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State/Territory Name: Oklahoma NIRT

State Plan Amendment (SPA) #: 16-0002

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

Financial Management Group

JUL 11 2016

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

RE: Oklahoma 16-02

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) 16-02. This amendment proposes a three percent rate reduction for inpatient hospital services provided in freestanding rehabilitation hospitals and DRG hospitals. This resulted in a decrease in provider payments, creating a budget impact of ($4,195,874) for Federal Fiscal Year (FFY) 2016 and ($9,752,120) for 2017.

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.

Because the proposed SPA would reduce or restructure provider payment rates, the Oklahoma Health Care Authority (OHCA) was also required to demonstrate compliance with 42 CFR 447.204(b)(2) and 42 CFR 447.204(b)(3) by completing an analysis of the effect of the change in payment rates on access and a specific analysis of the information and concerns expressed in input from affected stakeholders. The State must adhere to the public process requirements set forth in 42 CFR 447.204 and establish monitoring plan procedures in compliance with 42 CFR 447.203(b)(6)(ii). To demonstrate compliance with these requirements, the State submitted the following to CMS with the proposed SPA:

a. The State utilized an analysis of multiple data sources that encompassed a comparative rate analysis, assessment of the available provider network, number of members with a paid claim in the past State Fiscal Year and utilization of services over time to determine that access was currently sufficient and access would not be negatively impacted by the proposed rate reduction. The State concluded that the data reflected adequate access to inpatient hospital services across the State.

b. Several stakeholder meetings were conducted in 2015 with providers, advocates, and beneficiaries to engage in discussion regarding the extent of the agency's budget challenges, rate modifications and the reasons for the modifications. OHCA posted the proposed rate cut information on the agency web page for the entire month of December 2015 to advise providers, members, and the public of the pending rate reduction. On December 4, 2015, a public notice of the proposed rate reduction and public hearings appeared in the five major newspapers of the state. The rate reduction was addressed at the meeting of the State Plan Amendment Rate Committee held December 9, 2015, and the meeting of the Board held December 10, 2015. No comments were submitted to the posting on the agency web page and the State has not received complaints from the public regarding this rate reduction in response to any other public notifications.

c. In compliance with the regulations at 42 CFR 447.203(b)(6)(ii), the State has affirmed that all expenditures by provider type will be monitored through the Medicaid Management Information System by the Finance Division. The Finance Division will report any fluctuations in payments on a monthly basis, and if reductions in expenditures/utilization of five percent or more are noted, the State will do further analyses as to the type and location of the reductions and canvass those that do change, so that action may be taken. In addition to monitoring Helpline calls and reported expenditures, the State has implemented a process for immediate notification to the Director of Provider Services if any provider requests to terminate a contract. The Provider Services department is continually making site visits for the purposes of recruitment and education, and will continue making personal contacts with the provider community if a network decrease is noted, and recruit additional providers to ensure that the network is sufficient.

   Additionally, the agency will monitor complaints from recipients and advocates to determine whether an access problem arises in accordance with the regulation at 42 CFR 447.203(b)(6)(ii). If the analyses and reported problems from providers and recipients increase, then the agency will intensify interventions to improve access and assist with each situation on a case-by-case basis, including utilizing the methods described above.

Based on CMS's review of this information, the State has satisfactorily documented access to care consistent with the requirements of 42 CFR 447.204(b)(2) and 42 CFR 447.204b)(3); described the monitoring procedures required at 42 CFR 447.203(b)(6)(ii); and conducted the public process and notice described in 42 CFR 447.204 and 447.205. CMS will be periodically contacting the State to understand how the State's monitoring activities are progressing. CMS reminds the State that for all changes in policies or rates that could potentially affect access to care or quality of care, notifications to providers, consumers, and other stakeholders must specifically list those services and programs affected by those changes. Such public notice issued by the State should follow the guidance as described in the Center for Medicaid & Chip Services Informational Bulletin "Reminder of Federal Requirements: Notice and public process requirements for changes to Medicaid payment rates" issued June 24, 2016.

This letter affirms that OK 16-02 is approved effective January 1, 2016 as requested by the State. We are enclosing the CMS-179 and the following amended plan pages.

