DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification

Dr. Garth Splinter
State Medicaid Director
Oklahoma Health Care Authority
4545 North Lincoln Blvd., Suite 124
Oklahoma City, Oklahoma 73105
Attention: Cindy Roberts

MAR 22 2011

RE: TN 10-35

Dear Dr. Splinter:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 10-35. This amendment changes the method of assessing the provider tax on nursing facilities and clarifies existing methodologies in the Oklahoma state plan.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. As part of the review process the State was asked to provide information regarding funding of the State share of expenditures under Attachment 4.19-D. Based upon the assurances provided, Medicaid State plan amendment 10-35 is approved effective November 1, 2010. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Sandra Dasheiff, CPA at (214) 767-6490.

Sincerely,

[redacted]

Cindy Mann
Director
Center for Medicaid, CHIP, and Survey & Certification

Enclosures

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: 10-35

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
November 1, 2010

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

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS A 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 2011 $0
b. FFY 2012 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
See Attachment

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

10. SUBJECT OF AMENDMENT
In the proposed changes, we are incorporating implementation of a Waiver of Uniformity for our Provider Tax levied on this facility type. We are requesting approval for a change to our method of assessing the provider tax on our nusing facilities.

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
The Governor does not review State Plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mike Fogarty

14. TITLE
Chief Executive Officer

15. DATE SUBMITTED
October 13, 2010

16. RETURN TO
Oklahoma Health Care Authority
Attn: Cindy Roberts
2401 N.W. 23rd Street Suite 1A
Oklahoma City, OK 73107

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 13 October 2010

18. DATE APPROVED: 03-22-11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: NOV - 1 2010

20. [redacted] CIAL:

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMCS

23. REMARKS:

Attachment Oklahoma SPA 10-35

Box 8.	Box 9.
Attachment 4.19-D Page 1	Same Page, Revised 07-01-05, TN # 05-03
Attachment 4.19-D Page 2	Same Page, Revised 09-01-00, TN # 00-16
Attachment 4.19-D Page 3	Same Page, Revised 09-01-01, TN # 01-17
Attachment 4.19-D Page 4	Same Page, Revised 09-01-01, TN # 01-17
Attachment 4.19-D Page 5	Same Page, Revised 09-01-01, TN # 01-17
Attachment 4.19-D Page 6	Same Page, Revised 09-01-01, TN # 01-17
Attachment 4.19-D Page 7	Same Page, Revised 09-01-01, TN # 01-17
Attachment 4.19-D Page 8	Same Page, Revised 09-01-01, TN # 01-17
Attachment 4.19-D Page 9	Same Page, Revised 09-01-01, TN # 01-17
Attachment 4.19-D Page 10	Same Page, Revised 09-01-01, TN # 01-17
Attachment 4.19-D Page 11	Same Page, Revised 01-01-04, TN # 03-19
Attachment 4.19-D Page 12	Same Page, Revised 09-01-01, TN # 01-17
Attachment 4.19-D Page 13	Delete Page
Attachment 4.19-D Page 13(a)	Delete Page
Attachment 4.19-D Page 13(b)	Delete Page
Attachment 4.19-D Page 13(c)	Delete Page
Attachment 4.19-D Page 13(d)	Delete Page
Attachment 4.19-D Page 13(e)	Delete Page
Attachment 4.19-D Page 14	Delete Page
Attachment 4.19-D Page 15	Delete Page
Attachment 4.19-D Page 16	Delete Page
Attachment 4.19-D Page 17	Delete Page
Attachment 4.19-D Page 18	Delete Page
Attachment 4.19-D Page 19	Delete Page
Attachment 4.19-D Page 20	Delete Page
Attachment 4.19-D Page 21	Delete Page
Attachment 4.19-D Page 22	Delete Page
Attachment 4.19-D Page 23	Delete Page
Attachment 4.19-D Page 24	Delete Page
Attachment 4.19-D Page 25	Delete Page
Attachment 4.19-D Page 26	Delete Page
Attachment 4.19-D Page 27	Renumbered to Attachment 4.19-D Page 13, Revised 04-01-10, TN # 10-08
Attachment 4.19-D Page 28	Renumbered to Attachment 4.19-D Page 14, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 29	Renumbered to Attachment 4.19-D Page 15, Revised 04-01-10, TN # 10-08
Attachment 4.19-D Page 30	Renumbered to Attachment 4.19-D Page 16, Revised 07-01-07, TN # 07-10
Attachment 4.19-D Page 31	Renumbered to Attachment 4.19-D Page 17, Revised 07-01-05, TN # 05-03
Attachment 4.19-D Page 32	Renumbered to Attachment 4.19-D Page 18,

	Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 33	Renumbered to Attachment 4.19-D Page 19, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 34	Renumbered to Attachment 4.19-D Page 20, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 35	Renumbered to Attachment 4.19-D Page 21, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 36	Renumbered to Attachment 4.19-D Page 22, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 37	Renumbered to Attachment 4.19-D Page 23, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 38	Renumbered to Attachment 4.19-D Page 24, Revised 01-01-02, TN # 02-04
Attachment 4.19-D Page 39	Renumbered to Attachment 4.19-D Page 25, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 40	Renumbered to Attachment 4.19-D Page 26, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 41	Renumbered to Attachment 4.19-D Page 27, Revised 07-01-07, TN # 07-10
Attachment 4.19-D Page 42	Renumbered to Attachment 4.19-D Page 28, Revised 04-01-10, TN # 10-08
Attachment 4.19-D Page 43	Renumbered to Attachment 4.19-D Page 29, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 44	Renumbered to Attachment 4.19-D Page 30, Revised 07-01-05, TN # 05-03
Attachment 4.19-D Page 45	Renumbered to Attachment 4.19-D Page 31, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 46	Renumbered to Attachment 4.19-D Page 32, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 47	Renumbered to Attachment 4.19-D Page 33, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 48	Renumbered to Attachment 4.19-D Page 34, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 49	Renumbered to Attachment 4.19-D Page 35, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 50	Renumbered to Attachment 4.19-D Page 36, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 51	Renumbered to Attachment 4.19-D Page 37, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 52	Renumbered to Attachment 4.19-D Page 38, Revised 09-01-01, TN # 02-04
Attachment 4.19-D Page 53	Renumbered to Attachment 4.19-D Page 39, Revised 07-01-07, TN # 07-10
Attachment 4.19-D Page 54	Renumbered to Attachment 4.19-D Page 40, Revised 07-01-07, TN # 07-10
Attachment 4.19-D Page 55	Renumbered to Attachment 4.19-D Page 41,

Revised 04-01-10, TN # 10-08

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.

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 (CONTD)

e. **Audits of Cost Reports**. The Authority will conduct desk reviews to verify the completeness and mathematical accuracy of all totals and extensions in each cost report. Census information may be independently verified through other OHCA sources. In addition, a sample number of cost reports will be audited independently by an auditor retained by OHCA. Any NF that is subject to an audit is required to make its records available to OHCA and to any auditor engaged by OHCA

2. **ALLOWABLE AND UNALLOWABLE COSTS**

Only "allowable costs" may be included in the cost reports. (Costs should be net of any offsets or credits.) Allowable costs include all items of SoonerCare-covered expense that NF's incur in the provision of routine (i.e., non-ancillary) 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, 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 NF rate should not be included in the NF cost report and are not allowable costs. Quality of Care assessment fees are allowable costs for reporting purposes. OHCA reserves the right to exclude from its analysis unallowable costs, whether included in the cost report or not.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS (CONTD)

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.

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 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 Quality of Care Rating System.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS (CONTD)

3. PROCESS:

Annually, any funds over and above those to cover the Base Rate plus the estimated Focus on Excellence 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 (CONTD)

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 07-01-07 the total available pool amount for establishing Rate Components for Direct Care and Other Costs as described in 1 and 2 was set at $99,275,444.

For the rate period beginning 11/01/08, the total available pool amount for establishing the rate components' described in 1 and 2 was set at $118,007;540.

For the rate period beginning 01/01/10, the total available' pool amount for establishing the rate components described in 1 and 2 was set at $115,979,147.

For the rate period beginning 04/01/10, the total available pool amount for establishing the rate components described in 1 and 2 was set at $99,248,541.

For the rate period beginning 11/01/10, the total available pool amount for establishing the rate components described in 1 and 2 is $97,607,577.

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 percent (1%) 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
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:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS (CONTD)

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:

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
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
1 to two points earned level:

The add-on is set at 1% to 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)

(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: A score of 3.50, or better
(9). Nursing Staffing per patient Day: The Median Score, 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 *"0"* or less and 3. any subsequent non-care scope/severity citations are "E" or less.

4. 56 Okla. Stat. § 2002 requires that all licensed nursing facilities pay a statewide average per patient day Quality of Care assessment fee based on the 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 and a part of the base rate component as it relates to Medicaid services.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS (CONTD)

5. **SPECIALIZED SERVICES**

Payment will be made for non-routine nursing facility services identified in an individual treatment plan prepared by the State MR Authority. Services are limited to individuals approved for NF and specialized services as the result of a PASSR/MR Level II screen. The per diem add-on is calculated as the difference in the statewide average standard private MR base rate and the statewide NF facility standard base rate. If the Standard private MR average base rate falls below the standard nursing facility base rate or equals

the standard facility base rate for regular nursing facilities the payment will not be adjusted for specialized services.

6. **COSTS OF COMPLIANCE WITH OMNIBUS BUDGET RECONCILIATION ACT**

(OBRA) OF 1987

All of the costs of compliance appear in provider cost reports used to develop rates. Therefore, no further adjustment or add-on is required.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING AIDS PATIENTS

A statewide prospective rate of payment shall be reviewed, at a minimum, annually for Oklahoma Nursing Facilities serving AIDS patients. The rate 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 period. The rate is 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.

