Oklahoma Health Care Authority
Oklahoma City, Oklahoma

Medicaid Program for Disproportionate Share Hospital Payment Final Rule Medicaid State Plan Rate Year 2007

Independent Accountant's Report On Applying Agreed-Upon Procedures

December 15, 2010

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Clifton Gunderson LLP
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INDEPENDENT ACCOUNTANT'S REPORT
ON APPLYING AGREED-UPON PROCEDURES

To the Chief Executive Officer of the Oklahoma Health Care Authority
Oklahoma City, Oklahoma

We have performed the procedures in the attached schedule, which were agreed-to by the Oklahoma Health Care Authority (OHCA), solely to assist OHCA in evaluating the State of Oklahoma's (State) compliance with the six verifications outlined in the *Medicaid Program for Disproportionate Share Hospital Payment Final Rule* (DSH Rule) during the Medicaid State Plan (MSP) rate year 2007. 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 and the standards applicable to attestation engagements contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. The sufficiency of these procedures is solely the responsibility of the OHCA. Consequently, we make no representation regarding the sufficiency of the procedures described in the attached Schedule of Agreed-Upon Procedures, either for the purpose for which this report has been requested, or for any other purpose. The results of the agreed-upon procedures are listed 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 the 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 OHCA and is not intended to be and should not be used by anyone other than these specified parties.

Clifton Gunderson LLP

Austin, Texas
December 15, 2010

OKLAHOMA HEALTH CARE AUTHORITY
SCHEDULE OF AGREED-UPON PROCEDURES
FOR MEDICAID STATE PLAN RATE YEAR 2007

Verification 1

Each hospital that qualifies for a Disproportionate Share Hospital (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 (i/p) hospital and outpatient (o/p) 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.

Procedures

State Level Procedures:

We verified either the certified public expenditure (CPE) or the intergovernmental transfer (IGT) funding mechanism at the state level.

> Results: We found that OHCA finances their DSH program through appropriations from the legislature and intragovernmental transfers between state agencies. The State does not utilize intergovernmental transfers from any of the hospitals.

We verified with the OHCA if any redistribution or recovery has been made and if so, we obtained documentation from the OHCA that the redistribution or recovery was made based on the results of the hospital verification procedures.

> Results: We found that as part of our verification procedures, OHCA recovered DSH payments from eight hospitals that were initially paid in excess of hospital-specific limits and a redistribution was made.

We verified that OHCA has updated the DSH Reporting Schedule (DRS) to include DSH payments made by out-of-state Medicaid agencies.

> Results: We found that for MSP rate year 2007, the State did not utilize a DRS that identified or maintained the payments made by out-of-state Medicaid Agencies.

Hospital Procedures:

We verified if every hospital qualified under the federal DSH criteria and OHCA-defined DSH criteria**.**

> Results: We found that four hospitals did not meet the requirements for eligibility as a DSH hospital. The eligibility requirement that was not met included not meeting the requirement related to obstetricians with staff privileges or two physicians for a rural facility. We found that an additional nine hospitals were not able to produce documentation that would allow us to verify their compliance with the qualification criteria.

We verified each hospital's receipt of the full DSH allotment.

> Results: We found that 26 hospitals had a variance between the State-calculated DSH allotment and the hospital support for the payment received. For 16 of these hospitals, the hospital did not provide any documentation to support receipt of DSH payments. In the remaining ten cases, the hospital provided incomplete or incorrect documentation.

Overall Verification Assessment Procedure:

We prepared an overall verification assessment for Verification 1 based on the results of the procedures to note whether the OHCA's procedures satisfy the federal regulation at Section 1923 (g)(1)(A) of the Social Security Act (Act) and identify any providers that did not qualify for DSH.

> Results: We found that of the 65 hospitals that received DSH payments during MSP rate year 2007, four did not meet the federal or the State's qualification criteria for participation in the DSH program. Three of the four facilities that provided documentation were non-rural facilities and did not qualify since they failed to provide adequate support to show that they had two obstetricians who had staff privileges and have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under the State plan. The one rural facility did not provide any physician information. Another nine facilities did not provide documentation that allowed us to verify their qualification status. The 52 hospitals that met the qualifications criteria received 98.41 percent of the DSH payments made for MSP year 2007.
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> We also found that of the remaining 52 hospitals that qualified for a DSH payment, all 52 were allowed to retain that payment so that the payment was available to offset the hospitals' uncompensated care costs for furnishing i/p hospital and o/p 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.

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 must be measured against the actual uncompensated care cost in that same audited MSP rate year.

