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, 2010

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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, 2010. 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, 2013

UTAH DEPARTMENT OF HEALTH

Schedule of Agreed-Upon Procedures
Medicaid State Plan Rate Year Ended September 30, 2010

VERIFICATION 1 – DSH Payment Qualification and 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 that hospital did not offer non-emergency obstetric services when federal Medicaid DSH regulations were enacted on December 22, 1987). In addition to meeting the obstetrical and minimum utilization rate requirements, hospitals must meet at least one of the following five conditions in order to be deemed a disproportionate share provider as defined under the Utah State Plan.

- The hospital's MIUR is at least one standard deviation above the mean MIUR.
- The hospital's low income utilization rate (LIUR) exceeds 25 percent.
- The hospital's MIUR exceeds 14 percent.
- The hospital's Primary Care Network (PCN) participation is at least 10 percent of the total of all Utah hospitals' PCN patient care charges.
- The hospital meets the definition of a "sole community hospital." A sole community hospital is defined as a hospital that is located in a rural county and is more than 29 miles from another hospital.

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.

Results:
We noted that one of the 40 hospitals receiving DSH payments did not qualify. One privately owned urban hospital did not meet any of the five DSH qualification requirements outlined under the State Plan. The remaining 39 hospitals all qualified to receive DSH payments during the Medicaid State Plan rate year ended September 30, 2010. DSH payments to the one ineligible hospitals totaled $3,248 for the Medicaid State Plan rate year ended September 30, 2010.

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, 2010.

We agreed the add-on and supplemental DSH payments reported by the hospitals to the Medicaid Management Information System (MMIS) data provided by the State, and resolved any differences that were initially observed. We also traced all supplemental DSH payments for the period to payment summaries provided by the State and verified the type, amount, and that the payments were reported in the proper period. In addition, we obtained written representation from hospital management verifying that each hospital retained its full DSH payment.

Results:
We noted that some of the hospitals omitted or misstated DSH add-on payments or supplemental DSH payments in the calculation of uncompensated care costs in their survey. We verified that the hospitals revised the surveys and that these corrections are reflected in the DSH payments reported on Exhibit 1 (column 17).

All 40 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 17) presents verified DSH payments by hospital for the Medicaid State Plan rate year ended September 30, 2010.

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, 2010 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 21 of the 39 eligible hospitals reported DSH payments that exceeded the hospitals' reported uncompensated care costs for the period. Excess DSH payments aggregated approximately $2.1 million and ranged by hospital from $8,785 to $753,850, with the highest excess noted for a government-owned rural hospital. For the remaining 17 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 $63.4 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 none of the seven rural hospitals received supplemental DSH payments in excess of the limit outlined in the approved Medicaid State Plan.

Exhibit 1 (columns 2 and 17) presents the hospital-specific DSH limit and the DSH payments for the Medicaid State Plan rate year ended September 30, 2010.

The hospital DSH survey required each provider to report uncompensated care costs for the Medicaid State Plan rate year ending September 30, 2010. We also verified that DSH payments were measured against uncompensated care costs for that same period. In order to report uncompensated care costs for the period, routine days, ancillary charges, and claims payment information was determined for the Medicaid State Plan rate year, and hospitals quantified costs of hospital inpatient and outpatient services using cost data from two or more *Medicare 2552-96 hospital cost reports* (MCR) when their reporting periods did not correspond with the Medicaid State Plan rate year.

Results:

The DSH survey completed by each hospital measured DSH payments against actual uncompensated care costs for that same Medicaid State Plan rate year ended September 30, 2010.

Exhibit 1 (columns 16 and 17) presents reviewed total uncompensated care costs and total DSH payments, by hospital, for the Medicaid State Plan rate year ended September 30, 2010.

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 are required to submit 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 each qualifying hospital, DSH payments are calculated as a percentage add-on to their normal Diagnostic Related Group (DRG) payment, with the exception of the IMD which received a supplemental DSH payment through its annual Medicaid cost settlement rather than an add-on to its claims payments during this period. In addition, the state-owned teaching hospital and other government-owned rural hospitals are also eligible to receive supplemental DSH payments.

