Oklahoma Health Care Authority
Oklahoma City, Oklahoma

Medicaid Program for Disproportionate Share
Hospital Payment Final Rule
Medicaid State Plan Rate Year 2009

Independent Accountant's Report On Applying Agreed-Upon Procedures

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Table of Contents

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 2009. 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, is not intended to be, and should not be used by anyone other than this specified party.

PHBV Partners LLP

Austin, Texas
August 17, 2012

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

> **Results**: We found OHCA paid DSH funds to one hospital that qualified based on the state's initial calculation. OHCA subsequently recalculated their hospital specific DSH limits and found that this provider was paid in excess of the recalculated limit. Subsequently, OHCA recovered the total amount of DSHs payment from this provider and redistribution was made in accordance with the OHCA MSP.

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 2009, 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 three hospitals did not meet the federal or state requirements for eligibility as a DSH hospital. The eligibility requirement that was not met, was the requirement related to obstetricians with staff privileges, or two physicians for a rural facility.

We performed procedures to verify each hospital's receipt of the full DSH allotment and requested representations from the hospitals relating to retention of DSH funds.

> **Results**: We found that 17 hospitals had a variance between the State-calculated DSH allotment and the hospital support for the payment received. For 12 of these hospitals, the hospital did not provide any documentation to support receipt of DSH payments. For four of these hospitals, the hospital provided support for receipt of less than their full DSH allotment. For one hospital, the hospital provided support for receipt of more than

their full DSH allotment. Therefore, we were unable to verify that 16 hospitals received the full DSH allotment.

We found that 20 of the 65 hospitals receiving DSH funds did not represent to us that the hospital was allowed to retain the entire DSH payment made by the state during MSP 2009, or that they did not have any agreements to transfer 2009 DSH funds to any other entity. All remaining 45 hospitals that received 2009 DSH funds did represent that they did not have to return any of the DSH funds and they did not have any other agreements to transfer 2009 DSH funds to outside parties.

Overall Verification Assessment Procedure:

We prepared an overall verification assessment for Verification 1 based on the results of the procedures to note whether 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 2009, three did not meet the federal or state qualification criteria for participation in the DSH program. Two of the three facilities failed to provide adequate support to show that they had two obstetricians, or two physicians for rural facilities, 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 remaining facility claimed to be a grandfathered facility but was unable to provide documentation to support their grandfathered status.

We also found that of the remaining 62 hospitals that qualified for a DSH payment, 46 hospitals could support the receipt of their full DSH allotment and 45 hospitals represented to us that they were able 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. We were not able to verify that the remaining 17 providers were allowed to retain the entire DSH payment made by the state during MSP 2009.

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) (compiled by PHBV Partners 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 2009 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 actual DSH payments to the initial DSH payment limits calculated by the state and found one hospital was paid in excess of their state calculated DSH limit. We compared the hospital-specific DSH payments to the uncompensated care costs calculated by PHBV Partners and found that six qualified facilities exceeded their hospital-specific limit. Additionally, the three non-qualified facilities are considered to have exceeded their hospital-limit since they did not qualify for the payment made by the state.

Hospital Procedures:

We compiled the 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 2009. 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 Act and identify any providers that exceeded their hospital-specific DSH payment limit.

Results: We found that DSH payments made to 55 of 65 hospitals did not exceed the hospital-specific DSH payment limit while the DSH payments made to six qualifying and three non-qualifying hospitals exceeded the hospital-specific DSH payment limit for those hospitals. Six hospitals that exceeded their limit provided support for significantly less uninsured data than they reported to OHCA. Three hospitals did not qualify for the payment that they received from the state. The remaining hospital initially received a DSH payment that was subsequently returned to the state. Additionally, one of the unqualified hospitals was paid in excess of the state calculated DSH limit.

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 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 and per diems.

Results: There were 44 hospitals that were considered desk review facilities based on a risk assessment. Out of these 44, 41 facilities qualified for DSH payments (See Verification 1). We found that of the 41 qualified facilities, 31 were able to provide the auditors with documentary support for their uninsured costs and charges, while the remaining ten facilities did not provide documentation to support their uninsured costs and charges. We also found that of the remaining three unqualified desk review facilities, two did not provide uninsured charge data to support the uninsured costs and charges.

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

Results: We calculated the Medicaid costs and payments for all of the qualified hospitals using the cost center specific cost-to-charge ratios and per diems 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 21 hospitals that were considered detailed desk review facilities based on a risk assessment. We found that all 21 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 20 of the 21 detailed desk review 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. One facility did not provide any uninsured data.

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 and per diems.

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

We selected a sample of out of state (OOS) Medicaid payers and requested a list of charges sent to them from the hospital.

