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STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
Hartford, Connecticut

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

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INDEPENDENT ACCOUNTANT'S REPORT

Connecticut Department of Social Services:
Hartford, Connecticut

We have examined the State of Connecticut'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 Connecticut Department of Social Services' (DSS) 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.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants (AICPA) and the standards applicable to attestation engagements contained in *Government Auditing Standards*, issued by the Comptroller General of the United States and, accordingly, included examining, on a test basis, evidence supporting management's compliance and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion.

Our examination considered management's compliance with the following six verifications:

(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

In our opinion, each hospital that qualifies for a DSH payment in the State is allowed to retain that payment received in accordance with 42 CFR §455.304 (d)(1) relating to the Medicaid Program's DSH Rule.

Verification 2

Our examination disclosed that one of the qualifying hospitals exceeded their hospital-specific DSH payment limit, based on the methodology for calculating the hospital-specific limit as specified in the DSH Rule effective as of January 19, 2009.

Our examination disclosed that a number of hospitals were unable to provide documentation from their financial accounting records related to 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:

- For two hospitals, we were unable to test a sample of uninsured accounts for a portion of the MSP rate year. The hospitals indicated that they were unable to provide documentation to support the accounts selected for testing.

- Two hospitals' uninsured account summary file charges did not agree with the uninsured revenue code detail file charges. As such, the revenue code detail was used as it was the lesser amount.

- One hospital submitted uninsured payments based on the accrual basis (i.e., all payments received as of the date the self pay report was prepared) instead of the cash basis (i.e., payments received during the cost reporting period) as required by the DSH rule.

- Sixteen hospitals did not separately report dual eligible bad debts on the Medicare 2552 cost report worksheets E Part A, E Part B and/or E-3 Part II. Medicare reimbursement related to dual eligible bad debts should be reported on the cost report so that these amounts can be offset against dual eligible costs.

- One hospital improperly submitted inpatient Medicaid MCO charge and payment data based on admissions falling within the cost reporting period. This is inconsistent with the State's Medicaid cost reporting procedures which require that Medicaid payment data be reported based on discharges falling within the cost reporting period.

- Four hospitals' out-of-state Medicaid charge and payment data did not include "No Pay" claims, Medicare crossover claims, third party payments, and/or coinsurance and deductible information for all or a portion of the MSP rate year.

- One hospital failed to confirm that the out-of-state Medicaid charge and payment data included "No Pay" claims, Medicare crossover claims, third party payments, or coinsurance and deductible information.

In our opinion, except for the effects discussed in the preceding paragraphs and except for the matters we might have discovered had we been able to apply adequate procedures to the hospitals that did not provide documentation, DSH payments made to thirty-three of thirty-four qualifying hospitals comply with the hospital-specific DSH payment limit in accordance with 42 CFR §455.304 (d)(2) relating to the Medicaid Program's DSH Rule. DSH payments made to one of thirty-four qualifying hospitals did not comply with the hospital-specific DSH payment limit in accordance with 42 CFR §455.304 (d)(2) relating to the Medicaid Program's DSH Rule.

Verification 3

In our opinion, 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 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.

Verification 4

In our opinion, 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.

Verification 5

In our opinion, 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.

Verification 6

In our opinion, the State included in the information and records it retained a description of the methodology for calculating each hospital's DSH payment limit and definitions of incurred inpatient and outpatient costs 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 January 25, 2013 on our consideration of DSS' 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 DSS, 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
January 25, 2013

INDEPENDENT ACCOUNTANT'S REPORT ON INTERNAL CONTROL OVER THE DISPROPORTIONATE SHARE HOSPITAL PROGRAM IN THE STATE OF CONNECTICUT 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

Connecticut Department of Social Services:
Hartford, Connecticut

We have examined the State of Connecticut'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 DSS's internal controls over the DSH Program, in order to determine our examination procedures for the purpose of expressing our opinion on management's compliance with 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 DSS'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 3 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 DSS'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 4.

