

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 OHCA's procedures satisfy the federal regulation at Section 1923 (g)(1)(A) of the Social Security Act (Act) and identify any providers that did not qualify for DSH.

Results: We found that of the 65 hospitals that received DSH payments during MSP rate year 2007, four did not meet the federal or the State's qualification criteria for participation in the DSH program. Three of the four facilities that provided documentation were non-rural facilities and did not qualify since they 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. The one rural facility did not provide any physician information. Another nine facilities did not provide documentation that allowed us to verify their qualification status. The 52 hospitals that met the qualifications criteria received 98.41 percent of the DSH payments made for MSP year 2007. We also found that of the remaining 52 hospitals that qualified for a DSH payment, all 52 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 nine hospitals that did not provide adequate documentation for the purposes of this audit received a total of \$370,855 (or 0.86%) in DSH allocations for 2007.

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.

One of the four hospitals that did not meet the OB/GYN verification process submitted an attestation after the audit was complete indicating that it was in business and did not offer non-emergency obstetric services to the general population prior to December 22, 1987. These four hospitals received a total of \$311,610 (or 0.72%) in DSH allocation for 2007.

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 50 of 52 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 OHCA. DSH payments were made to an additional four hospitals that did not meet the requirements for DSH eligibility and another nine hospitals for which 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.

It is important to note that the rules by which our DSH program is being reviewed today in these audits did not exist in 2007. Oklahoma is using the opportunity afforded by the rules to work with our hospitals in strengthening and improving our reporting abilities.

The two hospitals in question received a total of \$605,344.2 (or 1.40%) in DSH allocation for 2007.

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 effective October 1, 2005, defines 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, there is no definition of uncompensated costs in the MSP effective January 1, 2007.

We also identified that the DSH survey instrument that was used by the State to calculate the hospital-specific limit collected charity charge information instead of costs associated with patients that have no health insurance or source of third-party payment. Charity charges are defined separately by each facility and can include costs that do not meet the uncompensated care cost definition found in the DSH Rule. We found that all the qualified hospitals we tested did not use only uncompensated care costs of furnishing i/p and o/p hospital services to Medicaid-eligible individuals and that individuals with no third-party coverage were included in the calculation of the hospital-specific DSH payment limit, as described in section 1923(g)(1)(A) of the Social Security 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 2007. 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 under section 1923 (g)(1)(A) of the Social Security Act.

Results: We found that Section 1011 or supplemental/enhanced Medicaid payments made to three of 52 qualified DSH hospitals for furnishing i/p hospital and o/p hospital services to Medicaid-eligible individuals, which are in excess of the Medicaid-incurred costs of such services, were not applied against the uncompensated care costs of furnishing i/p hospital and o/p hospital services to individuals with no source of third party coverage for such services. We found that the Medicaid FFS rate payments for all 52 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 2007. 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; and any payments made on behalf of the uninsured from payment adjustments had not been separately documented and retained by OHCA. OHCA has assigned responsibility 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 DSH Rule; and any payments made on behalf of the uninsured from payment adjustments under the DSH 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 2007.