UTAH DEPARTMENT OF HEALTH

REVIEW OF THE UTAH DEPARTMENT OF HEALTH'S MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS PROGRAM

Independent Accountants' Report on
Applying Agreed Upon Procedures

Medicaid State Plan Rate Year
Ending September 30, 2008

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CARVER FLOREK & JAMES, CPA's
CERTIFIED PUBLIC ACCOUNTANTS

Steven L. Carver, CPA
Brent R. Florek, CPA
Gordon H. James, CPA
Kerby L. Cate, CPA

Independent Accountants' Report on Applying Agreed-Upon Procedures

To Michael Hales – Director, Division of Medicaid and Health Financing:

We have performed the procedures enumerated in the attached schedule, which were agreed to by the Utah Department of Health (UDOH or the State), solely to assist in evaluating the State of Utah's compliance with the six verifications outlined in the *Medicaid Program; Disproportionate Share Hospital (DSH) Payments; Final Rule - 42 CFR Parts 447 and 455* (Final Rule) during the Medicaid State Plan rate year ending September 30, 2008. Management is responsible for the State's compliance with those requirements. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in this report.

The procedures we performed and the results of those procedures are outlined in the attached *Schedule of Agreed-Upon Procedures.*

We were not engaged to and did not conduct an examination, the objective of which would be an expression of an opinion on compliance. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the UDOH, the Centers for Medicare and Medicaid Services, and the Utah hospitals which received DSH payments, and is not intended to be and should not be used by anyone other than these specified parties.

Carver Florek & James, CPA's

September 30, 2011

2246 NORTH UNIVERSITY PARK BLVD. • LAYTON, UT 84041 • PHONE (801) 926-1177 • FAX (801) 926-1178
MEMBER AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS

UTAH DEPARTMENT OF HEALTH

Schedule of Agreed-Upon Procedures
Medicaid State Plan Year Ended September 30, 2008

VERIFICATION 1 – DSH Payment Retention

Each hospital that qualifies for a DSH payment in the State is allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State Plan rate year to Medicaid-eligible individuals and individuals with no source of third-party coverage for the services in order to reflect the total amount of claimed DSH expenditures.

BACKGROUND

DSH payment eligibility is established under *Section 1923 of the Social Security Act* and *Attachment 4.19-A* of the *Utah State Plan under Title XIX of the Social Security Act Medical Assistance Program* (State Plan). Generally, in order to qualify for DSH payments, hospitals must have a Medicaid inpatient utilization rate (MIUR) of at least one percent and, if offering non-emergency obstetrical services, have at least two obstetricians (OB) who have staff privileges and agree to provide such services to individuals entitled to medical assistance (this OB requirement does not apply to children's hospitals). In addition, hospitals must have either a MIUR of at least 14 percent or a low income utilization rate (LIUR) of at least 25 percent to qualify. However, certain rural hospitals need only have an MIUR of at least one percent and provide OB services in order to qualify.

PROCEDURES AND RESULTS

We examined the survey obtained from each hospital, which documented the DSH eligibility requirements. We traced the MIUR and LIUR calculations reported in the survey to supporting documentation provided by the hospitals. We also verified that, as applicable, each hospital provided the names of the obstetricians, or other qualified physicians who provided obstetric services in rural communities, as required under the Final Rule and the State Plan.

Results:
We noted that 2 of the 38 hospitals receiving DSH payments did not qualify. One of the government-owned rural hospitals did not meet the MIUR requirement of at least one percent, and one of the urban privately owned hospitals did not meet the DSH qualification requirement of either a MIUR of at least 14 percent or a LIUR of at least 25 percent. The remaining 36 hospitals all qualified to receive DSH payments during the Medicaid State Plan rate year ended September 30, 2008.

Exhibit 1 (columns 3-5) presents the hospitals' DSH qualifications as defined under the Utah State Plan for the Medicaid State Plan rate year ended September 30, 2008.

We reviewed the methodology used for measuring DSH payments. In addition, we agreed the supplemental DSH payments reported by the hospitals to the Medicaid Management Information System (MMIS) data provided by the State, and resolved differences where differences were initially reported. We also traced all supplemental DSH payments for the period to payment vouchers retained by the State to verify the payment types and amounts, and that the information was reported in the proper period. We examined documentation supporting any out-of-state DSH payments reported by the hospitals. In addition, we obtained written representation from hospital management verifying that each hospital retained its full DSH payment.

Results:

We noted that overpayments pertaining to the State's fee for administering DSH were refunded to four of the government-owned rural hospitals with their final DSH payment for the Medicaid State Plan rate year ending September 30, 2008. As a result, these refunds were inadvertently reported as supplemental DSH payments provided to the hospitals and ranged from $7 to approximately $50,000. In addition, some of the hospitals omitted or misstated DSH add-on payments or out-of-state DSH payments in the survey. We verified that the hospitals revised the surveys and these corrections are reflected in the DSH payments reported on Exhibit 1 (column 18).

All 38 of the hospitals confirmed that they were allowed to retain 100 percent of the DSH payments received to offset their uncompensated care costs for providing hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage.

Exhibit 1 (column 18) presents verified DSH payments by hospital for the Medicaid State Plan rate year ended September 30, 2008.

