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OKLAHOMA HEALTH CARE AUTHORITY

Agenda
SPARC
June 18, 2015
10:00 a.m.
Board Room

Rate issues to be addressed:

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Diagnosis-Related Group (DRG) Hospital

1. Is this a "Rate Change" or a "Method Change"?
   Method 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 methodology and reimbursement structure for Diagnosis-Related Group (DRG) Hospital Payments.

   The Oklahoma Health Care Authority Board must take action to reduce SoonerCare expenditures to file a balanced budget. As a result, OHCA recommends the following method change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, 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.

   OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for DRG Payments to Inpatient Acute Care Hospitals and Critical Access Hospitals are outlined below.

3. Current methodology and/or rate structure.

New Methodology	Current Methodology
Reduce Diagnosis-Related Group (DRG) Outlier payments by increasing the DRG threshold to $50,000. Costs (billed amount times hospital specific cost to charge ratio) on the claim must now be $50,000 (was $27,000) greater than the DRG base payment to trigger a high cost outlier payment. The outlier calculation description: *Outlier Amount = (claim total amount billed) X (billing provider's Cost-*	Currently, the DRG threshold is $27,000. It varies from state to state which threshold amount is used and how it is applied.

to-Charge Ratio (CCR) - (DRG Weight X Peer Group Base Rate) – (threshold of $50,000) X (marginal cost factor 70%), or zero, whichever is greater.	
Pay the lesser of billed charges or the Diagnosis-Related Group (DRG) amount. For DRG claims, the payment may not exceed billed charges.	Currently, payment is made at the DRG allowable amount.
Transfers pay the lesser of transfer fee or Diagnosis-Related Group (DRG). In the case of a transfer, the Transfer Allowable Fee for the Transferring Facility shall be calculated as follows: *Transfer Allowable Fee = (MS-DRG Allowable Fee/Mean Length of Stay) X (Length of Stay + 1 day).* The total Transfer Allowable Fee paid to the transferring facility shall be capped at the amount of the MS-DRG Allowable Fee for a non-transfer case. No outlier payments will be paid to the transferring hospital on transfer cases. Payment to the receiving facility, if it is also the discharging facility, will be at the DRG allowable plus outlier if applicable.	Currently, both the transferring facility and the receiving facility are paid at the DRG allowable plus outlier if applicable.

*MS-DRG means Medical Severity Diagnosis Related Groups

4. New methodology or rate.
   See the new methodology in the table above.

5. Budget estimate.
   The change in the outlier threshold will result in an estimated annual savings in the amount of $18,881,600 total dollars; $6,694,786 state share.

   Paying the lesser of the billed charges or DRG will result in an estimated annual savings in the amount of $11,914,717 total dollars; $4,224,561 state share.

   Paying the lesser of the transfer fee or DRG will result in an estimated annual savings in the amount of $2,774,924 total dollars; $983,896 state share.

   All three DRG changes implemented together will result in a total estimated annual savings of $33,571,241 total dollars; $11,903,243 state share.

6. Agency estimated impact on access to care.
   This method change should not have a negative impact to 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 method change for the DRG Hospital payments.

8. Effective date of change.
   July 1, 2015.

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Facility vs. Non-Facility Relative Value Unit (RVU) Expenses

1. Is this a "Rate Change" or a "Method Change"?
   Method 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 methodology and reimbursement structure for physician/practitioner Resource Based Relative Value Scale (RBRVS) reimbursement. The OHCA is proposing a methodology similar to Medicare for assigning Relative Value Units (RVUs) based on Facility or Non-Facility place of service. Currently, the OHCA exclusively uses the non-facility RVU.

   The Oklahoma Health Care Authority Board must take action to reduce SoonerCare expenditures to file a balanced budget. As a result, OHCA recommends the following method change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, 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.

   OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for physician/practitioner Resource Based Relative Value Scale (RBRVS) reimbursement are outlined below.

3. Current methodology and/or rate structure.
   Currently, OHCA applies the non-facility Relative Value Units (RVUs) to all physician/practitioner Resource Based Relative Value Scale (RBRVS) reimbursed services.

