STATE OF COLORADO
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Denver, Colorado

Independent Accountant's Report on Program Operation as Related to Disproportionate Share Hospital Payments Final Rule for Medicaid State Plan Rate Year Ending June 30, 2009

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INDEPENDENT ACCOUNTANT'S REPORT

Colorado Department of Health Care Policy and Financing:
Denver, Colorado

We were engaged to examine the State of Colorado's (State) compliance with the requirements of each of the six verifications set forth in Title 42 of the Code of Federal Regulations (CFR) §455 relating to the Medicaid Disproportionate Share Hospital Payments Final Rule (DSH Rule) for Medicaid State Plan (MSP) rate year 2009. The Colorado Department of Health Care Policy and Financing (DHCPF) management is responsible for compliance with those requirements. Our responsibility is to express an opinion on the compliance with each of the six verifications based on our examination.

The following are the six verifications set forth in 42 CFR §455:

(1) *Verification 1:* 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 MSP 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.

(2) *Verification 2:* DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. For each audited MSP rate year, the DSH payments made in that audited MSP rate year are measured against the actual uncompensated care cost in that same audited MSP rate year.

(3) *Verification 3:* 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.

(4) *Verification 4:* 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.

(5) *Verification 5:* 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; and any payments made on behalf of the uninsured from payment adjustments have been separately documented and retained by the State.

(6) *Verification 6:* The information specified in the preceding verification (Verification 5) includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Social Security Act. Included in the description of the methodology, the State has specified how it 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 services they received.

Verification 1

Section 1923(d)(3) of Social Security Act requires that a hospital must have a Medicaid utilization of at least one percent to qualify as a Disproportionate Share Hospital. All DSH hospitals in the State of Colorado met this requirement.

In conjunction with the one percent Medicaid utilization, a hospital cannot be a Disproportionate Share Hospital unless it meets the obstetric requirements set forth in Section 1923(d)(1) and 1923(d)(2) of the Social Security Act. DHCPF sent to each DSH hospital a certification from hospital personnel that the hospital provided obstetric services as defined in Section 1923(d) of the Social Security Act or whether hospitals qualified under the following exceptions to non-emergency obstetric services requirement: (1) if the hospital is located in a rural area, two physicians can be on staff that perform non-emergency obstetric services; (2) the hospital's inpatient population is predominately under the age of 18; or (3) the hospital did not provide non-emergency obstetric services prior to December 22, 1987. Based on confirmations received from hospitals, 48 of 49 DSH hospitals met the obstetric requirement set forth in Social Security Act Section 1923(d). The one hospital stated it met exception (3) stated above but was certified for Medicare purposes on January 1, 1999 and does not meet the exception.

In addition to the qualification of the hospitals under the requirements set forth in Section 1923(d) of the Social Security Act, the right of the hospitals to retain the funds received under the DSH program needed to be verified. The State owned and non-State government owned hospitals participated in the Certification of Public Expenditures (CPE) program and the amount reported under the CPE program constituted their DSH payment. The provision of retaining payments is not applicable to the 24 hospitals under the CPE program.

For the hospitals not participating in the CPE program, confirmations were sent out by DHCPF to each hospital to verify the amount of DSH payments for the MSP rate year and that the hospital "had no restrictions on the retaining of funds by the State." All 25 hospitals not participating in the CPE program submitted certifications and the right of those hospitals to retain DSH payments cannot be verified.

Based on the certifications provided, management complied with this Verification in regards to 48 of the 49 hospitals under the DSH program.

Verification 2

A determination of the hospital specific DSH limit for each hospital was developed from the following source documentation:

- Documentation that the DHCPF received from hospitals in the process of determining payments under the Colorado Indigent Care Program (CICP), "a program that distributes federal and State funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population."
- Documentation that DHCPF received from hospitals based on additional requests by DHCPF in relation to Medicaid Managed Care and Medicaid Out-of-State beneficiaries.
- Documentation that DHCPF received from hospitals for individuals the hospitals identified as individuals with no third party insurance.
- The DSH Final Rule published on December 18, 2009 and the CMS General DSH Audit and Reporting protocol required the use of each hospital's CMS Form 2552-96. DHCPF supplied certain worksheets from the hospital's CMS Form 2552-96. For those hospitals that did not have applicable cost report worksheets, the cost report worksheets were obtained from other sources. Cost-to-charge ratios and cost-per-diems from the CMS Form 2552-96 cost reports were used in the calculation of uncompensated care cost.
- Medicaid Fee for Service data supplied by the DHCPF in a summarized form was used for the calculation of Medicaid cost related to Fee for Service activities and the applicable payments necessary in the determination of the hospital specific DSH limit for each hospital.

Our examination disclosed that the DHCPF was unable to provide the documentation from the hospitals' financial accounting records related to the determination of the hospital-specific DSH limit as specified in 42 CFR §447.209 and expanded upon in the CMS General DSH Audit and Reporting Protocol. The issues related to documentation include:

- Twenty-six hospitals did not provide any support for CICP charges and days for cost reports related to the MSP rate year 2009.
- Forty-seven hospitals did not provide any documentation related to Medicaid Managed Care services. For the remaining two hospitals, detailed data of the Medicaid Managed Care activity was not provided to allow for a determination of the completeness of the data.
- Forty-seven hospitals did not provide any documentation related to Medicaid Out-of-State services. For the remaining two hospitals, detailed data of the Medicaid Out-of-

State activity was not provided to allow for a determination of the completeness of the data.

