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STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

March SPARC Agenda
March 20, 2019
11:00 AM
OHCA Board Room

Rate issues to be addressed:

1. Residential Behavior Management Services (RBMS) Rates
2. Partial Hospitalization (PHP) Services Rates
3. CCBHC Rates
4. ITFC Rates
5. Medicare Crossover SPA

RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES (RBMS) RATES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Department of Human Services (DHS) and the Oklahoma Office of Juvenile Affairs (OJA) requests a rate and a rate method change for Residential Behavioral Management Services (RBMS) rates. The rates and rate method has not been changed or updated since 1996. Due to the rate/rate methodology being developed over 20 years ago, the exact calculations for the current rates are not available.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current methodology is similar to the proposed methodology. The current methodology was created in 1996 and the direct care cost adjustment factors could not be located.

Group Home Cost at Current Rates

Level	Total Beds Budgeted	2018 Per Diem Rate amount	Direct Care Cost Adj Factor	Proposed Medicaid Rate	Total Bed Days	Medicaid Days - Medicaid % x total days
C	12	$100.10	18.00%	$18.02	4,380	4,336
D	28	$101.72	N/A	$0.00	10,220	10,118
D+	104	$134.20	33.10%	$44.42	37,960	37,580
E	188	$169.40	52.65%	$89.20	68,620	67,934
E+	16	$256.00	52.65%	$134.78	5,840	5,782
Enhanced E	12	$307.20	52.65%	$161.74	4,380	4,336
ITS	9	$214.50	53.96%	$115.74	3,285	3,252

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The proposed methodology is similar to the previous methodology using updated calculations. The proposed methodology is as follows:

   Staff cost is calculated by using state salary and benefit package guidelines for similar jobs. Jobs at the group homes consist of Direct Care staff and supervisors, Nurses, Therapist,

Program Director, and administrative staff. The total staff cost can then be divided into a, per day per child rate.
Facility cost is based on the Oklahoma Child Care licensing standard for the minimum square foot in the living quarters for each resident. That square footage is then grossed up to include common spaces, administrative office space, and activity areas. The total square footage is used to calculate the total facility cost by using the standard rent estimates for Oklahoma. The total cost is then divided into a, per day per child rate.

Operational cost include food, clothing, transportation, liability insurance (required), accreditation (if applicable), and miscellaneous. The amounts for food, clothing, and transportation come from the USDA cost of raising a child report. Liability Insurance and miscellaneous come from actual cost incurred by facilities and reported on audited financial statements. The total cost is then divided into a, per day per child rate.

The total per child per day rate is sum of all three and is referred to as the group home per diem rate for that level of care with an additional 15% admin cost. The per diem rate is compensable for both Medicaid and Title IV-E funding. The allocation of cost between the two programs is as follows.
Staff – Direct care staff perform Basic Living Skills Redevelopment, Social Skills Redevelopment, and Behavior redirection to children in the facility during all times the child is awake and not in school, whether on or off campus school, therefore the direct care staff time allocated to Medicaid is calculated as follows:

24 hr. per day
8 hr. average sleep time per day
2.96 hr. average time per day in school (Oklahoma requires 1,080 per year)
13.04 hr. allocated to Medicaid or 54.34%

Therapist and Nurses salary are 100% compensable to Medicaid. Using the formula below gives the percent of program staff allocated to Medicaid.

(54.34% x Direct Care Sal. + Therapist Sal. + Nurse Sal.)
(Direct Care Sal. + Therapist Sal. + Nurse Sal.)

This percentage will then be applied to the Program Director, Administrative personnel, facility cost, miscellaneous, and the 15% admin cost because these cost apply at that percent to both Medicaid and IV-E. Food, clothing, transportation, liability insurance, and accreditation cost are allocated entirely to Title IV-E.

