Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's Proposed Changes Blog.

OHCA COMMENT DUE DATE: February 15, 2019

The proposed policy is a Permanent Rule. The proposed policy was presented at the January 8, 2019 Tribal Consultation. Additionally, this proposed change will be presented at a Public Hearing scheduled for February 20, 2019. This proposal is scheduled to be presented to the Medical Advisory Committee on March 14, 2019 and to the OHCA Board of Directors on March 21, 2019.
Reference: APA WF 18-15B

SUMMARY:
Change Timeframes for Appeals – The proposed revisions change all of the agency's appeals rules, to extend the length of time that appeals can be submitted from twenty days to thirty days of the date of an adverse agency action.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Act, Section 5007 (F)(1) and (3) of Title 63 of Oklahoma Statutes; Section 5003 through 5016 of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; 42 C.F.R. § 431.200 to 431.246 and 455.422; 12 O.S. § 951; 56 O.S. § 1011.9; 63 O.S. § 5030.3; 68 O.S. § 205.2; 75 O.S. §§ 305 and 309

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Nicole Nantois
Legal Services

FROM: Harvey Reynolds
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF # 18-15B

A. Brief description of the purpose of the rule:

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The proposed revisions change all of the agency's appeals rules, to extend the length of time that appeals can be submitted from twenty days to thirty days of the date of an adverse agency action.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

SoonerCare members and providers who wish to file an appeal will be positively affected by the proposed rule change. This rule change should not place any cost burden on private or public entities. No information on any cost impacts were received from any entity.

C. A description of the classes of persons who will benefit from the proposed rule:

The proposed rule will benefit SoonerCare members and providers by giving them an additional ten days within which to file an appeal.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivisions.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

Agency staff estimates that the proposed rule change will be budget neutral.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or

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require their cooperation in implementing or enforcing the rule:

The proposed rule change will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule change.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The agency does not anticipate that the proposed rule changes will have an adverse effect on small businesses.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there are no other legal methods to achieve the purpose of the proposed rule changes. Measures included a formal public comment period and tribal consultation.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule changes should not have any effect on the public health, safety or environment. The proposed rule changes are not designed to reduce significant risks to the public health, safety or environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effect on the public health, safety or environment if the proposed rule is not implemented.

K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared date: November 1, 2018

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-2.1. Program Integrity Audits/Reviews

(a) This section applies to all contracted providers. The following words and terms, when used in this Section, shall have the following meaning:

(1) **"Contractor/provider"** means any person or organization that has signed a provider agreement with the Oklahoma Health Care Authority (OHCA).

(2) "**Error Rate"** means the percentage of dollars of audited claims found to be billed in error.

~~(2)~~(3) **"Extrapolation"** means the methodology of estimating an unknown value by projecting, with a calculated precision (i.e., margin of error), the results of a probability sample to the universe from which the sample was drawn.

~~(3)~~(4) **"Probability sample"** means the standard statistical methodology in which a sample is selected based on the theory of probability (a mathematical theory used to study the occurrence of random events).

~~(4)~~(5) "**Universe"** means all paid claims or types of paid claims audited/reviewed during a specified timeframe.

~~(5)~~(6) "**Sample"** means a statistically valid number of claims obtained from the universe of claims audited/reviewed.

~~(6) "**Error Rate"** means the percentage of dollars of audited claims found to be billed in error.~~

(b) An OHCA audit/review includes an examination of provider records, by either an on-site or desk audit. Claims may be examined for compliance with provider contracts and/or relevant Federal and State laws and regulations, as well as for practices indicative of fraud, waste, and/or abuse of the SoonerCare program, including, but not limited to, inappropriate coding and consistent patterns of overcharging.

(c) An initial audit/review report contains preliminary findings. Within ~~twenty (20)~~thirty (30) calendar days of the date of notice regarding the audit/review report, a provider may elect to:

(1) Remit the identified overpayment to the OHCA;

(2) Request informal reconsideration of the initial audit report ~~per~~pursuant to ~~OAC 317:30-3-2.1(d)~~Oklahoma Administrative Code (OAC) 317:30-3-2.1(d); or

(3) Request a formal appeal of the initial audit report ~~per~~pursuant to OAC 317:30-3-2.1(e).

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(d) If a provider requests an informal reconsideration, the provider, within ~~twenty (20)~~thirty (30) calendar days of the date of notice of the audit/review report, shall:

(1) Produce any and all written existing documentation that is relevant to, and could reasonably be used to clarify or rebut, the findings ~~as~~ identified in the initial report. Documents submitted for reconsideration shall not be altered or created for purposes of the audit; and

(2) Specifically identify those claims and findings to be reviewed for reconsideration. Any claims or findings not specifically identified by the provider for reconsideration will be deemed to have been waived by the provider for purposes of both the informal reconsideration and the formal appeal, if requested. The reconsideration findings will replace the initial findings and be identified as the final audit report.

(e) A request for an informal reconsideration does not limit a provider's right to a formal appeal as long as any formal appeal of the final audit report is received by the OHCA Legal Docket Clerk within ~~twenty (20)~~thirty (30) calendar days of the date of notice of the final audit report. However, all claims and findings not specifically identified by the provider upon an informal reconsideration request will be deemed to have been waived by the provider for purposes of a subsequent formal audit appeal. Additionally, the provider must specifically identify each claim to be contested on appeal, and any remaining appealable claim that has not already been waived during the informal reconsideration and is not specifically identified in the initial appeal filing, will be deemed waived on appeal.

(f) If the provider does not request either an informal reconsideration or a formal appeal within the specified timeframe, the initial report will become the final audit report and the provider will be obligated to reimburse OHCA for any identified overpayment, which amount shall be immediately due and payable to OHCA. OHCA may, at its discretion, withhold the overpayment amount from the provider's future payments.

(g) When OHCA conducts a probability sample audit, the sample claims are selected on the basis of recognized and generally accepted sampling methods. If an audit reveals an error rate exceeding ~~10%~~ten percent (10%), OHCA shall extrapolate the error rate to the universe of the dollar amount of the audited paid claims.

(1) When using statistical sampling, OHCA uses a sample that is sufficient to ensure a minimum confidence level of ~~95%~~ninety-five percent (95%).

(2) When calculating the amount to be recovered, OHCA ensures that all overpayments and underpayments reflected in the

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probability sample are totaled and extrapolated to the universe from which the sample was drawn.

(3) OHCA does not consider non-billed services or supplies when calculating underpayments and overpayments.

(h) If a probability sample audit reveals an error rate of ~~10%~~ten percent (10%) or less, the provider will be required to reimburse OHCA for any overpayments noted during the audit/review.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC SERVICES

317:30-5-95.31. Prior Authorization and extension procedures for children

(a) Prior authorization for inpatient psychiatric services for children must be requested from the ~~OHCA~~Oklahoma Health Care Authority (OHCA) or its designated agent. The OHCA or its designated agent will evaluate and render a decision within ~~24~~twenty-four (24) hours of receiving the request. A prior authorization will be issued by the OHCA or its designated agent, if the member meets medical necessity criteria. For the safety of SoonerCare members, additional approval from OHCA, or its designated agent is required for placement on specialty units or in special population programs or for members with special needs such as very low intellectual functioning.

(b) Extension requests (psychiatric) must be made through OHCA, or its designated agent. All requests are made prior to the expiration of the approved extension. Requests for the continued stay of a child who has been in an acute psychiatric program for a period of ~~15~~fifteen (15) days and in a psychiatric residential treatment facility for ~~3~~three (3) months will require a review of all treatment documentation completed by the OHCA designated agent to determine the efficiency of treatment.

(c) Providers seeking prior authorization will follow OHCA's, or its designated agent's, prior authorization process guidelines for submitting behavioral health case management requests on behalf of the SoonerCare member.

(d) In the event a member disagrees with the decision by OHCA, or its designated agent, the member receives an evidentiary hearing under ~~OAC 317:2-1-2(a)~~Oklahome Administrative Cod (OAC) 317:2-1-2(b). The member's request for such an appeal must ~~commence~~be received within ~~20~~thirty (30) calendar days of the initial decision.

PART 9. LONG-TERM CARE FACILITIES

317:30-5-136. Nursing Facility Supplemental Payment Program

(a) **Purpose.** The Nursing Facility Supplemental Payment Program (NFSPP) is a supplemental payment, up to the Medicare upper payment limit (UPL), made to a non-state government-owned entity that owns and as applicable has operating responsibility for a nursing facility(ies).

(b) **Definitions.** The following words and terms, when used in this Section have the following meaning, unless the context clearly indicates otherwise:

(1) **"Funds"** means a sum of money or other resources, as outlined in Public Funds as the State Share of Financial Participation, 42 Code of Federal Regulation(C.F.R.), Sec.433.51, appropriated directly to the State or local Medicaid agency, or funds that are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or funds certified by the contributing public agency as representing expenditures eligible for Federal Financial Participation (FFP).

(2) **"Intergovernmental transfer (IGT)"** means a transfer of state share funds from a non-state government-owned entity to the Oklahoma Health Care Authority (OHCA).

(3) **"Non-state government-owned (NSGO)"** means an entity owned and/or operated by a unit of government other than the state and the application packet is accepted and determined complete by OHCA as a qualified NSGO.

(4) **"Resource Utilization Groups (RUGs)"** means the system used to set Medicare per diem payments for skilled-nursing facilities, as the basis to demonstrate a Medicare payment estimate for use in the UPL calculation.

(5) **"Supplemental payment calculation period"** means the State Fiscal Year for which supplemental payment amounts are calculated based on Medicaid paid claims (less leave days) compiled from the state's Medicaid Management Information System (MMIS) at a minimum yearly to a maximum quarterly.

(6) **"Upper payment limit (UPL)"** means a reasonable estimate of the amount that would be paid for the services furnished by a facility under Medicare equivalent payment.

(c) **Eligible nursing facilities.** A nursing facility that is owned and as applicable under the operational responsibility of an NSGO, is eligible for participation when the following conditions are met:

(1) the nursing facility is licensed and certified by the Oklahoma State Department of Health;

(2) the participating NSGO has provided proof that it holds the facility's license and has complete operational responsibility for the facility;

(3) the participating NSGO has completed and submitted the Agreement of Participation application at minimum thirty (30)

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days prior to the start of the participation quarter and received the application packet is accepted and determined complete by OHCA;

(4) the facility is an active participant in the Focus on Excellence program and has earned at minimum ~~100~~one-hundred (100) points; does not receive an immediate jeopardy (IJ) scope and severity tag for abuse or neglect on three (3) separate surveys within a twelve (12) month period; and

(5) the facility and NSGO comply with care criteria requirements. All facilities shall provide supporting documentation (e.g., baselines, written plan, improvement summary, data sources) for the care criteria metrics.

(d) **NSGO participation requirements.** The following conditions are required of the NSGO:

(1) shall provide proof of ownership, if applicable (i.e. Change of Ownership) as licensed operator of the nursing facility;

(2) shall provide proof of proximity requirements of no greater than one hundred fifty (150) miles of NSGO. Exceptions may be made at the sole discretion of OHCA;

(3) shall execute a nursing facility provider contract as well as an agreement of participation with the OHCA;

(4) shall provide OHCA with an executed Management Agreement between the NSGO and the facility manager;

(5) shall provide and identify the state share dollars' source of the IGT;

(6) shall pay the calculated IGT to OHCA by the required deadline;

(7) shall utilize program dollars for health care related expenditures; and

(8) shall provide per facility, the per patient per Medicaid day (PPMD) IGT within specified timeframe of receipt of the Notice of Program Reimbursement (NPR) as indicated below:

(A) For the first year-$6.50 PPMD.

(B) For the second year-$7.50 PPMD.

(C) For the third year-$8.50 PPMD, or the equivalent of ten percent (10%) of nursing facility budget of the current fiscal year, whichever is less. This amount excludes any IGT for actual administration cost associated with the nursing home UPL supplemental program. Any remaining IGT after administration cost shall be distributed through the rate setting methodology process. Distribution shall occur once escrowed funds reach an amount sufficient to distribute as determined by OHCA.

(e) **Change in ownership.**

(1) A nursing facility participating in the supplemental payment program shall notify the OHCA of changes in ownership

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(CHOW) that may affect the nursing facility's continued eligibility within thirty (30) days after such change.

(2) For a nursing facility that changes ownership on or after the first day of the SoonerCare supplemental payment limit calculation period, the data used for the calculations will include data from the facility for the entire upper payment limit calculation period relating to payments for days of service provided under the prior owner, pro-rated to reflect only the number of calendar days during the calculation period that the facility is owned by the new owner.

