



## Medicaid DSH Audit Frequently Asked Questions

The following questions are representative of questions accumulated during the preparation for the audit of the 2006 and 2006 Medicaid DSH hospital-specific DSH UPLs as required by the Medicaid DSH Audit Rule as published in the [December 19, 2008 Federal Register](#).

These answers are an accumulation of responses from Clifton Gunderson, investigation of the final rule and other information provided on the CMS website based on a best-effort approach of data accumulation. These answers do not necessarily represent the opinion of SCHA and SCHA accepts not responsibility as to their accuracy. CMS is preparing a listing of their own Frequently Asked Questions which will be available on the CMS website. For further information, contact [Barnev Osborne](#).

1. Can hospitals request an extension?
  - Yes, hospitals with specific challenges can request a brief extension in reporting data, but the report is a statewide report provided to CMS by DHHS after the CG audit is complete and must include all hospitals. CG cannot allow extensions that might place the entire state's report at risk. CMS has indicated that they have no intention of delaying their own December 31 deadline.
2. Can SC contract with CG as the DSH auditors while they are still performing routine Medicaid audits?
  - Per DHHS this is not a conflict.
3. Has CG indicated to CMS that they can complete the audits by year-end? If so is that realistic?
  - Per DHHS they feel that it is credible.
4. Has anyone requested an extension?
  - Not yet. Per CG, CMS is not flexible on the December 31, 2009 deadline.
5. Will there be any further action taken on the 2004 DSH audits? Will incomplete 2004 DSH audits be finalized?
  - Per DHHS No. Not outside of their routine impact on the Medicaid audit.
6. CMS plans to obtain data from Medicare Cost Reports. What if the cost report for the period is not closed?
  - Per the Fed Reg, they will use the best data available which may include unaudited cost reports. CG concurs.
7. Downloading each uninsured account payment separately will create huge files. Would CG consider choosing a sample from the original listing and allowing us to only download the detail from that sample?
  - Some hospitals would prefer a sample while others would like to "get it over" the first time. CG will not accept a sample as they will only be performing a limited number of on-site audits. Most hospital's data will be scrubbed offsite to produce potential disallowances therefore the entire file will be required.
8. Does the 1987 OBGYN exception still apply?
  - Yes. The moratorium should also apply and for small facilities, a letter from two general physicians stating that they agree to provide non-emergent OB services will suffice.
9. If a hospital "broke" the December 21, 1987 moratorium by opening and closing an OB program during the time frame, would the non-OB physician letters still suffice.
  - CG does not recognize this as a concern.
10. What is required to prove that you offer non-emergency OB SERVICES?