VERIFICATION 2 – Uncompensated Care vs. DSH Payments

DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. For each audited Medicaid State Plan rate year, the DSH payments made in that audited Medicaid State Plan rate year must be measured against the actual uncompensated care cost in that same audited Medicaid State Plan rate year.

PROCEDURES AND RESULTS

We compared the DSH payments with the uncompensated care costs for the Medicaid State Plan rate year ended September 30, 2008, and noted any hospitals where DSH payments exceeded the hospital-specific uncompensated care costs. We compared DSH payments for the period with the hospital-specific DSH payments against limits set forth in the State Plan.

Results:
We noted that 16 of the 36 eligible hospitals reported DSH payments that exceeded the hospitals' reported uncompensated care costs for the period. Excess DSH payments aggregated approximately $2.4 million and ranged by hospital from approximately $1,200 to $1 million, with the highest excess noted for a government-owned rural hospital. For the remaining 19 hospitals, excluding the Institution for Mental Disease (IMD) for which the DSH payment is limited under the Federal Register, aggregate uncompensated care costs exceeded DSH payments by approximately $42.5 million.

In addition to the IMD hospital, seven government-owned rural hospitals had specific DSH limits set forth in the State Plan. We noted that one of the seven rural hospitals received supplemental DSH payments in excess of the limit outlined in the approved Medicaid State Plan in the amount of approximately $12,000.

Exhibit 1 (columns 2 and 18) presents the hospital-specific DSH limit and the DSH payments for the Medicaid State Plan rate year ended September 30, 2008.

The hospital DSH survey required each provider to report uncompensated care costs for the Medicaid State Plan rate year ending September 30, 2008. In order to report uncompensated care costs for the period, charge and payment information was determined for the Medicaid State Plan rate year and hospitals used two or more *Medicare 2552-96 hospital cost reports* (MCR) when their reporting periods did not correspond with the Medicaid State Plan rate year. We compiled DSH payments for the year ended September 30, 2008, and measured against uncompensated care costs for that same period.

Results:
The DSH survey completed by each hospital measured DSH payments against actual uncompensated care costs for that same Medicaid State Plan year ended September 30, 2008.

Exhibit 1 (columns 17 and 18) presents verified total uncompensated care costs and total DSH payments, by hospital, for the Medicaid State Plan year ended September 30, 2008.

VERIFICATION 3 – Qualifying Uncompensated Care and the DSH Payment

Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals and individuals with no third-party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g)(1)(A) of the Social Security Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923(g)(1)(A) of the Social Security Act.

BACKGROUND

For purposes of the DSH review, hospitals were required to report uncompensated care costs for patients eligible for Medicaid benefits and other uninsured individuals using a comprehensive survey, developed jointly by Carver Florek & James, CPA's and the State, following the cost principles outlined in the Final Rule and the *General DSH Audit and Reporting Protocol - CMS-2198-F*. All hospitals that received DSH monies prepared and submitted a survey to document their hospital-specific DSH limit. The survey included discrete sections to report uncompensated care costs for furnishing inpatient and outpatient hospital services to in-state Medicaid-funded patients, out-of-state Medicaid-funded patients, and other patients with no source of third-party coverage. The primary source documents used to develop cost and payment information for the DSH survey included MMIS data provided by the State, hospital billing records and other hospital accounting information for the uninsured and Medicaid out-of-state, and the MCR.

Our verification procedures were tailored based on the type of hospital and the nature and availability of hospital records as well as the magnitude of DSH payments received during the year. For verification purposes, hospitals were broken out into the following five categories: (1) State-owned teaching hospital, (2) State-owned Institution for Mental Diseases (IMD), (3) Other government-owned rural hospitals, (4) Urban and rural privately owned hospitals that received DSH payments in excess of $100,000 via an add-on to their normal Diagnostic Related Group (DRG) payment, and (5) Urban and rural privately owned hospitals that received DSH payments in amounts less than $100,000 via an add-on to their normal DRG payment.

Exhibit 1 (column 17) presents verified total uncompensated care costs, by hospital, for the Medicaid State Plan year ended September 30, 2008.

PROCEDURES AND RESULTS

State-owned teaching hospital

Utah has one state-owned teaching hospital that received DSH funds during the year. The hospital utilized internal hospital billing records for Medicaid in-state and out-of-state claims and payments. This was necessary in order to present charges on a basis consistent with the manner in which cost-to-charge ratios were developed in the MCR.

We obtained and reviewed the hospital's DSH survey for the Medicaid State Plan rate year ended September 30, 2008, which reported uncompensated care costs for the period. We traced charge and payment information in the survey to detail data files maintained by the hospital that supported charges for Medicaid in-state, Medicaid out-of-state, and uninsured patients. We examined a selection of claims from detail charge data for each of the three categories of patients. We verified days and charge information by examining billing and other hospital accounting records. We verified Medicaid eligibility for Medicaid patients and reconciled Medicaid claims to the State's MMIS for consistency with the State data. For uninsured patients, we examined the claims' financial class and reviewed other billing records searching for evidence of third-party insurance to verify the "uninsured" status of the claim.

