Clifton Gunderson LLP
Certified Public Accountants & Consultants

To: Stephen Weiss, Sr. Policy Advisor:

We have completed our agreed-upon procedures of the Oklahoma State (State) Disproportionate Share Hospital (DSH) Program compliance with the Disproportionate Share Hospital Payments Final Rule (Rule) and have issued our report dated March 3, 2011. We conducted our examination in accordance with the applicable 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.

In connection with our agreed-upon procedures, we are providing this additional information to assist you in further understanding the report findings and PDSS that we delivered to you as part of our engagement.

UNQUALIFIED HOSPITALS

Medicaid State Plan (MSP) 2008
During MSP rate year 2008, OHCA did not verify the information provided by hospitals on their applications for DSH funding related to meeting the obstetrician requirement or physician requirement for hospitals located in a rural area prior to making DSH payments.

We found that the following provider did not meet the DSH qualification under the MSP, as prescribed in Section 1923 (d) of the Social Security Act, received DSH payments in MSP rate year 2008:

Hospital	Reason for not Qualifying	City	DSH Payment
Park View Hospital	Did not meet OB or rural facility requirement. Facility provided the names of 2 physicians, but neither were OB providers.	El Reno	$114,710

This facility represents $114,710, or .23% of the total DSH payments distributed during MSP 2008.

The following providers received DSH payments in MSP rate year 2008. However, they did not provide documentation that would allow us to verify that they did not exceed their hospital specific DSH limit.

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- Seiling Municipal Hospital
- Woodward Regional Hospital
- Elkview General Hospital
- Haskell County Hospital
- Memorial Hospital of Texas County
- Valir Rehabilitation Hospital

These facilities represent $329,400, or .65% of the total DSH payments distributed during MSP 2008.

Recommendation
In order to ensure compliance with the DSH Rule in the future and that only qualified hospitals receive DSH payments, OHCA should implement a review process to verify the obstetrician or physician information provided by the hospitals on their applications for DSH funding. For future MSP rate years, MIUR and LIUR should be recomputed using source documentation, such as MMIS data, when such information becomes available. The Center for Medicaid and Medicare Services (CMS) also provides the following guidance in its General Comments on Auditing and Reporting Provisions for the DSH Rule, "States …must provide for adjustments to ensure that final qualification and payments are based on actual data for the relevant time period. Consistent with that principle, the LIUR, MIUR or alternative DSH qualifying statistics must be reported in the audit using the actual hospital utilization, payment and cost data applicable to the MSP rate year under audit."

DSH MONIES RECEIVED AND RETAINED

MSP 2008
The following 22 providers were issued DSH payments but were unable to provide sufficient evidence of receiving and retaining the funds:

Hospital	Provider ID	Amount per State	Amount per Hospital	Variance
Carl Albert CMHC	374006	$452,848	$451,001	$(1,844.00)
Claremore Regional Hospital	370039	$178,035	$178,671	$636
Cleveland Area Hospital	371320	$75,945	$74,394	$(1,551)
Craig General Hospital	370065	$80,058	$0	$(80,058)
Cushing Regional Hospital	370099	$204,247	$210,203	$5,956
Elkview General Hospital	370153	$54,903	$0	$(54,903)
George Nigh Rehabilitation Center	373026	$12,296	$9,691	$(2,605)
Haskell County Hospital	370084	$49,448	$0	$(49,448)
Henryetta Medical Center	370183	$101,216	$104,168	$2,952

