Table of Contents

State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 15-0015 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

CENTERS FOR MEDICARE & MEDICAID SERVICES

Financial Management Group

MAR 22 2016

Ms. Becky Pasternik-Ikard
State Medicaid Director
2401 NW 23rd Street, Suite 1A
Oklahoma City, Oklahoma 73107

RE: Oklahoma 15-05

Dear Ms. Pasternik-Ikard:

We have reviewed the proposed State plan amendment (SPA) to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 15-05. This amendment revises the methodology and reimbursement structure for Diagnosis Related Group (DRG) hospital payments. The proposed changes for DRG Payments to Inpatient Acute Care Hospitals and Critical Access Hospitals are as follows:

1. Reduce Diagnosis-Related Group (DRG) Outlier payments by increasing the DRG threshold from $27,000 to $50,000.
2. Pay the lesser of billed charges or the Diagnosis-Related Group (DRG) amount. For DRG claims, the payment may not exceed billed charges.
3. Transfers pay the lesser of transfer fee or Diagnosis-Related Group (DRG).

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.

Based upon the information provided by the State, Medicaid State plan amendment 15-05 is approved effective July 1, 2015. We are enclosing the Form CMS-179 and the new plan pages.

If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,

Kristin Fan
Director

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: 15-05

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, 2015

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 447.250

7. FEDERAL BUDGET IMPACT
a. FFY 2015 $ (5,228,720.79)
b. FFY 2016 $ (20,475,099.89)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A; Page 1
Attachment 4.19-A; Page 9
Attachment 4.19-A; Page 13.1
Attachment 4.19-A; Page 13.2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A; Page 1, TN# 07-07;
Attachment 4.19-A; Page 9, TN# 05-006;
Attachment 4.19-A; Page 13.1, TN# 07-20
Attachment 4.19-A; Page 13.2, TN# 06-13

10. SUBJECT OF AMENDMENT
Revise elements of DRG hospitals reimbursement

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
Joel Nico Gomez

14. TITLE
Chief Executive Officer

15. DATE SUBMITTED
September 26,2015

16. RETURN TO
Oklahoma Health Care Authority
Attn: Tywanda Cox
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
September 26, 2015

18. DATE APPROVED
MAR 22 2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2015

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
Kristen Fan

22. TITLE
Director, FMG

23. REMARKS
c: Nico Gomez
Garth Splinter
Tywanda Cox

FORM CMS-179 (07/92)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES INPATIENT HOSPITAL SERVICES

The Oklahoma Title XIX Program reimburses appropriately licensed and certified hospitals for inpatient services as outlined in this plan. Procedures and policies governing state licensure, certification of providers, utilization review, and any other aspect of State regulation of the Title XIX Program not relating to the method of computing payment rates for inpatient services are affected by this plan.

I. PUBLIC PROCESS

The state has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

II. GENERAL REIMBURSEMENT POLICY

The Oklahoma Health Care Authority (hereafter called the OHCA) will reimburse inpatient hospital services rendered on or after October 1, 2005, in the following manner:

A. Covered inpatient services (including organ transplants) provided to eligible Medicaid recipients admitted to in-state acute care hospitals and acute care inpatient units will be reimbursed by the methodology set forth in Section VI of this plan, unless the hospital or unit is classified into one of the categories outlined in subsections C through F below.

B. Covered inpatient services provided to eligible recipients of the Oklahoma Medicaid program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals by the methodology set forth in Section VI of this plan, unless the hospital is classified in the category in subsection F below.

C. Inpatient services provided in Freestanding Rehabilitation and Freestanding Psychiatric Hospitals will be reimbursed using the per diem system outlined in Section III of this plan. Pediatric, psychiatric, substance abuse, and rehabilitation cases treated in Medicare PPS non-exempt general acute care hospitals or non-PPS exempt units will be included in the DRG PPS in Section VI of this plan. Freestanding Rehabilitation and Freestanding Psychiatric hospitals operated by units of government and Children's Hospitals included in the DRG PPS in Section VI of this plan may receive an additional payment not to exceed 100% of their allowable costs under Medicare payment principles.

D. Long Term Care Hospitals serving children will be reimbursed using the per diem system outlined in Section IV of this plan.

E. Indian Health Services hospitals will be reimbursed using a per diem rate published by the Office of Management and Budget.

State: Oklahoma
Date Received: September 26, 2015
Date Approved: MAR 22 2016
Date Effective: July 1, 2015
Transmittal Number: 15-05

Revised 07-01-2015

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS

Payment for admissions for all covered inpatient services rendered to Title XIX recipients admitted to acute care hospitals (other than those identified in Section II, subsections C through E) on or after October 1, 2005, shall be either the lesser of billed charges or based on a prospective payment approach which compensates hospitals an amount per discharge for discharges classified according to the Diagnosis Related Group (DRG) methodology. For each Medicaid recipient's stay, a peer group base rate is multiplied by the relative weighting factor for DRG which applies to the hospital stay. The result is the DRG payment to the hospital for the specific stay. In addition to the DRG payment, an "outlier" payment may be made to the hospital for very high cost cases.

