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State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 18-0002

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

December 4, 2018

Becky Pasternik-Ikard
Chief Executive Officer
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma 73105

Our Reference: SPA OK 18-0002

Dear Ms. Pasternik-Ikard:

We have reviewed the proposed State plan amendment (SPA) to Attachment 3.1-A and 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 18-0002. This amendment proposes to align settings and reimbursement methodology of inpatient psychiatric services for individuals under 21 with federal regulation and guidance. The proposed SPA revises the identification of settings where inpatient psychiatric services for individuals under 21 are provided and delineate requirements for reimbursement within each setting. Additionally, the SPA will update the list of accrediting bodies for psychiatric facilities to meet federal regulations. Other revisions include page format and grammatical changes.

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 18-0002 is approved effective January 1, 2018. 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 SERVCES
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: 18 – 0002
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, 2018

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 440.160; 42 CFR 441.151

7. FEDERAL BUDGET IMPACT
a. FFY 2018 $9,224.78
b. FFY 2019 $13,099.80

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1-A, Page 7
Attachment 3.1-A, Page 7a-2
Attachment 4.19-A, Page 33
Attachment 4.19-A, Page 34
Attachment 4.19-A, Page 34a
Attachment 4.19-A, Page 35
Attachment 4.19-A, Page 36
Attachment 4.19-A, Page 37

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 3.1-A, Page 7, TN # 17-06
Attachment 3.1-A, Page 7a-2, TN # 15-04
Attachment 4.19-A, Page 33, TN # 16-21
Attachment 4.19-A, Page 34, TN # 15-04
Attachment 4.19-A, Page 34a, New
Attachment 4.19-A, Page 35, TN # 16-21
Attachment 4.19-A, Page 36, TN # 10-16
Attachment 4.19-A, Page 37, TN # 06-12

10. SUBJECT OF AMENDMENT

Updating accreditation and delineating Acute Level 1, Acute Level 2, and PRTF services within the inpatient psychiatric services for individuals age under 21 benefit

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
March 29, 2018

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
March 29, 2018

18. DATE APPROVED
DEC 04 2018

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
Kristin Fan

22. TITLE
Director, FMG

23. REMARKS
c: Becky Pasternik-Ikard
Tywanda Cox

FORM CMS-179 (07/92)

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

[X] Provided [ ] No limitations [X] With limitations* [ ] Not Provided:

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

[X] Provided [ ] No limitations [X] With limitations* [ ] Not Provided:

16. Inpatient psychiatric facility services for individuals under 21 years of age.

[X] Provided [X] No limitations [ ] With limitations* [ ] Not Provided:

17. Nurse-midwife services

[X] Provided [X] No limitations [ ] With limitations* [ ] Not Provided:

18. Hospice care for individuals under 21 years of age (in accordance with section 1905(o) of the Act).

[ ] Provided [ ] No limitations [X] Provided in accordance with section 2302 of the Affordable Care Act

[X] With limitations* [ ] Not Provided:

*Description provided on attachment

State: Oklahoma
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Date Approved: DEC 04 2018
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Transmittal Number: 18-02

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED CATEGORICALLY NEEDY

16. Inpatient Psychiatric Services for individuals under Age 21 (42 CFR 440.160)

(A) Eligible Providers (42 CFR 441.151; 42 CFR 440.160)

Inpatient psychiatric services for individuals under age 21 (or age 22 if the individual was receiving services prior to reaching age 22) are provided under the direction of a physician pursuant to an individual's plan of care and are limited to those who are receiving such services in an institution which is:

- A psychiatric hospital that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital as specified in 42 CFR 482.60, or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by CMS; or

- A hospital with an inpatient psychiatric program that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital, as specified in 42 CFR part 482, or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS; or

- A psychiatric facility that is not a hospital (defined as a Psychiatric Residential Treatment Facility (PRTF) in 42 CFR 483.352) that is accredited by the Joint Commission on Accreditation of Healthcare Organizations (TJC), the Council on Accreditation for Families and Children, the Commission on Accreditation of Rehabilitation Facilities (CARF), or by any other accrediting organization, with comparable standards, that is recognized by the State.

The State assures that it meets all requirements in 42 CFR 440.160, 42 CFR 441 Subpart D, and 42 CFR 483 Subpart G.

(B) Services Provided under Arrangement

The State assures that psychiatric facilities:

- arrange for and oversee the provision of all services;
- maintain all medical records of care furnished to the individual; and
- ensure that all services are furnished under the direction of a physician.