Hospital	Provider ID	Amount per State	Amount per Hospital	Variance
Integris Canadian Valley Regional Hospital	370211	$162,805	$204,703	$41,898
Integris Grove General Hospital	370113	$197,887	$190,890	$(6,997)
Integris Mayes County Medical Center	370015	$115,011	$29,622	$(85,389)
Jackson County Memorial Hospital	370022	$279,162	$280,377	$1,215
Jim Taliaferro CMHC	374008	$583,976	$437,982	$(145,994)
Lakeside Women's Hospital	370109	$11,556	$5,784	$(5,772)
Memorial Hospital of Texas County	370138	$82,140	$0	$(82,140)
Midwest Regional Medical Center	370094	$629,724	$633,189	$3,465
Newman Memorial Hospital	370007	$40,679	$39,241	$(1,438)
Park View Hospital	370011	$114,710	$113,999	$(711)
Seiling Municipal Hospital	371332	$11,068	$0	$(11,068)
Valir Rehabilitation Hospital	373025	$41,935	$0	$(41,935)
Woodward Regional Hospital	370002	$89,906	$0	$(89,906)

HOSPITAL-SPECIFIC DSH PAYMENTS LIMIT

MSP 2008

The following qualified providers received DSH payments that exceeded their hospital-specific DSH limit in MSP rate year 2008 (calculated based on the Rule):

Hospital Name	Total Annual Uncompensated Care Costs	Disproportionate Share Hospital Payments	Comment
Cedar Ridge (Formerly High Pointe)	$(34,077)	$42,844	Facility provided significantly less uninsured data than provided on the DSH survey
J. D. McCarty Center	$74,263	$317,608	Facility provided significantly less uninsured data than provided on the DSH survey
Jim Taliaferro Community Mental Health Center	$214,808	$583,976	Facility provided significantly less uninsured data than provided on the DSH survey

Recommendation
We recommend that OHCA perform a review of uninsured charges provided by facilities on the DSH survey to ensure that it includes only uncompensated cost for furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals and individuals with no insurance or any other third-party coverage.

UNINSURED ACCOUNTS

We examined the uninsured account details provided by eighteen hospitals for MSP rate year 2008, which received, in total, at least 90 percent of the DSH payments in each of the MSP rate years.

Seventeen of the eighteen hospitals provided their uninsured data for our review. J. D. McCarty Center did not provide any uninsured data. Per our review, none of the hospitals provided only allowable charges. The seventeen hospitals for MSP rate year 2008 included individuals with unallowable charges in its uninsured account details, which we identified through our AUP procedures:

Hospital	Total IP Amount Removed	Total OP Amount Removed	Total Amount Removed
OU Medical Center	$ 7,301,255	$ 220,873	$ 7,522,128
Carl Albert Community Mental Health Center	$ 10,290	$ 9,447	$ 19,737
Deaconess Hospital	$ 66,324	$ 117,693	$ 184,017
Griffin Memorial Hospital	$ 4,055,714	$ -	$ 4,055,714
Integris Baptist Medical Center	$ 91,001	$ 2,615,803	$ 2,706,804
Integris Bass Baptist Medical Center	$ -	$ 375,313	$ 375,313
Integris Southwest Medical Center	$ 5,627	$ 579,033	$ 584,660
Jane Phillips Memorial Health Center	$ 7,440,260	$ 652,359	$ 8,092,619
Jim Taliaferro CMHC	$ 22,816	$ (0)	$ 22,816
Mercy Health Center	$ 1,733,124	$ 627,385	$ 2,360,509
Mercy Memorial Health Center	$ 583,527	$ 693,232	$ 1,276,759
Midwest Regional Hospital	$ 8,562,120	$ 9,702,705	$18,264,825
Norman Regional Medical Center	$ 1,426,344	$ 3,348,267	$ 4,774,611
Saint Francis Hospital	$ 784,091	$ 1,902,737	$ 2,686,828
Southcrest Hospital	$ 1,247,002	$ 560,425	$ 1,807,427
St. Anthony Hospital	$ 3,049,214	$ 1,224,998	$ 4,274,212
St. John Medical Center	$11,077,135	$ 8,758,537	$19,835,672

The following table provides the types of unallowable charges we identified:

