

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit <http://www.okhca.org/proposed-rule-changes.aspx>

OHCA COMMENT DUE DATE: February 17, 2017

The proposed policy was submitted to the Medical Advisory Committee (MAC) on November 17, 2016 as an emergency policy change. The proposed policy was presented for Tribal Consultation on November 3, 2015. The proposed Permanent Rule is scheduled to be presented to the MAC on March 9, 2017 and to the OHCA Board of Directors on March 23, 2017.

Reference: APA WF # 16-16B

SUMMARY:

Nursing Facility Supplemental Payment Program – The proposed revisions add guidelines for the nursing facility supplemental payment program.

LEGAL AUTHORITY

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 30-101 of Title 11 of Oklahoma Statutes; Section 790.1 of Title 19 of Oklahoma Statutes; Section 176 of Title 60 of Oklahoma Statutes; Sections 1-1902 and 1-1905 of Title 63 of Oklahoma Statutes.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

FROM: Demetria Bennett
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF # 16-16B

A. Brief description of the purpose of the rule:

The proposed policy adds a supplemental payment program for nursing facilities owned and/or operated by non-state government owned or operated (NSGO) organizations. The policy adds requirements and criteria for supplemental payments to be made to participating NSGOs up to the allowable Medicare upper payment limit (UPL). In addition, proposed revisions define terms related to the program and set forth criteria and eligibility requirements. Rules are also added to outline cost reporting, change in ownership, disbursement of payment, and appeal requirements.

- 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:

Nursing facilities owned and/or operated by NSGOs and nursing facility residents will be affected by the proposed rule. The program will leverage federal dollars governed under federal policy. The federal dollars are in addition to the current nursing facility reimbursement. The additional dollars will be available by leveraging the gap between Medicaid and Medicare payments up to the UPL. The effect to nursing facilities will be additional funding that could help sustain financially challenged urban and rural nursing facilities. The effect to nursing home residents, as a result of the funding, will be an enhancement in the quality of care. The NSGOs will bear the cost of providing the state share match for the program.

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

Nursing facilities, NSGOs, and nursing home residents will benefit from the proposed rule.

- 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:

The probable impact for the proposed rule change is a positive impact as the additional funds are critical to financial sustainability of financially challenged urban and rural nursing facilities. NSGOs will be required to fund the state share and may be required to modify business practices

to be sure program requirements are met.

In addition, this change could result in a negative economic impact for school districts if an NSGO purchases the real estate from the nursing home owner, as NSGOs are exempt from ad valorem taxes which assist with funding to school district.

- 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:

There is no cost to the OHCA as the state share will be financed by the NSGO and will be transferred to the state by way of an intergovernmental transfer for claiming of federal financial participation.

- 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 additional funding for successful program participation may provide stability for institutions owned by a government other than the state and will require the cooperation of NSGOS for implementation.

- 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:

There is no adverse economic impact on small businesses as a result of this rule. Please refer to item D listed above.

- 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 is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule. Opportunities for public input are provided throughout the rulemaking

process, in addition to formal public comment periods and tribal consultations.

- 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 is intended to improve the public health, safety and environment for nursing home residents.

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

Without the additional funds and sustainability for financially challenged nursing facilities, the detrimental effect on the public health and safety of SoonerCare members may be impacted. Financially challenged facilities may continue to struggle with keeping their doors open.

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

Prepared November 7, 2016.

Revised December 2, 2016.

RULE TEXT

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

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

(a) Purpose. The Nursing Facility Supplemental Payment Program is a supplemental payment, up to the Medicare upper payment limit, 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 42 Code of Federal Regulations 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.

(3) **"Non-state government-owned (NSGO)"** means an entity owned and as applicable operated by a unit of government other than the state and approved by OHCA as a qualified NSGO. Pursuant to federal and OHCA approval an NSGO may include public trusts pursuant to the Trust Authorities established under Oklahoma Statute Title 60.

(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 upper payment limit calculation.

(5) **"Supplemental payment calculation period"** means the calendar quarter for which supplemental payment amounts are calculated based on adjudicated claims for days of service provided in the qualifying quarter. Note, in the event there are no paid days in the quarter as a result of the time in which the claims are adjudicated, the supplemental payment will be calculated on days billed in a subsequent quarter.

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

(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) days prior to the start of the participation quarter and received approval from OHCA for participation;

(4) the NSGO has signed an attestation that a plan towards the reduction and mitigation of unnecessary Return to Acute Admissions (RTA) will be implemented within six months of program participation start date;

(5) the facility is an active participant in the Focus on Excellence program; and

(6) the facility and NSGO comply with care criteria requirements. All facilities must 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) must execute a nursing facility provider contract as well as an agreement of participation with the OHCA;

(2) must provide and identify the state share dollars' source of the IGT;

(3) must pay the calculated IGT to OHCA by the required deadline;

(4) must provide proof of ownership, if applicable (i.e. Change of Ownership) as Licensed Operator of the nursing facility;

(5) must provide OHCA with an executed Management Agreement between the NSGO and the facility Manager;

(6) must provide proof of district authority for nursing facility participants which include proximity requirements of no greater than one hundred fifty (150) miles of NSGO. Exceptions may be made at the sole discretion of OHCA; and

(7) must 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 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 will be distributed through the rate setting methodology process. Distribution will occur once escrowed funds reach an amount sufficient to distribute as determined by OHCA.

(e) **Care Criteria.**

(1) Each facility will be required to meet or exceed at minimum two of the five established care criteria metrics contained in paragraphs (A) through (E) of this section. The facility will be required to develop and implement a plan and identify the current baseline for each criterion. Each facility must demonstrate ongoing progress through baseline outcomes, performance summary and goals. Care criteria data and forms must be completed and submitted within five (5) business day after quarter end.

