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MARY FALLIN
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STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

SPARC Agenda
December 1, 2017
10:00 AM
OHCA Board Room

Rate issues to be addressed:

OUTPATIENT HOSPITAL DENTAL AND ENT 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?**
   Dentists throughout the State have notified OHCA of the lack of access to hospital operating rooms due to the low reimbursement rate for dental services under the outpatient hospital payment structure that relies on Medicare rates for rate setting. OHCA has designed a new rate methodology for outpatient hospital dental services and a set of other services with similar costs. The new rate for these services will be cost based and will equalize the rates to improve access for dental services to be rendered in the hospital setting.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Currently, the agency pays for dental services and certain ENT services provided in an outpatient hospital separately and at a percentage of the Medicare rate.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   OHCA proposes to increase the rate paid for certain outpatient dental services provided in an outpatient hospital to $914.71. These services will be reimbursed on a cost basis effective on or after January 1, 2018. Dental and ear, nose, and throat (ENT) surgical procedures will be classified into a payment group based on specific CPT codes. Historical utilization and a facility specific outpatient cost to charge ratio (CCR) from the hospital Medicare cost report will be used to determine average cost per unit by facility, then in total. The result is an increase in the dental rate and a decrease in certain ENT rates which will make this change budget neutral. All procedures within this payment group will be paid a single rate.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for state fiscal year 2018 is estimated to be $0.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

The Oklahoma Health Care Authority does not anticipate any negative 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). Currently, there are not enough providers to fulfill the demand for these services. It is believed this rate increase will encourage providers to increase participation and thus have a positive impact on access to care.

8. 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 dental services and certain ENT services to a cost based rate.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

REINSTATEMENT OF 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 reinstatement in the amount of 9.00%, to the current 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 9% reduction from the applicable rate structures, implemented in April of 2010, July 2014, January 2016, and December 2017.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   OHCA seeks to reinstate the current rates by 9.00% of the applicable rate structure. The proposed reduction excludes services financed through appropriations to other state agencies, services provided under a waiver, and services where a reduction could severely limit access or not cover costs (in the aggregate). 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 $68,409,743; $28,342,157 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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 reinstatement of the 9.00% rate reduction for all providers excluding those providers/services that have an exception provision.

9. EFFECTIVE DATE OF CHANGE.

December 1, 2017

ACROSS THE BOARD PROVIDER RATE REDUCTION

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of a 6.00% reduction, to the current rates and reimbursement structure in the SoonerCare program. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   OHCA currently reimburses providers under a variety of different rate structures; diagnostic-related group (DRG), per diem, max fee, percent of Medicare, and a percent of costs are some examples. Our current rates reflect a 3.25% reduction, a 7.75% reduction, and a 3.00% reduction from the applicable rate structures, implemented in April of 2010, July 2014, and January 2016.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   Effective January 1, 2018, OHCA seeks to decrease the current rates by 6.00% of the applicable rate structure. The proposed reduction excludes services financed through appropriations to other state agencies, services provided under a waiver, and services where a reduction could severely limit access or not cover costs (in the aggregate). 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 a decrease 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

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?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a change to the effective date of implementation of the revision to the methodology for payment of Medicare crossover claims to Nursing Facilities. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates:
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The OHCA Board approved on November 9, 2017 to pay 0% of Medicare Part A coinsurance and deductible, and 0% of Medicare Part B coinsurance and deductible on crossover claims to nursing facilities with an effective date of December 1, 2017.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in the proposed rate methodology to pay 0% of Medicare Part A and B coinsurance and deductible on crossover claims to nursing facilities; however, there is a request to change the effective date of the method change from December 1, 2017 to January 1, 2018.

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be a decrease 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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 implementation of a method change to pay 0% of Coinsurance and Deductible of Medicare Part A and B Crossover claims to nursing facilities from an effective date of December 1, 2017 to an effective date of January 1, 2018.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

REINSTATEMENT OF 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 reinstatement in the amount of 4.00% to Regular Nursing Facilities provider rates.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular Nursing facilities calls for the establishment of a prospective rate which consists of four components. The current components are as follows:
   A. Base Rate Component is $107.55 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 is $150,326,168.

The Quality of Care (QOC) fee is $11.05 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a rate change for Regular Nursing facilities because of the reinstatement of Regular Nursing Facility rates by 4.00%.

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 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 $10,669,304; with $4,384,017 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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 in the base rate component from $107.55 per patient day to $107.79 per patient day.
- An increase in the combined pool amount for the "Other Cost" and "Direct Care" Components from $150,326,168 to $160,636,876.