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 IMD hospital, (3) Other government-owned rural hospitals that received supplemental DSH payments, (4) Urban and rural privately owned hospitals that received DSH payments equal to or greater than $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 16) presents verified total uncompensated care costs, by hospital, for the Medicaid State Plan rate year ended September 30, 2010. Negative uncompensated care

amounts represent total payments in excess of total hospital service costs for Medicaid eligible and uninsured patients.

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 the uninsured. 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, 2010, 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.

For purposes of the 2010 survey, charges were mapped to the respective cost centers using service patterns from the hospital's fiscal year ended 2010. In prior years, we examined the allocation of charges among cost centers by verifying the source of a sample of charges from that fiscal year and testing the integrity of the allocation formulas. No additional allocation testing was performed, as the methodology used in 2010 was consistent with prior years.

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 over 1,750 duplicate claims totaling over $1M in net uncompensated care costs. We verified that all duplicate claims and any related payments were removed from the DSH survey. A review of the hospital's organ acquisition costs identified two additional Medicaid dual-eligible kidney transplants that had been excluded from the original survey. Minor modifications were made to the hospital's nursery per diems and ancillary cost-to-charge ratios. In addition, adjustments were made to the hospital's LIUR to exclude outpatient hospital charges attributable to charity care and to revise cash subsidies and patient net revenues to agree with the information contained in the applicable MCRs. We also noted that a correction was made to the hospital's MIUR computation to report total inpatient days for the 12 months ending September 30, 2010 rather than the hospital's fiscal year end.

Due to the manner in which payments are received on behalf of patients with no source of third party coverage, the teaching hospital reported all payments pertaining to a claim, regardless of the timing, as of the date the DSH survey was prepared. Since this methodology differs from that outlined in CMS's *General DSH Audit and Reporting Protocol (CMS 2198-F), an analysis was performed to quantify any additional payments from the prior year that were received after the 2009 DSH survey was prepared. As a result, an adjustment was made to include approximately $34,500 in additional payments pertaining to uninsured claims from the prior year. Of the $33.9 million in uninsured payments, the additional $34,500 represented only 0.1 percent of the total payments. The state-owned teaching hospital's uncompensated care cost for the Medicaid State Plan rate year ended September 30, 2010 is presented in Exhibit 1 (column 16).*

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 is considered to have no 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, 2010, 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. In order to be consistent with the Medicaid approach, costs were determined using Medicaid cost settlement data since routine service per diems in the Medicaid cost settlement were presented on a more granular basis than in the IMD's MCR. We traced the total days to the hospital's accounting records. We traced Medicare, Medicaid, and forensic patients' days to supporting documents provided by the hospital. We traced per diems to the applicable Medicaid cost settlement reports. Uninsured ancillary charges were excluded, as they could not be reasonably obtained from the hospital's books and records. As a result, uninsured service costs for the IMD are potentially understated by an undetermined amount for ancillary charges not reported in the DSH survey. 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 designated for healthcare services.

Results:

We verified that all Medicaid charges and any related payments were excluded from the uncompensated care costs reported in the DSH survey as the hospital undergoes an annual Medicaid cost settlement with the State of Utah and has little, if any, Medicaid uncompensated care. In addition, self-pay payments of approximately $728,000 were adjusted in the survey because the hospital reported the payments from its fiscal year ended June 30, rather than for the 12 months ending September 30, 2010. The per diems reported in the survey were agreed to the applicable Medicaid cost settlements rather than the MCRs. 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 rather than a single combined cost center.

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 survey for the Medicaid State Plan rate year ended September 30, 2010, 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 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, 2010. We also discovered claims with third-party coverage in the uninsured uncompensated care calculation for four of the seven hospitals. The primary source documents used to develop FFS and FFS crossover routine costs for the DSH survey was the MMIS data provided by the State. During our review we discovered that the routine days reported in the MMIS data inadvertently included non-covered incremental nursing days and swing bed days. We verified that the hospitals revised the surveys, and that these costs were excluded from the uncompensated care costs reported on Exhibit 1 (column 16).

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' supporting documentation were resolved. Minor modifications were made to six of the seven hospitals' mapping of Medicaid and/or uninsured charges by revenue code to more closely align with the methodology used to assign charges to cost centers for Medicare cost reporting purposes. 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.

