DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification

Dr. Garth Splinter
State Medicaid Director
Oklahoma Health Care Authority
4545 North Lincoln Blvd., Suite 124
Oklahoma City, Oklahoma 73105
Attention: Cindy Roberts

JUL 2 0 2010

RE: TN 10-10

Dear Dr. Splinter:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 10-10. This amendment makes changes to the Disproportionate Share Hospital (DSH) state plan language to conform to guidance related to Federal DSH audit rules.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. As part of the review process the State was asked to provide information regarding funding of the State share of expenditures under Attachment 4.19-A. Based upon your assurances we are pleased to inform you that Medicaid State plan amendment 10-10 is approved effective January 1, 2010. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Sandra Dasheiff, CPA at (214) 767-6490.

Sincerely,

[redacted]

Director
Center for Medicaid, CHIP, and Survey & Certification

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 1 0 – 1 0

2. STATE: Oklahoma

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2010

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS A NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 U.S.C 1396a 42 CFR 447 42 CFR 455

7. FEDERAL BUDGET IMPACT
a. FFY 2010 $0
b. FFY 2011 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Refer to Attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Refer to Attachment

10. SUBJECT OF AMENDMENT
Revisions to Disproportionate Share Hospital Payment Methodology

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor does not review State Plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mike Fogarty

14. TITLE
Chief Executive Officer

15. DATE SUBMITTED

16. RETURN TO
Oklahoma Health Care Authority
Attn: Cindy Roberts
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105

Date Rec'd in RO 6/30/10 – Effective Date – 6/1/10 – William Lamusski

FORM CMS-179 (07/92)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. HOSPITALS DEEMED DISPROPORTIONATE SHARE

A. DEFINITIONS

State Plan – The approved Oklahoma state plan for medical assistance payments as required by Section 1902 [42 U.S.C. 1396a] of the Social Security Act.

Medical Assistance Payments – Medicaid payments.

Private and Community Hospital – A licensed facility located within the boundaries of the State of Oklahoma that provides medical and / or surgical treatment and care for the sick or the injured.

Public Hospital - A public hospital is one that is located within the boundaries of the State of Oklahoma and is owned or operated by the State or by an instrumentality or a unit of government within the state.

High Disproportionate Share Public Hospital – A public hospital that is located within the boundaries of the State of Oklahoma that meets at least two of the following criteria: (a) a Medicaid utilization rate at least one standard deviation above the mean Medicaid utilization rate in the state; (b) a low income utilization rate at least twice the federal minimum required; or (c) the hospital with the greatest number of Medicaid inpatient days of any hospital in the state in the previous year.

Teaching Hospital – A licensed acute care hospital located within the boundaries of the State of Oklahoma that has a medical school affiliation or belongs to the Council on Teaching Hospitals. A major teaching hospital has 150 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

Public - Private Major Teaching Hospital – A major teaching hospital owned by the State of Oklahoma that entered into a joint operating agreement with a private hospital system.

Institution(s) for Mental Disease (IMD) – An institution located within the boundaries of the State of Oklahoma that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, meets the federal definition established in 42 CFR 435.1009 and whose facility is licensed by the Oklahoma Department of Health as a Specialized Hospital: Psychiatric.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

Hospital Specific Cost to Charge Ratio – Cost to Charge Ratio (CCR) data is extracted from CMS' Healthcare Cost Report Information System (HCRIS). CCRs are computed using the following method:

1) Select data from worksheet B-1 column 27 (total cost) and worksheet C-1, columns 6 (inpatient charges) and 7 (outpatient charges).
2) Compute the CCR for each cost report according to the formula:
    a. Numerator (cost) = B-1, Col. 27, Line 95 minus sum of Lines 63 through 94, including subscripts.
    b. Denominator (charges) = (C-1, Col. 6, Line 101) plus (C-1, Col. 7, Line 101) minus (the sum of Col. 6 Lines 63 through 100, including subscripts), minus (the sum of Col. 7 Lines 63 through 100, including subscripts).
    c. Ratio (CCR) = Numerator / Denominator.
3) Compute the average CCR for each CMS ID over all their cost reports in the most recent three years.
4) Join the CCRs to OHCA providers using the CMS ID cross-walk, which results in three kinds of matches:
    a. OHCA providers with one CCR get the computed CCR.
    b. OHCA providers with more than one CCR get the average of all the CCRs for matching CMS ID numbers.
    c. OHCA providers with no CCR get the overall average of all similar providers (i.e. the default CCR) – Critical Access Hospitals (CAH) get the average of all CAH, and non-CAH get the average of all non-CAH hospitals.