This report is intended solely for the information and use of DSS, 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
January 25, 2013

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
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 and have agreed to provide non-emergency obstetric services to Medicaid patients, as well as a Medicaid inpatient utilization rate (MIUR) of not less than one percent to qualify as a disproportionate share hospital.

Condition
We found that the State was unable to document that any review was conducted to ensure that the hospitals which received DSH payments qualified under the Social Security Act Section 1923(d) obstetrician requirement.

Recommendation
We recommend that DSS implement a review process to ensure hospitals that receive DSH payments meet the obstetrician qualification requirement to be deemed 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. This rule also requires that DSH payments made in the audited MSP rate year are measured against the actual uncompensated care cost in that same audited MSP rate year.

Condition
We found that thirty-four hospitals in the State received DSH payments in MSP rate year 2009. We found that one of the hospitals received DSH payments exceeding their hospital-specific DSH payment limits calculated based on the methodology stipulated by the DSH Rule.

Additionally, we noted that the State had no procedures to calculate the hospital-specific DSH limits based on Medicaid and uninsured cost, charge and payment information from MSP rate year 2009 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 is not estimating the DSH limit using a methodology that emulates the DSH rule prior to making payment to the hospitals.

Recommendation
We recommend that DSS implement the necessary procedures to estimate the hospital-specific DSH limits in accordance with the methodology specified in the DSH rule and the CMS General DSH Audit and Reporting Protocol, prior to making DSH payments to the hospitals as well as to calculate the DSH limits based on actual cost, charge and payment information after the close of the MSP rate year.

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 that a number of hospitals were unable to provide documentation from their financial accounting records related to 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:

- For two hospitals, we were unable to test a sample of uninsured accounts for a portion of the MSP rate year. The hospitals indicated that they were unable to provide documentation to support the accounts selected for testing.

- Two hospitals' uninsured account summary file charges did not agree with the uninsured revenue code detail file charges. As such, the revenue code detail was used as it was the lesser amount.

- One hospital submitted uninsured payments based on the accrual basis (i.e., all payments received as of the date the self pay report was prepared) instead of the cash basis (i.e., payments received during the cost reporting period) as required by the DSH rule.

- Sixteen hospitals did not separately report dual eligible bad debts on the Medicare 2552 cost report worksheets E Part A, E Part B and/or E-3 Part II. Medicare reimbursement related to dual eligible bad debts should be reported on the cost report so that these amounts can be offset against dual eligible costs.

- One hospital improperly submitted inpatient Medicaid MCO charge and payment data based on admissions falling within the cost reporting period. This is inconsistent with the State's Medicaid cost reporting procedures which require that Medicaid payment data be reported based on discharges falling within the cost reporting period.

- Four hospitals' out-of-state Medicaid charge and payment data did not include "No Pay" claims, Medicare crossover claims, third party payments, and/or coinsurance and deductible information for all or a portion of the MSP rate year.

- One hospital failed to confirm that the out-of-state Medicaid charge and payment data included "No Pay" claims, Medicare crossover claims, third party payments, or coinsurance and deductible information.

Recommendation
We recommend that DSS 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. DSS 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
The CMS General DSH Audit and Reporting Protocol requires that states develop their own audit protocols for use by DSH hospitals to determine Medicaid and uninsured uncompensated care cost.

Condition
The State did not have a formal written audit protocol for use by DSH hospitals to determine Medicaid and uninsured uncompensated care costs.

Recommendation
We recommend DSS develop a formal written audit protocol for use by DSH hospitals to determine Medicaid and uncompensated care costs in accordance with the DSH Rule. The audit protocol should reflect the guidelines contained in the CMS General DSH Audit and Reporting Protocol.

