PUBLICATION

New Medicaid DSH Audit Guidance: Its Impact on Pending and Recent State DSH Audits

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On December 31, 2018, the Center for Medicaid and CHIP Services issued a notice indicating that CMS was altering its prior audit guidance for Medicaid Disproportionate Share Hospital (DSH) audits that had previously been issued in January 2010. In relevant part, this notice states that CMS is withdrawing Frequently Asked Question (FAQ) responses 33 and 34 from its Medicaid DSH audit guidance.

FAQs 33 and 34 directed DSH auditors to subtract Medicare and private insurance payments received on behalf of Medicaid-eligible patients from the costs of DSH hospitals' IP/OP services to Medicaid-eligible patients; this reduces the hospital-specific DSH payment limit for many DSH hospitals.

The December 31, 2018 DSH audit guidance states:

> As of December 31, 2018, and in light of four recent appellate court decisions, the Center for Medicare and Medicaid Services (CMS) is withdrawing questions 33 and 34 from the Medicaid Disproportionate Share Hospital (DSH) guidance that was issued in January 2010 titled "Additional Information on the DSH Reporting and Audit Requirements". . . .
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> As a result, questions 33 and 34 are no longer operative, and CMS will accept revised DSH audits that cover hospital services furnished before June 2, 2017. Ultimately, whether or not a state submits revised DSH audits, CMS expects states to comply with 42 C.F.R. § 433.312(a), and expects that any overpayments identified in the audits will either be redistributed to other DSH-eligible hospitals in accordance with the applicable state plan, see 73 Fed. Reg. 77904 (Dec. 19, 2008), or that the federal portion will be refunded to CMS in accordance with the regulation. **At this time, CMS does not intend to provide additional guidance regarding whether individual states should submit revised DSH audits.** States are encouraged to review any applicable district court or appellate court decisions. See, e.g., *Tenn. Hosp. Ass'n v. Azar*, 908 F.3d 1029 (6th Cir. Nov. 14, 2018); *Children's Health Care v. CMS*, 900 F.3d 1022 (8th Cir. Aug. 20, 2018); *Children's Hosp. of the King's Daughters, Inc. v. Azar*, 896 F.3d 615 (4th Cir. July 23, 2018); *New Hampshire Hosp. Ass'n v. Azar*, 887 F.3d 62 (1st Cir. Apr. 4, 2018). (Emphasis added.)

These statements by CMS raise a number of issues, especially as to states that are still processing or analyzing DSH audits for Medicaid State Plan rate years 2014 through 2017.

The *THA v. Azar* case was decided by the Sixth Circuit Court of Appeals. Tennessee, Kentucky, Ohio and Michigan are in the Sixth Circuit's jurisdiction. In this decision, the Sixth Circuit held that FAQs 33 and 34 caused Tennessee's DSH auditors to violate 42 C.F.R. § 447.299(c), CMS's DSH reporting requirement rule component promulgated on December 19, 2008. See *Azar*, at 908 F.3d 1029, 1045:

> Yet, as plaintiffs detail in their briefs, none of the "data elements" set forth in 42 C.F.R. §§ 447.299(c)(6)-(c)(16) accounts for payments by Medicare or private insurance. There is thus a disconnect between the preamble – which assures hospitals that the 2008 rule identifies all the

data necessary to calculate and report their respective DSH limits – and CMS's current interpretation – which essentially says that proper calculation and reporting requires additional data (i.e., third-party payments) that are never directly mentioned or requested in the published text of the rule.

Indeed, the mismatch between the "data elements" the rule identifies as "necessary to comply with [the statute's] reporting and auditing requirements," 73 Fed. Reg. at 77, 907, and the payments CMS now argues the hospitals ought to have deducted may explain why Tennessee's own auditor violated the 2008 rule in its efforts to comply with CMS's payment deduction policy.

As CMS has now admitted in its December 31, 2018 notice, CMS has ceased, as of December 31, 2018, to rely upon FAQs 33 and 34 in the Medicaid DSH audit guidance previously given by CMS in January 2010. These FAQs, also called questions 33 and 34, are stated by the December 31, 2018 notice to be "no longer operative."

Despite CMS's withdrawal of FAQs 33 and 34 from the audit guidance it had given in January 2010, CMS has decided not to provide the states with any guidance regarding whether individual states should submit revised DSH audits for audits that predate December 31, 2018 which may have resulted in recoupment demands made on DSH hospitals based upon audits that may have violated 42 C.F.R. § 447.299(c) because they applied FAQs 33 and 34.

