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, 2009

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CARVER FLOREK & JAMES, CPA's
CERTIFIED PUBLIC ACCOUNTANTS

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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, 2009. 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 28, 2012

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UTAH DEPARTMENT OF HEALTH

Schedule of Agreed-Upon Procedures
Medicaid State Plan Year Ended September 30, 2009

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 (a hospital is exempt from this OB requirement if that hospital's patients are predominantly under 18 years of age, or if that hospital did not offer non-emergency obstetric services when federal Medicaid DSH regulations were enacted on December 22, 1987). 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 generally 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 by SSA§1923(d), 42 U.S.C. §1396r-4(d), the Final Rule, and the State Plan.

<u>Results</u>:
We noted that 3 of the 39 hospitals receiving DSH payments did not qualify. One of the government-owned rural hospitals that received a supplemental DSH payment did not meet the DSH qualification requirement of having at least two obstetricians who provide these services, and the other two 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, 2009.

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, 2009.

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 known differences. We also traced all supplemental DSH payments for the period to documentation provided by the State to verify the payment types and amounts, and that the payments were 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:
All 39 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.

We noted that some of the hospitals omitted or misstated DSH add-on payments or out-of-state DSH payments in the calculation of total uncompensated care costs in their survey. We verified that the hospitals revised the surveys and these corrections are reflected in the DSH payments reported on Exhibit 1 (column 18).

Exhibit 1 (column 18) presents verified DSH payments by hospital for the Medicaid State Plan rate year ended September 30, 2009.

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 received by the hospitals for the Medicaid State Plan rate year ended September 30, 2009, with the uncompensated care costs for the same period and quantified the amounts where DSH payments exceeded the hospital-specific uncompensated care costs. We also compared DSH payments for the period with the hospital-specific DSH payment limits set forth in the State Plan.

Results:
We noted that 12 of the 36 eligible hospitals reported DSH payments that exceeded the hospitals' reported uncompensated care costs for the period. Excess DSH payments aggregated approximately $684,000 and ranged by hospital from $13,369 to $207,834, with the highest excess noted for a government-owned rural hospital. For the remaining 23 hospitals, excluding the state-operated 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 $69.2 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 neither the state-operated IMD nor any of the seven rural hospitals received supplemental DSH payments in excess of the limits outlined in the approved Medicaid State Plan.

Exhibit 1 (columns 2 and 18) presents the hospital-specific DSH limit (measured based on total uncompensated care cost in the surveys) and the DSH payments for the Medicaid State Plan rate year ended September 30, 2009.

The hospital DSH survey required each provider to report uncompensated care costs for the Medicaid State Plan rate year ending September 30, 2009. 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 quantified costs of hospital services using 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 also performed procedures to ensure that DSH payments for the year ended September 30, 2009, were 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, 2009.

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, 2009.

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. The survey quantified hospital service costs 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.

For most hospitals, DSH payments are awarded based on a percentage add-on to their normal Diagnostic Related Group (DRG) payment, with the exception of the IMD which received a DSH component through its Medicaid cost settlement rather than an add-on to claims payments during the period. In addition, the teaching hospital and government-owned rural hospitals also received larger supplemental DSH payments separate from the routine DRG payment.

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 classified into the following five categories: (1) State-owned teaching hospital, (2) State-owned IMD hospital, (3) Other government-owned rural hospitals that received supplemental DSH payments, (4) Urban and rural privately owned hospitals that received DSH payments in excess of $100,000 via an add-on to their normal 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, 2009.

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, 2009, 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 each claim's 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 2009 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 from the fiscal 2008 data and testing 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 and DGME payments to supporting documentation retained by the State.

Results:

We noted that the survey initially submitted by the hospital contained 795 Medicaid dual eligible duplicate claims totaling $790,000, and one self pay duplicate claim totaling $41,000. We verified that these claims and any related payments were removed from the uncompensated care costs reported on the DSH survey. Section 1011 payments of approximately $64,000 were also omitted from the original survey. Minor modifications were made to the hospital's LIUR to exclude outpatient hospital charges attributable to charity care. A correction was made to the hospital's MIUR computation to report total inpatient days for the year ending September 30, 2009 rather than the hospital's fiscal year end. The state-owned teaching hospital's uncompensated care costs for the Medicaid State Plan rate year ended September 30, 2009 are presented in Exhibit 1 (column 17).