Disproportionate Share Hospital Data Reporting Form

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
DISPROPORTIONATE SHARE HOSPITAL DATA REPORTING FORM

Definition of Uncompensated Care

The definition of uncompensated care cost is based on Social Security Act Section 1923(g)(1)(A), and guidance published by CMS in the final DSH rule (73 Fed. Reg. 77904, December 19, 2008), and the CMS General DSH Audit and Reporting Protocol. Uncompensated care cost is the cost of providing inpatient and outpatient hospital services to Medicaid eligible and uninsured individuals, less the payments received for these services. Medicaid eligible includes individuals with in-state and out-of-state FFS Medicaid, Medicaid Crossover, and Medicaid Managed Care. Uninsured, for these purposes, includes individuals with no source of third party coverage. The cost of providing inpatient and outpatient hospital services for these categories is calculated based on Medicare cost reimbursement principles. The cost of these services was calculated using the appropriate per diems or cost-to-charge ratios from each hospital's Medicare cost report. This cost is then reduced by the payments received for these services, including any Medicaid supplemental payments, Section 1011 payments, or additional Medicare payments relating to dual eligible individuals (i.e. bad debts, reimbursement for para-medical education, GME, etc) where applicable. Uninsured payments are those payments received by the hospital during the cost reporting period relating to patients with no source of third party coverage.

