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State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 18-0012 NIRT

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

Financial Management Group

APR 06 2018

Ms. Becky Pasternik-Ikard
State Medicaid Director
2401 NW 23rd Street, Suite 1A
Oklahoma City, Oklahoma 73107

Our Reference: SPA OK 18-12

Dear Ms. Pasternik-Ikard:

We have reviewed the proposed State plan amendment (SPA) to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 18-12. The purpose of this amendment is the redaction of wage enhancement add-on payments to certain nursing facilities serving adults and ICFs/IIDs to comply with the repeal of sections 5022 and 5022.1 of Title 63 of the Oklahoma Statutes.

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

We are pleased to inform you that Medicaid State plan amendment 18-12 is approved effective January 1, 2018. We are enclosing the CMS-179 and the amended plan pages.

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

Sincerely,

[redacted]

Kristin Fan
Director

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: 18-12
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: January 1, 2018

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 440.150; 42 CFR 440.155

7. FEDERAL BUDGET IMPACT
a. FFY 2018 $ $0
b. FFY 2019 $ $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D, Page 23	Attachment 4.19-D, Page 23, TN # 10-35
Attachment 4.19-D, Page 24,	Attachment 4.19-D, Page 24, TN # 10-35
Attachment 4.19-D, Page 25	Attachment 4.19-D, Page 25, TN # 10-35
Attachment 4.19-D, Page 26, DELETED	Attachment 4.19-D, Page 26, TN # 10-35
Attachment 4.19-D, Page 27, DELETED	Attachment 4.19-D, Page 27, TN # 10-35
Attachment 4.19-D, Page 28, DELETED	Attachment 4.19-D, Page 28, TN # 17-08
Attachment 4.19-D, Page 35	Attachment 4.19-D, Page 35, TN # 10-35
Attachment 4.19-D, Page 36	Attachment 4.19-D, Page 36, TN # 10-35
Attachment 4.19-D, Page 37	Attachment 4.19-D, Page 37, TN # 10-35
Attachment 4.19-D, Page 38	Attachment 4.19-D, Page 38, TN # 10-35
Attachment 4.19-D, Page 39, DELETED	Attachment 4.19-D, Page 39, TN # 10-35
Attachment 4.19-D, Page 40, DELETED	Attachment 4.19-D, Page 40, TN # 10-35
Attachment 4.19-D, Page 41, DELETED	Attachment 4.19-D, Page 41, TN # 17-08

10. SUBJECT OF AMENDMENT
Redaction of state plan language regarding wage enhancement add-on payments to specified nursing facilities serving adults and ICFs/IIDs to comply with the repeal of sections 5022 and 5022.1 of Title 63 of the Oklahoma Statutes.

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
Becky Pasternik-Ikard

14. TITLE
Chief Executive Officer

15. DATE SUBMITTED
February 23, 2018

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
February 23, 2018

18. DATE APPROVED
APR 06 2018

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
KRISTIN FAN

22. TITLE
Director, FMCO

23. REMARKS
c: Becky Pasternik-Ikard
Tywanda Cox

FORM CMS-179 (07/92)

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)*

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

D. Adjustment For Change In Law Or Regulation *(continued)*

4. 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.

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 $(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 09-01-00 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 ICFs/IID 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 dentures 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.

State: Oklahoma
Date Received: February 23, 2018
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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 (ICF'S/IID) *(continued)*

A. COST ANALYSES *(continued)*

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

D. Adjustment For Change In Law Or Regulation *(continued)*

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 $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 per day determined in 2 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.

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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 (ICF'S/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.

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INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

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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)*

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

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

The direct care staff-to-patient ratios required and the employees to be included in the ratios are defined in Section 1-1925.2 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.

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SPECIALIZED PRIVATE ICFs/IID 16 BED OR LESS

A. COST ANALYSES *(continued)*

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

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

4. 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 09-01-00 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.

5. 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 dentures 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.

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SPECIALIZED PRIVATE ICFs/IID 16 BED OR LESS

A. COST ANALYSES *(continued)*

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

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

6. 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 per day determined in 2 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.

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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.

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

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