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, 2009, which reported uncompensated care costs for the period. Uninsured days were determined 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. We traced per diems (used to quantify cost in the survey) to the applicable Medicaid cost settlements rather than the hospital's MCR's. *The per diems reported in the Medicaid cost settlements are a better representation of the hospital's true costs, as the costs per day are measured separately for youth, adult, and forensic patients in the IMD.* Uninsured ancillary charges were excluded, as they could not be reasonably obtained from the hospital's books and records. Charges were then offset against all payments received from the Office of Recovery Services (ORS) as well as any self-pay payments including social security (SS) or Veterans Affairs (VA) payments allocated for healthcare services.

Results:

We verified that all Medicaid charges and any related payments were removed as the hospital undergoes an annual Medicaid cost settlement with the State of Utah and this settlement results in little, if any, Medicaid uncompensated care. Uninsured days were prorated for the Medicaid State Plan rate year ending September 30, 2009. In addition, self-pay payments of approximately $780,000 were omitted from the survey initially submitted by the IMD. The per diems reported in the survey were revised to agree with the applicable Medicaid cost settlements. Minor modifications were also made to the hospital's LIUR to report Medicaid payments for the Medicaid State Plan rate year ending September 30, 2009.

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

Other government-owned rural hospitals that received supplemental DSH payments

We obtained and reviewed the hospitals' DSH surveys for the Medicaid State Plan rate year ended September 30, 2009, 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 those disclosed in the MCR.

Results:

We noted that for some hospitals, uncompensated care costs initially included disallowed physician costs, bad debt, clinic and finance charges, and claims outside the Medicaid State Plan rate year ended September 30, 2009. We also discovered claims with third-party coverage in the uninsured uncompensated care calculation for four of the seven hospitals. In addition, we identified 114 duplicate claims totaling approximately $58,000 for one hospital. We verified that the hospitals revised their surveys, and that these items were excluded from the uncompensated care costs reported on Exhibit 1 (column 17).

We noted that in some instances, minor 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' records were resolved. Minor modifications were made to five of the seven hospitals' mapping of charges by revenue code to more closely conform with the MCR. In addition, three of the seven hospitals were unable to readily map uninsured charges to cost-to-charge ratios on the MCR due to system limitations in capturing detailed charges. In these instances, the weighted average cost-to-charge ratio derived from the Medicaid ancillary charges was applied to total uninsured charges.

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 2008 DSH payments totaling approximately $82,000 were included in 2009 DSH payments for one of the seven hospitals. We verified that this amount was removed from the DSH payments.

We verified that the hospitals revised the surveys and that these corrections were 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, 2009, 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 Medicaid Managed Care (MCO) and Primary Care Network (PCN) days from their internal accounting systems, as the information was not available from MMIS. In these instances, the reported inpatient days were traced to hospitals' internal 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 internal 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 internal records provided by the hospitals and MCRs, as applicable.

Results:
We noted that, for one hospital, corrections were required as the cost-to-charge ratios reported did not agree to the applicable MCR amounts.

We verified that the hospital revised their survey and that these corrections are incorporated in the calculation of 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, 2009, 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:
For some hospitals we noted one or more instance 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, 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 seven of the hospitals initially excluded Section 1011 payments totaling approximately $138,000. Minor modifications were made to the MIUR and LIUR initially reported by some of the hospitals. We also noted that corrections were required to the per diems and cost-to-charge ratios reported in the survey to agree with the applicable MCR amounts.

We noted that 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 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 with 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, 2009, 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 internal 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 some instances where FFS, MCO and PCN payments reported in the surveys did not reconcile to supporting documents provided by the hospitals. We verified that 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 tolerable amounts.

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, 2009.

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 have 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, 2009.

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 the cost of uncompensated care.

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,* 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, 2009