- Forty-five hospitals did not provide any documentation related to non-CICP uninsured services. For the remaining four hospitals, detailed data of the non-CICP activity was not provided to allow for a determination of the completeness of the data.
- No hospital supplied detailed data of uninsured charges to determine the amount of payments made by or on behalf of individuals with no source of third party insurance.

Because of the restriction on the scope of our examination discussed in the preceding paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on management's compliance with this Verification.

Verification 3

The DHCPF was unable to provide the documentation from the hospital's financial accounting records necessary to determine whether 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 were included in the calculation of the hospital-specific DSH payment limit in accordance with 42 CFR §455.304 (d)(3) relating to the Medicaid Program's DSH Rule. Specifically, detailed documentation from the hospital's financial accounting records was not supplied related to the following categories of activities to determine if the claims were 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:

- CICP days and/or charges supplied by 23 hospitals
- Medicare Managed Care days and/or charges supplied by two hospitals
- Medicaid Out-of-State days and/or charges supplied by two hospitals
- Non-CICP uninsured days and/or charges supplied by four hospitals

In addition to the lack of documentation, information from various hospitals indicated the inclusion of ambulance services, federally qualified health clinics, rural health clinics, and dental services which do not meet the definition of inpatient and outpatient services under 42 CFR §440.10 and 42 CFR §440.20. In addition to the Federal regulations, these services were not deemed as inpatient and/or outpatient services under the Colorado Medicaid State Plan. The hospitals including such services were as follows:

- Eight hospitals which provided CICP days and/or charges
- One hospital which provided Medicaid Managed Care days and/or charges
- One hospital which provided Non-CICP days and/or charges for services for individuals with no third party payer.

Because of the restriction on the scope of our examination discussed in the preceding paragraph, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on management's compliance with this Verification.

Verification 4

While DHCPF was able to furnish data related to Medicaid Fee for Service and supplemental payments made under the Colorado Medicaid program, DHCPF was unable to provide the documentation from the hospital's financial accounting records necessary for Medicaid managed care claims at 47 hospitals and Medicaid out of state claims at 47 hospitals to determine whether all Medicaid payments that 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 in accordance with 42 CFR §455.304 (d)(4) relating to the Medicaid Program's DSH Rule.

Because of the restriction on the scope of our examination discussed in the preceding paragraph, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on management's compliance with this Verification.

Verification 5

As indicated above, the DHCPF was unable to provide documentation related to the costs and payments related to the DSH program on a per hospital basis sufficient to support the Verifications Two through Four. DHCPF did provide documentation related to the Medicaid State Plan and DSH payment calculations. As such, we were unable to determine that the State has separately documented and retained information and records of costs and payments related to the DSH program in accordance with 42 CFR §455.304 (d)(5) relating to the Medicaid Program's DSH Rule.

Because of the restriction on the scope of our examination discussed in the preceding paragraph, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on management's compliance with this Verification.

Verification 6

In our opinion, 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 Social Security Act, and includes definitions of incurred inpatient and outpatient costs. Documentation was maintained by DHCPF in accordance with 42 CFR §455.304 (d)(6) relating to the Medicaid Program's DSH Rule.

In accordance with *Government Auditing Standards*, we have also issued our report dated December 14, 2012, on our consideration of the DHCPF's internal controls over the DSH Program in the State for the MSP rate year 2009 as it relates to the six verifications set forth in 42 CFR §455 relating to the Medicaid Program's DSH Rule. The purpose of that report is to describe the scope of our testing of internal controls over the DSH Program in the State for the MSP rate year 2009 as it related to the aforementioned six verifications set forth in the DSH Rule and the results of that testing, and not to provide an opinion on the internal controls over compliance with the DSH Rule. That report is an integral part of an examination performed in

accordance with *Government Auditing Standards* and should be considered in assessing the results of our examination.

This report is intended solely for the information and use of the DHCPF, the State Legislature, hospitals participating in the State DSH program, and CMS and is not intended to be, and should not be, used by anyone other than these specified parties.

PHBV Partners LLP

Baltimore, Maryland
December 14, 2012

INDEPENDENT ACCOUNTANT'S REPORT ON INTERNAL CONTROL OVER THE DISPROPORTIONATE SHARE HOSPITAL PROGRAM IN THE STATE OF COLORADO FOR THE MEDICAID STATE PLAN RATE YEAR 2009 AS RELATED TO THE SIX VERIFICATIONS SET FORTH IN 42 CFR §455 DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FINAL RULE

The Colorado Department of Health Care Policy and Financing:
Denver, Colorado

We have examined the State of Colorado's (State) compliance with the requirements of each of the six verifications set forth in Title 42 of the Code of Federal Regulations (CFR) §455 relating to the Medicaid Disproportionate Share Hospital Payments Final Rule (DSH Rule) for Medicaid State Plan (MSP) rate year 2009. We conducted our examination in accordance with the attestation standards established by AICPA and the standards applicable to attestation engagements contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

In planning and performing our examination, we considered DHCPF's internal controls over the DSH Program, in order to determine our examination procedures for the purpose of expressing our opinion on management's assertion related to the six verifications set forth in the DSH Rule and not to provide an opinion on the internal controls over compliance with the DSH Rule. Accordingly, we do not express an opinion on the effectiveness of DHCPF's internal control over compliance with the DSH Rule.

