State of Michigan
Department of Community Health
Lansing, Michigan

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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INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES

Department of Community Health
Actuarial Division
Lansing, Michigan 48909

We have performed the procedures in the attached schedule, which were agreed-to by the State of Michigan, Department of Community Health (MDCH), solely to assist MDCH in evaluating the State of Michigan'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 MDCH. 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 MDCH, is not intended to be, and should not be used by anyone other than this specified party.

PHBV Partners LLP

Austin, Texas
September 28, 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 hospital and outpatient hospital services during the MSP rate year to Medicaid-eligible individuals and individuals with no source of third-party coverage for the services, in order to reflect the total amount of claimed DSH expenditures.

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 MDCH finances their DSH program through certified public expenditures, intergovernmental transfers, and general fund revenues.

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

> **Results**: We found MDCH did not make any DSH payments in excess of the State's calculated hospital specific limit. The State did not have to redistribute or recover any payments based on the hospital verification procedures.

We verified that MDCH 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 MDCH-defined DSH criteria**.**

> **Results**: We found that 4 hospitals did not meet the federal or state requirements for eligibility as a DSH hospital. Two hospitals did not meet the eligibility requirement related to the Medicaid utilization rate of at least 1% and two hospitals did not meet the Medicaid utilization rate of at least 1% and the obstetrician requirement because no documentation was provided.

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 20 hospitals had a variance between the State-calculated DSH allotment and the hospital support for the payment received. For 5 of these hospitals, the hospital did not provide any documentation to support receipt of DSH payments. For 13 of these hospitals, the hospital provided support for receipt of less than their full DSH allotment. For 2 of these hospitals, the hospital provided only the DSH payment notification letter received from MDCH to support the receipt of their full DSH allotment. Therefore, we were unable to verify that 20 hospitals received the full DSH allotment.

We found that 33 of the 127 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 94 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 MDCH'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 127 hospitals that received DSH payments during MSP rate year 2009, 4 did not meet the federal or state qualification criteria for participation in the DSH program. Two of the four facilities failed to provide documentation in response to the hospital request list. Two of the four facilities failed to meet the requirement related to a Medicaid utilization rate of at least 1%.

We also found that of the remaining 123 hospitals that qualified for a DSH payment, 103 hospitals could support the receipt of their full DSH allotment and 93 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 inpatient hospital and outpatient hospital services during the MSP rate year to Medicaid-eligible individuals and individuals with no source of third-party coverage for the services in order to reflect the total amount of claimed DSH expenditures. We were not able to verify that the remaining 20 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 no hospitals were 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 23 qualified facilities exceeded their hospital-specific limit. Additionally, the four 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 127 facilities that received DSH payments in MSP rate year 2009.

Overall Verification Assessment Procedures:

We prepared an overall verification assessment for Verification 2, to note whether MDCH'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 100 of 127 hospitals did not exceed the hospital-specific DSH payment limit while the DSH payments made to 23 qualifying and four non-qualifying hospitals exceeded the hospital-specific DSH payment limit for those hospitals.

Verification 3

Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals and individuals with no third-party coverage for the inpatient and outpatient hospital services they received as described in section 1923(g)(1)(A) of the 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 using the "as filed" uninsured charges and cost center specific cost-to-charge ratios and per diems.

> **Results**: There were 77 hospitals that were considered desk review facilities. Out of these 77, 74 facilities qualified for DSH payments (See Verification 1). We found that of the 74 qualified facilities, 68 were able to provide PHBV with documentary support for their uninsured costs and charges, while the remaining six facilities did not provide documentation to support their uninsured costs and charges. We also found none of the remaining three unqualified desk review facilities provided 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 50 hospitals that were considered detailed desk review facilities. We found that 49 of these facilities submitted uninsured charge data for review. Of the 49 facilities that submitted uninsured data, unallowable charges were removed from 47 of them.

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 44 of the 50 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:** Thirty-seven of the 50 detailed desk review hospitals submitted OOS charge 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 MDCH's procedures satisfy the federal regulation under section 1923(g)(1)(A) of the Act.

> **Results**: We found that 44 of the 49 qualified hospitals we tested did not use only uncompensated care costs of furnishing inpatient and outpatient 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 127 hospitals that received DSH payments during MSP 2009, 10 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 inpatient hospital and outpatient hospital services to Medicaid-eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third-party coverage for such services.

