STATE OF MINNESOTA DEPARTMENT OF HUMAN SERVICES
MEDICAID DSH AUDIT & REPORTING PROTOCOL
CALENDAR YEAR 2011

Background

The Centers for Medicare and Medicaid Services (CMS) published the final Medicaid Disproportionate Share Hospital (DSH) audit and reporting rule in the Federal Register on December 19, 2008 to implement Section 1001 (d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also known as the Medicare Modernization Act or MMA). A hospital's DSH payments may not exceed the costs incurred by that hospital in furnishing services to Medicaid participants and the uninsured less other Medicaid payments made to the hospital and payments made by or on behalf of the uninsured. Cost and payment data needs to be supplied by the hospitals to verify that payments to individual hospitals do not exceed the costs of providing inpatient and outpatient hospital care to Medical Assistance (MA) recipients and those not covered by insurance or other third-party payers (also known as the hospital specific DSH limit). CMS classifies recipients in the State of Minnesota's General Assistance Medical Care program (GAMC) as being not covered by insurance or other third-party payers. The MA and GAMC services subject to this process include recipients enrolled under the fee-for-service (FFS) plan and those enrolled with a managed care organization (MCO).

The final rule applies to hospitals receiving the inpatient fee-for-service MA disproportionate population adjustment add-on payment (DPA also known as DSH by the federal government) and also those hospitals that receive inpatient and outpatient GAMC payments for which the State of Minnesota receives federal DSH funds.

Using the data collected from the individual hospitals, the Department will prepare a report using the reporting format developed by CMS. This report will be subject to federal audit requirements. The audit will be performed by an independent auditor contracted by the State of Minnesota. The report prepared by the State of Minnesota and the independent auditor's report must be submitted to CMS.

Data for calendar year 2011 must be collected and the resulting report and independent auditor's report submitted to CMS. The audit must be completed by September 30, 2014 and the audit report must be submitted to CMS within 90 days of the completion of the audit.

The costing of the claims data must be done using a hospital's finalized Medicare cost report for the appropriate time period (or the submitted cost report if the Medicare fiscal intermediary hasn't finalized the cost report). Please note that CMS recently updated the DSH reporting and audit requirements that will change the information needed for the DSH audit for calendar year 2011. For example, CMS wants Medicare dual eligible recipients reported which was not requested for previous DSH audits. Because of CMS changes, hospitals that have split Medicare cost reporting periods will need to submit updated DSH spreadsheets for the year that was used for the DSH audit for calendar year (CY) 2010. For example, a DSH hospital that has a Medicare cost reporting period of July 1 through June 30 already submitted a spreadsheet for July 1, 2010 through June 30, 2011 which was used for the CY 2010 audit. The spreadsheet used last year did not include the new data needed for the CY 2011 DSH audit and therefore needs to be updated with the new data. This means that hospitals with split years will need to

submit two audit reports this year instead of one report. The hospital will send an updated spreadsheet for July 1, 2010 through June 30, 2011 and a new spreadsheet for July 1, 2011 through June 30, 2012. Hospitals that submit Medicare cost reports on a CY basis will continue to submit just one report. Hospitals that have a split year will have the costs prorated based on the number of months in CY 2011. Hospitals should not prorate the costs and payments since this will be done by the Department.

The data generated and used for this audit should be retained for four years after the Department submits the certified audit report to CMS and all audit issues are resolved.

Cost and payment reporting

The hospitals have already submitted claims data to the Minnesota Hospital Association (MHA) but without the necessary data to identify the individuals receiving the services. The claims data was collected by MHA for the Minnesota Department of Health (MDH) as part of the Hospital Annual Report (HAR). MHA will send the claim data back to the hospitals. A hospital will need to re-populate the claims with the data necessary to identify the individual a particular claim pertains to. This data will include the name, SSAN, and PMI. The hospital will then send the claims to the Department using the Department's ITS-Mailbox system (MN-ITS). Because some hospitals have all of their historical data, they may choose to submit the identified data from their records rather than the data received from MHA. If a hospital chooses to submit the data from their records rather than using the data received from MHA, it must still submit all the claims data to the Department using MN-ITS. This is an important step in the process for the Department to verify data submitted by the hospital.

