MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

Agenda
Rates & Standards Hearing
August 30, 2011
1:00 pm
Ponca Conference Room

Rate issues to be addressed:

- Children's Long Term Care Sub-Acute Hospitals
- OSDH – Public Health Clinic Services
- Supplemental Outpatient Hospital Payment to Level I Trauma Centers
- Proposed Reimbursement Method for Nursing Facilities Serving Adults

Presentation to the Committee on Rates and Standards
Proposed Revision to Payment Rate for
Children's Long Term Care Sub-Acute Hospitals
August 2010

Background

Since May 01, 2000 reimbursement for all Children's Sub-Acute Long Term Care Hospitals been made through a prospective rate. The rate was initially set at 85.7% of the existing statewide median rehab level of care per diem rate. Currently, the Children's Center located in Bethany, Oklahoma, is the only facility of this type contracting with the OHCA. For the period beginning 05-01-09 the rate was set at the estimated allowable cost of $537.40 per day and as part of the budget crises and the OHCA efforts to comply with our constitutional responsibility under Article10, Section 23 of the Oklahoma Constitution the rate was adjusted to $519.93 per day on April 1, 2010.

Proposed Change

For the period beginning 10-01-11 OHCA staff proposes that the rate for this facility type be adjusted by $2.61 PPD to $522.54 PPD to adjust for the Children's Center switching from transporting the children to OU Med Center for Botox injections and performing all of the procedures in-house. These costs were paid outside of the rate directly to OU in separate invoices for the service and for the Botox. OHCA passed rules that require both the service and the Botox to be on the same 1500 claim, i.e. insuring that the treatment was made by qualified practitioners. The Children's center has physicians qualified to render the treatments and wishes to do them on an inpatient basis. The only cost not currently in their rate calculation is for the cost of the meds; the $2.61 per day. The main reason for this change is to lessen the trauma to these fragile patients by not having to transport them to other locations for the treatment.

Budget Impact

There is no annual budget impact to the OHCA. The increase in the rate is offset by the reduction in expenditures for the drugs to the OU Med Center.
A copy of the analysis is attached

ALLERGAN

INVOICE

TO JENNIFER

OK TO PAY

CHG ACCT #

CCCC841-CCC1C27 060897

RETURN TO BUS OFF.

Bill To No: 90092

THE CHILDRENS CENTER
6800 NW 39TH EXPY
BETHANY OK 73008

OUR INFORMATION

Invoice No:	**1065982511**	**Payer No:**	**90092**
Invoice Date:	**05/10/2011**	**Sold To No:**	**90092**
Order No:	**111703974**	**Ship To No:**	**416279**
Delivery No:	**613994932**	**Bill To No:**	**90092**

YOUR INFORMATION

Order Date:	**05/10/2011**	5-10-11
Purchase Order No:	**btx**	252
Payment Terms:	**Net 90**	
Disc. Due Date:		7917-146
Net Due Date:	**08/08/2011**	

Order Qty	Ship Qty	B.O. Qty	U/M	Batch/ S.N.	Product Num.	Description	Unit Price	Ext. Price
15	15		EA	C2633 C3	91223US	BOTOX 100 Units/Vial	525.00	7,875.00

NDC# 00023-1145-01 / BOTOX® is now available in a 200-U vial.

Tax: 0.00

Single Parcel BOL#: 423760973382

The Children's Center
Business Office
MAY 17 2011

HOLD
TIL
7-20

PAID 4/2

Cash Discount	**0.00**	**Disc. Net Amount**	**7,875.00**	**Please Pay This Amount**	**7,875.00**

Shipping Information

Ship-to Address:

EDWARD ANTHONY WRIGHT MD
C-O THE CHILDREN CENTER
6800 NW 39TH EXPY
BETHANY OK 73008

Ship To No:	416279
Shipped Via:	USBTX STD NXT DY FDX
Weight:	6.00 LB
Ship Date:	05/10/2011
Shipped From:	Allergan USA, Inc., Kuehne & Nagel DC 1800 Waters Ridge Dr. Ste 100, Lewisville, TX. 75067

