PMTS
Psychiatric Medical Education	PSYCH MED ED PAYMT
Academic Medical Center	ACADEMIC MED CTR DSH PYMT
	ACAD MED DSH, LESS URBAN
	HIGH VOLUME COMPREHENSIVE DSH
	INDEPENDENT AMC DSH
	RURAL ACAD MED ED DSH
	REGIONAL ACAD MED ED
Enhanced ER Access	ENHANCED ER DSH
GA DSH[30]	Individual FFS Claim Detail

20. What is the SFY 2018-2019 Medicaid DSH Report Survey? Why is my hospital required to complete one?

The SFY 2018-2019 Medicaid DSH Report Survey is a one-page form that DHS requests hospitals to complete and return via email. The SFY 2018-2019 Medicaid DSH Report Survey is designed to capture data elements for the Medicaid DSH Report that DHS is unable to determine from the FFS claims and MCO encounters retrieved from MMIS (e.g. self-pay, uninsured, and underinsured charges and revenues, OOS charges and revenues, local and county government programs, and how hospitals treated their assessment obligations).

DHS will send the SFY 2018-2019 Medicaid DSH Report Survey directly to hospitals via email. Hospitals are afforded two weeks to complete the SFY 2018-2019 Medicaid DSH Report Survey and return it to DHS. Hospitals should report data derived from claims records determined to be within the period based on discharge date. DHS requires all hospitals subject to inclusion in the Medicaid DSH Report to complete the SFY 2018-2019 Medicaid DSH Report Survey. Failure to complete an SFY 2018-2019 Medicaid DSH Report Survey will result in zero values for the data elements captured by the SFY 2018-2019 Medicaid DSH Report Survey.

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

CMS regulations require the Medicaid DSH Report to include costs incurred and revenues received by hospitals for OOS Medicaid patients[31]. Following CMS' "General

[30] 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, https://www.dhs.pa.gov/providers/Quick-Tips/Documents/11%20-%20The%20Eligibility%20Verification%20System%20(EVS).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: https://www.dhs.pa.gov/contact/Pages/MA-Providers-Contact.aspx).

[31] See 42 C.F.R. §447.299(c).

DSH Audit and Reporting Protocol"[32], "Additional Information on the DSH Reporting and Audit Requirements (Part 1)"[33], and "Additional Information on the DSH Reporting and Audit Requirements (Part 2)"[34], DHS utilizes MMIS as the source for PA MA FFS and PA MA MCO charges and revenues. DHS' MMIS captures information related solely to PA MA beneficiaries, therefore, DHS is requesting hospitals provide information specific to OOS FFS, OOS MCO, and OOS dual-eligible beneficiaries.

22. Why is DHS asking for information specific to the underinsured patients?

While lines 16 and 17 of the SFY 2018-2019 PA Medicaid Cost Report, Schedule S-7, Part I relate to self-pay and uninsured charges and revenues, the reported amounts may include elements of charity care that do not qualify for inclusion under CMS guidelines. Relatedly, charges and revenues associated with patients with insurance, but no coverage for the specific service received ("underinsured"[35]) are permitted but may not have been reported on the Schedule S-7.

23. How will DHS determine uninsured costs using the information provided on the SFY 2017-2018 Medicaid DSH Report Survey?

DHS will apply a blended CCR to the total uninsured and self-pay charges reported on the SFY 2018-2019 Medicaid DSH Report Survey.

24. Does DHS utilize denied FFS claims or denied MCO encounters when compiling the Medicaid DSH Report?

Denied FFS claims and encounters submitted for MCO-denied claims are not costs to treat Medicaid patients and therefore are not utilized in the Medicaid DSH Report.

25. How will DHS treat $0-paid FFS claims and $0-paid MCO encounters in the Medicaid DSH Report?

DHS includes $0-paid FFS claims and $0-paid MCO encounters filed in MMIS in the Medicaid DSH Report. MMIS is the source for all FFS claim and MCO encounter data extraction. All FFS claims and MCO encounters should be filed to MMIS, including those anticipated to pay $0.

[32] https://downloads.cms.gov/cmsgov/archived-downloads/MedicaidGenInfo/downloads/CMS2198FRptProtocol.pdf

[33] https://www.medicaid.gov/medicaid/downloads/part-1-additional-info-on-dsh-reporting-and-auditing.pdf

[34] https://www.medicaid.gov/medicaid/downloads/part-2-additional-info-on-dsh-reporting-and-auditing.pdf

[35] See FAQ #10, *supra*.

