METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
FOR NURSING FACILITIES

SUPPLEMENTAL PAYMENTS FOR NON-STATE GOVERNMENT OWNED NURSING FACILITIES

1. Effective for dates of service on or after January 1, 2018, the following nursing facilities, which are owned or operated by a non-state government organization (NSGO) and have entered into an agreement with the Oklahoma Health Care Authority (OHCA) to participate, shall qualify for a Medicaid supplemental payment, in addition to the Medicaid rates paid to nursing facilities. The Participating Nursing Facilities effective for May 1, 2018 are as follows:

NSGO	Participating Nursing Facilities
City of Hugo	Antlers Nursing Home
City of Hugo	Boyce Manor Nursing Home
City of Hugo	Calera Manor
City of Hugo	Choctaw Nation Nursing Home
City of Hugo	Homestead of Hugo
City of Hugo	Shawnee Care Center
City of Hugo	Southern Pointe Nursing Center
City of Hugo	Talihina Manor
City of Pauls Valley	Ada Care Center
City of Pauls Valley	Cedar Creek Nursing Center
City of Pauls Valley	Garland Road Nursing & Rehab
City of Pauls Valley	Grace Living Center – Edmond
City of Pauls Valley	Grace Living Center – SW OKC
City of Pauls Valley	Grace Living Center – Wildewood
City of Pauls Valley	Medical Park Rehab & Skilled Care
City of Pauls Valley	Montevista Rehab & Skilled Care
City of Pauls Valley	Tulsa Nursing Center
City of Pauls Valley	Tuscany Village Nursing Center
Town of Vici	Town of Vici Nursing Home

2. The aggregate Medicaid supplemental payments made to Participating Nursing Facilities shall not exceed the upper payment limit (UPL) in the current state fiscal year, calculated in accordance with 42 CFR 447.272 and Medicare payment principles using the Medicare Resource Utilization Groups (RUGs).

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

SUPPLEMENTAL PAYMENTS FOR NON-STATE GOVERNMENT OWNED NURSING FACILITIES (continued)

3. Payment Calculations

The total potential Medicaid supplemental payment for each individual Participating Nursing Facility will be established as the individual nursing facility differential between the estimated and adjusted Medicare equivalent payments for Medicaid nursing facility residents, and the adjusted Medicaid payments for those same nursing facility residents. The payment will be subject to additional adjustment based on each Participating Nursing Facility satisfying quality of care requirements. A more detailed description of the Medicaid supplemental payment process is described below:

a. The calculation of the Medicaid supplemental payment for each Participating Nursing Facility will be made at least annually but no more frequently than quarterly, and will include the following five components:

i. Determine Medicare-equivalent payments for the Participating Nursing Facility residents using Medicare payment principles;
ii. Determine Medicaid payments for the Participating Nursing Facility;
iii. Adjust payments for coverage differences between Medicare payment principles and Medicaid payment principles;
iv. Calculate the differential between the calculated Medicare-equivalent payments for the Participating Nursing Facility, and the Medicaid payments for the Participating Nursing Facility; and
v. Determine the Quality-Based Percentage of Eligible Supplemental Payment to be received.

b. Calculating Medicare-Equivalent rates using Medicare payment principles.

The average Medicare rate that would have been paid for the Participating Nursing Facility using Medicare payment principles will be calculated for each Participating Nursing Facility.

i. Using each resident's most current minimum data set (MDS) assessment from the calculation period, the applicable RUG-IV 66 grouper code for Medicaid residents of that Participating Nursing Facility will be identified. A frequency distribution of Medicaid residents in each of the Medicare RUG classification categories is then generated for each Participating Nursing Facility.

1. The resident minimum data set assessments will be from the most recently available minimum data set assessments from the calculation period.

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SUPPLEMENTAL PAYMENTS FOR NON-STATE GOVERNMENT OWNED NURSING FACILITIES (continued)

3. Payment Calculations (continued)

b. Calculating Medicare-Equivalent rates using Medicare payment principles (continued)

ii. The Medicare rate tables applicable to the time period of the MDS assessment and published by CMS will be adjusted for each Participating Nursing Facility to reflect the rural and urban rate differentials and wage index adjustments.

1. Medicare rate tables will be established using information published in 42 CFR part 483 where available. Should the finalized Medicare rate tables for any portion of the applicable calculation period be unavailable, the most recent preliminary Medicare rate adjustment percentage published in the federal register available as of the development of the Medicaid supplemental payment calculation demonstration will be utilized as the basis of the Medicare rate for that portion of the calculation period.