4. New methodology or rate.
   Pay like Medicare for physician services performed in a facility place of service (21-Inpatient Hospital, 22-Outpatient Hospital, 23-Emergency Room, 24-Ambulatory Surgical Center, 31-Skilled Nursing Facility, or 42-Ambulance Air, etc.). The Medicare Physician Fee Schedule has Relative Value Units (RVUs) for some Current Procedural Terminology (CPT) codes for both facility and non-facility places of service. For the CMS developed fee schedule, each code has three components: work RVU, practice

expense RVU and malpractice expense RVU. For services performed in a facility the practice expense RVU is typically lower because not as much expense is required for overhead, staff, equipment and supplies. The non-facility RVU is for services performed in the office or home and these RVUs are in most cases higher because the physician practice has greater overhead expense. The OHCA will implement an edit that will detect place of service and apply the correct RVU (facility or non-facility), thus applying the correct RVU Practice Expense similar to Medicare. This change will apply to all rendering physicians/practitioners reimbursed based on the physician RBRVS fee schedule.

For example, CPT code 36557 (Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age):
Note: These values are used for this demonstration only and are not real values.

Work RVU:	5.09
Non-Facility Practice Expense RVU:	21.20
Malpractice RVU:	0.57

Total RVUs (adjusted for Oklahoma region-Geographic Pricing Cost Index (GPCI): 23.41254
Total RVUs multiplied by the statewide conversion factor 37.8975 results in a fee of $887.28. For state employed physicians, this would be $1,242.19.

In the new method, this service is identified as performed in the hospital setting, and payment will be:

Work RVU:	5.09
Facility Practice Expense RVU:	2.66
Malpractice RVU:	0.57

Total RVUs (adjusted for Oklahoma region- Geographic Pricing Cost Index (GPCI): 7.57938
Total RVUs multiplied by the statewide conversion factor 37.8975 results in a fee of $287.24. For state employed physicians, this would be $402.14.

5. Budget estimate.
The change will result in an estimated annual savings in the amount of $7,376,605 total dollars; $2,615,498 state share.

6. Agency estimated impact on access to care.
This method change should not have a negative impact to 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 method change for physician/practitioner RBRVS reimbursement.

8. Effective date of change.
July 1, 2015.

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Mid-Level Practitioners

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 to the current methodology and reimbursement structure for the payments to Mid-Level Practitioners.

   The Oklahoma Health Care Authority Board must take action to reduce SoonerCare expenditures to file a balanced budget. As a result, OHCA recommends the following rate change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, 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.

   OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for Mid-Level Practitioners are outlined below.

3. Current methodology and/or rate structure.
   Currently, payments to Mid-Level practitioners are paid at 100% of the appropriate physician fee schedule.

4. New methodology or rate.
   Payments to Mid-Level Practitioners (Physician Assistants, Nurse Practitioners, etc.) will be reduced to 95% of the appropriate physician fee schedule. This will only apply to Medicaid Fee-For-Service payments, not to Medical Home care coordination or incentive payments. Certified Registered Nurse Anesthetists and Anesthesiology Assistants providers are excluded. This change will also not apply to Insure Oklahoma Mid-Level Practitioners.

5. Budget estimate.
   The rate change will result in an estimated annual savings in the amount of $4,949,513 total dollars; $1,754,932 state share.

6. Agency estimated impact on access to care.
   This rate change should not have a negative impact to 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 rate change for the Mid-Level Practitioners.

8. Effective date of change.
   July 1, 2015.

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Medicare Crossover Claims (Coinsurance and Deductible) for Nursing Facilities

1. Is this a rate change or a method change?
   This is a method change.

1b. Is this change an increase, decrease or no impact?
   This change will decrease crossover claims payment from 100% to 75%. The annual expenditures will decrease by an estimated $6,179,930 ($2,191,197 in State funds).