(f) **Care Criteria.** Each facility shall be required to participate in the following care criteria components to receive UPL financial reimbursement.

(1) **Component 1- Quality Improvement Plan.** A facility shall hold monthly Quality Improvement Plan meetings. The meetings shall be tailored to identify an improvement plan for quality enhancement focused on nursing facility safety, quality of resident life, personal rights, choice and respect. Consistent with 42 CFR 483.75. Quality indicators shall be identified during the meetings and include the following:

(A) A written plan to include but not limited to the development, implementation and evaluation of the quality enhancement indicator. The plan shall be reviewed monthly for ongoing quality indicator progress, completion of the quality indicator and/or routine updates on the sustainability of current and/or prior indicators achieved.

(B) The design and scope of the plan should include the specific system and service that will be utilized to monitor and track performance improvement, the staff included to improve the quality indicator, resident choice, subjective/objective evidence and ongoing measures taken to ensure stability and enhancement. This may include but not be limited to a written policy, a procedure manual, data collections systems, management practices, resident/staff interviews, and trainings.

(C) Outcomes shall include evidence of improvement, cost expenditures toward improvement goal, how the facility shall continue to monitor the effectiveness of its quality enhancement and how it shall have ongoing sustainability.

(D) Facility shall submit program documentation monthly. The information shall include A-D as well as OHCA required form LTC-19.

(E) The quality improvement plan shall be reviewed monthly by the OHCA quality review team. Payment shall be assessed in increments of 20 percent (20%) per month for a total of 60 percent (60%) per quarter if approved.

(2) **Component 2- Health Improvement Plan.**

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(A) A facility shall hold quarterly Health Improvement Plan meetings. The meetings shall be tailored to identify an improvement plan for the quality indicators of urinary tract infection, unintended weight loss, developing or worsening pressure ulcers, and received antipsychotic medication. Meetings include the following:

(i) A written plan to include but not limited to the development, implementation and evaluation of the quality enhancement indicator. The plan shall be reviewed quarterly for ongoing quality indicator progress, completion of the quality indicator and/or routine updates on the sustainability of current and/or prior indicators achieved.

(ii) The design and scope of the plan should include the specific system and service that shall be utilized to monitor and track performance improvement, the staff included to improve the quality indicator, resident choice, subjective/objective evidence and ongoing measures taken to ensure stability and enhancement. This may include but not be limited to a written policy, a procedure manual, data collections systems, management practices, resident/staff interviews, and trainings.

(iii) Outcomes shall include evidence of improvement, cost expenditures toward improvement, how the facility will continue to monitor the effectiveness of its quality enhancement and how it shall have ongoing sustainability.

(iv) Facility shall submit program documentation quarterly. The information will include i-iii as well as OHCA required form LTC-18.

(B) The health improvement plan shall be reviewed quarterly by the OHCA quality review team. Payment shall be assessed in increments of ten percent (10%) by achieving five percent (5%) relative improvement or by achieving the national average benchmark per each of the four (4) components quarterly for a total of forty percent (40%) per quarter if approved.

(3) **Care Criteria Evaluation and Audit.** The care criteria measures may be evaluated at the discretion of OHCA on an annual basis after each fiscal year, following implementation of the program. However, OHCA reserves the right to conduct intermittent evaluations within any given year based on the quality, care and safety of SoonerCare members. The evaluation may be conducted by an independent evaluator. In addition, care criteria metrics may be internally evaluated after each fiscal year at the discretion of OHCA. The OHCA may make adjustments to the care criteria measures based on findings and

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recommendations as a result of the independent or internal evaluation.

(g) **Supplemental Payments.**

(1) The nursing facility supplemental payments to a NSGO under this program shall not exceed Medicare payment principles pursuant to Inpatient Services: Application of Upper Payment Limits, 42 ~~Code of Federal Regulation~~C.F.R., Sec. 447.272. Payments are made in accordance with the following criteria:

(A) The methodology utilized to calculate the upper payment limit is the RUGs.

(B) The eligible supplemental amount is the difference/gap between the SoonerCare payment and the Medicare equivalent payment as determined based on compliance with the care criteria metrics.