Charges for purposes of the 2008 survey were mapped to the respective cost centers using service patterns from the hospital's fiscal year ended 2008. We examined the allocation of charges among cost centers by verifying the source of a sample of charges by cost center from the fiscal 2008 data and tested the integrity of the allocation formulas.

We traced per diems and cost-to-charge ratios (used in the survey to quantify cost) to the applicable MCRs. Organ acquisition costs were verified using hospital records and other cost data from the MCRs. Indirect medical education (IME) and direct graduate medical education (DGME) costs were traced to an analysis prepared by the hospital and source MCR data. We also traced all supplemental IME, DGME, and UPL payments to payment vouchers retained by the State.

Results:

We noted that the survey initially submitted by the hospital omitted Medicaid supplemental payments (UPL, IME, DGME) totaling $36.6 million and Section 1011 payments of approximately $35,000. Minor modifications were also made to the ratio of dual eligible charges used to allocate Medicare DSH and other supplemental payments to include both routine and ancillary charges. We also noted that corrections were required to the uninsured query (used to quantify uncompensated care costs) to exclude claims with some form of credible third-party coverage. A number of transplant claims were also removed from the final survey as the hospital was unable to capture the related payments associated with these claims. These revisions to the survey reduced uninsured uncompensated care costs by approximately $2.1 million. Exhibit 1 (column 17) presents the state-owned teaching hospital's uncompensated care costs for the Medicaid State Plan rate year ending September 30, 2008.

No other significant exceptions were noted that represented departures from the approved methodology for calculating uncompensated care costs.

State-owned IMD hospital

Utah has one state-owned IMD hospital that received DSH payments during the period. The IMD hospital has little, if any, in-state Medicaid uncompensated care costs as the hospital undergoes an annual Medicaid cost settlement with the State of Utah. Further, the hospital did not provide services to any out-of-state Medicaid patients during the period. Accordingly, only

individuals with no third-party coverage were included in the determination of the hospital-specific DSH limit.

We obtained and reviewed the hospital's DSH survey for the Medicaid State Plan rate year ended September 30, 2008, which reported uncompensated care costs for the period. Uninsured days were determined by the hospital by taking total days, as reported in the hospital's accounting records, and removing any days related to Medicaid, Medicare, or forensic (prison) patients. We traced the total days to the hospital's accounting records. We traced Medicare and Medicaid days to the MCR and forensic patients' days to supporting documents provided by the hospital. The uninsured days were reduced by a factor representing an estimate of days with some form of third-party liability (TPL) insurance. The TPL factor was conservatively estimated by calculating the ratio of days with any form of payment (TPL, self-pay, or otherwise), and dividing it by the total days for the period. Days with any form of payment were traced to reports from the hospital's billing system.

Uninsured ancillary charges were determined by taking the ratio of uninsured days to total days and applying this ratio to the cost center specific total ancillary charges in the MCR. We traced total charges to the MCRs and the uninsured ratio to supporting documents provided by the hospital. The ancillary charges were also reduced by the TPL factor.

We traced per diems and cost-to-charge ratios (used to quantify cost in the survey) to the applicable MCR amounts.

Results:
We noted that in the survey initially submitted by the IMD, no adjustments were made to uncompensated care costs for claims with credible third-party coverage. We verified that the routine days and ancillary charges were reduced by a factor representing claims with some form of third-party coverage. This adjustment to the survey reduced uninsured uncompensated care costs by approximately $4.8 million. Minor modifications were also made to the IMD's mapping of charges to the appropriate cost centers in the survey to reflect service patterns for the period under review. Exhibit 1 (column 17) presents the IMD's uncompensated care costs for the Medicaid State Plan rate year ending September 30, 2008.

No other significant exceptions were noted that represented departures from the approved methodology for calculating uncompensated care costs.

Other government-owned rural hospitals

We obtained and reviewed the hospitals' DSH surveys for the Medicaid State Plan rate year ended September 30, 2008, which reported uncompensated care costs for the period.

We traced day, charge and payment data stemming from claims for Medicaid patients to data derived from the State's MMIS, where applicable.

We examined days and charges summarized by revenue code from the MMIS for consistency with the mapping of days and charges to cost centers in the survey.

We examined a selection of claims for Medicaid out-of-state and uninsured patients and traced the claims to hospital billing and other accounting records to verify that only eligible days and charges were included in the hospital-specific DSH limit.

We traced per diems and cost-to-charge ratios (used to quantify cost in the survey) to the applicable MCR amounts.

Results:
We noted that revisions were required to the Medicaid In-State days, charges, and payments to exclude retracted days, denied claims, reprocessed claims, and coinsurance information that were inadvertently included in the MMIS data provided to all seven of the hospitals.

We noted that in some instances, corrections were required to the per diems and cost-to-charge ratios reported in the survey to agree to the applicable MCR amounts. We verified that any differences between the routine days and ancillary charges reported in the survey and the hospitals' supporting documentation were resolved. In addition, significant modifications were made to six of the seven hospitals' mapping of charges by revenue code to more closely align with the methodology used to assign charges to cost centers for Medicare cost reporting purposes.

We noted that certain supplemental payments (e.g., Medicare DSH, Medicare IME & GME, Medicare bad debt) applicable to dual eligible patients were also omitted by some of the hospitals. We also noted an instance where DSH payments of approximately $48,000 and $64,000 were included in the regular claims payments for one of the seven hospitals. We verified these amounts were removed from the claims payments, and reported solely as DSH payments by the hospital.

We noted that for some hospitals, uncompensated care costs initially included disallowed physician costs, bad debt, and clinic and finance charges. We also noted that additional uncompensated care costs were added to one of the surveys for claims with no credible source of third-party coverage as described under the "excepted benefits" examples in 45 CRF 146.145. In addition, duplicate claims in the amount of approximately $7,000 were removed from the uninsured uncompensated care costs for one of the hospitals.

We verified that the hospitals revised the surveys and that these corrections are reflected in the uncompensated care costs reported on Exhibit 1 (column 17). No other significant exceptions were noted that represented departures from the approved methodology for calculating uncompensated care costs.

Urban and rural private hospitals that received DSH payments in excess of $100,000 via an add-on to their normal DRG payment

We obtained and reviewed the hospitals' DSH survey for the Medicaid State Plan rate year ended September 30, 2008, which reported uncompensated care costs for the period.

We traced day, charge and payment data stemming from claims for Medicaid patients to data derived from the State's MMIS, where applicable. In addition, some hospitals reported Medicaid Managed Care (MCO) and Primary Care Network (PCN) days from their internal accounting

systems, as the information was not available from MMIS. Inpatient days were traced to hospitals' accounting records.

We examined days and charges summarized by revenue code from the MMIS for consistency with the mapping of days and charges in the survey.

We examined a selection of claims for uninsured patients and traced the claims to hospital billing and other accounting records to verify that only eligible days and charges were included in the uncompensated care costs.

We traced per diems and cost-to-charge ratios (used to quantify cost in the survey) to the applicable MCR amounts. We traced organ acquisition and IME/DGME costs and related payments to supporting documentation provided by the hospitals and MCRs, as applicable.

Results:

We noted that, in some instances, the hospitals' mapping of charges by revenue code did not reconcile to the supporting documents provided by the hospital or was inconsistent with the methodology used in prior years. Various corrections were made to the survey to conform to the supporting documentation provided by the hospital and improve the mapping of charges to various cost centers. We noted that additional revisions pertaining to the mapping of charges and quantification of uncompensated care costs were agreed to by another hospital, however, no adjustments were made to the survey as the overall effect on uncompensated care costs appeared to be immaterial.

We noted that, for one hospital, corrections were made to the DGME costs reported in the survey to reflect the information in the applicable MCRs. Minor modifications were also made to the liver and heart costs per organ used to quantify organ acquisition costs. Rather than using the cost per organ for Medicare claims the survey reflected the cost per organ for all claims, as there were no Medicare organ transplants in that fiscal year at the hospital.

We also noted that two of the four surveys submitted by the hospitals initially excluded Section 1011 payments totaling approximately $912,000.

We verified that the hospitals revised the surveys and that these corrections are reflected in the uncompensated care costs reported on Exhibit 1 (column 17). No other significant exceptions were noted that represented departures from the approved methodology for calculating uncompensated care costs.

Urban and rural privately owned hospitals that received DSH payments in amounts less than $100,000 via an add-on to their normal DRG payment

We obtained and reviewed the hospitals' DSH survey for the Medicaid State Plan rate year ended September 30, 2008, which reported uncompensated care costs for the period.

We traced day, charge and payment data stemming from claims for Medicaid patients to data derived from the State's MMIS, where applicable. Some hospitals reported MCO and PCN days from their internal accounting systems. Inpatient days were traced to hospital accounting records.

We examined days and charges summarized by revenue code from the MMIS for consistency with the mapping of days and charges in the survey.

We traced per diems and cost-to-charge ratios (used to quantify cost in the survey) to the applicable MCR amounts.

Results:
We noted that revisions were required to the Medicaid In-State days, charges, and payments for the hospitals that relied solely on the MMIS data for Medicaid fee-for-service (FFS) and FFS crossover claims. The surveys were revised to exclude retracted days, denied claims, reprocessed claims, and payment fields with known errors that were inadvertently included in the MMIS data.

The remaining nine hospitals relied upon their internal records to report Medicaid charges and payments, rather than the State's MMIS. The providers noted that by using their records, hospitals were able to consistently report FFS, MCO and PCN charges and payments, and reconcile any unknown revenue code classifications.

We noted one or more instance per hospital, where the surveys contained charges and payments that did not reconcile to the supporting documents provided by the hospitals. We verified that any differences between the routine days and ancillary charges reported in the survey and the hospitals' supporting documentation were resolved. In addition, corrections were required to the per diems and cost-to-charge ratios reported in the survey to agree to the applicable MCR amounts. Significant modifications were made to 8 of the 25 hospitals' mapping of charges by revenue code to more closely align with the methodology used for Medicare cost reporting purposes. In addition, certain supplemental payments (e.g., Medicare DSH, Medicare IME & GME, Medicare bad debt) applicable to dual eligible patients were also omitted by some of the hospitals.

We noted that the surveys submitted by 12 of the hospitals initially excluded Section 1011 payments totaling approximately $930,000.

