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State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 23-0008

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Financial Management Group

October 24, 2023

Traylor Rains, Director
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

RE: Oklahoma State Plan Amendment (SPA) 23-0008

Dear Director Rains:

We have reviewed the proposed amendment to Attachment 4.19-A and 4.19-B of your Medicaid state plan submitted under transmittal number (TN) 23-0008 effective for services on or after September 1, 2023. The proposed amendment appropriately identifies the Health Care Acquired Conditions for inpatient settings and Other Provider-Preventable Conditions for any health care setting and describes how reimbursement is amended to deny payments for these conditions.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act. We hereby inform you that Medicaid State plan amendment 23-0008 is approved effective September 1, 2023. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Diana Dinh at Diana.Dinh@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

Enclosure

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: 23-0008

2. STATE: OK

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447, 434, 438, and 1902(a)(4) and 1903

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 24 $ 0.00
b. FFY 25 $ 0.00

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Refer to attachment for full list of pages modified

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Refer to attachment for full list of pages modified

9. SUBJECT OF AMENDMENT
Amendment to add provisions to comply with the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

10. 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's office does not review state plan material.

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Traylor Rains

13. TITLE
State Medicaid Director

14. DATE SUBMITTED
09/06/2023

15. RETURN TO
Oklahoma Health Care Authority
Attn: Traylor Rains
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

cc: Kasie McCarty; Heather Cox

FOR CMS USE ONLY

16. DATE RECEIVED
September 6, 2023

17. DATE APPROVED
October 24, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
September 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

Instructions on Back

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A, Page 2	Attachment 4.19-A, Page 2; TN# 10-03
Supplement to Attachment 4.19-A, Page 1	Supplement to Attachment 4.19-A, Page 1; NEW
Attachment 4.19-B, Page 1	Attachment 4.19-B, Page 1; #18-026
Attachment 4.19-B, Page 3	Attachment 4.19-B, Page 3; #23-0011
Attachment 4.19-B, Page 20a	Attachment 4.19-B, Page 20a; #18-026
Attachment 4.19-B, Page 21	Attachment 4.19-B, Page 21; #18-026
Supplement to Attachment 4.19-B, Page 1	Supplement to Attachment 4.19-B, Page 1; NEW

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

II. GENERAL REIMBURSEMENT POLICY *(continued)*

F. Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rate will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by Medicaid recipients and the provider will not accept the payment rate established under Section V of this plan. Prior Authorization is required.

G. New providers entering the Medicaid program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG PPS payment method of the statewide median rate for per diem methods.

H. All hospitals which meet the criteria in Section VI of this plan will be eligible for graduate medical education payments.

I. All hospitals which meet the criteria in Section VIII of this plan will be eligible for a disproportionate share adjustment.

J. Medical assistance will not be paid for Provider-Preventable Conditions (PPCs) as described on Supplement 1 to Attachment 4.19-A.

III. PAYMENT METHODOLOGY FOR FREESTANDING REHABILITATION, AND FREESTANDING PSYCHIATRIC HOSPITALS

Effective October 1, 2005, reimbursement to freestanding rehabilitation and psychiatric hospitals for inpatient hospital services is paid on a prospective per diem level of care payment system. There are two distinct payment components under this system. Total per diem reimbursement will equal the sum of:

Level of care operating per diem
+
Fixed capital per diem

A. Level of Care Operating Per Diem Rates

1.The level of care per diem rates are payments for allowable operating costs and movable capital costs as defined in HCFA publications 15-1 for Medicare cost reporting purposes and reported on the HCFA 2552. No return on equity is included in the per diem rate. There are eight levels of care. For each level of care category, the payment rate was established based on the statewide rate in effect on September 30, 2005, for providing services within that level of care.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

Payment Adjustment for Provider-Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19-A

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Outpatient Hospital Reimbursement

General

These provisions apply to all hospitals approved for participation in the Oklahoma SoonerCare program. In no case can reimbursement for outpatient hospital services exceed the upper payment limits as defined under 42 CFR 447.321. Laboratory services will not exceed maximum levels established by Medicare. Clinical diagnostic lab services (not laboratory services) do not exceed the maximum levels.

Medical assistance will not be paid for Provider-Preventable Conditions (PPCs) as described on Supplement 2 to Attachment 4.19-B.