A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to initiate, authorize, record, process, or report financial data reliably such that there is more than a remote likelihood that noncompliance with the six verifications set forth in the DSH Rule that is more than inconsequential will not be prevented or detected by the entity's internal control. We consider the deficiencies described in the accompanying Schedule of Findings to be significant deficiencies in internal control in relation to the six verifications set forth in the DSH Rule.

A material weakness is a significant deficiency, or combination of significant deficiencies that results in more than a remote likelihood that a material deviation from the requirements of the six verifications set forth in the DSH Rule will not be prevented or detected by the entity's internal controls. Of the significant deficiencies described above, we consider findings 1 through 5 to be material weaknesses.

Our consideration of internal control relating to the six verifications set forth in the DSH Rule was for the limited purpose described in the first paragraph of this section and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the DHCPF's operation of the DSH program in the State is in compliance with the requirements of the six verifications set forth in the DSH Rule, we performed tests of its compliance with certain provisions of laws, regulations, and contracts, noncompliance with which could have a direct and material effect on the compliance with the six verifications set forth in the DSH Rule. However, providing an opinion on compliance with those provisions was not an objective of our examination, and accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and which are described in the accompanying Schedule of Findings as Findings 1 through 5.

This report is intended solely for the information and use of the DHCPF, the State Legislature, the hospitals that participated in the State DSH program and CMS and is not intended to be, and should not be, used by anyone other than these specified parties.

PHBV Partners LLP

Baltimore, Maryland
December 14, 2012

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
SCHEDULE OF FINDINGS RELATING TO THE SIX VERIFICATIONS OF THE DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FINAL RULE FOR THE MEDICAID STATE PLAN RATE YEAR 2009

Finding 1 –

Criteria
Social Security Act Section 1923(d) requires that, unless exempt, a hospital must have at least two obstetricians, or two physicians if the hospital is located in a rural area, who have staff privileges at the hospital, as well as a Medicaid inpatient utilization rate (MIUR) of not less than one percent to qualify as a disproportionate share hospital.

Condition
One of forty-nine hospitals that received DSH payments in MSP rate year 2009 did not have at least two obstetricians or two physicians if the hospital is located in a rural area, who have staff privileges at the hospital.

Recommendation

We recommend that the DHCPF implement a review process to ensure hospitals that receive DSH payments meet the qualification requirements to be deemed as a disproportionate share hospital.

Finding 2 –

Criteria
Social Security Act Section 1923(g)(1)(A) specifies that DSH payments to hospitals shall not exceed the Medicaid eligible and uninsured cost incurred (net of the payments received) during the MSP rate year. Section 42 CFR §455.304(d)(2) further clarifies that DSH payments made to each qualifying hospital shall comply with the hospital-specific DSH payment limit.

Condition
We found that we could not make an accurate determination of uncompensated cost of care for either Medicaid eligible individuals or individuals with no source of third party coverage due to the amount of documentation that was not provided for all hospitals in some manner.

Additionally, we noted that the State has no procedures to calculate the hospital-specific DSH limit based on current year Medicaid and uninsured cost, charge and payment information in accordance with 42 CFR 455.304(d)(2), and the methodology described in the CMS General DSH Audit and Reporting Protocol. The State also has no procedures to estimate the hospital-specific limits based on these rules prior to making DSH payments to the hospitals.

Recommendation
We recommend that the DHCPF develop procedures to calculate the hospital-specific DSH limits based on current year cost, charge and payment information for Medicaid-eligible and uninsured individuals. We further recommend that the DHCPF establish a process to collect and

retain the documentation necessary to calculate the hospital-specific DSH limits. In this regard, the CMS General DSH Audit and Reporting Protocol specifies that the DSH limits are based on the following data sources:

- MMIS Data (including supplemental/enhanced Medicaid payments)
- Medicare 2552-96 Hospital Cost Report
- Audited Hospital Financial Statements and Other Auditable Hospital Accounting Records
    - Hospital revenues from Medicaid managed care organizations.
    - Medicaid payments from other States (including regular payments, add-ons, supplemental and enhanced payments and DSH payments).
    - Medicaid inpatient and outpatient hospital payments from all sources other than the State.
    - Hospital revenues from or on behalf of individuals with no source of third party coverage (i.e., uninsured patients).
    - Days and charges for inpatient and outpatient Medicaid hospital services for out of state Medicaid patients.
    - Days and charges for inpatient and outpatient hospitals services provided to individuals with no source of third party coverage (i.e., uninsured patients).
    - Days and charges for inpatient and outpatient hospital services provided to Medicaid managed care patients.

The DSH Protocol also requires that Medicaid-eligible and uninsured charges and days be applied to cost center specific cost-to-charge ratios and per diems on the Medicare 2552-96 Hospital Cost Report.