(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	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	$ 869,964	36.93%	N/A	Qualifies. See Footnote (1)(a).	$ 1,210,948	$ -	$ -	$ -	$ 1,210,948	$ 1,706,614	$ 495,667	$ 464,217	$ -	$ 925,432	$ 461,215	$ 956,882	$ 869,964
American Fork Hospital	25,898	17.15%	11.49%	Qualifies. See Footnote (1)(b).	9,845,514	505,578	-	3,841	10,354,933	7,886,415	(2,468,518)	703,519	8,379	2,340,339	1,628,441	(840,077)	25,898
Ashley Regional Medical Center	15,481	19.89%	N/A	Qualifies. See Footnote (1)(a).	3,875,033	170,103	-	12,263	4,057,399	3,101,970	(955,430)	559,805	-	1,870,310	1,310,505	355,075	15,481
Bear River Valley Hospital	2,154	14.05%	N/A	Qualifies. See Footnote (1)(a).	1,023,548	20,894	-	372	1,044,814	1,070,840	26,026	209,069	-	675,597	466,528	492,555	2,154
Beaver Valley Hospital	870,421	26.72%	N/A	Qualifies. See Footnote (1)(a).	1,085,387	57,841	-	3,342	1,146,569	1,481,569	334,999	354,863	-	924,529	569,665	904,665	870,421
Brigham City Hospital	16,974	33.12%	N/A	Qualifies. See Footnote (1)(a).	4,194,355	302,000	-	(225)	4,496,130	3,063,984	(1,432,146)	231,358	3,503	833,962	599,101	(833,046)	16,974
Castleview Hospital	47,865	26.51%	N/A	Qualifies. See Footnote (1)(a).	5,609,362	252,219	-	5,044	5,866,625	4,645,888	(1,220,737)	257,682	-	773,079	515,397	(705,340)	47,865
Central Valley Medical Center	14,155	30.92%	N/A	Qualifies. See Footnote (1)(a).	2,394,225	-	-	-	2,394,225	1,775,544	(618,682)	228,817	-	820,996	592,180	(26,502)	14,155
Davis Hospital	13,414	6.13%	8.98%	Hospital does not qualify.	4,037,129	-	-	3,287	4,040,416	2,789,534	(1,250,883)	710,036	272	2,130,375	1,420,068	169,185	13,414
Delta Community Medical Center	8,276	32.77%	N/A	Qualifies. See Footnote (1)(a).	1,155,937	14,624	-	-	1,170,561	1,063,988	(106,573)	85,880	578	415,681	329,223	222,650	8,276
Dixie Medical Center	68,383	18.80%	11.85%	Qualifies. See Footnote (1)(b).	24,579,200	2,191,519	-	76,618	26,847,337	25,585,796	(1,261,541)	1,935,075	55,051	9,714,421	7,724,295	6,462,754	68,383
Fillmore Hospital	5,826	24.09%	N/A	Qualifies. See Footnote (1)(a).	644,606	2,159	-	-	646,765	635,343	(11,422)	32,574	-	213,645	181,071	169,649	5,826
Garfield Memorial Hospital	512,753	17.64%	N/A	Qualifies. See Footnote (1)(a).	415,313	13,857	-	(5,661)	423,508	546,239	122,730	167,161	-	379,551	212,390	335,120	512,753
Gunnison Valley Hospital	445,671	22.57%	N/A	Qualifies. See Footnote (1)(a).	1,333,621	-	-	-	1,333,621	1,144,397	(189,224)	230,290	-	657,352	427,061	237,838	445,671
Heber Valley Medical Center	10,404	22.35%	N/A	Qualifies. See Footnote (1)(a).	1,471,889	27,492	-	-	1,499,381	1,360,537	(138,845)	306,838	-	929,042	622,203	483,359	10,404
Intermountain Medical Center	211,345	15.80%	11.75%	Qualifies. See Footnote (1)(b).	58,990,966	5,666,540	1,599,738	532,596	66,789,840	52,817,767	(13,972,074)	2,586,775	134,346	26,400,515	23,679,393	9,707,320	211,345
Jordan Valley Hospital	49,933	15.11%	15.13%	Qualifies. See Footnote (1)(b).	16,024,017	-	-	20,590	16,044,608	12,119,090	(3,925,518)	2,249,407	121,344	9,001,979	6,631,228	2,705,710	49,933
Kane County Hospital	711,751	28.30%	N/A	Qualifies. See Footnote (1)(a).	199,202	43,924	-	451	243,576	865,988	622,412	34,006	-	362,570	328,564	950,976	711,751
Lakeview Hospital	6,984	19.32%	10.57%	Qualifies. See Footnote (1)(b).	3,962,366	3,057,971	-	42,474	7,062,812	6,914,800	(148,011)	843,643	-	3,492,357	2,648,714	2,500,703	6,984
LDS Hospital	130	19.52%	15.25%	Qualifies. See Footnote (1)(b).	20,048,622	2,157,888	11,290	87,437	22,305,236	20,840,384	(1,464,852)	1,947,310	84,454	14,290,657	12,258,893	10,794,041	130
