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State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 11-04 NIRT

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services

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

JAN 17 2012

RE: TN 11-04

Dear Dr. Splinter:

We have reviewed the proposed amendment to Attachments 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 11-04. This amendment implements supplemental payments for hospitals participating in the Supplemental Hospital Offset Payment Program (SHOPP).

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 Attachments 4.19-A and 4.19-B. Based upon the assurances provided, Medicaid State plan amendment 11-04 is approved effective July 1, 2011. 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]

Cindy Mann
Director
Center for Medicaid and CHIP Services

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: 11-04
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: July 1, 2011

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 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY 2012: 267,094,902
b. FFY 2013: 214,077,316

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: New Pages 4.19-A 32.3, 32.4, 32.5 & 4.19-B 1c, 1d and 1e

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: None

10. SUBJECT OF AMENDMENT

Supplemental payments for hospitals participating in the Supplemental Hospital Offset Payment Program (SHOPP)

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 1-22-2011

18. DATE APPROVED: JAN 17 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2011

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

X. SUPPLEMENTAL PAYMENTS FOR HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP)

1. Supplemental Payment Pools

The components of the Medicare Inpatient Prospective Payment System (PPS) were used to reasonably estimate what Medicare would pay for Medicaid DRG reimbursed inpatient hospital services. The DRG upper payment limit (UPL) methodology consists of determining a Case Mix Adjusted Medicare DRG base rate, computing a Medicare pass-through payment per discharge, calculating Medicaid costs for hospitals not paid on a DRG basis, and then calculating the overall aggregate UPL for each of the three classes of hospitals.

a. Case Mix Adjusted Medicare DRG Base Rate

The Case Mix Adjusted Medicare DRG base rate is computed using Medicare hospital base rate amounts and relative weights to determine a Medicare base payment per Medicaid claim. Oklahoma Medicaid inpatient hospital claims paid in the previous state fiscal year were extracted from the OHCA MMIS claims processing system. The Oklahoma Medicaid DRG relative weights from the extracted claims were replaced with Medicare Hospital PPS Final Relative Weights for the applicable dates of service. DRG codes newborn claims (Oklahoma Medicaid Newborn DRG codes N01 thru N80) were manually mapped to the Medicare newborn DRG codes (MS-DRG codes 789 thru 795) based on the OHCA Newborn Logic flowchart. After replacing the Medicaid relative weights with the Medicare weights, a hospital specific case mix index (CMI) is computed by summing the Medicare weights for each hospital then dividing the sum of the weights by the number of claims for each hospital. The CMI for each hospital is then multiplied by the hospital's Medicare base rate from the Medicare Hospital PPS Final Rates and Weights for the applicable federal fiscal year to derive a Case Mix Adjusted Medicare DRG Base Rate.

b. Medicare Pass-Through Payments

In addition to the base DRG payment, the Medicare inpatient PPS includes pass-through payments. Medicare pass-through payments include outliers, capital adjustments, GME, IME, DSH, routine and ancillary services pass-through, reimbursable bad debt and organ acquisition cost. The Medicare pass-through payments are identified on the Medicare hospital cost report form 2552, Worksheet E, Part A. In order to calculate the hospital specific pass-through payment per discharge, all pass-through payments are summed and divided by the Medicare discharges from Worksheet S-3, Part 1, line 12.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

X. SUPPLEMENTAL PAYMENTS FOR HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP) (continued)

c. Non-DRG hospitals

The UPL for Non-DRG reimbursed hospitals are calculated using inpatient hospital specific cost to charge ratios. To determine the ratios, inpatient hospital costs are extracted from the most recently available Medicare hospital cost report form 2552 Worksheet C, Part 1, column 5, line 25-33 and inpatient hospital charges from Worksheet C, Part 1, column 8, lines 25-33. This cost to charge ratio is multiplied by allowable charges for Medicaid inpatient hospital claims to determine the cost of these services.

d. Upper Payment Limit Gaps

Payments calculated in paragraphs a, b and c shall be summed across the three classes of hospitals: privately owned, non-state government owned, and state government owned. These sums will equal the upper payment limits for each class of hospital. Total Medicaid payments for each class of hospital will be subtracted from its respective upper payment limit to determine the upper payment limit gaps.

2. Disbursement of payments to hospitals:

a. All hospitals shall be eligible for inpatient hospital access payments each year as set forth in this subsection except the following:

i. A hospital that is owned or operated by the state or a state agency, the federal governments, a federally recognized Indian tribe, or the Indian Health Service;
ii. a hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA;
iii. a hospital that specializes in any one of the following: (i) treatment of a neurological injury (ii) treatment of cancer, (iii) treatment of cardiovascular disease, (iv) obstetrical or childbirth services, (v) surgical care, except that this exemption shall not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority of inpatient days are for back, neck, or spine surgery; and
iv. a hospital that is certified by the federal Centers for Medicaid and Medicare Services as a long-term acute care hospital or as a children's hospital;

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

X. SUPPLEMENTAL PAYMENTS FOR HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP) (continued)

b. In addition to any other funds paid to critical access hospitals for inpatient hospital services to Medicaid patients, each critical access hospital (CAH) shall receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services, as determined by using a CCR calculated from the three most recently available Medicare hospital cost report form 2552 Worksheet B, Part 1, column 27, lines 25-62 and inpatient hospital charges from Worksheet C, Part 1, columns 6 and 7, lines 25-62. A CCR for each year is calculated and then they are averaged. This cost to charge ratio is multiplied by allowable charges to determine the cost of these services.