(2) The amount of the eligible supplemental payment is associated with improvement of care of SoonerCare nursing facility residents as demonstrated through the care criteria. The quality components are evaluated monthly with a quarterly payout. Component 1 is assessed at twenty percent (20%) per month with a possible total achievement of sixty percent (60%) per quarter. Component 2 is assessed at ten percent (10%) per each of the four (4) components with a possible total achievement of 40 percent (40%) per quarter. Facilities will be reimbursed accordingly based on the percentage of care criteria earned.

(h) **Disbursement of payment.** NSGOs shall secure allowable IGT funds from a NSGO to fund the non-federal share amount. The method is as follows:

(1) The OHCA or its designee will notify the NSGO of the non-federal share amount to be transferred by an IGT, via electronic communications and NPR, for purposes of seeking federal financial participation (FFP) for the UPL supplemental payment, within twenty-five (25) business days after the end of the quarter. This amount will take into account the percentage of metrics achieved under the care criteria requirement. The NSGO will have five (5) business days to sign the participant agreement and make payment of the state share in the form of an IGT either in person or via mail. The date the NPR is sent by OHCA or its designee to the provider (NSGO) is the official date the clock starts to measure the five (5) business days. In addition, the NSGO shall also be required to remit, upon receipt of the NPR, the applicable PPMD IGT in full, pursuant to (d) (7) above.

(2) If the full IGT and the PPMD IGT are received within five (5) business days, the UPL payment will then be disbursed to the NSGO by OHCA within ten (10) business days in accordance with established payment cycles.

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(i) **Penalties.**

(1) Receipt of the total IGT(s) within five (5) business days is not subject to any penalty.

(2) Any total IGT received after the fifth (5th) business day, but with an OHCA date stamp or mailing postal mark on or prior to five (5) business days from the official date of the receipt of the NPR will not be subject to penalty.

(3) Any total IGT with an OHCA date stamp or mailing postal mark received with a date after five (5) business days of receipt of the NPR, but not exceeding eight (8) business days of receipt of the NPR shall be deemed late and subject to a penalty in accordance with (3)(A) below.

(A) A five percent (5%) penalty will be assessed for the total IGT payments received after five (5) business days, but within eight (8) business days of receipt of the NPR. The five percent (5%) penalty will be assessed on the total eligible supplemental payment for the quarter in which the IGT is late and assessed to the specific NSGO as applicable.

(B) OHCA will notify the NSGO of the assessed penalty via invoice. If the NSGO fails to pay OHCA the assessed penalty within the time frame noted on the invoice to the NSGO, the assessed penalty will be deducted from the nursing facility's Medicaid payment. The penalty shall be paid regardless of any appeals action requested by the NSGO. Should an appeals decision result in a disallowance of a portion or the entire assessed penalty, reimbursement to the NSGO will be made to future nursing facility Medicaid payments.

(C) An NSGO that remits payment of the total IGT under the circumstances listed in (i) (2) or (i) (3) above will receive payment during the next available OHCA payment cycle.

(4) The first violation by an NSGO to remit the full IGT as indicated on the NPR by OHCA or its designee within the defined timeframes shall subject the NSGO to a penalty. The second violation by an NSGO to remit the full IGT indicated on the NPR by OHCA or its designee within the defined timeframes shall subject the NSGO to a penalty and a suspension for two (2) consecutive quarters. The NSGO will not be eligible to participate in the program during suspended quarters. A third violation by an NSGO to remit the full IGT indicated on the NPR by OHCA or its designee within the defined timeframes shall subject the NSGO to termination from the NFSPP. If the NSGO desires to participate again, it will be required to reapply. Reentry into the program is at the sole discretion of the OHCA. If the NSGO is readmitted to the program, terms of participation may include a probationary period with defined requirements.

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(5) If OHCA receives a partial IGT or receives a full IGT after eight (8) business days of the receipt of the NPR, the NSGO shall be deemed to have voluntarily elected to withdraw participation in the NFSPP.

(6) If a nursing facility fails to meet the benchmarks of component 1 and/or component 2 of the care criteria for two (2) consecutive quarters, the facility shall be suspended for two (2) subsequent quarters and will not be eligible to participate in the program during suspended quarters. A facility that has been suspended for a total of four (4) quarters within a two (2) year period due to non-compliance with the Care Criteria shall be terminated from the program, and if the facility wishes to participate again, it will be required to reapply. Reentry into the program is at the sole discretion of the OHCA. If the facility is readmitted to the program, terms of participation may include a probationary period with defined requirements as it relates to care.

