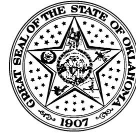
KEVIN S. CORBETT
CHIEF EXECUTIVE OFFICER



J. KEVIN STITT
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

September SPARC Agenda
September 16, 2019
1:00 PM
OHCA Board Room

Rate issues to be addressed:

1. Neonatal, Infant, and Young Child Rates
2. Diabetes Self-Management Training
3. Manual Pricing of Durable Medical Equipment
4. Regular Nursing Facility Rates
5. AIDS Rate for Nursing Facilities

Oklahoma Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

NEONATAL, INFANT, & YOUNG CHILD SERVICE RATES

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 is requesting to increase rates for Neonatal services.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Currently, Neonatal, Infant, and Young Child services are paid at 89.17% of the Medicare Physician Fee Schedule.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The proposed rate methodology is to pay certain Neonatal, Infant, and Young Child services at 100% of the Medicare Physician Fee Schedule. Neonatal, Infant, and Young Child services will be using an existing rate methodology that is used for physician services. The payment amount for each service paid 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 amount. CMS updates the RVU and CF annually. The current proposed rates are as follows:

CODE	DESCRIPTION	CURRENT RATE	OCTOBER 1, 2019 RATE
99238	HOSPITAL DISCHARGE DAY MANAGEMENT, 30 MINUTES OR LESS	$63.65	$71.38
99239	HOSPITAL DISCHARGE DAY MANAGEMENT, MORE THAN 30 MINUTES	$93.37	$104.71
99460	INITIAL HOSPITAL OR BIRTHING CENTER CARE, PER DAY, FOR EVALUATION AND MANAGEMENT OF NORMAL NEWBORN INFANT	$84.57	$94.84
99462	SUBSEQUENT HOSPITAL CARE, PER DAY, FOR EVALUATION AND MANAGEMENT OF NORMAL NEWBORN	$37.14	$41.65

99463	INITIAL HOSPITAL OR BIRTHING CENTER CARE, PER DAY, FOR EVALUATION AND MANAGEMENT OF NORMAL NEWBORN INFANT ADMITTED AND DISCHARGED ON THE SAME DATE	$97.37	$109.19
99464	ATTENDANCE AT DELIVERY (WHEN REQUESTED BY THE DELIVERING PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL) AND INITIAL STABILIZATION OF NEWBORN	$66.16	$74.19
99465	DELIVERY/BIRTHING ROOM RESUSCIATION, PROVISIONS OF POSITIVE PRESSURE VENTILATION AND/OR CHEST COMPRESSION IN THE PRESENCE OF ACUTE INADEQUATE VENTILATION AND/OR CARDIAC OUTPUT	$128.90	$144.56
99468	INITIAL INPATIENT HOSPITAL CRITICAL CARE OF NEWBORN, 28 DAYS OF AGE OR YOUNGER, PER DAY	$811.53	$910.08
99469	SUBSEQUENT INPATIENT HOSPITAL CRITICAL CARE OF NEWBORN, 28 DAYS OF AGE OR YOUNGER, PER DAY	$350.84	$393.45
99471	INITIAL INPATIENT HOSPITAL CRITICAL CARE OF INFANT OR YOUNG CHILD, 29 DAYS THROUGH 24 MONTHS OF AGE, PER DAY	$702.58	$787.90
99472	SUBSEQUENT INPATIENT HOSPITAL CRITICAL CARE OF INFANT OR YOUNG CHILD, 29 DAYS THROUGH 24 MONTHS OF AGE, PER DAY	$359.37	$403.01
99475	INITIAL INPATIENT HOSPITAL CRITICAL CARE OF INFANT OR YOUNG CHILD, 2 THROUGH 5 YEARS OF AGE, PER DAY	$494.40	$554.44
99476	SUBSEQUENT INPATIENT HOSPITAL CRITICAL CARE OF INFANT OR YOUNG CHILD, 2 THROUGH 5 YEARS OF AGE, PER DAY	$307.11	$344.40
99477	INITIAL INTENSIVE CARE OF NEWBORN, 28 DAYS OF AGE OR YOUNGER, PER DAY	$307.45	$344.79
99478	SUBSEQUENT INTENSIVE CARE OF RECOVERING LOW BIRTH WEIGHT INFANT, PER DAY	$120.81	$135.48

99479	SUBSEQUENT INTENSIVE CARE OF RECOVERING LOW BIRTH WEIGHT INFANT, PER DAY	$109.87	$123.21
99480	SUBSEQUENT INTENSIVE CARE OF RECOVERING LOW BIRTH WEIGHT INFANT, PER DAY	$105.21	$117.98

6. **BUDGET ESTIMATE.**
   The estimated budget impact for the remainder of SFY2020 will be an increase in the total amount of $536,318; with $187,121 in state share. The estimated budget impact for SFY2021 will be an increase in the total amount of $715,090; with $234,264 in state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

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 above rates for Neonatal, Infant, and Young Child services.

