

## **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:** September 17, 2019

The proposed policy consists of emergency rule changes. The proposed policy was presented at the July 2, 2019 Tribal Consultation. This proposal is scheduled to be presented to the Medical Advisory Committee on September 5, 2019 and the OHCA Board of Directors on September 18, 2019.

**Reference: APA WF 19-13B**

### **SUMMARY:**

**Long-Term Care Facilities** - The proposed revisions will bring the Oklahoma Health Care Authority (OHCA) into compliance with Senate Bill 280.

### **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; Senate Bill 280

### **RULE IMPACT STATEMENT:**

#### **STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY**

TO: Maria Maule  
Legal Services

FROM: Carmen Johnson  
Federal and State Authorities

SUBJECT: Rule Impact Statement  
APA WF # 19-13B

#### **A. Brief description of the purpose of the rule:**

The proposed revisions will increase rates and recalculate the Quality of Care fee for regular long-term care facilities and long-term care facilities serving residents with Acquired Immune Deficiency Syndrome. Revisions will establish new

quality measures and criteria as well as recalculate the incentive reimbursement rate plan for long-term care facilities participating in the Pay-for-Performance program. In addition, revisions will direct certain redistribution of funds; update staffing ratios; establish an advisory group; and increase the personal needs allowance for residents of long-term care facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs).

- 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:

The classes of persons who will most likely be affected by this rule proposed rule are long-term care facilities who can receive incentives for meeting quality benchmarks. This rule 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 changes will benefit long-term care facilities by providing guidelines regarding reconsideration of cost report adjustments and allowable cost plus providing monetary incentives for meeting certain benchmarks. SoonerCare members residing in long-term care facilities will also benefit from these revisions by strengthening the policy regarding quality of care measures.

- 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 impact of the proposed rule changes upon any classes of persons or 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 effect

on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The estimated budget impact for the remainder of SFY2020 will be an increase in the total amount of \$95,819,280; with \$32,559,391 in state share (\$4,400,309 of the state share is from QOC fees paid by providers). The estimated budget impact for SFY2021 will be an increase in the total amount of \$127,759,040; with \$43,412,522 in state share (\$6,286,156 of the state share is from QOC fees paid by providers).

- F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

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

- 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 is 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: August 16, 2019

Modified date: September 5, 2019

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 9. LONG-TERM CARE FACILITIES**

**317:30-5-132. Cost reports**

Each Medicaid-participating ~~long-term~~long-term care facility is required to submit an annual uniform cost report, designed by ~~OHCA,~~the Oklahoma Health Care Authority (OHCA), for the state fiscal year just completed. The state fiscal year is July 1 through June 30. The reports must be submitted to the OHCA on or before ~~the last day of October of the subsequent year.~~31. Cost reports are public records.

(1) 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. The OHCA's cost report instructions are publicly available on the OHCA's website, in the Nursing Home Cost Report Instruction Manual: A Guide for Entering Annual Nursing Home Cost Report Data via the OHCA Secure Site (hereinafter referred to as "Cost Report Instruction Manual").

(2) The cost report must be filed using the Secure Website~~.~~, The instructions and data entry screen simulations will be made available on the OHCA public website as set forth in the Cost Report Instruction Manual.

(3) When there is a change of operation or ownership, the selling or closing ownership is required to file a cost report for that portion of the fiscal year it was in operation. The successor ownership is correspondingly required to file a cost report for that portion of the fiscal year it was in operation.

These "Partial Year Reports" must be filed on paper or electronically by e-mail (not on the ~~secure website~~Secure Website system) to the Finance Division of the OHCA on the forms and by the instructions found ~~on the OHCA public website~~ (see ~~directions as noted above~~).in the Cost Report Instruction Manual.

~~(4) Normally, all ordinary and necessary expenses net of any offsets of credits incurred in the conduct of an economical and efficiently operated business are recognized as allowable. Allowable costs include all items of Medicaid covered expense which nursing facilities incur in the provision of routine services. "Routine services" include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, dental examinations, dentures and related services, eye glasses, routine eye examinations, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. (The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.). Ancillary items reimbursed outside the nursing facility rate are not included in the cost report and are not allowable costs. A long-term care facility may request an extension of time to submit an annual cost report, not to exceed fifteen (15) calendar days. Extensions of time shall be requested by a letter addressed to the Finance Division or by email, as is set forth in the Cost Report Instruction Manual. Any such request must be received by October 1, and must explain the good faith reason for the extension. OHCA shall provide a written notice of any denial of a request for an extension, which shall become effective on the date it is sent to the long-term care facility. Decisions to deny requests for extensions are solely within the discretion of the OHCA and are not administratively appealable.~~

~~(5) All reports are~~may be subject to on-site audits ~~and are deemed public records.~~ An on-site audit may result in cost adjustment(s), by which the OHCA, or its designee, identifies and corrects for costs that were included in the cost report. The OHCA or its designee shall provide written notice of any cost adjustment(s) it makes to a cost report, to the long-term care facility affected by the cost adjustment(s). Such notice shall contain, but is not limited to, a written list of the audit findings with a summary explanation of why any cost is deemed allowable.

