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State/Territory Name: Oklahoma

State Plan Amendment (SPA) # OK 21-0027

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

October 4, 2021

Melody Anthony
State Medicaid Director
Oklahoma Health Care Authority
4345 North Lincoln Boulevard
Oklahoma City, Oklahoma 73105

RE: Oklahoma State Plan Amendment (SPA) 21-0027

Dear Ms. Anthony:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 21-0027 effective for services on or after July 1, 2021. The purpose of this SPA is Oklahoma's Annual Rebasing of Rates for regular nursing facilities, nursing facilities serving residents with Acquired Immune Deficiency Syndrome (AIDS), and acute and regular Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IIDs) and increasing the add-on rates to facilities serving Medicaid beneficiaries who require ventilators.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act. We hereby inform you that Medicaid State plan amendment 21-0027 is approved effective July 1, 2021. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Tom Caughey at (517) 487-8598.

Sincerely

[redacted]

Rory Howe

Director

Enclosure

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: 21 — 0027

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
July 1, 2021

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR § 440.155

7. FEDERAL BUDGET IMPACT
a. FFY 2021 $ 6,398,237.00
b. FFY 2022 $ 25,592,950.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-D; Page 3;
Attachment 4.19-D; Page 5;
Attachment 4.19-D; Page 11;
Attachment 4.19-D; Page 13(b);
Attachment 4.19-D; Page 13(c);
Attachment 4.19-D; Page 13(d);
Attachment 4.19-D; Page 13(e);
Attachment 4.19-D; Page 15;
Attachment 4.19-D; Page 25;
Attachment 4.19-D; Page 38

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

Attachment 4.19-D; Page 3; TN # 19-0031-B
Attachment 4.19-D; Page 5; TN # 20-0028
Attachment 4.19-D; Page 11; TN # 20-0028
Attachment 4.19-D; Page 13(b); TN # 10-08
Attachment 4.19-D; Page 13(c); TN # 07-10
Attachment 4.19-D; Page 13(d); TN # 09-11
Attachment 4.19-D; Page 13(e); TN # 09-11
Attachment 4.19-D; Page 15; TN # 10-35
Attachment 4.19-D; Page 25; TN # 20-0028
Attachment 4.19-D; Page 38; TN # 20-0028

10. SUBJECT OF AMENDMENT

Annual Rebasing of Rates for regular nursing facilities, nursing facilities serving residents with Acquired Immune Deficiency Syndrome (AIDS), and acute and regular Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IIDs) and Increasing the add-on rates to facilities serving Medicaid beneficiaries who require ventilators.

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Melody Anthony

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 13, 2021

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 13, 2021

18. DATE APPROVED
October 4, 2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted] For

21. TYPED NAME
Rory Howe

22. TITLE
Director, Financial Management Group

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS *(continued)*

B. RATE SETTING PROCESS

Beginning July 1, 2007, the Oklahoma Health Care Authority uses the following method to adjust rates of payment for nursing facilities:

1. DEFINITIONS*:*

Base Rate Component is the rate in effect on June 30, 2005, defined as $103.20 per day. Included in the base rate is the QOC Fee. Any changes to the base rate will be made through future Plan changes if required. For the rate period beginning September 01, 2012, the base rate will be $106.29. For the rate period beginning July 1, 2013, the base rate will be $107.24. For the rate period beginning July 1, 2016, the base rate will be $107.57 per patient day. For the rate period beginning July 1, 2017, the base rate will be $107.79 per patient day. For the rate period beginning July 1, 2018, the base rate will be $107.98 per patient day. For the rate period beginning October 1, 2018, the base rate will be $108.12 per patient day. For the rate period beginning July 1, 2019, the base rate will be $108.31 per patient day. For the rate period beginning October 1, 2019, fifty percent (50%) of new funding shall be allocated toward an increase of the existing base rate and distributed accordingly. For the rate period beginning October 1, 2019, the base rate will be $120.57 per patient day. For the rate period beginning July 1, 2020, the base rate will be $121.30 per patient day. For the rate period beginning July 1, 2021, the base rate will be $123.22 per patient day.