We verified that the hospitals revised the surveys and these items were excluded from uncompensated care costs reported on Exhibit 1 (column 17). No other significant exceptions were noted that represented departures from the approved methodology for calculating uncompensated care costs.

VERIFICATION 4 – Application of Payments

For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed-care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third-party coverage for such services.

BACKGROUND

For hospitals in the State of Utah, payments offset against hospital service costs for purposes of the hospital-specific limit included: Medicaid claims payments, Medicaid managed-care payments, Medicaid supplemental payments (UPL, IME, DGME, etc.), third-party payments (including patient co-pays), Medicare regular rate payments, Medicare cross-over (including any patient co-pays, coinsurance and deductibles), Medicare cross-over allowable bad debt payments, and supplemental and enhanced Medicare payments attributable to dual eligible patients (including Medicare DSH, IME and DGME payments).

The State provided the hospitals the FFS regular Medicaid rate claims payments made to each DSH hospital from MMIS for the period covering the Medicaid State Plan rate year under review. Using their accounting records, hospitals reported all MCO and PCN information associated with the Section 1115 waiver program including supplemental and enhanced payments applicable to patients eligible for both Medicare and Medicaid.

PROCEDURES AND RESULTS

We examined the surveys obtained from each hospital to verify that all Medicaid payments were reported by the hospitals for the Medicaid State Plan rate year ended September 30, 2008, regardless of the related service cost. Regular FFS Medicaid payments were traced to the MMIS data provided by the State and to each hospital's accounting books and records. MCO and PCN payments were reconciled to the hospitals' accounting books and records. We also confirmed supplemental payments with the State.

Results:
We noted that revisions were required to the FFS Medicaid and FFS crossover claims payments to exclude denied claims, reprocessed claims, and coinsurance information that were inadvertently included in the MMIS data provided to the hospitals. In some instances, MCO and PCN payments reported in the surveys did not reconcile to supporting documents provided by the hospitals. We verified that major differences between the survey and the hospitals'

supporting documentation were resolved. In addition, we traced supplemental IME and DGME payments to records maintained by the State without exception.

Some hospitals initially omitted supplemental Medicare payments from the survey. Adjustments were made to each applicable DSH survey to include the Medicare DSH, IME, DGME and allowable bad debt payments applicable to dual eligibles, as required. Accordingly, all available Medicaid payments, including supplemental payments, were included in the revised calculation of the hospital-specific DSH payment limit, or uncompensated care costs outlined in the survey.

Due to the manner in which cost-to-charge ratios are established, the government-owned teaching hospital relied upon its internal records to report Medicaid charges and payments, rather than the State's MMIS. The charge and payment information provided was traced to applicable accounting records and reconciled to the MMIS, within reason.

Nine privately owned hospitals relied upon their internal records to report Medicaid charges and payments, rather than the State's MMIS. The providers noted that by using their records, hospitals were able to correct any payments relating to unknown contractual adjustments and spend-down estimates. The charge and payment information provided was traced to each hospital's applicable accounting records.

See Exhibit 1 (columns 6-10) for the verified Medicaid payments by hospital for the Medicaid State Plan rate year ended September 30, 2008.

VERIFICATION 5 – Information and Record Retention

Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under 42 CFR Section 455.304; and any payments made on behalf of the uninsured from payment adjustments under that Section has been separately documented and retained by the State.

PROCEDURES AND RESULTS

We examined the State's practices regarding document retention in connection with information and records pertaining to regular claimed expenditures (and related payments) by providers under the Medicaid program. Supplemental Medicaid payments including DSH, IME and DGME made to qualifying hospitals, hospital service costs and related payments made on behalf of the uninsured were also evaluated.

Results:
All pertinent records and documentation required to support payment adjustments, as described in 42 CFR §455.304, were available for our review. The primary record documenting uncompensated care costs for Medicaid and uninsured patients was a comprehensive survey developed jointly with the State for the DSH audit, which was submitted by each hospital that received DSH payments during the fiscal year ended September 30, 2008.

The State maintains archived records from the MMIS. The MMIS documents inpatient and outpatient hospital service costs and payments made under the FFS Medicaid in-state program, which supports Medicaid charge and payment information included in the surveys.

The State also retains records of the claims add-on and supplemental DSH payments made by the State, quarterly CMS 64 reports (which contain total DSH expenditures for the period), and copies of the approved State Plan outlining the methodology used by the State to make DSH payments.

VERIFICATION 6 – DSH Payment Limit Methodology

The information specified in Verification 5 includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act. Included in the description of the methodology, the audit report must specify how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the inpatient hospital and outpatient hospital service they received.

BACKGROUND

The primary documents which set forth the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act include the State Plan and the State's revised hospital survey document, which includes detailed instructions to hospitals and a spreadsheet model based on the approved methodology used to calculate uncompensated care costs.

PROCEDURES AND RESULTS

We reviewed the State Plan for provisions related to the definition of uncompensated care costs. We reviewed *42 CFR - Part 447 and 455, Medicaid Program; Disproportionate Share Hospital Payments; Final Rule,* (Final Rule) and CMS's *General DSH Audit and Reporting Protocol* - CMS-2198-F for rules on quantifying uncompensated care costs.