- CG has not given a formal response to this question, but it appears that, unless there blatant non-compliance, CG will respect SCDHHS' 05-06 determinations. They have made it clear; however that CMS may not respect this decision.
11. For most hospitals, this is state-supplied data. For hospitals with less than 100 beds, documentation of two physician(s) licensed for OB services and credential by the hospital for non-emergent OB services. Is there any exception for small hospitals – can they have only one OB.
    - No. There must be two credentialed physicians on staff that are willing to provide non-emergent OB care. For hospitals less than 100 beds, they can be general practitioners.
  12. Dropping data by individual payment will be overwhelming, are we required to list every payment made on an account.
    - Agreed and yes.
  13. If we are supplying patient payments on the detailed audit list, why are they requiring a list of all payments received during the audit period? Do they realize that the two amounts will not reconcile?
    - The listing of payments received during the period should be comparable to a cash posting report and is a balance sheet function. You are correct in that these amounts may not compare to the total of payments listed on the detail account listing because of timing. The purpose of the separate cash payments log is to track payments received to specific accounts to help verify that all payments on a specific account were included on the account log.
  14. After 2011 basing payments on a current FY will be impossible.
    - Periods after 2011 will be based on prior audited yrs prospectively and then adjusted after the completed audit of that FY very similar to the Medicaid retro adjustments. Ex. 2011 initial or interim distributions will be based on 05-06 data and redistributed or settled based on the audited 2011 data in after that audit up to three years later. This is why it is so important to supply complete and consistent data for 05 and 06 as they will determine your distributions in 2011. SCDHHS is already considering using CG's audited 06 data to distribute next year's DSH making the impact almost immediate. This is why it is so important to provide accurate data for 05 and 06 even though no retroactive adjustments will be made.
  15. Can CG functionally perform physically 150 audits before Sept 30?
    - CG only intends to perform a limited number of actual on-site audits. Most audits will consist of scrubbing the data supplied. They feel that they can complete the process in time.
  16. What if data is not available because of system changes?
    - These will have to be individual determinations. I'll assist you in taking special issues to CG if you like.
  17. Per the Final Rule "Uncompensated care charges data obtained through surveys of hospitals, and other self-reported data used for DSH determining payments and hospital-specific limits, should not be used for future DSH calculations. These charges require independent and separate verification by the auditor." Does this mean that CG will be auditing 05 data to retroactively determine 05 allocations, or are they auditing the actual data that we provided to SCDHHS to make the initial determinations?
    - Unlike the audit of Medicare bad debt where the actual account listings supplied in the cost report are audited, CG will audit Medicaid Eligible and uninsured that occur within that period after the period end. In the future they will either adjust hospitals to the actual audited amount or redistribute the funds throughout the state based on the audit results.
  18. Per the Final Rule, "While CMS recognizes that States must use estimates to determine initial DSH payments in a given Medicaid State plan rate year, section 1923(j) of the Act requires confirmation that such payments do not exceed the cost limitations imposed by Congress under the Omnibus Budget Reconciliation Act of 1993". How do they plan to develop distributions in the future if they have to use actual historical data sources?
    - Prior audit results will be applied prospectively and then audit adjusted.
  19. Per the Final Rule, "States may not calculate uncompensated care costs by using prior year data updated for inflation."
    - Does Clifton Gunderson have a proposed plan for creating "estimates"?
      - Prior audit results applied prospectively and then audit adjusted.
  20. Does the state have the option to adjust overages/underages for the years audited?
    - There is no retroactivity. 05 and 06 data is used for informational purposes and to refine the audit process. It will then, however, be used by the state to distribute 2010 funds and by CMS nationally beginning 2011.

