



**Oklahoma Health Care Authority  
Oklahoma City, Oklahoma**

**Medicaid Program for Disproportionate Share  
Hospital Payment Final Rule  
MSP Rate Year 2006**

**Independent Accountant's Report  
On Applying Agreed-Upon Procedures  
October 29, 2010**

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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

This report supersedes our earlier report dated December 31, 2009 on the Independent Accountant's Report on Applying Agreed-Upon Procedures on the Oklahoma Health Care Authority (OHCA) Medicaid Program for Disproportionate Share Hospital (DSH) Payment Final Rule for Medicaid State Plan (MSP) Rate Year 2006.

The previously issued report should have no reliance placed on it. This report is being reissued because of certain clarifications on information that had been provided to us relating to the OHCA DSH payments for MSP rate year 2006 that have necessitated a revision in the report. These changes are noted in the appropriate sections of this report.

We have performed the procedures in the attached schedule, which were agreed-to by OHCA, solely to assist the specified party 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* (Rule) during the Medicaid State Plan (MSP) rate year 2006. 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 the party specified in this report.

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 31, 2009

**OKLAHOMA HEALTH CARE AUTHORITY**  
**SCHEDULE OF AGREED-UPON PROCEDURES**  
**FOR MEDICAID STATE PLAN RATE YEAR 2006**

**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 legislature and intragovernmental transfers between state agencies. The State does not utilize intergovernmental transfers.

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

Results: We found that as part of the verification procedures, a recovery from a non-qualifying hospital did occur and an appropriate redistribution was made.

We verified that the State 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 2006, 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 State-defined DSH criteria.

Results: We found that 4 hospitals did not meet the requirements for eligibility as a DSH hospital. The eligibility requirements that were not met included not providing i/p services, not meeting the Low Income Utilization Rate (LIUR) qualification requirement of Section 1923 of the Social Security Act, or not providing information relating to obstetricians with staff privileges. We found that an additional 17 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 36 hospitals had a variance between the State-calculated DSH allotment and the hospital support for the payment received. The variances were the result of hospitals not providing support or providing incomplete documentation to support receipt of DSH funds.

## **Overall Verification Assessment Procedure:**

We prepared an overall verification assessment for Verification 1 based on the results of the procedures to note whether the State'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 72 hospitals that received DSH payments during MSP rate year 2006, four did not meet the federal or the State's qualification criteria for participation in the DSH program and another 17 did not provide documentation that allowed us to verify their qualification status. The 51 hospitals that met the qualifications criteria received 94.98 percent of the DSH payments made for MSP year 2006. Of the four facilities that provided documentation but did not qualify, one facility did not provide i/p services (the State subsequently recovered the DSH payments to this facility), and three facilities met the one percent Medicaid Inpatient Utilization Rate (MIUR) qualification, but 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. We found 17 facilities did not provide any support that would allow us to either calculate the MIUR, the LIUR, or validate that they had met the 2 obstetrician requirement.

We also found that of the 51 hospitals that qualified for a DSH payment, all 51 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:**

We prepared a summary schedule detailing the State's procedures performed to determine whether or not the State made DSH payments that exceeded any provider's specific DSH limit during the MSP rate year.

Results: We prepared a summary schedule detailing the State's procedures and utilized it to determine whether DSH payments were made that exceeded any hospital's specific DSH limit.

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 under examination.

Results: We used the PDSS to summarize the hospital-specific uncompensated care costs incurred during the 2006 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. We were unable to determine if one additional facility exceeded its hospital-specific limit because the hospital did not provide any support for its uninsured charges.

### **Hospital Procedures:**

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

Results: The PDSS was compiled for 72 facilities that received DSH payments in MSP rate year 2006. We provided a copy of this PDSS to the State.

### **Overall Verification Assessment Procedures:**

We prepared an overall verification assessment for Verification 2 to note whether the State's procedures satisfy the federal regulation at 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 48 of 51 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 the State<sup>1</sup>. A third facility did not provide support for its uninsured charges and therefore we were unable to determine if the hospital exceeded its hospital-specific limit. DSH payments were made to an additional four hospitals that did not meet the requirements for DSH eligibility and another 17 hospitals that 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 Act are eligible for inclusion in the calculation of the hospital-specific DSH payment limit, as described in Section 1923(g)(1)(A) of the Act.

### **Procedures**

#### **State Level Procedures:**

We prepared a summary schedule detailing the State's procedures performed to determine that only the uncompensated care costs of providing i/p and o/p hospital services to Medicaid eligible individuals and uninsured individuals are included in the calculation of the hospital-specific limits.

Results: We prepared a summary schedule detailing the State's procedures.

We determined whether the State's procedures only use uncompensated care costs of i/p and o/p hospital services in calculation of hospital-specific limits.

Results: We identified that the DSH survey required hospitals to report charity charges and individuals with third-party coverage. The charity charges were used to calculate the hospital-specific limit.

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<sup>1</sup> The previously issued report, which should not be relied on, stated that only one of these hospitals had exceeded their limit because it had provided support for significantly less uninsured data than they reported to the State.

## **Hospital Procedures:**

### *Minimal risk facility procedures:*

We calculated the uninsured costs and payments using the "as filed" uninsured charges and an overall cost-to-charge ratio.