Hospital	IP Charges Removed	Dollars	OP Charges Removed	Dollars
OU Medical Center	• Charges that had payments that equaled more than 40% of charges (indicative of insurance payments) • Charges that insurance payments identified in the data provided by OU Medical Center.	As a result of our test work and extrapolation, charges totaling $7,301,255 were identified.	• Charges that had payments that equaled more than 40% of charges (indicative of insurance payments) • Charges that insurance payments identified in the data provided by OU Medical Center.	As a result of our test work and extrapolation, charges totaling $220,873 were identified.
Carl Albert Community Mental Health Center	• Charges on the uninsured listing that were also on the MMIS data. • Charges on the dual eligible listing that were also on the MMIS data	$120 $10,170	• Charges on the dual eligible listing that were also on the MMIS data • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	$5,564 $883
Deaconess Hospital	• Charges that had payments that equaled more than 40% of charges (indicative of insurance Payments)	As a result of our test work and extrapolation, charges totaling $66,324 were identified.	• Charges that were duplicated in the uninsured data • Charges on the uninsured listing that were also on the MMIS data. • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	$4,422 $54,078 As a result of our test work and extrapolation, charges totaling $59,193 were identified.
Griffin Memorial Hospital	• Charges that were not in the scope of MSP 2008 • Charges on the uninsured listing that were also on MMIS data	$4,008,098 $47,616	• This hospital did not provide outpatient services	

Hospital	IP Charges Removed	Dollars	OP Charges Removed	Dollars
Integris Baptist Medical Center	• Charges that insurance payments identified in the data provided by Integris Baptist Medical Center • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	As a result of our test work and extrapolation, charges totaling $91,001 were identified.	• Charges on the uninsured listing that were also on the MMIS data • Charges that insurance payments identified in the data provided by Integris Baptist • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	$18,604 As a result of our test work and extrapolation, charges totaling $2,597,198 were identified.
Integris Bass Baptist Medical Center	• Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	As a result of our test work and extrapolation, no charges were identified	• Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	As a result of our test work and extrapolation, charges totaling $375,313 were identified
Integris Southwest Medical Center	• Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	As a result of our test work and extrapolation, charges totaling $5,627 were identified	• Charges that insurance payments identified in the data provided by Integris Southwest Medical Center • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	As a result of our test work and extrapolation, charges totaling $579,033 were removed for these two reasons
Jane Phillips Memorial Medical Center	• Charges on the out of state Medicaid listing that were also on the MMIS data • Charges that insurance payments identified in the data provided by	$7,322,082 As a result of our test work and extrapolation, charges	• Charges that were not in the scope of MSP 2008 • Charges on the uninsured listing that were also on the MMIS data • Charges on the out of state Medicaid	$2,254 $139,054 $460,816

Hospital	IP Charges Removed	Dollars	OP Charges Removed	Dollars
	Jane Phillips Memorial Medical Center • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	totaling $118,178 were identified	listing that were also on the MMIS data • Charges that insurance payments identified in the data provided by Jane Phillips Memorial Medical Center • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	As a result of our test work and extrapolation, charges totaling $50,235 were identified
Jim Taliaferro CMHC	• Charges on the uninsured listing that were also on the MMIS data	$22,816	• No outpatient charges were removed.	
Mercy Health Center	• Charges on the out of state Medicaid listing that were also on the MMIS data • Charges that insurance payments identified in the data provided by Mercy Health Center • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	$81,734 As a result of our test work and extrapolation, charges totaling $1,651,391 were identified	• Charges on the uninsured listing that were also on the MMIS data • Charges on the out of state Medicaid listing that were also on the MMIS data • Charges that insurance payments identified in the data provided by Mercy Health Center • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	$4,565 $289,760 As a result of our test work and extrapolation, charges totaling $333,060 were identified
Mercy Memorial	• Charges on the uninsured listing	$20,974	• Charges on the uninsured listing	$106,320