9. **EFFECTIVE DATE OF CHANGE.**
   October 1, 2019, contingent upon CMS approval.

DIABETES SELF-MANAGEMNT TRAINING (DSMT) RATES

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

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 is requesting the establishment of rates for Diabetes Self-Management Training (DSMT) services.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Currently, Diabetes Self-Management Training (DSMT) services are not covered.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   Diabetes Self-Management Training (DSMT) will be using an existing rate methodology that is used for physician services. The payment amount for each service paid 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 amount. CMS updates the RVU and CF annually. The current proposed rates are as follows:

Code	Description	January 1, 2020 Rate
G0108	DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES, INDIVIDUAL, PER 30 MINUTES	$50.30
G0109	DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES, GROUP SESSION (2 OR MORE), PER 30 MINUTES	$13.87

6. **BUDGET ESTIMATE.**
   The estimated budget impact for the remainder of SFY2020 will be an increase in the total amount of $109,107; with $37,074 in state share. The estimated budget impact for SFY2021 will be an increase in the total amount of $218,214; with $72,163 in state share.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.
The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

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 rates for Diabetes Self-Management Training (DSMT) services:

- Procedure Code G0108: $50.30/30 minutes
- Procedure Code G0109: $13.87/30 minutes

9. EFFECTIVE DATE OF CHANGE.
January 1, 2020, contingent upon CMS approval.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) FAIR MARKET VALUE RATES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   Changes to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are being made to change some procedure codes to a manual pricing method.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current methodology for DMEPOS Procedure Codes B4087, B4088, E0240, E0625, E1399, E2599, and K0108 is paid a percentage of the Medicare fee schedule or a Fair Market Value fee determined by the OHCA.

   Manual pricing is reasonable when one HCPCS code covers a broad range of items with a broad range of costs, since a single fee may not be a reasonable fee for all items covered under the HCPCS code, resulting in access-to-care issues. Examples include: 1) HCPCS codes with a description of not otherwise covered, unclassified, or other miscellaneous items; and 2) HCPCS codes covering customized items. Effective October 1, 2014, if manual pricing is used, the provider is reimbursed the documented Manufacturer's Suggested Retail Price (MSRP) less 30% or the provider's documented invoice cost plus 30%, whichever is less.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
The proposed methodology for the below DMEPOS Procedure Codes is to use a manual pricing method. The provider is reimbursed the documented Manufacturer's Suggested Retail Price (MSRP) less 30% or the provider's documented invoice cost plus 30%, whichever is less.

Procedure Code	Description
B4087	GASTROSTOMY/JEJUNOSTOMY TUBE, STANDARD, ANY MATERIAL, ANY TYPE, EACH
B4088	GASTROSTOMY/JEJUNOSTOMY TUBE, LOW-PROFILE, ANY MATERIAL, ANY TYPE, EACH
E0240	BATH/SHOWER CHAIR, WITH OR WITHOUT WHEELS, ANY SIZE
E0625	PATIENT LIFT, BATHROOM OR TOILET, NOT OTHERWISE CLASSIFIED
E1399	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS
E2599	ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED
K0108	WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED

6. **BUDGET ESTIMATE.**
The estimated budget impact for SFY2020 and SFY2021 is budget neutral.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

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 proposed methodology to reimburse providers the documented Manufacturer's Suggested Retail Price (MSRP) less 30% or the provider's documented invoice cost plus 30%, whichever is less for DMEPOS Procedure Codes B4087, B4088, E0240, E0625, E1399, E2599, and K0108.

9. **EFFECTIVE DATE OF CHANGE.**
October 1, 2019

REGULAR NURSING FACILITIES RATE

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 change is being made to implement Senate Bills 1044 and 280. Senate Bill 1044 mandates OHCA to increase Regular Nursing Facility rates by 5%, and Senate Bill 280 mandates OHCA to increase the average rate for nursing facilities to equal to the statewide average cost as derived from audited cost reports for SFY 2018, ending June 30 2018, after adjustment for inflation. Also, Senate Bill 280 directed OHCA to change the current Focus on Excellence (FOE) to a new quality assurance component; Pay For Performance (PFP) program. Under the new quality assurance program, payments can be earned quarterly based on facility specific performance achievement of four equally-weighted, Long-Stay Quality Measures as defined by the Centers for Medicare and Medicaid Services. Additionally, this change will increase the Quality of Care (QOC) fee, and the pool amount for “Direct Care” and “Other” Components of the rate.

