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STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

Agenda
SPARC
June 24, 2014
1:00 pm
Board Room

Rate issues to be addressed:

- Blood Glucose Supplies; a durable medical equipment (DME) product
- Reduce Medicare physician and other Part B crossover co-insurance claims
- Provider rate reduction in the amount of 7.75%
- Long Term Care Reimbursement

State Plan Amendment Rate Committee (SPARC)
June 24, 2014
Blood Glucose Supplies

1. **Is this a "Rate Change" or a "Method Change"?**
   Methodology Change

1b. **Is this change an increase, decrease, or no impact?**
   Decrease

2. **Presentation of issue – Why is change being made?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for blood glucose supplies. Our current State Plan requires OHCA to follow Medicare's rates / methodology. Medicare went to a competitive bid rate July 1, 2013. OHCA could elect to change the State Plan to no longer follow Medicare's methodology however this change also coincides with a time that OHCA has a budget shortfall and changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates:

   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

3. **Current methodology and/or rate structure.**
   Currently, OHCA pays 60% of the 2010 Medicare rate; the rate is $19.96 for over the counter and $16.97 for mail order. With 91% of supplies being provided over the counter and 9% being provided through mail order the average rate is $19.69.

4. **New methodology or rate.**
   July 1, 2013 Medicare implemented a competitive bid rate of $10.41. OHCA seeks to implement this rate.

5. **Budget estimate.**
   The estimated annual change is a decrease in the amount of $797,964; $297,401 state share.

6. **Agency estimated impact on access to care.**
   A reduction of the per unit blood glucose supply rate should not negatively impact access and quality of care to SoonerCare members.

7. **Rate or Method change in the form of a motion.**
   The agency requests the State Plan Amendment Rate Committee to approve reducing payment for blood glucose supplies to the competitive bid national rate of $10.41 per unit.

8. **Effective date of change.**
   July 1, 2014

State Plan Amendment Rate Committee (SPARC)
June 24, 2014
Physician and Other Medicare Part B Crossovers Co-Insurance Claims

1. **Is this a "Rate Change" or a "Method Change"?**
   Methodology change

1b. **Is this change an increase, decrease, or no impact?**
   Decrease

2. **Presentation of issue – Why is change being made?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for physician and other Part B crossover claims. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution , which prohibits a state agency from spending more money than is allocated.

   Federal Requirements
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

3. **Current methodology and/or rate structure.**
   Currently physician and other Medicare Part B crossover claims are reimbursed 100% of the deductible and co-insurance amounts.

4. **New methodology or rate.**
   Federal regulations require State's payments for crossover claims, when combined with Medicare's payment, to at least equal the Medicaid allowed amount. Currently the Medicaid allowed amount is 96.75% of Medicare; that would translate to a payment of 83.75% of the co-insurance amount. Since OHCA plans to reduce payments further to 89.25% of Medicare (an additional 7.75%) the cumulative effect would be a payment of 46.25% of Medicare co-insurance amount. We do not seek to make any changes in the deductible amount; OHCA will continue to pay 100% of the deductible.

Examples of co-insurance payments based on the % of Medicare			
Percent of Medicare	**100%**	**96.75%**	**89.25%**
Allowed Amount	100	100	100
Medicare Pays	80	80	80
Co-insurance	20	20	20
OHCA Pays	20	16.75	9.25
% of co-insurance	100%	83.75%	46.25%

5. **Budget estimate.**
   The estimated annual change is a decrease in the amount of $29,693,982; $11,194,631 state share.

6. **Agency estimated impact on access to care.**
   A reduction in payment of the co-insurance amount should not negatively impact access and quality of care to SoonerCare members.

7. **Rate or Method change in the form of a motion.**
   The agency requests the State Plan Amendment Rate Committee to approve a rate change for physician and other part B crossover claims from 100% to 46.25% of co-insurance amount.