Direct Care Cost Component is defined as the component established based on each facilities' relative expenditures for Direct Care which are those expenditures reported on the annual costs reports for salaries (including professional fees and benefits), for registered nurses, licensed practical nurses, nurse aides, and certified medication aides.

Other Cost Component is defined as the component established based on monies available each year for all costs other than direct care and incentive payment totals, i.e., total allowable routine and ancillary costs (including capital and administrative costs) of nursing facility care less the Direct Care Costs and incentive payment totals.

Incentive Rate Component is defined as the component earned each quarter under the Pay-for-Performance (PFP) program.

Rate Period is defined as the period of time between rate calculations.

2. GENERAL:

The estimated total available funds will include the estimated savings or loss to the program as a result of the automatic cost of living adjustment on Social Security benefits as published in the federal register and the resulting effect to the spend-down required of the recipients. For Regular Nursing facilities, the effect is $.32 per day for each one (1) percent change in the SSI determined from the average effect of SSI increases from CY 2004 to CY 2009.

Individual rates of payment will be established as the sum of the Base Rate plus add-ons for Direct Care, Other Costs, and the Pay-for-Performance (PFP) Quality of Care Rating System.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITIES SERVING ADULTS *(continued)*

For new facilities beginning operations in the current rate period, the rate will be the median of those established rates for the year.

For the rate period beginning 01/01/12, the total available pool amount for establishing the rate components described in 1 and 2 is $102,318,569.
For the rate period beginning 09/01/12, the total available pool amount for establishing the rate components described in 1 and 2 is $147,230,204.
For the rate period beginning 07/01/13, the total available pool amount for establishing the rate components described in 1 and 2 is $162,205,189.
For the rate period beginning 07/01/14, the total available pool amount for establishing the rate components described in 1 and 2 is $158,391,182.
For the rate period beginning 07/01/16, the total available pool amount for establishing the rate components described in 1 and 2 is $158,741,836.
For the rate period beginning 07/01/17, the total available pool amount for establishing the rate components described in 1 and 2 is $160,636,876.
For the rate period beginning 07/01/18, the total available pool amount for establishing the rate components described in 1 and 2 is $158,938,847.
For the rate period beginning 10/01/18, the total available pool amount for establishing the rate components described in 1 and 2 is $174,676,429.
For the rate period beginning 07/01/19, the total available pool amount for establishing the rate components described in 1 and 2 is $186,146,037.
For the rate period beginning 10/01/19, the total available pool amount for establishing the rate components described in 1 and 2 is $220,482,316.
For the rate period beginning 07/01/20, the total available pool amount for establishing the rate components described in 1 and 2 is $250,302,699.
For the rate period beginning 07/01/21, the total available pool amount for establishing the rate components described in 1 and 2 is $251,196,155.

3. Since July 1, 2007, Nursing Facilities Serving Adults and AIDS Patients have been able to earn additional reimbursement for “points” earned in an Oklahoma Quality Rating Program. This program, which was originally called “Focus on Excellence,” was revised by statute in 2019, and is now called “Pay-for-Performance”.

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

(1) Decrease percent of high risk/unstageable pressure ulcer for long stay residents;
(2) Decrease percent of unnecessary weight loss for long stay residents;
(3) Decrease percent of use of anti-psychotic medications for long stay residents; and
(4) Decrease percent of urinary tract infection for long stay residents.

If either quality metric listed above is substituted or removed by CMS; an alternative CMS Long Stay quality metric may be chosen.

Payment to nursing facilities for meeting the metrics will be awarded quarterly as follows:

- A facility may earn a minimum of $1.25 per Medicaid patient per day for each qualifying metric.
- A facility receiving a deficiency of “I” or greater related to a specific quality measure within the PFP Quality of Care Rating System is disqualified from receiving an award related to that PFP measure for that quarter.
- Funds that remain as a result of payment not earned, shall be pooled and redistributed to facilities who achieve the metrics each quarter based on facilities’ individual performance in the PFP program.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING AIDS PATIENTS *(continued)*

