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State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: CORRECTED 19-0031-B

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

December 4, 2019

Kevin S. Corbett
Chief Executive Officer
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma 73105

Our Reference: SPA OK 19-0031-B

Dear Mr. Corbett:

We have reviewed the proposed State plan amendment (SPA) to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 19-0031-B. This amendment proposes to increase the nursing facility pool amounts, base rate components for nursing facilities serving adults and Aids patients. Additionally, the SPA revises the Pay-for-Performance (PFP) program, formerly known as the Focus on Excellence (FOE) program.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

Based upon the information provided by the State, Medicaid State plan amendment 19-0031-B is approved effective October 1, 2019. We are enclosing the Form CMS-179 and the new plan pages.

If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,

[redacted]

Kristin Fan
Director

cc:
Tia Lyles
Tamara Sampson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19 — 00 31 B

2. STATE: Oklahoma

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR § 440.155

7. FEDERAL BUDGET IMPACT
a. FFY 2020 $ 81,597,689
b. FFY 2021 $ 82,734,767

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-D, Page 1
Attachment 4.19-D, Page 3
Attachment 4.19-D, Page 4
Attachment 4.19-D, Page 5
Attachment 4.19-D, Page 6
Attachment 4.19-D, Page 7
Attachment 4.19-D, Page 7.1
Attachment 4.19-D, Page 11
Attachment 4.19-D, Page 12

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 4.19-D, Page 1; TN # ~~10-35~~ 19-0025 *Pen and Ink change 01-09-2020
Attachment 4.19-D, Page 3; TN # 19-0025
Attachment 4.19-D, Page 4; TN # 10-35
Attachment 4.19-D, Page 5; TN # 19-0025
Attachment 4.19-D, Page 6; TN # 11-10, Page Reserved
Attachment 4.19-D, Page 7; TN # 13-14, Page Reserved
Attachment 4.19-D, Page 7.1; TN # 13-14, Page Reserved
Attachment 4.19-D, Page 11; TN # 19-0025
Attachment 4.19-D, Page 12; TN # 10-35

10. SUBJECT OF AMENDMENT

Nursing Facility Rate Changes and Pay-for-Performance Program Changes

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
■ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Melody Anthony

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
October 2, 2019

16. RETURN TO
Oklahoma Health Care Authority
Attn: Maria Maule
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
October 2, 2019

18. DATE APPROVED
DEC 04 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
Kristin Fan

22. TITLE
Director, FMG

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

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).

If payments exceed the Upper Payment Level (UPL) in aggregate, the OHCA will recoup payments proportionate to the nursing facility's contribution to the amount exceeding the UPL.

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.

State: Oklahoma
Date Received: October 2, 2019
Date Approved: December 4, 2019
Date Effective: October 1, 2019
Transmittal Number: 19-0031-B

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.

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 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 Pay-for-Performance (PFP) Quality of Care Rating System.

State: Oklahoma
Date Received: October 2, 2019
Date Approved: DEC 04 2019
Date Effective: October 1, 2019
Transmittal Number: 19-0031-B

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS *(continued)*

3. PROCESS:
Annually, any funds over and above those to cover the Base Rate plus the estimated 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.

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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.

3. 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".

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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS *(continued)*

Reserved page.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS *(continued)*

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS *(continued)*

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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.

(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.*

State: Oklahoma
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING AIDS PATIENTS *(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 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.

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