

**Oklahoma Health Care Authority**  
**Summary of the Rate Setting Methodology for Long Term Care Facilities**  
**February, 2012**

**PREFACE:**

The following details the methods used by the OHCA and approved by CMS to meet the requirements in legislation. Specifically, the legislation establishing the QOC Fee in HB2019 (2001); the establishment of payment based on relative expenditure for Direct Care in SB1622 (2006), and the implementation of payments enhance for Quality of Care Performance as established under HB2842 (2007).

*The following rate components apply to Regular Nursing Facilities:*

- a. **Base Rate**-established by legislation at \$103.20 per day.
- b. **Enhanced Performance Payments** are paid based on a facility's performance level under the Focus on Excellence Program. A facility may earn up to five points. Each facility may earn from 1 to 500 points with payment of \$.01 per point. The projected average payment per day is \$2.43 per day.
- c. The **Other Cost Component** is established at a per day estimate which is calculated by dividing 30 % of the funds available after meeting the costs of the base rate and bonus components by the estimated days. This component is the same for all facilities. The current component is \$ 6.38 per day.
- d. The **Direct Care Cost Component** is determined by arraying the direct care costs for each facility, setting the costs at a maximum of the 90<sup>th</sup> percentile and determining a per day component for each facility based on their relative expense for direct care. The total funds after meeting the other cost components is used to establish the available funds for this allocation. The current average component is \$14.89 per day and the component ranges from \$8.75 to \$18.71 per day
- e. The current average rate per day is \$126.90.

**NF Rate Process**

**Step One:**

**-----Determination of Available Funds:**

Total available funds are determined by totaling the funds from the following sources:

1. Funds deposited from QOC Fee Collections plus the federal match.
2. Appropriations from the legislature plus the federal match.
3. Spend-down and Third Party Liability paid by the recipients or others on their behalf.

**Step Two:**

**----Determination of Upper Payment Limit**

Based on the latest cost report data adjusted for any audit findings, the cost is brought forward to the rate period by the Global Insight inflators. The estimate of the cost of any new requirements, such as Minimum Wage increases, is added to this figure to determine

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the UPL. This is the method that OKHCA currently uses and has been accepted by our federal partners. If the available funds were to exceed this amount then the OHCA would be use them to enhance elderly programs, with first priority given to the nursing home population. One example would be to raise rates, while also raising staffing levels.

### **Step Three:**

#### **---Determination of cost of covering the base rate and available funds for the other rate components.**

An estimate of the number of Medicaid days for the rate year is multiplied by the base rate of \$103.20 to determine the funding needed to cover the base rate. The base rate component requirement is deducted from the total funds available (see steps 1 and 2) to determine the funds available for the other rate components.

### **Step Four:**

#### **---Determination of the Per Day amounts for the other rate components.**

In order to determine the Other Cost and Direct Care Cost rate components an algebraic formula is employed that determines the pool amount available after paying for the estimated bonus payments and the base rate. This formula determines the bonus amount per day for each percentage point earned and then this estimate is used to determine the total expenditure for enhancements by taking the estimated points to be earned by the amount per point. The net available after meeting the enhanced payment and base rate components is then divided into two other pools, one pool is for Other Cost Component (30% of the available funds) and one pool is for the Direct Care Cost Component (70% of the available funds). The 30% Other Cost pool is divided by the total estimated days to establish an equal rate component for each facility. The Direct Care Cost (as defined in legislation) component is determined for each facility by arraying the costs for each and setting those at higher than the 90<sup>th</sup> percentile to the 90<sup>th</sup> percentile. Then the pool of funds is allocated to each facility by their relative cost for Direct Care versus all other facility's direct care costs. Each facility is established a specific per diem amount which is the reported amount times a factor determined by dividing the pool amount by the total amount of direct care. As defined in the legislation the Direct Care is the sum of the salaries (including outside professional fees) and benefits for RN's; DON's, LPN's, Certified Nurse Aides, Certified Medication Aides and Therapy Aides/Assistants.

Total Rate:

---The rate for payment of regular claims is the sum of the Base Rate Component, the Other Rate Component and the Facility- Specific Direct Care Rate Component. The current range is from \$118.33 to \$128.09 (\$118.33 to \$133.09, including enhancements for Quality of Care).

The enhancement points earned are reported determined quarterly by the OHCA and its' representatives and the point total is set in the system to pay on Medicaid days of service rendered at the established amount for each point earned. This payment will be made and will show up as a separate line on each remittance advice.

Note: For ICF MR Facilities (both Regular, and Acute Care -16 Bed or Less) the Available Funds and UPL are determined as detailed above and the rate established based on the total allowable costs, or total funds available. The current rates are set at \$117.76 and \$151.65, respectively.