The rate is 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 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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING AIDS PATIENTS (CONTD)

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.

e. Audits of Cost Reports. The Authority will conduct a desk review to verify the completeness and mathematical accuracy of all totals and extensions in each cost report. Census information may be independently verified through other OHCA sources. In addition, a sample number of cost reports will be audited independently by an auditor retained by OHCA. Any NF that is subject to an audit is required to make its records available to OHCA and to any auditor engaged by OHCA.

2. ALLOWABLE AND UNALLOWABLE COSTS

Only "allowable costs" may be included in the cost reports (Costs should be net of any offsets or credits.) Allowable costs include all items of SoonerCare covered expense that NF's incur in the provision of routine (i.e., non-ancillary) 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, 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 NF Aids rate should not be included in the cost report and are not allowable costs. Quality of Care assessment fees are allowable costs for reporting purposes.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING AIDS PATIENTS (CONTD)

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 11-01-10 is $178.64, the difference in the costs reported for aids facilities and regular nursing facilities plus the average rate for 11-01-10 for regular nursing facilities, not including the incentive payment component ($193.79 less $138.17 plus $123.02); or $178.64 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 the 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)

(B) 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 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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING VENTILATOR – DEPENDENT PATIENTS

A statewide enhanced reimbursement rate shall be reviewed, at a minimum, annually for nursing facilities (NFs) serving ventilator-dependent patients.

Definitions – Reimbursement is limited to the average standard rate paid to NFs serving adults plus an enhancement for ventilator patients. The enhanced payment is an amount reflecting the additional costs of meeting the specialized care needs of ventilator-dependent patients. To qualify for the enhanced payment, a facility must (1) not have a waiver under Section 1919(b)(4)(C)(ii) of the Social Security Act, and (2) submit a treatment plan and most recent doctor's orders and/or hospital discharge summary to the Oklahoma Health Care Authority for prior authorization.

Rate Determination – The add-on rate is determined prospectively as follows:

1. The estimated cost of direct care personnel is calculated using ventilator care-related criteria developed by the State of Minnesota. The criteria identifies the tasks, caregiver time estimate (in minutes per day) and caregivers (RN, LPN, etc.) required to complete each element of care on a daily basis. (For blood gas tasks, a respiratory therapist was substituted for the RN).

2. Each care giver time estimate, within each task category, is added together to arrive at a total caregiver time estimate within each task category. The total caregiver time estimate is converted to hours per day. It is then multiplied by a projected hourly wage rate by class of caregiver to arrive at a cost per day for each caregiver within each task category. Each cost per day for each caregiver is added together to arrive at a total caregiver cost within each task category. Each total caregiver cost is added together to arrive at a total caregiver cost to complete all identified tasks. The projected hourly wage rates were derived from the most recently available NF cost reports.

3. A factor for fringe benefits is calculated by dividing total employee benefits by total salaries and wages. The total caregiver cost to complete all identified tasks is multiplied by the factor for fringe benefits to arrive at a fringe benefit cost. The fringe benefit cost is added back into the total caregiver cost to complete all identified tasks to arrive at an adjusted total caregiver cost. Total employee benefits and total salaries and wages were derived from the most recently available NF cost reports.

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Effective 11-01-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

7. RATE ADJUSTMENTS BETWEEN REBASING PERIODS (continued)

(1) As of July 1, 2007, individual rates of payment will be established as the sum of the Base Rate plus add-ons for Direct Care, Other Costs and the add-on earned under the Oklahoma Focus on Excellence Quality of Care Rating System.

(2) Annually, any funds over and above those to cover the Base Rate plus the Focus on excellence Program payments will be used to create two pools of funds to be used to establish the rate add-ons for each facility (a statewide uniform rate add-on). The estimated total 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.

(a) The Other Cost pool will be 30% of the available funds. This pool of funds will be divided by the total estimated Medicaid days to determine the add-on for each facility (a statewide uniform rate add-on).

(b) The Direct Care cost pool will be 70% of the available funds. This pool of funds will be used to establish facility specific add-ons to the rates. These add-ons will be determined 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 Medicaid days and added together to calculate the aggregate estimated Medicaid direct care cost. The estimated annual Medicaid days will be determined by using the latest CY MMIS 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.

STATE Oklahoma DATE RECD 12-18-2009 DATE APPV'D 2-14-2010 DATE EFF 1-1-2010 HCFA 179 09-11	A

Revised 01-01-10

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State: OKLAHOMA

STATE Oklahoma
DATE REC'D 3-5-10
DATE APPV'D 5-21-10
DATE EFF 4-1-10
HCFA 179 10-08

A

Attachment 4.19-D
Page 13(b)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

7. RATE ADJUSTMENTS BETWEEN REBASING PERIODS (continued)

Step Three: The Direct Care Pool of available funds will be divided by the aggregate estimated Medicaid 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 rate year. For homes not filing a cost report, the rate will be the sum of the base rate plus the Other Cost add-on, only. For new facilities beginning operations in the rate year, the rate will be the median of those established rates for the year.

(c) For the rate period beginning 7/1/05, the total funds available for establishing the pools in (a) and (b) is zero (0).

(d) For the rate period beginning 7/1/06, the total available pool amount for establishing rates as described in (a) and (b) is $71,396,300.

(e) For the rate period beginning 07-01-07 the total available pool amount for establishing annual rates as described in (a) and (b) is $99,275,444.

(f) For the rate period beginning 11/01/08, the total available pool amount for establishing the rate components described in (a) and (b) is $118,007,540.

(g) For the rate period beginning 01/01/10, the total available pool amount for establishing the rate components described in (a) and (b) is $115,979,147.

(h) For the rate period beginning 04/01/10, the total available pool amount for establishing the rate components described in (a) and (b) is $99,248,541.

(1) As of July 1, 2007 Nursing Facilities Serving Adults and Aids Patients will be able to earn additional reimbursement for "points" earned in the Oklahoma Focus on Excellence Quality Rating Program.

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State: OKLAHOMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
FOR NURSING FACILITIES

7. RATE ADJUSTMENTS BETWEEN REBASING PERIODS (continued)

For the period beginning 07-01-07, facilities participating in the Focus on Excellence Program will receive a bonus equal to one percent (1%) 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 disagreement occurs as to whether the facility has successfully submitted the required data and surveys.

For the period beginning 01-01-08, the reimbursement is 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 plus the Other Component (as described in 7 above);

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STATE Oklahoma
DATE RECT 4-26-07
DATE APP'D 9-5-07
DATE EFF 7-1-07
HCFA 179 07-10

3 to 4 points earned level:
The add-on is set at 2% of the sum of the Base Rate plus the Other Component (as described in 7 above);

5 to 6 points earned level:
The add-on is set at 3% of the sum of the Base Rate plus the Other Component (as described in 7 above);

7 to 8 points earned level:
The add-on is set at 4% of the sum of the Base Rate plus the Other Component (as described in 7 above);

9 to 10 points earned level:
The add-on is set at 5% of the sum of the Base Rate plus the Other Component (as described in 7 above).

New Page 07-01-07

Deleted by 10-35
Effective 11-01-10

State: OKLAHOMA

STATE Oklahoma
DATE RECD 12-18-2009
DATE APPV'D 2-14-2010
DATE EFF 1-1-2010
HCFA 179 09-11

A

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

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

1 to two points earned level:
The add-on is set at 1% of the sum of the Base Rate plus the Other Component (as described in 7, above);

3 to 4 points earned level:
The add-on is set at 2% of the sum of the Base Rate plus the Other Component (as described in 7, above);

5 to 6 points earned level:
The add-on is set at 3% of the sum of the Base Rate plus the Other Component (as described in 7, above);

7 to 8 points earned level:
The add-on is set at 4% of the sum of the Base Rate plus the Other Component (as described in 7, above);

9 to 10 points earned level:
The add-on is set at 5% of the sum of the Base Rate plus the Other Component (as described in 7, above);

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. **Employee 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.
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 is the median score.

SUPERSEDES: TN- 07-10

Revised 01-01-10

Deleted by 10-35
Effective 11-01-10

State: OKLAHOMA

Attachment 4.19-D
Page 13(e)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

For the period beginning 01-01-2010 and until changed by amendment the established thresholds for each measure are 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 of 58.0, or better
5. Nurse Turnover & Retention A score of 60.0, or better
6. System-wide Culture Change A score of 72.0, or better
7. Clinical Measures A score of 58.0, or better
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.

STATE Oklahoma	A
DATE REC'D 12-18-2009	
DATE APPV'D 2-14-2010	
DATE EFF 1-1-2010	
HCFA 179 09-11	

SUPERSEDES: TN- 07-10

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TN# 09-11 Approval Date 2-14-2010 Effective Date 1-1-2010
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TN# 07-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
FOR NURSING FACILITIES

4. Based on provider input, and other survey information, the estimated average hours of specialized care required by ventilator-dependent patients was 9 hours per day. Each caregiver time estimate within each task category was added together to arrive at a total time estimate to complete all identified tasks, which was 13.69 hours. The adjusted total caregiver cost is multiplied by the ratio of 9 hours divided by 13.69 hours to arrive at a specialized caregiver cost.

5. The total patient care cost from the most recently available NF cost reports was calculated. The total patient care costs include nursing personnel including nursing employee benefits, medical director including employee benefits, social and ancillary service personnel including employee benefits, contract nursing, other contract personnel, medical equipment, dietary, drugs and medical supplies.

6. The difference between 24 hours and the estimated average hours of specialized care required by ventilator-dependent patients (9 hours) is divided by 24 hours. It is then multiplied by the total patient care cost which is then added to the specialized caregiver cost to arrive at the total 24 hour cost of patient care.

7. Five percent of the total patient care cost will be allowed for the additional cost of medical supplies not reimbursed by Medicare. A $4.00 per day adjustment will be allowed for nutritional therapy. Both additional costs are added back into the total 24 hour cost of patient care.

8. The difference between the total 24 hour cost of patient care (step 6) and the total patient care cost (step 5) is the add-on for ventilator patients.

9. The add-on for ventilator patients was inflated to the midpoint of the rate year using the fourth quarter publication of the Data Resources Inc., (DRI) Nursing Facility Marketbasket Index's forecast.