2. Presentation of Issue – Why is change being made?
   The Oklahoma Health Care Authority (OHCA) recommends a revision to the current methodology for payment of crossovers.

   The Oklahoma Health Care Authority Board must take action to reduce SoonerCare expenditures to file a balanced budget. As a result, OHCA recommends the following rate change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, 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.

   OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for crossovers are outlined below.

3. Current Methodology/Rate Structure.
   The current rate methodology pays the crossover claims at 100%.

4. New Methodology/Rate Structure.
   The proposed rate methodology is to pay crossover claims at 75%

5. Budget Estimate.
   The annual budget will decrease by an estimated total of $6,179,930 funded by $2,191,197 in state funds.

6. Estimated impact on access to care.
   This change will continue to insure access for this fragile population by insuring the financial viability of these facilities.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve the method for Deductibles & Co-insurance for nursing facility Medicare Crossover claims at 75%.

8. Effective Date of Change.
   July 1, 2015

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Stationary Oxygen System

1. Is this a "Rate Change" or a "Method Change"?
   NEW rate methodology and corresponding rates

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

2. Presentation of issue – Why is change being made?
   The change is being made to align OHCA payment rates with CMS competitive bid rates established in July 2013 for Oklahoma City for stationary oxygen systems.

3. Current methodology and/or rate structure.
   Current rates are based off of discounted CMS rates prior to the CMS competitive bidding process

4. New methodology or rate.
   The change is set to allow for matching the competitive bid rate in effect for Oklahoma City. The current budget reduction rates will not be applied to this rate structure.

TABLE 1 – OXYGEN RATE COMPARISON			
	Current Rate Monthly Rental	C-BID Rate Monthly Rental	Rate Reduction
Home			
Stationary	$ 141.20	$ 96.48	- $ 44.72
			-
Nursing Facility			
Stationary	$ 120.02	$ 96.48	- $ 23.54

5. Budget estimate.
   Budget reduction estimate equals ($ 546,715 State $) and ($ 1,413,430 Total $)

6. Agency estimated impact on access to care.
   OHCA has an adequate provider base to provide oxygen equipment for medically qualified members at the proposed rate.

7. Rate or Method change in the form of a motion.
   The agency requests the SPARC to approve the new reimbursement methodology and the corresponding rates in Table 1 for stationary oxygen system monthly rental.

8. Effective date of change.
   July 1, 2015

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Polycarbonate Lens

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 OHCA has paid $6.45 million dollars for polycarbonate lenses for CY 2014 based on claims data retrieved April 2015. Current payment for frames for CY 2014 is less at $5.73 million, and single vision lenses totals $6.57 million in CY 2014.

   Other states pay for polycarbonate lenses based on diagnosis (for members with high probability of falls); based on age limitations (up to 7 years old in Iowa); or require PA for this service. Oklahoma has no limitations on polycarbonate other than "when medically necessary".

   The rate was $7.06 per lens until 2007, when it was restructured and changed to $34.01 per lens. The rate was restructured in September 2007 to align with CMS DME pricing. However, our understanding is the CMS rate is indicative of the lens AND polycarbonate (as one unit), not as an add on code, in addition to the lens.

3. Current methodology and/or rate structure.
   Current rate is set at max fee methodology, and for BR2015 is set at $30.35 per lens. (HCPC V2784), resulting in a payment of $60.70 per pair of glasses for polycarbonate lens.

4. New methodology or rate.
   Many states bundle polycarbonate lens into the cost of the lens. Some states have sole source providers and do not pay separately for polycarbonate lens. The cost of polycarbonate lens to the provider is between $9.00 to $25.00 per pair of glasses, depending on single vision or plastic lenses. Some states reimburse between $4.57 to $45.00 for polycarbonate lens.

   OHCA proposes to decrease the reimbursement of the polycarbonate lens to $10.00 per unit, or $20.00 per pair of glasses.

5. Budget estimate.
   Based on the number of units reimbursed for CY14, should the reimbursement of V2784 polycarbonate lenses be reduced to $10.00 per lens, the estimated annual cost for polycarbonate lens would change from $6.45 million to $2.36 million, a total cost savings of $4,150,150, with state savings of $1,471,505.

