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State/Territory Name: Okalhoma

State Plan Amendment (SPA) #: 16-0029

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

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 16-29

Dear Ms. Pasternik-Ikard:

We have reviewed the proposed State plan amendment (SPA) to Attachment 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 16-29. This amendment proposes to revise the methodology for supplemental payments for hospitals participating in the supplemental hospital offset payment program (SHOPP).

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 16-29 is approved effective January 1, 2017. 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: 16-29

2. STATE: Oklahoma

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAI[

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

4. PROPOSED EFFECTIVE DATE: January 1, 2017

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 433.68

7. FEDERAL BUDGET IMPACT
a. FFY 2017 $ (15,620,584)
b. FFY 2018 $ (20,351,409)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-A, Page 32.3
Attachment 4.19-A, Page 32.4
Attachment 4.19-A, Page 32.5
Attachment 4.19-B, Page 1c
Attachment 4.19-B, Page 1d

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 4.19-A, Page 32.3, TN# 11-04
Attachment 4.19-A, Page 32.4, TN# 11-04
Attachment 4.19-A, Page 32.5, TN# 11-04
Attachment 4.19-B, Page 1c, TN# 11-04
Attachment 4.19-B, Page 1d, TN# 11-04

10. SUBJECT OF AMENDMENT

Update Supplemental Hospital Offset Payment Program state plan pages

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: November 30, 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: 30-Nov-16

18. DATE APPROVED: FEB 14 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 01-Jan-17

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)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

X. SUPPLEMENTAL PAYMENTS FOR HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP)

1. Supplemental Payment Pools

The components of the Medicare Inpatient Prospective Payment System (PPS) were used to reasonably estimate what Medicare would pay for Medicaid DRG reimbursed inpatient hospital services. The DRG upper payment limit (UPL) methodology consists of determining a Case Mix Adjusted Medicare DRG base rate, computing a Medicare pass-through payment per discharge, calculating Medicaid costs for hospitals not paid on a DRG basis, and then calculating the overall aggregate UPL for each of the three classes of hospitals.

a. Case Mix Adjusted Medicare DRG Base Rate

The Case Mix Adjusted Medicare DRG base rate is computed using Medicare hospital base rate amounts and relative weights to determine a Medicare base payment per Medicaid claim. Oklahoma Medicaid inpatient hospital claims paid in the previous state fiscal year were extracted from the OHCA MMIS claims processing system. The Oklahoma Medicaid DRG relative weights from the extracted claims were replaced with Medicare Hospital PPS Final Relative Weights for the applicable dates of service. DRG codes newborn claims (Oklahoma Medicaid Newborn DRG codes N01 thru N80) were manually mapped to the Medicare newborn DRG codes (MS-DRG codes 789 thru 795) based on the OHCA Newborn Logic flowchart. After replacing the Medicaid relative weights with the Medicare weights, a hospital specific case mix index (CMI) is computed by summing the Medicare weights for each hospital then dividing the sum of the weights by the number of claims for each hospital. The CMI for each hospital is then multiplied by the hospital's Medicare base rate from the Medicare Hospital PPS Final Rates and Weights for the applicable federal fiscal year to derive a Case Mix Adjusted Medicare DRG Base Rate.

b. Medicare Pass-Through Payments

In addition to the base DRG payment, the Medicare inpatient PPS includes pass-through payments. Medicare pass-through payments include outliers, capital adjustments, GME, IME, DSH (including uncompensated care DSH), routine and ancillary services pass-through, reimbursable bad debt and organ acquisition cost. The Medicare pass-through payments are identified on the Medicare hospital cost report form 2552, Worksheet E, Part A. Payments are trended a single year using the CMS published Inpatient Hospital PPS Market Basket Update for the applicable year. In order to calculate the hospital specific pass-through payment per discharge, all pass-through payments are summed and divided by the Medicare discharges from Worksheet S-3.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

X. SUPPLEMENTAL PAYMENTS FOR HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP) (continued)

c. Non-DRG hospitals

The UPL for Non-DRG reimbursed hospitals are calculated using inpatient hospital specific cost to charge ratios. To determine the ratios, inpatient hospital costs and charges are extracted from the most recently available Medicare hospital cost report form 2552 Worksheet C. This cost to charge ratio is multiplied by allowable charges for Medicaid inpatient hospital claims to determine the cost of these services. Costs for these services are trended to the mid-point of the applicable year using the CMS published Inpatient Hospital PPS Market Basket Update for each year.

d. Upper Payment Limit Gaps

Payments calculated in paragraphs a, b and c shall be summed across the three classes of hospitals: privately owned, non-state government owned, and state government owned. These sums will equal the upper payment limits for each class of hospital. Total Medicaid payments for each class of hospital will be subtracted from its respective upper payment limit to determine the upper payment limit gaps.