	1	2	3	4	5	6	7	8	9	10
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	Total Medicaid IP/OP Payments	Total Cost of Care Medicaid IP/OP Services	Total Medicaid Uncompensated Care
BRIDGEPORT HOSPITAL	$ 11,522,657	N/A	N/A	Note 4, Note 5, Note 6, Note 7	$ 57,611,726	$ 23,155,332	$ 16,331	$ 80,783,389	$ 100,830,004	$ 20,046,615
BRISTOL HOSPITAL INC.	$ 2,268,646	N/A	N/A	Note 4, Note 5, Note 6	$ 4,309,449	$ 3,279,801	$ (42,176)	$ 7,547,074	$ 11,635,383	$ 4,088,309
CHARLOTTE HUNGERFORD HOSPITAL	$ 2,243,008	N/A	N/A	Note 4, Note 5, Note 6	$ 16,586,948	$ 4,914,068	$ -	$ 21,501,016	$ 27,139,317	$ 5,638,301
CT CHILDRENS MED CTR	$ 16,049,643	N/A	N/A	Note 1, Note 4	$ 19,346,008	$ 44,653,301	$ 16,064	$ 64,015,373	$ 81,606,020	$ 17,590,647
DANBURY HOSPITAL	$ 5,080,614	N/A	N/A	Note 4, Note 5, Note 6	$ 34,912,277	$ 8,649,278	$ (1,858,219)	$ 41,703,336	$ 66,661,874	$ 24,958,538
DAY KIMBALL HOSPITAL	$ 1,450,657	N/A	N/A	Note 4, Note 5, Note 6	$ 3,926,016	$ 4,219,496	$ 16,679	$ 8,162,191	$ 9,729,615	$ 1,567,424
DEPT.OF VETERAN AFFAIRS (DVA) HOSPITAL	$ 13,100,848	N/A	N/A	Note 3	$ 12,014,849	$ -	$ -	$ 12,014,849	$ 18,389,370	$ 6,374,521
GREENWICH HOSPITAL	$ 1,298,134	N/A	N/A	Note 4, Note 5, Note 6	$ 8,645,594	$ 2,332,724	$ -	$ 10,978,318	$ 17,991,549	$ 7,013,231
HARTFORD HOSPITAL	$ 18,110,848	N/A	N/A	Note 4, Note 5, Note 6, Note 7	$ 106,744,977	$ 23,933,416	$ (1,394,174)	$ 129,284,219	$ 184,115,174	$ 54,830,955
HOSPITAL OF SAINT RAPHAEL	$ 8,727,789	N/A	N/A	Note 4, Note 5, Note 6, Note 7	$ 64,856,751	$ 14,667,074	$ 133,707	$ 79,657,532	$ 88,762,308	$ 9,104,776
JOHN DEMPSEY HOSPITAL	$ 7,938,113	N/A	N/A	Note 4, Note 5, Note 8	$ 36,109,427	$ 16,603,132	$ (798,862)	$ 51,913,697	$ 69,145,399	$ 17,231,702
LAWRENCE & MEMORIAL HOSPITAL	$ 4,514,048	N/A	N/A	Note 4, Note 5, Note 6	$ 30,525,880	$ 11,372,566	$ 16,550	$ 41,914,996	$ 50,832,076	$ 8,917,080
MANCHESTER MEMORIAL HOSPITAL	$ 2,624,433	N/A	N/A	Note 4, Note 5, Note 6	$ 15,889,330	$ 6,500,851	$ 40,413	$ 22,430,594	$ 28,559,928	$ 6,129,334
MIDDLESEX HOSPITAL	$ 4,081,691	N/A	N/A	Note 4, Note 5, Note 6	$ 24,348,324	$ 8,911,410	$ 15,875	$ 33,275,609	$ 38,363,844	$ 5,088,235
MIDSTATE MEDICAL CENTER	$ 2,628,369	N/A	N/A	Note 4, Note 5, Note 6	$ 21,011,899	$ 7,144,821	$ 16,000	$ 28,172,720	$ 34,135,218	$ 5,962,498