Group Home Cost at Proposed Rates

Level	Total Beds Budgeted	2018 Per Diem Rate amount Proposed	Direct Care Cost Adj Factor	Proposed Medicaid Rate	Total Bed Days	Medicaid Days - Medicaid % x total days
C	12	$172.07	53.18%	$91.51	4,380	4,336
D	32	$140.81	0.00%	$0.00	11,680	11,563
D+	108	$201.80	61.43%	$123.97	39,420	39,026
E	188	$225.86	59.21%	$133.73	68,620	67,934
E+	16	$307.45	57.23%	$175.95	5,840	5,782
Enhanced E	12	$339.03	55.17%	$187.04	4,380	4,336
ITS	9	$312.75	58.50%	$182.96	3,285	3,252

6. **BUDGET ESTIMATE.**

The estimated budget impact for the remainder of SFY2020 will be an increase of $5,309,136 total; of which $1,804,045 is state share. The state share will be paid by the Oklahoma Department of Human Services (DHS).

The estimated budget impact for the remainder of SFY2020 will be an increase of $1,323,638 total; of which $449,772 is state share. The state share will be paid by the Oklahoma Office of Juvenile Affairs (OJA).

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**

The Oklahoma Department of Human Services (DHS) and the Oklahoma Office of Juvenile Affairs (OJA) does not anticipate any negative impact on access to care.

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

The Oklahoma Department of Human Services (DHS) and the Oklahoma Office of Juvenile Affairs (OJA) requests a rate and a rate method change for Residential Behavioral Management Services (RBMS) rates listed in the following table:

Group Home Cost at Proposed Rates

Level	Total Beds Budgeted	2018 Per Diem Rate amount Proposed	Direct Care Cost Adj Factor	Proposed Medicaid Rate	Total Bed Days	Medicaid Days - Medicaid % x total days
C	12	$172.07	53.18%	$91.51	4,380	4,336
D	32	$140.81	0.00%	$0.00	11,680	11,563
D+	108	$201.80	61.43%	$123.97	39,420	39,026
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E+	16	$307.45	57.23%	$175.95	5,840	5,782
Enhanced E	12	$339.03	55.17%	$187.04	4,380	4,336
ITS	9	$312.75	58.50%	$182.96	3,285	3,252

9. EFFECTIVE DATE OF CHANGE.

September 1, 2019

PARTIAL HOSPITALIZATION (PHP) SERVICES RATE

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?**
   Current reimbursement for Partial Hospitalization Programs (PHP) is made using a one hour unit of service of at least 3 hours per day and no more than 4 hours per day. However, the national HCPCS code used for PHP (H0035) is an encounter code of less than 24 hours, not an hourly code. In order to avoid a potential perm error with CMS, ODMHSAS is recommending to convert the current hourly code to a daily reimbursement rate.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current reimbursement rate is $42.80 per hour, which is converted from a blend of the 2010 Medicare two tiered per diem payment approach for partial hospitalization services: one for days with three services (APC172) and one for days with four or more services (APC173). Physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, qualified psychologist services and services furnished to SNF residents are separately covered and not paid as partial hospitalization services.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   A survey of the PHP providers in the state and a review of claims data showed that average minimum PHP treatment days consist of 3.5 hours of treatment services with no more than 4 hours in a day. Accordingly, the new reimbursement rate of $160.50 per day is based on the 2010 Medicare cost assumptions for PHP services, but is a blend of a 3.5 hour treatment day and a 4 hour treatment day. Physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, qualified psychologist services and services furnished to SNF residents are separately covered and not paid as partial hospitalization services.

6. **BUDGET ESTIMATE.**
   This change is estimated to be budget neutral.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The agency has determined that this change will not have an impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The agency requests the SPARC to approve the proposed reimbursement methodology for partial hospitalization services of a daily rate of $160.50 per day which is a blend of the current hourly rate for a 3.5 hour treatment day and a 4 hour treatment day.