Hospital	IP Charges Removed	Dollars	OP Charges Removed	Dollars
Health Center	that were also on the MMIS data • Charges that insurance payments identified in the data provided by Mercy Memorial Health Center • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	As a result of our test work and extrapolation, charges totaling $562,553 were identified	that were also on the MMIS data • Charges that insurance payments identified in the data provided by Mercy Memorial Health Center • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	As a result of our test work and extrapolation, charges totaling $586,912 were identified
Midwest Regional Hospital	• Charges that were duplicated in the uninsured data • Charges that were not in the scope of MSP 2008 • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	$1,799,923 $6,575,755 $186,442	• Charges that were duplicated in the uninsured data • Charges that were not in the scope of MSP 2008 • Charges that insurance payments identified in the data provided by Midwest Regional Hospital	$821,637 $6,681,569 $2,199,499
Norman Regional Hospital	• Charges on the uninsured listing that were also on the MMIS data • Charges that insurance payments identified in the data provided by Norman Regional Hospital • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	$49,824 $852,051 $524,469	• Charges on the uninsured listing that were also on the MMIS data • Charges on the dual eligible listing that were also on the MMIS data • Charges that insurance payments identified in the data provided by Norman Regional Hospital • Charges that had payments that equaled more than 40% of charges	$124,187 $316 $925,483 $2,298,282

Hospital	IP Charges Removed	Dollars	OP Charges Removed	Dollars
			(indicative of insurance payments)	
Saint Francis Hospital	• Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	As a result of our test work and extrapolation, charges totaling $784,091 were identified	• Charges that were not in the scope of MSP 2008 • Charges that insurance payments identified in the data provided by Saint Francis Hospital • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	$1,763,615 As a result of our test work and extrapolation, charges totaling $139,122 were identified
Southcrest Hospital	• Charges on the out of state Medicaid listing that were also on the MMIS data • Charges that insurance payments identified in the data provided by Southcrest Hospital • Charges that had payments that equaled more than 40% of charges (indicative of insurance Payments)	$21,786 As a result of our test work and extrapolation, charges totaling $1,225,216 were identified	• Charges that insurance payments identified in the data provided by Southcrest Hospital • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	As a result of our test work and extrapolation, charges totaling $560,425 were identified
St. Anthony Hospital	• Charges on the uninsured listing that were also on the MMIS data • Charges that insurance payments identified in the data provided by	$47,318 As a result of	• Charges that were duplicated in the uninsured data • Charges on the uninsured listing that were also on the MMIS data • Charges that	$2,180 $1,378 As a result of our

Hospital	IP Charges Removed	Dollars	OP Charges Removed	Dollars
	St. Anthony Hospital • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	our test work and extrapolation, charges totaling $3,001,896 were identified	insurance payments identified in the data provided by St. Anthony Hospital • Charges that had payments that equaled more than 40% of charges (indicative of insurance payments)	test work and extrapolation, charges totaling $1221,440 were identified
St. John Medical Center	• Charges on the uninsured listing that were also on the MMIS data. • Charges that had insurance payments identified in the data provided by St. John Medical Center. • Charges that had payments that equaled more than 40 % of the charges (indicative of insurance payments).	$916,129 $8,159,325 $2,001,681	• Charges on the uninsured listing that were also on the MMIS data. • Charges that had insurance payments identified in the data provided by St. John Medical Center. • Charges that had payments that equaled more than 40 % of the charges (indicative of insurance payments).	$267 $7,696,280 $1,061,989

Recommendation

OHCA should provide guidance to the DSH hospitals that clarifies the definition of uninsured persons, as well as costs and payments eligible to be included in the calculation of hospital-specific DSH payment limits as defined in Social Security Act 1923(g)(1)(A) and 42 CFR Part 455.304(d).