6. Agency estimated impact on access to care.
   There is no impact to access to care estimated. Reimbursement will still cover the cost of the polycarbonate lens.

7. Rate or Method change in the form of a motion.

   The agency requests the SPARC to approve the new reimbursement methodology.

8. Effective date of change.

   July 1, 2015.

CODE	DESCRIPTION	RATE 7/1/2014	# UNIQUE CLAIMS 2014	# UNIQUE MEMBERS 2014	# UNITS PAID CY2014	REIMB CY2014	OHCA PA
V2020	**Frames**	$44.88		110,153	125,413	$5,733,575	
V2784	**Polycarbonate**	$30.35	119,472	104,641	235,505	$6,450,037	
	Single Vision Lense, Glass or Plastic						
V2100	Sphere, single vision, plano to plus or minus 4.00, per lens	$28.03	74,640	64,499	141,417	$3,794,678	
V2101	Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens	$29.54	2,537	2,334	4,305	$129,521	
V2102	Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens	$41.57	772	680	1,460	$51,577	
V2103	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	$24.34	43,939	39,745	78,512	$1,963,061	
V2104	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens	$26.96	6,135	5,417	9,657	$267,823	
V2105	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens	$29.35	1,188	1,064	1,761	$52,872	
V2106	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	$32.57	151	123	243	$7,759	
V2107	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, 0.12 to 2.00d cylinder, per lens	$30.98	3,379	3,024	5,475	$172,265	
V2108	Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	$32.08	1,104	965	1,641	$53,145	
V2109	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	$35.49	314	279	456	$16,007	
V2110	Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens	$35.02	53	52	93	$2,892	
V2111	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	$36.50	542	489	859	$31,230	
V2112	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens	$39.85	265	226	401	$15,508	
V2113	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	$44.91	78	68	108	$4,479	
V2114	Spherocylinder, single vision, sphere over plus or minus 12.00d, per lens	$48.65	120	106	212	$9,948	
V2115	Lenticular, (myodisc), per lens, single vision	$52.95	6	4	10	$501	
V2118	Aniseikonic lens, single vision	$52.49	0	0	0	$0	✶
V2121	Lenticular lens, per lens, single	$54.20	0	0	0	$0	✶
V2199	Not otherwise classified, single vision lens	manual	3	3	6	$459	✶
						$6,573,725	
	Bifocal, Glass or Plastic						
V2200	Sphere, bifocal, plano to plus or minus 4.00d, per lens	$36.69	1,353	1,234	2,539	$91,407	
V2201	Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens	$39.99	70	61	115	$4,767	
V2202	Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens	$47.07	31	29	59	$2,791	
V2203	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	$37.02	673	624	1,159	$43,504	

V2204	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens	$38.70	126	111	209	$8,321	
V2205	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens	$41.85	13	12	20	$837	
V2206	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	$44.95	6	4	11	$478	
V2207	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens	$40.89	92	82	155	$2,376	
V2208	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	$42.92	32	30	55	$2,376	
V2209	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	$46.22	3	3	4	$189	
V2210	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens	$50.97	0	0	0	$0	
V2211	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	$52.87	20	19	34	$1,654	
V2212	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens	$54.58	7	6	13	$760	
V2213	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	$55.14	2	2	2	$120	
V2214	Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens	$59.93	6	6	11	$675	
V2215	Lenticular (myodisc), per lens, bifocal	$60.84	3	3	6	$375	
V2218	Aniseikonic, per lens, bifocal	$72.40	0	0	0	$0	✶
V2219	Bifocal seg width over 28mm	$31.87	0	0	0	$0	✶
V2220	Bifocal add over 3.25d	$25.85	0	0	0	$0	✶
V2221	Lenticular lens, per lens, bifocal	$63.23	0	0	0	$0	✶
V2299	Specialty bifocal (by report)	manual	3	3	6	$379	✶
						$161,009	