Finding 3 –

Criteria

Social Security Act Section 1923(g)(1)(A) specifies that DSH payments to hospitals shall not exceed the Medicaid eligible and uninsured cost incurred (net of the payments received) during the MSP rate year. Section 42 CFR §455.304(d)(2) further clarifies that DSH payments made to each qualifying hospital shall comply with the hospital-specific DSH payment limit. Additionally, the CMS General DSH Audit and Reporting Protocol describes the documentation that DSH hospitals must maintain and make available for review in order to calculate the hospital-specific DSH limits.

Condition

We found that the DHCPF failed to provide critical documentation related to the determination of the hospital-specific DSH limit. The critical documentation not provided includes:

- Twenty-six of forty-nine hospitals did not provide any support for CICP charges and days for cost reports related to the MSP rate year 2009.
- Forty-seven of forty-nine hospitals did not provide any documentation related to Medicaid Managed Care services.

- For the two hospitals that supplied Medicaid Managed Care activity, detailed data of the Medicaid Managed Care activity was not provided to allow for a determination of the completeness of the data.
- Forty-seven of forty-nine hospitals did not provide any documentation related to Medicaid Out-of-State services.
- For the two hospitals that supplied Medicaid Out-of-State data, detailed data of the Medicaid Out-of-State activity was not provided to allow for a determination of the completeness of the data.
- Forty-five of forty-nine hospitals did not provide any documentation related to non-CICP uninsured services.
- For four hospitals that submitted non-CICP data, detailed data of the non-CICP activity was not provided to allow for a determination of the completeness of the data.
- No hospital supplied detailed data of uninsured charges of uninsured charges to determine the amount of payments made by or on behalf of individuals with no source of third party insurance.

Recommendation
We recommend that the DHCPF develop and provide comprehensive instructions to DSH hospitals on the types of documentation they must develop and maintain in order to properly calculate the hospital-specific DSH limits. The DHCPF should also implement periodic monitoring procedures to ensure that the DSH hospitals are maintaining complete and accurate data and records to support the calculation of these limits.

Finding 4 –

Criteria
Social Security Act Section 1923(g)(1)(A) specifies that the hospital-specific DSH payment limit should be subject to costs net of all non-DSH payments received under Title XIX of the Social Security Act. Section 42 CFR §455.304(d)(4) echoes this requirement and states that all Medicaid payments in excess of Medicaid cost must be applied against uncompensated care costs for the purposes of the hospital-specific DSH limit calculation.

Condition
Due to the lack of procedures and supporting documentation specified in Finding 2, we were unable to ensure that all Medicaid payments made to a DSH hospital that are in excess of Medicaid costs, are applied against the uncompensated care cost of uninsured individuals.

Recommendation
We recommend that the DHCPF establish procedures to ensure that all Medicaid payments made to a DSH hospital that are in excess of Medicaid costs are identified and applied against the uncompensated care cost of uninsured individuals. We further recommend that the DHCPF establish a process to collect and retain documentation supporting all Medicaid payments. In addition to regular fee-for-service payments, this also includes Medicaid managed care payments, add-on payments and any payments received for services provided to beneficiaries of Medicaid Agencies from other States.

Disproportionate Share Hospital Data Reporting Form

State of Colorado
Department of Health Care Policy and Financing
State Fiscal Year Ended June 30, 2009

