METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING ADULTS

Prospective rates of payment shall be reviewed, at a minimum, annually for Oklahoma nursing facilities serving adults (NF's). The rates in effect will be determined pursuant to these methods and standards and approved by the Oklahoma Health Care Authority Board in advance of the rate periods. The rates are established based on analyses of cost reports and other relevant cost information, the use of national and, where appropriate, Oklahoma-specific trends in costs, including trends in salary levels and changes in minimum wage levels, analyses of the economic impact of changes in law or regulations, and discussions with recognized representatives of the nursing home industry.

Effective October 1, 2019, subject to the availability of funds, the average rate for nursing facilities shall be equal to the statewide average cost as derived from audited cost reports for state fiscal year (SFY) 2018, ending June 30, 2018, after application of an adjustment that is calculated from the average of cost report audit adjustments from the five, immediately-preceding state fiscal years; provided, however, that this average shall exclude the highest and lowest cost report audit adjustments from the five-year period prior to calculation. The average cost for nursing facilities shall then be adjusted for inflation.

The rates are at, or above, the level that the Oklahoma Health Care Authority (OHCA) finds reasonable and adequate to reimburse the costs that must be incurred by economically and efficiently operated facilities to the extent specified by 42 U.S.C. Section 1396a(a)(13)(A).

A. COST ANALYSES

The Oklahoma Health Care Authority (OHCA) is principally responsible for implementing the Medicaid (SoonerCare) program in Oklahoma. OHCA staff will prepare necessary analyses to support the rate determination process. Part of the process will be to analyze the costs as reported by the facilities.

1. UNIFORM COST REPORTS

Each SoonerCare participating nursing facility must submit, on uniform cost reports designed by the Authority, cost and related statistical information necessary for rate determinations.

a. **Reporting Period.** Each nursing facility must prepare the cost report to reflect the allowable costs of services provided during the immediately preceding fiscal year ending June 30. Where the ownership or operation is commenced, a fractional year report is required for each period of time the NF was in operation during the year.

b. **Reporting Deadline.** The report must be filed by October 31 of each following year. Extensions of not more than 15 days may be granted on a showing of just cause.

c. **Accounting Principles**. The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions.

d. **Signature**. The cost report shall be signed by an owner, partner or corporate officer of the NF, by an officer of the company that manages the NF, and by the person who prepared the report, either physically or through use of the secure website reporting system.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS (continued)

B. RATE SETTING PROCESS

Beginning July 1, 2007, the Oklahoma Health Care Authority uses the following method to adjust rates of payment for nursing facilities:

1. DEFINITIONS*:*

Base Rate Component is the rate in effect on June 30, 2005, defined as $103.20 per day. Included in the base rate is the QOC Fee. Any changes to the base rate will be made through future Plan changes if required. For the rate period beginning September 01, 2012, the base rate will be $106.29. For the rate period beginning July 1, 2013, the base rate will be $107.24. For the rate period beginning July 1, 2016, the base rate will be $107.57 per patient day. For the rate period beginning July 1, 2017, the base rate will be $107.79 per patient day. For the rate period beginning July 1, 2018, the base rate will be $107.98 per patient day. For the rate period beginning October 1, 2018, the base rate will be $108.12 per patient day. For the rate period beginning July 1, 2019, the base rate will be $108.31 per patient day. For the rate period beginning October 1, 2019, fifty percent (50%) of new funding shall be allocated toward an increase of the existing base rate and distributed accordingly. For the rate period beginning October 1, 2019, the base rate will be $120.57 per patient day.

Commented [KM1]: Considering this language as approved as it was submitted in SPA 19-0025 and is currently under CMS review.

Direct Care Cost Component is defined as the component established based on each facilities relative expenditures for Direct Care which are those expenditures reported on the annual costs reports for salaries (including professional fees and benefits), for registered nurses, licensed practical nurses, nurse aides, and certified medication aides.