Payment Information

PLEASE TEAR OFF THIS SLIP AND RETURN IT WITH YOUR PAYMENT:

ALLERGAN

SEND PAYMENTS TO:

Allergan USA, Inc.
12975 COLLECTION CENTER DRIVE
CHICAGO, IL 60693

Payer No:	90092
Invoice Number:	**1065982511**
Disc. Net Amt.:	7,875.00
Disc. Amount:	0.00
Please Pay This Amount:	**7,875.00**

For billing inquiries, please call 1-800-811-4148 (Mon. - Fri. 6:30 AM - 4:00 PM, PST)

The Children's Center
Inpatient Botox Injections
Rates and Standards Attachment

Cost per Vial (100 units)	$ 531.00	
Average vials/injection	2.50	
Cost per injection		$ 1,327.50
Injections performed	17	
Injections needed	21	
Injections performed/needed		38.00
IP Botox Cost (6 months)		$ 50,445.00
Total Days (6 months)		19,295.00
Cost per Day		**$ 2.61**

*The current rate paid by OHCA to a pharmacy is $5.31 per unit and a vial contains 100 units so the reimbursement is $531 per vial.

PRESENTATION TO THE STATE PLAN REIMBURSEMENT COMMITTEE
PUBLIC HEALTH CLINIC SERVICES
AUGUST, 2011

ISSUE

County Health Departments (CHDs) have been enrolled as SoonerCare providers of clinical services and billing "like physicians" using CPT codes, since the implementation of the national code sets mandated by the HIPAA code conversion. Public Health Nurses (PHNs) employed by CHDs provide screening and preventive health services within their scope of practice in accordance with state law. PHNS include RNs, LPNs and Nurse Practitioners (NPs). Generally, PHN primary and preventive services are provided under "approved orders" without the presence of a physician on site. However, PHNs that are not NPs meet only the provider qualifications for a limited number of nurse CPT codes with the physician in the office suite. Further, CPT codes under the SoonerCare Physician Fee Schedule (PFS) do not allow the OSDH to receive full cost reimbursement. Prior to HIPAA, local codes were used by PHNs to bill for compensable services.

OSDH PROPOSED REIMBURSEMENT

A. Public Health Clinic Fee Schedule

OSDH requests that OHCA implement a separate fee schedule for Clinic services that would allow CHDs to receive full cost reimbursement. Since a standardized cost report has not been developed for this provider type, the rates have been established from existing fees. (Refer to Attachment A for Cost analysis). Under CMS guidelines (Federal Register Notice CMS-2213-P, issued September 28, 2007) a State may pay more than Medicare for some services or facilities, and less than Medicare for others, as long as the aggregate Medicaid payment is equal to or less than the amount that Medicare would pay in the aggregate. (Refer to Attachment B - Fee Schedule for proposed rates).

B. Primary Care Incentive Payments for Nurse Practitioners employed by CHDs

OSDH requests the following changes be made to the base rates for paid claims billed by NPs employed by CHDs: 1) an adjustment to 100% of Medicare for all services; and 2) a 10% bonus payment be allowed for NP primary care services**.** Currently OHCA pays NPs a base rate that is based on a percentage of the PFS (currently at about 97% of Medicare). The proposed bonus payment aligns with Section 5501(a) of The Affordable Care Act that revises section 1833 of The Social Security Act by adding new paragraph (x), "Incentive Payments for Primary Care Services." Section 1833(x) of the Social Security Act states that, in the case of primary care services furnished on or after January 1, 2011 and before January 1, 2016 by a primary care practitioner, there also will be paid on a monthly or quarterly basis an amount equal to 10 percent of the payment amount for such services under Part B.