Procedures

State Level Procedures:

Utilizing the individual Provider Data Summary Schedules (PDSS) (prepared by Clifton Gunderson LLP per the hospital-level procedures described below), we summarized the hospital-specific uncompensated care costs incurred during the MSP year.

> Results: We used the PDSS to summarize the hospital-specific uncompensated care costs incurred during the 2007 MSP.

We compared the hospital-specific DSH payments to the uncompensated care costs and noted any providers where the DSH payments exceeded the hospital-specific uncompensated care costs.

> Results: We compared the hospital-specific DSH payments to the uncompensated care costs and found that two qualified facilities exceeded their hospital-specific limit.

Hospital Procedures:

We prepared individual PDSS using information and calculations from documents supplied by the hospital facilities.

> Results: The PDSS was compiled for 65 facilities that received DSH payments in MSP rate year 2007. We provided a copy of this PDSS to OHCA.

Overall Verification Assessment Procedures:

We prepared an overall verification assessment for Verification 2 to note whether OHCA's procedures satisfy the federal regulation under section 1923(g)(1)(A) of the Social Security Act and identify any providers that exceeded their hospital-specific DSH payment limit.

> Results: We found that DSH payments made to 50 of 52 qualifying hospitals complied with the hospital-specific DSH payment limit while the DSH payments made to two qualifying hospitals exceeded the hospital-specific DSH payment limit for those hospitals. The two hospitals provided support for significantly less uninsured data than they reported to OHCA. DSH payments were made to an additional four hospitals that did not meet the requirements for DSH eligibility and another nine hospitals for whom we were unable to verify their qualification status (see Verification 1).

Verification 3

Only uncompensated care costs of furnishing i/p and o/p hospital services to Medicaid-eligible individuals and individuals with no third-party coverage for the i/p and o/p 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 DSH payment limit.

Procedures

Hospital Procedures:

Desk Review facility procedures:

We calculated the uninsured costs and payments using the "as filed" uninsured charges and cost center specific cost-to-charge ratios.

> Results: There were 48 hospitals that were considered desk review facilities. Out of these 48, 35 facilities qualified for DSH payments (See Verification 1). We found that of the 35 qualified facilities, 32 were able to provide the auditors with documentary support for their uninsured costs and charges, while the remaining three did not provide documentation to support their uninsured costs and charges. We also found that of the remaining 13 unqualified desk review facilities, 10 did not provide uninsured charge data to support the uninsured costs and charges.

We calculated the Medicaid costs and payments using the overall cost-to-charge ratio.

> Results: We calculated the Medicaid costs and payments for all of the qualified hospitals using the overall cost-to-charge ratio from the Centers for Medicare and Medicaid Services (CMS) 2552-96 cost report and the Medicaid Management Information System (MMIS) data for the charges and payments.

Detailed Desk Review facility procedures:

We reviewed the uninsured charges and removed any unallowable charges.

> Results: There were 16 hospitals that were considered detailed desk review facilities. We found that all sixteen of these facilities qualified for DSH payments (See Verification 1).

We compiled a listing of unallowable charges and provided this listing to the hospitals. The hospitals were asked to respond to the disallowance of these charges and provide additional support for including these charges as allowable charges.

> Results: We found that all sixteen facilities included: individuals who were Medicaid-eligible and compensated by Medicaid; individuals who had a source of third-party coverage; duplicate charges; or reported uninsured charges and costs from another MSP rate year.

We calculated the uninsured cost using the cost center specific cost-to-charge ratios.

Results: We provided the State with a schedule of recalculated costs.

We calculated the Medicaid cost using the cost center specific cost-to-charge ratios.

Results: We provided the State with a schedule of recalculated costs.

On-Site Review Facility procedures:

We reviewed the uninsured charges and removed any unallowable charges.

Results: We conducted procedures at one on-site facility. We found that this facility reported as uninsured individuals who were Medicaid-eligible and compensated by Medicaid or had third-party coverage.

We compiled a listing of unallowable charges and provided this listing to the hospital. The hospital was asked to respond to the disallowance of these charges and provide additional support for determining if these charges were allowable charges.

Results: We reviewed the additional support provided by the facility and determined if the charges should remain as uninsured, or if the documentation provided identified third-party coverage in which case the charges would be removed from the uninsured charge data. We found that this facility included individuals who were Medicaid-eligible and compensated by Medicaid or had a source of third-party coverage and therefore these charges would be removed from the uninsured charge data.

We tested a sample of the allowable uninsured charges on site at the facility.