Corrections were made to the hospitals' MIUR computations to report total inpatient days for the 12 months ending September 30, 2010, rather than the hospitals' fiscal year end. 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 verified that the hospitals revised the surveys and that these corrections were reflected in the uncompensated care costs reported on Exhibit 1 (column 16). 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, 2010, 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 PCN days from their internal accounting systems, as the information was not available from MMIS. In these instances, 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, minor corrections were required to ancillary cost-to-charge ratios reported in two of the hospitals' surveys to agree to the applicable MCR amounts. In addition, certain supplemental payments (e.g., Medicare DSH, Medicare IME & GME, Medicare bad debt) applicable to dual eligible patients were also omitted by one of the hospitals.

We verified that the hospitals revised their surveys and that these corrections are reflected in the uncompensated care costs reported on Exhibit 1 (column 16). 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, 2010, 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 instances 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. The primary source documents used to develop FFS and FFS crossover routine costs for the DSH survey was the MMIS data provided by the State. During our review we discovered that the routine days reported in the MMIS data inadvertently included incremental nursing days and swing bed days. We verified that these non-covered days were excluded from the uncompensated care costs reported on Exhibit 1 (column 16).

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. 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 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 that these items were excluded from uncompensated care costs reported on Exhibit 1 (column 16). 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, 2010, 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 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, 2010.

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, 2010.

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,* 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 should 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. For the IMD, total costs were determined using routine service per diems from the hospital's Medicaid cost settlement.*