Contact Lenses

V2510	Contact lens, gas permeable, spherical, per lens	$79.42	6	6	8	$559	
V2511	Contact lens, gas permeable, toric, prism ballast, per lens	$114.10	1	1	1	$228	
V2513	Contact lens, gas permeable, extended wear, per lens	$113.21	21	15	31	$3,252	
V2520	Contact lens, hydrophilic, spherical, per lens	$74.65	15	13	25	$1,730	
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens	$129.96	7	5	11	$1,037	
V2523	Contact lens, hydrophilic, extended wear, per lens	$107.78	42	19	57	$6,067	
V2530	Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see 92325)	$133.88	4	4	6	$803	
V2599	Contact lens, other type	manual	1	1	1	$185	✶

V2700	Balance lens, per lens	$31.36	10	9	11	$308	
V2710	Slab off prism, glass or plastic, per lens	$45.89	1	1	1	$46	
V2715	Prism, per lens	$8.32	671	620	1,184	$9,209	
V2718	Press on lens, Fresnel prism, per lens	$20.44	7	6	13	$111	
V2730	Special base curve glass or plastic per lens	$15.09	0	0	0	$0	✶
V2744	Tint, photochromatic, per lens	$11.74	241	241	458	$5,502	✶
V2780	Oversize lens per lens	$8.97	0	0	0	$0	✶
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79, glass, excludes polycarb, per lens	$41.39	1	1	2	$85	✶

V2783	Lens, > Or equal to 1.66 plastic or > than or equal to 1.80 glass, excludes polycarb, per lens	$46.68	25	25	49	$2,358	✶

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Acute (16 Bed-or-Less) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

1. Is this a rate change or a method change?
   Rate change

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

2. Presentation of Issue – Why is change being made?:
   The change is made to increase the Quality of Care (QOC) Fee for Acute ICF/IID Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional fees and match them through rate increases to providers. The current fee is $9.09 and will increase to $9.18. The ***fee*** increase of $0.09 per day when matched with federal funds will mean an increase of $0.23 to the ***daily rate*** for this facility type changing the base rate from $155.96 to $156.19. The fee is recalculated annually.

3. Current Methodology/Rate Structure.
   The current rate methodology calls for the establishment of a prospective rate which is based on the reported allowable cost per day.

4. New methodology or rate.
   There is no change in methodology; however there is a rate change as a result of the required annual recalculation of the QOC fee.

5. Budget Estimate.
   The annual budget will increase by an estimated $61,297 funded by $28,710 in state matching funds coming from the increased QOC Fee (which is paid by the facilities) and $37,587 in federal matching funds.

6. Estimated impact on access to care.
   The agency does not anticipate this change will impact access to care.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve the rate change as follows:
   - *Base Rate*-to increase the base rate by 0.1474% ($.0.23) from $155.96 to $156.19.

8. Effective Date of Change.
   July 1, 2015

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Acquired Immune Deficiency Syndrome (AIDS) Rate for Nursing Facilities

1. Is this a rate change or a method change?
   Rate change

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

2. Presentation of Issue – Why is change being made?
   The change is made to increase the Quality of Care (QOC) Fee for AIDS rate per 56 O.S. 2011, Section 2002. This change allows the OHCA to collect additional fees and match them through rate increases to providers. The current fee is $10.74 and will increase to $10.79. The ***fee*** increase of $0.05 per day when matched with federal funds will mean an increase of $0.18 to the ***daily rate*** for this facility type changing the base rate from $198.04 to $198.22. The fee is recalculated annually.

3. Current Methodology/Rate Structure.
   The current rate methodology calls for the establishment of a prospective rate based on reported allowable costs.

4. New methodology or rate.
   There is no change in methodology; however there is a rate change as a result of the required annual recalculation of the QOC fee.

5. Budget Estimate.
   The annual budget will increase by an estimated $1,769 funded by $684 state funds coming from the increased QOC Fee (which is paid by the facilities) and federal matching funds of $1085.