Logan Regional Medical Center	39,373	24.43%	13.76%	Qualifies. See Footnote (1)(b).	13,591,546	567,857	-	(7,006)	14,152,396	13,236,720	(915,676)	1,049,422	-	3,935,131	2,885,709	1,970,033	39,373
McKay Dee Hospital	106,626	21.76%	15.64%	Qualifies. See Footnote (1)(b).	35,958,195	4,770,477	756,221	172,903	41,657,796	32,339,043	(9,318,753)	1,479,114	-	14,886,651	13,407,537	4,088,785	106,626
Milford Valley Memorial Hospital	150,585	17.86%	N/A	Hospital does not qualify.	24,026	533	-	-	24,559	81,007	56,447	16,632	-	74,449	57,817	114,265	150,585
Mountain View (Columbia) Hospital	13,369	23.95%	16.52%	Qualifies. See Footnote (1)(b).	4,098,853	4,939,926	-	(370)	9,038,409	7,082,297	(1,956,112)	627,018	1,330	2,069,895	1,441,548	(514,565)	13,369
Mountain West Medical Center	42,864	19.72%	N/A	Qualifies. See Footnote (1)(a).	6,267,262	-	-	6,741	6,274,003	3,638,428	(2,635,576)	1,668,766	-	1,644,471	(24,295)	(2,659,871)	42,864
Ogden Regional Medical Center	17,730	23.07%	13.24%	Qualifies. See Footnote (1)(b).	8,095,757	11,914,175	-	27,267	20,037,199	14,664,963	(5,372,237)	745,131	593	4,161,539	3,415,815	(1,956,422)	17,730
Orem Community Hospital	14,184	35.64%	21.47%	Qualifies. See Footnote (1)(b).	4,550,632	68,045	-	-	4,618,677	4,579,310	(39,366)	295,966	2,332	851,159	552,861	513,494	14,184
Primary Childrens Medical Center	834,823	39.60%	27.77%	Qualifies. See Footnote (1)(b).	65,435,175	28,330,065	2,773,457	1,923	96,540,620	95,920,806	(619,814)	1,035,869	-	8,165,191	7,129,322	6,509,508	834,823
Salt Lake Regional Medical Center	8,558	10.80%	7.11%	Hospital does not qualify.	4,599,902	-	-	62,297	4,662,199	4,910,744	248,545	404,681	10,678	2,589,529	2,174,171	2,422,717	8,558
San Juan Hospital	790,270	37.70%	N/A	Qualifies. See Footnote (1)(a).	1,046,990	-	-	-	1,046,990	1,572,840	525,850	147	-	324,154	324,007	849,857	790,270
Sanpete Valley Hospital	14,181	32.73%	N/A	Qualifies. See Footnote (1)(a).	2,054,118	22,495	-	-	2,076,613	1,646,463	(430,150)	79,992	1,800	605,678	523,886	93,736	14,181
Sevier Valley Medical Center	24,080	30.32%	N/A	Qualifies. See Footnote (1)(a).	3,428,196	21,178	-	(3,064)	3,446,310	2,441,696	(1,004,613)	208,082	704	608,581	399,795	(604,819)	24,080
St Mark's Hospital	38,857	22.79%	14.65%	Qualifies. See Footnote (1)(b).	20,269,572	18,627,196	607,896	246,642	39,751,306	26,617,393	(13,133,914)	2,626,684	-	8,984,566	6,357,882	(6,776,032)	38,857
Timpanogos Regional Medical Center	12,137	20.12%	11.46%	Qualifies. See Footnote (1)(b).	5,841,155	4,785,998	-	10,232	10,637,385	8,869,312	(1,768,073)	481,407	47	3,506,453	3,024,998	1,256,925	12,137
Uintah Basin Medical Center	36,662	34.90%	N/A	Qualifies. See Footnote (1)(a).	3,240,159	-	-	-	3,240,159	4,313,771	1,073,612	2,212,736	-	2,352,477	139,741	1,213,353	36,662
University Of Utah Hospital	21,026,282	29.46%	14.01%	Qualifies. See Footnote (1)(b).	114,817,320	-	36,448,844	2,340,447	153,606,611	150,820,915	(2,785,696)	20,901,015	64,247	63,841,670	42,876,408	40,090,712	21,026,282
Utah Valley Regional Medical Center	185,902	25.59%	17.50%	Qualifies. See Footnote (1)(b).	48,185,450	4,818,411	1,025,242	109,706	54,138,809	44,427,804	(9,711,005)	1,889,657	28,746	13,444,198	11,525,795	1,814,789	185,902
Valley View Medical Center	57,150	27.91%	N/A	Qualifies. See Footnote (1)(a).	7,790,306	1,242,394	-	(5,197)	9,027,502	6,707,913	(2,319,589)	504,731	3,868	2,042,636	1,534,037	(785,553)	57,150
Utah State Hospital (IMD)	934,586	17.49%	102.69%	Qualifies. See Footnote (1)(b).	-	-	-	-	-	-	-	780,890	-	18,525,531	17,744,640	17,744,640	893,362

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, 2009. The State IMD DSH limit is set under Federal

(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 services 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