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, 2012

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CARVER
FLOREK &
JAMES, CPA's
CERTIFIED PUBLIC ACCOUNTANTS

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

Jason Lund, CPA
Brent James, CPA
Rebecca Balaich, CPA
Nicole Stites

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, 2012. 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, CPAs

September 28, 2015

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

Most eligible Utah hospitals receive DSH payments as a percentage add-on to their normal Diagnostic Related Group (DRG) payment. In addition, the state-owned teaching hospital, state-owned Institution for Mental Disease (IMD), and other local government-owned rural hospitals are also eligible to receive supplemental DSH payments. 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 is located in a rural county. (Urban counties are Cache, Davis, Salt Lake, Utah, Washington, and Weber).

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 OB's, 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 all 40 hospitals qualified to receive DSH payments during the Medicaid State Plan rate year ended September 30, 2012.

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, 2012.

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).

We also noted that no Medicaid out-of-state payments were made to any of the hospitals for the 12-months ending September 30, 2012.

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, 2012.

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

The DSH survey completed by each hospital was used to determine if the hospitals receiving DSH payments under the State Plan actually qualified to receive such payments, and that the actual DSH payments made did not exceed the hospital-specific DSH limit for the same period.

We compared the DSH payments received by the hospitals for the Medicaid State Plan rate year ended September 30, 2012 with the uncompensated care costs for the same period. 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 20 of the 40 eligible hospitals reported DSH payments that exceeded the hospitals' reported uncompensated care costs for the period. Excess DSH payments aggregated approximately $2 million and ranged by hospital from $7,400 to $884,000, with the highest excess noted for a government-owned rural hospital. For the remaining 19 hospitals, excluding the IMD for which the annual DSH payment is limited under the Federal rule, aggregate uncompensated care costs exceeded DSH payments by approximately $81 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, 2012.

The hospital DSH survey required each provider to report uncompensated care costs for the Medicaid State Plan rate year ending September 30, 2012. We verified that DSH surveys reported 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 hospital cost reports*

(CMS-2552-10 or 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 (determined in accordance with the CMS DSH audit and reporting protocol) for that same Medicaid State Plan rate year ended September 30, 2012.

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, 2012.

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, Utah 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. The survey included discrete sections to report uncompensated care costs for furnishing inpatient and outpatient hospital services to in-state Medicaid-funded patients, out-of-state Medicaid-funded patients, and other patients with no source of third-party coverage. The primary source documents used to develop cost and payment information for the DSH survey included MMIS data provided by the State, hospital billing records and other hospital accounting information for the uninsured and Medicaid out-of-state, and the MCR.

Our verification procedures were tailored based on the type of hospital and the nature and availability of hospital records as well as the magnitude of DSH payments received during the year. For verification purposes, hospitals were broken out into the following five categories: (1) State-owned teaching hospital, (2) State-owned IMD hospital, (3) other government-owned rural hospitals that received supplemental DSH payments in addition to an add-on to their normal DRG payment, (4) urban and rural 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, 2012. Negative values represent total payments in excess of total hospital service costs for Medicaid-eligible and uninsured patients. Accordingly, for hospitals with negative values there was no uncompensated care for Medicaid and uninsured patients as determined using the CMS DSH audit and reporting protocol.

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 as well as the uninsured. Hospital records were used to report Medicaid claims in order to calculate the cost of charges on a basis consistent with the manner in which cost-to-charge ratios were developed in the MCR. In addition, Medicaid eligible patient services where Medicaid did not receive the claim or have any cost sharing (including prisoners who received inpatient services at the hospital and were determined to be eligible for Medicaid under the State's program) were reported by the hospital for inclusion in the DSH uncompensated care costs.

We obtained and reviewed the hospital's DSH survey for the Medicaid State Plan rate year ended September 30, 2012, 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 on a service-specific basis.