(j) **Appeals.** Applicant and participant appeals may be filed in accordance with grievance procedures found at Oklahoma Administrative Code ~~317:2-1-2(b)~~317:2-1-2(c) and 317:2-1-16.

317:30-5-136.1. Focus on Excellence

(a) **Purpose.** The Focus on Excellence (FOE) program was established through Oklahoma State Statute, Title 56, Section 56-1011.5. FOE's mission is to enhance the quality of life for target citizens by delivering effective programs and facilitating partnerships with providers and the community they serve. The program has a full commitment to the very best in quality, service and value which will lead to measurably improved quality outcomes, healthier lifestyles; greater satisfaction and confidence for our members.

(b) **Eligible Providers.** Any Oklahoma long-term care nursing facilities that are licensed and certified by the Oklahoma State Department of Health and accommodate SoonerCare members at their facility as defined in Oklahoma Administrative Code (OAC) 317:30-5-120.

(c) **Quality measure care criteria.** To maintain status in the FOE program, each nursing facility must enter quality data either monthly, quarterly, annually for the following care criteria metrics. All metrics in detail can be found on the Oklahoma Health Care Authority's (OHCA) FOE website or on FOE/QOC (Quality of Care) Data Collection Portal.

(1) **Person-Centered Care.** Facility must meet six (6) out of ten (10) of the established measurement criteria for this metric to receive the points. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.

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(2) **Direct-Care Staffing**. Facility must maintain a direct care staffing ratio of three and a half (3.5) hours per patient day to receive the points for this metric. This metric must be completed monthly by the 15th of each month.

(3) **Resident/Family Satisfaction.** Facility must maintain a score of 76 of a possible 100 points on overall satisfaction to receive the points for this metric. This metric is collected in a survey format and must be completed once a year in the fall. Surveys are to be completed by the resident, power of attorney and/or with staff assistance.

(4) **Employee Satisfaction.** Facility must maintain a score of 70 points or higher in order to receive the points for this metric. Surveys are completed by FOE facility employees and must be completed once a year in the fall.

(5) **Licensed-Nurse Retention.** Facility must maintain a one-year tenure rate of 60 percent (60%) or higher of its licensed nursing staff to receive the points for this metric. This metric must be completed monthly by the 15th of the month.

(6) **Certified Nurse Assistant (CNA) Retention.** Facility must maintain a one-year tenure rate of 50 percent (50%) or higher of its CNA staff to receive the points for this metric. This metric must be completed monthly by the 15th of the month.

(7) **Distance Learning Program Participation.** Facility must contract and use an approved distance learning vendor for its frontline staff in order to receive points for this metric. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.

(8) **Peer Mentoring.** Facility must establish a peer-mentoring program in accordance with OHCA guidelines. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.

(9) **Leadership Commitment.** Facility must meet six (6) out of ten (10) of the established measurement criteria for this metric to receive the points. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.

(d) **Payment.** The amount of eligible dollars is reimbursable based on the SoonerCare FOE nursing facility meeting the quality metric thresholds listed in (b). Facilities must meet a minimal of 100 points to even be eligible for reimbursement.

(1) **Distribution of Payment.** OHCA will notify the FOE facility of the quality reimbursement amount on a quarterly basis.

(2) **Penalties.** Facilities that do not submit on the appropriate due dates will not receive reimbursable dollars. Facilities that do not submit quality measures will not receive reimbursable dollars for those specific measures. Due dates can be found on the OHCA FOE webpage.

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(e) **Appeals.** Facilities can file an appeal with the Quality Review Committee and in accordance, with the grievance procedures found at OAC ~~317:2-1-2(b)~~317:2-1-2(c) and 317:2-1-16.

PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES

317:30-5-746. Appeal of Prior Authorization Decision

If a denial decision is made, an appeal may be initiated by the member or the member's legal guardian. The denial can be appealed to the Oklahoma Health Care Authority within ~~20~~thirty (30) calendar days of the receipt of the notification of the denial by the OHCA or its designated agent.

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