OHCA sends a letter to each hospital administrator to verify their assigned CMS ID number and validate the calculated CCR

Disproportionate Share Hospital Survey (DSH) – The annual survey of hospitals conducted by the Oklahoma Health Care Authority. Surveys are to be completed in full, electronically submitted when possible and signed and mailed pursuant to the instructions contained on the survey document.

Uninsured Charges – Uninsured charges are the total amount of inpatient and outpatient charges where no third party insurance exists, are a subset of bad debt and charity care charges, and only include outpatient hospital charges that are under the hospital benefit. The uninsured include all people documented as self pay by the hospital who have no creditable health insurance coverage of any kind. Uninsured charges are defined by Federal Law (Section 1923. [42 U.S.C. 1396r–4] of the Social Security Act and 42 CFR Parts 447 & 455).

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

Medicaid Gross Charges – Medicaid gross charges represent a provider's usual and customary charges billed on claims submitted which reach a paid status in the Oklahoma Medicaid Management Information System (MMIS).

Dual Eligibles – Dual eligibles are people that qualify for both Medicaid and Medicare. The definition of dual eligible costs and charges for the purposes of this plan are consistent with the federal definitions as stated in the Federal Register / Vol. 73, No. 245 / Friday, December 19, 2008 / Rules and Regulations. Consistent with the federal definition, in calculating the Medicare payment for service, the hospital has to include the Medicare DSH adjustment and any other Medicare payment adjustment (Medicare IME and GME) with respect to that service.

Bad Debt Allowance – Bad debt allowance represents non-payment on behalf of an individual who has third party coverage. Bad debt allowance is only factored into the state allocation formula portion of this plan (Section E) and consistent with 42 CFR Parts 447 & 455 will not be a part of the hospital specific DSH Limit calculation.

Charity Care Gross Charges – "Charity care" is a term used by hospitals to describe an individual hospital's program of providing free or reduced charge care to those that qualify for the particular hospital's charity care program. Gross charges are those charges attributable to people under the hospital's charity care policy. Charity care gross charges are only factored into the state allocation formula portion of this plan (Section E) and consistent with 42 CFR Parts 447 & 455 will not be a part of the hospital specific DSH Limit calculation.

For the purposes of meeting the mandatory federal requirements in Section IX C. of this State Plan to qualify as a disproportionate share hospital, the term "Rural Hospital" means a hospital located in any county not included in a Metropolitan Statistical Area, or beginning in 2003 Core-Based Statistical Area (CBSA). The CBSAs are reported each year in the Final Rule for the Medicare Inpatient Prospective Payment System.

B. MINIMUM FEDERAL CRITERIA

Pursuant to Section 1923(b) of the Social Security Act and 42 CFR Parts 447 & 455:

A hospital as defined in this section of the Oklahoma State Plan which meets the following requirements is deemed to be a disproportionate share hospital if:

(1) The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

The term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage).

The numerator of which is the hospital's total number of Oklahoma inpatient days attributable to patients who (for such days) were eligible for medical assistance in a period (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care program) and Oklahoma dual eligible days.

The denominator of which is the total number of the hospital's inpatient days in that same period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere. Inpatient days include psychiatric days and exclude swing bed and skilled nursing days. They also include days attributable to individuals eligible for Medicaid in another state. They do not include days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease (IMDs) or days which are attributable to services rendered in a separately licensed/certified off-site entity;

Or

(2) The hospital's low-income utilization rate exceeds 25 percent.

The term "low-income utilization rate" means, for a hospital, the sum of (a) and (b) below:

(a) the fraction (expressed as a percentage):

(i) the numerator of which is the sum (for a period) of the total revenues paid the hospital for patient services under the Oklahoma State plan under this title (regardless of whether the services were furnished on a fee-for-service basis or through a managed care program) and the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

(b) the fraction (expressed as a percentage):

(i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies for patient services received directly from State and local governments in the period reasonably attributable to inpatient hospital services, (the numerator shall not include contractual allowances and discounts other than for indigent patients not eligible for medical assistance under the State plan), and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

C. MANDATORY FEDERAL REQUIREMENTS TO QUALIFY AS DISPROPORTIONATE SHARE HOSPITAL

(1) Except as provided in paragraph (2) below, no hospital may be defined or deemed as a disproportionate share hospital unless the hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2) (a) The preceding requirement shall not apply to a hospital which:

(i) the inpatient days are attributed predominantly to individuals under 18 years of age; or

(ii) did not offer non-emergency obstetric services to the general population prior to December 21, 1987.