State: Oklahoma
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

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16. Inpatient Psychiatric Services for Individuals under Age 21 (42 CFR 440.160)

16.a. Inpatient Psychiatric Services for Individuals under Age 21

(A) General

Except as otherwise noted in the plan, all Medicaid services furnished to individuals receiving acute level 2 services in private psychiatric hospitals and general hospitals with a psychiatric unit are considered all-inclusive of the service, i.e., all medical services provided to residents of psychiatric hospital and general hospitals with psychiatric units with 17 beds or more should be billed to the psychiatric hospital and general hospitals with psychiatric units.

(B) Payment to State-owned Government Providers

State-owned psychiatric hospitals will be paid an interim rate based on the previous year's cost report (HCFA 2552) data and settled to total allowable costs based on the current year's cost report. Total allowable cost will be determined in accordance with Medicare principles of reimbursement.

(C) Payment to State–licensed, Private Psychiatric Hospitals and General Hospitals with Psychiatric Units

i. Base Rate

A prospective per diem payment is made for covered services based on facility peer group. State licensure requires RN staffing 24 hours per day for hospitals at a ratio of one RN for up to 15 patients. An additional RN must be added for more than 15 patients; however, an LPN may be substituted for 16-20 patients. A second RN is needed for 21 patients and above.

The rates listed below are effective as of 05-01-2016 and are equivalent to a 15 percent rate reduction from the rates in effect on 04-30-2016 for private psychiatric hospitals and general hospitals with psychiatric units.

Peer Group	Psychiatric Hospital	Hospital Psychiatric Unit
Standard	$293.29	$293.29
Specialty 1 – Sexual Offender	$293.29	$293.29
Specialty 2 – Eating Disorder, TBI	$367.42	$367.42

ii. The following services will not be reimbursed outside of the per diem:

- Dental (excluding orthodontia);
- Vision;
- Prescription Drugs;
- Practitioner Services; and
- Other medically necessary services not otherwise specified.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

16. Inpatient Psychiatric Services for Individuals under Age 21 (42 CFR 440.160) *(continued)*

16.a. Inpatient Psychiatric Services for Individuals under Age 21 *(continued)*

(C) Payment to State–licensed, Private Psychiatric Hospitals and General Hospitals with Psychiatric Units *(continued)*

iii. Add-on Payments

(a) Intensive Treatment Services (ITS) Add-on Per Diem

An ITS per diem of **$110.99** will be allowed for children requiring intensive staffing supports in an acute level 2 or PRTF setting when it is determined that there is medical necessity for non-acute care, the services are documented in the facilities' records, and are prior authorized.

(b) Prospective Complexity Add-on Per diem for Non-verbal Children

A per diem of **$77.51** will be allowed to recognize the increased cost of serving children with a mental health diagnosis complicated with non-verbal communication in an acute level 2 setting. These services must be medically necessary, documented in the facilities' record, and prior authorized.

(c) Outlier Intensity Adjustment

(A) An outlier payment adjustment may be made on a case by case basis for complex cases. The intent of the outlier payment is to promote access to inpatient psychiatric services for individuals under 21 for those patients who require services beyond the cost of services provided by both ITS and Prospective Complexity add-on payments.

(B) The outlier adjustment may be a short stay outlier adjustment or a high cost outlier adjustment.

(C) In order to be eligible for the short stay outlier adjustment:

1. The private psychiatric hospital and general hospital with a psychiatric unit must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and
2. The total length of stay must be less than 6 days.
3. The outlier adjustment will be the lessor of the following:
   a. 100% of the private psychiatric hospital's and general hospital's with a psychiatric unit cost; or
   b. 120% of the peer group per diem multiplied by the LOS.

(D) In order to be eligible for the high cost outlier adjustment:

1. The private psychiatric hospital or general hospital with a psychiatric unit must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and
2. The outlier payment will be made if the psychiatric hospital's or general hospital's with a psychiatric unit total cost of care exceeds 115% of the Medicaid payment.
3. The appropriate outlier amount will be determined by comparing the total cost and 115% of the Medicaid payment for the entire stay, and multiplying the difference by a loss sharing ratio of .20 to the psychiatric hospital or general hospital with a psychiatric unit and .80 to the state, if the stay is less than or equal to 90 days, and .40 to the Medicare certified hospital and .60 to the state for a stay > 90 days.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

16. Inpatient Psychiatric Services for individuals under age 21 (42 CFR 440.160) *(continued)*
16.a. Inpatient Psychiatric Services for Individuals under Age 21 *(continued)*
(C) Payment to State–licensed, Private Psychiatric Hospitals and General Hospitals with Psychiatric Units *(continued)*

iv. Services Provided under Arrangement

Separate payment may be made directly to individual practitioners or suppliers for services provided under arrangement using existing State plan methodologies and fees. The State assures there is no duplication of payment between the psychiatric hospitals' or general hospitals with psychiatric units' base rate and the items paid for separately. The State also assures that no duplication of payment will be made for transitioning services to both a community Case Manager provider and a Health Home provider for the same person.

