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State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 16-0017 NIRT

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved Page

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

NOV 22 2016

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

Our Reference: SPA OK 16-17

Dear Ms. Pasternik-Ikard:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 16-17. Effective for services on or after April 1, 2016 this amendment proposes to revise the criteria associated with the potentially preventable readmission (PPR) reimbursement adjustment.

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 16-17 is approved effective April 1, 2016. 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,

[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: 16-17
2. STATE: Oklahoma
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAI[illegible]

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

4. PROPOSED EFFECTIVE DATE: April 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 447.250

7. FEDERAL BUDGET IMPACT
a. FFY 2016 $ ($958,241)
b. FFY 2017 $ ($941,744)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, Page 14;
Attachment 4.19-A, Page 14.1 (NEW);
Attachment 4.19-A, Page 14.2 (NEW)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A, Page 14, TN# 05-24;
Attachment 4.19-A, Page 14.1 (NEW);
Attachment 4.19-A, Page 14.2 (NEW)

10. SUBJECT OF AMENDMENT
Hospital Potentially Preventable Readmissions

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
Becky Pasternik-Ikard

14. TITLE
Chief Executive Officer

15. DATE SUBMITTED
June 15, 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: JUNE 15, 2016
18. DATE APPROVED: NOV 22 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APRIL 1, 2016
20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME:
22. TITLE: Director, FMG

23. REMARKS:

c: Becky Pasternik-Ikard
Tywanda Cox

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)

1. Payment for Readmissions

Readmissions occurring within 30 days of prior acute care admission for a related condition will be reviewed under a retrospective utilization review policy to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the OHCA.

OHCA does not have any prior authorization requirement for inpatient services. Utilization reviews of inpatient stays occur after members have been served and the hospitals file claims; an analysis by the QIO is based on a review of the claims.

Effective April 1, 2016 the OHCA implemented a hospital readmissions initiative designed to reduce the rate of potentially preventable readmissions (PPR). The OHCA approach to achieving this goal is payment reduction for those facilities that have higher than expected PPR rates after adjusting for the types of diagnoses, severity of illness, age groups, and mental health comorbidities seen at individual facilities.

The methodology is as follows:
PPR Assignment
OHCA collects data from all inpatient admissions, but some admissions are excluded from the analysis by third party software. Global exclusions currently include Medicare crossover claims for dual eligible members, admissions related to HIV or eye care, admissions where the patient left against medical advice, most malignancy and neonatal admissions, and non-events such as transfers between acute care facilities or admission to non-acute care facilities. A maximum of 30 days can elapse between the discharge date of an admission and the admitting date of a readmission. If the third party software algorithm determines that a readmission is clinically related to a prior admission, it is considered a PPR. The prior hospitalization that is clinically related to the PPR is called an Initial Admission (IA). An initial admission is the start of a PPR chain that includes at least one PPR; more than one PPR can be attributed to a single initial admission. A hospitalization that is not clinically related to a prior or subsequent admission within a 30-day period is considered an Only Admission (OA). Initial Admissions and Only Admissions combined are Qualifying Admissions (QA), which are used in calculating PPR rates.

State: Oklahoma
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Revised 04-01-16

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

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

Clinically Related Admissions

The key component of the third party software assignment is the proprietary algorithm that determines whether admissions are clinically related. Readmissions are considered to be potentially preventable in the following cases:

- Medical readmission for a continuation or recurrence of the reason for the IA, or for a condition closely related to the reason for the IA
- Ambulatory care sensitive conditions as designated by the Agency for Healthcare Research and Quality (AHRQ)
- All other readmissions for a chronic problem that may be related to care either during or after the IA
- Medical readmission for an acute medical condition or complication that may be related to or may have resulted from care during the IA or in the post-discharge period after the IA
- Readmission for a surgical procedure to address a continuation or a recurrence of the problem causing the IA
- Readmission for a surgical procedure to address a complication that may be related to or may have resulted from care during the IA
- Readmission for mental health or substance abuse reasons

Statewide PPR Calculations

Each admission is assigned to an All Patient Refined Diagnosis Related Groups (APR DRGs) according to the reason for admission. Each admission is also assigned to one of four severity of illness (SOI) levels based on both comorbidities and severity of the underlying illness. A statewide average PPR rate for each APR DRG-SOI combination is defined by the ratio of IA/QA for that APR DRG-SOI. APR DRG-SOI combinations with less than 5 QA across the state are excluded from the analysis.

The third party software also identifies admissions with secondary diagnoses of major mental health conditions. It is well-established that individuals with mental health comorbidities are more likely to be readmitted. Therefore, the third party software output can be used to calculate a PPR adjustment factor to account for the presence or absence of mental health comorbidities when determining the number of expected PPRs for a facility. Likewise, an age group adjustment factor is applied to account for the fact that pediatric patients are less likely to be readmitted than adults.

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

Facility-Specific PPR Calculations

The third party software classifies each admission within a specific facility as an IA, OA, readmission, or excluded admission. Each admission is also assigned to an APR DRG-SOI. For each APR DRG-SOI observed within each hospital's data set, the expected number of PPR chains is calculated by multiplying the statewide average PPR rate for that APR DRG-SOI by the number of QA for that APR DRG-SOI. That expected value is also multiplied by the adjustment factor for the appropriate age group and mental health status. Some states set a "target" PPR rate that is different from the statewide average PPR rate. At this time, OHCA has chosen a target rate of 102% decreasing annually by one percent until the target rate reaches 100%. The expected number of PPR chains for the hospital is the sum of the expected number of PPR chains across all APR DRG-SOI. If a hospital has a higher number of actual PPR chains than would be expected based on the statewide average, then the number exceeding the expectation are considered excess PPR chains and are subject to payment reduction. The payment reduction is equal to the number of excess PPR chains multiplied by the average reimbursement for PPRs clinically related to initial admissions originating at that facility. Currently, to be included in the reporting process, a hospital must have at least 40 qualifying admissions, 5 actual PPR chains, and 5 expected PPR chains. The minimum number or qualifying admissions, actual PPR chains, and expected PPR chains may be reconsidered as the program evolves. At this time, only facilities that are paid on a DRG basis are subject to payment reduction. Included and excluded facilities may be reconsidered as the program evolves.

Penalty Recoupment Process

OHCA will process the payment reduction through a lump sum recoupment process. After the penalty calculations are completed in the final quarter of the state fiscal year, OHCA will distribute PPR data and notify all hospitals of total penalty amount owed. OHCA will then create accounts receivable for each facility in the MMIS for the total amount of the facility specific penalty. OHCA may set up the accounts receivable to recoup the penalty amount over more than one week. The PPR penalty shall not be included in uncompensated care claims submitted by the hospitals. If the State determines that a participating provider has erroneously filed an uncompensated care claim that incorporates denials for preventable readmissions, the State will notify pertinent auditors of the need to take appropriate steps to disallow these amounts and educate the providers accordingly.

2. Payment for Inappropriate Brief Admissions

Hospital stays less than three days in length will be reviewed under a retrospective utilization review policy for medical necessity and appropriateness of care. (Discharges involving healthy mother and healthy newborns may be excluded from this review requirement.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient stay will be denied.

. Provisions Relating to Organ Transplants

In order for a hospital to receive payment for medically necessary organ transplant services, the following criteria must apply:

The transplant must be prior authorized by the OHCA. Prior authorization request must be submitted jointly by the hospital and the transplant surgeon, and must include written documentation attesting to the appropriateness of the proposed transplant. Payment will not be made without prior authorization approval.

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