BACKGROUND

➢ Billing Issues

- PHNs provide immunizations under approved orders in accordance with the Advisory Committee on Immunization Practice (ACIP) guidelines for adults. Current OHCA rules for PHYSICIAN services indicate that the cost for vaccine administration (e.g., CPT 90465) is included in the cost of the vaccine and is therefore not separately payable[1]. OSDH believes

[1] However, the pricing methodology for the vaccine product (% of AWP) does not include the cost of administration.

that a separate administration fee is covered as a preventive service under OHCA rules for Public Health Clinics at OAC 317:30-5-1155, that specify that immunizations are administered in accordance with ACIP guidelines[2]. CHDs have been enrolled as Public Health Clinics since October 2010. OHCA has concerns with payment for the vaccine administrative fee to CHDs as a preventive service based on the exclusion in PHYSICIAN rules.

- Recently OHCA auditors have discovered improper coding for services rendered by PHNs (RNs and LPNs) under approved orders. OSDH has revised its billing instructions to CHDs to specify that only the nurse code (CPT 99211) is appropriate, and only if the client is "established". These guidelines are not compatible with the CHD business model and for the population served by CHDs. For example, some clinic visits do not require the professional level of a physician or Nurse Practitioner (NP) (e.g. services to determine eligibility for pregnancy related services provided to a new patient, in accordance with OAC 317:35-6-38). Therefore all of these and other standing order screening and preventive services for "new" patients would not be reimbursable.

- **Medicaid Benefits and Financing**

  Medicaid benefits can be provided under different benefit categories, and are often shaped by the financing arrangements by which they are delivered. According to Section 4385 of the State Medicaid Manual, preventive services may be covered in a variety of contexts. In addition to including preventive services as an integral component of PHYSICIAN services, the preventive aspects of CLINIC services and EPSDT services are specifically included in Medicaid regulations. The OHCA and the OSDH have executed an interagency agreement (IAA) to make maximum use of public health and Title V services, with OSDH providing state matching funds for covered services.

  Under current Medicaid law, governmentally operated health care providers may receive the full cost of furnishing Medicaid services, which could mean rates that substantially exceed those available to other classes of providers. In 2005, a state plan amendment was approved for reimbursement to CHDs under the Medicaid "Clinic" benefit Section 1905(a)(9) of the Social Security Act). This separate classification would allow CHDs the opportunity to receive full cost reimbursement for serving SoonerCare members.

DESCRIPTION OF PUBLIC HEALTH NURSING VISIT (T1001)

Eligible Practitioners

- Licensed Public Health Nurses (PHNs) employed by a County Health Department

Billable Visits

[2] In addition, Section 4106 of the Affordable Care Act amended Section 1905 (a)(13) of the Social Security Act to add clarification for covered preventive services: "with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) *and their administration*" (emphasis added)

PRESENTATION TO THE STATE PLAN REIMBURSEMENT COMMITTEE
PUBLIC HEALTH CLINIC SERVICES
AUGUST, 2011

A PHN visit would include the following services provided within the PHN scope of practice and state law, as authorized by OAC rules at 317:30-5-1158:

- health promotion and counseling education;
- medication management;
- nursing assessment, execution of medical regime including administration of medications and treatment;
- home visits;
- nursing treatments;
- administration of injectable medications;
- family planning follow-up encounter visits (OAC 317:30-5-466(1)(C).

Non-Covered Services

- Services that are part of the WIC (Women, Infants and Children Food Program) clinic package such as height, weight, B/P and client history.

BUDGET IMPACT AND PROPOSED EFFECTIVE DATE
Through the IAA, OSDH pays the state match for services provided by CHDs. There is no budget impact to OHCA. The effective date is_____