The Department will process the claims using its recipient eligibility match program. After processing the claims through the recipient eligibility match program, the Department will identify the claims for individuals enrolled with an MCO in one of the Minnesota Health Care Programs (MHCP) and will be scored to determine if the claim meets a probable match with the Department's eligibility system. These PMAP claims will be separated from the other claims. The PMAP claims will then be further separated into the programs jointly funded by MA and those funded by the State only. The PMAP claims determined to be a probable match will be returned to the appropriate hospital using MN-ITS grouped by MA funding and State funding.

The hospital will then need to prepare a detailed claims file and a summary file by revenue code for the PMAP claims data. This is a Provider Statistical and Reimbursement Report (PS&R) that the hospital will use to enter data on the Department's MA DSH spreadsheet discussed below. Hospitals needing assistance in preparing the PS&R may choose to submit the returned PMAP claims data to MHA using MHA's mailbox system if the payment data was included in the claims data provided to MHA. If the reimbursement data was not provided to MHA, the hospital will have to determine the reimbursement amounts. The hospital will have to prepare a PS&R report from the claims data for services provided to non-Minnesota MA recipients, the uninsured, and to undocumented aliens for which the hospital is receiving payments under Section 1011 of MMA. The Section 1011 payments are for federal reimbursement of emergency health services provided to undocumented aliens and other specified aliens. These payments are

not reported to the Department by CMS, so the data must be supplied by any hospital that has participated in this program.

The Department will transmit fee-for-service (FFS) claims data grouped the same way as the PMAP claims to the hospitals using MN-ITS. The Department's claim data will be in the form of a PS&R report and will contain both detailed claims data and a summary report by revenue code numbers.

Using the data generated from the various PS&R reports, the hospital will then enter the data onto an electronic version of an Excel workbook (Department's MA DSH Spreadsheet) that can be downloaded from the Department's public web site. The spreadsheet was developed by MHA in consultation with the Department. Only one workbook needs to be submitted to the Department with a separate worksheet completed for each Medicare cost report period used by a hospital for the audit period. Please name the tab of the worksheet to match the cost report period the data pertains to. The Department will enter the data from the worksheet onto the reporting form that must be submitted to CMS. The Department will prorate the data from hospitals that do not use the calendar year as the Medicare cost report period to match the appropriate reporting year. The hospital should not prorate the data before submitting it to the Department.

The spreadsheet is divided into an upper section and a lower section. On the upper section, the costs, charges, and patient days are entered. On the lower section, costs are calculated by program (ie, MA, state funded, etc.) using the data entered in the upper section. Also included on the lower section is the payment data by program.

The spreadsheet is designed to mirror Worksheet C of the Medicare cost reporting form. It contains the inpatient routine and ancillary service cost centers used on the Medicare cost report. The spreadsheet is designed using the basic cost centers from the cost report, so it will be necessary for some hospitals to add cost centers to meet their individual requirements. If a hospital needs additional cost centers but does not use any existing cost centers, then it is preferred that the hospital changes the name and cost report line as long as it is changed consistently on the upper and lower section of the spreadsheet.

If it is necessary for a hospital to add one or more rows to accommodate additional cost centers, precautions need to be taken. The location for an additional cost center should be consistent on both the upper and lower sections, ie, the new cost center should follow the same existing cost center in each section. Also, the formulas in some of the cells contain both absolute and relative values. Because of this, when a new row is added and formulas from an existing row are copied to be pasted in the new row, it is important to make sure that the formulas in the new row reference the proper cells.

The revenue codes for ambulance services (054x), professional services (096x, 097x, and 098x), and patient convenience (099x) must not be costed because either they are not considered a hospital service by CMS or are non-covered services; however, the charges should be reported

on the form to show that they have been accounted for. Other cost centers not considered a hospital service or considered non-covered by CMS should be treated similarly.

