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State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 16-0018

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved Page(s)

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S3-14-28  
Baltimore, Maryland 21244-1850



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**Financial Management Group**

**AUG 04 2016**

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

RE: Oklahoma 16-18

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) 16-18. This amendment proposes that the transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer case.

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 16-18 is approved effective April 1, 2016. We are enclosing the Form CMS-179 and the new plan page.



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

Sincerely,

A black rectangular redaction box covering the signature of Kristin Fan.

Kristin Fan  
Director

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER <b>1 6 - 1 8</b>	2. STATE <b>Oklahoma</b>
		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 <b>April 1, 2016</b>	
5. TYPE OF PLAN MATERIAL (Check One) <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS A NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION <b>42 CFR 447.50</b>		7. FEDERAL BUDGET IMPACT a. FFY 2016 \$ <b>\$97,994</b> b. FFY 2017 \$ <b>\$195,988</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  <b>Attachment 4.19-A Page 13.2</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)  <b>Attachment 4.19-A; Page 13.2, TN 15-05</b>	
10. SUBJECT OF AMENDMENT  <b>Diagnosis-Related Group (DRG) outlier payments to transferring hospitals</b>			
11. GOVERNOR'S REVIEW (Check One) <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      The Governor does not review State <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL      Plan material.			
12. SIGNATURE OF STATE AGENCY OFFICIAL 		16. RETURN TO  <b>Oklahoma Health Care Authority Attn: Tywanda Cox 4345 N. Lincoln Oklahoma City, OK 73105</b>	
13. TYPED NAME <b>Joel Nico Gomez</b>			
14. TITLE <b>Chief Executive Officer</b>			
15. DATE SUBMITTED <b>June 16, 2016</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED <b>16-Jun-16</b>		18. DATE APPROVED <b>AUG 04 2016</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL <b>01-Apr-16</b>		20. SIGNATURE OF REGIONAL OFFICIAL 	
21. TYPED NAME <b>Kristin FAN</b>		22. TITLE <b>Director, FMCO</b>	
23. REMARKS c. Nico Gomez Becky Pasternik-Ikard Tywanda Cox			
FORM CMS-179 (07/92)			

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
INPATIENT HOSPITAL SERVICES**

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

E. Special Prospective Payment Provisions (continued)

3. Payment for Transfer Cases (continued)

- a. The following methodology will be used to reimburse the transferring and discharging hospitals for appropriate transfer if both hospitals and any hospital units involved are included in the PPS:
1. A hospital inpatient shall be considered "transferred" when he or she has been moved from one inpatient facility to another inpatient facility. Movement of a patient from one unit to another unit within the same hospital shall not constitute a transfer, unless the patient is being moved to a different Medicare certified unit within the hospital.
  2. The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer case. Should the stay in the transferring hospital qualify for an outlier payment, then the care may be paid as an outlier as described in Attachment 4.19-A, Pages 13 and 13.1 of this plan. In the case of a transfer, the Transfer Allowable Fee for the Transferring Facility shall be calculated as follows:  $\text{Transfer Allowable Fee} = (\text{MS-DRG Allowable Fee} / \text{Mean Length of Stay}) \times (\text{Length of Stay} + 1 \text{ day})$ .
  3. The receiving hospital which ultimately discharges the patient will receive the full DRG payment amount, and if applicable, any outlier payments associated with the care. All other hospitals which admitted and subsequently transferred the patient to another hospital during a single spell of illness shall be considered transferring hospitals.
- b. If the transferring or discharge hospital or unit is exempt from the PPS, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or unit.

State: Oklahoma
Date Received: June 16, 2016
Date Approved: <b>AUG 04 2016</b>
Date Effective: April 1, 2016
Transmittal Number: 16-18

Revised 04-01-16

TN# 16-18  
Supersedes  
TN# 15-05

Approval Date **AUG 04 2016**

Effective Date 4-1-2016