(b) In the case of a hospital located in a rural area (as defined by section 1886 of the Social Security Act), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

(3) No hospital may be defined or deemed as a disproportionate share hospital unless the hospital has a Medicaid inpatient utilization rate (as defined in Section (B) (1)) of no less than 1 percent.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

D. REQUIREMENTS TO QUALIFY AS AN OKLAHOMA DISPROPORTIONATE SHARE HOSPITAL

(1) Hospitals as defined in Section A which meet the requirements in Section C will automatically be qualified as an Oklahoma disproportionate share hospital and, for the purpose of payment, will be treated in the same manner as all other hospitals within their group as defined below.

(2) IMD hospitals as defined in Section A must meet the requirements in Section B and the requirements in Section C in order to be qualified as an Oklahoma disproportionate share hospital.

E. STATE ALLOCATION METHODOLOGY AND FORMULAS

The aggregate total amount of DSH payments to all hospitals and IMDs deemed Oklahoma Disproportionate Share Hospitals will equal the annual CMS disproportionate share hospital amount allocated to the State.

Eligibility for disproportionate share payments will be determined annually. All information used for all allocation calculations will be derived from the Annual Disproportionate Share Hospital Survey conducted by OHCA, the OHCA MMIS system and the most currently available United States Bureau of Economic Analysis reports.

Only hospitals that return disproportionate share surveys in accordance with the date specified in the instructions of the survey will be considered for DSH payments. The information used to complete the survey must be extracted from the hospital's financial records and fiscal year cost report ending in the most recently completed calendar year.

Any hospital providing incomplete surveys to OHCA may be deemed ineligible to receive funds allocated pursuant to this Section of the State Plan.

(1) Effective January 1, 2007, Oklahoma disproportionate share hospital payments may be allocated from the following funding pools:

(a) Hospitals meeting the definitions of a High Disproportionate Share Public Hospital / Public - Private Major Teaching Hospital will receive an amount equal to the federal fiscal year 2006 allocation, $25,546,749, plus an inflationary increase each year equal to the amount published by the U.S. Department of Labor Bureau of Labor Statistics for the first six months of the most current calendar year (Consumer Price Index - 12 Months Percent Change for All Urban Consumers).

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

(b) Private and Community or Public Hospitals will receive an amount equal to the state disproportionate share hospital allocation published by the Centers for Medicare & Medicaid Services in the Federal Register less the amount reserved for IMD hospitals and less the amount reserved for hospitals allocated funds in subsection (a) of this section.

(c) IMD hospitals will receive an amount equal to the amount allocated and published in the federal register by the Centers for Medicare & Medicaid Services.

(2) The funds allocated to the pool described in subsection (1) (b) above for Private and Community or Public Hospitals will be distributed in the following manner:

(a) Hospitals will be grouped as follows by licensed bed size based on the Oklahoma State Department of Health Medical Facilities Division health care facility directory:

- Group 1 will include hospitals with 300 or more licensed beds.
- Group 2 will include hospitals with more than 100 but less than 300 licensed beds.
- Group 3 will include hospitals with less than 100 licensed beds.

(b) The DSH Allocation reserved for this pool will be divided between the three groups based on each group's total Medicaid inpatient days divided by the aggregate total number of all Medicaid inpatient days provided by all three groups combined. If the total percentage calculated for hospitals in Group 1 exceeds 65% of the total to be distributed in any given year the distribution will be reduced to 65% for that Group and the balance will be distributed accordingly to the remaining two groups.

(c) Hospitals in each group will receive funds based on their relationship to the total amount of Indigent Care Costs provided by the group. Indigent Care Costs are reported to OHCA by each hospital using the annual DSH Survey.

