General DSH Audit and Reporting Protocol

Areas of Responsibility

States:

1. States are responsible for obtaining the independent audit on an annual basis
   - In response to the statutory language, "independent," audits must be certified by Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency and the subject hospitals. States may not rely on non-CPA firms, fiscal intermediary, independent certification programs currently in place to audit UCC, nor expand hospital financial statements to obtain audit certification of the hospital specific DSH limits.
   - The Single State Audit is an Office of Inspector General process. Although there may be some overlap in resources used to complete both audits, the DSH Audit is particular to Medicaid and is the sole responsibility of CMS to enforce and monitor and thus cannot be combined within the Single State Audit Act.
2. Providing the auditor and the DSH hospitals subject to audit with instructions on the data elements necessary to insure compliance
   - The DSH audit will rely on existing cost reporting tools and documents as primary sources for the data necessary to evaluate DSH payments against hospital specific DSH costs. Two of the primary source documents are the Medicare 2552-96 hospital cost report and audited hospital financial statements (and other auditable hospital accounting records). Rather than requiring that states or hospitals create new documents and potentially new financial standards, CMS will rely on the financial standards that apply to the use of these documents in their current form. Any hospital participating in the Medicare program already completes the Medicare 2552-96 cost report and is familiar with the accounting standards applicable to this document. Similarly, hospital financial statements are subject to certain financial reporting standards to produce the information that will be used in the DSH audit. Each of these documents will produce data used to develop cost and payment information for the DSH audit using the financial reporting standards applicable to each.
   - Developing audit protocol for use by DSH hospitals to determine costs. This protocol 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 State plan rate year. Situations in which a hospitals fiscal year does not coincide with the Medicaid State plan rate year, hospitals will need to provide the two (or more, if there are short-period, i.e., less than twelve-month, cost reports involved)

overlapping cost reports and financial statements and other auditable hospital accounting records to properly reflect cost incurred during the full State Plan rate year.

3. Provide DSH hospitals and auditor with fee for service (FFS) Medicaid IP and OP hospital days and charges based on Medicaid Management Information System (MMIS) data for the cost reporting period(s) covering the Medicaid State plan rate year under audit.
4. Provide DSH hospitals and auditor with all information related to IP/OP hospital regular Medicaid rate payments (including all rate add-ons), all Medicaid supplemental and enhanced payments, and all DSH payments made to each DSH hospital for the cost reporting year(s) covering the State plan rate year.
5. Provide auditor with methodologies utilized by the State to determine DSH eligible hospitals under the Medicaid State plan (LIUR, MIUR, Other) and payment methodologies used to generate DSH payments under the approved Medicaid State plan.
6. Provide auditor with hospital-generated IP/OP hospital cost report information; Medicaid managed care IP/OP hospital days, charges, and payment information; and uninsured IP/OP hospital days, charges, and payment information received from DSH hospitals.
7. Report the findings of the audit to CMS within 90 days of receiving audit. In recognition of timing issues related to initiating the audit process. States may concurrently complete the Medicaid State plan rate year 2005 and 2006 audits by September 30, 2009. The report associated with Medicaid State plan rate years 2005 and 2006 are due no later than December 31, 2009 to CMS.
8. Use audit findings for rate year 2005 – 2010 to prospectively adjust DSH payments beginning with Medicaid State plan rate year 2011.
9. Use audit findings for rate year 2011 to determine over/underpayments (final report available in 2014).

DSH Hospitals:

1. Use the Medicare 2552-96 hospital cost report to determine cost center specific routine per diems and ancillary ratios of cost to charges (RCC) based on Medicare Cost Principles (Medicare cost allocation process).
2. Utilize MMIS data provided by the state for Medicaid FFS IP/OP hospital ancillary charges and Medicaid FFS IP hospital routine days.
3. Utilize hospital financial statements and other auditable hospital accounting records as source for IP/OP hospital Medicaid managed care ancillary charges and routine days and IP/OP hospital uninsured ancillary charges and routine days (individuals with no source of third party coverage). These charges and days will be used with cost center specific RCCs and per diems, respectively, to allocate hospital costs to each relevant payer category described above.
4. Utilize revenue information from financial statements and other auditable hospital accounting records to identify payments made by or on behalf of patients with no

source of third party coverage for IP/OP hospital services. Note that payments for IP/OP hospital services from state-only or local-only programs for the uninsured should not be included as revenues.