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

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC REIMBURSEMENT

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) was awarded a demonstration grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS) to implement Certified Community Behavioral Health Clinic (CCBHC) pilots in Oklahoma. Oklahoma was one of 8 states chosen for this 2- year demonstration (demo) program. Three outpatient behavioral health clinics (2 urban and 1 rural) were certified and are responsible for directly providing nine required types of behavioral health treatment services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health. CCBHCS are reimbursed utilizing a Prospective Payment System (PPS). In establishing the PPS rate, CCBHC completed cost reports for the period of April 1, 2017 to March 31, 2018 that include the cost of providing all services to all patients to establish a Per-Member Per Month (PMPM) cost of serving patients in that clinic. The reports included actual plus anticipated costs related to new services or new costs which will be provided or incurred during the demonstration phase. This demonstration will end March 31, 2019. In order to sustain this delivery model, the state will submit a state plan amendment that will be open to any willing and qualified provider. If approved by the OHCA board, this change will be effective April 1, 2019, contingent upon CMS approval.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   CCBHC receive a fixed PMPM reimbursement rate for every individual who has at least one qualifying visit in the month. There is a standard CCBHC (or base) rate and five Separate Reimbursement Rates for Special Populations (SPPOP). The ODMHSAS developed SPPOP categories that recognize the higher costs and resource needs for individuals who have been assessed and designated as Severely Mentally Ill (SMI), Severe Emotional Disturbance

(SED), homeless and those requiring intensive substance abuse programming. Each provider assigns a client to a SPPOP category based on the established criteria.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
New CCBHCS will receive an interim rate of 90% of the rates established for urban CCBHCS that participated in the 2-year demonstration until a provider specific cost report is completed.

Effective April 1, 2019, there will be two separate reimbursement rates for special populations instead of five. The ODMHSAS has developed a list of individuals who are "most in need" and the provider may choose from this list to assign individuals to SPPOP rate categories and bill for the SPPOP rate. At the end of 90 days, ODMHSAS will review care needs and rates for clients assigned to special populations to determine a need for continued stay at this level of service intensity. If the client has been admitted for an inpatient psychiatric hospital stay during this time period, the state will recoup the difference in the applicable provider-specific SPPOP rate and the standard rate. The rate will then be updated annually based on the Medicare Economic Index (MEI)

6. **BUDGET ESTIMATE.**
Federal impact: Due to CCBHC moving from a demonstration to a State Plan Medicaid covered service, the Centers for Medicare & Medicaid Services (CMS) views the budget as new Medicaid program and requires the total net budget to be reported. Prior to the CCBHC demonstration, most of the amounts below were being paid on a fee-for-service basis and are now paid on a Prospective Payment System (PPS) methodology. The net increase for the six remaining months of FFY2019 will be $42,048,685 total, 26,444,418 federal share. The net increase for FFY2020 will be $84,097,370 total, $55,521,084 federal share.

State impact: The net increase to ODMHSAS for the three months remaining in SFY2019 is $1,683,210 total, $618,222 state share which will be paid by ODMHSAS. Due to the rebasing and change in methodology for special populations, the estimated SFY2020 budget impact is a savings to ODMHSAS of $259,849 total, $90,661 state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The agency anticipates there will be increased access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The agency requests the SPARC to approve the proposed change in reimbursement method for CCBHCS.

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

ITFC RATES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   THE OKLAHOMA DEPARTMENT HUMAN SERVICES (DHS) REQUEST A NEW RATE AND A RATE METHODOLOGY FOR INTENSIVE THERAPEUTIC FOSTER CARE (ITFC).

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   This is a new program so there is no current methodology.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   ITFC IS TREATMENT FOCUSED PROGRAM THAT SERVES CHILDREN IN THE CUSTODY IN A FAMILY SETTING THAT UTILIZES A TEAM APPROACH OF PROFESSIONALS INCLUDING THERAPIST, CARE COORDINATORS, AND THE FOSTER PARENT TO PROVIDE THE SERVICES. THE RATE IS A PER DIEM RATE THAT ENCOMPASSES THE COST OF PROVIDING A FOSTER HOME ENVIRONMENT (IV-E COMPENSABLE ACTIVITIES) ALONG WITH THE EVIDENCED BASED AND TRAUMA INFORMED THERAPIES AND TREATMENTS (TITLE XIX COMPENSABLE ACTIVITIES).
   THE RATE CONSIDERS COST TO COVER THE RECRUITMENT, LICENSING, AND SUPPORT OF THE FOSTER PARENT ALONG WITH COST ASSOCIATED PLACING A CHILD IN THIS TYPE OF FAMILY SETTING AND THE ROOM AND BOARD COST, THE FOSTER CARE REIMBURSEMENT RATE ESTABLISHED FOR ALL FOSTER PARENTS, ALL OF WHICH ARE TITLE IV-E COMPENSABLE ACTIVITIES. THE RATE ALSO INCLUDES THE COST OF THERAPIST THAT SERVE UP TO 12 CHILDREN EACH AND THE PAYMENT TO THE FOSTER PARENT FOR SERVICES AND TREATMENT THEY PROVIDE IN THE HOME, ALL OF WHICH ARE TITLE XIX COMPENSABLE ACTIVITIES. THE IV-E ACTIVITIES ACCOUNT FOR 37.01% AND THE TITLE XIX ACTIVITIES ACCOUNT FOR 62.99%. THERE ARE ALSO COST THAT BENEFIT BOTH PROGRAMS SUCH AS PROGRAM DIRECTOR SALARY, LIABILITY INSURANCE, AND GENERAL OVERHEAD OF WHICH ARE SPLIT BETWEEN THE PROGRAMS AT THE 37.01% TO TITLE IV-E AND 62.99% TO TITLE XIX.