B. RATE SETTING PROCESS

1. DEFINITIONS AND METHODOLOGY

Base Rate Component is the rate component representing the allowable cost of the services rendered in an AIDS nursing facility and for the period beginning November 1, 2010 is $178.64, the difference in the costs reported for aids facilities and regular nursing facilities plus the average rate for November 1, 2010 for regular nursing facilities, not including the incentive payment component ($193.79 less $138.17 plus $123.02); or $178.64 per patient day. For the rate period beginning September 1, 2012, the Base Rate Component will be $192.50. For the rate period beginning July 1, 2013, the Base Rate Component will be $196.95. For the rate period beginning July 1, 2014, the Base Rate Component will be $197.49. For the rate period beginning July 1, 2016, the Base Rate Component will be $199.19 per patient day. For the rate period beginning July 1, 2017, the Base Rate Component will be $200.01 per patient day. For the rate period beginning July 1, 2018, the Base Rate Component will be $201.32 per patient day. For the rate period beginning October 1, 2018, the Base Rate Component will be $207.86 per patient day. For the rate period beginning July 1, 2019, the Base Rate Component will be $209.50 per patient day. For the rate period beginning October 1, 2019, the Base Rate Component will be $213.10 per patient day. For the rate period beginning July 1, 2020, the Base Rate Component will be $215.00 per patient day. For the rate period beginning July 1, 2021, the Base Rate Component will be $224.05 per patient day.

(A) *56 Okla. Stat.* § 2002 requires that all licensed nursing facilities pay a statewide average per patient day *Quality of Care assessment fee* based on maximum percentage allowed under federal law of the average gross revenue per patient day. Gross revenues are defined as Gross Receipts (i.e., total cash receipts less donations and contributions). *The assessment is an allowable cost as it relates to Medicaid services and a part of the base rate component.*

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

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Reserved 07-01-21

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

STANDARD NURSING FACILITY SERVING VENTILATOR-DEPENDENT PATIENTS *(continued)*

Rate Determination *(continued)*

The add-on rate for nursing facility serving ventilator-dependent patients 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%.

For the rate period beginning July 1, 2021, the statewide add-on will be increased by 37.81%.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

STANDARD PRIVATE INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICFs/IID) *(continued)*

A. COST ANALYSES *(continued)*

4. 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 Individuals with Intellectual Disabilities (ICFs/IID) 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.

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

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

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

For the rate period beginning September 1, 2012, the statewide rate will be increased by 1.93%.

For the rate period beginning July 1, 2013, the statewide rate will be increased by 0.56%.

For the rate period beginning July 1, 2016, the statewide rate will be increased by 0.2951%, resulting in a rate of $122.32 per patient per day.

For the rate period beginning July 1, 2017, the statewide rate will be increased by 0.3104%, resulting in a rate of $122.77 per patient per day.

For the rate period beginning October 1, 2018, the statewide rate will be increased by 3.47%, resulting in a rate of $127.49 per patient per day.

For the rate period beginning July 1, 2020, the statewide rate will be increased by 0.2024% resulting in a rate of $128.72 per patient per day.

For the rate period beginning July 1, 2021, the statewide rate will be increased by 0.6046% resulting in a rate of $129.79 per patient per day.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

SPECIALIZED PRIVATE ICFs/IID 16 BED OR LESS

A. COST ANALYSES *(continued)*

4. 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 Individuals with Intellectual Disabilities 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.

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

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

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

For the rate period beginning September 1, 2012, the statewide rate will be increased by 1.86%.

For the rate period beginning July 1, 2013, the statewide rate will be increased by 0.30%.

For the rate period beginning July 1, 2016, the statewide rate will be increased by 0.2048%, resulting in a rate of $156.51 per patient per day.

For the rate period beginning July 1, 2017, the statewide rate will be increased by 0.2937%, resulting in a rate of $157.03 per patient per day.

For the rate period beginning October 1, 2018, the statewide rate will be increased by 3.56%, resulting in a rate of $163.04 per patient per day.

For the rate period beginning July 1, 2020, the statewide rate will be increased by 0.0122% resulting in a rate of $163.94 per patient per day.

For the rate period beginning July 1, 2021, the statewide rate will be increased by 0.2557% resulting in a rate of $164.62 per patient per day.

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