MILFORD HOSPITAL INC.	$ 811,870	N/A	N/A	Note 4, Note 6	$ 5,529,422	$ 2,258,235	$ 15,752	$ 7,803,409	$ 11,824,287	$ 4,020,878
NEW MILFORD HOSPITAL	$ 553,875	N/A	N/A	Note 4, Note 5, Note 6	$ 4,719,201	$ 1,341,711	$ 13,899	$ 6,074,811	$ 8,515,337	$ 2,440,526
NORWALK HOSPITAL	$ 4,380,733	N/A	N/A	Note 4, Note 5, Note 6	$ 28,616,087	$ 7,241,278	$ 15,752	$ 35,873,117	$ 49,935,784	$ 14,062,667
ROCKVILLE GENERAL HOSPITAL INC.	$ 878,482	N/A	N/A	Note 4, Note 6	$ 5,480,639	$ 3,277,934	$ 15,953	$ 8,774,526	$ 14,192,690	$ 5,418,164
SAINT FRANCIS HOSPITAL	$ 14,493,070	N/A	N/A	Note 4, Note 5, Note 6, Note 7	$ 85,023,761	$ 24,272,842	$ 74,075	$ 109,370,678	$ 120,221,683	$ 10,851,005
SHARON HOSPITAL	$ 304,911	N/A	N/A	Note 4, Note 6	$ 5,694,125	$ 947,480	$ 16,679	$ 6,658,284	$ 7,748,849	$ 1,090,565
ST MARYS HOSPITAL	$ 5,973,429	N/A	N/A	Note 4, Note 5, Note 6, Note 7	$ 37,830,121	$ 12,263,018	$ 16,161	$ 50,109,300	$ 54,902,353	$ 4,793,053
ST VINCENTS MEDICAL CENTER	$ 9,387,717	N/A	N/A	Note 4, Note 5, Note 6, Note 7	$ 53,886,970	$ 10,344,573	$ (3,312,909)	$ 60,918,634	$ 74,925,823	$ 14,007,189
THE GRIFFIN HOSPITAL	$ 1,851,217	N/A	N/A	Note 4, Note 5, Note 6	$ 13,197,081	$ 4,206,042	$ (185,268)	$ 17,217,855	$ 20,665,543	$ 3,447,688
THE HOSPITAL OF CENTRAL CT	$ 9,284,902	N/A	N/A	Note 4, Note 5, Note 6, Note 7	$ 44,466,858	$ 23,111,258	$ (1,939,331)	$ 65,638,785	$ 80,119,440	$ 14,480,655
THE STAMFORD HOSPITAL	$ 7,585,841	N/A	N/A	Note 4, Note 5, Note 6, Note 7	$ 32,247,616	$ 9,480,971	$ (2,531,311)	$ 39,197,276	$ 54,684,915	$ 15,487,639
THE WILLIAM W. BACKUS HOSPITAL	$ 4,736,083	N/A	N/A	Note 4, Note 5, Note 6	$ 27,161,422	$ 8,676,987	$ 16,281	$ 35,854,690	$ 46,377,101	$ 10,522,411
WATERBURY HOSPITAL	$ 6,185,326	N/A	N/A	Note 4, Note 5, Note 6, Note 7	$ 35,345,666	$ 10,042,442	$ 31,762	$ 45,419,870	$ 58,127,083	$ 12,707,213
WINDHAM COMMUNITY MEMORIAL HOSPITAL	$ 1,696,859	N/A	N/A	Note 4, Note 5, Note 6	$ 11,923,023	$ 4,527,910	$ (658,314)	$ 15,792,619	$ 18,412,008	$ 2,619,389
YALE-NEW HAVEN HOSPITAL	$ 30,238,837	N/A	N/A	Note 4, Note 5, Note 6, Note 7	$ 185,956,967	$ 62,972,346	$ 99,471	$ 249,028,784	$ 314,746,524	$ 65,717,740
Institutes for Mental Disease										

