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State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 16-0003

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID & CHILDREN'S HEALTH OPERATIONS

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

July 26, 2016

Our Reference: SPA OK 16-03

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

Dear Ms. Pasternik-Ikard:

Enclosed is a copy of approved Oklahoma State Plan Amendment (SPA) No. 16-03, with an effective date of January 1, 2016. This amendment was submitted to implement a three percent reduction for Outpatient Hospital Provide rates. This resulted in a decrease in provider payments, creating a budget impact of ($1,871,133) for Federal Fiscal Year (FFY) 2016 and ($4,348,900) 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), and 1903(a) 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, 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 laboratory 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 22, 2016.

This letter affirms that OK 16-03 is approved effective January 1, 2016 as requested by the State.

We are enclosing the HCFA-179 and the following amended plan pages.

- Attachment 4.19-B, Page 1
- Attachment 4.19-B, Page 1a
- Attachment 4.19-B, Page 1b

If you have any questions regarding this matter you may contact Stacey Shuman at 214-767-6479, or by email at stacey.shuman@cms.hhs.gov.

Sincerely,

[redacted]

for

Bill Brooks
Associate Regional Administrator

CC: Billy Bob Farrell, DMCH Dallas
Stacey Shuman, DMCH Dallas
Jeremy Silanskis, CMS Baltimore
Linda Tavener, CMS Baltimore
Mark Pahl, CMS Baltimore

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: 16-03
2. STATE: Oklahoma
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAI[

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 440.20, 42 CFR 440.50, 42 CFR 440.60, 42 CFR 440.166

7. FEDERAL BUDGET IMPACT
a. FFY 2016 $ ($1,871,133)
b. FFY 2017 $ ($4,348,900)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B, Page 1
Attachment 4.19-B, Page 1a
Attachment 4.19-B, Page 1b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B, Page 1, TN# 14-19
Attachment 4.19-B, Page 1a, TN# 14-19
Attachment 4.19-B, Page 1b, TN# 14-19

10. SUBJECT OF AMENDMENT
Three Percent Outpatient 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
24 February, 2016

18. DATE APPROVED
26 July, 2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
1 January, 2016

20. SIGNATURE OF REGIONAL OFFICIAL
for [redacted]

21. TYPED NAME
Bill Brooks

22. TITLE
Associate Regional Administrator, Division of Medicaid and Children's Health

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

FORM CMS-179 (07/92)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

I. Outpatient Hospital Reimbursement

General

The agency's fee schedule rate was set as of December 1, 2008, and is effective for service provided on or after that date. All rates are published on the agency's website at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency's website. These provisions apply to all hospitals approved for participation in the Oklahoma SoonerCare program. In no case can reimbursement for outpatient hospital services exceed the upper payment limits as defined under 42 CFR 447.321. Laboratory services will not exceed maximum levels established by Medicare. Clinical diagnostic lab services (not laboratory services) do not exceed the maximum levels.

Effective February 1, 2010, payment for outpatient services will not be made for three national coverage determinations which relate to serious, preventable errors in medical care. These errors include surgery performed on wrong body part, surgery performed on wrong patient, and wrong surgery performed on patient.

Effective for services provided on or after 04-01-10, the rates in effect on 03-31-10 will be decreased by 3.25%.

Effective for services provided on or after 07-01-14, the rates in effect on 06-30-14 will be decreased by 7.75%.

Effective for services provided on or after 01-01-16, the rates in effect on 12-31-15 will be decreased by 3%.

A. Emergency Room Services

1. Payment will be made based on Medicare APC groups for Type A and Type B Emergency Departments. All rates are published on the agency's website at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

2. Effective for services provided on or after 04-01-10, the rates in effect on 03-31-10 will be decreased by 3.25%.

3. Effective for services provided on or after 07-01-14, the rates in effect on 06-30-14 will be decreased by 7.75%

4. Effective for services provided on or after 01-01-16, the rates in effect on 12-31-15 will be decreased by 3%.

B. Outpatient Surgery

1. Payment will be made for certain outpatient surgical procedures provided in hospitals and ambulatory surgery centers based on the Medicare Ambulatory Surgery Center (ASC) facility services payment system. The surgical procedures are classified into payment groups based on Current Procedural Terminology (CPT). All procedures within the same payment group are paid at a single payment rate. For purposes of specifying the services covered by the facility rate, the OHCA hereby adopts and incorporates herein by reference the Medicare ASC procedures. All rates are published on the agency's website at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

I. Outpatient Hospital Reimbursement (continued)

B. Outpatient Surgery (continued)

2. Facility fees for surgical procedures not covered as ASC procedures and otherwise covered under Medicaid will be reimbursed according to a state-specific fee schedule based on APC pricing. Bilateral or multiple procedures performed in one day will be subject to discounting. All rates are published on the agency's website at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

3. Separate fees for outpatient surgery services are not payable to the hospital if the patient is admitted to the same hospital within 72 hours.