Indigent Care Costs are calculated based on the following hospital specific formula:

Indigent Care Costs =

(Medicaid Gross Charges + Uninsured Charges + Dual Eligibles + Bad Debt Allowance + Charity Care Gross Charges) x (Hospital Specific Cost to Charge Ratio)

Once allocations are made to each hospital they are compared to the hospital specific DSH upper payment limit and then adjusted down, if necessary, so as to not exceed the limit as calculated below.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

In the event it is necessary to reduce the amount of DSH payments to remain within the DSH Upper Payment limit(s), the OHCA shall calculate a pro rata increase to all other qualifying hospitals by recycling the remaining amounts through the allocation formula.

Factors in this formula are used only to determine the allocation of the payments under this section. All payments are made in recognition of allowable uncompensated costs incurred in providing inpatient and outpatient hospital services to Medicaid individuals and individuals who have no health insurance or other source of third party coverage.

(3) The funds allocated to the pool described in subsection (1) (c) above for IMDs will be distributed in the following manner:

IMDs will receive funds based on their relationship to the total amount of Indigent Care Costs provided by all IMDs. Indigent Care Costs are reported to OHCA by each hospital using the annual DSH Survey.

Indigent Care Costs are calculated based on the following hospital specific formula:

Indigent Care Costs =

(Medicaid Gross Charges + Uninsured Charges + Dual Eligibles + Bad Debt Allowance + Charity Care Gross Charges) x (Hospital Specific Cost to Charge Ratio)

Once allocations are made to each IMD they are compared to the hospital specific DSH upper payment limit and then adjusted down, if necessary, so as to not exceed the limit as calculated below.

In the event it is necessary to reduce the amount of DSH payments to remain within the DSH Upper Payment limit(s), the OHCA shall calculate a pro rata increase to all other qualifying hospitals by recycling the remaining amounts through the allocation formula.

Factors in this formula are used only to determine the allocation of the payments under this section. All payments are made in recognition of allowable uncompensated costs incurred in providing inpatient and outpatient hospital services to Medicaid individuals and individuals who have no health insurance or other source of third party coverage.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

F. HOSPITAL SPECIFIC DSH UPPER PAYMENT LIMIT (UPL)

Pursuant to Section 1923(g) of the Social Security Act, hospitals will be subject to hospital specific DSH limits.

Any hospital found to have been paid more than their hospital specific DSH UPL or was inappropriately paid DSH at any time or in any year subject to audit will be required to pay the funds back to the state in full. The state will reallocate any funds recovered due to overpayment to other DSH hospitals that were not paid up to their hospital specific DSH UPL. Recovered funds will be reallocated based on the most current allocation and distribution method used by the state.

After the final payment during the federal fiscal year has been issued, no adjustment will be given on DSH payments, even if subsequently submitted documentation demonstrates an increase in uncompensated care costs for the qualifying hospital.

Hospitals and / or units which close or withdraw from the Medicaid Program shall become ineligible for further DSH pool payments for the remainder of the current DSH pool payment cycle.

G. REPORTS AND AUDITS

Each hospital will be responsible for maintaining its own supporting documents and records related to information reported to OHCA on the annual DSH survey.

Pursuant to Section 1923(j) of the Social Security Act, hospitals will be subject to annual audits. Hospitals found to be out of compliance as a result of the audits will be responsible for reimbursing the state for any DSH payments incorrectly made during the period reviewed.

Pursuant to 42 CFR 433.32, which relates to Fiscal policies and accountability, hospitals receiving DSH funds are required to:

(a) Maintain an accounting system and supporting fiscal records used by the hospital to complete the annual DSH survey;
(b) Retain records for 3 years from date of submission of a final expenditure report; and
(c) Retain records beyond the 3-year period if audit findings have not been resolved.

The State reserves the right to request any other information from hospitals receiving DSH funds as may be necessary to meet the audit and reporting requirements of federal law.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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IX. **HOSPITALS DEEMED DISPROPORTIONATE SHARE** (continued)

H. APPEALS

Any hospital required to pay back any or all portions of DSH funds allocated pursuant to this Section will have the right to an appeal pursuant to the appeal provisions included in this State Plan.

Marks, Marsha L. (CMS/SC)

From: Cooley, Mark S. (CMS/CMSO)
Sent: Wednesday, July 21, 2010 8:20 AM
To: Dasheiff, Sandra (CMS/CMCHO); GOLDSTEIN, STUART S. (CMS/CMSO)
Cc: Marks, Marsha L. (CMS/SC)
Subject: Approval Package 10-010
Attachments: OK 10-010.pdf

Approval Package for Oklahoma 10-010

Hard copy to be mailed due to darkness of the 179 form