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
DISPROPORTIONATE SHARE HOSPITAL DATA REPORTING FORM

	1	2	3	4	5	6	7	8	9	10
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	Total Medicaid IP/OP Payments	Total Cost of Care Medicaid IP/OP Services	Total Medicaid Uncompensated Care
CEDARCREST REGIONAL HOSPITAL	$ 17,028,519	N/A	N/A	Note 2	$ 3,634,639	$ -	$ -	$ 3,634,639	$ 7,153,445	$ 3,518,806
CT MENTAL HEALTH CENTER	$ 4,160,516	N/A	N/A	Note 2	$ 979,508	$ -	$ -	$ 979,508	$ 2,545,855	$ 1,566,347
CT VALLEY HOSPITAL	$ 75,612,532	N/A	N/A	Note 2	$ 6,711,308	$ -	$ -	$ 6,711,308	$ 15,429,129	$ 8,717,821
SOUTHWEST CT MENTAL HEALTH SYSTEM	$ 7,286,766	N/A	N/A	Note 2	$ 1,289,260	$ -	$ -	$ 1,289,260	$ 3,517,425	$ 2,228,165
Out-of-State DSH Hospitals										
BAYSTATE MEDICAL CENTER	$ (42,864)	N/A	N/A	Note 4	$ 234,112		$ -	$ 234,112		
BERKSHIRE MEDICAL CENTER	$ 97,954	N/A	N/A	Note 4	$ 9,499		$ -	$ 9,499		
BRIGHAM & WOMENS HOSPITAL	$ 34,897	N/A	N/A	Note 4	$ 86,573		$ -	$ 86,573		
FAIRVIEW HOSPITAL INC	$ 15,032	N/A	N/A	Note 4	$ 903		$ -	$ 903		
FRANKLIN MEDICAL CENTER	$ (333)	N/A	N/A	Note 4	$ 38,234		$ -	$ 38,234		
HUBBARD REGIONAL HOSPITAL	$ (15)	N/A	N/A	Note 4	$ 2,532		$ -	$ 2,532		
JAMAICA HOSPITAL MEDICAL CTR	$ 3,612	N/A	N/A	Note 4	$ 14,512		$ -	$ 14,512		
LANDMARK MEDICAL CENTER	$ 581	N/A	N/A	Note 4	$ 2,790		$ -	$ 2,790		
MASSACHUSETTS GENERAL HOSPITAL	$ (1,512)	N/A	N/A	Note 4	$ 673,567		$ -	$ 673,567		
MEMORIAL HOSPITAL FOR CANCER AND ALLIED DISABLED	$ 245	N/A	N/A	Note 4	$ 35,491		$ -	$ 35,491		
MERCY HOSPITAL INC	$ 2,349	N/A	N/A	Note 4	$ 44,213		$ -	$ 44,213		
MIRIAM HOSPITAL INC	$ 1,218	N/A	N/A	Note 4	$ -		$ -	$ -		
NEWPORT HOSPITAL	$ 148	N/A	N/A	Note 4	$ 951		$ -	$ 951		
NORTHERN WESTCHESTER HOSPITAL	$ 3,582	N/A	N/A	Note 4	$ -		$ -	$ -		
RHODE ISLAND HOSPITAL	$ 103,802	N/A	N/A	Note 4	$ 293,509		$ -	$ 293,509		
SOUTH COUNTY HOSPITAL INC	$ 198	N/A	N/A	Note 4	$ 1,268		$ -	$ 1,268		
UMASS MEMORIAL MEDICAL CENTER	$ 290,416	N/A	N/A	Note 4	$ 2,000,682		$ -	$ 2,000,682		
WESTCHESTER MEDICAL CENTER	$ 19,756	N/A	N/A	Note 4	$ 131,049		$ -	$ 131,049		
WESTERLY HOSPITAL	$ 119,891	N/A	N/A	Note 4	$ 355,877		$ -	$ 355,877		
WOMEN & INFANTS HOSPITAL	$ 58,843	N/A	N/A	Note 4	$ 202,533		$ -	$ 202,533		