(a) **Case Management Transitioning Services** – Transitional case management services are considered to be psychiatric hospital or general hospital with a psychiatric unit services, when services exceed and do not duplicate inpatient discharge planning during the last 30 days of a covered stay. Case management transitioning services to assist children transitioning from a psychiatric hospital or general hospital with a psychiatric unit to a community setting will not duplicate inpatient discharge planning services. Case management transitioning services will be billed by the psychiatric hospital or general hospital with a psychiatric unit as inpatient psychiatric services for individuals under age 21 services and claimed as inpatient psychiatric services for individuals under age 21 services. Payment for Case Management transition services provided under arrangement with the psychiatric hospital or general hospital with a psychiatric unit will be directly reimbursed to a qualified community-based Case Management provider. Payment is made to Outpatient Behavioral Health Agencies with qualified case managers in accordance with the methodology in Attachment 4.19-B, Page 22.

(b) **Health Home Transitioning Services** – Health Home services are considered to be inpatient psychiatric services for individuals under age 21, when services exceed and do not duplicate inpatient discharge planning during the last 30 days of a covered stay. Payment for Health Home transitioning services provided under arrangement with the psychiatric hospital or general hospital with a psychiatric unit will be directly reimbursed to the Health Home. Payment is made to certified Health Homes at the Tier 2 Resource Coordination level of care rate, in accordance with the methodology in OK HHA Page 22.

Transitional services are exempt from the payment methodology at 16.a.C.ii on Attachment 4.19-A, Page 33.

(c) **Evaluation and psychological testing by a licensed Psychologist** - Payment is made in accordance with the methodology in Attachment 4.19-B, Page 8.

(D) Payment for Out–of–State Services

Reimbursement for out-of-state placements for individuals under the age of 21 shall be made in the same manner as in-state providers. In the event that comparable services cannot be purchased from an out-of-state provider using Medicaid established rates, a rate may be negotiated that is acceptable to both parties. The rate will generally be the lesser of usual and customary charges or the Medicaid rate in the state in which services are provided. Reimbursement shall not be made for inpatient psychiatric services for individuals under age 21 provided out of state unless the services are medically necessary and are not available within the State and prior authorization has been granted.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of inpatient psychiatric services for individuals under 21. The agency's fee schedule rate was set as of May 1, 2016 and is effective for services provided on or after that date. All rates are published on the Agency's website www.okhca.org/feeschedules.

TN# 18-02
Supersedes TN# New

Approval Date DEC 04 2018

Effective Date 1-1-2018

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Transmittal Number: 18-02

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

16. Inpatient Psychiatric Services for individuals under age 21 (42 CFR 440.160) *(continued)*

16.b. Residential Level of Care in a Psychiatric Residential Treatment Facility (PRTF)

(A) Payment to PRTFs with 17 beds or more

i. Base Rate.
A prospective per diem payment is made based on the facility peer group for a comprehensive package of services and room and board which requires 24-hour nursing care supervised by an RN. An RN or LPN must be onsite to meet the ratio of 1:30 during routine waking hours and 1:40 during times residents are asleep.

ii. The following services will not be reimbursed outside of the base rate:
- Dental (excluding orthodontia);
- Vision;
- Prescription drugs;
- Practitioner services; and
- Other medically necessary services not otherwise specified.

Refer to paragraph 16.a.(C)iii.(a)-(b) for add-on payment and 16.b.(D). for services provided under arrangement.

The rates listed below are effective as of 05-01-2016 and are equivalent to a 15 percent rate reduction from the rates in effect on 04-30-2016 for private, in-state PRTFs with 17 beds or more.

