

Oklahoma Health Care Authority

Long Term Care Facility Rate Setting Methodology Summary

PREFACE

The following details the rate setting methods used by the OHCA and approved by CMS to meet the requirements in legislation-SB280 (2019).

The following rate components apply to Regular Long Term Care Facilities:

1. **Base Rate:** established per legislation at \$121.30 per day.
2. **Other Cost Component:** 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 enhanced performance payments by the estimated days. This component is the same for all facilities. The current component is \$15.98 per day.
3. **Direct Care Cost Component:** established at a per day estimate which is calculated by dividing 70% of the funds available after meeting the costs of the base rate and enhanced performance payments by the estimated days. It is determined by arraying the direct care costs for each facility, setting the costs at a maximum of the 90th 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 \$37.29 per day and the component ranges from \$23.23 to \$47.28 per day.
4. **Enhanced Performance Payments:** paid based on a facility's performance level under the Pay for Performance Program. A facility may earn an average \$5 per patient day.
5. The total current average rate is \$179.57 per patient per day.

Long Term Care Facilities 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 Total Cost

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 the total cost. Upper Payment Limit (UPL) is calculated utilizing Medicare equivalent payment rate.

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 \$121.30 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.

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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 the Pay for Performance component (enhanced performance payments) must be determined first. The enhanced performance payments amount is determined by taking the estimated Medicaid days times the average payment to arrive at an estimated enhanced amount. The net amount 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 Other Cost Component pool is divided by the total estimated days to establish an equal rate component for each facility. The Direct Care Cost component is determined for each facility by arraying the costs for each and setting those at higher than the 90th percentile to the 90th 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 direct care cost per diem amount (which is the **reported** direct care amount times a factor determined by dividing the direct care pool amount by the total amount of direct care costs). As defined in the legislation the Direct Care Cost Component 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 \$160.51 to \$184.56. The range **including** the Pay for Performance Component is \$165.16 to \$189.56. The enhancement dollars earned are determined quarterly by the OHCA.

Note: For Regular and Acute Care (16 beds or less) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Facilities, the Available Funds are determined as detailed above and UPL is calculated utilizing cost based methodology. The rate established is based on the total allowable costs, or total funds available. The current rates are set at \$128.72 for Regular ICF/IID and \$163.94 for Acute Care ICF/IID (16 Beds or Less).