Given the frequency and scope of litigation about Medicaid DSH audits around the country, it is clear that states should seriously consider submitting revised DSH audits. If the states fail to do so, the improper audit will have imposed the now-withdrawn FAQs 33 and 34 on those states' DSH hospitals. This can cause the audits to understate those hospitals' total cost of care for Medicaid IP/OP services to Medicaid-eligible patients because, as required by FAQs 33 and 34, Medicare and private insurance payments have been deducted in the DSH audits from those hospitals' total incurred costs for IP/OP hospital services to those Medicaid-eligible patients. This in turn can lead to inflated DSH recoupment demands from CMS as to DSH hospitals, which were identified by audits applying FAQs 33 and 34 as having received "overpayments" of Medicaid DSH funds in the audited year. The prior years' audits' use of these "no longer operative" audit requirements could thus cause prior and recently completed Medicaid DSH audits, and the demands for recoupments of overpayments that follow them for many such hospitals, to be erroneous as a matter of fact and law.

The "overpayment" recoupment issues for DSH hospitals arise under federal regulations related to Medicaid's refund regulations and Medicaid's requirement for independent certified audits of state DSH payment adjustments. At 42 C.F.R. § 455.304(a), CMS has set forth the following rule on audit requirements for states receiving DSH payments:

(1) The State must submit an independent certified audit to CMS for each completed Medicaid State Plan rate year, consistent with the requirements of this subpart, to receive federal payments under Section 1903(a)(1) of the Act based on state expenditures for disproportionate share hospital (DSH) payments for Medicaid State Plan rate years subsequent to the date the audit is due, . . .

(2) 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 . . . .

State Medicaid agencies receiving DSH funds are required to complete and file such an audit for DSH hospitals in each particular state's plan rate year (TennCare's audit for state plan rate year 2015 was filed on December 31, 2018, for example). The audit performed by the independent auditors is required by 42 C.F.R. §

455.301 to include a review of the state's audit protocol to ensure that federal regulations are satisfied, an opinion for each verification detailed in the regulation, and the determination of whether or not the state made DSH payments that exceeded any hospital's specific DSH limit in the Medicare State Plan rate year under audit.

If a state made DSH payments to a hospital that exceeded the DSH limit as calculated by the audit, then the state is required to deem that as an "overpayment" under applicable federal Medicaid regulations. Such an overpayment would be covered by 42 C.F.R. § 433.310(a)(1) as an overpayment made to providers that was discovered by the state. CMS DSH regulations require any such overpayments to be recovered by the state Medicaid agency. As to recovered DSH funds, the state Medicaid agency is required to refund to CMS any recovered DSH overpayments not redistributed, or, if the applicable Medicaid state plan permits, redistribute the overpayments to other DSH hospitals that may have been underpaid for DSH purposes that year.

Overpayment refund regulations under Medicaid, at 42 C.F.R. § 433.312(a), provide that:

> (1) . . . the state Medicaid agency has one year from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the federal share must be refunded to CMS.
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> (2) The state Medicaid agency must refund the federal share of overpayments at the end of the one-year period following discovery in accordance with the requirements of this subpart, whether or not the state has recovered the overpayment from the provider.

Thus, if the audit carried out by the state Medicaid agency has not been revised under the new December 31, 2018 Guidance, but has in reliance on FAQs 33 and 34 found overpayments to exist as to individual hospitals, the states would be required, absent injunctive relief from the courts, to seek to recover the overpayment so identified, even if those overpayments are caused by the applications of the now-withdrawn FAQs 33 and 34, and then redistribute them as noted above or refund the overpayments (including any not redistributed) to CMS. Because DSH audits carried out prior to December 31, 2018 utilized FAQs 33 and 34 (unless prohibited in certain states by injunctions), it appears that a significant number of hospitals could be labeled as having received DSH "overpayments" and could therefore face state efforts (mandated by CMS) to recoup such overpayments, despite those overpayment recoupment demands potentially being based on the application of the now "no longer operative" FAQs 33 and 34.

If you have any questions about the content of this alert, please contact any member of Baker Donelson's Health Law Group.

* FFP means Federal Financial Participation, the federal funds component of Medicaid.