The prospective rates for each hospital's Medicaid discharges will be determined by the OHCA in the manner described in the following subsections.

A. Services Included in or Excluded from the Prospective Rate

1. Prospective payment rates shall constitute payment in full for each Medicaid discharge. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient stay, except as described below. Hospitals may submit a claim for payment only upon the final discharge of a patient or upon completion of the transfer of the patient to another acute care hospital or a rehabilitation level of care.

2. The prospective payment rate shall include all services provided to the hospital inpatients, including:

   All items and non-physician services furnished directly or indirectly to hospital inpatients including but not limited to: (1) laboratory services; (2) pacemakers and other prosthetic devices including lenses and artificial limbs, knees, and hips; (3) radiology services; (4) transportation, (including transportation by ambulance), to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services.

State: Oklahoma
Date Received: September 26, 2015
Date Approved: MAR 22 2016
Date Effective: July 1, 2015
Transmittal Number: 15-05

Revised 07-01-2015

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS
(continued)

State: Oklahoma
Date Received: September 26, 2015
Date Approved: MAR 2 2 2016
Date Effective: July 1, 2015
Transmittal Number: 15-05

E. Special Prospective Payment Provisions (continued)

1. Cost Outlier Adjustment (continue)

b. For children and adults, hospitals receive an additional "outlier" payment to compensate for discharges with exceptionally high costs. Hospitals qualify for an outlier payment if costs exceed DRG payment by $50,000 or more. The payment is equal to 70% of costs in excess of the $50,000 threshold. Outlier amount is computed with this formula:

Outlier Amount = [(claim total amount billed) X (billing provider's CCR
- (DRG Weight X Peer Group Base Rate)
- (threshold of $50,000)] X (marginal cost factor 70%).

2. Day Outlier Adjustment

Effective December 1, 2005, the OHCA will make an outlier payment adjustment to general medical/surgical hospitals with children's specialty units paid under DRG methodology, for covered inpatient hospital services involving exceptionally long lengths of stay.

a. Eligibility for this payment shall be determined as follows:

i. First calculate the average Medicaid inpatient length of stay for children's hospitals contracted with Oklahoma Medicaid for the base year. This shall be determined by averaging the mean length of stay for all Children's Hospitals contracted with Oklahoma Medicaid.
ii. Second, calculate the standard deviation for the Medicaid inpatient length of stay statistics in step 2ai.
iii. Third, add one and one-half times the state wide standard deviation for Medicaid inpatient length-of-stay, to the state wide average Medicaid Children's hospital inpatient length of stay. Any stay equal to or lengthier than the sum of these two numbers shall constitute an exceptionally long length of stay for purposes of payment adjustment under this section.

b. Payment will be made from an annual pool of funds not to exceed $1,000,000. Payment will made from the pool of funds for each qualifying inpatient stay that does not reach DRG high-cost outlier status. The day outlier will be based on the number of days that exceed the day outlier threshold, multiplied by an administrative day rate.

3. Payment for Transfer Cases

a. Cases which indicate transfer from one acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made by OHCA for inappropriate transfers.

Revised 07-01-2015

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS (continued)

E. Special Prospective Payment Provisions (continued)

3. Payment for Transfer Cases (continued)

b. Effective 07-01-15, the following methodology will be used to reimburse the transferring and discharging hospitals for appropriate transfer if both hospitals and any hospital units involved are included in the PPS:

1. A hospital inpatient shall be considered "transferred" when he or she has been moved from one inpatient facility to another inpatient facility. Movement of a patient from one unit to another unit within the same hospital shall not constitute a transfer, unless the patient is being moved to a different Medicare certified unit within the hospital.

2. The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer case. Should the stay in the transferring hospital qualify for an outlier payment, then the care may be paid as an outlier as described in Attachment 4.19-A, Pages 13 and 13.1 of this plan. In the case of a transfer, the Transfer Allowable Fee for the Transferring Facility shall be calculated as follows: Transfer Allowable Fee = (MS-DRG Allowable Fee/Mean Length of Stay) X (Length of Stay + 1 day). The total Transfer Allowable Fee paid to the transferring facility shall be capped at the amount of the MS-DRG Allowable Fee for a non-transfer case. No outlier payments will be paid to the transferring hospital on transfer cases. Payment to the receiving facility, if it is also the discharging facility, will be at the DRG allowable plus outlier if applicable.

3. The receiving hospital which ultimately discharges the patient will receive the full DRG payment amount, and if applicable, any outlier payments associated with the care. All other hospitals which admitted and subsequently transferred the patient to another hospital during a single spell of illness shall be considered transferring hospitals.

c. If the transferring or discharge hospital or unit is exempt from the PPS, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or unit.

State: Oklahoma
Date Received: September 26, 2015
Date Approved: MAR 22 2016
Date Effective: July 1, 2015
Transmittal Number: 15-05

Revised 07-01-2015