c. In addition to any other funds paid to hospitals for inpatient hospital services to Medicaid patients, each eligible hospital shall receive inpatient hospital access payments each year equal to the hospitals pro rata share of the inpatient supplemental payment pool available to the hospital's class of hospitals, as reduced by the payments distributed in paragraph 2(b). The pro rata share will be based upon the hospital's Medicaid payments for inpatient services divided by the total Medicaid payments for inpatient services of all eligible hospitals within each class of hospital.

d. The inpatient supplemental payment pool available to each class of hospitals will be determined by multiplying the class's upper payment limit gap, as determined under X.1.d. above, by the available funds ratio. The available funds ratio is determined by dividing the total of all funds available under the Supplemental Hospital Offset Payment Program, less the CAH supplemental payments described in Attachment 4.19-A Page 32.5, X 2(b) and Attachment 4.19-B Page 1d, H 2(b), by the total of the inpatient and outpatient upper payment limit gaps for all classes of hospital eligible for supplemental payments under this paragraph.

3. Frequency of Payments

The OHCA will pay from the Supplemental Hospital Offset Payment Program Fund quarterly installment payments to hospitals, not to exceed the UPL, of amounts available for supplemental payments for Critical Access Hospitals and supplemental inpatient payments.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES OTHER TYPES OF CARE OUTPATIENT HOSPITAL SERVICES

H. SUPPLEMENTAL PAYMENTS FOR OUTPATIENT HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP)

1. Hospital Outpatient Supplemental Payment Pools

Components of the Medicare Cost Report form 2552 were used to reasonably estimate what Medicare would pay for Medicaid outpatient hospital services. The upper payment limit (UPL) methodology consists of determining a hospital specific Medicare outpatient cost to charge ratio, applying that to Medicaid charges and then calculating the overall aggregate UPL for each of the three classes of hospitals.

a. Cost to Charge Ratios

The UPL was calculated using outpatient hospital specific cost to charge ratios. To determine the ratios, outpatient hospital costs were extracted from the most recently available Medicare hospital cost report form 2552 Worksheet C, Part 1, column 5, lines 37-68 and charges from Worksheet C, Part 1, column 8, lines 37-68 less applicable RHC charges.

b. Upper Payment Limit Gaps

The hospital specific cost to charge ratio in 1(a) shall be applied to hospital specific total outpatient hospital Medicaid charges. That amount calculated shall be separately summed across the three classes of hospitals: privately owned, non-state government owned, and state government owned. These sums will equal the upper payment limits for each class of hospitals. Total Medicaid payments for each class of hospitals will be subtracted from its respective upper payment limit to determine the upper payment limit gaps.

2. Disbursement of payments to hospitals:

a. All hospitals shall be eligible for outpatient hospital access payments each year as set forth in this subsection except the following:
   i. A hospital that is owned or operated by the state or a state agency, the federal governments, a federally recognized Indian tribe, or the Indian Health Service;
   ii. a hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA;

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE OUTPATIENT HOSPITAL SERVICES

H. SUPPLEMENTAL PAYMENTS FOR OUTPATIENT HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP) (continued)

iii. a hospital that specializes in any one of the following: (i) treatment of a neurological injury (ii) treatment of cancer, (iii) treatment of cardiovascular disease, (iv) obstetrical or childbirth services, (v) surgical care, except that this exemption shall not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority of inpatient days are for back, neck, or spine surgery; and

iv. a hospital that is certified by the federal Centers for Medicaid and Medicare Services as a long-term acute care hospital or as a children's hospital;

b. In addition to any other funds paid to critical access hospitals for outpatient hospital services to Medicaid patients, each critical access hospital (CAH) shall receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services, as determined using the CCR as described in paragraph 1(a). This cost to charge ratio is multiplied by allowable charges to determine the cost of these services.

c. In addition to any other funds paid to hospitals for outpatient hospital services to Medicaid patients, each eligible hospital shall receive outpatient hospital access payments each year equal to the hospital's pro rata share of the outpatient supplemental payment pool available to the hospital's class of hospitals, less the payments distributed in paragraph 3(b), based upon the hospital's Medicaid payments for outpatient services divided by the total Medicaid payments for outpatient services of all eligible hospitals within each class of hospital.

d. The outpatient supplemental payment pool available to each class of hospitals will be determined by multiplying the class's upper payment limit gap, as determined under H.1.b. above, by the available funds ratio. The available funds ratio is determined by dividing the total of all funds available under the Supplemental Hospital Offset Payment Program, less the CAH supplemental payments described in Attachment 4.19-A Page 32.5, X 2(b) and Attachment 4.19-B Page 1d, H 2(b), by the total of the inpatient and outpatient upper payment limit gaps for all classes of hospital eligible for supplemental payments under this paragraph.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE OUTPATIENT HOSPITAL SERVICES

H. SUPPLEMENTAL PAYMENTS FOR OUTPATIENT HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP) (continued)

a. The total amount of payments shall not exceed the upper payment limit gap calculated in paragraph 1 for any of the three classes of hospitals.

2. Frequency of Payments

The OHCA will pay from the Supplemental Hospital Offset Payment Program Fund quarterly installment payments to hospitals of amounts available, not to exceed the UPL, for supplemental payments for Critical Access Hospitals and supplemental outpatient payments.