21. If we do not comply with the September 30<sup>th</sup> deadline and lose next year's DSH will we still be required to pay the hospital tax?
  - Yes. The tax is a state law. We would have to have the law changed to avoid paying the tax.
22. If SCDHHS is required to use data from the last completed DSH audit, the data will be at least 3 years old.
  - Correct.
23. Page 77911 05 – 10 audits will not be given weight except to the extent that they impact prospective DSH payments from 2011 and forward. Does this mean that, while no settlements will be made for 04-10, audit denials will impact the calculations for DSH appropriations 2011 and after?
  - Yes. This will eventually correct itself as the 2011 DSH will be audited and redistributed to actual. Three years is allowed as hospitals taking a particularly large loss could incur cash flow problems. For hospitals with procedural or documentation problems that cannot be retroactively resolved, those procedures will have to be corrected and they lose that portion of their DSH until the first period in which the changes were made. For example, if 05-06 documentation was insufficient and they lose DSH all or part of their DSH, if the errors are not corrected until the end of 09, 2010 will be the first year that they could begin receiving funds again which will probably be resolved in 2014. DSH periods based on 05-09 (probably 2011, 2012, and 2013) would show fewer DSH qualifying accounts and therefore would receive no distributions until audited. These would require some sort of special dispensation based maybe on an appeal.
24. How must Section 1011 payments for undocumented aliens be reported? Does the state have a record of this usage?
  - Auditors reply "provider or third party source"-not sure what that means. I also can't quantify the risks.
25. The one-hour estimated time requirement mentioned by CMS in the final rule is unrealistic.
  - Agreed!
26. Is CG comfortable with SCDHHS method of determining cost by applying a prior year's CCR?
  - CG will be applying RCCs from the associated period's cost report.
27. Can we include hospital-based physician charges?
  - No. Hospital inpatient and Outpatient charges only.
28. Can we include non-professional hospital-based clinic charges?
  - This depends on the routine practices of the state in all matters as well as the historical reimbursement of the clinic. Non-professional hospital based clinic charges (such as x-rays and labs) may be allowed, but only if they have been billed as ancillaries on the hospital's provider number in the past. A very simple consideration is whether or not they have been included in the cost report in the past. These hospital specific determinations will be made by CG.
29. How will CG identify elective procedures such as cosmetic surgery?
  - This is still unknown as there is no procedural code included on the worksheets.
30. Please define Medicaid eligibles.
  - There are many definitions for Medicaid Eligibles for different programs. For the sake of this audit, CG has confirmed that "Medicaid Eligibles" are card-holding Medicaid beneficiaries on the date of service, whether or not the particular service is covered under the patients Medicaid plan.
31. If charges are not covered under a patient's commercial insurance, can they be included as Uninsured charges.
  - The prevalent answer in the Final Rule is no, they cannot be included, however CMS contradicts itself. We have posed this question to CMS.
32. Can we later send in revised/corrected reports for 05-06 before the numbers are used for 2011?
  - We have been unable to find this answer in the Federal Register and CG had no answer. This was included in the letter to CMS.
33. Does CG own the HIPAA Risks for information after it goes on their site?
  - CG had no answer
34. Will we have to identify SCHIP separately?
  - No
35. For hospitals with a FYE date other than September, does CG have to perform a full audit for FY07?
  - Yes, however the 2007 audit will not be duplicated later. Depending on their FYE, some hospitals also have to prepare 2004 reports.

36. Can we use general ledger revenue departments rather than UB revenue codes?
- CG seemed flexible as long as you can prove that the dollars end up in the correct buckets.
37. Will they adjust cost overages on commercially insured dual-eligibles?
- Commercial payments paid on Medicaid dual-eligibles that exceed costs will have a negative impact on your uninsured totals.
38. How do we record payments on accounts that have both pro fee charges and hospital charges?
- Per CG, the payment will have to be prorated between hospital and professional based on the total charges.
39. Do we include Medicare/Medicaid dual-eligibles?
- Detail on South Carolina traditional Medicare/Medicaid duals will be provided by SCDHHS. SC does not assign duals to Medicaid MCOs so this should not be an issue. SCDHHS, however does not have access to out-of-state Medicaid accounts, therefore on question 20 and 21, Medicare/Medicaid dual eligible data will have to be provided along with all other dual eligibles.
  - UPDATE: SCDHHS only has information on Inpatient dual-eligibles if there was a Medicaid payment or a 555 was issued on the account. (SCDHHS tested 3 hospitals and 20% of dual eligibles were not included because there was not payment/555 information). See #42.
40. Do all IGTs and taxes need to be included in number 26? For example do MIAP and county taxes have to be included?
- CG is only requesting a list of IGTs and taxes directly related to the state's funding of its matching funds for the Federal DSH allotment. This excludes the MIAP tax and any other state, county, or local taxes.
41. If an account has both professional fees and facility fees you can segregate the charges by revenue code, but cannot always segregate the payments. How should these be listed?
- The charges should be segregated to remove the pro fees and the payments should be apportioned between facility and pro based on pro fee charges as a percent of total.
42. We have verified with SCDHHS that information on Medicaid dual eligible accounts where either no payment was made or no 555 crossover was issued is not available to SCDHHS for their own submission to CG. This also applies to readmits within 60 days where there is no deductible, other instances where there is no Medicaid component to bill but the account is still dual eligible. Medicaid accounts that did not pay due to provider error (such as untimely filing) also fall within CMS' definition of Medicaid eligible but would not be included in the DHHS information. Can these accounts be included in the hospital-specific cap and should the hospitals prepare a separate "Medicaid Eligible' log for these accounts?

#### 43. Transfers