26. How will DHS treat unbilled Medicare Part C charges for dual eligible patients?

CMS requires DHS to utilize MMIS as the data source for FFS claims and MCO encounters included in the Medicaid DSH Report. Hospitals must submit all FFS claims, and MCOs must submit all encounters, to MMIS, even if they anticipate they will be $0-paid.

27. Will DHS utilize the Ratio of Cost-to-Charges (RCCs) on Worksheet C of the Medicare Cost Report for the Medicaid DSH Report, or will DHS utilize other Medicare Cost Report Worksheets to calculate CCRs for the Medicaid DSH Report?

DHS intends to utilize Medicare Cost Report Worksheets other than Worksheet C to determine CCRs for the Medicaid DSH Report. DHS will utilize the costs contained in the Medicare Cost Report to calculate a CCR for the twenty-two cost centers DHS identified.

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

For each cost center on Worksheet C Part I, costs from Column 5 are added together with cost center specific Medical Education costs from Worksheet B Part I, Column 21 (Intern & Resident Salary & Fringes) and Column 22 (Intern & Resident Program Costs) to determine total costs (including Medical Education). If subscripted Medical Education cost centers are reported, they are rolled up into the main cost center (i.e. 21.01 is rolled up into 21; 22.01 is rolled up into 22). 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 cost center categories. Costs and charges in each consolidated cost center are subtotaled, then the CCRs for the twenty-two consolidated cost centers are calculated by dividing total costs by total charges.

29. The Medicare Cost Report contains a Reasonable Compensation Equivalent (RCE) Disallowance adjustment on Schedule A-8-2. This adjustment is not part of the PA Medicaid Cost Report. Will DHS remove the RCE Disallowance from the Medicaid DSH Report?

The RCE Disallowance is an adjustment to costs applied by Medicare on Schedule A-8-2 that is not included in the calculation of Medicare Cost Report RCC factors for the Worksheet C Schedules. Therefore, the DSH Limit calculations will not include any RCE limitations.

30. How did DHS determine the twenty-two cost center groupings?

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

31. How will DHS treat costs not directly captured in the twenty-two cost centers?

DHS will utilize the Medicare Crosswalk to price FFS claims and MCO encounters. Hospitals will have an opportunity to provide additional information during the thirty-day preliminary review period. DHS will make cost center and revenue code groupings ("crosswalks") available online.

32. How will DHS calculate the "ungroupable" CCR (i.e. the twenty-third CCR)

The calculation is as follows:

Sum of costs in cost centers 1 through 22
Divided by
Sum of charges in cost centers 1 through 22

33. Will DHS use charity care charges from the PA Medicaid Cost Report as uninsured charges?

No. Section 1923(g) of the Social Security Act sets forth the allowable costs for inclusion in the Medicaid DSH Report. Costs for hospital services associated with uncompensated Medicaid costs and uncompensated costs of hospital services provided to individuals without health insurance. Conversely, "Charity Care" is a term used by hospitals to describe an individual hospital's program of providing care for free, or at reduced charges, to those patients that qualify for that hospital's program.

Charges associated with the uninsured patients 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 charges qualify for inclusion in the Medicaid DSH Report. To the extent that hospitals do not separately identify uncompensated care related to services provided to patients with no source of third-party coverage, hospitals will need to modify their accounting systems to do so. Hospitals must also ensure no duplication of such charges in their accounting records[36].

[36] 73 FR 77911.

34. How does DHS treat bad debt in the Medicaid DSH Report?

Bad debt is not included in the Medicaid DSH Report.

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."[37]

35. How does DHS treat the Statewide Quality Care Assessment (QCA) and Philadelphia Hospital Assessment (PHA) costs allocated to the Medicaid and uninsured patient costs?

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

36. How does DHS treat the QCA and PHA in the Medicaid DSH Report?

DHS is requesting that hospitals indicate on the SFY 2017-2018 Medicaid DSH Report Survey whether they paid an assessment, how much assessment they paid, and how much assessment cost remains in both the Medicare and PA Medicaid Cost Reports after reclassification adjustments.

If a hospital did not report the assessment amount paid as a cost on its Medicare Cost Report, then the hospital should indicate in the SFY 2018-2019 Medicaid DSH Report Survey how the assessment cost was treated in the hospital's accounting records. Supporting documentation is not required with the SFY 2018-2019 Medicaid DSH Report Survey submission, however, hospitals should retain supporting documentation for audit purposes.