(A) Facilities must develop and implement a written plan

for the mitigation of unnecessary Return to Acute Admissions (RTA) within six (6) months of participation. The plan will include the RTA for the trailing twelve (12) month period. The resulting outcome is to improve the efficiency and care avoidance cost to the overall SoonerCare program. A written plan must be developed and must include the following:

- (i) the RTA management tool which identifies those residents at high risk for the potential return to acute;
- (ii) the RTA management tools to support effective communications;
- (iii) advance directive planning and implementation;
- and
- (iv) application of Quality Assurance/Program Integrity (QA/PI) methodology in review of RTAs for the root cause analysis and teaching needs.

(B) Facilities are required to implement a pro-active Pneumonia/Flu Vaccination program which will result in improved vaccination scores above the facility specific baseline at or above the national average, as measured using the CMS Quality Metrics. The resulting outcome is to improve efficiency and care avoidance costs to the overall SoonerCare program. A written plan must be developed and must include the following:

- (i) the latest available three quarter average of CMS measure code 411 (% of long-stay residents assessed and appropriately given the seasonal influenza vaccine) and 415 (% of long-stay residents assessed and appropriately given the pneumococcal vaccine) to establish baseline;
- (ii) the current measure code 411 and 415 score; and
- (iii) the written plan for flu and pneumonia vaccination program to address new admissions and current residents.

(C) Facilities are required to participate in the Oklahoma Healthy Aging Initiative. The resulting outcome is to improve the quality of care and health of members. Facilities must attest to elevate healthy aging in Oklahoma by implementing a plan that accomplishes at least one of the following strategies:

- (i) preventing and reducing of falls;
- (ii) improving of nutrition;
- (iii) increasing physical activity; or
- (iv) reducing depression.

(D) Facilities are required to actively take part in an OHCA approved satisfaction survey. The resulting outcome is to improve the quality of care being delivered to

members. A written plan must be developed and implemented and must include the following:

- (i) the satisfaction survey results;
- (ii) analysis of satisfaction survey with identification of, at minimum, one area for improvement; and
- (iii) plan of action towards identified areas of improvement.

(E) Facilities are required to demonstrate improvement above the facility specific baseline in the five (5) Star Quality Measures Composite scoring. Metrics will be determined based upon CMS Nursing Home Compare composite score over the trailing twelve (12) month period. Facilities with Quality Measures star rating of three (3) or better for the most recent quarter or showing improvement in composite scoring with no two (2) quarters consistently below three (3), will be recognized as meeting the care criteria. The resulting outcome is to improve the quality of care being provided.

- (i) Facilities must provide the most recent three (3) quarter average of the CMS quality measure star rating to establish baseline.
- (ii) Facilities are required to have a star rating of (3) or better or must demonstrate improvement over previous quarter with no two (2) quarters below three (3) stars.

(2) 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, in collaboration with an advisory committee composed of OHCA agency staff and provider representatives. The OHCA may make adjustments to the care criteria measures based on findings and recommendations as a result of the independent or internal evaluation.

(f) Supplemental Payments.

(1) The nursing facility supplemental payments to a NSGO under this program shall not exceed Medicare payment principles pursuant to 42 CFR 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 upper

payment limit 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. NSGO participants receive payment under the program based on earned percentages related to the care criteria. The NSGO must meet or exceed at least two (2) of the five (5) established care criteria metrics to be eligible for UPL payment for each quarter. After at least two (2) of the five (5) metrics have been met, the NSGO is eligible for eighty-five percent (85%) of the total eligible UPL amount for participating nursing facilities. The NSGO may qualify for the remaining fifteen percent (15%) of the total UPL by attribution in five percent (5%) increments for each additional care criterion that is met resulting in the full one hundred percent (100%) of the eligible UPL amount.

(g) Change in ownership.

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

(h) Disbursement of payment to facilities. Facilities must secure allowable Intergovernmental Transfer funds (IGT) 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 a designated portal 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. In addition, the NSGO will be responsible to also remit, upon receipt of the NPR, the applicable PPMD IGT in full, pursuant to (d)(7) above.

(2) If the total transfer and 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. An IGT that is not received by the date specified by OHCA, or that is not the total indicated on the NPR shall be subject to penalty and suspension from the program.

(i) **Penalties/Adjustments.** Failure by an NSGO to remit the full IGT indicated on the NPR by OHCA or its designee within the defined timeframes below indicates the NSGO has voluntarily elected to withdraw participation for that current quarter and may reapply for participation in the program in subsequent quarter(s).

(1) The total IGT must be received within five (5) business days from receipt of the NPR uploaded by OHCA or its designee in the program portal.

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

(B) The date the NPR is uploaded to the portal is the official date the clock starts to measure the five (5) business days.

(2) Any IGT received after the fifth 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 uploaded NPR in the portal will not be subject to penalty; however, payment will be disbursed during the next available OHCA payment cycle.

(3) Any 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 will be deemed late and subject to a penalty in accordance with (3)(B) below.

(A) Any NSGO that remits payment of the total IGT under the above circumstances will receive payment during the next available OHCA payment cycle including an assessed penalty as described below.

(B) A five percent (5%) penalty will be assessed for total IGT payments received after five (5) business days but within eight business days of receipt of the NPR of assessed amount. 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.

(C) The OHCA will notify the NSGO of the assessed penalty via invoice. If the provider fails to pay the 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 must 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.

(4) If a nursing facility fails to achieve at a minimum, two (2) of the care criteria metrics for two (2) consecutive quarters, the facility will 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 will 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, taking into consideration input from the advisory committee and/or stakeholders. 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 OAC 317:2-1-2(b) and 317:2-1-16.