4. Effective for services provided on or after 04-01-10, the rates in effect on 03-31-10 will be decreased by 3.25%.

5. Effective for services provided on or after 07-01-14, the rates in effect on 06-30-14 will be decreased by 7.75%.

6. Effective for services provided on or after 01-01-16, the rates in effect on 12-31-15 will be decreased by 3%.

C. Dialysis Services

1. Dialysis visits will be reimbursed at the provider's Medicare composite rate for dialysis services determined by Medicare under 42 CFR 413 subpart H. The facility's composite rate is a comprehensive prospective payment for all modes of facility and home dialysis and constitutes payment for the complete dialysis treatment, except for a physician's professional services, separately billable laboratory services and separately billable drugs.

2. The provider must furnish all of the necessary dialysis services, equipment and supplies. Reimbursement for dialysis services and supplies is further defined in the Medicare Provider Reimbursement Manual, HCFA Pub. 15 (referred to as "Pub. 15"). For purposes of specifying the services covered by the composite rate and the services that are separately billable, the agency hereby adopts and incorporates herein by reference Pub. 15. All rates are published on the agency's website at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

3. Effective for services provided on or after 04-01-10, the rates in effect on 03-31-10 will be decreased by 3.25%.

4. Effective for services provided on or after 07-01-14, the rates in effect on 06-30-14 will be decreased by 7.75%.

5. Effective for services provided on or after 01-01-16, the rates in effect on 12-31-15 will be decreased by 3%.

D. Ancillary Services, Imaging and Other Diagnostic Services

Ancillary services, imaging services, and other diagnostic services will be reimbursed on a prospective basis by paying the lower of usual and customary charges or a fee basis.

1. Services such as physical, occupational, and speech therapy services are reimbursable at a flat statewide fee schedule rate. The rate is based on APC group 0600.

2. For each imaging service or procedure, the fee will be the technical component of the Medicare resource-based relative value scale (RBRVS).

3. For each diagnostic service or procedure, the fee will be the technical component of the RBRVS. For those services where there is no technical component under RBRVS, the fee will be 100 percent of the global value.

4. A facility fee will be reimbursed to the hospital for the services listed in D.2-3 in accordance with the methodology described in I.F. below. All rates are published on the agency's website at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

5. Effective for services provided on or after 04-01-10, the rates in effect on 03-31-10 will be decreased by 3.25%.

6. Effective for services provided on or after 07-01-14, the rates in effect on 06-30-14 will be decreased by 7.75%.

7. Effective for services provided on or after 01-01-16, the rates in effect on 12-31-15 will be decreased by 3%.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

I. Outpatient Hospital Reimbursement (continued)

E. Therapeutic Services

1. Payment is made for drugs and supplies for outpatient chemotherapy. A separately billable facility fee payment is made for administration based on Medicare APC group 0117. Claims cannot be filed for an observation room, clinic, or ER visits on the same day.

2. For each therapeutic radiology service or procedure, payment will be the technical component of the Medicare RBRVS. All rates are published on the agency's website at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

3. Effective for services provided on or after 04-01-10, the rates in effect on 03-31-10 will be decreased by 3.25%.

4. Effective for services provided on or after 07-01-14, the rates in effect on 06-30-14 will be decreased by 7.75%.

5. Effective for services provided on or after 01-01-16, the rates in effect on 12-31-15 will be decreased by 3%.

F. Clinic Services and Observation/Treatment Room

A fee will be established for clinic visits and certain observation room visits. Reimbursement is limited to one unit per day per patient, per provider. The payment rates are based on APC groups 601 and 0339, respectively. Separate payment will not be made for observation room following outpatient surgery. All rates are published on the agency's website at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

Effective for services provided on or after 04-01-10, the rates in effect on 03-31-10 will be decreased by 3.25%.

Effective for services provided on or after 07-01-14, the rates in effect on 06-30-14 will be decreased by 7.75%.

Effective for services provided on or after 01-01-16, the rates in effect on 12-31-15 will be decreased by 3%.

G. Hospital-based Community Mental Health Centers (CMHCs) Operated by Units of Government

1. CMHCs will be paid on the basis of cost in accordance with the following methodology: An overall outpatient cost- to- charge ratio (CCR) for each hospital will be calculated using the most recently available cost reports, with data taken from Worksheet C, Part 1. The overall CCR for each hospital will be applied to the Medicaid charges for the state fiscal year to determine the Medicaid costs for the year.

2. The agency's fee schedule rates are set as of July 1, 2006 and in effect for services provided on or after that date. All rates are published on the agency's website located at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

3. Effective for services provided on or after 04-01-10, the rates in effect on 03-31-10 will be decreased by 3.25%

H Partial Hospitalization Services (PHP)

PHP services are provided in accordance with 42CFR 410.43

Any child 0-20 that is an eligible member and who meets the medical necessity and programmatic criteria for behavioral health services qualifies for PHP. Treatment is time limited and must be offered a minimum of 3 hours per day, 5 days a week. Therapeutically intensive clinical services are limited to 4 billable hours per day. Services are prior authorized for 1-3 months based on medical necessity criteria.

The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse vendor. An initial prior authorization will be required by OHCA or its designated agent. This initial prior authorization will ensure that the level of service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

Revised 01-01-16

State: Oklahoma
Date Received: 24 February, 2016
Date Approved: 26 July, 2016
Effective Date: 1 January, 2016
Transmittal Number: 16-03