6. Estimated impact on access to care.
   The agency does not anticipate this change will impact access to care.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve the rate change as follows:
   - *Base Rate*- increase the base rate component by 0.090% ($0.18) from $198.04 to $198.22.

8. Effective Date of Change.
   July 1, 2015

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Regular Nursing Facilities

1. Is this a rate change or a method change?
   Rate change

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

2. Presentation of Issue – Why is change being made?
   The change is made to increase the Quality of Care (QOC) Fee for Regular Nursing Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional fees and match them through rate increases to providers. The current fee is $10.74 and will increase to $10.79. The ***fee*** increase of $0.05 per day when matched with federal funds will mean an increase of $0.18 to the ***daily rate*** for this facility type changing the base rate from $107.24 to $107.29. The fee is recalculated annually.

   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 of 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. New methodology or rate.
   There is no change in methodology; however there is a rate change as a result of the annual recalculation of the QOC fee and reallocation of Direct Care Cost per State Plan.

5. Budget Estimate.
   The annual budget will increase by an estimated $833,616 funded by $322,443 in state funds coming from the increased QOC Fee collections (which is paid by the facilities) and the federal matching funds of $511,173.

6. Estimated impact on access to care.
   The agency does not anticipate this change will impact access to care.

7. Rate of Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve the rate change as follows:
   - *Base Rate* - increase the base rate component from $107.24 to $107.29 which matches the increase in the Quality of Care Fee of $0.05 ($10.74 to $10.79).
   - *Pool Amount* – decrease the pool amount in the state plan for the "Other" and "Direct Care" Components from $158,391,182 to $155,145,293 to account for the decrease in days.

8. Effective Date of Change:
   July 1, 2015

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Regular Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

1. Is this a rate change or a method change?
   Rate change

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

2. Presentation of Issue – Why is change being made?
   The change is made to increase the Quality of Care (QOC) Fee for Acute ICF/IID Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional fees and match them through rate increases to providers The current fee is $7.20 and will increase to $7.25. The fee increase of $0.05 per day when matched with federal funds will mean an increase of $0.13 to the daily rate for this facility type changing the base rate from $121.83 to $121.96. The fee is recalculated annually.

3. Current Methodology/Rate Structure.
   The current rate methodology calls for the establishment of a prospective rate which is based on the reported allowable cost per day.

4. New methodology or rate.
   There is no change in methodology; however there is a rate change as a result of the required annual recalculation of the QOC fee.

5. Budget Estimate.
   The annual budget will increase by an estimated $28,291 funded by $10,943 in state matching funds coming from the increased QOC Fee (which is paid by the facilities) and $17,348 in federal matching funds.

6. Estimated impact on access to care.
   The agency does not anticipate this change will impact access to care.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve the rate change as follows:
   - *Base Rate*- increase the base rate by 0.1067% ($0.13) from $121.83 to $121.96.

8. Effective Date of Change:
   July 1, 2015

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Developmental Disabilities Services

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

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

2. Presentation of issue – Why is change being made?
   The Developmental Disabilities Services (DDS) is restructuring the Agency Companion services program and offering only the Agency Companion - Contractor services. The redesign of the program eliminates the need for the Agency Companion (Employee) services and the correlating Respite service codes; however, requires a rate to be established for the Agency Companion (Contractor) Intermittent services and its correlating Respite service code.

   Agency Companion Service is a living arrangement developed to meet the specific needs of the service recipient and provide a live-in companion for supervision, supportive assistance, and training in daily living skills, and is provided in a home shared by the companion and the service recipient. The companion is contracted by an agency, but is selected by the waiver participant. Companions may assist or supervise the service recipient with such tasks as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. This service is provided in accordance with a therapeutic goal in the plan of care and is not purely diversional in nature. The companion is responsible for on-going supports and is available whenever required by the service recipient so that the service recipient may successfully cope with the challenges that occur in his/her life. Agency Companion levels include: (1) pervasive – for service recipients with behavioral or emotional challenges; (2) enhanced supervision – for service recipients with extensive needs; (3) close supervision – for service recipients with moderate needs; and (4) intermittent supervision – for service recipients with limited needs.