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

Results:

Minor modifications were made to the hospital's per diems and ancillary cost-to-charge ratios to agree with the information contained in the applicable MCR. In addition, corrections were made to the hospital's MIUR, DGME costs, and organ acquisition costs to agree with the information contained in the applicable MCR or accounting books and records. We also discovered uninsured claims with service dates outside of the 12-months ending September 30, 2012. Corrections were made to the hospital's uncompensated care costs to exclude these claims.

The state-owned teaching hospital's uncompensated care cost for the Medicaid State Plan rate year ended September 30, 2012 is presented in Exhibit 1 (column 16).

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, 2012, 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 days related to Medicaid, Medicare, or forensic (prison) patients. In order to be consistent with the Medicaid approach, DSH survey costs were determined using the Medicaid cost settlement data. 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. 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 therefore has no reported Medicaid uncompensated care. In addition, the per diems reported in the survey were agreed to the applicable Medicaid cost settlements rather than the MCR. A minor correction was made to the hospital's DSH survey to report the hospital's correct Medicare provider number.

The state-owned IMD hospital's uncompensated care cost for the Medicaid State Plan rate year ended September 30, 2012 is presented in Exhibit 1 (column 16).

Other government-owned rural hospitals that received supplemental DSH payments in addition to an add-on to their normal DRG payment

Utah has seven government-owned rural hospitals that received supplemental DSH payments during the period. We obtained and reviewed the hospitals' DSH surveys for the Medicaid State Plan rate year ended September 30, 2012, 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.

Six of the seven government-owned rural hospitals reported Medicaid Managed Care (MCO) and MCO crossover uncompensated care costs from their internal records, as the information was not available from the State's MMIS. In these instances, inpatient days and charges were traced to the hospitals' accounting records. In addition, Medicaid eligible patient services where Medicaid

did not receive the claim or have any cost sharing on the claim were reported by one of the seven rural hospitals for inclusion in the DSH uncompensated care costs.

We examined a selection of claims for Medicaid-funded patients and patients with no source of third-party coverage. We 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.

Results:

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 for some hospitals. Adjustments were made to four of the rural hospitals to exclude Children's Health Insurance Program (CHIP) and other Non-Title XIX services from the uncompensated care costs reported in the survey. In addition, two of the rural hospitals' uncompensated care costs initially included disallowed physician costs. We also discovered some duplicate claims in the Medicaid MCO population and claims with third-party coverage in the uninsured population. Corrections were made to the uncompensated care costs reported in the survey to exclude these claims.

We noted that in some instances, minor modifications were made to the per diems and cost-to-charge ratios reported in the survey to agree to the applicable MCR. In addition, corrections were made to the MIUR and total hospital costs reported by the hospitals to agree with the applicable accounting books and records. 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 four 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.

Two 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 the MCO and MCO crossover charges, as well as the uninsured charges

We verified that the hospitals revised the surveys and that the corrections described above were reflected in the uncompensated care costs reported on Exhibit 1 (column 16).

Urban and rural hospitals that received DSH payments equal to or greater than $100,000 via an add-on to their normal DRG payment

There were three hospitals with DSH payments in excess of $100,000. We obtained the hospitals' DSH surveys for the Medicaid State Plan rate year ended September 30, 2012, and we traced day, charge and payment data stemming from claims for Medicaid patients to data derived from the State's MMIS, where applicable. Both hospitals reported Medicaid Managed Care (MCO) and MCO crossover days from their internal accounting systems, as the information was not available from the State's MMIS. In these instances, inpatient days and charges were traced to hospitals' accounting records.

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

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.

Results:

We noted that in some instances, minor modifications were made to the hospitals' per diems and ancillary cost-to-charge ratios to agree with the information contained in the applicable MCR. In addition, corrections were made to the LIUR, provider tax assessment allocation, and total hospital costs reported by the hospitals to agree with the applicable accounting books and records.

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).

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

There were 28 private hospitals with DSH payments less than $100,000. We obtained and reviewed the hospitals' DSH surveys for the Medicaid State Plan rate year ended September 30, 2012, 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 MCO crossover days from their internal accounting systems, as the information was not available from the State's MMIS. In these instances, inpatient days and charges were traced to hospitals' accounting records.

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

Results:

For some hospitals we noted one or more instances where the surveys contained days, charges, and related payments that did not reconcile to the supporting documents provided by the hospitals. We verified that any differences between the information reported in the survey and the hospitals' supporting documentation were resolved. The primary information source 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 for some hospitals. Corrections were made to the hospitals' uncompensated care costs to exclude these claims.

Minor modifications were made to the hospitals' per diems and ancillary cost-to-charge ratios to agree with the information contained in the applicable MCR. In addition, corrections were made to the MIUR, LIUR, and total hospital costs initially reported by some of the hospitals to agree with the information contained in the applicable MCR or hospitals' accounting books and records. We also noted that corrections were made to the Medicaid and uninsured allocation of the provider tax assessment.

We noted that eight 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 consistently report FFS, MCO and MCO crossover charges, and related payments, and reconcile any unknown revenue code classifications.

We verified that the hospitals revised the surveys and that the corrections described above were reflected in the uncompensated care costs reported on Exhibit 1 (column 16).

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 Utah hospitals, 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 MCO crossover information, 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, 2012. 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 MCO crossover payments were reconciled to the hospitals' accounting books and records. We also confirmed other supplemental Medicaid payments with the State, where applicable.

We noted that the teaching hospital and 8 privately owned rural hospitals relied upon their internal hospital billing records to report Medicaid FFS claims and related payments, rather than relying upon 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. Regular FFS Medicaid payments were traced to the hospital's applicable accounting books and records, and reconciled to the MMIS within tolerable amounts.

Results:

Minor corrections were made to the Medicaid payments reported by some hospitals to exclude any DSH add-on payments. In addition, an adjustment was made to 10 of the Critical Access Hospitals' (CAH) Medicaid payments to include any CAH payments (takebacks) applicable to the 12-months ending September 30, 2012. Moreover, certain supplemental payments (e.g., Medicare DSH, Medicare IME & DGME, Medicare bad debt) applicable to dual eligible patients were also omitted or misstated by some of the hospitals. Accordingly, all available Medicaid payments, including supplemental payments, were included in the revised calculation of the hospital-specific DSH payment limit and uncompensated care costs reported on Exhibit 1.

For five of the rural hospitals, an adjustment was made to the hospitals' Medicaid In-State, Medicaid Out-of-State, and uninsured payments to exclude a portion of the claims payments applicable to professional service fees. We noted that the hospitals could not readily identify the pro-fee portion of the payment from their accounting books and records, so the ratio of professional service fee charges to total hospital charges was used as a reasonable estimate.

In accordance with the Final Rule, patient payments for the uninsured should be reported on a cash basis, while all other payor payments should be reported using the accrual method of accounting. However, due to the teaching hospital and several rural hospitals' system limitations in tracking these self-pay payments over time, the hospitals reported all payments pertaining to claims during the 12-months ending September 30, 2012, as of the date the DSH survey was prepared, regardless of the period in which the payment was received.

In addition, an analysis was performed for the teaching hospital to quantify any additional patient payments for the uninsured that were received since the hospital's prior year's survey was prepared. As a result, an adjustment was made to include approximately $470,000 in additional payments pertaining to uninsured claims, which were received subsequent to the submission of the prior years' surveys.

We noted that no Section 1011 payments for undocumented aliens were made to any of the hospitals for the 12-months ending September 30, 2012.

See Exhibit 1 (columns 6-10) for the verified Medicaid payments and (column 13) for the verified uninsured payments by hospital for the Medicaid State Plan rate year ended September 30, 2012.

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, 2012.

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-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-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 on a service-specific basis 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' MCR. 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.*