Results: We found that the facility included in the uninsured data individuals who were Medicaid-eligible and could have been reimbursed by Medicaid, and individuals who had a source of third-party coverage.

We calculated the uninsured cost using the cost center specific cost-to-charge ratios.

Results: We provided the State with a schedule of recalculated costs.

We calculated the Medicaid cost using the cost center specific cost-to-charge ratios.

Results: We provided the State with a schedule of recalculated costs.

Overall Verification Assessment Procedure:

We prepared an overall verification assessment for Verification 3 to note whether OHCA's procedures satisfy the federal regulation under section 1923(g)(1)(A) of the Social Security Act.

Results: We found that the MSP effective October 1, 2005, defines uncompensated cost as the cost of furnishing i/p and o/p hospital services to a Medicaid patient, net of Medicaid payments (excluding DSH payments) and costs associated with patients who have no health insurance or source of third-party payment for services provided during the year, less the amount of payments paid by them. However, there is no definition of uncompensated costs in the MSP effective January 1, 2007. We also identified that the DSH survey instrument that was used by the State to calculate the hospital-specific limit collected charity charge information instead of costs associated with patients that have no health insurance or source of third-party payment. Charity charges are defined separately by each facility and can include costs that do not meet the uncompensated

care cost definition found in the DSH Rule. We found that all the qualified hospitals we tested did not use only uncompensated care costs of furnishing i/p and o/p hospital services to Medicaid-eligible individuals and that individuals with no third-party coverage were included in the calculation of the hospital-specific DSH payment limit, as described in section 1923(g)(1)(A) of the Social Security Act.

Verification 4

For purposes of the 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 DSH hospital for furnishing i/p hospital and o/p 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 i/p hospital and o/p hospital services to individuals with no source of third-party coverage for such services.

Procedures

State Level Procedures:

We determined whether the State's procedures take into account all payments (Medicaid fee-for-service (FFS), Medicaid managed care, and supplemental/enhanced Medicaid payments) in the calculation of hospital-specific limits.

Results: We found that OHCA did not obtain and utilize payments from out-of-state Medicaid agencies, including out-of-state Medicaid supplemental/enhanced payments, or the Section 1011 program payments when calculating the hospital-specific limit. We found that forty-four facilities received supplemental/enhanced payments and four facilities (three qualified and one unqualified) received 1011 payments that the State did not include in their calculation.

Hospital Procedures:

We verified all payments are considered, calculated and entered into the individual PDSS.

Results: We found that 46 of the 52 qualified hospitals did not respond or provide documentation or support for out–of-state Medicaid supplemental/enhanced payments. The remaining six hospitals submitted documentation for out-of-state Medicaid supplemental/enhanced payments.

Overall Verification Assessment Procedure:

We prepared an overall verification assessment for Verification 4 to note whether the State's procedures satisfy the federal regulation under section 1923 (g)(1)(A) of the Social Security Act.

Results: We found that Section 1011 or supplemental/enhanced Medicaid payments made to three of 52 qualified DSH hospitals for furnishing i/p hospital and o/p hospital services to Medicaid-eligible individuals, which are in excess of the Medicaid-incurred costs of such services, were not applied against the uncompensated care costs of furnishing i/p hospital and o/p hospital services to individuals with no source of third-party coverage for such services. We found that the Medicaid FFS rate payments for all 52 DSH hospitals were applied against the uncompensated care costs of furnishing i/p hospital and o/p hospital services to individuals with no source of third-party coverage for such services. We found that OHCA was not obtaining and including in its hospital-specific DSH limit the out-of-state Medicaid payments, including any out-of-state Medicaid supplemental/ enhanced payments.

Verification 5

Any information and records of all of its i/p and o/p hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured i/p and o/p 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.

Procedures

State Level Procedures:

We obtained copies of OHCA's policies and procedures regarding documentation retention related to information and records of all i/p and o/p hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured i/p and o/p hospital service costs in determining payment adjustments; and, any payments made on behalf of the uninsured from payment adjustments under section 1923 of the Social Security Act.

> Results: We found that OHCA has retained the following documents pertaining to the DSH program: MSP, DSH survey received from the hospitals, correspondence received from the hospitals, OHCA-prepared DSH calculation worksheets, and the MMIS data.

We prepared a summary schedule detailing the State's documentation procedures, including the specific data elements retained by the State.

> Results: The State maintains a document retention policy that establishes the retention period for files, but does not identify the particular records that are required to be maintained in the file.