	1	2	3	4	5	6	7
Hospital Name	**State Estimated Hospital-Specific DSH Limit**	**Medicaid IP Utilization Rate**	**Low-Income Utilization Rate**	**State-Defined DSH Qualification Criteria**	**Regular IP/OP Medicaid FFS Basic Rate Payments**	**IP/OP Medicaid MCO Payments**	**Supplemental/ Enhanced IP/OP Medicaid Payments**
Arkansas Valley Regional Medical Center	596,280	41.67%	Note #1	Exceed 1% MIUR and OB met	5,388,283	-	264,570
Aspen Valley Hospital District	324,680	9.67%	Note #1	Exceed 1% MIUR and OB met	536,521	-	454,382
Boulder Community Hospital	10,806	11.94%	Note #1	Exceed 1% MIUR and OB met	7,858,221	-	1,062,494
Colorado Plains Medical Center	1,504	29.88%	Note #1	Exceed 1% MIUR and OB met	3,727,048	-	208,747
Community Hospital	136	6.61%	Note #1	Exceed 1% MIUR and OB met	1,454,656	-	13,300
Conejos County Hospital	910	48.47%	Note #1	Exceed 1% MIUR and OB met	901,991	-	287,393
Delta County Memorial Hospital	726,620	11.56%	Note #1	Exceed 1% MIUR and OB met	2,324,071	-	1,141,550
Denver Health Medical Center	97,406,488	61.34%	Note #1	Exceed 1% MIUR and OB met	59,011,465	68,645,230	30,327,656
East Morgan County Hosital	284,974	31.94%	Note #1	Exceed 1% MIUR and OB met	1,168,396	-	147,576
Estes Park Medical Center	447,650	17.80%	Note #1	Exceed 1% MIUR and OB met	454,362	-	6,266,646
Gunnison Valley Hospital	10,002	22.61%	Note #1	Exceed 1% MIUR and OB met	943,806	-	512,572
Heart of the Rockies Regional Medical Center	544,232	18.84%	Note #1	Exceed 1% MIUR and OB met	1,663,291	-	786,114
Kremmling Memorial Hospital District	6,638	33.33%	Note #1	Exceed 1% MIUR and OB met	213,884	-	156,526
Longmont United Hospital	12,136	20.21%	Note #1	Exceed 1% MIUR and OB met	10,692,070	-	1,206,431
McKee Medical Center	19,224	21.17%	Note #1	Exceed 1% MIUR and OB met	8,192,303	-	1,890,176
Medical Center of the Rockies	13,426	9.21%	Note #1	Exceed 1% MIUR and OB met	4,361,844	-	1,320,270
Melissa Memorial Hospital	24,792	38.00%	Note #1	Exceed 1% MIUR and OB met	482,873	-	407,500
Memorial Health System	15,746,814	28.46%	Note #1	Exceed 1% MIUR and OB met	59,152,041	17,211	17,431,225
Mercy Regional Medical Center	7,058	18.47%	Note #1	Exceed 1% MIUR and OB met	5,847,460	-	951,852
Montrose Memorial Hospital	526,880	10.96%	Note #1	Exceed 1% MIUR and OB met	2,648,319	-	5,724,084
Mt San Rafael Hospital	1,592	31.99%	Note #1	Exceed 1% MIUR and OB met	2,091,913	-	236,233
National Jewish Health	13,160	44.07%	Note #1	Note #4	2,874,216	-	1,293,992
North Colorado Medical Center	7,748,888	28.03%	Note #1	Exceed 1% MIUR and OB met	28,840,061	-	6,121,413
Parkview Medical Center	34,816	27.32%	Note #1	Exceed 1% MIUR and OB met	28,812,237	-	3,423,450
Penrose/St Francis Healthcare	19,650	13.82%	Note #1	Exceed 1% MIUR and OB met	19,759,452	-	1,958,490
Pikes Peak Regional Hospital	562	15.29%	Note #1	Exceed 1% MIUR and OB met	569,476	-	55,052
Platte Valley Medical Center	17,312	34.33%	Note #1	Exceed 1% MIUR and OB met	7,649,769	-	1,702,110
Poudre Valley Hospital	5,827,450	17.14%	Note #1	Exceed 1% MIUR and OB met	17,222,592	-	8,270,004
Presbyterian St Luke Medical Center	22,082,388	26.51%	Note #1	Exceed 1% MIUR and OB met	22,082,388	-	-
Prowers Medical Center	1,614,850	38.03%	Note #1	Exceed 1% MIUR and OB met	3,284,147	-	772,690
Rio Grande Hospital	1,088	44.60%	Note #1	Exceed 1% MIUR and OB met	1,032,851	-	227,699
San Luis Valley Regional	13,386	44.38%	Note #1	Exceed 1% MIUR and OB met	8,178,917	-	1,805,244
Sedgwick County Health Center	51,896	30.61%	Note #1	Exceed 1% MIUR and OB met	392,218	-	70,777
Southeast Colorado Hospital	92,996	39.33%	Note #1	Exceed 1% MIUR and OB met	707,996	-	87,671
Southwest Memorial Hospital	375,376	30.36%	Note #1	Exceed 1% MIUR and OB met	4,968,353	-	4,831,296
Spanish Peaks Medical Center	234,446	35.66%	Note #1	Exceed 1% MIUR and OB met	675,058	-	317,298
St Mary's Hospital	14,736	14.61%	Note #1	Exceed 1% MIUR and OB met	12,999,976	-	1,814,479
St Thomas More Hospital	4,200	32.59%	Note #1	Exceed 1% MIUR and OB met	4,124,855	-	566,258
St Vincent General Hospital	39,136	33.52%	Note #1	Exceed 1% MIUR and OB met	561,532	-	196,636
St Mary Corwin	31,930	26.21%	Note #1	Exceed 1% MIUR and OB met	18,503,541	-	4,172,457
Sterling Regional Medical Center	4,824	29.28%	Note #1	Exceed 1% MIUR and OB met	2,951,881	-	773,343

State of Colorado
Department of Health Care Policy and Financing
State Fiscal Year Ended June 30, 2009

	1	2	3	4	5	6	7
Hospital Name	**State Estimated Hospital-Specific DSH Limit**	**Medicaid IP Utilization Rate**	**Low-Income Utilization Rate**	**State-Defined DSH Qualification Criteria**	**Regular IP/OP Medicaid FFS Basic Rate Payments**	**IP/OP Medicaid MCO Payments**	**Supplemental/ Enhanced IP/OP Medicaid Payments**
The Children's Hospital	29,822	54.57%	Note #1	Note #2	86,698,763	-	42,791,518
The Memorial Hospital	37,352	22.81%	Note #1	Exceed 1% MIUR and OB met	1,408,601	-	458,772
University Of Colorado Hospital	49,531,284	30.56%	Note #1	Exceed 1% MIUR and OB met	55,567,385	-	42,399,659
Valley View Hospital	6,098	40.44%	Note #1	Exceed 1% MIUR and OB met	9,640,431	-	822,428
Vibra (North Valley Rehab)	18,142	23.01%	Note #1	Note #3	885,176	-	-
Wray Community District Hospital	43,550	26.29%	Note #1	Exceed 1% MIUR and OB met	666,878	-	290,199
Yampa Valley Medical Center	3,438	23.22%	Note #1	Exceed 1% MIUR and OB met	1,995,016	-	463,226
Yuma District Hospital	177,624	23.75%	Note #1	Exceed 1% MIUR and OB met	1,380,640		3,166,450
Institute for Mental Disease							
Out-of-State DSH Hospitals							

NOTE #1: Data not provided to calculate the LIUR.

