

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.

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.

State Response

The State recognizes the need to strengthen the accounting of DSH payments with our hospitals and is working with the hospitals and the Oklahoma Hospital Association to improve the hospital accounting of these funds.

The seventeen hospitals that did not provide adequate documentation for the purposes of this audit received a total of \$901,918 in DSH allocations for 2006. One of the hospitals in question was identified in 2007; the \$927,158 allocated to that facility was recovered and reallocated by the State. This hospital did not believe it should have been subjected to the audit requirements.

The State was not aware that we had to maintain a DRS for out-of-state Medicaid agencies until the final rule was published December 19, 2008. Neither the proposed rule (Federal Register / Vol. 70, No. 165 / Friday, August 26, 2005 / Proposed Rules, page 50262 - 50268) nor the federal statute required such a DRS prior to that time.

The OB/GYN verification process was questioned by one of the hospitals and needs to be clarified for the State and the hospitals. CMS designates hospitals as "Urban Designated" through the Core Based Statistical Area (CBSA) while Medicare reimbursement designates certain hospitals as "Urban" through the CMS Geographic Reclassification process. A hospital may be designated as "Rural" under the CBSA but "Urban" under the Medicare Geographic Reclassification process.

Research by Clifton Gunderson found that for any given year, any county not included in a Metropolitan Statistical Area or, beginning in 2003, Core-Based Statistical Area (CBSA) would be considered a rural area. The CBSAs are reported each year in the Final Rule for the Medicare Inpatient Prospective Payment System.

Also, Sections 1923 (d) (2)(A)(ii) exempts hospitals from the OB/GYN requirement if the hospital stopped providing the service prior to December 22, 1987. There is no process for making this determination. To date we have relied on the hospital administrators attestation contained within our state survey instrument.

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.

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. Of the two facilities that exceeded their limit, one provider received Medicaid payments that exceeded their Medicaid and uninsured cost, and one provided support for significantly less uninsured data than they reported to the State. 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).

State Response

The State recognizes the need to strengthen the accounting systems and methodologies related to uncompensated care and we are working with the hospitals and the Oklahoma Hospital Association to improve them. The two hospitals, noted above, exceeded the DSH limit by a combined \$153,023 for the year. One of the hospitals in question was identified by OHCA in 2007; the money was recovered and reallocated by the State. This hospital did not believe it should have been subjected to the audit requirements.

It is important to note that the rules by which our DSH program is being reviewed today in these audits did not exist in 2005 and 2006. Oklahoma is using the opportunity afforded by the rules to work with our hospitals in strengthening and improving our reporting abilities.

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.

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.

State Response

The State recognizes the need to strengthen the accounting systems and methodologies related to uncompensated care and we are working with the hospitals and the Oklahoma Hospital Association to improve them.

It is important to note that the rules by which our DSH program is being reviewed today in these audits did not exist in 2005 and 2006. Oklahoma submitted two state plan amendments related to its DSH program between 2005 when the proposed rules were issued and 2008 when the final rules were written. Oklahoma's definition of the term "charity care" was not questioned by CMS except in terms of its relationship to "bad debt."

Oklahoma is using the opportunity afforded by the rules to work with our hospitals in strengthening and improving our reporting abilities.

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.

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.

State Response

The State recognizes the need to strengthen the accounting of DSH payments with our hospitals and is working with the hospitals and the Oklahoma Hospital Association to improve the hospital accounting of these funds.

The State was not aware that we had to maintain a DRS for out-of-state Medicaid agencies until the final rule was published December 19, 2008. Neither the proposed rule (Federal Register / Vol. 70, No. 165 / Friday, August 26, 2005 / Proposed Rules, page 50262 - 50268) nor the federal statute required such a DRS prior to that time.

It is important to note that the rules by which our DSH program is being reviewed today in these audits did not exist in 2005 and 2006. Oklahoma submitted two state plan amendments related to its DSH program between 2005 when the proposed rules were issued and 2008 when the final rules were written. Both plans were approved by CMS and included detailed explanations of the state's methodology and calculations related to the DSH limit.

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.

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.

State Response

The State recognizes the need to strengthen the accounting of DSH payments with our hospitals and is working with the hospitals and the Oklahoma Hospital Association to improve the hospital accounting of these funds.

Oklahoma submitted two state plan amendments related to its DSH program between 2005 when the proposed rules were issued and 2008 when the final rules were written. Both plans were approved by CMS and included detailed explanations of the state's methodology and calculations related to the DSH limit. The plans explicitly stated that the hospitals were responsible for maintaining the supporting data necessary to comply with audits. It is important to note that the rules by which our DSH program is being reviewed today in these audits did not exist in 2005 and 2006.

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.

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.

State Response

The State recognizes the need to strengthen the accounting of DSH payments with our hospitals and is working with the hospitals and the Oklahoma Hospital Association to improve the accounting of these funds.