2. The resulting Medicare rates are multiplied by the number of Medicaid residents in each RUG category, summed and averaged. The Medicare rate tables applicable to the calculation period will be multiplied by an estimate of Medicaid paid claims days (less leave days) for the specified period to determine the Unadjusted Medicare-Equivalent payments for each Participating Nursing Facility. Medicaid paid claims days will be compiled for the calculation period from the state's Medicaid Management Information System (MMIS), as of the development of the Medicaid supplemental payment calculation.

c. Determining Medicaid payments for Oklahoma Medicaid nursing facility residents.

Each participating nursing facility's base Medicaid payment rates shall be the Medicaid rates determined pursuant to other provisions in Attachment 4.19-D of the Oklahoma Medicaid state plan. The Medicaid nursing facility reimbursement rates in effect for the Medicaid supplemental payment calculation period will be utilized. These reimbursement rates will be multiplied by Medicaid days (less leave days) compiled from claims adjudicated through the state's MMIS system for the calculation period to establish total Unadjusted Medicaid payments.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
FOR NURSING FACILITIES

SUPPLEMENTAL PAYMENTS FOR NON-STATE GOVERNMENTAL ORGANIZATION NURSING FACILITIES
(continued)

3. Payment Calculations: (continued)

d. Adjusting for differences between Medicare principles and Oklahoma Medicaid nursing facility rates.

i. Adjustments to the calculation of the Unadjusted Medicare-Equivalent payments and the Unadjusted Medicaid payments for each Participating Nursing Facility will be performed to account for the differences in coverage between the Medicare rate and what Oklahoma Medicaid covers within the reimbursement otherwise provided in this Attachment 4.19-D. To accomplish this, estimates will be calculated for pharmacy, laboratory, radiology, durable medical equipment services, and therapy services. These estimates will then be subtracted from the Unadjusted Medicare-Equivalent payments, or added to the Unadjusted Medicaid payments for each Participating Nursing Facility, as applicable. This will create Adjusted Medicare-Equivalent payments, and Adjusted Medicaid payments for each Participating Nursing Facility that represent the total payment for equivalent services under each program.

ii. An adjustment will be made to the total Unadjusted Medicaid payments for each Participating Nursing Facility to account for coverage included in Medicaid payments but not included in Medicare rates (and not covered by Medicare). In particular, an estimate for amounts included in the Medicaid payments for professional fees for vision and dental services will be calculated using the percentage attributable to these services in the base year used to calculate the Medicaid payments. This percentage will be subtracted from Unadjusted Medicaid payments to create Adjusted Medicaid payments for each Participating Nursing Facility.

e. Determining the differential between the Adjusted Medicare-Equivalent payments for each Participating Nursing Facility, and the Adjusted Medicaid payments for those same facilities.

i. The total potential Medicaid supplemental payment for each Participating Nursing Facility will be equal to the facility's differential between the calculated Adjusted Medicare-Equivalent payments and the calculated Adjusted Medicaid payments for the applicable calculation period.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
FOR NURSING FACILITIES

SUPPLEMENTAL PAYMENTS FOR NON-STATE GOVERNMENTAL ORGANIZATION NURSING FACILITIES
(continued)

f. Determining Quality-Based Percentage of Eligible Supplemental Payment to be Received. Each Participating Nursing Facility will have an opportunity to receive up to 100% of the potential Medicaid supplemental payment amount based on achievement of defined quality of care metrics. Compliance with quality of care metrics will be assessed each quarter.

i. Sixty percent (60%) of the potential annual Medicaid supplemental payment amount is achievable based on completion of monthly Quality Assurance Performance Improvement (QAPI) meetings. Payments for each quarter will be reduced by 20 percent for any month in which a QAPI meeting was not held.

ii. Forty percent (40%) of the potential annual Medicaid supplemental payment amount is achievable based on achieving 5 percent relative improvement each quarter from baseline, which is determined as a result of self-reporting facility data: monthly, quarterly and/or annually; on the four below measures (each worth ten percent (10%)), or, alternatively, by meeting or exceeding the national average benchmark for those four measures.

1. Received an Antipsychotic Medication (lower is improvement)
2. Obtained urinary track infection (lower is improvement)
3. Unintended weight loss (lower is improvement)
4. Developed new or worsening pressure ulcers (lower is improvement)

4. Payment Frequency

The Medicaid supplemental payments will be reimbursed through a calendar quarter based lump sum payment. The amount of the calendar quarter lump sum payment will be equal to the SFY total annual Medicaid supplemental payment calculation divided by four (as adjusted by application of the quality of care metrics) or the quarterly supplemental payment calculation (as adjusted by application of the quality of care metrics) whichever is applicable. Determination of the total potential Medicaid supplemental payment will occur for each SFY following the July quarterly Medicaid rate setting process or after the calculation quarter.

No payment under this section is dependent on any agreement or arrangement for provider or related entities to donate money or services to a governmental entity.