Results: The majority of our sample included claims for clients that were Medicaid recipients in the state of Arkansas. We did not receive a response from the Arkansas Medicaid agency to our request for a list of charges sent to them by Oklahoma hospitals. Therefore, we were not able to fully perform this procedure. Fourteen of the 21 detailed desk review hospitals submitted OOS charge data. However, when compared to total charges, the OOS charges were not material. In the aggregate, OOS charges account for less than one percent of total charges. Therefore, this area is considered low risk and the reported OOS payments reported by the hospitals were deemed to be the best available data. All OOS payments reported by the hospitals were used to offset costs in calculating the hospital specific limit for each hospital.

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 Act.

Results: We found that all of 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 Act. Of the 65 hospitals that received DSH payments during MSP 2009, 13 did not provide documentary support for their uninsured cost and charges.

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 63 facilities (60 qualified and 3 unqualified) received FFS supplemental/enhanced payments and eleven facilities (ten 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 55 of the 62 qualified hospitals did not respond or provide documentation or support for out–of-state Medicaid supplemental/enhanced payments. The remaining seven hospitals submitted documentation for out-of-state Medicaid supplemental/enhanced payments.

Detailed Desk Review facility procedures:

We requested a listing of payments made by out of state Medicaid Managed Care Organizations (MCO) and Medicaid agencies from each hospital.

> **Results:** Twelve of the 21 detailed desk review providers submitted MCO payment data. However, in every case, we found that the payment data submitted by the provider was a duplication of the claims that were already included in the MMIS data. Therefore, the separate MCO payment data submitted by the provider was not used in the hospital specific DSH limit calculation because it was already taken into account through consideration of the MMIS data.

We requested a listing of payments made by non-third party payers or state and local government indigent programs in order to trace them to the data provided by the hospital.

> **Results:** Since none of the 21 detailed desk review providers submitted non-third party or state and local government indigent program payment data, this procedure was not applicable. However, during our review of the hospital's working trial balance, we identified payments for collections on bad debt accounts for uninsured patients for five hospitals. These payments were used to offset the cost of care for uninsured individuals for these hospitals.

We requested a listing of revenue by payer code from the hospital and compared it to the detailed listing of self-pay payments to verify completeness of hospital reported self-payments.

Results: The self-pay summary agreed with the payer code listing for 2 of the 21 detailed desk review hospitals. The detail listing was greater than the payer code listing for 10 hospitals while the detail listing was less than the payer code listing for 8 hospitals. The remaining hospital did not submit any self-pay data.

We obtained a listing of supplemental state Medicaid payments from the hospital and from the state and reconciled any differences between the two lists in order to verify completeness of hospital-reported supplemental Medicaid payments.

Results: The hospital provided supplemental state payment documentation agreed with OHCA's documentation for 13 of the 21 detailed desk review hospitals. Five hospitals did not submit any documentation. OCHA records indicated that these hospitals received payments. Two hospitals submitted documentation for payments that were greater than the state listing. The remaining hospital submitted documentation for payments that were less than the state listing.

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 Act.

Results: We found that Section 1011, or supplemental/enhanced Medicaid payments made to 10 of 62 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 60 of the 62 qualified 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. The remaining two qualified hospitals did not receive supplemental payments. 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 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 OHCA's documentation procedures, including the specific data elements retained by OHCA.

> **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 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.
>
> OHCA has assigned responsibility for maintaining detailed records to each hospital in the program. We found that the 62 qualified facilities, which 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 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 inpatient (i/p) hospital and outpatient (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 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 2009 and determined it included a description of the methodology for calculating each hospital's payment limit under section 1923(g)(1) of the 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, effective 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 Act.

Results: We compared the MSP section covering DSH payments to section 1923(g)(1) of the 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 does not define 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. OHCA staff utilizes 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 Act.

Results: The MSP, effective January 1, 2007, does not contain a definition of i/p and hospital uncompensated costs. However, the State utilized the OAC for the specific determinations of allowable charges. 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 only 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. The State uses indigent care as a basis for calculating hospital payment limits. The MSP effective January 1, 2007, defines 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 Act.

Hospital Detailed Audit Findings Consultation

We prepared a findings summary for each detailed desk review hospital.

Results: A finding summary was e-mailed to each detailed desk review provider on August 17, 2012. The finding summary included:

- The as filed charge data reported from OHCA's Medicaid Managed Care Information System (MMIS), Manager Care Organizations (MCO), Out of State (OOS), Dual Eligible (DE), and Uninsured hospital reports
- Adjustments made to charge data with routine explanations
- As filed payment data reported from OCHA's MMIS, MCO, OOS, DE, and uninsured
- Adjustments to the payment data with routine explanations
- The newly calculated hospital-specific limit and determination of whether the hospital was paid over its new limit.