Note 1: State Plan Attachment 4.19A(10) - Private Freestanding short-term Children's General Hospital which provides Uncompensated Care.
Note 2: State Plan Attachment 4.19A(7) - Psychiatric Hospitals Serving Low-Income Persons .
Note 3: State Plan Attachment 4.19A(14) - Public Chronic Disease Hospital that provides Uncompensated Care.
Note 4: State Plan Attachment 4.19A(15) - Hospitals Serving Low-Income Persons (defined as SAGA for this section) within the State and comparable out-of-state border hospitals.
Note 5: State Plan Attachment 4.19A(13) - Hospitals Serving Low-Income Persons (defined as General Assistance Behavioral Health Program for this section).
Note 6: State Plan Attachment 4.19A(8) - Private Acute Care Hospitals (short-term General Hospitals) which provide Uncompensated Care.
Note 7: State Plan Attachment 4.19A(9) - Short-Term General Hospitals located in distressed municipalities and targeted investment communities with enterprise zones.
Note 8: State Plan Attachment 4.19A(12) - Public Acute Care Hospitals (short-term General Hospitals) which provide Uncompensated Care under Section 1923 of the Social Security Act.

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
DISPROPORTIONATE SHARE HOSPITAL DATA REPORTING FORM

	11	12	13	14	15	16
Hospital Name	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
BRIDGEPORT HOSPITAL	$ 1,063,911	$ 130	$ 13,699,372	$ 12,635,331	$ 32,681,946	$ 11,522,657
BRISTOL HOSPITAL INC.	$ 307,662	$ -	$ 3,286,764	$ 2,979,102	$ 7,067,411	$ 2,268,646
CHARLOTTE HUNGERFORD HOSPITAL	$ 912,593	$ -	$ 6,112,969	$ 5,200,376	$ 10,838,677	$ 2,243,008
CT CHILDRENS MED CTR	$ 182,134	$ -	$ 1,002,966	$ 820,832	$ 18,411,479	$ 16,049,643
DANBURY HOSPITAL	$ 815,328	$ 128,339	$ 16,243,760	$ 15,300,093	$ 40,258,631	$ 5,080,614
DAY KIMBALL HOSPITAL	$ 162,785		$ 3,329,255	$ 3,166,470	$ 4,733,894	$ 1,450,657
DEPT.OF VETERAN AFFAIRS (DVA) HOSPITAL	$ 54,603		$ 1,219,350	$ 1,164,747	$ 7,539,268	$ 13,100,848
GREENWICH HOSPITAL	$ 3,667,048	$ -	$ 10,432,601	$ 6,765,553	$ 13,778,784	$ 1,298,134
HARTFORD HOSPITAL	$ 4,443,864	$ -	$ 36,705,723	$ 32,261,859	$ 87,092,814	$ 18,110,848
HOSPITAL OF SAINT RAPHAEL	$ 967,784	$ -	$ 17,441,828	$ 16,474,044	$ 25,578,820	$ 8,727,789
JOHN DEMPSEY HOSPITAL	$ 700,757	$ -	$ 1,647,345	$ 946,588	$ 18,178,290	$ 7,938,113
LAWRENCE & MEMORIAL HOSPITAL	$ 628,234	$ -	$ 9,119,077	$ 8,490,843	$ 17,407,923	$ 4,514,048
MANCHESTER MEMORIAL HOSPITAL	$ 322,444	$ -	$ 4,686,254	$ 4,363,810	$ 10,493,144	$ 2,624,433
MIDDLESEX HOSPITAL	$ 1,421,464	$ -	$ 9,371,261	$ 7,949,797	$ 13,038,032	$ 4,081,691
MIDSTATE MEDICAL CENTER	$ 669,952	$ 13,471	$ 8,257,363	$ 7,573,940	$ 13,536,438	$ 2,628,369
MILFORD HOSPITAL INC.	$ 611,249	$ -	$ 3,376,258	$ 2,765,009	$ 6,785,887	$ 811,870
NEW MILFORD HOSPITAL	$ 448,795	$ -	$ 2,397,336	$ 1,948,541	$ 4,389,067	$ 553,875
NORWALK HOSPITAL	$ 1,872,020	$ -	$ 13,503,616	$ 11,631,596	$ 25,694,263	$ 4,380,733
ROCKVILLE GENERAL HOSPITAL INC.	$ 199,490	$ -	$ 2,528,567	$ 2,329,077	$ 7,747,241	$ 878,482
SAINT FRANCIS HOSPITAL	$ 669,952	$ -	$ 24,580,147	$ 23,910,195	$ 34,761,200	$ 14,493,070
SHARON HOSPITAL	$ 379,915	$ -	$ 1,168,276	$ 788,361	$ 1,878,926	$ 304,911
ST MARYS HOSPITAL	$ 596,797	$ 29,372	$ 10,133,997	$ 9,507,828	$ 14,300,881	$ 5,973,429
ST VINCENTS MEDICAL CENTER	$ 2,472,721	$ -	$ 21,734,400	$ 19,261,679	$ 33,268,868	$ 9,387,717
THE GRIFFIN HOSPITAL	$ 7,013	$ -	$ 5,707,331	$ 5,700,318	$ 9,148,006	$ 1,851,217
THE HOSPITAL OF CENTRAL CT	$ 1,189,359		$ 8,860,992	$ 7,671,633	$ 22,152,288	$ 9,284,902
THE STAMFORD HOSPITAL	$ 1,630,542	$ -	$ 19,084,637	$ 17,454,095	$ 32,941,734	$ 7,585,841
THE WILLIAM W. BACKUS HOSPITAL	$ 454,875	$ 1,737	$ 8,767,218	$ 8,310,606	$ 18,833,017	$ 4,736,083
WATERBURY HOSPITAL	$ 1,024,215	$ -	$ 11,093,904	$ 10,069,689	$ 22,776,902	$ 6,185,326
WINDHAM COMMUNITY MEMORIAL HOSPITAL	$ 173,707	$ -	$ 4,257,390	$ 4,083,683	$ 6,703,072	$ 1,696,859
YALE-NEW HAVEN HOSPITAL	$ 2,653,661	$ 27	$ 57,962,308	$ 55,308,620	$ 121,026,360	$ 30,238,837
Institutes for Mental Disease						

