JOEL NICO GOMEZ
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

SPARC Agenda
May 20, 2016
1:00 PM
OHCA Boardroom

Rate issues to be addressed:

25.00% ACROSS-THE-BOARD PROVIDER RATE REDUCTION

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of an up to 25.00% 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.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   OHCA currently reimburses providers 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, a 7.75% reduction and a 3.00% reduction from the applicable rate structures, implemented in April of 2010, July 2014, and January 2016.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
Effective June 1, 2016, OHCA seeks to decrease the current applicable rates by up to 25.00% of the applicable rate structure.

The proposed 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). Nursing Homes are included in the budget cuts, but are listed in a separate brief. While this list of exclusions is fairly comprehensive it is not exhaustive.

- Complex Rehabilitation Technology Products
- Child Abuse Exams
- Non-Emergency Transportation
- Insure Oklahoma
- Payments for drug ingredients/physician supplied drugs
- Services provided under a waiver
- Services paid for by other state agencies
- Services provided to Native Americans through Indian Health Services Indian/Tribal/Urban Clinics
- Private Duty Nursing

6. **BUDGET ESTIMATE.**
The estimated savings for SFY2017 will be a decrease in the total amount of up to $403,603,407; up to $160,634,156 state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
Given the uncertainty and potential range (0% to 25%) of any actual rate reduction, the Oklahoma Health Care Authority is unable at this time to determine the nature and extent of any possible impact to access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of potential rate reductions, the agency initiated discussions with contracted providers in or about January 2016 regarding the possibility of budget reductions due to declining state revenues. These proactive activities were conducted as an effort by the Oklahoma Health Care Authority to remain transparent throughout the process and to give contracted providers ample notice of any impending budget reductions.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the up to 25.00% rate reduction for all providers excluding those providers/services that have an exception provision.

9. **EFFECTIVE DATE OF CHANGE.**
   June 1, 2016

MEDICARE CROSSOVER CLAIMS REDUCTION

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Method Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision to the payment methodology to consider the Medicare paid amount as payment in full for all crossover claims, excluding pharmacy, physician administered drugs, as well as services provided by Indian/Tribal/Urban (ITU) Clinics. 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.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   OHCA current methodology pays 75% of deductible and 25% of coinsurance on crossover claims for hospital services.

   OHCA current methodology pays 20% of Medicare Part A and 75% for Medicare part B coinsurance and deductible on crossover claims to nursing homes.

   OHCA current methodology pays 100% of deductible and 46.25% of coinsurance for all other services.

This excludes pharmacy, physician administered drugs, as well as services provided by Indian/Tribal/Urban (ITU) providers, all of which deductible and coinsurance are paid at 100%.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
The proposed methodology is to consider the Medicare paid amount payment in full for all crossover claims, excluding pharmacy, physician administered drugs, as well as services provided by ITU providers.

6. **BUDGET ESTIMATE.**
The estimated savings for SFY2017 will be a decrease in the total amount of $84,761,623; $33,735,126 state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
Given the uncertainty and potential range (0% to 25%) of any actual rate reduction, the Oklahoma Health Care Authority is unable at this time to determine the nature and extent of any possible impact to access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of potential rate reductions, the agency initiated discussions with contracted providers in or about January 2016 regarding the possibility of budget reductions due to declining state revenues. These proactive activities were conducted as an effort by the Oklahoma Health Care Authority to remain transparent throughout the process and to give contracted providers ample notice of any impending budget reductions.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the method change to pay 0% of Coinsurance and Deductible of Medicare Crossover claims, excluding pharmacy, physician administered drugs, as well as services provided by ITU providers.

9. **EFFECTIVE DATE OF CHANGE.**
June 1, 2016

REGULAR NURSING FACILITIES RATE REDUCTION

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of up to a 25.00% reduction, to the Regular Nursing facilities provider rates. 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.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular Nursing facilities calls for the establishment of a prospective rate which consists of four components. The current components are as follows:
   A. Base Rate Component is $107.29 per patient day.
   B. A Focus on Excellence (FOE) Component defined by the points earned under this performance program range from $1.00 to $5.00 per patient day.
   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 of funds to each facility (on a per day basis) based on their relative expenditures for direct care.