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 $108.31 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 Components 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 current combined pool amount for “Direct Care” and “Other Cost” components is $186,146,037. The Quality of Care (QOC) fee is $11.81 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
There is a change in methodology; for the rate period beginning October 1, 2019, fifty percent (50%) of the resulting rate increase will be allocated toward an increase of the existing base reimbursement rate and distributed accordingly. $5 per patient will be reserved for the PFP component of the rate. The remaining fifty percent (50%) will be allocated in accordance with the currently approved 70/30 reimbursement rate methodology as outlined in the existing State Plan. Also, under the PFP program, payments will be earned quarterly based on facility specific performance achievement of four equally-weighted, Long-Stay Quality Measures as defined by the Centers for Medicare and Medicaid Services. Points earned under this performance program can be average of $5.00 per patient day. The new Base Rate Component will be $120.57 per patient day. The new combined pool amount for “Direct Care” and “Other Cost” components will be $220,482,316. The recalculated Quality of Care (QOC) fee will be $12.92 per patient day.

6. **BUDGET ESTIMATE.**
The estimated budget impact for the remainder of SFY2020 will be an increase in the total amount of $95,819,280; with $32,559,391 in state share ($4,400,309 of the state share is from QOC fees paid by providers). The estimated budget impact for SFY2021 will be an increase in the total amount of $127,759,040; with $43,412,522 in state share ($6,286,156 of the state share is from QOC fees paid by providers)

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The Oklahoma Health Care Authority anticipates a positive 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:

- An increase to the base rate component from $108.31 per patient day to $120.57 per patient day.
- A change to the combined pool amount for “Direct Care” and “Other Cost” Components from $186,146,037 to $220,482,316 for reallocation of the Direct Care Cost Component.
- For the data collection period beginning 10-01-2019, with a payment effective date of first quarter of 2020, change the assurance program measures and payment (Please see Attachment 1) to the following:
    - Payment points of $1.25 per patient day can be earned by achieving either five percent (5%) relative improvement each quarter from the baseline or by achieving or exceeding the National Average Benchmark for each of the following CMS measures:
    - percentage of long-stay, high-risk residents with pressure ulcers,
    - percentage of long-stay residents who lose too much weight,
    - percentage of long-stay residents with a urinary tract infection, and
    - percentage of long-stay residents who got an antipsychotic medication.

9. EFFECTIVE DATE OF CHANGE.

October 1, 2019, contingent upon CMS approval.

Attachment 1

Long Term Care Focus on Excellence Quality Measures Program
Focus on Excellence is comprised of nine quality metrics. The quality metrics focus on fairness in ratings and payment allocation, expansion of information to consumers, improvement in program accountability, and focusing on residents personal needs and desires in a home like atmosphere. The metrics are as follows:

- Person-Centered Care — Point Value 90
- Direct Care Staffing — Point Value 50
- Resident/Family Satisfaction — Point Value 80
- Employee Satisfaction — Point Value 50
- Licensed Nurse Retention — Point Value 65
- CNA Retention — Point Value 65
- Distance Learning — Point Value 35
- Peer Mentoring — Point Value 30
- Leadership Commitment — Point Value 35

- ***A FACILITY WHO SCORES A SCOPE AND SEVERITY TAG OF "I" OR GREATER IN ONE OF THE METRICS ABOVE WILL NOT BE ELIGIBLE TO PARTICIPATE IN THE PROGRAM REIMBURSEMENT FOR THE QUARTER THEY ARE OUT OF COMPLIANCE***

Payment is made quarterly with a reimbursement potential of $5.00 per Medicaid resident per day equal to $.0.1 per point.

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) NURSING FACILITES RATES

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 change is being made to increase the Quality of Care (QOC) Fee for nursing facilities serving residents with AIDS per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provides rate increases to the facilities.

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 rate for this provider type is $209.50 per patient day. The Quality of Care (QOC) fee is $11.81 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 as a result of recalculation of the Quality of Care (QOC) fee. The rate for this provider type will be $213.10 per patient day. The recalculated Quality of Care (QOC) fee will be $12.92 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for the remainder of SFY2020 will be an increase in the total amount of $43,781; with $14,877 in state share. The estimated budget impact for SFY2021 will be an increase in the total amount of $38,653; with $ $13,134 in state share

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority anticipates a positive 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:

- An increase to the AIDS rate from $209.50 per patient day to $213.10 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**

October 1, 2019, contingent upon CMS approval.