**STATE OF MINNESOTA DEPARTMENT OF HUMAN SERVICES**
**MEDICAID DSH AUDIT & REPORTING PROTOCOL**
**CALENDAR YEAR 2021**

## Background

The federal law requires the Department of Human Services to have an independent certified audit of its Disproportionate Share Hospital Program (DSH). In order to comply with Section 1923(j)(2) of the Social Security Act, the certified independent audit must verify:

- The extent to which hospitals in the state have reduced uncompensated care costs to reflect the total amount of claimed expenditures made under Section 1923 of the Act.
- That the DSH payments to each hospital comply with the applicable hospital-specific DSH payment limit.
- That only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals and uninsured individuals as described in Section 1923(g)(1)(1) of the Act are included in the calculation of the hospital-specific limits.
- That the State included all Medicaid payments, including applicable supplemental payments, in the calculation of such hospital specific limits.
- That the State has separately documented and retained a record of all its costs under the Medicaid program, claimed expenditures under the Medicaid program, uninsured costs in determining adjustments under Section 1923 of the Act and any payments made on behalf of the uninsured from payment adjustments under Section 1923 of the Act.
- That state complies with the prohibition on claiming Federal matching funds for DSH payments to hospitals that exceed the hospital's facility specific DSH limit.

On December 19, 2008, CMS published final rule 42 C.F.R § 447.299(c)(3) which specified elements for the required DSH report and the verifications required for the audit. In January 2010, CMS posted "Additional Information on the DSH Reporting and Audit Requirements" on its website. This document took the form of a list of Frequently Asked Questions (FAQs) and CMS' responses. FAQ #33 required DSH audits to include costs and payments for Medicaid enrollees that have private insurance in addition to Medicaid even if hospitals received full payment from the private insurance and Medicaid was never billed. FAQ #34 required the DSH audits to include both the costs and payments for patients that are dually enrolled in Medicaid and Medicare even when Medicare is the primary payer.

The enforcement of these two FAQ has resulted in several hospitals filing suit against CMS. Minnesota Children's' hospitals were among the first to file in June of 2016. (*Children's Health Care v. CMS, 16-cv4064 WMW/DTS).* Gillette Hospital was later added as an additional plaintiff. Ultimately, the court issued a summary judgement for Children's prohibiting CMS from enforcing FAQ #33. Because of the court's decision, CMS was enjoined from enforcing FAQ #33 for Minnesota Children's hospitals for any services provided prior to April 3, 2017.

On April 3, 2017, CMS published final rule 42 C.F.R § 447.299(c)(3) to clarify the policies laid out in FAQ #33 and #34. The rule followed CMS' existing interpretation that uncompensated care costs include only those costs for Medicaid eligible individuals that remain after accounting for payments made to hospitals by or on behalf of Medicaid eligible individuals, including payments from Medicare and other third party payers that compensate the hospitals for the Medicaid patient's care. Several lawsuits challenging this rule were filed. Litigation around FAQ #33 and #34 has ended and CMS withdrew the FAQ's on December 31, 2018.

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On December 21st, 2020 the Consolidated Appropriations Act, 2021 was enacted resolving the CMS FAQ #33 and #34 issue. Section 1923 of the Social Security Act (42 U.S.C. 1396r–4)(g)(B)(i) defines Individuals as those eligible for medical assistance for whom the State plan or waiver is the primary payer. This would eliminate the requirement for DSH audits to include enrollees where private insurance or Medicare is the primary payer. This change in policy will take effect in DSH audit calendar year 2021. Date TBD.

BerryDunn, Portland, Maine office, is Minnesota's contracted independent DSH auditor for the Calendar Year (CY) 2021 DSH Audit.

All Minnesota hospitals that received and elected to retain a DSH payment in CY 2021 are required to supply cost and payment data for all their patients covered by Medical Assistance. For CY 2021, DSH eligible hospitals were limited to qualifying non-critical access hospitals located within the state of Minnesota. The purpose of the audit is to verify that total payments, including DSH payments, to individual hospitals did not exceed the hospital's actual costs of providing inpatient and outpatient hospital care to Medical Assistance and uninsured patients. The Medical Assistance services subject to the audit include services provided to recipients enrolled under in fee-for-service (FFS) or enrolled with a managed care organization (MCO).

BerryDunn will prepare a final audit report in accordance with CMS requirements. This report must be approved by the State of Minnesota and submitted to CMS. Once submitted to CMS, the report will be public.

Hospitals have the option to opt-out of the DSH audit process in a given audit year. Hospitals wishing to exercise this option must complete a form certifying the return to DHS of the full amount of DSH funds paid to the hospital for the given audit year. The CEO or CFO of the hospital must sign this form. DHS will recoup the DSH payments from hospitals that opt out of the audit via a gross adjustment of claims and a reduction to current Medicaid reimbursement.

Data for calendar year 2021 will be collected by the audit firm and the audit work must be completed by the deadline established by DHS. Each hospital will be required to provide finalized hospital cost reporting period information and audited financial statements (or other hospital accounting records as needed) that cover the calendar year 2021 DSH audit period. The cost reporting periods must cover the entire calendar DSH year. If the end date for cost report period is before the end date of the DSH year, the next period cost report must also be reported. These submitted documents will provide the data used to compute the cost and payment information for the 2021 DSH audit.