The current combined pool amount for "Direct Care" and "Other Component" is $155,145,293.

The current Quality of Care (QOC) fee is $10.79 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
There is no change in methodology; however, there is a proposed rate change for Regular Nursing facilities as a result of the proposed decrease of up to 25.00% for Regular Nursing Facility provider rates by the Oklahoma Health Care Authority.

The proposed Base Rate Component will be no lower than $98.28 per patient day.

The proposed combined pool amount for "Direct Care" and "Other" Component will be no lower than $126,078,309.

The proposed Quality of Care (QOC) fee will be no lower than $10.10 per patient day.

6. **BUDGET ESTIMATE.**
The estimated savings for SFY2017 will be a decrease in the total amount of up to $87,273,327; with up to $34,734,784 in state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
Given the uncertainty and potential range (0% to 25%) of any actual rate reduction, the Oklahoma Health Care Authority is unable at this time to determine the nature and extent of any possible impact to access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of potential rate reductions, the agency initiated discussions with contracted providers in or about January 2016 regarding the possibility of budget reductions due to declining state revenues. These proactive activities were conducted as an

effort by the Oklahoma Health Care Authority to remain transparent throughout the process and to give contracted providers ample notice of any impending budget reductions.

8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular Nursing facilities:

- A decrease in the base rate component from $107.29 per patient day to no lower than $98.28 per patient day.
- A decrease in the total pool amount for the "Other" and "Direct Care" Components from $155,145,293 to no lower than $126,078,309 to account for the:
    - Recommended rate reduction of up to 25.00%
    - Annual reallocation of the Direct Care Cost Component per The State Plan.
- A decrease in the Quality of Care fee from $10.79 per patient day to no lower than $10.10 per patient day.

9. EFFECTIVE DATE OF CHANGE.

June 1, 2016

REGULAR (MORE THAN 16 BEDS) INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) RATE REDUCTION

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of up to a 25.00% reduction, to Regular ICF/IID facilities provider rates. 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.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**

The current rate methodology for Regular ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day. The current base rate for this provider type is $121.96 per patient day and the Quality of Care (QOC) fee is $7.25 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
There is no change in methodology; however, there is a rate change for Regular ICF/IID facilities as a result of the recommendation of up to a 25.00% reduction to provider rates and the annual recalculation of the Quality of Care (QOC) fee.

The proposed base rate for this provider type is no lower than $97.23 per patient day and the proposed Quality of Care (QOC) fee will be no lower than $6.05 per patient day.

6. **BUDGET ESTIMATE.**
The estimated savings for SFY2017 will be a decrease in the total amount of up to $4,495,200; with up to $1,789,090 in state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
Given the uncertainty and potential range (0% to 25%) of any actual rate reduction, the Oklahoma Health Care Authority is unable at this time to determine the nature and extent of any possible impact to access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of potential rate reductions, the agency initiated discussions with contracted providers in or about January 2016 regarding the possibility of budget reductions due to declining state revenues. These proactive activities were conducted as an effort by the Oklahoma Health Care Authority to remain transparent throughout the process and to give contracted providers ample notice of any impending budget reductions.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular ICF/IID facilities:
   - A decrease in the base rate component from $121.96 per patient day to no lower than $97.23 per patient day.
   - A decrease in the Quality of Care fee from $7.25 per patient day to no lower than $6.05 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
June 1, 2016

ACUTE (16 BEDS-OR-LESS) INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) RATE REDUCTION

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of up to a 25.00% reduction, to Acute ICF/IID facility provider rates. 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.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Acute ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day. The current base rate for this provider type is $156.19 per patient day and the Quality of Care (QOC) fee is $9.18 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
There is no change in methodology; however, there is a rate change for Acute ICF/IID facilities as a result of the recommendation of up to a 25.00% reduction in provider rates and the required annual recalculation and the Quality of Care (QOC) fee.