The term uninsured is defined in the final Medicaid DSH audit and reporting rule as individuals who have no health insurance or other source of third party coverage. CMS received many comments to the proposed Medicaid DSH rule stating that the current accounting systems at most hospitals do not allow them to accurately segregate payments received from individuals with third party coverage from payments received from individuals without third party coverage. CMS responded that it expected hospitals to modify their accounting systems to do so from this point forward. Comments were also made to CMS that the vast majority of the DSH hospitals achieve compliance with the hospital specific DSH limit because the DSH payments are less than the Medicaid uncompensated care costs; therefore, it would be highly unlikely that inclusion of the costs less the payments received for services provided to the uninsured would result in the hospital exceeding the hospital specific DSH limit.

CMS responded that it will accept reporting limited to Medicaid uncompensated care costs if the hospital provides certification that it incurred additional uncompensated care costs serving the uninsured individuals. The certification should match the hospital's cost report period that is being submitted for the audit. Any hospital choosing to use the form should always download the current version of the form from the Departments MA DSH audit website. The form should be submitted to the Department on the hospital's letterhead, and should be signed by the hospital's administrator and chief financial officer. CMS has stated that they will consider more flexibility if warranted after it has received and reviewed the initial audit reports submitted by the states and may address this issue in future instructions.

DEPARTMENT'S MA DSH SPREADSHEET

A. Upper Section – The following needs to be entered in this section. Please note that the Medicare cost report was changed to CMS-2552-10 in 2011. This means that some hospitals will be using the new Medicare cost report, the old report (CMS-2552-96) or a combination of both.

Top of Spreadsheet – Update the top portion of the spreadsheet including the hospital name, provider number, date prepared, reporting period, total inpatient costs, and the amount of inpatient charity charges for the reporting period.

Column A – Cost report line number.
Column B – Original Excel Line
Column C – Cost center description/title.
Column D – Total costs from Worksheet B, Part I, column 27 (CMS-2552-96) or Worksheet B, Part I, column 26 (CMS-2552-10). There is an exception for the Adults & Pediatrics cost center. The total costs for this cost center should be entered from Worksheet D-1, Part I, Title XVIII, Hospital, line 37 (CMS-2552-96 and CMS-2552-10). This deviation is necessary because many of the small, non-metro area hospitals include the costs of nursing

home swing beds on Worksheet B. Worksheet D-1 removes these costs from the hospital costs.
Column E –Direct medical education costs (DME) from Worksheet B, Part I, column 26 (CMS-2552-96) or Worksheet B, Part I, column 25 (CMS-2552-10). **Because the Department includes the DME of teaching hospitals in the calculation of MA** payments, the removal of these costs on the cost report needs to be reversed. Please be sure to include only the DME costs. Any other adjustments on Worksheet B-2 should not be included in this column.
Column F – Nothing needs to be entered in this column. This column is formatted to add the amount from column C to column D. The result is the total costs.
Column G –Total charges by cost centers from Worksheet C, Part I, column 8. There is an exception for the Adults & Pediatrics cost center. The total costs for this cost center should be entered from Worksheet D-1, Part I, Title XVIII, Hospital, line 28 (CMS-2552-96 and CMS-2552-10). This deviation is necessary because many of the small, non-metro area hospitals include the costs of nursing home swing beds on Worksheet B. Worksheet D-1 removes these charges from the hospital charges.
Column H –Total patient days from Worksheet S-3, Part I, column 6 (CMS-2552-96) or column 8 (CMS-2552-10), for the inpatient routine service cost centers. There is an exception for the Adults & Pediatrics cost center. The total patient days for this cost center should be entered from Worksheet D-1, Part I, Title XVIII, Hospital, line 2 (CMS-2552-96 and 2552-10). This deviation is necessary because many of the small, non-metro area hospitals include the days of nursing home swing beds on Worksheet S-3. Worksheet D-1 removes these days from the hospital days.
Column I – Nothing needs to be entered in this column. This column is formatted to calculate a per diem cost for the inpatient routine cost centers.
Column J – Nothing needs to be entered in this column. This column is formatted to calculate a revised ratio of costs to charges for the ancillary service cost centers. There is an exception for the Observation Beds cost center. The cost-to-charge ratio should be entered from Worksheet C, Part I, Column 9. This deviation is necessary because the cost for this cost center is not reported separately on Worksheet B.
Column K – Inpatient MA FFS days from the PS&R report supplied by the Department. Inpatient days should be entered for the inpatient routine service cost centers.
Column L – Inpatient MA FFS charges from the PS&R report supplied by the Department. Charges should be entered for the ancillary service cost centers.
Column M – Inpatient MA PMAP days from the PS&R report created by MHA. Inpatient days should be entered for the inpatient routine service cost centers.
Column N – Inpatient MA PMAP charges from the PS&R report created by MHA. Inpatient charges should be entered for the ancillary service cost centers.
Column O – Inpatient non-Minnesota MA days from the PS&R report created by the hospital from its records. Inpatient days should be entered for the inpatient routine service cost centers.
Column P – Inpatient non-Minnesota MA charges from the PS&R report created by the hospital from its records. Inpatient charges should be entered for the ancillary service cost centers.