5. Utilize revenue information from financial statements and other auditable hospital accounting records to identify Medicaid payments not directly paid by the State in which the hospital is located, including all IP/OP Title XIX payments from other States (regular, supplemental and enhanced and DSH), all payments from Medicaid managed care organizations for IP/OP hospital services provided to Medicaid MCO enrollees, and all payments from other non-State sources for Medicaid IP/OP hospital services.
6. Provide state with hospital specific cost and revenue data, including backup documentation, so that independent auditor may utilize in developing audit report. Continue to provide state information already required to determine DSH qualifications (LIUR, MIUR, other).

Auditor:

1. Review State's methodology for estimating hospital's OBRA 1993 hospital-specific DSH limit and the State's DSH payment methodologies in the approved Medicaid State plan for the State plan rate year under audit.
2. Review state's DSH audit protocol to ensure consistency with IP/OP Medicaid reimbursable services in the approved Medicaid State plan. Review DSH audit protocol to ensure that only costs eligible for DSH payments are included in the development of the hospital specific DSH limit.
3. Compile hospital specific IP/OP cost report data and IP/OP revenue data to measure hospital specific DSH limit in auditable year. In determining this limit, the auditor must measure both components of the hospital specific DSH limit. To determine the existence of a Medicaid shortfall, Medicaid IP/OP hospital costs (including Medicaid managed care costs) must be measured against Medicaid IP/OP revenue received for such services in the audited State Plan rate year (including regular Medicaid rate payments, add-ons, supplemental and enhanced payments and Medicaid managed care revenues). Costs associated with patients with no source of third party coverage must be reduced by applicable revenues and added to any Medicaid shortfall to determine total eligible DSH costs.
4. Compile total DSH payments made in auditable year to each qualifying hospital (including DSH payments received by the hospitals from other States).
5. Compare hospital specific DSH costs limits against hospital specific total DSH payments in the audited Medicaid State plan rate year. Summarize findings identifying any overpayments/underpayments to particular hospitals.

Data Sources:

The following are to be considered the primary data sources utilized by states, hospitals and the independent auditors to complete the DSH audit and the accompanying report. In many instances, hospital financial and cost report periods will differ from the Medicaid

State plan rate year. In these instances, hospitals should use multiple audited financial reports and hospital cost reports to fully cover the Medicaid State plan rate year under audit. The data should be directly allocated based on the months covered by the financial or cost reporting period that directly related to the Medicaid State plan period under audit. For instance, if a Medicaid State plan rate year runs from 7/1/04 to 6/30/05 but a DSH hospital receiving payments under the Medicaid State plan operates its financial and cost reporting based on a calendar year, the hospital would need to use financial and cost reports for calendar years 2004 and 2005. The hospital would allocate 50% of all costs and revenues in each financial and cost reporting period to determine costs and revenues associated with the Medicaid State plan rate year 2005.

1. MMIS Data

- State MMIS generated IP hospital payments, ancillary charges and routine days for the cost reporting period(s) covering the Medicaid State plan rate year under audit for each DSH hospital.
- State MMIS generated OP hospital payments and ancillary charges for the cost reporting period(s) covering the Medicaid State plan rate year under audit for each DSH hospital.

2. Approved Medicaid State Plan

- LIUR, MIUR or other DSH hospital determination criteria and data used to determine eligibility for the Medicaid State plan rate year under audit.
- Medicaid State Plan DSH payment methodologies for the Medicaid State plan rate year under audit.
- State DSH payments to each DSH hospital for the Medicaid State plan rate year under audit.
- State methodology for determining the hospital-specific DSH limit, the data used to determine such limit and the hospital-specific cost limit generated by methodology and data for the Medicaid State plan rate year under audit.

3. Medicare 2552-96 Hospital Cost Report

- Medicare 2552-96 hospital cost report(s) for the Medicaid State plan rate year under audit (finalized when available, or as filed).

4. Audited Hospital Financial Statements and Other Auditable Hospital Accounting Records

- Hospital revenues from Medicaid managed care organizations, Medicaid payments from other States (regular payments including add-ons, supplemental and enhanced payments, DSH payments), and Medicaid IP/OP hospital payments from all sources other than the State from hospital financial reports and records for the cost reporting period(s) covering the Medicaid State plan rate year under audit.
- Hospital revenues from or on behalf of with no source of third party coverage for the hospital services provided.

- Days and charges for IP/OP Medicaid hospital services for services provided to out of state Medicaid patients.
- Days and charges for IP/OP hospital services provided to patients with no source of third party coverage for the hospital services provided.
- Days and charges for IP/OP hospital services provided to Medicaid managed care patients.

General Cost Determination: Uncompensated Care Cost Determination

Hospitals must use the Medicare 2552-96 Hospital Cost Report(s) for the Medicaid State plan rate year to determine allowable IP/OP Medicaid service costs and costs of providing IP/OP hospital services to patients with no source of third party coverage for the hospital services provided.

The Medicare cost allocation process will be used to determine facility costs for inclusion in determining DSH eligible hospital costs. In order to provide complete financial information for the Medicaid State plan rate year under audit, hospitals must use two or more Medicare costs reports if the cost reporting period does not correspond with the Medicaid State plan rate year under audit. Once costs are allocated according to the Medicare cost allocation process, those costs should be allocated to the Medicaid State plan rate year on a pro-rata basis to develop 12 full months of costs.

1. Hospitals determine IP FFS Medicaid costs
   Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a per diem is computed for each routine cost center, and a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each routine cost center are apportioned to a specific program by applying that cost center's program days to the cost center's computed per diem, and total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

   The program data used in this apportionment process in determining hospital inpatient fee-for-service Medicaid costs are the days and charges pertaining to hospital inpatient services furnished to Medicaid fee-for-service individuals. The primary source of the program data is the MMIS. The program days and charges must pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to services paid by Title XIX fee-for-service. As required by the 2552-96

cost report apportionment process, the program data must be reported by hospital cost centers.

By applying program days defined above to the cost-report-computed per diems and applying program charges defined above to the cost report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital inpatient fee-for-service Medicaid cost

2. Hospitals determine IP Medicaid managed care costs
Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a per diem is computed for each routine cost center, and a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each routine cost center are apportioned to a specific program by applying that cost center's program days to the cost center's computed per diem, and total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital inpatient Medicaid managed care costs are the days and charges pertaining to hospital inpatient services furnished to individuals under Medicaid managed care. The program data must be derived from auditable documentation and may include reports from Medicaid managed care plans. The auditable documentation must show that the program days and charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to Title XIX services paid by the Medicaid managed care plans. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying program days defined above to the cost-report-computed per diems and applying program charges defined above to the cost-report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital inpatient Medicaid managed care cost.

3. Hospitals determine IP costs for hospital services provided to patients with no source of third party coverage
Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a per diem is computed for each routine cost

center, and a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each routine cost center are apportioned to a specific program by applying that cost center's program days to the cost center's computed per diem, and total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital uninsured inpatient costs are the days and charges pertaining to hospital inpatient services furnished to individuals who have no source of third party coverage. The program data must be derived from auditable documentation. The auditable documentation must show that the program days and charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to services furnished to individuals who have no source of third party coverage (services furnished to individuals who are covered only by state-only/local governmental programs may be included). As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying the program days defined above to the cost-report-computed per diems and applying the program charges defined above to the cost-report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital uninsured inpatient cost.

4. Hospitals determine OP FFS Medicaid costs

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital outpatient fee-for-service Medicaid costs are the charges pertaining to hospital outpatient services furnished to Medicaid fee-for-service individuals. The primary source of the program data is the MMIS. The program charges must pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to outpatient hospital services furnished and not services furnished by practitioners which can be billed separately as professional services;

and c) only to services paid by Title XIX fee-for-service. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying the program charges defined above to the cost-report-computed cost-to-charge ratios and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital outpatient fee-for-service Medicaid cost.

5. Hospitals determine OP Medicaid managed care costs

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital outpatient Medicaid managed care costs are the charges pertaining to hospital outpatient services furnished to individuals under Medicaid managed care. The program data must be derived from auditable documentation and may include reports from Medicaid managed care plans. The auditable documentation must show that the program charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to OP hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to Title XIX services paid by the Medicaid managed care plans. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying program charges defined above to the cost-report-computed cost-to-charge ratios and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital outpatient Medicaid managed care cost.

6. Hospitals determine OP costs for hospital services provided to patients with no source of third party coverage

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital uninsured outpatient costs are the charges pertaining to hospital outpatient services furnished to individuals who have no source of third party coverage. The program data must be derived from auditable documentation. The auditable documentation must show that the program charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to OP hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to services furnished to individuals who have no source of third party coverage (services furnished to individuals who are covered only by state-only/local governmental programs may be included). As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying the program charges defined above to the cost-report-computed cost-to-charge ratios and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital uninsured outpatient cost.

7. Hospital report revenues from Medicaid managed care organizations, Medicaid payments from other States (regular payments including add-ons, supplemental and enhanced payments, DSH payments), and other non-State Medicaid payments
Since the State's MMIS system will not have information about payments generated from Medicaid managed care organizations or Medicaid and DSH payments from other States and other non-State sources, hospitals must use their financial statements and other auditable hospital accounting records to identify:
   - All Medicaid managed care payments received during the cost reporting period(s) covering the Medicaid State plan rate year under audit. Any managed care payments received that include payments for services other than those that qualify for IP or OP hospital services must be separated to include that portion of the payment applicable to IP or OP hospital services. If the hospital cannot separate the component parts of a managed care payment, the full amount of the payment must be counted as in IP/OP hospital managed care payment.
   - All Medicaid payments received from out of state during the cost reporting period(s) covering the Medicaid State Plan rate year under audit. Hospitals must separately identify a) Medicaid regular rate payments (including add-ons); b) supplemental Medicaid payments, and; c) DSH payments.
   - All Medicaid payments received during the cost reporting period(s) covering the Medicaid State plan rate year under audit from non-State sources not already accounted for, including payments from or on behalf of patients for Medicaid services.

8. Hospital report revenue from or on behalf of patients with no source of third party coverage for the hospital services provided
   Since the State's MMIS system will not have information about payments by or on behalf of patients with no source of third party coverage for the hospital services provided, hospitals must use their financial statements and other auditable hospital accounting records to identify:
   - All payments received during cost reporting period(s) covering the Medicaid State plan rate year under audit by or on behalf of patients with no source of third party coverage. There will be no attempt to allocate payments received during the state plan rate year to services provided in prior periods. Since the goal of the audit is to determine uncompensated DSH costs in a given Medicaid State plan rate year, all payments received in the year will be counted as revenue to the hospital in that same year. It is understood that some costs incurred during the State Plan rate year under audit may be associated with future revenue streams (legal decisions, payment plans, recoveries) but that the payments are not counted as revenue until actually received.
   - IP or OP hospital payments received from state or local government programs for individuals with no source of third party coverage for the hospital services they received should not be included as a revenue in this category.

9. Auditor applies MMIS generated total IP/OP hospital Medicaid FFS payments (other than DSH) to total IP/OP hospital Medicaid FFS cost

10. Auditor applies IP/OP hospital Medicaid managed care revenues against IP/OP hospital Medicaid managed care costs

11. Auditor applies IP/OP hospital revenues for patients with no source of third party coverage against the costs for IP/OP hospital services provided to such individuals

12. Sum of steps 9-11 are summed to determine the total amount of costs eligible for DSH reimbursement and considered the OBRA 1993 hospital specific DSH limit

13. Compare DSH payments to the amount determined in step 12