The proposed base rate for this provider type is no lower than $122.65 per patient day and the proposed Quality of Care (QOC) fee will be no lower than $7.39 per patient day.

6. **BUDGET ESTIMATE.**
The estimated savings for SFY2017 will be a decrease in the total amount of up to $8,185,542; with up to $3,257,846 in state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
Given the uncertainty and potential range (0% to 25%) of any actual rate reduction, the Oklahoma Health Care Authority is unable at this time to determine the nature and extent of any possible impact to access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of potential rate reductions, the agency initiated discussions with contracted providers in or about January 2016 regarding the possibility of budget reductions due to declining state revenues. These proactive activities were conducted as an effort by the Oklahoma Health Care Authority to remain transparent throughout the process and to give contracted providers ample notice of any impending budget reductions.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Acute ICF/IID facilities:
   - A decrease in the base rate component from $156.19 per patient day to no lower than $122.65 per patient day.
   - A decrease in the Quality of Care fee from $9.18 per patient day to no lower than $7.39 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
June 1, 2016

NURSING FACILITES SERVING RESIDENTS WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) RATE REDUCTION

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of up to a 25.00% reduction, to nursing facilities serving residents with AIDS rate. 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.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for nursing facilities serving residents with AIDS requires the establishment of a prospective rate which is based on the reported allowable cost per day. The current base rate for this provider type is $198.22 per patient day and the Quality of Care (QOC) fee is $10.79 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
There is no change in methodology; however, there is a rate change for nursing facilities serving residents with AIDS patients as a result of the recommendation of up to a 25.00% reduction to provider rates and the required annual recalculation of the Quality of Care (QOC) fee.

The proposed base rate for this provider type is no lower than $167.59 per patient day and the proposed Quality of Care (QOC) fee will be no lower than $10.10 per patient day.

6. **BUDGET ESTIMATE.**
The estimated savings for SFY2017 will be a decrease in the total amount of up to $229,505; with up to $91,343 in state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
Given the uncertainty and potential range (0% to 25%) of any actual rate reduction, the Oklahoma Health Care Authority is unable at this time to determine the nature and extent of any possible impact to access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of potential rate reductions, the agency initiated discussions with contracted providers in or about January 2016 regarding the possibility of budget reductions due to declining state revenues. These proactive activities were conducted as an effort by the Oklahoma Health Care Authority to remain transparent throughout the process and to give contracted providers ample notice of any impending budget reductions.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities serving residents with AIDS:
   - A decrease in the base rate component from $198.22 per patient day to no lower than $167.59 per patient day.
   - A decrease in the Quality of Care fee from $10.79 per patient day to no lower than $10.10 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
June 1, 2016

VENTILATOR ADD-ON FOR NURSING FACILITIES RATE REDUCTION

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of up to a 25.00% reduction, to the Ventilator Add-On for nursing facilities provider rates. The change is 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.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current Ventilator Add-On for nursing facilities rate is $135.43 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for the Ventilator Add-On for nursing facilities as a result of the recommendation of up to a 25.00% reduction to provider rates. The proposed rate will be no lower than $107.59 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated savings for SFY 2017 will be a decrease in the total amount of up to $1,580,035; with up to $628,854 in state funds.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   Given the uncertainty and potential range (0% to 25%) of any actual rate reduction, the Oklahoma Health Care Authority is unable at this time to determine the nature and extent of any possible impact to access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of potential rate reductions, the agency initiated discussions with contracted providers in or about January 2016 regarding the possibility of budget reductions due to declining state revenues. These proactive activities were conducted as an effort by the Oklahoma Health Care Authority to remain transparent throughout the process and to give contracted providers ample notice of any impending budget reductions.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve a decrease in the Ventilator Add-On rate for nursing facilities from $135.43 per patient day to no lower than $107.59 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   June 1, 2016