2. Disbursement of payments to hospitals:

a. All hospitals shall be eligible for inpatient hospital access payments each year as set forth in this subsection except the following:

i. A hospital that is owned or operated by the state or a state agency, the federal governments, a federally recognized Indian tribe, or the Indian Health Service;
ii. a hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA;
iii. a hospital that specializes in any one of the following: (i) treatment of a neurological injury (ii) treatment of cancer, (iii) treatment of cardiovascular disease, (iv) obstetrical or childbirth services, (v) surgical care, except that this exemption shall not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority of inpatient days are for back, neck, or spine surgery; and
iv. a hospital that is certified by the federal Centers for Medicaid and Medicare Services as a long-term acute care hospital or as a children's hospital;

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

X. SUPPLEMENTAL PAYMENTS FOR HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP) (continued)

b. In addition to any other funds paid to critical access hospitals for inpatient hospital services to Medicaid patients, each critical access hospital (CAH) shall receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services, as determined by using a CCR as described in paragraph 1(c) This cost to charge ratio is multiplied by allowable charges to determine the cost of these services. Costs for these services are trended to the mid-point of the applicable year using the CMS published Inpatient Hospital PPS Market Basket Update for each year.

c. In addition to any other funds paid to hospitals for inpatient hospital services to Medicaid patients, each eligible hospital shall receive inpatient hospital access payments each year equal to the hospitals pro rata share of the inpatient supplemental payment pool available to the hospital's class of hospitals, as reduced by the payments distributed in paragraph 2(b). The pro rata share will be based upon the hospital's Medicaid payments for inpatient services divided by the total Medicaid payments for inpatient services of all eligible hospitals within each class of hospital.

d. The inpatient supplemental payment pool available to each class of hospitals will be determined by multiplying the class's upper payment limit gap, as determined under X.1.d. above, by the available funds ratio. The available funds ratio is determined by dividing the total of all funds available under the Supplemental Hospital Offset Payment Program, less the CAH supplemental payments described in Attachment 4.19-A Page 32.5, X 2(b) and Attachment 4.19-B Page 1d, H 2(b), by the total of the inpatient and outpatient upper payment limit gaps for all classes of hospital eligible for supplemental payments under this paragraph.

3. Frequency of Payments

The OHCA will pay from the Supplemental Hospital Offset Payment Program Fund quarterly installment payments to hospitals, not to exceed the UPL, of amounts available for supplemental payments for Critical Access Hospitals and supplemental inpatient payments.

State: Oklahoma
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Revised 01.01.17

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES OTHER TYPES OF CARE OUTPATIENT HOSPITAL SERVICES

I. SUPPLEMENTAL PAYMENTS FOR OUTPATIENT HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP)

1. Hospital Outpatient Supplemental Payment Pools

Components of the Medicare Cost Report form 2552 were used to reasonably estimate what Medicare would pay for Medicaid outpatient hospital services. The upper payment limit (UPL) methodology consists of determining a hospital specific Medicare outpatient cost to charge ratio, applying that to Medicaid charges and then calculating the overall aggregate UPL for each of the three classes of hospitals.

a. Cost to Charge Ratios

The UPL was calculated using outpatient hospital specific cost to charge ratios. To determine the ratios, ancillary outpatient hospital costs were extracted from the most recently available Medicare hospital cost report form 2552 Worksheet Cless applicable RHC charges.

b. Upper Payment Limit Gaps

The hospital specific cost to charge ratio in 1(a) shall be applied to hospital specific total outpatient hospital Medicaid charges. Costs for these services are trended to the mid-point of the applicable year using the CMS published Outpatient Hospital PPS Market Basket Update for each year. That amount calculated shall be separately summed across the three classes of hospitals: privately owned, non-state government owned, and state government owned. These sums will equal the upper payment limits for each class of hospitals. Total Medicaid payments for each class of hospitals will be subtracted from its respective upper payment limit to determine the upper payment limit gaps.

2. Disbursement of payments to hospitals:

a. All hospitals shall be eligible for outpatient hospital access payments each year as set forth in this subsection except the following:
   i. A hospital that is owned or operated by the state or a state agency, the federal governments, a federally recognized Indian tribe, or the Indian Health Service;
   ii. a hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA;

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE OUTPATIENT HOSPITAL SERVICES

I. SUPPLEMENTAL PAYMENTS FOR OUTPATIENT HOSPITALS PARTICIPATING IN THE SUPPLEMENTAL HOSPITAL OFFSET PAYMENT PROGRAM (SHOPP) (continued)

iii. a hospital that specializes in any one of the following: (i) treatment of a neurological injury (ii) treatment of cancer, (iii) treatment of cardiovascular disease, (iv) obstetrical or childbirth services, (v) surgical care, except that this exemption shall not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority of inpatient days are for back, neck, or spine surgery; and

iv. a hospital that is certified by the federal Centers for Medicaid and Medicare Services as a long-term acute care hospital or as a children's hospital;

b. In addition to any other funds paid to critical access hospitals for outpatient hospital services to Medicaid patients, each critical access hospital (CAH) shall receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services, as determined using the CCR as described in paragraph 1(a). This cost to charge ratio is multiplied by allowable charges to determine the cost of these services. Costs for these services are trended to the mid-point of the applicable year using the CMS published Outpatient Hospital PPS Market Basket Update for each year.

c. In addition to any other funds paid to hospitals for outpatient hospital services to Medicaid patients, each eligible hospital shall receive outpatient hospital access payments each year equal to the hospital's pro rata share of the outpatient supplemental payment pool available to the hospital's class of hospitals, less the payments distributed in paragraph 3(b), based upon the hospital's Medicaid payments for outpatient services divided by the total Medicaid payments for outpatient services of all eligible hospitals within each class of hospital.

d. The outpatient supplemental payment pool available to each class of hospitals will be determined by multiplying the class's upper payment limit gap, as determined under H.1.b. above, by the available funds ratio. The available funds ratio is determined by dividing the total of all funds available under the Supplemental Hospital Offset Payment Program, less the CAH supplemental payments described in Attachment 4.19-A Page 32.5, X 2(b) and Attachment 4.19-B Page 1d, H 2(b), by the total of the inpatient and outpatient upper payment limit gaps for all classes of hospital eligible for supplemental payments under this paragraph.