Hospitals must retain supporting documentation for all data elements provided within the DSH survey for a minimum of five years.

**DHS Supplied Data**

For 2021, the Department of Human Services will send claims data reports to the MN-IT's mailboxes of each DSH hospital. The claims data include all FFS and managed care claims for Medical Assistance enrollees as well as claims for enrollees of programs funded solely with state dollars. The claims reports will cover the entire period required for the audit.

There will be six files, three relating to FFS claims and three relating to Managed Care claims. All of the files are tab delimited text files.

The data in the FFS files is complete and accurate. However, the data included in the CY 2021 Inpatient Managed Care files does not include the health plan reimbursement amount. In addition, health plan encounter claim data may not be complete for hospitals that bill the health plans using consolidated billing numbers. The six files are:

DSH_IPFFS_Main – File includes patient demographic data, hospital account data, and claim charges and payments including DSH payments related to FFS claims

DSH_IPFFS_RevCds – File includes hospital account data and claim charges, units and revenue code detail related to FFS claims

DSH_OPFFS_Main – File includes hospital account data, program and eligibility type, claim charges, units and revenue code detail related to FFS claims

DSH_IPMCO_Main – File includes hospital account data, program and eligibility type, patient name, and covered days and charges related to managed care encounter claims

DSH_IPMCO_RevCds – File includes hospital account data and claim charges, units and revenue code detail related to managed care encounter claims

DSH_OPMCO_Main – File includes hospital account data, program and eligibility type, patient name, covered days, charges and revenue codes related to managed care encounter claims

Each of the claim report files include detailed lines for all of the inpatient, outpatient, crossover and non-crossover claims with discharge dates within the audit period. These claims reports will also be provided to the independent auditor. See Appendix A for a Data Dictionary description of the fields included in each of the reports.

**Definition of Uninsured and Treatment of Payments and Costs**

In accordance with federal regulations, uninsured patients are individuals with no source of third party healthcare coverage (insurance) or third party liability for the specific hospital services provided**.**

Services to uninsured patients must be costed using Medicare cost reporting methodologies. Hospitals will need to report the uninsured days of care they provide each cost-reporting period by routine cost center as well as inpatient and outpatient ancillary service revenue by cost report center. The data relating to uninsured patients must be maintained in a reviewable format. It must also only include charges for inpatient and outpatient hospital services, excluding physician charges and other non-hospital charges.

Payments received directly from state or local government programs for inpatient and outpatient hospital services provided to the uninsured should not be included as a revenue in this category.

**Submission of Completed Audit Documents**

Completed Cost Report year surveys (Part II), along with the Part I DSH Year Survey, and Uninsured data analyses (Exhibits A and B), and Medicaid Eligible internally queried Exhibits C (PMAP eligible and Medicaid FFS eligible not included in MMIS reports) must be submitted electronically to BerryDunn.

The submitted surveys contain Protected Health Information (PHI) and should preferably be uploaded via the BerryDunn's secure web portal or sent on CD or DVD via U.S. mail or via other carrier authorized to transfer PHI.

Following the submission of the Final Audit Report, DHS will notify each hospital of their final audit results indicating whether or not individual hospitals are in compliance with the federal requirement that DSH payments do not exceed the hospital's uncompensated care costs (UCC) limit. Hospitals whose DSH payments exceed their facility specific limit will also be notified of the amount of DSH funding that will be recouped.

**Redistribution of Returned DPA Amounts**

DHS implemented a new DSH payment methodology effective for discharges on or after July 1, 2015. The new methodology requires DHS to recoup all DSH funding paid in excess of a hospital's hospital specific DSH limit. Recouped DSH funds will be redistributed to other qualifying DSH hospitals on a pro-rata basis in accordance with the State's approved Medicaid State Plan.

To qualify for redistributed DSH funds, hospitals must still be eligible to receive DSH payments, have a Medicaid Inpatient Utilization Rate (MIUR) that is at least one standard deviation above the statewide mean, and not be licensed as a Children's hospital. Any additional redistributed DSH payments to a hospital will be limited to the receiving hospital's facility-specific DSH limit.

**Below are CMS web links that are relevant to the Medicaid DSH audit and reporting requirements:**

Final rule published in the Federal Register on April 3, 2017 relating to Treatment of Third Party Payers in Calculating UCC's: https://www.gpo.gov/fdsys/pkg/FR-2017-04-03/pdf/2017-06538.pdf

Final rule published in the Federal Register on December 3, 2014 relating to the uninsured definition: https://www.gpo.gov/fdsys/pkg/FR-2015-12-03/pdf/2015-28424.pdf

Final rule published in the Federal Register on December 19, 2008 relating to the DSH Audit requirements: http://edocket.access.gpo.gov/2008/pdf/E8-30000.pdf

Technical correction to the final rule published in the Federal Register on April 24, 2009: http://edocket.access.gpo.gov/2009/pdf/E9-9232.pdf

CMS guidance on the audit and reporting protocol: http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf

CMS master reporting form: http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptFmt.pdf