RECORD RETENTION

OHCA's record retention policy lacks specific details on the types of DSH program documents that should be retained by it and by the DSH hospitals. Additionally, although OHCA required the providers to maintain necessary documents for the purpose of audit, many providers claimed that certain documents requested in conjunction with our procedures were not available or their

accounting systems were not able to retrieve the data requested. The following 6 hospitals provided minimal or none of the documentation requested. Therefore, we were not able to complete our procedures for MSP 2008:

- Seiling Municipal Hospital
- Woodward Regional Hospital
- Elkview General Hospital
- Haskell County Hospital
- Memorial Hospital of Texas County
- Valir Rehabilitation Hospital

Recommendation
To ensure compliance with the DSH Rule in the future, OHCA should require DSH hospitals to retain adequate, accurate, and detailed information to support, for audit and regulatory purposes, data reported on their DSH applications. This information and record of data should include, at minimum, information listed on the attached *Schedule of Information and Records of Data Needed for DSH Audit*. OHCA should also make hospitals aware that CMS suggests that providers would need to modify their accounting system to ensure documents, such as those needed to segregate uncompensated costs, are available for future audits.

In addition, OHCA should consider revising its record retention policy to specify the types of records, such as DSH application packages, which should be retained for DSH programs, and the length of such retention.

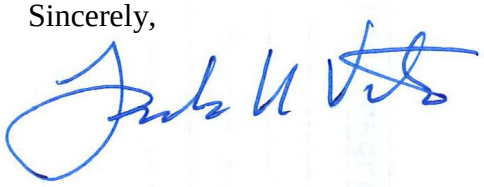
MEDICAID STATE PLAN

We also noted the following areas for improvement to ensure compliance with the Rule:

- The MSP can be enhanced with a detailed description of the methodology for calculating the hospital-specific DSH payment limit, as well as the costs and payments to be included in this calculation to ensure that hospital-specific DSH payment limits include only uncompensated costs for furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals and individuals with no insurance or any other third-party coverage, instead of utilizing charity care charges;
- The definitions of "incurred inpatient 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 services they received]" can be further clarified to mirror that of the Rule.
- The Medicaid State Plan can be enhanced with a detailed description of the eligible payments as specified in Social Security Act 1923(g)(1)(A) and 42 Code of Federal Regulations (CFR) Part 455.304(d) that should be applied against the calculated uncompensated cost,

This letter is intended solely for the information and use of management and others within the organization and is not intended to be and should not be used by anyone other than these specified parties.

Sincerely,



Frank N. Vito, CPA
Partner

Enclosed: Provider Data Summary Schedule
Attached: Schedule of Information and Records of Data Needed for DSH Audit

Schedule of Information and Records of Data Needed for DSH Audit

For the period of MSP rate year under review:

1. If a hospital provided non-emergency obstetric services, please provide the names of two obstetricians with staff privileges and their Unique Physician Identification Number (UPIN). If a hospital is classified as a rural hospital, two names and UPIN numbers of physicians of any specialty may be provided as long as the physician has staff privileges.

2. Summary and detailed Working Trial Balance.

3. Audited (if available) Financial Statements. Consolidated Financial Statements is acceptable if separate financial statements for the hospital under review are included.

4. Expenses and Revenue Mapping to Worksheet A and Worksheet C of the Medicare 2552-96 cost report.

5. If your hospital is a transplant facility, provide all transplants (Medicaid, uninsured, Medicare, and others) by organ, and note if reimbursed through Medicaid FFS, Medicaid Managed Care, out-of-state, uninsured, etc.

6. Payer Code Listing.

7. A Crosswalk (mapping) of revenue codes to Medicare 2552-96 cost report's cost center line number for the following information: Medicaid Inpatient Routine Days, Medicaid Inpatient Charges, and Medicaid Inpatient Ancillary Services Charges.

8. A Crosswalk (mapping) of revenue codes to Medicare 2552-96 cost report's cost center line number for Medicaid Outpatient Ancillary Services.

9. A Crosswalk (mapping) of revenue codes to Medicare 2552-96 cost report's cost center line number for Self-Pay Inpatient Routine Days, Self-Pay Inpatient Routine Charges, and Self-Pay Inpatient Ancillary Services Charges.

10. A Crosswalk (mapping) of revenue codes to Medicare 2552-96 cost report's cost center line number for Self-Pay Outpatient Ancillary Services.

11. Summary listing of payments received by payer code during the cost reporting period that were received during the MSP years under review.