9. EFFECTIVE DATE OF CHANGE.

December 1, 2017

REGULAR NURSING FACILITIES RATE REDUCTION

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of 1.00% reduction to Regular Nursing Facilities provider rates. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular Nursing facilities calls for the establishment of a prospective rate which consists of four components. The current components are as follows:
   A. Base Rate Component is $107.79 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 current combined pool amount for "Direct Care" and "Other Cost" Components is $160,636,876.

The current Quality of Care (QOC) fee is $11.29 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a proposed rate change for Regular Nursing Facilities because of the proposed 1% decrease to Regular Nursing Facility provider rates.

The new Base Rate Component will be $107.73 per patient day, a decrease of $0.06 per patient day.

The new average "Direct Care" Component is $23.54 per patient day, a decrease of $0.78 per patient day.

The new "Other Cost" Component is $10.09 per patient, a decrease of $0.33 per patient day.

The new combined pool amount for "Direct Care" and "Other Cost" Components will be $158,498,444.

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

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be a decrease 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

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

- A decrease in the base rate component from $107.79 per patient day to $107.73 per patient day.
- A decrease in the combined pool amount for the "Other Cost" and "Direct Care" Components from $160,636,876 to $158,498,444 to account for the 1% reduction in rates for Regular Nursing Facilities.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

REINSTATEMENT OF 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 reinstatement in the amount of 4.00% to Regular ICF/IID facilities provider rates.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day.

   The current rate for this provider type is $118.50 per patient day.

   The current Quality of Care (QOC) fee is $7.31 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a proposed rate change for Regular (ICF/IID) facilities because of the reinstatement of Regular ICF/IID facilities rates by 4.00%.

The reinstated rate for this provider type 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 $444,759; with $182,752 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 anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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:

- An increase in the rate from $118.50 per patient day to $122.77 per patient day.

9. EFFECTIVE DATE OF CHANGE.

December 1, 2017

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?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of 1.00% reduction to Regular ICF/IID facilities provider rates. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day.

   The current rate for this provider type is $122.77 per patient day.

   The Quality of Care (QOC) fee is $7.54 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a proposed rate change for Regular ICF/IID facilities because of the proposed decrease of 1.00% to the rates of this provider type.

The proposed rate will be $121.70 per patient day.

The Quality of Care (QOC) fee will be $7.51 per patient.

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be a decrease 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

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

- A decrease in the rate from $122.77 per patient day to $121.70 per patient day.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

REINSTATEMENT OF 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 reinstatement in the amount of 4.00% to Acute ICF/IID facilities rates.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Acute ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day.

   The current rate for this provider type is $151.44 per patient day.

   The current Quality of Care (QOC) fee is $9.17 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a proposed rate change for Acute ICF/IID facilities because of the reinstatement of Acute ICF/IID facilities rates by 4%.

The reinstated rate for this provider type 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 $789,944; with $324,588 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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:

- An increase in the rate from $151.44 per patient day to $157.03 per patient day.

9. EFFECTIVE DATE OF CHANGE.

December 1, 2017

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?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of 1.00% reduction to Acute ICF/IID facilities provider rates. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Acute ICF/IID facilities 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 $157.03 per patient day.

   The Quality of Care (QOC) fee is $9.50 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a proposed rate change for Acute ICF/IID facilities because of the proposed 1.00% decrease to the rates of this provider type.

The proposed rate will be $155.63 per patient day.

The Quality of Care (QOC) fee will be $9.46 per patient day.

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be a decrease 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Acute ICF/IID facilities:

- A decrease in the rate from $157.03 per patient day to $155.63 per patient day.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

REINSTATEMENT OF 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 reinstatement in the amount of 4.00% to nursing facilities serving residents with AIDS provider rates.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for nursing facilities serving residents with AIDS requires the establishment of a prospective rate which is based on the reported allowable cost per day.

   The current rate for this provider type is $193.53 per patient day.

   The current Quality of Care (QOC) fee is $11.05 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 because of the reinstatement of rates of this provider type by 4.00%.

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 $31,557; with $ 12,967 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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 in the AIDS rate from $193.53 per patient day to $200.01 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
December 1, 2017

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?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of 1.00% reduction to nursing facilities serving residents with AIDS provider rates. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for 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 $200.01 per patient day.

   The Quality of Care (QOC) fee is $11.29 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 because of the proposed 1% decrease to the rates of this provider type.

The proposed rate will be $ $198.39 per patient day.

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

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be a decrease 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities serving residents with AIDS:

- A decrease in the AIDS rate from $200.01 per patient day to $198.39 per patient day.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018