Facility Peer Group	Base Rate
Special Populations (Developmental Delays, Eating Disorders)	$340.04
Standard	$286.08
Extended	$271.61

iii. Outlier Intensity Adjustment
(A) An outlier payment adjustment may be made on a case by case basis for complex cases. The intent of the outlier payment is to promote access to inpatient psychiatric services for individuals under 21 for those patients who require services beyond the cost of services provided by both ITS and Prospective Complexity add-on payments.
(B) The outlier adjustment may be a short stay outlier adjustment or a high cost outlier adjustment.
(C) In order to be eligible for the short stay outlier adjustment:
1. The facility must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and
2. The total length of stay must be less than 6 days.
3. The outlier adjustment will be the lessor of the following:
   a. 100% of the facility's cost; or
   b. 120% of the peer group per diem multiplied by the LOS.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

16. Inpatient Psychiatric Services for individuals under age 21 (42 CFR 440.160) *(continued)*

16.b. Residential Level of Care in a PRTF *(continued)*

(A) Payment to PRTFs with 17 beds or more *(continued)*

iv. Outlier Intensity Adjustment *(continued)*

(D) In order to be eligible for the high cost outlier adjustment:
1. The facility must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and
2. The outlier payment will be made if the facility's total cost of care exceeds 115% of the Medicaid payment.
3. The appropriate outlier amount will be determined by comparing the total cost and 115% of the Medicaid payment for the entire stay, and multiplying the difference by a loss sharing ratio of .20 to the facility and .80 to the state, if the stay is less than or equal to 90 days, and .40 to the facility and .60 to the state for a stay > 90 days.

(B) Payment to Private, in-state PRTFs with 16 beds or less

i. Base Rate

The rate listed below is effective as of 05-01-2016 and is equivalent to a 15 percent rate reduction from the rate in effect on 04-30-2016 for private, in-state PRTFs with 16 beds or less.

A prospective per diem payment of $187.42 is made for a comprehensive package of services provided under the direction of a physician, as well as and room and board.

Refer to paragraph 16.a.(C)iii(a)-(b) for add-on payment and 16.b.(D) for services provided under arrangement.

ii. Physician and Other Ancillary Services

All other medically necessary services, i.e., EPSDT services, are arranged by the PRTF with 16 beds or less and billed separately. The reimbursement for the EPSDT service does not duplicate billing for inpatient psychiatric services under section 1905(a)(16)(A) of the Act by the PRTF with 16 beds or less or a provider furnishing inpatient psychiatric services under arrangement with the PRTF with 16 beds or less. Payment for the EPSDT service is made in accordance with the applicable State plan payment methodologies and fees. Claiming of such expenditures for federal financial participation (FFP) are in accordance with the CMS-64 form claiming guidance for EPSDT services

(C) Payment for Out–of–State Services

Reimbursement for out-of-state placements for individuals under the age of 21 shall be made in the same manner as instate providers. In the event that comparable services cannot be purchased from an out-of-state provider using Medicaid established rates, a rate may be negotiated that is acceptable to both parties. The rate will generally be the lesser of usual and customary charges or the Medicaid rate in the state in which services are provided. Reimbursement shall not be made for private PRTF services provided in out of state unless the services are medically necessary and are not available within the State and prior authorization has been granted.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

16. Inpatient psychiatric services for individuals under (42 CFR 440.160) *(continued)*

6.b. Residential Level of Care in a PRTF *(continued)*

(D) Services Provided under Arrangement

Separate payment may be made directly to individual practitioners or suppliers for services provided under arrangement using existing State plan methodologies and fees. The State assures there is no duplication of payment between the PRTF base rate and the items paid for separately. The State also assures that no duplication of payment will be made for transitioning services to both a community Case Manager provider and a Health Home provider for the same person.

i. **Case Management Transitioning Services** – Transitional case management services are considered to be PRTF services, when services exceed and do not duplicate PRTF discharge planning during the last 30 days of a covered stay. Case management transitioning services to assist children transitioning from a PRTF to a community setting will not duplicate PRTF discharge planning services. Case management transitioning services will be billed by the PRTF as PRTF services and claimed as PRTF services. Payment for Case Management transition services provided under arrangement with the PRTF will be directly reimbursed to a qualified community-based Case Management provider. Payment is made to Outpatient Behavioral Health Agencies with qualified case managers in accordance with the methodology in Attachment 4.19-B, Page 22.

ii. **Health Home Transitioning Services** – Health Home services are considered to be PRTF services, when services exceed and do not duplicate PRTF discharge planning during the last 30 days of a covered stay. Payment for Health Home transitioning services provided under arrangement with the PRTF will be directly reimbursed to the Health Home. Payment is made to certified Health Homes at the Tier 2 Resource Coordination level of care rate, in accordance with the methodology in OK HHA Page 22.

iii. **Evaluation and psychological testing by a licensed Psychologist** - Payment is made in accordance with the methodology in Attachment 4.19-B, page 8.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of inpatient psychiatric services for individuals under 21. The agency's fee schedule rate was set as of May 1, 2016 and is effective for services provided on or after that date. All rates are published on the Agency's website www.okhca.org/feeschedules.

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