12. Detail listing of self-pay or private-pay (financial class) payments received during the MSP rate year under review. The listing is to include the following details:

- Account Name
- Patient Name
- Financial Class
- Payment Date
- Payment Amount
- Date of Admit
- Date of Discharge

13. Documentation related to inpatient services from Medicaid Managed Care Organizations which can either be:
    - A detailed log by revenue code for each patient with charges, days and payments for discharge dates for the cost reporting period that is within the MSP rate year; or
    - Detail and Summary reports from the various Medicaid Managed Care Organizations detailing patient specific activity including days, charges by revenue code, and payments.

14. Documentation related to outpatient services from Medicaid Managed Care Organizations which can either be:
    - A detailed log by revenue code for each patient with charges and payments for discharge dates for the cost reporting period that is within the MSP rate year; or
    - Detail and Summary reports from the various Medicaid Managed Care Organizations detailing patient specific activity including charges by revenue code and payments.

15. Documentation related to inpatient services from Out-of-state Medicaid State Agencies which can either be:
    - A detailed log by revenue code for each patient with charges, days and payments for discharge dates for the cost reporting period that is within the MSP rate year; or
    - Detail and Summary reports from the various State Medicaid Agencies detailing patient specific activity including days, charges by revenue code, and payments.

16. Documentation related to outpatient services from Out-of-state Medicaid State Agencies which can either be:
    - A detailed log by revenue code for each patient with charges and payments for discharge dates for the cost reporting period that is within the MSP rate year; or
    - Detail and Summary reports from the various State Medicaid Agencies detailing patient specific activity including charges by revenue code and payments.

17. A log of all dual-eligible individuals that were seen as inpatients and outpatients with charges by revenue code and payments made by Medicare.

18. Documentation on Supplemental/Enhanced Medicaid payments made by the State. (Supplemental/Enhanced Medicaid payments include Upper Payment Limit payments, cost report settlements (tentative and/or final), additional payments for graduate medical

education, and all Medicaid additional payments made for inpatient and outpatient services covered by DSH.)

19. Documentation on Supplemental/Enhanced Medicaid payments and DSH Payments that are received from Medicaid Managed Care Organizations. (Supplemental/Enhanced Medicaid payments include Upper Payment Limit payments, cost report settlements (tentative and/or final), additional payments for graduate medical education, and all Medicaid additional payments made for inpatient and outpatient services covered by DSH.)

20. Documentation on Supplemental/Enhanced Medicaid payments and DSH Payments that are received from Out-of-state Medicaid Agencies. (Supplemental/Enhanced Medicaid payments include Upper Payment Limit payments, cost report settlements (tentative and/or final), additional payments for graduate medical education, and all additional Medicaid payments made for inpatient and outpatient services covered by DSH.)

21. Documentation detailing payment of intergovernmental transfers, if applicable.

22. Documentation detailing the recording of payments received for all DSH payments received from the State.

23. If applicable, listing of Federal Section 1011 payments (federal payments for treatment of eligible undocumented aliens) detailing payments received during the MSP rate year under review. Documentation should be detailed by patient with account numbers

24. A log of all Medicaid-eligible inpatient and outpatient accounts by revenue code that was not billed to Medicaid. The log should include patient information on charges and payments if payments were made by third party liability.

25. Documentation supplied to Medicare Intermediary to support Medicaid-eligible days reported on the Medicare cost report.

26. Inpatient detail listing of uninsured charges by patient.

27. Outpatient detail listing of uninsured charges by patient.

28. The audited electronic cost report form Medicare for your cost report years covering MSP 2008. If you not have the electronic version, then a scanned copy along with the adjustment from Medicare and a copy of the NPR letter that accompanies the audited cost report.

The following information should be retained for items 13 -17, 26 and 27:

- Account Number
- Medical Record Number
- Patient Name
- Date of Service
- Admit Date

- Discharge Date
- Primary Payer
- Secondary Payer
- Hospital Charges
- Professional Charges
- Primary Payer Payments
- Secondary Payer Payments
- Patient Payments