Other Cost Component is defined as the component established based on monies available each year for all costs other than direct care and incentive payment totals, i.e., total allowable routine and ancillary costs (including capital and administrative costs) of nursing facility care less the Direct Care Costs and incentive payment totals.

Incentive Rate Component is defined as the component earned each quarter under the ~~Focus on Excellence~~ Pay-for-Performance (PFP) program.

Rate Period is defined as the period of time between rate calculations.

2. GENERAL:

The estimated total available funds will include the estimated savings or loss to the program as a result of the automatic cost of living adjustment on Social Security benefits as published in the federal register and the resulting effect to the spend-down required of the recipients. For Regular Nursing facilities, the effect is $.32 per day for each one (1) percent change in the SSI determined from the average effect of SSI increases from CY 2004 to CY 2009.

Individual rates of payment will be established as the sum of the Base Rate plus add-ons for Direct Care, Other Costs, and the ~~incentive add-on earned under the Oklahoma Focus on Excellence~~ Pay-for-Performance (PFP) Quality of Care Rating System.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS ~~(CONTD)~~ *~~(continued)~~*

3. PROCESS:
Annually, any funds over and above those to cover the Base Rate plus the estimated ~~Focus on Excellence~~ Pay-for-Performance (PFP) Program payments will be used to create two pools of funds used to establish the rate components for *other costs* and *direct care costs*.

1. An *Other Costs* Pool (30 % of the available funds, after meeting estimated base rate and incentive payments) is used to establish a uniform statewide rate component (defined as the total pool divided by the total estimated Medicaid days of service).

2. A *Direct Care Cost* Pool (70% of the available funds, after meeting estimated base rate and incentive payments) is used to establish facility specific add-ons based on relative expenditures for direct care for SoonerCare clients as follows:

Step One: The OHCA will construct an array of the facilities' allowable Direct Care per patient day (as reported on the cost report for the most recent reporting period), with each facility's value in the array being the lesser of actual cost per day or a ceiling set at the 90th percentile of the array of all facilities.

Step Two: For each facility in the array, the Direct Care Cost established in step one will be multiplied by their estimated annual SoonerCare days and added together to calculate the aggregate estimated SoonerCare direct care cost. The estimated annual SoonerCare days will be determined by using MMIS data from the latest available annual period paid days. In the case of facilities with less than a year's experience, then the OHCA will determine an estimate from any available actual data for that facility or like facilities.

Step Three: The Direct Care Pool of available funds will be divided by the aggregate estimated SoonerCare Cost determined in step two to determine an add-on percent for Direct Care.

Step Four: The Direct Care add-on for each facility will be determined by applying the percent calculated in step three to each facility's per patient day Direct Care Value determined in step one.

Step Five: The sum of the Base Rate and add-ons for Direct Care and Other Costs will be the facility specific rate for the period. The only exceptions to this logic are for homes that do not file a report and for new homes established in the current rate period. For homes not filing a cost report, the rate will not include the direct care component and will be the sum of the base rate plus the Other Cost add-on, only.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS (continued)

For new facilities beginning operations in the current rate period, the rate will be the median of those established rates for the year.

For the rate period beginning 01/01/12, the total available pool amount for establishing the rate components described in 1 and 2 is $102,318,569.
For the rate period beginning 09/01/12, the total available pool amount for establishing the rate components described in 1 and 2 is $147,230,204.
For the rate period beginning 07/01/13, the total available pool amount for establishing the rate components described in 1 and 2 is $162,205,189.
For the rate period beginning 07/01/14, the total available pool amount for establishing the rate components described in 1 and 2 is $158,391,182.
For the rate period beginning 07/01/16, the total available pool amount for establishing the rate components described in 1 and 2 is $158,741,836.
For the rate period beginning 07/01/17, the total available pool amount for establishing the rate components described in 1 and 2 is $160,636,876.
For the rate period beginning 07/01/18, the total available pool amount for establishing the rate components described in 1 and 2 is $158,938,847.
For the rate period beginning 10/01/18, the total available pool amount for establishing the rate components described in 1 and 2 is $174,676,429.
For the rate period beginning 07/01/19, the total available pool amount for establishing the rate components described in 1 and 2 is $186,146,037.
For the rate period beginning 10/01/19, the total available pool amount for establishing the rate components described in 1 and 2 is $220,482,316.