Cost Report Requirements – Uniform cost reports will be required of each nursing facilities and the State will provide for periodic audits of such reports. Facilities will be required to submit a separate cost report for ventilator care.

Adjustments – The add-on rate will be inflated when standard NF rates are changed by the fourth quarter publication of the Data Resources Inc., (DRI) Nursing Facility Marketbasket Index's forecast to the midpoint of the State Fiscal Year of the rate change.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

The add-on rate will be established prospectively according to the methods described above until a reimbursement rate can be derived from the cost reports which will reasonably reimburse the cost of an economic and efficient provider for ventilator patient care.

For the period beginning January 1, 2004, no adjustment will be made to the add-on.

For the rate period beginning July 1, 2006, the statewide add-on will be increased by 9.155%.

For the rate period beginning April 1, 2010, the statewide add-on will be decreased by 3.25%.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

PUBLIC INTERMEDIATE CARE FACILITES FOR THE MENTALLY RETARDED

Reimbursement for public ICF's/MR shall be based on each facility's reasonable and allowable cost and shall be paid on an interim basis with an annual retroactive adjustment. Reasonable costs shall be based on Medicare principles of cost reimbursement.

Service Fee 56 Okla. Stat. § 2002 requires that all licensed nursing facilities pay a statewide average per patient day Quality of Care assessment fee based on the 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.

STANDARD PRIVATE INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF'S/MR)

A statewide prospective rate of payment shall be reviewed, at a minimum, annually for Oklahoma standard private intermediate care facilities for the mentally retarded. The rate will be determined pursuant to these methods and standards and approved by the Oklahoma Health Care Authority Board in advance of the rate period.

The rate will be 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.

The rate is 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).

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

A. COST ANALYSES

The Oklahoma Health Care Authority (OHCA) is principally responsible for implementing the Medicaid program in Oklahoma. OHCA staff will prepare necessary analyses to support the rate determination process, as described below.

1. UNIFORM COST REPORTS

Each Medicaid-participating ICF/MR facility must submit, on uniform cost reports designed by the Authority, cost and related statistical information necessary for rate determination.

a. **Reporting Period.** Each ICF/MR 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, covering each period of time the ICF/MR was in operation during the year.

b. **Report Deadline.** The report must be filed by October 31 of each 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 ICF/MR, by an officer of the company that manages the NF, and by the person who prepared the report.

e. **Audits of Cost Reports.** The Authority will conduct a desk review to verify the completeness and mathematical accuracy of all totals and extensions in each cost report. Census information may be independently verified through other OHCA sources. In addition, a sample number of cost reports will be audited independently by an auditor retained by OHCA. Any ICF/MR that is subject to an audit is required to make its records available to OHCA and to any auditor engaged by OHCA.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

2. ALLOWABLE AND UNALLOWABLE COSTS

Only "allowable costs" may be included in the cost reports. (Costs should be net of any offsets or credits.) Allowable costs include all items of Medicaid-covered expense that ICF'S/MR incur in the provision of routine (i.e., non-ancillary) 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, 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 NF rate should not be included in the ICF/MR cost report and are not allowable costs. Quality of Care assessment fees are allowable costs for reporting purposes.

3. COMPUTATION OF THE STATEWIDE FACILITY BASE RATE

Cost reports used to calculate the rate were those filed for the year ended June 30, 1999. ("base year"). A state plan will be submitted when costs are rebased. A description of the calculation of the base per diem rates for the periods beginning September 01, 2000, October 01, 2000, and December 01, 2000 are as follows:

A. Primary Operating Costs

1. Determine the weighted mean primary operating per diem by summing all reported primary operating expenses of all standard ICF/MR facilities and dividing by total period patient days. Primary operating costs consists of all non-capital costs excluding administrative services.

2. Determine the audit adjustment per diem to be extrapolated to all reporting facilities based on the desk reviews and independent sample audit findings. The audit adjustment is based on an average of the difference between the reported costs and audited costs. If no audit file is available, an average audit adjustment will be determined from the average audit adjustments for the last five available periods.

For the rate period beginning 09-01-01 an audit adjustment which reflects the latest available audit data will be made. This adjust-ment will be made to the base primary operating cost before trending forward to the midpoint of the state fiscal year of the rate period by the factors defined in 3.A.4, below. The new adjustment will be the difference between the factor determined in the previous rate as defined above and the average of the three most current available years audit data on file.

3. Determine the adjusted primary operating per diem by subtracting the audit adjustment per diem (step 2) from the weighted mean primary operating costs per diem determined in step 1.

4. Trend forward the adjusted primary operating per diem from the midpoint of the base year to the midpoint of the rate period state fiscal year using the inflation update factors. The Authority will use the update factors published in the Data Resources, Inc., ("DRI") nursing home without capital marketbasket index for the fourth calendar quarter of the previous fiscal year.

   For example, for the rates effective July 1, 1997, the Authority used the update factors for the fourth quarter of calendar year 1996.

B. Administrative Services

An imputed administrative services allowance will be used in lieu of actual owner/administrator salary and non-salary compensation. The imputed administrative services allowance is the state-established limit or value for the purposes of calculating the reimbursement rate.

The base allowance will be the same as that determined for the regular Nursing facilities. The allowance will be trended forward in the same manner as in 3.A.4, above.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

C. Capital

An imputed allowance will be used in lieu of actual depreciation, interest, and lease related to facilities and equipment. The imputed allowance is determined by dividing the total reported costs (from the base year cost reports) for the regular nursing facilities, plus that for the regular nursing facilities serving aids patients, plus that for the private standard intermediate care facilities for the mentally retarded plus that for the private specialized (16 bed or less) M/R facilities by the total "adjusted days" for those facilities. The "adjusted" days are determined by multiplying the allowable days from the base year cost report by a factor of .93 (i.e. adjust to a 93% occupancy level). To account for inflation this imputed capital allowance will be trended forward to the rate period state fiscal year by the Marshall-Swift replacement cost multipliers for facilities with Class C construction (District Comparative Cost Multipliers, Central Region) published in the January index of the year preceding the rate change period.

D. Adjustment For Change In Law Or Regulation

The Authority also considers possible effects on rate year costs compared to base year costs that might not be fully accounted for by the DRI index described above. Inasmuch as the index is an estimate of actual and forecasted national rates of change in the price of nursing home goods and services, DRI is not specific to any state. Thus during a given period, it might not sufficiently account for the economic effects of changes in federal laws or regulations which have a disparate impact on Oklahoma, or of changes in state laws, rules or circumstances that only affect Oklahoma.

The following circumstances may cause an adjustment to rate year costs: additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation, authorities, or applicable law (e.g., minimum staffing requirements, social security taxation of 501(c) (3) corporations, minimum wage change, etc.) and implementation of federal or state court orders and settlement agreements.

OHCA will evaluate available financial or statistical information, including data submitted on cost reports and special surveys to calculate any base rate adjustment. These adjustments will become permanent until such time a state plan amendment is submitted to rebase the rates.

Per HB 2019, the Oklahoma 2001 Health Care initiative, the following adjustments will be made.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED**

1. For the rate period beginning September 1, 2000 the OHCA has calculated an Oklahoma Specific additional cost of expected increase in Liability insurance rates. The rate will be adjusted by an additional $.51 for the expected cost. The amount of additional cost was determined from a sample of nursing facility invoices from the 1999 and 2000 fiscal years and from data from the base year cost reports. The total sample costs for 1999 were compared to the total sample costs for 2000 to get an overall percent of increase. Total available days from the base year cost report was divided by 365 to estimate the number of beds which in turn was multiplied by an estimated annual cost of $100 per bed (per industry survey) to get an annual estimate for the rate year period. The resulting cost was divided by the total patient days from the base year cost reports and multiplied by the percent increase from above to determine the added cost per day.

   This add-on will be trended forward by the same method as in 3.A.4, above.

2. For the rate period beginning September 1, 2000 the OHCA has calculated the additional cost of new direct care staffing requirements. These new requirements are to maintain staff-to-patient ratios of 1:8, 1:12 and 1:17 for the three 8 hours shifts for day, evening and night, usually beginning at 8:00 a.m., 4:00 p.m. and 12:00 a.m., respectively. The rate will be adjusted the cost of maintaining a level of staffing that is at 86.5% of the base year level above the minimum requirement.

   This adjustment is calculated as follows:

   1. Determine the direct care hours per day from the base year cost report data for all private facility types.
   2. Determine the direct care cost per day (including benefits) of the hours determined in 1 from the base year cost reports.
   3. Adjust the hours per day for the effect of the minimum wage requirement of HB 2019 by multiplying the factor determined in 2 by the percent of the cost of the minimum wage increase to the total salaries and benefits in the base period.
   4. Determine the amount of hours per day in the base period that actual direct care hours exceeds the minimum requirement.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED**

5. Apply a factor of .865 (86.5%) to the amount determined in 4. This is the estimated amount that the facilities will remain above the minimum required hours.
6. Add the amount determined in 5 to the amount of new required minimum hours per day to get the expected level of hours per day for the rate period. Divide the expected level of hours by the level of hours in the base year to get a percent increase.
7. The cost per day is determined by multiplying the percent in 6 by the cost in 3 to get the add-on. For the period beginning 09-01-00 this amount is $2.22.

The direct care staff-to-patient ratios required and the employees to be included in the ratios are defined in Section1-1925.2 of Title 63 of the Oklahoma Statutes. In general, direct care staff includes any nursing or therapy staff providing hands-on care. Prior to Sept. 1, 2002 Activity and Social Work staff not providing hands-on care are allowable. On Sept. 1, 2002 Activity and Social Work staff not providing hands-on care shall not be included in the direct care staff-to-patient ratios. The direct care staff-to-patient ratios will be monitored by the Authority through required monthly Quality of Care Reports. These reports and rules may be found in the Oklahoma Administrative Code at OAC 317:30-5-131.2. This section of the Code also includes rules for penalties for non-timely filing and the methods of collection of such penalties. Non compliance with the required staff-to-patient ratios will be forwarded to the Oklahoma State Department of Health who in turn under Title 63 Section 1-1912 through 1-1917 of the Oklahoma Statutes (and through the Oklahoma Administrative Act Code at 310:675) will determine "willful" non-compliance. The Health Department will inform the Authority as to any penalties to collect by methods noted in OAC 317:30-5-131.2.

This add-on will be trended forward by the same method as in 3.A.4, above.

3. 56 Okla. Stat. § 2002 requires that all licensed nursing facilities pay a statewide average per patient day Quality of Care assessment fee based on the 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 and a part of the base rate component as it relates to Medicaid services.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

4. For the rate period beginning October 1, 2000 an adjustment of $3.33 per day will be added to the rate for the estimated cost of a minimum wage for specified salaries as mandated by HB 2019. The minimum wage will be $6.65 per day for the following specified positions: Registered nurse, Licensed practical nurse, Nurse aides, Certified medication aides, Dietary staff, Housekeeping staff, Maintenance staff, Laundry staff, Social service staff, and other activities staff. The OHCA will monitor this requirement and assess penalties as discussed in 2 above.

   The adjustment is determined as follows:

   1. Determine the total cost per day for salaries and wages for the Private ICF M/R facilities plus the Specialized ICF/MR 16 bed or less facilities.
   2. Determine the total cost per day for the Private NF's and the Private NF's Serving Aids patients.
   3. Determine the percent difference between 1 and 2. If the difference is positive leave the result as positive for the factor below in 7.
   4. Determine the total cost per hour for salaries and wages for the Private ICF M/R facilities plus the Specialized ICF/MR 16 bed or less facilities.
   5. Determine the total cost per hour for the Private NF's and the Private NF's Serving Aids patients.
   6. Determine the percent difference between 4 and 5. If the difference is positive then the result is negative for the factor below in 7.
   7. Determine the salary cost add-on differential for M/R facilities by adding the results in 4 and 6.
   8. Multiply this result by the add-on cost determined for Regular NF's on D.4, page 8.

   This add-on will be trended forward by the same method as in 3.A.4, above.

5. For the rate period beginning December 1, 2000 the provider assessment fee set at September 1, 2000 will be adjusted to compensate for the actual fee determined by the surveys of data

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED**

6. For the rate period beginning October 1, 2000 an adjustment of $3.33 per day will be added to the rate for the estimated cost of a minimum wage for specified salaries as mandated by HB 2019. The minimum wage will be $6.65 per day for the following specified positions: Registered nurse, Licensed practical nurse, Nurse aides, Certified medication aides, Dietary staff, Housekeeping staff, Maintenance staff, Laundry staff, Social service staff, and other activities staff. The OHCA will monitor this requirement and assess penalties as discussed in 2 above.

   The adjustment is determined as follows:

   9. Determine the total cost per day for salaries and wages for the Private ICF M/R facilities plus the Specialized ICF/MR 16 bed or less facilities.
   10. Determine the total cost per day for the Private NF's and the Private NF's Serving Aids patients.
   11. Determine the percent difference between 1 and 2. If the difference is positive leave the result as positive for the factor below in 7.
   12. Determine the total cost per hour for salaries and wages for the Private ICF M/R facilities plus the Specialized ICF/MR 16 bed or less facilities.
   13. Determine the total cost per hour for the Private NF's and the Private NF's Serving Aids patients.
   14. Determine the percent difference between 4 and 5. If the difference is positive then the result is negative for the factor below in 7.
   15. Determine the salary cost add-on differential for M/R facilities by adding the results in 4 and 6.
   16. Multiply this result by the add-on cost determined for Regular NF's on D.4, page 8.

   This add-on will be trended forward by the same method as in 3.A.4, above.

7. For the rate period beginning December 1, 2000 the provider assessment fee set at September 1, 2000 will be adjusted to compensate for the actual fee determined by the surveys of data

received. The rate adjustment needed for this decreased cost is $(1.20). Surveys were sent to the nursing facilities collecting revenue and patient day data for calendar 1999. Per HB2019 this data was to be used to set provider fee assessment rates for the different facility types. The assessment fee for the period beginning 09-01-00 was set at $4.77. This adjustment is needed for the remainder of the state fiscal year to appropriately reflect the actual costs and adjust for the estimated assessment reimbursement portion of the rate set at 09-01-00 and revised at 10-01-00 (see D.3 above). The adjustment needed was determined by multiplying the difference between the estimated assessment in the rates at 09-01 and the actual assessments from the surveys by the total months that a difference occurred and dividing this total by the estimated days remaining in the rate period. After the initial rate period these adjustments will be amended to an annual basis.

8. HB 2019 directed the Nursing Facilities and ICF's/MR to provide for dentures, eyeglasses and non-emergency transportation attendants for Medicaid clients in nursing facilities. For the rate period beginning December 1, 2000 the rate adjustment for the estimated cost of these added items of coverage is $2.45 per day.

The costs were determined as follows:

For the transportation travel attendant the base year cost report average hourly cost for a social worker was brought forward to the rate state fiscal year and an adjustment made for the effects of minimum wage and benefits. The cost of two FTE's per 100 bed home were determined by multiplying that total by 2080. From the cost report data percent of occupancy it was estimated that this 100 bed home would have 29,000 patient days which when divided into the cost of the two FTE's gives an add-on of $1.78 per day.

For the cost of dentures it was estimated that 50% of the 25,000 Medicaid clients need eyeglasses once every three years. That correlates to an average of 4,165 services per year. The cost of those services was estimated at the Medicaid rates for one upper or lower one re-base and one reline (codes D5130, D5214, D5720 and D5751), or $567.47. This cost times the number of services divided by the estimated Medicaid patient days is the add-on needed for these services.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED**

For the cost of eyeglasses the total number of services needed is 75% of the 25,000 total population of Medicaid patients. It is estimated that 80% of those need services, or 15,000. The average cost per service was determined to be the total for one lens plus one frame plus one exam (codes W0105 to 0109,V2020 and 92002/92012). This total average cost per service is multiplied by the estimated total services per year and divided by the total estimated Medicaid days to get the per diem add-on.

This add-on will be trended forward by the same method as in 3.A.4, above.

9. For the rate period beginning December 1, 2000 the OHCA has added $2.69 to the rate to cover the loss of the "major fraction thereof" provision in meeting the minimum direct care staffing requirements. The add-on was determined as follows:

    1. The additional hours needed to cover the loss of the "major fraction thereof" provision in meeting the minimum staffing requirements was determined by arraying the required hours for levels of patients from 17 to 136 with the provision and without the provision. The average percent change in required hours was determined.
    2. The per day cost of the direct care salaries plus benefits was determined from the base year cost reports.
    3. The cost in 2 above was increased by a factor to cover the minimum wage requirements of HB 2019. The factor was determined by dividing the cost per day added to the rate in D .4 above by the direct care cost per day in 2.
    4. The factor in 3 was applied to the cost per day determined in 2 to get the current cost per day.
    5. The cost per day determined in 4 was multiplied by the percent determined in 1 to determine the rate add-on required to fund the loss of the "major fraction thereof" provision.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

3. **COMPUTATION OF THE STATEWIDE FACILITY BASE RATE** (continued)

D. Adjustment for Change in Law or Regulation (continued)

This add-on will be trended forward by the same method as in 3.A.4, above.

E. Statewide Base Rate

The statewide facility base rate is the sum of the primary operating per diem, the administrative services per diem, the capital per diem and the adjustments for changes in law or regulation less the enhancement in 4 below.

4. **ENHANCEMENTS**

The Authority may further adjust the statewide facility base rate to include estimates of the cost of enhancements in services that are not otherwise

required by law but which the Authority wishes to recommend as the basis for inclusion in the ICF/MR rates.

Effective May 1, 1997, the State will pay an interim adjustment of $4.20 per diem for specified staff to facilities who have elected to participate in the wage enhancement program.

Allowable costs include the salaries and fringe benefits for the following classifications: licensed practical nurses (LPNs), nurse aides (NAs), certified medication aides (CMAs), social service director (SSDs), other social service staff (OSSS), activities directors (ADs), other activities staff (OAS), and therapy aid assistants (TAA). These classifications do not include contract staff.

A settlement will be made based on the variance in the amount of enhanced payments and the amount expended for wages and benefits paid for the specified staff. The settlement will be capped at $4.20 per day.

Facility-specific target rates were determined for each provider. Fiscal year 1995 costs were used to set the rates. The target rates were calculated as follows:

1. The reported salaries and wages for the specified staff were summed for each facility (specified staff salaries).
2. An employee benefits ratio was determined by dividing total facility benefits by total facility salaries and wages.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

4. **Enhancements** (continued)

3. Total specified staff salaries were multiplied by the employee benefits ratio calculated in 2 above, to determine allowable employee benefits.
4. Specified staff salaries and allowable employee benefits were summed and divided by total facility patient days to arrive at the base year allowable cost per diem.
5. The base year allowable cost per diem for each facility was trended forward by factors of 2.9 percent and 3.1 percent.
6. An adjustment of $4.20 per day was added to the trended base year costs to arrive at the target rate for each facility.
7. For facilities demonstrating compliance for two consecutive quarters as of June 30, 2000, the reporting requirement is waived. Facilities not in compliance or not participating at July 1, 2000, may not participate in the program and receive the enhanced rate adjustment of $4.20. New facilities and facilities under new ownership may participate in the wage enhancement program and will be subject to the compliance requirements of the program. As of July 1, 2007 the adjustment for wage enhancement will be applied to 100% of the facilities due to 100% compliance in expenditure levels and due to the adjustments in 6 below.

5. **RATE ADJUSTMENTS BETWEEN REBASING PERIODS**

Beginning January 1, 2010, the rates 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. The estimated total 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 Standard Private Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) the effect is $.22 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.

6. For the rate period beginning July 1, 2006, the statewide rate will be increased by 10.32%.

7. For the rate period beginning July 1, 2008, the statewide rate will be increased by 4.57%.

8. For the rate period beginning April 1, 2010, the statewide rate will be decreased by 2.81%.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

SPECIALIZED PRIVATE ICF/MR FACILITIES 16 BED OR LESS

A separate statewide prospective rate of payment shall be reviewed, at a minimum, annually for specialized private intermediate care facilities for the mentally retarded with 16 beds or less (SF's/MR/16). These facilities must meet the higher direct care staffing requirements for licensure established by the Oklahoma State Department of Health for an SF/MR/16 serving severely impaired residents. SF'S/MR/16 must serve at least one severely or profoundly retarded resident or one who is moderately retarded and who is medically fragile or has serious physical or emotional problems. The rate will be determined pursuant to these methods and standards and approved by the Oklahoma Health Care Authority Board in advance of the rate period.

The rate will be 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.

The rate is 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 program in Oklahoma. OHCA staff will prepare necessary analyses to support the rate determination process, as described below.

1. UNIFORM COST REPORTS

Each Medicaid-participating SF/MR/16 facility must submit, on uniform cost reports designed by the Authority, cost and related statistical information necessary for rate determination.

a. **Reporting Period.** Each SF/MR/16 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, covering each period of time the SF/MR/16 was in operation during the year.

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

g. **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.

h. **Signature.** The cost report shall be signed by an owner, partner or corporate officer of the SF/MR/16, by an officer of the company that manages the NF, and by the person who prepared the report.

i. **Audits of Cost Reports.** The Authority will conduct a desk review to verify the completeness and mathematical accuracy of all totals and extensions in each cost report. Census information may be independently verified through other OHCA sources. In addition, a sample number of cost reports will be audited independently by an auditor retained by OHCA. Any SF/MR/16 that is subject to an audit is required to make its records available to OHCA and to any auditor engaged by OHCA.

2. **ALLOWABLE AND UNALLOWABLE COSTS**

Only "allowable costs" may be included in the cost reports. (Costs should be net of any offsets or credits.) Allowable costs include all items of Medicaid-covered expense that SF'S/MR/16 incur in the provision of routine (i.e., non-ancillary) 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, 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 SF/MR/16 rate should not be included in the ICF/MR cost report and are not allowable costs. Quality of Care assessment fees are allowable costs for reporting purposes.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

3. **COMPUTATION OF THE STATEWIDE FACILITY BASE RATE**

Cost reports used to calculate the rate were those filed for the year ended June 30, 1999. ("base year"). A state plan will be submitted when costs are re-based. A description of the calculation of the base per diem rates for the periods beginning September 01, 2000, October 01, 2000, and December 01, 2000 are as follows:

A. Primary Operating Costs

1. Determine the weighted mean primary operating per diem by summing all reported primary operating expenses of all standard SF/MR/16 facilities and dividing by total period patient days. Primary operating costs consists of all non-capital costs excluding administrative services,

2. Determine the audit adjustment per diem to be extrapolated to all reporting facilities based on the desk reviews and independent sample audit findings. The audit adjustment is based on an average of the difference between the reported costs and audited costs. If no audit file is available, an average audit adjustment will be determined from the average audit adjustments for the last five available periods.

   For the rate period beginning 09-01-01 an audit adjustment which reflects the latest available audit data will be made. This adjust-ment will be made to the base primary operating cost before trending forward to the midpoint of the state fiscal year of the rate period by the factors defined in 3.A.4, below. The new adjustment will be the difference between the factor determined in the previous rate as defined above and the average of the three most current available years audit data on file.

3. Determine the adjusted primary operating per diem by subtracting the audit adjustment per diem (step 2) from the weighted mean primary operating costs per diem determined in step 1.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED**

4. Trend forward the adjusted primary operating per diem from the midpoint of the base year to the midpoint of the rate period state fiscal year using the inflation update factors. The Authority will use the update factors published in the Data Resources, Inc., ("DRI") nursing home without capital market basket index for the fourth calendar quarter of the previous fiscal year.

   For example, for the rates effective July 1, 1997, the Authority used the update factors for the fourth quarter of calendar year 1996.

B. Administrative Services

An imputed administrative services allowance will be used in lieu of actual owner/administrator salary and non-salary compensation. The imputed administrative services allowance is the state-established limit or value for the purposes of calculating the reimbursement rate.

The base allowance will be the same as that determined for the regular Nursing facilities. The allowance will be trended forward in the same manner as in 3.A.4, above.

C. Capital

An imputed allowance will be used in lieu of actual depreciation, interest, and lease related to facilities and equipment. The imputed allowance is determined by dividing the total reported costs (from the base year cost reports) for the regular nursing facilities, plus that for the regular nursing facilities serving aids patients, plus that for the private standard intermediate care facilities for the mentally retarded plus that for the private specialized (16 bed or less) M/R facilities by the total "adjusted days" for those facilities. The "adjusted" days are determined by multiplying the allowable days from the base year cost report by a factor of .93 (i.e. adjust to a 93% occupancy level). To account for inflation this imputed capital allowance will be trended forward to the rate period state fiscal year by the Marshall-Swift replacement cost multipliers for facilities with Class C construction (District Comparative Cost Multipliers, Central Region) published in the January index of the year preceding the rate change period.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

D. Adjustment For Change In Law Or Regulation

The Authority also considers possible effects on rate year costs compared to base year costs that might not be fully accounted for by the DRI index described above. Inasmuch as the index is an estimate of actual and forecasted national rates of change in the price of nursing home goods and services, DRI is not specific to any state.
Thus during a given period, it might not sufficiently account for the economic effects of changes in federal laws or regulations which have a disparate impact on Oklahoma, or of changes in state laws, rules or circumstances that only affect Oklahoma.

The following circumstances may cause an adjustment to rate year costs: additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation, authorities, or applicable law (e.g., minimum staffing requirements, social security taxation of 501(c) (3) corporations, minimum wage change, etc.) and implementation of federal or state court orders and settlement agreements.

OHCA will evaluate available financial or statistical information, including data submitted on cost reports and special surveys to calculate any base rate adjustment. These adjustments will become permanent until such time a state plan amendment is submitted to rebase the rates.

Per HB 2019, the Oklahoma 2001 Health Care initiative, the following adjustments will be made.

1. For the rate period beginning September 1, 2000 the OHCA has calculated an Oklahoma Specific additional cost of expected increase in Liability insurance rates. The rate will be adjusted by an additional $.51 for the expected cost. The amount of additional cost was determined from a sample of nursing facility invoices from the 1999 and 2000 fiscal years and from data from the base year cost reports. The total sample costs for 1999 were compared to the total sample costs for 2000 to get an overall percent of increase. Total available days from the base year cost report was divided by 365 to estimate the number of beds which in turn was multiplied by an estimated annual cost of $100 per bed (per industry survey) to get an annual estimate for the rate year period. The resulting cost was divided by the total patient days from the base year cost reports and multiplied by the percent increase from above to determine the added cost per day.

   This add-on will be trended forward by the same method as in 3.A.4, above.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

2. For the rate period beginning September 1, 2000 the OHCA has calculated the additional cost of new direct care staffing requirements. These new requirements are to maintain staff-to-patient ratios of 1:8, 1:12 and 1:17 for the three 8 hours shifts for day, evening and night, usually beginning at 8:00 a.m., 4:00 p.m. and 12:00 a.m., respectively. The rate will be adjusted for the cost of maintaining a level of staffing that is at 86.5% of the base year level above the minimum requirement. This adjustment is calculated as follows:

   1. Determine the direct care hours per day from the base year cost report data for all private facility types.
   2. Determine the direct care cost per day (including benefits) of the hours determined in 1 from the base year cost reports.
   3. Adjust the hours per day for the effect of the minimum wage requirement of HB 2019 by multiplying the factor determined in 2 by the percent of the cost of the minimum wage increase to the total salaries and benefits in the base period.
   4. Determine the amount of hours per day in the base period that actual direct care hours exceeds the minimum requirement.
   5. Apply a factor of .865 (86.5%) to the amount determined in 4. This is the estimated amount that the facilities will remain above the minimum required hours.
   6. Add the amount determined in 5 to the amount of new required minimum hours per day to get the expected level of hours per day for the rate period. Divide the expected level of hours by the level of hours in the base year to get a percent increase.
   7. The cost per day is determined by multiplying the percent in 6 by the cost in 3 to get the add-on. For the period beginning 09-01-00 this amount is $2.22.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

The direct care staff-to-patient ratios required and the employees to be included in the ratios are defined in Section1-1925.2 of Title63 of the Oklahoma Statutes. In general, direct care staff includes any nursing or therapy staff providing hands-on care. Prior to Sept. 1, 2002 Activity and Social Work staff not providing hands-on care are allowable. On Sept. 1, 2002 Activity and Social Work staff not providing hands-on care shall not be included in the direct care staff-to-patient ratios. The direct care staff-to-patient ratios will be monitored by the Authority through required monthly Quality of Care Reports. These reports and rules may be found in the Oklahoma Administrative Code at OAC 317:30-5-131.2. This section of the Code also includes rules for penalties for non-timely filing and the methods of collection of such penalties. Non compliance with the required staff-to-patient ratios will be forwarded to the Oklahoma State Department of Health who in turn under Title 63 Section 1-1912 through 1-1917 of the Oklahoma Statutes (and through the Oklahoma Administrative Act Code at 310:675) will determine "willful" non-compliance. The Health Department will inform the Authority as to any penalties to collect by methods noted in OAC 317:30-5-131.2.

This add-on will be trended forward by the same method as in 3.A.4, above.

3. 56 Okla. Stat. § 2002 requires that all licensed nursing facilities pay a statewide average per patient day Quality of Care assessment fee based on the 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 and a part of the base rate component as it relates to Medicaid services.

4. For the rate period beginning October 1, 2000 an adjustment of $3.33 per day will be added to the rate for the estimated cost of a minimum wage for specified salaries as mandated by HB 2019.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED**

The minimum wage will be $6.65 per day for the following specified positions: Registered nurse, Licensed practical nurse, Nurse aides, Certified medication aides, Dietary staff, Housekeeping staff, Maintenance staff, Laundry staff, Social service staff, and other activities staff. The OHCA will monitor this requirement and assess penalties as discussed in 2 above.

The adjustment is determined as follows:

1. Determine the total cost per day for salaries and wages for the Private ICF M/R facilities plus the Specialized ICF/MR 16 bed or less facilities.
2. Determine the total cost per day for the Private NF's and the Private NF's Serving Aids patients.
3. Determine the percent difference between 1 and 2. If the difference is positive leave the result as positive for the factor below in 7.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED**

4. Determine the total cost per hour for salaries and wages for the Private ICF M/R facilities plus the Specialized ICF/MR 16 bed or less facilities.
5. Determine the total cost per hour for the Private NF's and the Private NF's Serving Aids patients.
6. Determine the percent difference between 4 and 5. If the difference is positive then the result is negative for the factor below in 7.
7. Determine the salary cost add-on differential for M/R facilities by adding the results in 4 and 6.
8. Multiply this result by the add-on cost determined for Regular NF's on D.4, page 8.

This add-on will be trended forward by the same method as in 3.A.4, above.

5. For the rate period beginning December 1, 2000 the provider assessment fee set at September 1, 2000 will be adjusted to compensate for the actual fee determined by the surveys of data received. The rate adjustment needed for this decreased cost is $(.85). Surveys were sent to the nursing facilities collecting revenue and patient day data for calendar 1999. Per HB2019 this data was to be used to set provider fee assessment rates for the different facility types. The assessment fee for the period beginning 09-01-00 was set at $4.77. This adjustment is needed for the remainder of the state fiscal year to appropriately reflect the actual costs and adjust for the estimated assessment reimbursement portion of the rate set at 09-01-00 and revised at 10-01-00 (see D.3 above). The adjustment needed was determined by multiplying the difference between the estimated assessment in the rates at 09-01 and the actual assessments from the surveys by the total months that a difference occurred and dividing this total by the estimated days remaining in the rate period. After the initial rate period these adjustments will be amended to an annual basis.

6. HB 2019 directed the Nursing Facilities and SF's/MR/16 to provide for dentures, eyeglasses and non-emergency transportation attendants for Medicaid clients in nursing facilities. For the rate period beginning December 1, 2000 the rate adjustment for the estimated cost of these added items of coverage is $2.45 per day.

The costs were determined as follows:

For the transportation travel attendant the base year cost report average hourly cost for a social worker was brought forward to the rate state fiscal year and an adjustment made for the effects of minimum wage and benefits. The cost of two FTE's per 100 bed home were determined by multiplying that total by 2080. From the cost report data percent of occupancy it was estimated that this 100 bed home would have 29,000 patient days which when divided into the cost of the two FTE's gives an add-on of $1.78 per day.

For the cost of dentures it was estimated that 50% of the 25,000 Medicaid clients need eyeglasses once every three years. That correlates to an average of 4,165 services per year. The cost of those services was estimated at the Medicaid rates for one upper or lower one re-base and one reline (codes D5130, D5214, D5720 and D5751), or $567.47. This cost times the number of services divided by the estimated Medicaid patient days is the add-on needed for these services.

For the cost of eyeglasses the total number of services needed is 75% of the 25,000 total population of Medicaid patients. It is estimated that 80% of those need services, or 15,000. The average cost per service was determined to be the total for one lens plus one frame plus one exam (codes W0105 to 0109,V2020 and 92002/92012). This total average cost per service is multiplied by the estimated total services per year and divided by the total estimated Medicaid days to get the per diem add-on.

This add-on will be trended forward by the same method as in 3.A.4, above.

7. For the rate period beginning December 1, 2000 the OHCA has added $6.79 to the rate to cover the loss of the "major fraction thereof" provision in meeting the minimum direct care staffing requirements. The add-on was determined as follows:

1. The additional hours needed to cover the loss of the "major fraction thereof" provision in meeting the minimum staffing requirements was determined by arraying the required hours for levels of patients from 1 to 16 with the provision and without the provision. The average percent change in required hours was determined.
2. The per day cost of the direct care salaries plus benefits was determined from the base year cost reports.
3. The cost in 2 above was increased by a factor to cover the minimum wage requirements of HB 2019. The factor was determined by dividing the cost per day added to the rate in D .4 above by the direct care cost per day in 2.
4. The factor in 3 was applied to the cost per day determined in 2 to get the current cost per day.
5. The cost per day determined in 4 was multiplied by the percent determined in 1 to determine the rate add-on required to fund the loss of the "major fraction thereof" provision.

This add-on will be trended forward by the same method as in 3.A.4, above.

E. Statewide Base Rate

The statewide facility base rate is the sum of the primary operating per diem, the administrative services per diem, the capital per diem and the adjustments for changes in law or regulation less the enhancement in 4 below.

4. **ENHANCEMENTS**

The Authority may further adjust the statewide facility base rate to include estimates of the cost of enhancements in services that are not otherwise required by law but which the Authority wishes to recommend as the basis for inclusion in the SCF/MR/16 rates.

Effective May 1, 1997 the State will pay an interim adjustment of $5.15 per diem for specified staff to facilities which have elected to participate in the wage enhancement program.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED**

Allowable costs include the salaries and fringe benefits for the following classifications: licensed practical nurses (LPNs), nurse aides (NAs), certified medication aides (CMAs), social service director (SSDs), other social service staff (OSSS), activities directors (ADs), other activities staff (OAS), and therapy aid assistants (TAA). These classifications do not include contract staff.

A settlement will be made based on the variance in the amount of enhanced payments and the amount expended for wages and benefits paid for the specified staff. The settlement will be capped at $5.15 per day.

Facility-specific target rates were determined for each provider. Fiscal year 1995 costs were used to set the rates. The target rates were calculated as follows:

1. The reported salaries and wages for the specified staff were summed for each facility (specified staff salaries).

2. An employee benefits ratio was determined by dividing total facility benefits by total facility salaries and wages.

3. Total specified staff salaries were multiplied by the employee benefits ratio calculated in 2 above, to determine allowable employee benefits.

4. Specified staff salaries and allowable employee benefits were summed and divided by total facility patient days to arrive at the base year allowable cost per diem.

5. The base year allowable cost per diem for each facility was trended forward by factors of 2.9 percent and 3.1 percent.

6. An adjustment of $5.15 per day was added to the trended base year costs to arrive at the target rate for each facility.

7. For facilities demonstrating compliance for two consecutive quarters as of June 30, 2000, the reporting requirement is waived. Facilities not in compliance or not participating at July 1, 2000 may not participate in the program and receive the enhanced rate adjustment of $5.15. New facilities and facilities under new ownership may participate in the wage enhancement program and will be subject to the compliance requirements of the program. As of July 1, 2007, the adjustment for wage enhancement will be applied to 100% of the facilities due to 100% compliance in expenditure levels and due to the adjustments in 6 below.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED**

5. **RATE ADJUSTMENTS BETWEEN REBASING PERIODS**

Beginning January 1, 2010, the rates 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. The estimated total 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 Specialized Private Intermediate Care Facilities for the Mentally Retarded 16 Bed or Less, the effect is $.20 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.

6. For the rate period beginning July 1, 2006, the statewide rate will be increased by 10.90%.

7. For the rate period beginning July 1, 2008, the statewide rate will be increased by 3.90%

8. For the rate period beginning April 1, 2010, the statewide rate will be decreased by 2.93%.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Deleted by 10-35
Effective 11-01-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

4. **Enhancements** (continued)

3. Total specified staff salaries were multiplied by the employee benefits ratio calculated in 2 above, to determine allowable employee benefits.
4. Specified staff salaries and allowable employee benefits were summed and divided by total facility patient days to arrive at the base year allowable cost per diem.
5. The base year allowable cost per diem for each facility was trended forward by factors of 2.9 percent and 3.1 percent.
6. An adjustment of $4.20 per day was added to the trended base year costs to arrive at the target rate for each facility.
7. For facilities demonstrating compliance for two consecutive quarters as of June 30, 2000, the reporting requirement is waived. Facilities not in compliance or not participating at July 1, 2000, may not participate in the program and receive the enhanced rate adjustment of $4.20. New facilities and facilities under new ownership may participate in the wage enhancement program and will be subject to the compliance requirements of the program. As of July 1, 2007 the adjustment for wage enhancement will be applied to 100% of the facilities due to 100% compliance in expenditure levels and due to the adjustments in 6 below.

5. **RATE ADJUSTMENTS BETWEEN REBASING PERIODS**

Beginning January 1, 2010, the rates 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. The estimated total 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 Standard Private Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) the effect is $.22 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.

6. For the rate period beginning July 1, 2006, the statewide rate will be increased by 10.32%.

7. For the rate period beginning July 1, 2008, the statewide rate will be increased by 4.57%.

8. For the rate period beginning April 1, 2010, the statewide rate will be decreased by 2.61%.

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Deleted by 10-35
Effective 11-01-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

SPECIALIZED PRIVATE ICF/MR FACILITIES 16 BED OR LESS

A separate statewide prospective rate of payment shall be determined annually for specialized private intermediate care facilities for the mentally retarded with 16 beds or less (SF's/MR/16). These facilities must meet the higher direct care staffing requirements for licensure established by the Oklahoma State Department of Health for an SF/MR/16 serving severely impaired residents. SF'S/MR/16 must serve at least one severely or profoundly retarded resident or one who is moderately retarded and who is medically fragile or has serious physical or emotional problems. The rate will be determined pursuant to these methods and standards and approved by the Oklahoma Health Care Authority Board in advance of the rate period.

The rate will be 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.

The rate is 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 program in Oklahoma. OHCA staff will prepare necessary analyses to support the rate determination process, as described below.

1. UNIFORM COST REPORTS

Each Medicaid-participating SF/MR/16 facility must submit, on uniform cost reports designed by the Authority, cost and related statistical information necessary for rate determination.

a. **Reporting Period.** Each SF/MR/16 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

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STATE OKLAHOMA
DATE RECT'D 03-29-02
DATE APP'VD 05-28-02
DATE EFF 01-01-02
HCFA 179 OK-02-04

A

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Effective 11-01-10

required, covering each period of time the SF/MR/16 was in operation during the year.

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

g. **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.

h. **Signature.** The cost report shall be signed by an owner, partner or corporate officer of the SF/MR/16, by an officer of the company that manages the NF, and by the person who prepared the report.

i. **Audits of Cost Reports.** The Authority will conduct a desk review to verify the completeness and mathematical accuracy of all totals and extensions in each cost report. Census information may be independently verified through other OHCA sources. In addition, a sample number of cost reports will be audited independently by an auditor retained by OHCA. Any SF/MR/16 that is subject to an audit is required to make its records available to OHCA and to any auditor engaged by OHCA.

2. **ALLOWABLE AND UNALLOWABLE COSTS**

Only "allowable costs" may be included in the cost reports. (Costs should be net of any offsets or credits.) Allowable costs include all items of Medicaid-covered expense that SF'S/MR/16 incur in the provision of routine (i.e., non-ancillary) 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, 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

Deleted by 10-35
Effective 11-01-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

reimbursed outside the SF/MR/16 rate should not be included in the ICF/MR cost report and are not allowable costs. Quality of Care assessment fees are allowable costs for reporting purposes.

3. **COMPUTATION OF THE STATEWIDE FACILITY BASE RATE**

Cost reports used to calculate the rate were those filed for the year ended June 30, 1999. ("base year"). A state plan will be submitted when costs are re-based. A description of the calculation of the base per diem rates for the periods beginning September 01, 2000, October 01, 2000, and December 01, 2000 are as follows:

A. Primary Operating Costs

1. Determine the weighted mean primary operating per diem by summing all reported primary operating expenses of all standard SF/MR/16 facilities and dividing by total period patient days. Primary operating costs consists of all non-capital costs excluding administrative services, which are described on page 4.

2. Determine the audit adjustment per diem to be extrapolated to all reporting facilities based on the desk reviews and independent sample audit findings. The audit adjustment is based on an average of the difference between the reported costs and audited costs. If no audit file is available, an average audit adjustment will be determined from the average audit adjustments for the last five available periods.

   For the rate period beginning 09-01-01 an audit adjustment which reflects the latest available audit data will be made. This adjustment will be made to the base primary operating cost before trending forward to the midpoint of the state fiscal year of the rate period by the factors defined in 3.A.4, below. The new adjustment will be the difference between the factor determined in the previous rate as defined above and the average of the three most current available years audit data on file.

3. Determine the adjusted primary operating per diem by subtracting the audit adjustment per diem (step 2) from the weighted mean primary operating costs per diem determined in step 1.

Revised 09-01-01

Deleted by 10-35
Effective 11-01-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

4. Trend forward the adjusted primary operating per diem from the midpoint of the base year to the midpoint of the rate period state fiscal year using the inflation update factors. The Authority will use the update factors published in the Data Resources, Inc., ("DRI") nursing home without capital market basket index for the fourth calendar quarter of the previous fiscal year.

   For example, for the rates effective July 1, 1997, the Authority used the update factors for the fourth quarter of calendar year 1996.

B. Administrative Services

An imputed administrative services allowance will be used in lieu of actual owner/administrator salary and non-salary compensation. The imputed administrative services allowance is the state-established limit or value for the purposes of calculating the reimbursement rate.

The base allowance will be the same as that determined for the regular Nursing facilities in 3.B on pages 3 and 4. The allowance will be trended forward in the same manner as in 3.B on page 4.

C. Capital

An imputed allowance will be used in lieu of actual depreciation, interest, and lease related to facilities and equipment. The imputed allowance is determined by dividing the total reported costs (from the base year cost reports) for the regular nursing facilities, plus that for the regular nursing facilities serving aids patients, plus that for the private standard intermediate care facilities for the mentally retarded plus that for the private specialized (16 bed or less) M/R facilities by the total "adjusted days" for those facilities. The "adjusted" days are determined by multiplying the allowable days from the base year cost report by a factor of .93 (i.e. adjust to a 93% occupancy level). To account for inflation this imputed capital allowance will be trended forward to the rate period state fiscal year by the Marshall-Swift replacement cost multipliers for facilities with Class C construction (District Comparative Cost Multipliers, Central Region) published in the January index of the year preceding the rate change period.

TN # OK-02-04 Approval Date 05-28-02 Effective Date 01-01-02

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TN # OK-01-17

STATE OKLAHOMA
DATE RECD 03-29-02
DATE APPVD 05-28-02
DATE EFF 01-01-02
HCFA 179 OK-02-04

A

Deleted by 10-35
Effective 11-01-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

D. Adjustment For Change In Law Or Regulation

The Authority also considers possible effects on rate year costs compared to base year costs that might not be fully accounted for by the DRI index described above. Inasmuch as the index is an estimate of actual and forecasted national rates of change in the price of nursing home goods and services, DRI is not specific to any state. Thus during a given period, it might not sufficiently account for the economic effects of changes in federal laws or regulations which have a disparate impact on Oklahoma, or of changes in state laws, rules or circumstances that only affect Oklahoma.

The following circumstances may cause an adjustment to rate year costs: additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation, authorities, or applicable law (e.g., minimum staffing requirements, social security taxation of 501(c) (3) corporations, minimum wage change, etc.) and implementation of federal or state court orders and settlement agreements.

OHCA will evaluate available financial or statistical information, including data submitted on cost reports and special surveys to calculate any base rate adjustment. These adjustments will become permanent until such time a state plan amendment is submitted to rebase the rates.

Per HB 2019, the Oklahoma 2001 Health Care initiative, the following adjustments will be made.

1. For the rate period beginning September 1, 2000 the OHCA has calculated an Oklahoma Specific additional cost of expected increase in Liability insurance rates. The rate will be adjusted by an additional $.51 for the expected cost. The amount of additional cost was determined from a sample of nursing facility invoices from the 1999 and 2000 fiscal years and from data from the base year cost reports. The total sample costs for 1999 were compared to the total sample costs for 2000 to get an overall percent of increase. Total available days from the base year cost report was divided by 365 to estimate the number of beds which in turn was multiplied by an estimated annual cost of $100 per bed (per

TN # OK-02-04 Approval Date 05-28-02 Effective Date 01-01-02

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TN # OK-01-17

STATE OKLAHOMA
DATE RECD 03-29-02
DATE APP'D 05-28-02
DATE EFF 01-01-02
HCFA 179 OK-02-04

A

Deleted by 10-35
Effective 11-01-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

industry survey) to get an annual estimate for the rate year period. The resulting cost was divided by the total patient days from the base year cost reports and multiplied by the percent increase from above to determine the added cost per day.

This add-on will be trended forward by the same method as in 3.A.4 on page 3.

2. For the rate period beginning September 1, 2000 the OHCA has calculated the additional cost of new direct care staffing requirements. These new requirements are to maintain staff-to-patient ratios of 1:8, 1:12 and 1:17 for the three 8 hours shifts for day, evening and night, usually beginning at 8:00 a.m., 4:00 p.m. and 12:00 a.m., respectively. The rate will be adjusted for the cost of maintaining a level of staffing that is at 86.5% of the base year level above the minimum requirement. This adjustment is calculated as follows:

   1. Determine the direct care hours per day from the base year cost report data for all private facility types.
   2. Determine the direct care cost per day (including benefits) of the hours determined in 1 from the base year cost reports.
   3. Adjust the hours per day for the effect of the minimum wage requirement of HB 2019 by multiplying the factor determined in 2 by the percent of the cost of the minimum wage increase to the total salaries and benefits in the base period.
   4. Determine the amount of hours per day in the base period that actual direct care hours exceeds the minimum requirement.
   5. Apply a factor of .865 (86.5%) to the amount determined in 4. This is the estimated amount that the facilities will remain above the minimum required hours.
   6. Add the amount determined in 5 to the amount of new required minimum hours per day to get the expected level of hours per day for the rate period. Divide the expected level of hours by the level of hours in the base year to get a percent increase.
   7. The cost per day is determined by multiplying the percent in 6 by the cost in 3 to get the add-on. For the period beginning 09-01-00 this amount is $2.22.

   The direct care staff-to-patient ratios required and the employees to be included in the ratios are defined in Section1-1925.2 of Title

TN # OK-02-04 Approval Date 05-28-02 Effective Date 01-01-02
STATE OKLAHOMA
DATE RECD 03-29-02
DATE APPVD 05-28-02
DATE EFF 01-01-02
HCFA 179 OK-02-04
A

Supersedes
TN # OK-01-17

Deleted by 10-35
Effective 11-01-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

63 of the Oklahoma Statutes. In general, direct care staff includes any nursing or therapy staff providing hands-on care. Prior to Sept. 1, 2002 Activity and Social Work staff not providing hands-on care are allowable. On Sept. 1, 2002 Activity and Social Work staff not providing hands-on care shall not be included in the direct care staff-to-patient ratios. The direct care staff-to-patient ratios will be monitored by the Authority through required monthly Quality of Care Reports. These reports and rules may be found in the Oklahoma Administrative Code at OAC 317:30-5-131.2. This section of the Code also includes rules for penalties for non-timely filing and the methods of collection of such penalties. Non compliance with the required staff-to-patient ratios will be forwarded to the Oklahoma State Department of Health who in turn under Title 63 Section 1-1912 through 1-1917 of the Oklahoma Statutes (and through the Oklahoma Administrative Act Code at 310:675) will determine "willful" non-compliance. The Health Department will inform the Authority as to any penalties to collect by methods noted in OAC 317:30-5-131.2.

This add-on will be trended forward by the same method as in 3.A.4 on page 3.

3. HB 2019 requires that all licensed nursing facilities pay a statewide average per patient day Quality of Care assessment fee based on 6% of the average gross revenue per patient day. An estimate of the Calendar 1999 surveys reporting this data was used to set the rate for the period beginning September 1, 2000. This estimate and rate adjustment will be $7.21 per day. For the period beginning October1, 2000 the adjustment will be $7.43. The estimate was determined by adding the primary operating cost, administrative services component, capital allowance component and "other" components for the rate period and dividing that total by .94 to get the total rate including the 6% fee. The total fee is the difference between the totals above. The OHCA was also directed to collect the assessment, assess penalties for late payment and deposit the assessments into a "Quality of Care Fund" and make payments from said fund for the purposes listed in the Bill. The actual rate for the period beginning 09-01-00 will be determined from calendar 1999 surveys at a later

TN # OK-02-04 Approval Date 05-28-02 Effective Date 01-01-02

Supersedes
TN # OK-01-17

STATE OKLAHOMA
DATE REC'D 05-29-02
DATE APPVD 05-28-02
DATE EFF 01-01-02
HCFA ID OK-02-04

A

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Effective 11-01-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

date. When received, an adjusted rate will be established that reimburses the facilities for the estimated actual costs to be incurred during the rate period state fiscal year. Gross revenues are defined as Gross Receipts (i.e. total cash receipts less donations and contributions). For subsequent state fiscal years the per day assessment fee will be determined in advance from the totals of the monthly Quality of Care Reports, Section C, for the 6 month period from October 1 through March 31 of the prior fiscal year, annualizing those figures and determining the fee by dividing the total revenues by the total days and taking that result and multiplying by .06 (6%).

For the rate period beginning 09-01-01 the rate component was adjusted to $8.47. This amount allows coverage of the provider fee currently in effect which was set as of 07-01-01 as defined in D.3 above. The rate period adjustment was determined by multiplying the actual fee increase by 365 days and dividing by the days left in the rate period (304, i.e. 12 month's fees spread over ten months) and adding to the previous fee ($6.81).

4. For the rate period beginning October 1, 2000 an adjustment of $3.33 per day will be added to the rate for the estimated cost of a minimum wage for specified salaries as mandated by HB 2019.

   The minimum wage will be $6.65 per day for the following specified positions: Registered nurse, Licensed practical nurse, Nurse aides, Certified medication aides, Dietary staff, Housekeeping staff, Maintenance staff, Laundry staff, Social service staff, and other activities staff. The OHCA will monitor this requirement and assess penalties as discussed in 2 above.

   The adjustment is determined as follows:

   1. Determine the total cost per day for salaries and wages for the Private ICF M/R facilities plus the Specialized ICF/MR 16 bed or less facilities.
   2. Determine the total cost per day for the Private NF's and the Private NF's Serving Aids patients.
   3. Determine the percent difference between 1 and 2. If the difference is positive leave the result as positive for the factor below in 7.

Revised 09-01-01

Deleted by 10-35
Effective 11-01-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
FOR NURSING FACILITIES

4. Determine the total cost per hour for salaries and wages for the Private ICF M/R facilities plus the Specialized ICF/MR 16 bed or less facilities.
5. Determine the total cost per hour for the Private NF's and the Private NF's Serving Aids patients.
6. Determine the percent difference between 4 and 5. If the difference is positive then the result is negative for the factor below in 7.
7. Determine the salary cost add-on differential for M/R facilities by adding the results in 4 and 6.
8. Multiply this result by the add-on cost determined for Regular NF's on D.4, page 8.

This add-on will be trended forward by the same method as in 3.A.4 on page 3.

5. For the rate period beginning December 1, 2000 the provider assessment fee set at September 1, 2000 will be adjusted to compensate for the actual fee determined by the surveys of data received. The rate adjustment needed for this decreased cost is $(.85). Surveys were sent to the nursing facilities collecting revenue and patient day data for calendar 1999. Per HB2019 this data was to be used to set provider fee assessment rates for the different facility types. The assessment fee for the period beginning 09-01-00 was set at $4.77. This adjustment is needed for the remainder of the state fiscal year to appropriately reflect the actual costs and adjust for the estimated assessment reimbursement portion of the rate set at 09-01-00 and revised at 10-01-00 (see D.3 above). The adjustment needed was determined by multiplying the difference between the estimated assessment in the rates at 09-01 and the actual assessments from the surveys by the total months that a difference occurred and dividing this total by the estimated days remaining in the rate period. After the initial rate period these adjustments will be amended to an annual basis.

6. HB 2019 directed the Nursing Facilities and SF's/MR/16 to provide for dentures, eyeglasses and non-emergency transportation attendants for Medicaid clients in nursing facilities. For the rate period beginning December 1, 2000 the rate adjustment for the estimated cost of these added items of coverage is $2.45 per day.

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Effective 11-01-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

The costs were determined as follows:

For the transportation travel attendant the base year cost report average hourly cost for a social worker was brought forward to the rate state fiscal year and an adjustment made for the effects of minimum wage and benefits. The cost of two FTE's per 100 bed home were determined by multiplying that total by 2080. From the cost report data percent of occupancy it was estimated that this 100 bed home would have 29,000 patient days which when divided into the cost of the two FTE's gives an add-on of $1.78 per day.

For the cost of dentures it was estimated that 50% of the 25,000 Medicaid clients need eyeglasses once every three years. That correlates to an average of 4,165 services per year. The cost of those services was estimated at the Medicaid rates for one upper or lower one re-base and one reline (codes D5130, D5214, D5720 and D5751), or $567.47. This cost times the number of services divided by the estimated Medicaid patient days is the add-on needed for these services.

For the cost of eyeglasses the total number of services needed is 75% of the 25,000 total population of Medicaid patients. It is estimated that 80% of those need services, or 15,000. The average cost per service was determined to be the total for one lens plus one frame plus one exam (codes W0105 to 0109,V2020 and 92002/92012). This total average cost per service is multiplied by the estimated total services per year and divided by the total estimated Medicaid days to get the per diem add-on.

This add-on will be inflated in the same manner as the Primary Operating Cost in 3.A.4.

This add-on will be trended forward by the same method as in 3.A.4 on page 3.

7. For the rate period beginning December 1, 2000 the OHCA has added $6.79 to the rate to cover the loss of the "major fraction thereof" provision in meeting the minimum direct care staffing requirements. The add-on was determined as follows:

TN # OK-02-04 Approval Date 05-28-02 Effective Date 01-01-02

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STATE OKLAHOMA
DATE RECD 03-29-02
DATE APPVD 05-28-02
DATE EFF 01-01-02
HCFA ID OK-02-04

A

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Effective 11-01-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

1. The additional hours needed to cover the loss of the "major fraction thereof" provision in meeting the minimum staffing requirements was determined by arraying the required hours for levels of patients from 1 to 16 with the provision and without the provision. The average percent change in required hours was determined.
2. The per day cost of the direct care salaries plus benefits was determined from the base year cost reports.
3. The cost in 2 above was increased by a factor to cover the minimum wage requirements of HB 2019. The factor was determined by dividing the cost per day added to the rate in D .4 above by the direct care cost per day in 2.
4. The factor in 3 was applied to the cost per day determined in 2 to get the current cost per day.
5. The cost per day determined in 4 was multiplied by the percent determined in 1 to determine the rate add-on required to fund the loss of the "major fraction thereof" provision.

This add-on will be trended forward by the same method as in 3.A.4 on page 3.

E. Statewide Base Rate

The statewide facility base rate is the sum of the primary operating per diem, the administrative services per diem, the capital per diem and the adjustments for changes in law or regulation less the enhancement in 4 below.

4. **ENHANCEMENTS**

The Authority may further adjust the statewide facility base rate to include estimates of the cost of enhancements in services that are not otherwise required by law but which the Authority wishes to recommend as the basis for inclusion in the SCF/MR/16 rates.

Effective May 1, 1997 the State will pay an interim adjustment of $5.15 per diem for specified staff to facilities which have elected to participate in the wage enhancement program.

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Effective 11-01-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

Allowable costs include the salaries and fringe benefits for the following classifications: licensed practical nurses (LPNs), nurse aides (NAs), certified medication aides (CMAs), social service director (SSDs), other social service staff (OSSS), activities directors (ADs), other activities staff (OAS), and therapy aid assistants (TAA). These classifications do not include contract staff.

A settlement will be made based on the variance in the amount of enhanced payments and the amount expended for wages and benefits paid for the specified staff. The settlement will be capped at $5.15 per day.

Facility-specific target rates were determined for each provider. Fiscal year 1995 costs were used to set the rates. The target rates were calculated as follows:

1. The reported salaries and wages for the specified staff were summed for each facility (specified staff salaries).
2. An employee benefits ratio was determined by dividing total facility benefits by total facility salaries and wages.
3. Total specified staff salaries were multiplied by the employee benefits ratio calculated in 2 above, to determine allowable employee benefits.
4. Specified staff salaries and allowable employee benefits were summed and divided by total facility patient days to arrive at the base year allowable cost per diem.
5. The base year allowable cost per diem for each facility was trended forward by factors of 2.9 percent and 3.1 percent.
6. An adjustment of $5.15 per day was added to the trended base year costs to arrive at the target rate for each facility.
7. For facilities demonstrating compliance for two consecutive quarters as of June 30, 2000, the reporting requirement is waived. Facilities not in compliance or not participating at July 1, 2000 may not participate in the program and receive the enhanced rate adjustment of $5.15. New facilities and facilities under new ownership may participate in the wage enhancement program and will be subject to the compliance requirements of the program. As of July 1, 2007, the adjustment for wage enhancement will be applied to 100% of the facilities due to 100% compliance in expenditure levels and due to the adjustments in 6 below.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

5. **RATE ADJUSTMENTS BETWEEN REBASING PERIODS**

Beginning January 1, 2010, the rates 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. The estimated total 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 Specialized Private Intermediate Care Facilities for the Mentally Retarded 16 Bed or Less, the effect is $.20 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.

6. For the rate period beginning July 1, 2006, the statewide rate will be increased by 10.90%.

7. For the rate period beginning July 1, 2008, the statewide rate will be increased by 3.90%

8. For the rate period beginning April 1, 2010, the statewide rate will be decreased by 2.93%.

The state has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.