ATTACHMENT A

Cost Calculation - PHNs

1	**$**	**20.37**	Mean Hourly Wage - All RN classes (Excluding APN)
2	**$**	**13.92**	Mean Hourly Wage - All LPN classes
3		0.93	Pct. RN
4		0.07	Pct LPN
5	**$**	**19.92**	Blended Hourly Wage
6		1.54	Fringe Benefits Factor
7	**$**	**30.68**	Total Salary & Benefits
8		1.226	Indirect Costs Factor, Off-site [1]
9	**$**	**37.61**	Sub- Total Labor Cost Per visit
10	$	3.00	Est for Basic Supplies
11	**$**	**40.61**	**Total Costs per FTE hour**
12		2080	FTE Hours per Year
13		5	Weeks Unavailable (Training, Non-clinical time, leave)
14		1880	Available Hours per Year (2080 - weeks unavailable * 40)
15	$	40.61	Cost Per FTE Hour (Line 11)
16	$	84,477.59	Annual Cost per FTE
17		1880	Available Hours
18	**$**	**44.93**	Rate per Available Hour (Encounter)

Cost Calculation - Advanced Practice Nurses

1	**$**	**28.34**	Mean Hourly Wage - Advanced Practice Nurse
2		1.54	Fringe Benefits Factor
3	**$**	**43.64**	Total Salary & Benefits
4		1.226	Indirect Costs Factor, Off-site [1]
5	**$**	**53.51**	Sub- Total Labor Cost Per visit
6	$	3.00	Est for Basic Supplies
7	**$**	**56.51**	**Total Costs per FTE hour**
8		2080	FTE Hours per Year

ATTACHMENT A

Cost Calculation - PHNs

1	**$**	**20.37**	Mean Hourly Wage - All RN classes (Excluding APN)
2	**$**	**13.92**	Mean Hourly Wage - All LPN classes
3		0.93	Pct. RN
4		0.07	Pct LPN
5	**$**	**19.92**	Blended Hourly Wage
6		1.54	Fringe Benefits Factor
7	**$**	**30.68**	Total Salary & Benefits
8		1.226	Indirect Costs Factor, Off-site [1]
9	**$**	**37.61**	Sub- Total Labor Cost Per visit
10	$	3.00	Est for Basic Supplies
11	**$**	**40.61**	**Total Costs per FTE hour**
12		2080	FTE Hours per Year
13		5	Weeks Unavailable (Training, Non-clinical time, leave)
14		1880	Available Hours per Year (2080 - weeks unavailable * 40)
15	$	40.61	Cost Per FTE Hour (Line 11)
16	$	84,477.59	Annual Cost per FTE
17		1880	Available Hours
18	**$**	**44.93**	Rate per Available Hour (Encounter)

Cost Calculation - Advanced Practice Nurses

1	**$**	**28.34**	Mean Hourly Wage - Advanced Practice Nurse
2		1.54	Fringe Benefits Factor
3	**$**	**43.64**	Total Salary & Benefits
4		1.226	Indirect Costs Factor, Off-site [1]
5	**$**	**53.51**	Sub- Total Labor Cost Per visit
6	$	3.00	Est for Basic Supplies
7	**$**	**56.51**	**Total Costs per FTE hour**
8		2080	FTE Hours per Year

9		5	Weeks Unavailable (Training, Non-clinical time, leave)
10		1880	Available Hours per Year (2080 - weeks unavailable * 40)
11	**$**	**56.51**	Cost Per FTE Hour (Line 11)
12	$	117,534.67	Annual Cost per FTE
13		1880	Available Hours
14	**$**	**62.52**	Cost Rate per Available Hour (Encounter)
15		**45.28**	Average Payment Per Claim (SFY11 Claims Pymnt data)
16	$	(17.24)	Gain (Loss) per APN Encounter

Source:

1 OSDH - F & A Cost Rate agreement, FY 2010

2 OHCA claims payment data, SFY2010

ATTACHMENT B
Public Health Fee Schedule

HCPC	Mod	Procedure Code Description	Unit
T1001	*	Nursing Assessment/Evaluation	Visit
S9446	HQ	Patient Education, NOC group	Session
SERVICES FOR PERSONS INFECTED WITH TB			
T1023		Screening to Determine the Appropriateness of an individual for participation in a specified program	Visit
H0033		Oral Medication Administration (DOT)	Visit
T1016		Case Management, Nurse	15 min