(6) In accordance with 63 Oklahoma Statute § 1-1925.2, a long-term care facility may contest any cost adjustment(s) it disagrees with by requesting reconsideration of the cost adjustment(s), and/or by requesting an administrative appeal of the cost adjustment(s), pursuant to Oklahoma Administrative Code (OAC) 317:30-5-132.1 and OAC 317:2-1-17, respectively.

### **317:30-5-132.1. Reconsideration of cost report adjustments**

(a) A long-term care facility may request reconsideration of cost report adjustment(s)/finding(s) within thirty (30) calendar days of the date of notification of the cost adjustment(s) by submitting a request for reconsideration to the Oklahoma Health Care Authority (OHCA), Chief Financial Officer (CFO), Finance /NF Cost Reporting, 4345 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105.

(b) Simultaneous with the request for reconsideration, the long-term care facility shall submit a statement as to why the request for reconsideration is being made and may submit any new or additional information that he or she wishes the CFO or his/her designee to consider. Any request for an informal meeting according to subsection (c), below, must be made at the same time as the request for reconsideration.

(c) At the request of the long-term care facility, the reconsideration may be conducted by the CFO or his/her designee as:

(1) An informal meeting between the long-term care facility and the CFO or his/her designee; or

(2) A review by the CFO or his/her designee of the information described below:

(A) A review of all information submitted by the long-term care facility; and,

(B) A review of the cost report adjustments made by the OHCA, in order to determine the accuracy of the adjustments.

(d) The CFO or his/her designee shall send a written decision of the reconsideration to the long-term care facility within thirty (30) calendar days of the date of OHCA's receipt of the reconsideration request, or the date of any informal meeting, whichever occurs later.

(e) If the provider disagrees with the decision rendered by the CFO or his or her designee, the provider may utilize the administrative appeals process in accordance with Oklahoma Administrative Code 317:2-1-17.

### **317:30-5-132.2. Allowable Costs**

The Oklahoma Health Care Authority (OHCA) shall reimburse long-term care facilities in accordance with its federally-approved Oklahoma Medicaid Plan. According to the Oklahoma Medicaid Plan, per-diem rates for long-term care facilities are established on,

among other things, analyses of annual uniform cost reports. These reports may only include allowable costs, as follows:

(1) To be allowable, the costs shall be reasonable and necessary for services related to resident care, and pertinent to the operation of the long-term care facility. More specifically:

(A) To be reasonable, costs shall be such as would ordinarily be incurred for comparable services provided by comparable facilities, for example, facilities of similar size and level of care; and

(B) To be necessary, costs related to patient care must be common and accepted occurrences; and,

(C) Allowable costs for services and items directly related to resident care include routine services, as established by Oklahoma Administrative Code (OAC) 317:30-5-133.1, and quality of care assessment fees, as established by OAC 317:30-5-131.2. Ancillary services, as established by OAC 317:30-5-133.2, are not allowable costs, but may be reimbursed outside the long-term care facility rate, unless reimbursement is available from Medicare or other insurance or benefit programs.

(2) The following costs shall not be allowable:

(A) Costs resulting from inefficient operations;

(B) Costs resulting from unnecessary or luxurious care;

(C) Costs related to activities not common and accepted in a long-term care facility, as determined by OHCA or its designee;

(D) Costs that are not actually paid by the provider, including, but not limited to, costs that are discharged in bankruptcy; forgiven; or converted to a promissory note;

(E) Costs that are paid to a related party that has not been identified on the reports;

(F) Cost of services, facilities, and supplies furnished by organizations related to the provider, by common ownership or control, that exceed the price of comparable services, facilities, or supplies purchased by independent providers in Oklahoma, in accordance with 42 Code of Federal Regulations § 413.17; and,

(G) Costs or financial transactions used to circumvent OHCA's applicable reimbursement rules.

(3) Allowable costs shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual, HCFA-Pub. 15.

**317:30-5-136.1. ~~Focus on Excellence~~Pay-for-Performance program**

(a) **Purpose.** The ~~Focus on Excellence (FOE)~~Pay-for-Performance (PFP) program was established through Oklahoma State Statute, Title 56, Section 56-1011.5~~, as amended.~~ ~~FOE's~~PFP'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~~PFP program, each nursing~~long-term care~~ 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.~~shall submit documentation as it relates to program metrics (below) upon the request of the Oklahoma Health Care Authority (OHCA). The program metrics can be found on the OHCA's PFP website or on PFP/Quality of Care (QOC) 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 15<sup>th</sup> of the month following the close of the quarter.~~

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

(1) Decrease of high risk pressure ulcers 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.

(4) Decrease percent of urinary tract infection for long stay residents.

~~(d)(e) **Payment.** The amount of eligible dollars is reimbursable based on the SoonerCare FOF nursing facility meeting the quality metric thresholds listed in (b). Facilities must meet a minimal of 100 points to even be eligible for reimbursement. Payment to long-term care facilities for meeting the metrics will be awarded quarterly. 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 targeted quality measure in the program is disqualified from receiving an award related to that measure for that quarter.~~

(1) **Distribution of Payment.** OHCA will notify the ~~FOEPFP~~ 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.~~ shall have performance review(s) and provide documentation upon request from OHCA to maintain program compliance. Program payments will be withheld from facilities that fail to submit the requested documentation fifteen (15) business days after the submission due date.

~~(e)~~ (f) **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) and 317:2-1-16.