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, 2010

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
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 & Medicare Supplemental Settlements	Total Cost of Care for Medicaid IP/OP Services	Total Medicaid Uncompensated Care	Uninsured IP/OP Revenues	Total Cost of IP/OP Care for the Uninsured	Total Uninsured IP/OP Uncompensated Care Costs	Total Annual Uncompensated Care Costs (Footnote 3 & 4)	Medicaid Disproportionate Share Hospital Payments
Allen Memorial Hospital	$ 1,200,442	21.00%	N/A	Qualifies. See Footnote (1).	$ 1,539,662	$ 31,614	$ -	$ -	$ 1,571,276	$ 1,643,748	$ 72,472	$ 336,538	$ 1,002,493	$ 665,955	$ 738,427	$ 1,200,442
Alta View Hospital	3,248	13.78%	8.90%	Hospital does not qualify.	5,617,094	837,146	625,833	476	7,080,548	5,313,406	(1,767,142)	1,038,270	4,331,481	3,293,211	1,526,070	3,248
American Fork Hospital	21,520	20.25%	13.08%	Qualifies. See Footnote (1).	10,375,375	560,437	1,125,822	14,827	12,076,461	9,511,648	(2,564,813)	949,417	3,077,899	2,128,482	(436,331)	21,520
Ashley Regional Medical Center	19,384	20.35%	N/A	Qualifies. See Footnote (1).	4,886,475	201,241	-	13,036	5,100,752	3,431,225	(1,669,527)	529,402	1,560,260	1,030,858	(638,669)	19,384
Bear River Valley Hospital	3,752	20.48%	N/A	Qualifies. See Footnote (1).	1,180,376	53,307	150,900	435	1,385,018	1,446,296	61,278	233,025	922,168	689,143	750,422	3,752
Beaver Valley Hospital	948,024	26.85%	N/A	Qualifies. See Footnote (1).	1,060,582	42,305	-	4,420	1,107,307	1,435,971	328,664	303,291	782,644	479,353	808,017	948,024
Brigham City Hospital	31,778	34.13%	N/A	Qualifies. See Footnote (1).	4,659,609	541,475	648,720	711	5,850,515	3,216,316	(2,634,199)	183,544	940,878	757,334	(1,876,865)	31,778
Castleview Hospital	61,534	26.95%	N/A	Qualifies. See Footnote (1).	6,706,168	53,436	-	2,782	6,762,386	5,027,971	(1,734,415)	297,339	672,602	375,263	(1,359,152)	61,534
Central Valley Medical Center	22,160	26.42%	N/A	Qualifies. See Footnote (1)(a).	3,207,240	-	-	(987)	3,206,253	1,990,905	(1,215,348)	267,162	859,646	592,484	(622,864)	22,160
Davis Hospital	10,280	21.72%	12.21%	Qualifies. See Footnote (1).	5,170,387	7,061,834	951,751	1,241	13,185,213	9,689,976	(3,495,237)	561,300	2,565,423	2,004,123	(1,491,114)	10,280
Delta Community Medical Center	9,184	36.49%	N/A	Qualifies. See Footnote (1).	1,114,301	22,802	332,925	-	1,470,028	1,100,432	(369,596)	112,223	316,312	204,089	(165,507)	9,184
Dixie Medical Center	53,009	18.68%	14.02%	Qualifies. See Footnote (1).	24,029,636	3,469,282	7,712,295	78,943	35,290,156	26,367,796	(8,922,360)	2,212,502	11,385,443	9,172,941	250,581	53,009
Fillmore Hospital	6,053	38.52%	N/A	Qualifies. See Footnote (1).	743,658	4,625	183,973	-	932,256	792,339	(139,917)	42,238	267,425	225,187	85,269	6,053
Garfield Memorial Hospital	320,969	19.42%	N/A	Qualifies. See Footnote (1).	293,855	23,655	445,920	17,736	781,167	667,611	(113,556)	153,306	359,743	206,437	92,881	320,969
Gunnison Valley Hospital	203,450	21.49%	N/A	Qualifies. See Footnote (1).	1,656,903	-	-	-	1,656,903	1,444,662	(212,240)	227,372	671,972	444,600	232,359	203,450
Heber Valley Medical Center	7,276	24.72%	N/A	Qualifies. See Footnote (1).	1,150,455	14,611	420,216	-	1,585,282	1,131,741	(453,541)	265,266	871,992	606,726	153,186	7,276
Intermountain Medical Center	163,589	15.87%	12.66%	Qualifies. See Footnote (1).	56,803,959	5,578,637	8,874,228	592,814	71,849,638	55,745,034	(16,104,604)	2,731,611	30,398,264	27,666,652	11,562,048	163,589
Jordan Valley Hospital	53,669	27.72%	13.97%	Qualifies. See Footnote (1).	17,538,713	10,483,417	5,244,461	27,334	33,293,924	26,015,212	(7,278,712)	1,845,426	8,565,111	6,719,685	(559,027)	53,669
Kane County Hospital	571,553	28.74%	N/A	Qualifies. See Footnote (1).	578,553	42,580	-	177	621,310	897,986	276,676	66,614	404,968	338,355	615,031	571,553
Lakeview Hospital	4,972	18.20%	9.07%	Qualifies. See Footnote (1).	4,168,261	2,817,888	502,943	15,246	7,504,338	6,670,894	(833,444)	706,556	3,099,708	2,393,152	1,559,708	4,972
LDS Hospital	23,908	18.80%	15.01%	Qualifies. See Footnote (1).	17,371,900	2,179,020	2,393,611	34,545	21,979,076	20,596,880	(1,382,197)	1,858,880	15,076,855	13,217,975	11,835,779	23,908
Logan Regional Medical Center	34,205	24.39%	15.81%	Qualifies. See Footnote (1).	12,392,683	602,753	4,520,651	3,357	17,519,444	12,841,794	(4,677,650)	1,319,806	3,982,460	2,662,654	(2,014,996)	34,205