Billing Limitations	Rate
One per day Administration of Injections included in rate. Labs and drugs billed separately. Cannot bill on same day as preventive exam e.g. (EPSDT; FP)	**$49.27**
Does not include nutritional counseling by nutritionist	**$20.80**
Visit after positive test. Investigations not covered. Lab and X-Ray, Drugs billed separately	**$97.74**
Cannot be billed on same day as T1016	**$9.32**
	$20.31

Source

Level 1 APC Clinic Rate - 2011

100% of 2011 Medicare - 99203
50% of 99211
Existing Fee

Oklahoma Health Care Authority
Finance Division
Presentation to the State Plan Reimbursement Committee
Supplemental Outpatient Hospital Payment to Level I Trauma Centers
August 30, 2011

Background

Under CMS regulations, States are allowed to pay hospitals up to the amount Medicare would pay under comparable circumstances. This is known as the upper payment limit (UPL). House Bill 1381, signed by the Governor on May 13, 2011, creates a Supplemental Hospital Offset Payment Program (SHOPP) which funds supplemental payments to hospitals up to their UPL. However some hospitals are excluded from the program.

This proposal seeks to pay all in-state hospitals that have Level I Trauma Centers that are excluded from the SHOPP Act a supplemental outpatient hospital payment using the Medicare cost methodology. Hospitals that have Level I Trauma Centers are currently eligible for a supplemental ***inpatient*** payment using the Medicare PPS methodology.

Proposed Rate Methodology for the Supplemental Outpatient Payment for Hospitals with Level I Trauma Centers

Allowable outpatient charges for eligible hospitals will be converted to costs using the hospital's cost to charge ratio (CCR). This is defined as the hospital's UPL. Allowable costs are then compared to corresponding Medicaid payments for the services. The difference is known as the UPL gap. Payments will be made up to the UPL to the extent that those facilities have and transfer to the OHCA the state share of the payments. The state share will meet all requirements from federal guidelines as allowable intergovernmental transfers.

2011 Upper Payment Limit Gap

Based on state fiscal year 2011 data, there is currently only one (1) Oklahoma hospital that has a Level I Trauma Center that would be eligible for a supplemental outpatient hospital payment. The allowable outpatient cost (UPL) for this facility is $37,296,843 (37.3 million dollars) while the corresponding payments are $22,840,217 (22.8 million dollars).The OHCA has determined that subtracting the total Medicaid payments from the UPL leaves a "gap" of $14,456,626 (14.4 million dollars). This dollar value sets the amount OHCA could pay for SFY2011. OHCA will use this amount as an estimate for SFY2012 and will reconcile to assure the UPL is not exceeded at the end of SFY2012. If any payments exceed the UPL, they will be recouped.

Budget Impact

The estimated cost to the Medicaid program will be 14.4 million dollars; since 5.2 million in state funds will be transferred from the qualifying hospitals there is no budget impact to OHCA.

Effective Date
October 1, 2011

Oklahoma Health Care Authority
Financial Services Division
Presentation to the Committee on Rates & Standards
Proposed Reimbursement Method for Nursing Facilities Serving Adults

Background

As found in O.S. 56-1011.5 the Legislature directed the Authority to develop a graduated or tiered reimbursement methodology for calculating state Medicaid program reimbursement in addition to the direct care, base rate and other components established under previous legislation. Under this direction the Authority solicited bids from qualified vendors to establish a system to support an incentive reimbursement methodology for Oklahoma Nursing Facilities. This program is titled "Focus on Excellence", (FOE), and the contracted vendor was *My Inner View*. The contract with My Inner View has lapsed and management has determined that it would be an opportune time to create a more logically organized performance metric set for the FOE program. The goals are to simplify the reporting process as much as possible gain more precision and fairness in ratings and payment allocations, expand information to consumers, add focus on culture of care and staff competency and lower OHCA administrative costs by rebalancing of insourcing and outsourcing of program operations. The Opportunities for Living Life (OLL) division organized an advisory board of providers and advocacy groups and contracted with ARC Consulting to review all data in use and the processes of collection in order to make recommendations for changes and additions to help meet our goals. The resulting recommendations will be implemented as per the proposal below.