Column Q – Inpatient State funded FFS days from the PS&R report supplied by the Department. Inpatient days should be entered for the inpatient routine service cost centers.
Column R – Inpatient State funded FFS charges from the PS&R report supplied by the Department. Inpatient charges should be entered for the ancillary service cost centers.
Column S – Inpatient State funded PMAP days from the PS&R report created by MHA. Inpatient days should be entered for the inpatient routine service cost centers.
Column T – Inpatient State funded PMAP charges from the PS&R report created by MHA. Inpatient charges should be entered for the ancillary service cost centers.
Column U – Federal Section 1011 inpatient days from the PS&R report created by the hospital from its records. Inpatient days should be entered for the inpatient routine service cost centers.
Column V – Federal Section 1011 inpatient charges from the PS&R report created by the hospital from its records. Inpatient charges should be entered for the ancillary service cost centers.
Column W – Uninsured inpatient days from the PS&R report created by the hospital from its records. Inpatient days should be entered for the inpatient routine service cost centers.
Column X – Uninsured inpatient charges from the PS&R report created by the hospital from its records. Inpatient charges should be entered for the ancillary service cost centers.
Column Y – Outpatient MA FFS charges from the PS&R report supplied by the Department.
Column Z – Outpatient MA PMAP charges from the PS&R report created by the MHA.
Column AA – Outpatient non-Minnesota MA charges from the PS&R report created by the hospital from its records.
Column AB – Outpatient State funded FFS charges from the PS&R report supplied by the Department.
Column AC – Outpatient State funded PMAP charges from the PS&R report created by MHA.
Column AD – Federal Section 1011 outpatient charges from the PS&R report created by the hospital from its records.
Column AE – Uninsured outpatient days and charges from the PS&R report created by the hospital from its records.
Column AF – Nothing needs to be entered in this column. The last cell in this column is formatted to sum the values of the other cells in the last row. This represents the net uncompensated costs prior to offsetting the MA supplemental payments and prior to including the costs and payments for serving the uninsured. This has been added to assist hospitals in analyzing whether to report the uninsured services or file the certification form discussed earlier.

B. Lower Section -- This section of the spreadsheet is formatted to calculate the inpatient and outpatient costs by program based on the data entered on the upper section of the spreadsheet. The payments need to be entered at the bottom of this section.

   The MA payments will include the program payments made by the Department (including FFS inpatient DPA payments) and the MCOs, copayments, third party liability (TPL) payments, recipient resource payments, Medicare Part B payments, and any other unspecified payments (excluding MA supplemental payments). (The Department will

include the MA supplemental payment data from its records on the reporting form to be filed with CMS. These payments include MERC, upper payment limit (UPL) largest 10% safety-net hospital payments, UPL CPEs, and quarterly payment adjustments.) A separate line has been included for the reporting of the MA inpatient DPA payments. These amounts will be subtracted from the program payments on the form but need to be accounted for separately.

Medicare Payments will be reported on two lines:
7.0 Medicare Part A payments to include base, outliers, GME, IME, DSH, Organ Acquisition, Bad Debts and any other Medicare payment, The provider is responsible for compiling and reporting this data.
7.1 Medicare Part B Payments. DHS will be providing this data to the providers consistent with prior periods.

A separate line has been included for reporting other non-specified payments. This includes the bonus payments received from the MCOs. A hospital should report only the portion that pertains to the inpatient and outpatient hospital MA services. In the comments to the final rule, CMS stated that if a hospital is not able to separate those payments from those received for other services, the hospital must offset the entire bonus payment against the costs of the MA services.