Commented [KM2]: Considering this language as approved as it was submitted in SPA 19-0025 and is currently under CMS review.

3. ~~As of July 1, 2007~~ ~~Nursing Facilities Serving Adults and AIDS Patients were/are able to earn additional reimbursement for "points" earned in the Oklahoma Focus on Excellence Quality Rating Program.~~

~~For the period beginning 07-01-07, facilities participating in the Focus on Excellence Program will receive an incentive component equal to one (1) percent of the sum of the Base Rate component plus the Other Component as defined above in this section. Participation is defined as having signed a contract amendment agreeing to participate and successfully remanding the required monthly data entry and annual surveys by the required time. Incomplete submissions and non-submissions are a breach and the facility will not receive bonus payments for those Quality Measurements not reported or reported incompletely, the Oklahoma Health Care Authority will have the final determination if a disagreement occurs as to whether the facility has successfully submitted the required data and surveys.~~

~~*For the period beginning 01-01-08*, the reimbursement was set at the following levels:~~

~~*Participation and/or 1 to 2 Points earned level:*~~
~~The add-on is set at 1% of the sum of the Base Rate and the Other Component~~
~~3 to 4 points earned:~~
~~The add-on is set at 2% of the sum of the Base Rate and the Other Component~~
~~5 to 6 points earned:~~
~~The add-on is set at 3% of the sum of the Base Rate and the Other Component~~

Since July 1, 2007, Nursing Facilities Serving Adults and AIDS Patients have been able to earn additional reimbursement for "points" earned in an Oklahoma Quality Rating Program. This program, which was originally called "Focus on Excellence," was revised by statute in 2019, and is now called "Pay-for-Performance".

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS ~~(CONTD)~~ *(continued)*

~~7 to 8 points earned:~~
~~The add-on is set at 4% of the sum of the Base Rate and the Other Component~~
~~9 to 10 points earned:~~
~~The add-on is set at 5% of the sum of the Base Rate and the Other Component~~

~~For the period beginning 07-01-2008, and thereafter the reimbursement was set at the following levels:~~

~~1 to 2 Points earned:~~
~~The add-on is set at 1 % of the sum of the Base Rate and the Other Component~~
~~3 to 4 points earned:~~
~~The add-on is set at 2% of the sum of the Base Rate and the Other Component~~
~~5 to 6 points earned:~~
~~The add-on is set at 3% of the sum of the Base Rate and the Other Component~~
~~7 to 8 points earned:~~
~~The add-on is set at 4% of the sum of the Base Rate and the Other Component~~
~~9 to 10 points earned:~~
~~The add-on is set at 5% of the sum of the Base Rate and the Other Component~~

~~Points will be awarded for homes that meet or exceed the established threshold on a range of 10 quality measures. The Quality Metrics are:~~

~~(1). Quality of Life: based on Annual Family & Resident Satisfaction Surveys,~~
~~(2). Resident/Family Satisfaction: based on Annual Family & Resident Satisfaction Surveys,~~
~~(3). Satisfaction: based on Annual Survey of Employees of the Facility,~~
~~(4). CNA/Nurse Assistant Turnover & Retention: based on monthly data collected from the providers,~~
~~(5). Nurse Turnover & Retention: based on monthly data collected from the providers,~~
~~(6). State Survey Compliance: based on the Standard Survey Results, including subsequent activity that results in F tag citations,~~
~~(7). System-wide Culture Change: based on Annual Employee Survey questions,~~
~~(8). Clinical Measures: based on monthly reported measures of: (a) residents without falls, (b) residents without acquired catheters, (c) residents without acquired physical restraints, (d) residents without unplanned weight loss/gain and (e) residents without acquired pressure ulcers~~

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS ~~(CONTD)~~ *(continued)*

~~(9). SoonerCare (Medicaid) Occupancy and Medicare Utilization: based on relative Medicaid and Medicare service days reported monthly.~~

~~(10). Nursing Staffing per Patient Day: based on monthly reported direct care hours per patient day.~~

~~For the period beginning 07-01-2007 and until changed by amendment the established threshold for each metric above was set at the median score.~~

~~For the period beginning 01-01-2010 and until changed by amendment the established thresholds for each measure were set as follows:~~

~~(1). Quality of Life: A score of 75.0, or better~~
~~(2). Resident/Family Satisfaction: A Score of 72.0, or better~~
~~(3). Employee Satisfaction: A score of 65.0, or better~~
~~(4). CNA/Nurse Assistant Turnover and Retention: A Score meeting or exceeding the 58th percentile,~~
~~(5). Nurse Turnover & Retention: A score meeting or exceeding the 60th percentile,~~
~~(6). System-wide Culture Change: A score of 72.0, or better~~
~~(7). Clinical Measures: A score meeting or exceeding the 58th percentile,~~
~~(8). SoonerCare Occupancy & Medicare Utilization: the Median Score, or better~~
~~(9). Nursing Staffing per patient Day: A score of 3.50 or better~~
~~(10). State Survey Compliance~~

~~A point will be awarded when:~~
~~(1) No citations were made as a result of the annual survey, and~~
~~(2) any subsequent care-related scope/severity citations are *"D"* or less and~~
~~(3) any subsequent non-care scope/severity citations are "E" or less.~~

~~For the data collection period beginning 07-01-13 and until changed by amendment the participating facilities may earn from 0 to 500 points for meeting the requirements of the established quality metrics. The established Quality Metrics and their maximum point values are:~~

~~(1) **Person Centered Care**: *Point Value of 90*~~
~~Facility must meet 6 out of 10 of the established measurement artifacts of culture change to receive the points for this metric.~~

~~(2) **Direct Care Staffing:** *Point Value of 50*~~
~~Facility must maintain a direct care staffing ratio of 3.5 hours per patient day to receive the points for this metric.~~

Pay-for-Performance (PFP) Program

For the period beginning October 1, 2019 and until changed by amendment, qualifying facilities participating in the pay-for-performance program have the potential to earn an average of the $5.00 quality incentive per Medicaid patient per day. Facility(s) baseline is calculated annually and will remain the same for a 12-month period. Facility(s) will meet or exceed five-percent (5%) relative improvement or the CMS national average each quarter for the following metrics:

(1) Decrease percent of high risk pressure ulcer for long stay residents;
(2) Decrease percent of unnecessary weight loss for long stay residents;
(3) Decrease percent of use of anti-psychotic medications for long stay residents; and
(4) Decrease percent of urinary tract infection for long stay residents.

Payment to nursing facilities for meeting the metrics will be awarded quarterly as follows:

- A facility may earn a minimum of $1.25 per Medicaid patient per day for each qualifying metric.
- A facility receiving a deficiency of "I" or greater related to a specific quality measure within the PFP Quality of Care Rating System is disqualified from receiving an award related to that PFP measure for that quarter.
- Funds that remain as a result of payment not earned, shall be pooled and redistributed to facilities who achieve the metrics each quarter based on facilities' individual performance in the PFP program.

Commented [BB3]: Will be placed on Attachment 4.19-D, Page 5.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS (CONTD)

(3.)**Resident/Family Satisfaction:** *Point Value of 80*
Facility must maintain a weighted score of 76.0 in order to receive the points for this metric.

Employee Satisfaction: *Point Value of 50*
Facility must maintain a weighted score of 70 or better in order to receive the points for this metric.

(4.)**Licensed Nurse Retention:** *Point Value of 65*
Facility must maintain a 1 year tenure rate for 60% or better of its Licensed Nursing Staff in order to receive the points for this metric.

(5.)**CNA Retention:** *Point Value of 65*
Facility must maintain a 1 year tenure rate for 50% or better if CNA Staff is to receive the points for this metric.