NOTE #2: Children's Hospital meeting exception of a majority of patients under the age of 18.

NOTE #3: Hospital states meets exception to OB rule as it did not provide non-emergency obstetric services prior to 12/22/87. However, hospital was certified after 1987 and is therefore not grandfathered.

NOTE #4: Hospital states meets exception to OB rule as it did not provide non-emergency obstetric services prior to 12/22/87.

State of Colorado
Department of Health Care Policy and Financing
State Fiscal Year Ended June 30, 2009

8	9	10	11	12	13	14	15	16
Total Medicaid IP/OP Payments	Total Cost of Care - Medicaid IP/OP Services	Total Medicaid Uncompensated Care	Uninsured IP/OP Revenue	Total Applicable Section 1011 Payments	Total cost of IP/OP Care for the Uninsured	Total Uninsured IP/OP Uncompensated Care Cost	Total Annual Uncompensated Care Costs	Disproportionate Share Hospital Payments
5,652,853	6,357,433	704,580	-	-	118,038	118,038	822,618	596,280
990,903	1,513,211	522,308	-	-	529,375	529,375	1,051,683	324,680
8,920,715	13,900,753	4,980,038	-	-	-	-	4,980,038	10,806
3,935,795	4,430,057	494,262	-	-	-	-	494,262	1,504
1,467,956	2,203,094	735,138	-	-	-	-	735,138	136
1,189,384	1,608,417	419,033	-	-	-	-	419,033	910
3,465,621	3,410,237	(55,384)	-	-	2,401,858	2,401,858	2,346,474	726,620
157,984,351	158,826,043	841,692	7,458,785	762,805	111,579,424	103,357,834	104,199,526	97,406,488
1,315,972	1,661,162	345,190	-	-	140,775	140,775	485,965	284,974
6,721,008	879,926	(5,841,082)	-	-	920,519	920,519	(4,920,563)	447,650
1,456,378	1,252,065	(204,313)	-	-	54,317	54,317	(149,996)	10,002
2,449,405	2,393,557	(55,848)	-	-	772,580	772,580	716,732	544,232
370,410	620,721	250,311	-	-	85,339	85,339	335,650	6,638
11,898,501	17,371,726	5,473,225	-	-	-	-	5,473,225	12,136
10,082,479	12,232,792	2,150,313	-	-	-	-	2,150,313	19,224
5,682,114	10,242,858	4,560,744	-	-	-	-	4,560,744	13,426
890,373	991,798	101,425	-	-	75,933	75,933	177,358	24,792
76,600,477	102,039,635	25,439,158	523,940	-	36,420,078	35,896,138	61,335,296	15,746,814
6,799,312	7,713,380	914,068	-	-	-	-	914,068	7,058
8,372,403	3,745,894	(4,626,509)	-	-	3,648,171	3,648,171	(978,338)	526,880
2,328,146	3,315,420	987,274	-	-	-	-	987,274	1,592
4,168,208	5,294,262	1,126,054	-	-	-	-	1,126,054	13,160
34,961,474	45,247,825	10,286,351	-	-	3,127,566	3,127,566	13,413,917	7,748,888
32,235,687	39,325,098	7,089,411	-	-	-	-	7,089,411	34,816
21,717,942	29,245,033	7,527,091	-	-	-	-	7,527,091	19,650
624,528	964,958	340,430	-	-	-	-	340,430	562
9,351,879	13,823,565	4,471,686	-	-	-	-	4,471,686	17,312
25,492,596	28,554,739	3,062,143	-	-	4,561,836	4,561,836	7,623,979	5,827,450
22,082,388	43,466,784	21,384,396	-	-	-	-	21,384,396	158,182
4,056,837	5,336,369	1,279,532	-	-	452,222	452,222	1,731,754	1,614,850
1,260,550	1,783,501	522,951	-	-	-	-	522,951	1,088
9,984,161	10,000,485	16,324	-	-	-	-	16,324	13,386
462,995	490,401	27,406	-	-	19,372	19,372	46,778	51,896
795,667	1,017,794	222,127	-	-	140,696	140,696	362,823	92,996
9,799,649	4,370,451	(5,429,198)	-	-	573,839	573,839	(4,855,359)	375,376
992,356	967,833	(24,523)	-	-	2,052	2,052	(22,471)	234,446
14,814,455	19,127,480	4,313,025	-	-	-	-	4,313,025	14,736
4,691,113	6,521,250	1,830,137	-	-	-	-	1,830,137	4,200
758,168	1,019,951	261,783	-	-	-	-	261,783	39,136
22,675,998	24,297,748	1,621,750	-	-	-	-	1,621,750	31,930
3,725,224	5,020,978	1,295,754	-	-	-	-	1,295,754	4,824

State of Colorado
Department of Health Care Policy and Financing
State Fiscal Year Ended June 30, 2009