A. Emergency Room Services

Payment will be made based on Medicare APC groups for Type A and Type B Emergency Departments.

B. Outpatient Surgery

1. Payment will be made for certain outpatient surgical procedures provided in hospitals based on the Medicare Ambulatory Surgery Center (ASC) facility services payment system unless otherwise denoted in this section. The surgical procedures are classified into payment groups based on Current Procedural Terminology (CPT). All procedures within the same payment group are paid at a single payment rate. For purposes of specifying the services covered by the facility rate, the OHCA hereby adopts and incorporates herein by reference the Medicare ASC procedures.

1a. Effective on or after January 1, 2018, certain outpatient surgical services provided in an outpatient hospital are reimbursed on a cost basis. Dental and Level 4 ear, nose, and throat (ENT) surgical procedures are classified into a payment group based on CPT codes. A facility specific outpatient cost to charge ratio (CCR) from the hospital Medicare cost report is used to determine average cost per unit by facility, then in total. Each individual procedure code for the dental (D9999) and Level 4 ENT (various codes) will be paid the same cost based single rate set based on statewide hospital costs. These rates will be recalculated annually using the most recent available cost report data from HCRIS.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment for physicians' services (includes medical and remedial care and services)

Payment for physician's services, radiology services and services rendered by other practitioners under the scope of their practice under State law, are covered under the Agency fee schedule. The payment amount for each service paid for under the fee schedule is the product of a uniform relative value unit (RVU) for each service and the Medicare conversion factor (CF). The Medicare CF converts the relative values into payment amounts. The general formula for calculating the fee schedule can be expressed as:

RVU x CF = Rate

EPSDT screenings and eye exams by optometrists have been incorporated into the fee schedule.

Medical assistance will not be paid for Provider-Preventable Conditions (PPCs) as described on Supplement 2 to Attachment 4.19-B.

Vaccines are paid the equivalent to the Medicare Part B allowed charge. When the Medicare Part B allowed charge is not available, an equivalent price is calculated using Wholesale Acquisition Cost (WAC). If no Medicare or WAC pricing is available, then the price will be calculated based on invoice cost. No payment will be made to physicians or other practitioners for vaccines that were received through the Vaccine for Children's program.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Anesthesiologists *(continued)*

Time (in Minutes)	Unit(s) Billed
1-15	1.0
16-30	2.0
31-45	3.0
46-60	4.0
61-75	5.0
76-90	6.0
91-105	7.0
106-120	8.0
Etc.	

Effective January 1, 2008, Anesthesia Healthcare Common Procedure Coding System (HCPC) modifiers must be reported for each anesthesia service billed and will determine the rate of reimbursement to each provider for anesthesia services. The modifiers are as follows:

2014 Published HCPC Modifier	Description	Payment Rate
AA	Anesthesia services performed personally by Anesthesiologist.	100%
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	Current Flat Rate; no time units
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	50%
QX	CRNA or AA service: with medical direction by a physician	50%
QY	Anesthesiologist medically directs one CRNA or AA	50%
QZ	CRNA or AA services	80%

Certified Registered Nurse Anesthetists (CRNA)

Modifiers must be reported for each anesthesia service billed and will determine the rate of reimbursement to each provider for anesthesia services. Payment is made to CRNAs at a rate of 80 percent of the allowable for physicians for anesthesia services without medical direction and at a rate of 50 percent of the allowable when medically directed.

Anesthesiologist Assistants

Modifiers must be reported for each anesthesia service billed and will determine the rate of reimbursement to each provider for anesthesia services. Payment is made to Anesthesiologist Assistants at a rate of 80 percent of the allowable for physicians for anesthesia services without medical direction and at a rate of 50 percent of the allowable when medically directed.

Medical assistance will not be paid for Provider-Preventable Conditions (PPCs) as described on Supplement 2 to Attachment 4.19-B.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Physician Assistants

Payment is made to physician assistants at 20 percent of the surgery allowable for physicians when service is assisting a surgeon at surgery.

All other services are reimbursed at 100 percent of the physician allowable.

Medical assistance will not be paid for Provider-Preventable Conditions (PPCs) as described on Supplement 2 to Attachment 4.19-B.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment Adjustment for Provider-Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-B

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan: