
POLICY TRANSMITTAL NO. 05-49	DATE: OCTOBER 21, 2005
AGING SERVICES DIVISION/OKLAHOMA HEALTH CARE AUTHORITY	DEPARTMENT OF HUMAN SERVICES OFFICE OF PLANNING, POLICY & RESEARCH

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-5-133.

EXPLANATION: **Policy revisions were approved by the Board and the Governor as required by the Administrative Procedures Act.**

Long Term Care Facilities reimbursement rules are revised to reflect a new methodology for establishing reimbursement rates.

Original signed on 10-19-05

Carey Garland, Interim Director
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WF # 05-AA (DT)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following a "DHS" number, such as personnel policy at DHS:2-1 and personnel rules at OAC 340:2-1. The "340" is the Title number that designates DHS as the rulemaking agency; the "2" specifies the Chapter number; and the "1" specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, DHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, DHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at (405) 521-3611.

REMOVE

317:30-5-133

INSERT

317:30-5-133, pages 1-5, revised 7-6-05

317:30-5-133. Payment methodologies

(a) Private Nursing Facilities.

(1) **Facilities.** Private Nursing Facilities include:

(A) Nursing Facilities serving adults (NF),

(B) Nursing Facilities serving Aids Patients (NF-Aids),

(C) Nursing Facilities serving Ventilator Patients (NF-Vents),

(D) Intermediate Care Facilities for the Mentally Retarded (ICF/MR),

(E) Intermediate Care Facilities with 16 beds or less serving Severely or Profoundly Retarded Patients (Acute ICF/MR), and

(F) 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 PASRR/MR Level II screen. The per diem add-on is calculated as the difference in the statewide standard private MR base rate and the statewide NF facility base rate.

(2) **Reimbursement calculations.** Rates for Private Nursing Facilities will be reviewed periodically and adjusted as necessary through a public process. The rates are based on a statewide rate for each type of facility which consists of the sum of one or more of four components.

(A) **Base Year Rate component.** The Base Year Rate component will consist of the Primary Operating Cost, the Administrative Services Allowance and the Capital Allowance. Each of these components is set through a review of statewide base year cost report data, as reported on the annual cost reports, and adjusted for a statewide average per diem audit amount. The Capital Allowance component is also adjusted to reflect an expected occupancy level of 93 percent in order to exclude payment for unfilled beds through the Medicaid program.

(B) **Discretionary Inflation Rate component.** A Discretionary Inflation Rate component may be added to the Base Year Rate component dependent upon the factors listed in (i)-(vii) of this paragraph. These factors may be reviewed individually or in the aggregate. Nothing in this paragraph shall mandate the State give majority consideration to any one factor or all factors. The factors include:

- (i) access to Medicaid Services;
- (ii) Medicaid utilization;
- (iii) Cost Report analyses;
- (iv) National and State-specific trends and costs including trends and salary levels and changes in minimum wage levels;
- (v) analyses of economic impact of changes in law or regulation;
- (vi) budget appropriations to OHCA; and
- (vii) Industry efforts to:
 - (I) reduce or contain employee benefits expenditures.
 - (II) consolidate or centralize personnel or departmental functions to reduce costs.
 - (III) review departmental staffing levels and to use lesser-skilled employees or reduce numbers of full-time equivalent employees where possible to do so without adversely affecting the quality of patient care.
 - (IV) standardize drugs and medical supplies in order to reduce costs that are unnecessary.
 - (V) expedite billings.
 - (VI) use volunteer service and fund raising.
 - (VII) control utility costs.
 - (VIII) reduce the incidence of employee injuries.

(IX) reduce employee turnover and to involve employees in cost containment efforts.

(X) review contractual arrangements to determine if more cost-effective ways of providing services and supplies can be achieved.

(XI) incorporate efficiency incentives into the compensation systems of employees.

(XII) use management information systems to plan and achieve efficiencies in operations (including but not limited to flexible budgeting, cost accounting, case-mix, group purchasing, etc.).

(C) **Wage Enhancement Payment component.** The Wage Enhancement payment is subject to Title 63 of Oklahoma Statute, Section 5022 and is described at OAC 317:30-5-131.1. The Wage Enhancement payment is added as per the methodology listed at OAC 317:30-5-131.1.

(D) **Periodic Incentive Payment component.** A Periodic Incentive payment may be made to certain facilities whose score on a predetermined array of factors meets levels that exceeds the standard or norm. Among factors under consideration are the Customer Satisfaction Surveys, the OSDH survey and Certification data, the Wage Enhancement audit data, the Recipient Trust Fund audit data, data from the State Ombudsman and Pharmacy Utilization (DUR program) data. This payment is made based upon the availability of additional funds and the reliability of the data collected.

(E) **Nursing Facilities serving ventilator-dependent patients.** A prospective statewide enhanced rate is paid to nursing facilities who do not have a waiver under Section 1919(b)(4)(C)(ii) of the Social Security Act on behalf of ventilator-dependent patients.

(i) Reimbursement is limited to the same rate paid for care of NF patients plus an enhancement for patients who are ventilator dependent. The enhanced rate is an amount reflecting the additional costs of meeting the specialized care needs of ventilator-dependent patients. In addition to increased skilled staffing costs, the following are used in calculating the enhanced rate:

- (I) additional nursing hours;
- (II) medical equipment and supplies;
- (III) nutritional therapy; and
- (IV) respiratory therapy.

(ii) Reimbursement for the enhanced rate requires prior authorization. In order for Medicaid eligible patients to be considered for prior authorization, the facility submits the treatment plan and most recent doctor's orders and/or hospital discharge summary for each ventilator-dependent patient to OHCA.

(iii) The enhanced rate will be reviewed periodically and adjusted as necessary through a public process.

(F) Nursing Facilities Serving Adults. Base Rate when used in this subpart is defined as the rate in effect on June 30, 2005, adjusted for any changes as described in (B) through (E) for which the legislature has specified appropriated funds. Direct Care Costs are defined as those costs for salaries, benefits and training for registered nurses, licensed practical nurses, nurse aides and certified medication aides. Other Costs are defined as the total allowable routine and ancillary costs of nursing facility care less the Direct Care Costs. As of July 1, 2005, Nursing Facilities Serving Adults will be reimbursed as follows:

(i) The rate for each facility will be the sum of the Base Rate plus the add-ons for Direct Care and Other Costs as described below.

(ii) Annually, any funds over and above those to cover the Base Rate described above will be used to create two pools of funds used to adjust the rates as follows:

(I) The first pool will be 30% of the total available funds and will be used to adjust the rates equally (a statewide adjustment) for Other Costs.

(II) The second pool will be 70% of the total available funds and will be used to adjust rates on a facility-

specific basis for Direct Care Costs. The add-on for each facility will be determined by multiplying each facility's reported direct care cost per day (with a maximum limit set at the 90th percentile) by the percent increase in the total direct care expenditures due to the addition of the direct care pool funds.

(iii) The available funds for establishing these pools and the subsequent add-ons for Direct Care and Other Costs will be re-determined and re-calculated annually and adjusted for changes in available funds and federal matching percentages.

(b) **Public Nursing Facilities.** Reimbursement for public Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall be based on each facility's reasonable 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. Rates for Public facilities will be reviewed periodically and adjusted as necessary through a public process.