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State/Territory Name: Okalhoma

State Plan Amendment (SPA) #: 16-0021

This file contains the following documents in the order listed:

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

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

FEB 14 2017

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

RE: Oklahoma 16-21

Dear Ms. Pasternik-Ikard:

Enclosed is a copy of approved Oklahoma State Plan Amendment (SPA) No. 16-21 with an effective date of May 1, 2016. This amendment was submitted to implement a 15 percent rate reduction for inpatient psychiatric hospital services for individuals under age 21. The three affected settings are private psychiatric hospitals, general hospitals with psychiatric units, and Psychiatric Residential Treatment Facilities.

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 (the Act) and the implementing Federal regulations at 42 CFR 447 Subpart C.

Because the proposed SPA would reduce or restructure provider payment rates, Oklahoma is required to provide documentation in support of its determination that the payments are consistent with efficiency, economy and quality of care and sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that these services are available to the general population, as established in Section 1902(a)(30)(A) of the Act and codified in 42 CFR 447.203(b)(6) and 42 CFR 447.204. To demonstrate compliance with these requirements, the state submitted the following to the Centers for Medicare & Medicaid Services (CMS) with the proposed SPA:

1. With respect to the public process requirements at 42 CFR 447.204(a)(2), Oklahoma provided documentation to show that the state considered input from beneficiaries, providers and other affected stakeholders on beneficiary access to the affected services, and the impact of the proposed rate change. Specifically, the state posted a notification of the proposed rate reduction on the Oklahoma Health Care Authority (OHCA) website on March 29, 2016. A stakeholder meeting was conducted on March 21, 2016 with providers, advocates, and

beneficiaries, and a Rates and Standards hearing open to the public regarding the proposed rate change was conducted at OHCA on April 25, 2016. Additionally, the proposed rate change was presented to the OHCA Board of Directors for approval at an open board meeting on April 28, 2016. The state reported it received two comments which were addressed by ensuring the State would monitor provider contracting, whether any providers were lost because of this reduction, and if access to care was affected as a result.

2. With respect to the access review requirements at 42 CFR 447.204(b), Oklahoma relied on an analysis that included an assessment of the available provider network, number of members with a paid claim in the past calendar year, utilization of services over time, and an analysis of the information and concerns expressed through stakeholder input. The state concluded that the data reflected adequate access to psychiatric inpatient hospital services for individuals under 21.

3. The state established procedures and thresholds to monitor continued access to care after implementation of these rate reductions, consistent with 42 CFR 447.203(b)(6). The Finance Division will report to the Board any fluctuations in payments on a monthly basis. 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 periodically makes site visits for the purposes of recruitment and education which allow OHCA to identify potential access issues and initiate interventions where appropriate.

4. The state also demonstrated that it has ongoing mechanisms for beneficiary and provider input on access to care. The Medicaid agency has two toll-free statewide member telephone numbers which allow beneficiaries to raise access issues as needed and to assist providers with resolution of claims, policy issues, and other concerns. The state monitors calls regarding access to care beneficiaries and advocates to determine if there is an access issue so that the proper interventions can be taken to improve access.

CMS is approving this SPA as the state has reasonably substantiated its conclusion that access for these services is sufficient through a process consistent with the requirements of 42 CFR 447.203 and conducted the public process and notice described in 42 CFR 447.204 and 42 CFR 447.205. Consistent with the aforementioned regulations, the state has committed to monitoring access and CMS will be periodically contacting the state to understand how the state's monitoring activities are progressing. If access deficiencies are identified, the state will submit a corrective action plan within 90 days of identification.

This letter affirms that the Oklahoma Medicaid State plan amendment 16-21 is approved effective May 1, 2016 as requested by the state.

We are enclosing the CMS-179 and the amended plan pages.

- Attachment 4.19-A, Page 33
- Attachment 4.19-A, Page 35

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: 16-21
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: May 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
Social Security Act § 1902(a)(30)(A)

7. FEDERAL BUDGET IMPACT
a. FFY 2016 ($4,094,451)
b. FFY 2017 ($8,188,902)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, Page 33; and
Attachment 4.19-A, Page 35

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A, Page 33, TN# 15-04; and
Attachment 4.19-A, Page 35, TN# 15-04

10. SUBJECT OF AMENDMENT
Rate Methodology Change/Budget Reduction for PRTFs and IMDs

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 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-Jun-16

18. DATE APPROVED
FEB 14 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
01-May-16

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
Kristin Fan

22. TITLE
Director, FMCo

23. REMARKS
c: Becky Pasternik-Ikard
Tywanda Cox

FORM CMS-179 (07/92)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

16. Inpatient Psychiatric Facility Services for individuals under age 21

16.a. Acute Level of Care

Private and Government hospitals will be paid in accordance with the methodologies described in Attachment 4.19-A of this plan.

16.b. Residential Level of Care

(A) General

Except as otherwise noted in the plan, all Medicaid services furnished to individuals receiving residential services in Institutions for Mental Disease (IMDs) are considered all-inclusive of the service, i.e., all medical services provided to residents of IMDs with more than 16 beds should be billed to the IMD.

(B) Payment to Government Providers

State-Owned psychiatric hospitals are 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 (IMDs) 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.

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 (IMDs) 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 base rate also includes the following when included in the plan of care:

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

State: Oklahoma
Date Received: June 24, 2016
Date Approved: FEB 14 2017
Date Effective: May 1, 2016
Transmittal Number: 16-21

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

16. Inpatient Psychiatric Facility Services for individuals under age 21 (cont'd)
16.b. Residential Level of Care (cont'd)

(D) Payment to Private, in-state PRTFs with 17 beds or more (IMDs)

i. **Base Rate.**
A prospective per diem payment is made based on facility peer group for a comprehensive package of services and room and board.

ii. The base rate is inclusive of other medically necessary services when included in the plan of care. Refer to paragraph (C)- ii for a description of these services. Refer to paragraph (C)-iii-IV for add-on services, and 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 (IMDs).

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

The service requirements for PRTFs with 16 beds or less are less intense. Individuals in PRTFs with 17 beds or more must receive 14 hours of documented active treatment services each week; the requirement for individuals in PRTFs with 16 beds or less is 10 hours per week.

(E) 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 room and board.

ii. **Physician and Other Ancillary Services**
All other medical services are separately billable. Payment is made in accordance with the applicable State plan payment methodologies and fees.

The service requirements for PRTFs with 16 beds or less are less intense. Individuals in PRTFs with 17 beds or more must receive 14 hours of documented active treatment services each week; the requirement for individuals in PRTFs with 16 beds or less is 10 hours per week.

(F) Payment for Out–of-State Services
Reimbursement for out-of-state placements 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, 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.

State developed fee schedule rates are the same for both public and private providers. The fee schedule(s) and any annualized/periodic adjustments to the fee schedule are published on the agency website.