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State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 19-0028

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

March 25, 2020

Melody Anthony
State Medicaid Director
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma 73105

Our Reference: SPA OK 19-0028

Dear Ms. Anthony:

We have reviewed the proposed State plan amendment (SPA) to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 19-0028. This SPA revises the payment methodology in Acute Level 2 settings of private psychiatric hospitals and general hospitals with psychiatric units and in psychiatric residential treatment facilities (PRTFs), to allow an additional patient-specific specialty add-on per diem rate of $210 for children with specialized treatment needs.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1923, and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

This is to inform you that Medicaid State plan amendment 19-0028 is approved effective September 1, 2019. The CMS-179 and the amended plan page(s) are attached.

If you have any additional questions or need further assistance, please contact Tamara Sampson at 214-767-6431 or Tamara.Sampson@cms.hhs.gov.

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: 19-0028

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
September 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS 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 2019 $ 298,755
b. FFY 2020 $ 3,794,253

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-A, Page 34
Attachment 4.19-A, Page 34a
Attachment 4.19-A, Page 35
Attachment 4.19-A, Page 36

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 4.19-A, Page 34, TN # 18-02
Attachment 4.19-A, Page 34, TN # 18-02
Attachment 4.19-A, Page 35, TN # 19-0020
Attachment 4.19-A, Page 36, TN # 19-0020

10. SUBJECT OF AMENDMENT

Establish specialty add-on per diem payment for inpatient psychiatric services for individuals under the age of 21

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

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Melody Anthony

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
9/24/2019

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED
03/25/20

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME

22. TITLE

23. REMARKS

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 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) Specialty Add-on Per Diem

A per diem of **$210.00** will be allowed to recognize the increased cost of serving children with specialized needs in an acute level 2 setting. These services must be medically necessary, documented in the facility's record, and prior authorized.

iv. 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 ITS, Prospective Complexity, and Specialty 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.

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)*

v. 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.

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 State-owned Government Providers

State-owned PRTF will be paid an interim rate based on the previous year's cost report (HCFA 2552) data and settled to total allowable costs determined by usual and customary charges. The agency may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances in accordance with 42 CFR 447.325.

(B) 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.

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

(C) 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.

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

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)*

(D) PRTF 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 a 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 a PRTF setting. These services must be medically necessary, documented in the facilities' record, and prior authorized.

(c) Specialty Add-on Per Diem

A per diem of **$210.00** will be allowed to recognize the increased cost of serving children with specialized needs in a PRTF setting. These services must be medically necessary, documented in the facility's record, and prior authorized.

(E) 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 ITS, Prospective Complexity, and Specialty 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.

(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.

(F) PRTF 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.

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)*

(E) PRTF Services Provided under Arrangement *(continued)*

(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.b.B.ii on Attachment 4.19-A, Page 35 and 16.b.C.ii on Attachment 4.19-A, Page 36.

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

(G) PRTF 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.