Current Methodology

The Authority currently pays an incentive payment of one to five percent to participating facilities participating in the Focus on Excellence program. For each two metrics that the facility meets the threshold, an additional percent is paid as a component of the rate.

The current metrics for payment are:

(1) Quality of Life
(2) Resident/Family Satisfaction
(3) Employee Satisfaction
(4) CNA/Nurse Assistant Turnover & Retention
(5) Nurse Turnover & Retention
(6) System-wide Culture Change
(7) Clinical Measures
(8) SoonerCare Occupancy and Medicare Utilization
(9) Nurse Staffing per patient day
(10) State Survey Compliance

Proposed Methodology

Staff, upon recommendations of the advisory board and ARC, proposes to establish the following metrics and thresholds for the FOE program.

1. **Person Centered Care**: *Point Value of 120*
   Facility must meet 6 out of 10 of the established measurement artifacts of culture change to receive the points for this metric.

Oklahoma Health Care Authority
Financial Services Division
Presentation to the Committee on Rates & Standards
Proposed Reimbursement Method for Nursing Facilities Serving Adults

2. **Direct Care Staffing:** *Point Value of 50*
   Facility must maintain a direct care staffing ratio of 3.5 hours per patient day to receive the points for this metric.
3. **Resident/Family Satisfaction:** *Point Value of 80*
   Facility must maintain a weighted score of 72.0 in order to receive the points for this metric.
4. **Employee Satisfaction:** *Point Value of 50*
   Facility must maintain a weighted score of 65 or better in order to receive the points for this metric.
5. **Licensed Nurse Retention:** *Point Value of 50*
   Facility must maintain a 1 year tenure rate for 60% or better of its Licensed Nursing Staff in order to receive the points for this metric.
6. **CNA Retention:** *Point Value of 50*
   Facility must maintain a 1 year tenure rate for 50% or better of is CNA Staff to receive the points for this metric.
7. **Distance Learning Program Participation:** *Point Value of 35*
   Facility must sign up and use approved distance learning programs for its direct care staff in order to receive the points for this metric. A percentage of participation will be established later when adequate data to establish thresholds has been collected.
8. **Peer Mentoring Program Participation:** *Point Value of 30*
   Facility must sign up and use approved peer mentoring programs in order to receive the points for this metric. A percentage of participation will be established later when adequate data to establish thresholds has been collected
9. **Leadership Commitment:** *Point Value of 35*
   Facility must meet 6 out of 10 of the established measurement artifacts in order to receive the points for this metric.

In addition to the Metrics and thresholds above:

- A facility will be able to earn from 1 to 500 points for meeting the established metrics and payment will be established at $.01 per point.
- A facility must earn a minimum of 100 points to receive any payment.
- A facility will forfeit all eligibility for payment in the FOE program for any measurement quarter that the facility receives a citation from the Health Department with a Severity Level of I or higher and the loss of eligibility will continue for any measurement quarters that CMS bans new admissions for the facility.

Effective Date of Change

The above changes will become effective with payment dates of April 1, 2012 based on data collections for the Quarter ending December 31, 2011.

Oklahoma Health Care Authority
Financial Services Division
Presentation to the Committee on Rates & Standards
Proposed Reimbursement Method for Nursing Facilities Serving Adults

Rates of payment based on the current methodology will be made for the fourth quarter ending December 31, 2011 and will be maintained for the quarter ending on March 31, 2012 while transition to the new methodology is accomplished.

Budget Impact

The OLL Division believes that there will be savings to the administrative costs of the program but an accurate projection is not available because bids for outside survey work have not been finalized. The OHCA will house the data and the public website for this program.

The payments under the new methodology to the facilities are projected to be at or near the same levels that are currently being paid. OHCA staff will be monitoring the points and payments and will adjust to the available funds for any material differences.

Date: 08-30-11