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 MDCH 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 117 facilities received FFS supplemental/enhanced payments and six qualified facilities 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 requested all payments related to the calculation of the hospital-specific limits from the hospitals and included this data in the PDSS. We found that 22 of the 123 qualified hospitals did not respond or provide documentation or support for out–of-state Medicaid supplemental/enhanced payments. Ten 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: Thirty-six of the 50 detailed desk review providers submitted out of state payment 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 50 detailed desk review providers submitted non-third party or state and local government indigent program payment data, this procedure was not applicable.

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 3 of the 50 detail desk review hospitals. The detail listing was greater than the payer code listing for 11 hospitals while the detail listing was less than the payer code listing for 9 hospitals. The remaining hospitals submitted payer code listings without self pay payments.

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: MDCH records indicated that 45 of the 50 detail desk review hospitals received supplemental state Medicaid payments. Due to lack of adequate documentation received from 42 hospitals, we were unable to reconcile hospital reported supplemental Medicaid payments to the state reported supplemental Medicaid payments. As a result, the list of supplemental Medicaid payments received from MDCH was used as the best available information.

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 supplemental/enhanced Medicaid payments made to 117 of the 124 qualified DSH hospitals for furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals were not applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital service to individuals with no source of third-party coverage for such services. The remaining seven qualified hospitals did not receive supplemental payments. We found that MDCH 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 inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under 42 CFR Section 455.304; 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 MDCH's policies and procedures regarding documentation retention related to information and records of all inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments; and, any payments made on behalf of the uninsured from payment adjustments under section 1923 of the Act.

Results: We found that MDCH has retained the following documents pertaining to the DSH program: MSP, electronic cost reports along with Michigan Medicaid Forms (MMFs), correspondence received from the hospitals, MDCH-prepared DSH calculation worksheets, and the MMIS data.

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

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 inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments and whether any payments made on behalf of the uninsured from payment adjustments have been separately documented and retained by the State.

Results: MDCH does not maintain or collect support for the cost reports or MMFs submitted by the hospitals. In accordance with the Medicaid Provider Manual, each hospital is responsible for maintaining its own supporting documents and records related to information reported to MDCH. We found that two of the 127 hospitals did not provide documentation in response to the 2009 DSH documentation request. Additionally, the State does not have a procedure to ensure hospitals participating in the DSH program are retaining the required records.

Overall Verification Assessment Procedure:

We prepared an overall verification assessment for Verification 5 to note whether MDCH'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 inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments; and any payments made on behalf of the uninsured from payment adjustments had not been separately documented and retained by MDCH.

MDCH has assigned responsibility for maintaining detailed records to each hospital in the program. We found that the 123 qualified facilities, which represent over 91 percent of the DSH payments, were able to provide substantially all the documentation required to support inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments 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 inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the inpatient hospital and outpatient hospital services they received.

Procedures

State Level Procedures

We obtained documentation from MDCH 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 inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the inpatient hospital and outpatient hospital services they received.

Results: We reviewed the information specified in paragraph (d)(5) of Title 42 CFR Part 455.304 for MSP rate year 2009 and the Medicaid Provider Manual 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 inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the i/p hospital and o/p hospital services they received. The State's methodology was not in compliance with the Federal regulations, specifically, uninsured charges are defined as, "charges for services provide to beneficiaries who do not have insurance coverage or for services not covered by the patient's insurance coverage."

We reviewed MDCH's DSH procedures to ensure consistency with inpatient and outpatient Medicaid reimbursable services in the approved MSP.

Results: We identified that MDCH's DSH procedures for inpatient and outpatient services are in compliance with the Medicaid Provider Manual.

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.

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 MDCH defines inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the inpatient hospital and outpatient hospital services they received.

Results: We found that the State's Medicaid Provider Manual includes a definition of inpatient and outpatient hospital services. Inpatient services are defined as "an individual who has been admitted to a hospital bed for occupancy with the expectation that he will remain at least overnight, even when it later develops that he can be discharged or is transferred to another hospital and does not use the bed overnight." Outpatient services are defined as "diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require inpatient hospitalization."

Overall Verification Assessment Procedure:

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

Results: The State utilizes the Medicaid Provider Manual for the specific determinations of allowable charges. The State uses indigent care as a basis for calculating hospital payment limits. The Medicaid Provider Manual also defines MDCH'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 Medicaid Provider Manual 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 by September 11, 2012. The finding summary included:

- The as filed charge data reported from MDCH'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 MDCH'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.