We determined whether the State has documented and retained information and records of all of its i/p and o/p hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured i/p and o/p hospital service costs in determining payment adjustments and whether any payments made on behalf of the uninsured from payment adjustments have been separately documented and retained by the State.

> Results: OHCA does not maintain or collect support for the DSH surveys completed by the hospital. In accordance with the MSP, each hospital is responsible for maintaining its own supporting documents and records related to information reported to OHCA on the annual DSH survey.

Overall Verification Assessment Procedure:

We prepared an overall verification assessment for Verification 5 to note whether OHCA's procedures satisfy the federal regulation under section 1923(g)(1)(A) of the Social Security Act.

> Results: We found that information and records of all of i/p and o/p hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured i/p and o/p hospital service costs in determining payment adjustments; and any payments made on behalf of the uninsured from payment adjustments had not been separately documented and retained by OHCA.
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> OHCA has assigned responsibility of maintaining detailed records to each hospital in the program. We found that the majority of the facilities that represent over 90 percent of the DSH payments were able to provide substantially all the documentation required to support i/p and o/p hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured i/p and o/p hospital service costs in determining payment adjustments under the DSH Rule; and any payments made on behalf of the uninsured from payment adjustments under the DSH Rule.

Verification 6
The information specified in paragraph (d)(5) of Title 42 Code of Federal Regulations (CFR) Part 455.304 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 audit report must specify how the State defines incurred i/p hospital and o/p hospital costs for furnishing i/p hospital and o/p hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the i/p hospital and o/p hospital services they received.

Procedures
State Level Procedures

We obtained documentation from OHCA outlining the methodology used to calculate the hospital-specific DSH limit and methodology used to calculate the various DSH payments. We reviewed this documentation to determine if it included a description of the methodology for calculating each hospital's payment limit under section 1923(g)(1) of the Social Security Act, including how the State defines incurred i/p hospital and o/p hospital costs for furnishing i/p hospital and o/p hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the i/p hospital and o/p hospital services they received.

> Results: We reviewed the information specified in paragraph (d)(5) of Title 42 CFR Part 455.304 for MSP rate year 2007 and determined it included a description of the methodology for calculating each hospital's payment limit under section 1923(g)(1) of the Social Security Act, including how the State defines incurred i/p hospital and o/p hospital costs for furnishing i/p hospital and o/p hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the i/p hospital and o/p hospital services they received.

We reviewed OHCA's DSH procedures to ensure consistency with i/p and o/p Medicaid reimbursable services in the approved MSP.

> Results: We identified that OHCA's DSH procedures for i/p and o/p Medicaid reimbursable services are consistent with the MSP approved July 1, 2006 and January 1, 2007.

We reviewed DSH procedures to ensure that only costs eligible for DSH payments are included in the development of the hospital-specific DSH limit.

> Results: We found that the MSP states that only costs eligible for DSH payments are to be included in the development of the hospital-specific DSH limit. However, the methodology used by OHCA to calculate the hospital-specific DSH limits included costs that are not eligible for DSH payments.

We determined if the MSP section covering DSH payments complies with section 1923(g)(1) of the Social Security Act.

> Results: We compared the MSP section covering DSH payments to section 1923(g)(1) of the Social Security Act and determined it to be compliant.

We determined how OHCA defines incurred i/p hospital and o/p hospital costs for furnishing i/p hospital and o/p hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the i/p hospital and o/p hospital services they received.

> Results: We found that the MSP defines uncompensated costs as the cost of furnishing i/p and o/p hospital services to Medicaid patients (net of Medicaid payments) and costs associated with patients who have no health insurance or source of third-party payment

for services provided during the year, less the amount of payments paid by them. Furthermore, the MSP continues under their General Provisions, that the "disproportionate share payments shall not exceed the Federal disproportionate share, State or other specific limits required by law." OHCA staff utilize the Oklahoma Administrative Code (OAC), which defines i/p hospital services and o/p hospital services in Title 317, Chapter 30, Subchapter 5, Part 3 (Section 317:30-5-41 and 317:30-5-42.1).

Overall Verification Assessment Procedure:

We prepared an overall verification assessment for Verification 6 to note whether OHCA's procedures satisfy the federal regulation under section 1923 (g)(1)(A) of the Social Security Act.

Results: The State uses indigent care as a basis for calculating hospital payment limits. The MSP's effective July 1, 2006 and January 1, 2007 both define OHCA's process for calculating hospital-specific limits. We found that the information specified in paragraph (d)(5) of Part 455.304 of Title 42 CFR was included in the MSP for calculating each hospital's payment limit under section 1923(g)(1) of the Social Security Act.