- Attachment 4.19-A, Page 6
- Attachment 4.10-A, Page 13

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

Sincerely,

[redacted]

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: 16-02
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, 2016

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 440.10, 42 CFR 440.50, 42 CFR 440.60, 42 CFR 440.166

7. FEDERAL BUDGET IMPACT
a. FFY 2016 $ ($4,195,874)
b. FFY 2017 $ ($9,752,120)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, Page 6
Attachment 4.19-A, Page 13

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A, Page 6, TN# 14-18
Attachment 4.19-A, Page 13, TN# 14-13

10. SUBJECT OF AMENDMENT
Three Percent Inpatient Hospital Provider Rate Reduction

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
February 24, 2016

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
February 24, 2016

18. DATE APPROVED
JUL 11 2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2016

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
Kristin Fan

22. TITLE
Director, FMG

23. REMARKS
c: Nico Gomez
Becky Paternik-Ikard
Tywanda Cox

FORM CMS-179 (07/92)

III. PAYMENT METHODOLOGY FOR FREESTANDING REHABILITATION, AND FREESTANDING PSYCHIATRIC HOSPITALS (continued)

C. Updates

1. The level of care operating and fixed capital per diem rates in effect on December 31, 2006, for psychiatric hospitals will be updated by a factor of 9.76% and 22.9% for rehabilitation hospitals. The rates in effect on December 31, 2007 will be updated by a factor of 3.2%.

2. Effective 05-01-09, Valir Rehab Hospital will be paid at a fixed rate per-diem based on its reported cost per day reported on the 12-31-07 cost report brought forward to the base rate period of Calendar year 2009 by the latest available Global Insight published "2002 Based CMS Hospital Prospective Reimbursement Market Basket" forecasts.

3. The rates will be reviewed annually and any annual updates will not exceed the marketbasket increase in rehabilitation, psychiatric, and long term care facilities (RPL) marketbasket index for the current rate year.

4. Effective 04-01-10, the rate in effect as of 03-31-10 will be decreased by 3.25%.

5. Effective 07-01-14, the rate in effect as of 06-30-14 will be decreased by 7.75%.

6. Effective for services provided on or after 01-01-16, the rate in effect as of 12-31-15 will be decreased by 3% for freestanding rehabilitation only.

IV. PAYMENT METHODOLOGY FOR LONG TERM CARE HOSPITALS SERVING CHILDREN (LTCHs-C)

Effective for services provided on or after July 1, 2012, payment will be made to freestanding long term care hospitals serving children for sub-acute care level of services.

A. Definitions

1. Ancillary Services. Refers to those services that are not considered inpatient routine services. Ancillary services include laboratory-and radiology. Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge.

2. Average Length of Stay. To be determined a long term care hospital, the hospital must have a Medicaid average length of stay of greater than 25 days.

3. Children. For the purpose of this reimbursement rate, children are defined as individuals under the age of 21.

4. Routine Services. Services include but are not limited to: regular room, prescription drugs, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, and the use and maintenance of equipment and facilities essential to the provision of routine care. Routine services should be patient specific and in accordance with standard medical care.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

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

C. Computation of Hospital Base Rates (continued)

4. The five hospital classification variables were joined to claim and encounter records that had been assigned a DRG by the DRG diagnosis grouper. Due to underreporting of encounter records, discharges that were reported as managed care encounters were given greater weight (1.335) than discharges reported as FFS claims (1.0) to account for the estimated likelihood that denied encounters would have been revised and resubmitted if providers had a financial incentive to do so. A multiple regression equation was estimated from the claim and encounter data to determine the expected cost associated with each of the five classification variables, controlling for DRG and length of stay.

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Date Effective:
January 1, 2016
Transmittal Number:
16-02

5. The five classification variables formed 32 possible combinations, or classes. Impossible combinations were eliminated. The expected cost for each remaining class was computed with the regression equation. Expected costs were totaled over all classes and the cumulative proportion of expected cost computed. Classes were grouped into five quintiles, such that each group accounts for 20% of the total expected cost.

6. For each group, the discharge-weighted average expected cost was calculated. After computing the discharge-weighted average expected cost for each peer group, the overall discharge weighted average was computed. The relative base rate was computed for each group as the ratio of the group-specific average to the over-all average.

7. The base year expected cost for each group was updated by the method in Section VI.B.4. of this plan.

8. The OHCA will determine the peer group assignment and appeal of assignment will be allowed only through the methods described in Section VI. F. of this Plan.

D. Updates

The DRG rates will be updated annually using the above described method.

Effective 4-01-10, the rate in effect on 03-31-10 is reduced by 3.25%.

Effective 7-01-14, the rate in effect on 06-30-14 is reduced by 7.75%.

Effective for services provided on or after 01-01-16, the rate in effect as of 12-31-15 will be decreased by 3% for DRG hospitals only.

E. Special Prospective Payment Provisions

1. Cost Outlier Adjustment

a. Effective for discharges on or after October 1, 2005, and in accordance with Section 4605 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, the OHCA provides for an outlier adjustment in payment amounts for medically necessary inpatient services involving exceptionally high costs for children who have not attained the age of six years in disproportionate share hospitals, and for infants under age one in all hospitals.