37. How will DHS treat Provider-Based Physician (PBP) adjustments to revenue?

DHS will not apply a broad-based adjustment for PBP revenue. If a hospital believes that a hospital-specific PBP adjustment is reasonable, the hospital should submit the following to DHS:

- The calculated amount of the requested adjustment to PA MA revenues;

[37] See 73 FR 77909.

- Supporting documentation, including:
  - a written explanation of the methodology used to compute the proposed adjustment;
  - the instances when bundled revenues for physician and hospital services are paid by the MCO to the hospital; and
  - a copy of the PA Medicaid Cost Report, Schedule A-4 for the PA Medicaid Cost Reporting period under review.
- The hospital must provide source documentation related to this adjustment upon request by DHS or the independent auditor.

If a hospital believes this adjustment is reasonable, it should present the adjustment to DHS as part of the thirty-day preliminary review period.

38. Will DHS provide hospitals with hospital-specific supporting data and calculations used to prepare the Medicaid DSH Report?

DHS will provide a Hospital-Specific Retrospective DSH UPL Analysis, derived from the Medicaid DSH Report, to hospitals determined to have received DSH payments in excess of their hospital-specific Retrospective DSH UPL. As was the case with Medicaid SPRYs 2014, 2015, 2016, 2017 and 2018 the Hospital-Specific Retrospective DSH Analysis will group Medicaid SPRY 2019 hospital charges by cost center, FFS separate from MCO, inpatient separate from outpatient, dual eligible separate from non-dual eligible, and GA separate from non-GA.

In addition to the Hospital-Specific Retrospective DSH UPL Analysis, DHS will provide hospitals determined to have received DSH payments in excess of their hospital-specific Retrospective DSH UPL with detailed listings of FFS claims and MCO encounters that were included in the analyses[38]. DHS will continue to include patient identification numbers to facilitate hospitals with cross-referencing the data.

39. Will my hospital have an opportunity to review a hospital-specific Retrospective DSH UPL analysis prior to DHS notification of a final determination or outcome?

As the Medicaid DSH Report determines if DSH Payments were made in excess of the hospital-specific Retrospective DSH UPL, DHS will provide hospitals determined to have DSH payments in excess of their retrospective hospital-specific DSH UPL a thirty-day preliminary review period to review their hospital-specific Retrospective DSH UPL analysis and submit additional information for the Medicaid SPRY under review. The thirty-day preliminary review period will begin prior to DHS submitting the Medicaid DSH Report for audit. Once the preliminary review period has closed, DHS will incorporate acceptable changes and submit the Medicaid DSH Report for audit.

[38] Consistent with DHS' effort to meet CMS' requirement that MMIS is the source of FFS claim and MCO encounter data, the listings are extracted exactly as the hospital or MCO entered them in the MMIS system.

40. When will DHS notify hospitals of a final determination or outcome?

DHS will notify hospitals determined to have received DSH payments in excess of their hospital-specific Retrospective DSH UPL in writing and via email, after submitting the Medicaid DSH Report to CMS. The notice will require return of overpaid funds within thirty days of the date on the letter. Specific appeal rights and repayment procedures are detailed in the notification sent to hospitals.

41. When will hospitals that received DSH Payments in excess of their hospital-specific Retrospective DSH UPL be required to return overpaid DSH funds?

Irrespective of whether hospitals appeal the final determination[39], hospitals are required to repay the excess DSH funds within thirty calendar days of DHS' written notice. Hospitals' failure to remit payment within thirty days will result in credit gross adjustments in the amount of the overpaid DSH funds.

42. Who can I contact with additional questions?

Please email additional questions to RA-pwdshpymt@pa.gov **Subject: "[Hospital Name] Medicaid SPRY 2019 Medicaid DSH Report Question(s)"**.

43. What resources are available related to the Medicaid DSH Report and reporting requirements for states, hospitals, and auditors?

Section 1923 of the Social Security Act:
http://www.ssa.gov/OP_Home/ssact/title19/1923.htm

December 19, 2008 DSH Audit and Reporting Final Rule
http://www.gpo.gov/fdsys/pkg/FR-2008-12-19/pdf/E8-30000.pdf

April 24, 2009 DSH Audit and Reporting Rule Correcting Amendment
http://www.gpo.gov/fdsys/pkg/FR-2009-04-24/pdf/E9-9232.pdf

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://downloads.cms.gov/cmsgov/archived-downloads/MedicaidGenInfo/downloads/CMS2198FRptProtocol.pdf

[39] See 55 Pa. Code §41.51.

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

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