8	9	10	11	12	13	14	15	16
Total Medicaid IP/OP Payments	**Total Cost of Care - Medicaid IP/OP Services**	**Total Medicaid Uncompensated Care**	**Uninsured IP/OP Revenue**	**Total Applicable Section 1011 Payments**	**Total cost of IP/OP Care for the Uninsured**	**Total Uninsured IP/OP Uncompensated Care Cost**	**Total Annual Uncompensated Care Costs**	**Disproportionate Share Hospital Payments**
129,490,281	158,877,010	29,386,729	-	-	-	-	29,386,729	29,822
1,867,373	2,395,387	528,014	-	-	242,822	242,822	770,836	37,352
97,967,044	80,350,308	(17,616,736)	-	-	42,697,657	42,697,657	25,080,921	49,531,284
10,462,859	16,793,327	6,330,468	-	-	-	-	6,330,468	6,098
885,176	1,701,659	816,483	-	-	-	-	816,483	18,142
957,077	1,143,253	186,176	-	-	41,993	41,993	228,169	43,550
2,458,242	4,082,714	1,624,472	-	-	-	-	1,624,472	3,438
4,547,090	1,867,623	(2,679,467)	-	-	130,037	130,037	(2,549,430)	177,624

Department's Responses to Audit Findings

DEPARTMENT'S RESPONSES TO AUDIT FINDINGS

The Colorado Department of Health Care Policy and Financing (Department) offers this audit report as evidence of the Department's good faith effort to use the best data available to the Department for the Disproportionate Share Hospital (DSH) audits for Medicaid State Plan year 2009 in compliance with the requirements set forth in Part 455 of Title 42 of the Code of Federal Regulations (CFR)**.** The Department's response to the DSH Audit Findings for Medicaid State Plan Year 2009, which corresponds to the State Fiscal Year (SFY) 2008-09, follows below in bold, italics font.

Based on audit findings for SFYs 2005, 2006, 2007 and 2008, the Department has improved its documentation and reporting in key areas for the necessary verifications in this SFY 2008-09 DSH audit. The Department will consider all findings and recommendations from its auditor in preparing for future audits and when establishing DSH specific limits for future payments.

The Department wishes to express its appreciation to PHBV Partners, LLP for its willingness to work with the Department to fulfill the Centers for Medicare and Medicaid Services' (CMS) unfunded retroactive audit of DSH specific limits. The Department appreciates PHBV Partners' recognition that the final rule offering explicit instructions related to the DSH audit and reporting requirements was not promulgated until December 2008 and the CMS audit standards were not consistent to standard operating practices used by most States prior to that period. It is unfortunate that CMS chose to set new verification standards through this audit process rather than making those requirements at the time CMS approved the Department's State Plan for DSH payments in 2004 through 2009. This unfunded mandate requiring states to contract with auditors to perform this work, rather than performing selective audits as is the traditional process, caused an additional burden. Due to the additional requirements, all documentation and data required by the CMS for the Medicaid State Plan Year 2009 audit was not available to PHBV Partners. This made the audit work considerably burdensome to the auditors, providers, and Department.

Through the Department's experience with the DSH audit process for these initial years, it is apparent that additional guidance from CMS for States and auditors is needed. The Department has raised questions concerning documentation requested by the auditor that appears to exceed the requirements in the DSH audit rule, protocol, and published additional guidance. The Department has asked CMS for clarification as these issues have arisen and appreciates the guidance received thus far. The Department requests that CMS publish additional clear and unambiguous guidance regarding questions raised by Colorado and other States about the DSH audits to assist all States and auditors in meeting the requirements without making the process more burdensome.

The Department appreciates CMS' willingness to work with States during the transition phase for audit years 2005 through 2010 and to employ a flexible enforcement strategy so that States and hospitals may implement the new requirements without undue hardships. The Department hopes that CMS will continue to reevaluate the regulation and many of the audit requirements.

Finding 1 –

Recommendation
We recommend that the DHCPF implement a review process to ensure hospitals that receive DSH payments meet the qualification requirements to be deemed as a disproportionate share hospital.

State's Response: ***Beginning with supplemental payments made in SFY 2010-11, the Department instituted a new process for ensuring that hospitals that receive DSH payments meet the obstetrics qualification and Medicaid inpatient utilization rate to be deemed as a disproportionate share hospital. The Department notes now that the one hospital referenced in "Finding 1, Condition" no longer receives DSH payments.***

Finding 2 –

Recommendation
We recommend that the DHCPF develop procedures to calculate the hospital-specific DSH limits based on current year cost, charge and payment information for Medicaid-eligible and uninsured individuals. We further recommend that the DHCPF establish a process to collect and retain the documentation necessary to calculate the hospital-specific DSH limits. In this regard, the CMS General DSH Audit and Reporting Protocol specifies that the DSH limits are based on the following data sources:

- MMIS Data (including supplemental/enhanced Medicaid payments)
- Medicare 2552-96 Hospital Cost Report
- Audited Hospital Financial Statements and Other Auditable Hospital Accounting Records
  - Hospital revenues from Medicaid managed care organizations.
  - Medicaid payments from other States (including regular payments, add-ons, supplemental and enhanced payments and DSH payments).
  - Medicaid inpatient and outpatient hospital payments from all sources other than the State.
  - Hospital revenues from or on behalf of individuals with no source of third party coverage (i.e., uninsured patients).
  - Days and charges for inpatient and outpatient Medicaid hospital services for out of state Medicaid patients.
  - Days and charges for inpatient and outpatient hospitals services provided to individuals with no source of third party coverage (i.e., uninsured patients).
  - Days and charges for inpatient and outpatient hospital services provided to Medicaid managed care patients.