The State-only funded program payments made by the Department and the MCO should not be reported; however, payments by other sources, including TPL, spenddown, etc., for these program services should be reported. This is because federal law exempts the offsetting of the state and local government payments for the state-only funded programs against the costs; however, it does require that any other payments received on behalf of these recipients be offset against the costs.

RTC MA DSH REPORTING SPREADSHEET

The State-owned RTCs do not submit the Department's MA DSH spreadsheet; rather, they submit a spreadsheet modeled after the CMS reporting spreadsheet. The data to be entered is from the work papers prepared in filing the settlement with the MA program.

Column A – Enter the name of hospital here.
Column B – Nothing will be reported here.
Column C – The Medicaid utilization rate will be reported here. This is calculated by dividing the Medicaid inpatient days by the total inpatient days.
Column D – Nothing will be reported here.
Column E – The same value as reported in column C will be reported here.
Column F – The payments received for inpatient and outpatient services provided to recipients on a fee-for-service basis who are covered by the joint federal and state funded programs need to be reported here. In addition to the payments received from the programs, these payments should also include payments received from the recipients or

from other sources on behalf of the recipients. The payments reported here should not include the DPA add-on payment or MA supplemental payments.
Column G – The payments received for inpatient and outpatient services provided to recipients enrolled with MCOs in the joint federal and state funded programs need to be reported here. In addition to the payments received from the MCOs, these payments should also include payments received from the recipients or from other sources on behalf of the recipients.
Column H – Nothing will be reported here. The MA supplemental payments will be entered by the Department on the CMS MA DSH reporting spreadsheet.
Column I – The sum of columns F and G will be reported here.
Column J – The costs of providing care to the recipients in the joint federal and state funded programs need to be recorded here. The costs should come from the MA settlement worksheet. Because the RTCs settle at cost, the amount reported here should match the amount reported in column I.
Column K – This should be the value of column J minus the value of column I.
Column L – The payments received for individuals with no insurance or other source of coverage should be reported here. This includes individuals in programs funded only by the State. The payments made by the state-funded program should not be reported. The payments made by MCOs for the state-funded programs should not be reported. However, payments made by the individuals or by others on behalf of the individuals must be reported.
Column M – Nothing will be reported here since the RTCs do not receive Section 1011 payments.
Column N – The cost of inpatient and outpatient services provided to individuals with no insurance or other source of coverage should be reported here. This includes individuals in programs funded only by the State. The costs should come from the MA settlement worksheet.
Column O – This should be the value of column N minus the value of column L minus the value of column M. A positive value represents a loss while a negative value represents a gain.
Column P – This should be the value of column K plus the value of column O. A positive value represents a loss while a negative value represents a gain.
Column Q – The DSH payments received should be reported here.

After completing the appropriate spreadsheet, the hospital will then transmit the spreadsheet to the Department by e-mailing it to joseph.heidkamp@state.mn.us. Questions related to completion and submission of the reporting spreadsheet should be directed to Joe Heidkamp by e-mail at the address in the previous sentence or by calling (651) 431-2540.

The Department will enter the data from the individual hospitals' spreadsheets onto a master reporting form in a format specified by CMS. The results after entering the data indicate whether or not individual hospitals are in compliance with the federal requirement that non-DSH payments cannot exceed costs. If a hospital exceeds its hospital specific DSH limit, the DSH payment will be considered a hospital payment adjustment under state law and no payment will be recovered from the hospital. However, the hospital payment adjustment is subject to the

Medicare upper payment limit and may reduce the MA supplemental payments. After the master reporting form is completed by the Department, the independent auditor will be able to commence the audit of the cost and payment data.

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

This is to the final rule published in the Federal Register on December 19, 2008:
http://edocket.access.gpo.gov/2008/pdf/E8-30000.pdf

This is to a technical correction to the final rule and was published in the Federal Register on April 24, 2009:
http://edocket.access.gpo.gov/2009/pdf/E9-9232.pdf

This is to the audit and reporting protocol:
http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf

This is to the master reporting form that the Department is responsible for submitting:
http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptFmt.pdf