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STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

SPARC Agenda
December 28, 2017
11:00 AM
OHCA Board Room

Rate issues to be addressed:

1. Rescission of the 6.00% Across-the-Board Provider Rate Reduction
2. Rescission of the Nursing Home Medicare Part A and B Cross-Over Claims Reduction
3. Rescission of the 1.00% Regular Nursing Facilities Rate Reduction
4. Rescission of the 1.00% Regular (Greater than 16 Beds) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Rate Reduction
5. Rescission of the 1.00% Acute (16 Bed-or-Less) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Rate Reduction
6. Rescission of the 1.00% Acquired Immune Deficiency Syndrome (AIDS) Rate for Nursing Facilities Rate Reduction

RESCISSON OF THE 6.00% 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?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, a rescission of the 6.00% across-the-board rate reductions that were set to take effect on January 1, 2018, to the rates and reimbursement structure in the SoonerCare program.

   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, a 3.00% reduction, and a 6.00% reduction from the applicable rate structures, implemented in April of 2010, July 2014, January 2016, and January 2018.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   OHCA seeks to rescind the 6.00% rate reduction that was set to take effect on January 1, 2018. The reduction and proposed rescission 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). While this list is fairly comprehensive it is not exhaustive.

Exclusions:

- Complex Rehabilitation Technology Provider Services
- Long term care facilities
- 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
- Emergency Transportation
- FQHCs/RHCs
- Choice Care Coordination
- Programs of All-inclusive Care for the Elderly (PACE)

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY 2018 will be an increase in the total amount of $38,005,413; $15,745,643 state share.

7. AGENCY ESTIMATED IMPACT ON 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 accordance with requirements at 42 CFR 447.203(b)(6).

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 rescission of the 6.00% rate reduction for all providers excluding those providers/services that have an exception provision.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

RESCISSION OF THE NURSING FACILITIES MEDICARE PART A AND B 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?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, a rescission of the rate methodology to pay 0% for Medicare crossover claims to Nursing Facilities that was approved to take effect on January 1, 2018.

   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 SPARC and OHCA Board approved a rate method change that was to take effect on January 1, 2018, to pay 0% of Medicare Part A and B coinsurance and deductible to nursing facilities.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The OHCA is proposing a reinstatement, to pay 20% of Medicare Part A coinsurance and deductible, and 75% of Medicare Part B coinsurance and deductible on crossover claims to nursing facilities.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for the remainder of SFY2018 will be an increase in the total amount of $2,936,027; with $1,216,396 state share.

7. AGENCY ESTIMATED IMPACT ON 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 accordance with requirements at 42 CFR 447.203(b)(6).

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 20% of Coinsurance and Deductible of Medicare Part A, and 75% of Coinsurance and Deductible of Medicare Part B on crossover claims to nursing facilities.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

RESCISSION OF THE 1.00% 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?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, a rescission of the 1.00% rate reduction to Regular Nursing Facilities providers that was set to take effect on January 1, 2018.

   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 rate components are as follows:
   A. Base Rate Component was approved to be $107.73 per patient day.
   B. A Focus on Excellence (FOE) Component defined by the points earned under this performance program ranging from $1.00 to $5.00 per patient day.
   C. An “Other Cost” 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 Component by the total estimated Medicaid days for the rate period. This component once calculated is the same for each facility.
   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 costs.

The combined pool amount for "Direct Care" and "Other Cost" Component was approved to be $158,498,444.

The Quality of Care (QOC) fee was to be $11.23 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a rate change because of the rescission of the 1.00% rate reduction to Regular Nursing Facilities providers.

The reinstated Base Rate Component will be $107.79 per patient day.

The reinstated combined pool amount for "Direct Care" and "Other Cost" Components will be $160,636,876.

The reinstated Quality of Care (QOC) fee will be $11.29 per patient day.

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be an increase in the total amount of $2,222,772; with $913,337 in state share.

7. AGENCY ESTIMATED IMPACT ON 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 accordance with requirements at 42 CFR 447.203(b)(6).

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 reinstatement of the base rate component to $107.79 per patient day.
- A reinstatement of the combined pool amount for the "Other Cost" and "Direct Care" Components to $160,636,876.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

RESCISSION OF THE REGULAR 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?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, a rescission of the 1.00% rate reduction to Regular ICF/IID facilities provider rates that was set to take effect on January 1, 2018.

   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 rate for this provider type was approved to be $121.70 per patient day.

   The Quality of Care (QOC) fee was approved to be $7.51 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a proposed rate change because of the rescission of the 1.00% rate reduction to Regular ICF/IID providers.

The reinstated rate will be $122.77 per patient day.

The reinstated Quality of Care (QOC) fee will be $7.54 per patient day.

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be an increase in the total amount of $92,658; with $38,073 in state share.

7. AGENCY ESTIMATED IMPACT ON 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 accordance with requirements at 42 CFR 447.203(b)(6).

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 reinstatement of the rate to $122.77 per patient day.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

RESCISSION OF THE ACUTE (16 BED-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?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, a rescission of the 1.00% rate reduction to Acute ICF/IID providers that was set to take effect on January 1, 2018.

   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 rate for this provider type was approved to be $155.63 per patient day.

   The Quality of Care (QOC) fee was approved to be $9.46 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a proposed rate change because of rescission of the 1.00% rate reduction for Acute ICF/IID providers.

The reinstated rate will be $157.03 per patient day.

The reinstated Quality of Care (QOC) fee will be $9.50 per patient day.

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be an increase in the total amount of $164,572; with $67,623 in state share.

7. AGENCY ESTIMATED IMPACT ON 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 accordance with requirements at 42 CFR 447.203(b)(6).

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 reinstatement of the rate to $157.03 per patient day.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

RESCISSION OF THE ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) NURSING FACILITES RATE REDUCTION

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, a rescission of the 1.00% rate reduction to nursing facilities serving residents with AIDS that was set to take effect on January 1, 2018.

   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 rate for this provider type was approved to be $198.39 per patient day.

   The Quality of Care (QOC) fee was approved to be $11.23 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a rate change because of the rescission of the 1.00% rate reduction to nursing facilities serving residents with AIDS.

The reinstated rate will be $200.01 per patient day.

The reinstated Quality of Care (QOC) fee will be $11.29 per patient day.

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be an increase in the total amount of $6,574; with $ 2,701 in state share.

7. AGENCY ESTIMATED IMPACT ON 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 accordance with requirements at 42 CFR 447.203(b)(6).

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 reinstatement of the AIDS rate to $200.01 per patient day.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018