The DSH Protocol also requires that Medicaid-eligible and uninsured charges and days be applied to cost center specific cost-to-charge ratios and per diems on the Medicare 2552-96 Hospital Cost Report.

State's Response: ***Prior to the final DSH audit rule issued in 2008, operating under its approved Medicaid State Plan, the Department had information for calculations to verify that DSH payments were under the hospital-specific DSH limit, but those calculations did not meet the requirements set forth through the DSH audit rule or audit protocol. It is not possible for the Department to retroactively update those calculations based on the new CMS regulation or audit protocol with the data available to the Department. For this SFY 2008-09 audit, the Department obtained from its three largest DSH hospitals and other hospitals detailed data following Medicare cost reporting principles for Medicaid managed care days, charges and payments; Medicaid out-of-state days, charges and payments; uninsured days, charges and payments; and where applicable, Section 1011 days, charges and payments. The Department intends to continue this process.***

The Department will use the knowledge it has gained from this audit process and its findings to evaluate current year payments in consideration of the hospital-specific DSH limits. However, the only way to gather this data is to require the hospitals to submit the necessary data following Medicare cost reporting principles. Providing the data in this format is yet another reporting requirement imposed retroactively on hospital providers by CMS. Fulfilling this requirement will place a significant unfunded mandate on hospital providers to report the data and then comply with the auditors to verify the data, but at this time no alternative process has been provided by CMS.

Finding 3 –

Recommendation
We recommend that the DHCPF develop and provide comprehensive instructions to DSH hospitals on the types of documentation they must develop and maintain in order to properly calculate the hospital-specific DSH limits. The DHCPF should also implement periodic monitoring procedures to ensure that the DSH hospitals are maintaining complete and accurate data and records to support the calculation of these limits.

State's Response: ***As a result of this audit and the previous DSH audits, the Department has been made aware of the need to work closely with hospitals currently and in the future to obtain crucial data elements available only to hospitals, specifically Medicaid managed care activity, out-of-state Medicaid activity and uninsured charges and patient days. The Department notes, however, that most Colorado Medicaid clients are fee-for-service with very low Medicaid managed care organization enrollment in Colorado. The Department is working with a contractor to develop and provide comprehensive instructions and trainings to Colorado hospitals that receive DSH payments in order to secure the necessary documentation. The Department will also consider establishing procedures to monitor hospitals' retention of necessary records and data elements and maintenance of reporting systems in future years. These processes will be in place by the SFY 2010-11 audit. Fulfilling this requirement will place a significant unfunded mandate on hospital providers to report the***

data and then comply with the auditors to verify the data, but at this time no alternative process has been provided by CMS.

Finding 4 –

Recommendation
We recommend that the DHCPF establish procedures to ensure that all Medicaid payments made to a DSH hospital that are in excess of Medicaid costs are identified and applied against the uncompensated care cost of uninsured individuals. We further recommend that the DHCPF establish a process to collect and retain documentation supporting all Medicaid payments. In addition to regular fee-for-service payments, this also includes Medicaid managed care payments, add-on payments and any payments received for services provided to beneficiaries of Medicaid Agencies from other States.

State's Response: ***The Department reiterates its response from Finding 2. The Department is working with its contractor to create a reporting document that calculates the hospital-specific DSH limit as prescribed by federal regulation for use in the SFY 2010-11 audit and beyond. For this SFY 2008-09 audit, the Department obtained from its three largest DSH hospitals and other hospitals detailed data following Medicare cost reporting principles for Medicaid managed care days, charges and payments; Medicaid out-of-state days, charges and payments; uninsured days, charges and payments; and where applicable, Section 1011 days, charges and payments. The Department intends to continue this process. As noted in the State's response to Finding 3, however, Medicaid managed care organization enrollment is very low in Colorado.***

During the Medicaid State Plan Years 2005-2010, which CMS refers to as the "transition period", the Department has relied upon reports and audits based on the best available information as directed by CMS. The Department has made a good faith effort to comply with all reporting requirements. Also, the Department would like to note that much of the data related to uninsured costs and Medicaid payments is housed entirely by the hospitals. In accordance with these audit recommendations and findings, the Department will seek to modify reporting systems and processes and to reach out to hospitals to more precisely report each required data element prospectively. However, the Department cannot underscore enough that this unfunded mandate by CMS will drive a significant amount of time and effort for the hospital providers. Through the submission of the audit report, the Department hopes that CMS will continue to review the December 2008 final DSH audit rule and the CMS audit standards and provide additional technical guidance to ease this burden on the auditors, hospital providers, and the Department. Lastly, the Department urges CMS to formally respond to Colorado's submitted DSH Audit processes and findings in a timely manner in order to best prepare for the SFY 2010-11 audit.