McKay Dee Hospital	98,785	23.63%	16.64%	Qualifies. See Footnote (1).	36,742,522	4,705,508	5,481,265	222,337	47,151,632	35,229,444	(11,922,188)	1,926,473	16,828,843	14,902,371	2,980,183	98,785
Milford Valley Memorial Hospital	226,064	20.45%	N/A	Qualifies. See Footnote (1).	102,845	3,627	-	-	106,472	233,101	126,629	12,438	117,983	105,545	232,174	226,064
Mountain View (Columbia) Hospital	8,910	25.86%	15.46%	Qualifies. See Footnote (1).	3,817,022	4,543,184	1,289,565	15,519	9,665,291	7,359,998	(2,305,293)	574,481	2,344,745	1,770,264	(535,029)	8,910
Mountain West Medical Center	44,830	21.55%	N/A	Qualifies. See Footnote (1).	7,139,880	-	1,025,632	2,469	8,167,981	4,329,395	(3,838,586)	1,967,523	2,024,505	56,982	(3,781,605)	44,830
Ogden Regional Medical Center	18,425	24.95%	13.58%	Qualifies. See Footnote (1).	9,728,721	11,629,549	1,695,023	26,458	23,079,751	16,415,740	(6,664,010)	892,664	4,485,856	3,593,192	(3,070,818)	18,425
Orem Community Hospital	15,818	39.55%	20.55%	Qualifies. See Footnote (1).	4,066,704	27,642	452,014	-	4,546,360	4,756,280	209,920	325,674	989,467	663,794	873,714	15,818
Primary Children's Medical Center	1,043,209	41.13%	31.64%	Qualifies. See Footnote (1).	74,727,203	26,038,357	11,437,925	2,293	112,205,778	107,427,709	(4,778,070)	1,157,537	7,749,991	6,592,454	1,814,384	1,043,209
Salt Lake Regional Medical Center	8,785	16.51%	7.47%	Qualifies. See Footnote (1).	5,433,434	4,081,767	935,835	68,151	10,519,187	6,718,360	(3,800,827)	271,329	2,102,369	1,831,040	(1,969,787)	8,785
San Juan Hospital	1,006,648	13.74%	N/A	Qualifies. See Footnote (1).	728,518	-	-	-	728,518	693,362	(35,156)	-	287,954	287,954	252,798	1,006,648
Sanpete Valley Hospital	22,818	35.48%	N/A	Qualifies. See Footnote (1).	2,390,904	8,324	695,915	-	3,095,143	1,863,174	(1,231,969)	140,725	567,880	427,155	(804,814)	22,818
Sevier Valley Medical Center	27,306	29.41%	N/A	Qualifies. See Footnote (1).	3,661,867	35,954	726,953	23,409	4,448,183	2,618,908	(1,829,275)	245,977	790,380	544,403	(1,284,872)	27,306
St Mark's Hospital	38,803	23.46%	12.19%	Qualifies. See Footnote (1).	21,685,703	15,202,743	4,034,306	250,451	41,173,203	26,698,214	(14,474,989)	1,979,942	8,550,093	6,570,151	(7,904,838)	38,803
Timpanogos Regional Medical Center	10,363	20.53%	12.16%	Qualifies. See Footnote (1).	5,483,248	4,139,955	894,733	9,945	10,527,881	8,882,994	(1,644,887)	446,409	2,605,738	2,159,329	514,442	10,363
Uintah Basin Medical Center	33,837	30.93%	N/A	Qualifies. See Footnote (1).	5,467,644	-	-	16,702	5,484,346	4,251,521	(1,232,825)	1,000,000	2,303,493	1,303,493	70,669	33,837
University Of Utah Hospital	20,747,192	28.63%	11.73%	Qualifies. See Footnote (1)(b).	109,863,081	-	37,234,660	3,485,881	150,583,622	153,515,884	2,932,261	33,962,726	82,539,365	48,576,639	51,508,900	20,747,192
Utah Valley Regional Medical Center	153,939	25.49%	18.11%	Qualifies. See Footnote (1).	43,492,346	4,067,107	8,696,878	152,003	56,408,334	44,212,647	(12,195,687)	2,375,768	16,310,686	13,934,918	1,739,230	153,939
Valley View Medical Center	61,663	30.63%	N/A	Qualifies. See Footnote (1).	8,114,577	1,704,356	1,961,493	82,073	11,862,498	7,842,994	(4,019,504)	689,723	2,467,888	1,778,165	(2,241,340)	61,663
Utah State Hospital (IMD)	934,586	18.74%	101.25%	Qualifies. See Footnote (1)(b).	-	-	-	-	-	-	-	728,022	21,504,421	20,776,399	20,776,399	934,586

Footnotes:

(1) A hospital is deemed a disproportionate share provider if, in addition to meeting the obstetrical and minimum utilization rate requirements, it meets at least one of the following five conditions: (I) The hospital's MIUR is a least one standard deviation above the mean MIUR. (II) The hospital's LIUR rate exceeds 25%. (III) The hospital's MIUR exceeds 14%. (IV) The hospital's PCN participation is at least 10 percent of the total of all Utah hospitals PCN patient care charges. (V) Hospitals located in rural counties qualify because they are sole community hospitals. A sole community hospital is defined as a hospital that is located more than 29 miles from another hospital.

(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, 2010. The State IMD DSH limit is set under Federal Register Vol. 72, No. 248.

(3) 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.

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

EXHIBIT 1