3. Current methodology and/or rate structure.
   The current rate structure for which the change is requested is fixed and uniform, and established through the State Plan Amendment Rate Committee. The current service codes and rates are as follows:

	Levels	Intermittent	Close	Enhanced	Pervasive
	Procedure Code (Therapuetic Leave-) {Respite - S5151}	**S5126 U1 (TV)**	**S5126 TF (TV)**	**S5126 (TV)**	**S5136 (TV)**
EMPLOYEE	**Salary**	**17,000.00**	**25,500.00**	**34,000.00**	**34,000.00**
	Benefits 28.65%	**4,870.50**	**7,305.75**	**9,741.00**	**9,741.00**
	PC Salary & Benefits $34,000 + 28.65% / 15	**2,916.07**	**2,916.07**	**2,916.07**	**2,916.07**
	Recruiter/Trainer - $30,000 + 28.65% / 30 Pervasive Only!				**1,286.50**
	Professional Supports - MSW Level $36,000 + 28.65% / 20 Perva sive Only!				**2,315.70**
	Administration & General Costs - 15%	**3,717.99**	**5,358.27**	**6,998.56**	**7,538.89**
	Total annual costs	**28,504.55**	**41,080.09**	**53,655.63**	**57,798.16**
	Daily Rate Rounded to nearest $0.25	**78.00**	**112.50**	**147.00**	**158.25**

	Procedure Code (Therapuetic Leave) {Respite - S5151}	**S5126 U4 (TV)**	**S5126 TG (TV)**	**S5136 TG (TV)**
INDEPENDENT CONTRACTOR	**Contracted Amount ***	**26,775.00**	**35,700.00**	**35,700.00**
	PC Salary & Benefits $34,000 + 28.65% / 15	**2,916.07**	**2,916.07**	**2,916.07**
	Recruiter/Trainer - $30,000 + 28.65% / 30 Pervasive Only!			**1,286.50**
	Professional Supports - MSW Level $36,000 + 28.65% / 20 Pervasive Only!			**2,315.70**
	Administration & General Costs - 15%	**4,453.66**	**5,792.41**	**6,332.74**
	Total annual costs	**34,144.73**	**44,408.48**	**48,551.01**
	Daily Rate Rounded to nearest $0.25	**93.50**	**121.75**	**133.00**

*** Contracted Companion amount reflects an additional 5% to assist with Self Employment tax.**

4. New methodology or rate.
The table below indicates the service codes to eliminate as well as the basis for the new rate.

Eliminate Service Codes

	Agency Companion - Employee (Therapuetic Leave)	
Intermittent	**S5126 U1 (TV)**	**78.00**
Close	**S5126 TF (TV)**	**112.50**
Enhanced	**S5126 (TV)**	**147.00**
Pervasive	**S5136 (TV)**	**158.25**
Respite *	**S5151**	

*Respite Rates Correlating to above services

New Rate

Procedure Code (Therapuetic Leave) {Respite - S5151}			**New**
INDEPENDENT CONTRACTOR	**Contracted Amount ***		**17,850.00**
	PC Salary & Benefits	**$34,000 + 28.65% / 15**	**2,916.07**
	Administration & General Costs - 15%		**3,114.91**
	Total annual costs		**23,880.98**
	Daily Rate	**Rounded**	**65.25**

5. Budget estimate.
The estimated total annualized savings in state share for the proposed rate change is $1,754 with a total federal plus state annualized savings of $4,654. The budget impact is budget neutral for the Oklahoma Health Care Authority.

6. Agency estimated impact on access to care.
Under (a)(30)(A) of the Medicaid Act, the agency expects a minimal but increased impact on access for these services.

7. Rate or Method change in the form of a motion.
The agency requests the State Plan Amendment Rate Committee to approve the method change for Agency Companion (Contractor) Intermittent and Respite Service.

8. Effective date of change.
July 1, 2015
9.