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OKLAHOMA HEALTH CARE AUTHORITY

August SPARC Agenda
August 19, 2019
1:00 PM
OHCA Board Room

Rate issues to be addressed:

1. 5.00% Across-the-Board Provider Rate Increase
2. Out-of-State Services
3. Inpatient Psychiatric Add-On Payment

5.00% ACROSS-THE-BOARD PROVIDER RATE INCREASE

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, in the amount of a 5.00% increase, to the current rate and reimbursement structures in the SoonerCare program. Upon passage of Senate Bill 1044, OHCA was mandated to increase most provider rates by 5.00%.

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 for most providers reflect a 3.25% reduction, a 7.75% reduction, a 3.00% reduction, and a 3.00% increase from the applicable rate structures, implemented in April of 2010, July 2014, January 2016, and October 2018. Some provider rates were not impacted by all rate reductions/increases.

5. NEW METHODOLOGY OR RATE STRUCTURE.

OHCA seeks to increase provider rates by 5.00% of the applicable rate structures. Per Senate Bill 1044, the proposed rate increases excludes: services financed through appropriations to other state agencies; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); non-emergency transportation capitation payments; services provided to Insure Oklahoma (IO) members; payments for drug ingredients/physician supplied drugs; Indian Health Services/Tribal/Urban Clinics (I/T/U); Federally Qualified Health Centers (FQHCs); Rural Health

Centers (RHCs); and Long-Term Care Facilities, which will be discussed at a later hearing date. Program for the All-Inclusive Care for the Elderly (PACE) was excluded from the legislatively mandated rate increases, however OHCA will increase these rates by 5.00% as well.

6. **BUDGET ESTIMATE.**
The estimated budget impact for the remainder of SFY2020 will be an increase of $62,867,943 total; of which $21,362,527 is state share. The estimated budget impact for SFY2021 will be an increase of $85,650,782 total; of which $28,324,714 is state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The Oklahoma Health Care Authority anticipates a positive impact on access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care, in accordance with requirements at 42 CFR 447.203(b)(6).

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the 5.00% across-the-board provider rate increase of the applicable rate structures for all providers excluding those providers/services mentioned.

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

OUT-OF-STATE SERVICES

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 to clarify coverage and reimbursement methodology for services rendered by providers that are physically located outside of Oklahoma.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Reimbursement for out-of-state will be made in the following manner:

- Inpatient hospital:
  - Services shall be reimbursed the lesser of the billed charges or the Diagnosis Related Group (DRG) amount.
  - In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays.
  - The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Covered inpatient services provided to eligible members of the Oklahoma SoonerCare program, when treated in out-of-state hospitals, will be reimbursed in the same manner as in-state hospitals.
  - Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.
- Outpatient hospital:
  - Hospital outpatient services shall be reimbursed on a rate-per-service basis that varies according to the Ambulatory Payment Classification (APC) group to which the services are assigned. If not assigned to an APC group and otherwise covered by SoonerCare, services may be reimbursed as determined by OHCA.

- Physician services:
    - Reimbursement for physician services shall be the lower of the SoonerCare maximum allowable fee as of the date the service was rendered, available at www.okhca.org (SoonerCare Fee Schedules), or the provider's actual charge.
    - Exceptions to the above reimbursement method are payments for outpatient clinical diagnostic laboratory tests performed by a physician or independent laboratory. These tests will be reimbursed at the lower of the provider's actual charge or a rate of reimbursement equal to the rate paid by Medicare.

5. NEW METHODOLOGY OR RATE STRUCTURE.

The only change is to add the following clarifying language to the State Plan: The OHCA may negotiate a higher reimbursement than the current Oklahoma Medicaid rate for an out-of-state service that is prior authorized, provided that the service is not available in Oklahoma and the negotiated reimbursement does not exceed the rate paid by Medicare, unless authorized in the Oklahoma State Plan.

6. BUDGET ESTIMATE.

This proposal is budget neutral as it sets out to standardize out-of-state coverage and payment methodologies as well as align with practice.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

The Oklahoma Health Care Authority anticipates no impact on access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care, in accordance with requirements at 42 CFR 447.203(b)(6).

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the proposed coverage and reimbursement methodology for services rendered by providers that are physically located outside of Oklahoma.

9. EFFECTIVE DATE OF CHANGE.

September 1, 2019, contingent upon CMS approval.

INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER AGE 21

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   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 Service (ODMHSAS) proposes to revise the payment methodology in Acute Level 2 settings of Private Psychiatric Hospitals and General Hospitals with Psychiatric Units and in Psychiatric Residential Treatment Facilities (PRTFs), to allow an additional patient-specific specialty add-on per diem rate. The state has seen a recent increase in children requiring treatment out-of-state. This change being to incentivize the development of in-state specialty programs or units that are high quality and outcome-based.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current methodology consists of prospective per diem base rates for Acute Level 2 settings and for PRTFs. The rates are $367.42 and $340.04, respectively. Depending on the needs of the child, a facility may also receive a patient-specific add-on per diem payment of $110.99 for Intensive Treatment Services (ITS), or $77.51 for Non-Verbal Children. An outlier intensity adjustment may also be requested on a case by case basis for those children who have costs beyond the payments made for the base rate and add-ons.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   This new methodology creates a third add-on, a specialty payment of $210 per diem. The add-on payments will not be mutually exclusive. For example, depending on the needs of the child and prior authorization, a facility may receive the base rate + ITS + non-verbal + a specialty add-on payment per day.

6. **BUDGET ESTIMATE.**
   The estimated total budget impact for the remainder of SFY2020 is $4,310,344; $1,500,000 state share and an annual total cost of $5,747,126; $2,000,000 state share for SFY2021. The state share will be paid by the Oklahoma Department of Mental Health and Substance Abuse Service (ODMHSAS).

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
Increase in access to care. We expect to provide access to 150 children, reduce lengths of stay and readmissions.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
ODMHSAS requests the SPARC to approve the proposed specialty add-on rate of $210 per day in Acute Level 2 settings of Private Psychiatric Hospitals, General Hospitals with Psychiatric Units and PRTFs.

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