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	11	12	13	14	15	16
Hospital Name	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
CEDARCREST REGIONAL HOSPITAL	$ 299,217	$ -	$ 37,929,212	$ 37,629,995	$ 41,148,801	$ 17,028,519
CT MENTAL HEALTH CENTER	$ 73,956	$ -	$ 11,217,739	$ 11,143,783	$ 12,710,130	$ 4,160,516
CT VALLEY HOSPITAL	$ 1,846,596	$ -	$ 117,060,539	$ 115,213,943	$ 123,931,764	$ 75,612,532
SOUTHWEST CT MENTAL HEALTH SYSTEM	$ 149,676	$ -	$ 20,191,704	$ 20,042,028	$ 22,270,193	$ 7,286,766
Out-of-State DSH Hospitals						
BAYSTATE MEDICAL CENTER						$ (42,864)
BERKSHIRE MEDICAL CENTER						$ 97,954
BRIGHAM & WOMENS HOSPITAL						$ 34,897
FAIRVIEW HOSPITAL INC						$ 15,032
FRANKLIN MEDICAL CENTER						$ (333)
HUBBARD REGIONAL HOSPITAL						$ (15)
JAMAICA HOSPITAL MEDICAL CTR						$ 3,612
LANDMARK MEDICAL CENTER						$ 581
MASSACHUSETTS GENERAL HOSPITAL						$ (1,512)
MEMORIAL HOSPITAL FOR CANCER AND ALLIED DISABLED						$ 245
MERCY HOSPITAL INC						$ 2,349
MIRIAM HOSPITAL INC						$ 1,218
NEWPORT HOSPITAL						$ 148
NORTHERN WESTCHESTER HOSPITAL						$ 3,582
RHODE ISLAND HOSPITAL						$ 103,802
SOUTH COUNTY HOSPITAL INC						$ 198
UMASS MEMORIAL MEDICAL CENTER						$ 290,416
WESTCHESTER MEDICAL CENTER						$ 19,756
WESTERLY HOSPITAL						$ 119,891
WOMEN & INFANTS HOSPITAL						$ 58,843

Department of Social Services' Response to Findings

Finding 1

The Department initiated an annual survey process in September 2012 to obtain all the information necessary to comply with Section 1923(d) of the Social Security Act. Prior to the beginning of the fiscal year, each DSH hospital that is not exempt will be required to provide the Department with a listing of at least two obstetricians. The Department will then verify that those obstetricians were enrolled in Connecticut's Medicaid program. No DSH payments will be made to hospitals that are out of compliance. The Department collected this information for federal fiscal year 2011, 2012, and 2013 in September 2012.

Finding 2

The Department amended its State Plan, Attachment 4.19A, to address interim and final DSH payments. CMS approved SPA 11-012 on May 8, 2012 with an effective date of July 1, 2011. This SPA stated that after the DSH Audit is completed, the DSH settlement will be calculated by subtracting each hospital's interim payment from its final payment. The settlement is limited to reductions for those hospitals over the limit with reallocation to the other hospitals.

Findings 3 & 4

The auditors found that several hospitals failed to provide documentation needed to determine the hospital-specific DSH limit. FFY 2009 is part of the transition period and the hospitals used the best available data. The issues have been brought to the attention of the applicable hospitals so they can make any necessary systems changes going forward.

The Department had not issued comprehensive instructions to the DSH hospitals for 2009 however in January 2011, the Department distributed a policy transmittal to each hospital regarding the DSH Audit requirements beginning with federal fiscal year 2010. The transmittal described the required methodology as well as the documentation and data elements to be maintained for audit. The Department is currently working to develop more comprehensive instructions.