Results: There were 60 facilities that were considered minimal risk facilities. Out of these 60, 40 facilities qualified for DSH payments (See Verification 1). We found that of the 40 minimal risk qualified facilities, 33 were able to provide the auditors with documentary support for their uninsured costs and charges, while the remaining 7 did not provide documentation to support their uninsured costs and charges. We also found that of the remaining 20 unqualified minimal risk facilities, 17 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 but one of the qualified hospitals using the overall cost-to-charge ratio from the CMS 2552-96 cost report and the Medicaid Management Information System (MMIS) data for the charges and payments. One facility was an out-of-state facility that we were unable to obtain the cost report, therefore we utilized the State-calculated cost-to-charge ratio derived from the DSH survey.

### *Low Risk facility procedures:*

We reviewed the uninsured charges and removed any unallowable charges.

Results: There were 11 facilities that were considered low risk providers. We found that of these 11, ten qualified for DSH payments (See Verification 1). We found that of the ten low risk qualified facilities, three did not provide documentation to support their uninsured costs and charges. We also found that the one unqualified low risk facility did not provide uninsured charge data to support its uninsured costs and charges.

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 six facilities included individuals that were Medicaid-eligible and compensated by Medicaid, had a source of third-party coverage, were duplicated charges, or reported charges and costs from another MSP rate year. One facility provided uninsured charges that contained no exceptions.

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.

### *High Risk Facility procedures:*

We reviewed the uninsured charges and removed any unallowable charges.

Results: We found that one hospital included individuals that 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 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 reviewed the additional support provided by the facility and determined if the charge should remain as uninsured, or if the documentation provided identified third-party coverage, then the charge was 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 that were Medicaid-eligible and could have been reimbursed by Medicaid, and individuals that 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 the State's procedures satisfy the federal regulation at Section 1923(g)(1)(A) of the Act.

Results: We found that the MSP does define 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, we identified that the DSH survey instrument that is used by the State to calculate the hospital specific limit collects 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 cost definition. As a result, we found that all 51 qualified hospitals did not use only uncompensated care costs of furnishing i/p and o/p hospital services to Medicaid-eligible individuals and 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.

### **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 prepared a summary schedule detailing the State's procedures performed to determine that all payments (Medicaid Fee for service (FFS), Medicaid managed care, and supplemental/enhanced Medicaid payments) have been included in the calculation of the hospital-specific DHS limits.

Results: We prepared a summary schedule detailing the State's procedures.

We determined whether the State's procedures take into account all payments (Medicaid 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 two facilities provided supplemental/enhanced payments or 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 four of the 51 qualified hospitals did not respond or provide documentation or support for out of state Medicaid supplemental/enhanced payments. An additional 24 of the 51 facilities did not provide documentation or support claiming it was not applicable to their facility.

We found that ten of the 51 qualified hospitals did not provide documentation supporting the DSH payments received, one that provided inadequate support that could not be utilized, three provided support that was greater than the DSH payment, and four provided support for less than the DSH payment .

### **Overall Verification Assessment Procedure:**

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

Results: We found that Section 1011 or supplemental/enhanced Medicaid payments made to two of 51 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 51 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 under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section has been separately documented and retained by the State.

## **Procedures**

### **State Level Procedures:**

We obtained copies of the State'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: State Plan, 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 under this section; and whether any payments made on behalf of the uninsured from payment adjustments under this section 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.

### **Overall Verification Assessment Procedure:**

We prepared an overall verification assessment for Verification 5 to note whether the State's procedures satisfy the federal regulation at 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 under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section had not been separately documented and retained by the State.

The 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 Rule; and any payments made on behalf of the uninsured from payment adjustments under the Rule.

## **Verification 6**

The information specified in paragraph (d)(5) of 42 CFR Section 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 i/p hospital and o/p hospital services they received.

## **Procedures**

### **State Level Procedures**

We obtained documentation from the State outlining the methodology used to calculate the hospital-specific DSH limit and methodology used to calculate the various DSH payments. We reviewed this documentation for compliance with applicable regulations.

Results: We reviewed the methodology outlined in the MSP for rate year 2006 and determined it was in compliance with applicable regulations. We found that OHCA applied an inflation factor to the Medicaid charges and the charity charges, which is in compliance with their State plan that was approved by CMS, and performed a reconciliation using the 2006 fiscal year end charges prior to making their last distribution for MSP 2006, which is in compliance with the Rule.

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

Results: We identified that the State's approved MSP defines the i/p hospital and o/p hospital Medicaid reimbursable services.

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, but that the methodology used by the State to calculate the hospital-specific DSH limits include costs that are not eligible for DSH payments.

We determined if the MSP section covering DSH payments complies with applicable federal regulations.

Results: We compared the State plan section covering DSH payments to the federal regulation and determined it to be compliant.

We determined 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 found that the State plan defines uncompensated costs as the cost furnishing i/p and o/p hospital services to Medicaid patients, net of Medicaid payments; 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 State plan 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 the State's procedures satisfy the federal regulation at Section 1923 (g)(1)(A) of the Act.

Results: We found that the information specified in paragraph (d)(5) of Section 455.304 of 42 CFR Part 455(a definition of incurred i/p hospital and i/p hospital costs for furnishing i/p 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) was included in the MSP for calculating each hospital's payment limit under Section 1923(g)(1) of the Act.