8. **Effective date of change.**
   July 1, 2014

State Plan Amendment Rate Committee (SPARC)
June 24, 2014
Providers 7.75% Rate Reduction

1. **Is this a "Rate Change" or a "Method Change"?**
   Rate change

1b. **Is this change an increase, decrease, or no impact?**
   Decrease

2. **Presentation of issue – Why is change being made?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of a 7.75% reduction, to the current rates and reimbursement structure in the SoonerCare program. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

3. **Current methodology and/or rate structure.**
   Oklahoma currently reimburses under a variety of different rate structures; diagnostic related group (DRG), per diem, max fee, percent of Medicare and a percent of costs are some examples. Our current rates reflect a 3.25% reduction from the applicable rate structure; this was implemented in 2010.

4. **New methodology or rate.**
   We seek to decrease the current rates by 7.75%; an effective rate of 89.25% of the applicable rate structure.

   The proposed rate reduction excludes services financed through appropriations to other state agencies, services provided under a waiver and services where a reduction could severely limit access or not cover costs (in the aggregate). Below are examples of the exclusions. While the list below is fairly comprehensive it is not exhaustive.

- Capitation / Care Coordination payments and incentive payments
- Child abuse exams
- Emergency and non-emergency transportation
- Insure Oklahoma
- Long term care facilities
- Payments for drug ingredients / physician supplied drugs
- Private duty nursing
- Services provided under a waiver
- Services paid for by other state agencies, excluding school based services
- Services provided to Native Americans through Indian Health Services / Indian/Tribal/Urban Clinics

5. **Budget estimate.**
The estimated annual change is a decrease in the amount of $128,916,969; $48,047,354 state share.

6. **Agency estimated impact on access to care.**
A 7.75% decrease to the rates should not negatively impact access and quality of care to SoonerCare members.

7. **Rate or Method change in the form of a motion.**
The agency requests the State Plan Amendment Rate Committee to approve the 7.75% rate reduction for all providers excluding those providers/services that have an exception provision.

8. **Effective date of change.**
July 1, 2014

Examples of co-insurance payments based on the % of Medicare			
Percent of Medicare	**100%**	**96.75%**	**89.25%**
Allowed Amount	100	100	100
Medicare Pays	80	80	80
Co-insurance	20	20	20
OHCA Pays	20	16.75	9.25
% of co-insurance	100%	83.75%	46.25%

State Plan Amendment Rate Committee (SPARC)
June 24, 2014
Regular Nursing Facilities

1. **Is this a rate change or a method change?**
   Rate Change – The statewide average rate will remain the same ($143.52). Individual Nursing Facility rates are modified due to a change in the pool amount consisting of the Direct Care Cost Component and Other Cost Component.

1b. **Is this change an increase, decrease or no impact?**
   No Impact

2. **Presentation of Issue:**
   The change is made to reflect adherence to the State Plan methodology for reallocation of Direct Care Costs and changes to the Direct Care Cost Component Pool as a result in the decline in Medicaid days.

3. **Current Methodology/Rate Structure:**
   The current rate methodology calls for the establishment of a prospective rate which consists of the following four components:
   (A) A Base Rate Component defined as $107.24 per day.
   (B) A Focus on Excellence (FOE) Component defined by the points earned under this performance program as defined in the state plan. The bonus component paid may be from $1.00 to $5.00 per day based on points earned.
   (C) An Other Component which is defined as the per day amount derived from dividing 30% of the pool of funds available after meeting the needs of the Base and FOE Components by the total estimated Medicaid days for the rate period.
   (D) A Direct Care Component which is defined as the per day amount derived from allocating 70% of the pool of funds available after meeting the needs of the Base and FOE Components to the facilities. This component is determined separately and is different for each facility. The method (as approved in the State Plan) allocates the 70% pool funds to each facility (on a per day basis) based on their relative expenditures for direct care.

4. **Budget Estimate:**
   This has no impact on the budget.

5. **Estimated impact on access to care:**
   The agency does not anticipate this change will impact access to care.

6. **Requested changes:**

The agency requests an amendment to remove specific dollar pool amounts from the State Plan. If this request cannot be accomplished, the agency further request the pool amounts be revised as indicated below:

- ***Pool Amount*** – decrease the pool amount in the state plan for the "Other" and "Direct Care" Components from $162,205,189 to $158,391,182.

7. **Effective Date of Change:**
   July 1, 2014