We worked directly with State personnel to develop a comprehensive hospital survey that quantifies uncompensated care costs for hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage using the principles set forth in the Final Rule and CMS's *General DSH Audit and Reporting Protocol (CMS 2198-F).*

Results:
The State Plan defines uncompensated care costs as "the amount of non-reimbursed costs written off as non-recoverable for services rendered to the uninsured, and includes the difference between cost of providing services to those eligible for medical assistance under the State Plan and the payment for those services by the State by Medicaid or any other payer."

The instructions which accompany the hospital survey for quantifying uncompensated care costs further clarifies that "uncompensated services for the uninsured include costs incurred for inpatient and outpatient hospital services to individuals with no source of third-party coverage for the hospital services they receive, including all Section 1011 charges for undocumented aliens. The uninsured uncompensated amount cannot include amounts associated with unpaid co-pays or deductibles for individuals with third-party insurance or any other unreimbursed costs associated with inpatient or outpatient services provided to

individuals with third-party coverage, but for which such third-party benefit package excludes such services. The uncompensated care cost does not include bad debt or payer discounts related to services furnished to individuals who have any form of insurance coverage. The total uncompensated care cost for the uninsured includes the cost of furnishing inpatient and outpatient services less any direct or indirect payments from or on behalf of such uninsured individuals." The instructions further specify that prisoners or other wards of the State are not considered uninsured.

The hospital survey includes a methodology for calculating incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the inpatient hospital and outpatient hospital service they received as follows:

1. *Medicaid FFS days and ancillary charges were derived from the State's MMIS and hospital accounting records and assigned to the applicable routine or nonroutine cost centers based on corresponding revenue code data.*

2. *Medicaid managed care days and ancillary charges were derived from hospital accounting records and assigned to the applicable routine or nonroutine cost centers based on corresponding revenue code data.*

3. *Uninsured days and charges were derived from hospital accounting and billing systems and allocated to routine and nonroutine cost centers using allocation methodologies based on service patterns for similar services or other means.*

4. *Total costs were determined by applying cost center days and charges to the respective routine per diems or nonroutine cost-to-charge ratios derived directly from the hospitals' 2552-96 MCRs.*

5. *All regular claims payments, managed care payments or other supplemental Medicaid or Medicare (dual eligible) payments, as well as any uninsured payments, including Section 1011 payments for undocumented aliens, were offset against total costs to determine the amount of total uncompensated care cost.*

UTAH DEPARTMENT OF HEALTH
HOSPITAL DATA SUMMARY SCHEDULE
FOR MEDICAID STATE PLAN RATE YEAR ENDED SEPTEMBER 30, 2008

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)
Hospital Name	Estimate of Hospital-Specific DSH Limit (Footnote 2)	Medicaid Inpatient Utilization Rate (MIUR)	Low Income Utilization Rate (LIUR)	State Defined DSH Qualification Criteria	IP/OP Medicaid Fee-For-Service (FFS) Basic Rate Payments	IP/OP Medicaid Managed Care Organization Payments	Supplemental /Enhanced Medicaid IP/OP Payments	Medicare Supplemental Settlements	Total Medicaid IP/OP Payments	Total Cost of Care for Medicaid IP/OP Services	Total Medicaid In-State & Out-Of-State Uncompensated Care	Uninsured IP/OP Revenues	Total Applicable Section 1011 Payments (Footnote 3)	Total Cost of IP/OP Care for the Uninsured	Total Uninsured IP/OP Uncompensated Care Costs	Total Annual Uncompensated Care Costs (Footnote 4 & 5)	Medicaid Disproportionate Share Hospital Payments
Allen Memorial Hospital	$ 616,415	5.89%	N/A	Qualifies. See Footnote (1)(a).	$ 1,758,978	$ -	$ -	$ -	$ 1,758,978	$ 1,867,370	$ 108,393	$ 1,058,000	$ -	$ 1,296,947	$ 238,947	$ 347,339	$ 616,415
American Fork Hospital	26,857	17.15%	11.35%	Qualifies. See Footnote (1)(b).	8,924,623	379,214	-	(4,646)	9,299,190	7,327,641	(1,971,549)	928,744	21,368	2,478,363	1,528,252	(443,297)	26,857
Ashley Regional Medical Center	12,182	17.67%	N/A	Qualifies. See Footnote (1)(a).	3,127,879	160,167	-	(1,651)	3,286,395	2,598,517	(687,877)	837,961	-	1,805,525	967,565	279,687	12,182
Bear River Valley Hospital	2,432	18.14%	N/A	Qualifies. See Footnote (1)(a).	886,043	14,029	-	(401)	899,672	847,215	(52,456)	239,671	-	495,592	255,921	203,465	2,432
Beaver Valley Hospital	620,345	22.15%	N/A	Qualifies. See Footnote (1)(a).	586,792	20,528	-	368	607,687	1,182,986	575,298	-	-	347,032	347,032	922,330	620,345
Brigham City Hospital	14,576	29.91%	N/A	Qualifies. See Footnote (1)(a).	3,188,058	304,301	-	(350)	3,492,009	2,699,704	(792,306)	208,946	1,062	838,561	628,553	(163,752)	14,576
Castleview Hospital	42,939	25.29%	N/A	Qualifies. See Footnote (1)(a).	5,382,311	230,311	-	3,476	5,616,098	4,754,068	(862,030)	350,927	-	626,888	275,960	(586,070)	42,939
Central Valley Medical Center	11,859	28.67%	N/A	Qualifies. See Footnote (1)(a).	2,303,385	-	-	189	2,303,574	1,843,070	(460,504)	193,431	-	590,252	396,820	(63,683)	11,859
Davis Hospital	8,528	15.53%	0.00%	Qualifies. See Footnote (1)(b).	3,612,419	5,498,582	-	2,989	9,113,990	6,331,015	(2,782,976)	888,723	-	2,139,700	1,250,977	(1,531,999)	8,528
Delta Community Medical Center	9,620	35.19%	N/A	Qualifies. See Footnote (1)(a).	1,074,536	2,718	-	-	1,077,254	1,019,726	(57,527)	90,152	68	296,471	206,251	148,724	9,620
Dixie Medical Center	71,669	16.64%	11.68%	Qualifies. See Footnote (1)(b).	21,851,048	1,881,814	-	981	23,733,843	22,665,610	(1,068,232)	2,174,609	261,455	10,307,273	7,871,210	6,802,978	71,669
Fillmore Hospital	5,144	31.64%	N/A	Qualifies. See Footnote (1)(a).	629,153	28	-	-	629,181	683,447	54,266	47,702	-	277,715	230,013	284,279	5,144
Garfield Memorial Hospital	341,464	14.96%	N/A	Qualifies. See Footnote (1)(a).	378,124	6,301	-	(19,309)	365,116	443,639	78,522	124,451	-	275,677	151,227	229,749	341,464
Gunnison Valley Hospital	533,514	24.67%	N/A	Qualifies. See Footnote (1)(a).	1,858,454	-	-	-	1,858,454	1,382,195	(476,259)	157,740	-	429,415	271,675	(204,584)	533,514
Heber Valley Medical Center	8,688	20.85%	N/A	Qualifies. See Footnote (1)(a).	1,265,996	6,245	-	-	1,272,241	1,140,267	(131,974)	349,182	-	1,007,174	657,992	526,018	8,688
Intermountain Medical Center	183,473	14.16%	11.06%	Qualifies. See Footnote (1)(b).	46,653,934	4,621,890	1,742,699	548,467	53,566,991	44,871,623	(8,695,368)	2,598,918	830,369	22,707,188	19,277,901	10,582,534	183,473
Jordan Valley Hospital	43,290	23.40%	0.00%	Qualifies. See Footnote (1)(b).	15,115,815	11,588,369	-	35,732	26,739,916	18,530,942	(8,208,974)	2,553,790	556,262	8,403,669	5,293,616	(2,915,357)	43,290
Kane County Hospital	622,732	33.37%	N/A	Qualifies. See Footnote (1)(a).	983,948	46,389	-	-	1,030,337	1,376,105	345,768	93,201	-	198,668	105,466	451,234	622,732
Lakeview Hospital	471	14.73%	6.50%	Qualifies. See Footnote (1)(b).	3,608,359	2,163,925	-	600	5,772,883	5,481,701	(291,183)	1,060,046	-	3,163,011	2,102,965	1,811,782	471
Logan Regional Medical Center	37,049	24.92%	13.53%	Qualifies. See Footnote (1)(b).	12,243,926	476,407	-	(3,929)	12,716,404	11,339,952	(1,376,453)	1,008,276	-	3,684,897	2,676,621	1,300,168	37,049
McKay Dee Hospital	117,087	22.94%	16.19%	Qualifies. See Footnote (1)(b).	36,219,276	3,844,438	814,410	137,902	41,016,027	32,933,617	(8,082,410)	1,572,847	-	12,638,799	11,065,952	2,983,542	117,087
Milford Valley Memorial Hospital	215,628	0.00%	N/A	Hospital does not qualify.	31,773	-	-	-	31,773	53,697	21,924	-	-	23,329	23,329	45,252	215,628
Mountain View (Columbia) Hospital	13,515	22.99%	11.25%	Qualifies. See Footnote (1)(b).	4,151,183	3,781,926	-	3,452	7,936,560	6,510,598	(1,425,963)	826,844	7,581	2,663,465	1,829,040	403,077	13,515
Mountain West Medical Center	22,974	19.38%	N/A	Qualifies. See Footnote (1)(a).	5,418,365	-	-	(7,963)	5,410,402	3,333,678	(2,076,724)	1,295,434	-	1,966,292	670,858	(1,405,866)	22,974
Ogden Regional Medical Center	1,191	20.75%	9.30%	Qualifies. See Footnote (1)(b).	8,268,522	9,408,128	-	(6,532)	17,670,118	13,406,072	(4,264,046)	953,926	11,895	3,687,546	2,721,725	(1,542,321)	1,191
Orem Community Hospital	10,366	32.41%	17.18%	Qualifies. See Footnote (1)(b).	3,906,604	97,606	-	(896)	4,003,314	3,872,421	(130,893)	345,597	6,235	892,183	540,351	409,458	10,366
Primary Childrens Medical Center	836,950	35.20%	26.65%	Qualifies. See Footnote (1)(b).	62,852,762	20,399,408	2,683,006	1,856	85,937,032	82,432,783	(3,504,249)	810,519	-	7,205,481	6,394,962	2,890,713	1,004,124
Salt Lake Regional Medical Center	10,650	9.01%	0.00%	Hospital does not qualify.	4,507,470	2,342,479	-	67,747	6,917,696	4,961,622	(1,956,073)	261,168	51,216	2,373,243	2,060,859	104,786	10,650
San Juan Hospital	1,023,883	31.46%	N/A	Qualifies. See Footnote (1)(a).	2,076,910	-	-	-	2,076,910	1,551,387	(525,523)	-	-	166,758	166,758	(358,765)	1,035,576
Sanpete Valley Hospital	21,619	33.42%	N/A	Qualifies. See Footnote (1)(a).	2,471,839	8,887	-	-	2,480,726	1,975,630	(505,096)	94,784	6,355	704,984	603,845	98,749	21,619
Sevier Valley Medical Center	18,282	26.94%	N/A	Qualifies. See Footnote (1)(a).	3,122,171	27,886	-	(13,135)	3,136,922	2,288,150	(848,772)	256,693	1,875	762,671	504,103	(344,669)	18,282
St Mark's Hospital	42,408	20.27%	8.73%	Qualifies. See Footnote (1)(b).	19,194,859	13,958,836	310,842	94,122	33,558,659	22,185,237	(11,373,422)	3,942,238	-	8,729,396	4,787,158	(6,586,264)	42,408
Timpanogos Regional Medical Center	297	17.72%	7.53%	Qualifies. See Footnote (1)(b).	4,819,620	2,849,345	-	(5,329)	7,663,636	6,326,680	(1,336,956)	608,674	-	2,003,835	1,395,161	58,205	297
Uintah Basin Medical Center	33,679	33.32%	N/A	Qualifies. See Footnote (1)(a).	3,726,719	-	-	18,419	3,745,138	3,479,203	(265,935)	-	-	2,321,910	2,321,910	2,055,975	33,679
University Of Utah Hospital	20,026,034	29.94%	15.55%	Qualifies. See Footnote (1)(b).	102,597,900	-	36,581,830	1,517,610	140,697,340	131,910,823	(8,786,518)	22,291,352	35,413	62,606,379	40,279,614	31,493,096	20,101,811
Utah Valley Regional Medical Center	199,705	24.82%	18.41%	Qualifies. See Footnote (1)(b).	47,772,353	3,933,714	1,017,854	101,940	52,825,861	44,546,271	(8,279,590)	1,930,905	81,254	11,987,479	9,975,320	1,695,730	199,705
Valley View Medical Center	54,346	26.09%	N/A	Qualifies. See Footnote (1)(a).	6,992,377	1,022,411	-	(37,225)	7,977,563	6,271,678	(1,705,886)	535,995	7,579	2,033,895	1,490,322	(215,563)	54,346
Utah State Hospital (IMD)	934,586	21.22%	102.17%	Qualifies. See Footnote (1)(b).	-	-	-	-	-	-	-	674,957	-	20,983,257	20,308,300	20,308,300	886,576

Footnotes:

(1) Utah State Plan DSH qualification criteria: (a). Rural Hospitals- All rural hospitals qualify automatically for DSH if they have met I and II. (b). IMD, Teaching & Urban Hospitals- Must have met I and II and at least one of the criteria shown in III or IV. (I). Have a MIUR of at least 1%. (II). Have at least 2 obstetricians who have staff privileges & agree to provide these services to individuals entitled to "medical assistance". (III). Have a MIUR of at least 14%. (IV). Have a LIUR of at least 25%.

(2) The hospital-specific DSH limit is the lower of the cap set forth in the State Plan or the actual DSH payment for the hospital's estimated uncompensated care costs less any out-of-state DSH monies paid for the Medicaid State Plan rate year ended September 30, 2008. The State IMD DSH limit is set under Federal Register Vol. 72, No. 248.

(3) Section 1011 payments were reported based on information requested by the Department of Health under the Freedom of Information Act (FOIA).

(4) Uncompensated care is defined as the amount of non-reimbursed costs written off as non-recoverable for services rendered to the uninsured, i.e., indigent, and includes the difference between cost of providing services to those eligible for medical assistance under the State Plan and the payment for those service by the State by Medicaid or any other payer. Uncompensated care also includes, costs incurred for inpatient and outpatient hospital services to individuals with no source of third-party coverage for the hospital services they receive, including all Section 1011 charges for undocumented aliens. The uninsured uncompensated amount cannot include amounts associated with unpaid co-pays or deductibles for individuals with third-party insurance or any other unreimbursed costs associated with inpatient or outpatient services provided to individuals with third-party coverage, but for which such third-party benefit package excludes such services. Nor does uncompensated care cost include bad debt or payer discounts related to services furnished to individuals who have any form of insurance coverage. The total uncompensated care costs for the uninsured includes the cost of furnishing inpatient and outpatient services less any direct or indirect payments from or on behalf of such uninsured individuals. Prisoners or other wards of the State are not considered uninsured.

(5) Negative uncompensated care amounts represent total payments in excess of total hospital service costs for Medicaid eligible and uninsured patients.

EXHIBIT 1