(6.)**Distance Learning Program Participation:** *Point Value of 35*
Facility must sign up and use approved distance learning programs for its direct care staff in order to receive the points for this metric. A percentage of participation will be established later when adequate data to establish thresholds has been collected.

(7.)**Peer Mentoring Program Participation:** *Point Value of 30*
Facility must sign up and use approved peer mentoring programs in order to receive the points for this metric. A percentage of participation will be established later when adequate data to establish thresholds has been collected.

(8.)**Leadership Commitment:** *Point Value of 35*
Facility must meet 6 out of 10 of the established measurement artifacts in order to receive the points for this metric.

Payment for meeting the metrics will be made as follows:

- A facility will be able to earn from 1 to 500 points for meeting the established metrics and payment will be established at $.01 per point.
- A facility must earn a minimum of 100 125 points to receive any payment.
- A facility will forfeit all eligibility for payment in the FOE program for any measurement quarter that the facility receives a citation from the Health Department with a Severity Level of I or higher and the loss of eligibility will continue for any measurement quarters that CMS bans new admissions for the facility.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING AIDS PATIENTS *(continued)*

B. RATE SETTING PROCESS

1. DEFINITIONS AND METHODOLOGY

Base Rate Component is the rate component representing the allowable cost of the services rendered in an AIDS nursing facility and for the period beginning November 1, 2010 is $178.64, the difference in the costs reported for aids facilities and regular nursing facilities plus the average rate for November 1, 2010 for regular nursing facilities, not including the incentive payment component ($193.79 less $138.17 plus $123.02); or $178.64 per patient day. For the rate period beginning September 1, 2012, the Base Rate Component will be $192.50. For the rate period beginning July 1, 2013, the Base Rate Component will be $196.95. For the rate period beginning July 1, 2014, the Base Rate Component will be $197.49. For the rate period beginning July 1, 2016, the Base Rate Component will be $199.19 per patient day. For the rate period beginning July 1, 2017, the Base Rate Component will be $200.01 per patient day. For the rate period beginning July 1, 2018, the Base Rate Component will be $201.32 per patient day. For the rate period beginning October 1, 2018, the Base Rate Component will be $207.86 per patient day. For the rate period beginning July 1, 2019, the Base Rate Component will be $209.50 per patient day. For the rate period beginning October 1, 2019, the Base Rate Component will be $213.10 per patient day.

Commented [KM4]: Considering this language as approved as it was submitted in SPA 19-0025 and is currently under CMS review.

(A) *56 Okla. Stat.* § 2002 requires that all licensed nursing facilities pay a statewide average per patient day *Quality of Care assessment fee* based on maximum percentage allowed under federal law of the average gross revenue per patient day. Gross revenues are defined as Gross Receipts (i.e., total cash receipts less donations and contributions). *The assessment is an allowable cost as it relates to Medicaid services and a part of the base rate component.*

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING AIDS PATIENTS ~~(CONTD)~~ *(continued)*

(C) Beginning January 1. 2010 the base rate component was and will be adjusted annually on January 1, in an amount equal to the estimated savings or loss to the program as a result of the automatic cost of living adjustment on Social Security benefits as published in the Federal Register and the resulting effect to the spend-down required of the recipients. For Regular Nursing Facilities the effect is $.32 per day for each one (1) percent change in the SSI determined from the average effect of SSI increases from CY 2004 to CY 2009. For Nursing Facilities and facilities serving AIDS patients, the effect is $.32 per day for each one (1) percent change in the SSI determined from the average effect of SSI increases from CY 2004 to CY 2009.

Incentive Rate Component Nursing Facilities Serving AIDS Patients are eligible for additional reimbursement for participation in and points earned in the Oklahoma ~~Focus on Excellence~~ Pay-for-Performance (PFP) Quality Rating Program. The points earned and additional reimbursements available are the same as those detailed in 4.19-D, in the description covering this program in the Standard Nursing Facilities Serving Adults section of this plan.