Component	Per Diem	IV-E Admin	IV-E Maint.	XIX
Recruitment	*$11.14*	$11.14		
Licensing	*$7.02*	$7.02		
Placement	*$8.70*	$8.70		
Support	*$22.41*	$22.41		
Therapy	*$24.74*			$24.74
Foster Parent	*$150.80*		$33.61	$117.19
Total	***$224.81***	***$49.27***	***$33.61***	***$141.93***

6. BUDGET ESTIMATE.

	Annual Budget	FY19 Est	FY20 Est
State	$9,595,439	$788,310	$5,032,209
IV-E	$2,125,376	$522,700	$3,088,192
XIX	$9,686,944	$889,621	$5,256,018
Total	$21,407,759	$2,264,062	$13,376,420

THE STATE SHARE WILL BE PAID BY DHS AND IS COST NEUTRAL BY REDUCING THE NUMBER OF BEDS IN TFC TO FUND ITFC. THE BEDS REDUCTION IS BUDGET ONLY AND WILL NOT IMPACT THE NUMBER OF CHILDREN CURRENTLY BEING SERVED.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

DHS DO NOT ANTICIPATE ANY NEGATIVE IMPACT ON ACCESS OF CARE.

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

DHS REQUEST A RATE AND A RATE METHOD FOR ITFC OF $224.81 WITH $141.61 MEDICAID RATE.

9. EFFECTIVE DATE OF CHANGE.

April 1, 2019 or approval by CMS

MEDICARE CROSSOVER CLAIMS

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?**
   The Oklahoma Health Care Authority (OHCA) proposes a change in the Oklahoma State Plan to align the payment methodology for Medicare Part A and Part B crossover claims with current practice.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The methodology of paying Medicare crossover claims is not changing, but the State Plan is being updated to align with current practice.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   Due to a provider type and specialty change for psychiatric hospitals and Psychiatric Residential Treatment Facilities (PRTF), Medicare crossover claims were paying incorrectly. The original intent was to pay psychiatric hospitals and PRTFs the same way as hospitals, as that was their previous provider type. Psychiatric hospitals and PRTFS are paid 75% of deductible and 25% of coinsurance for Medicare Part A crossover claims.

   Medicare medical services and dialysis are receiving payment of 100% of deductible and 46.25% of coinsurance for Medicare Part B crossover claims.

   Payment for Indian Health Services (IHS) clinics and transportation services are made at 100% of deductible and 100% of coinsurance for Medicare Part B crossover claims.

6. **BUDGET ESTIMATE.**
   The proposed State Plan amendment is budget neutral as this proposed amendment is being submitted to align with current practice.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   OHCA does not anticipate any impact on access of care.

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

OHCA requests the State Plan Amendment Rate Committee to approve the following State Plan amendment:

- Pay psychiatric hospitals and PRTFS 75% of deductible and 25% of coinsurance for Medicare Part A crossover claims.
- Pay Medicare medical services and dialysis 100% of deductible and 46.25% of coinsurance for Medicare Part B crossover claims.
- Pay Indian Health Services (IHS) clinics and transportation services 100% of deductible and 100% of coinsurance for Medicare Part B crossover claims.

9. EFFECTIVE DATE OF CHANGE.

April 1, 2019