

**OKLAHOMA HEALTH CARE AUTHORITY
PROPOSED RATE METHODOLOGY
FOR REGULAR NURSING FACILITIES
AS OF 11-01-08**

In order to incorporate all of the legislation that directs the Oklahoma HealthCare Authority (OHCA) to establish specific reimbursement methodologies/calculations for nursing facilities (which include HB 2019 establishing Quality of Care (QOC) Fee and minimum direct care staffing ratios; SB 1622 establishing facility-specific rates based on expenditures relating to direct care staffing; and HB 2842 establishing a graduated reimbursement system based on quality indicators), reimbursement will be calculated as follows:

Step 1: Determination of Total Available Funding (HB 2019)

- The total amount of available funds is determined from state appropriations; the QOC Fund estimated collections, the estimated spend-down and third party liability and the federal matching funds available. Total Facility reimbursement from these funds will be the sum of the Focus on Excellence and facility-specific rates.

Step 2: Focus on Excellence (FE) Component (HB 2842)

- Approximately 2.5% to 3% will be set aside from the total available funds to cover this program.
- OHCA will make an estimate of the level of participation in the new Focus on Excellence Program and the levels of reimbursements that will occur.
- Participating facilities may receive an additional payment of up to 5 percent (see step 3 below, a percentage point value is of the sum of the *base rate* and *other rate* components times one percent) of the statewide rate components for achieving levels of excellence based on the matrices in the new tiered reimbursement system.

Step 3: Determination of Facility-Specific Rates (SB 1622)

- After the FE set aside, facility-specific rates are determined from the following pools: the statewide base rate (BR) and the “additional available funding” (AAF) pool that rewards/incentivizes spending for direct care.
- **Base Rate (BR) Pool:** The BR is a statewide rate for all facilities established by law and is \$103.20 (the rate that was in effect on 6-30-06). The amount of funds needed to pay the base rate pool is then estimated from the product of the BR multiplied by the total estimated Medicaid days.
- **Additional Available Funding (AAF) Pool:** The net remaining funds make up the total AAF pool. The AAF pool is divided into two components: Direct Care (70%) and Other Costs (30%).
 - **The Direct Care Cost (DC)** component is allocated to each facility based on its relative expense for direct care to all other facilities expenses with a maximum set at the 90th percentile.
 - **The Other Cost (OC)** component is allocated equally to all facilities.

Step 4: Determination of Facility Total Rate

- A Participating FE facility’s rate will be the sum of:
 - A facility’s rate is the sum of the Base plus the Other Cost Component plus the facility specific Direct Care Component. Additional payment each quarter will be based on the facility’s Focus on Excellence score for which a facility may receive from 1 to 5 percent additional per day.
- A Non Participating FE facility’s rate will be the sum of:
 - Base Plus the
 - Other Cost Component Plus the Direct Care Component.

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AIDS FACILITY/PATIENT RATE:

- Under HB 2019 the Aids rate was established as the sum of the primary operating cost per diem, the administrative cost per diem, the capital cost per diem and the adjustments for changes in law or regulation. For the rate period up to 06-30-06 the above was based on the 1999 cost reports brought forward to the rate periods by the nationally recognized inflators (DRI for operating and Marshall-Swift for capital) and adjusted for additional requirements for staffing, etc established by legislation.
- For the rate period beginning 07-01-06 the statewide rate was increased by 4.12% based on national inflators and reported costs.

VENTILATOR PATIENT RATE ADD-ON:

- Payment for ventilator patients in regular nursing facilities is paid at the standard rate for that facility plus an add-on for the enhanced cost of caring for these patients.
- The add-on was calculated from the added costs associated with the additional estimated hours of caregiver service, the additional supplies required including medical nutritional and therapy needs. The add-on was brought forward to the base year of SFY 2006, coinciding with the regular nursing facility changes from HB 2019.
- For the rate period beginning 07-01-06 the rate was increased by 9.155% based on national inflators and estimated costs.

RATES FOR ICF M/R FACILITIES:

- Under HB 2019 the rates for Regular and Acute Care (16 bed or less) ICF MR was established as the sum of the primary operating cost per diem, the administrative cost per diem, the capital cost per diem and the adjustments for changes in law or regulation. For the rate period up to 06-30-06 the above was based on the 1999 cost reports brought forward to the rate periods by the nationally recognized inflators (DRI for operating and Marshall-Swift for capital) and adjusted for additional requirements for staffing, etc established by legislation.
- For the rate period beginning 07-01-06 the statewide rate for regular MR facilities was increased by 10.32% and the rate for the Acute Care (16 bed-or-less) MR facilities was increased by 10.90% based on national inflators and reported costs.