STATE OF OKLAHOMA

1st Session of the 57th Legislature (2019)

COMMITTEE SUBSTITUTE
FOR
SENATE BILL 280 By: Simpson

COMMITTEE SUBSTITUTE

An Act relating to long-term care; amending 56 O.S. 2011, Section 1011.5, which relates to nursing facility incentive reimbursement rate plan; modifying composition and focus of certain task force; modifying reimbursement methodology; directing certain redistribution of funds; establishing certain advisory group; specifying certain quality measures; requiring annual review of quality measures; listing certain criteria; deleting certain requirement to make refinements and requiring certain audit; amending 56 O.S. 2011, Section 2002, as last amended by Section 1, Chapter 183, O.S.L. 2013 (56 O.S. Supp. 2018, Section 2002), which relates to Nursing Facilities Quality of Care Fee; modifying certain allowable expenses; updating term; updating statutory language; amending 63 O.S. 2011, Section 1-1925.2, which relates to reimbursements from Nursing Facility Quality of Care Fund; striking certain condition; deleting certain provision related to calculation; updating term; modifying certain staffing and ratio procedures; deleting obsolete language; modifying certain calculation criteria; setting forth certain provisions related to rate and methodology; directing the Oklahoma Health Care Authority to provide certain access and revise certain forms; providing an effective date; and declaring an emergency.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 56 O.S. 2011, Section 1011.5, is amended to read as follows:

Section 1011.5. A. 1. The Oklahoma Health Care Authority ~~in cooperation with the State Department of Health, a statewide organization of the elderly, representatives of the Health and Human Services Interagency Task Force on long-term care, and representatives of both statewide associations of nursing facility operators~~ shall develop an incentive reimbursement rate plan for nursing facilities ~~that shall include, but may not be limited to, the following:~~

~~1. Quality of life indicators that relate to total management initiatives;~~

~~2. Quality of care indicators;~~

~~3. Family and resident satisfaction survey results;~~

~~4. State Department of Health survey results;~~

~~5. Employee satisfaction survey results;~~

~~6. CNA training and education requirements;~~

~~7. Patient acuity level;~~

~~8. Direct care expenditures pursuant to subparagraph e of paragraph 2 of subsection I of Section 1-1925.2 of Title 63 of the Oklahoma Statutes; and~~

~~9. Other incentives which include, without limitation, participation in quality initiative activities performed and/or recommended by the Oklahoma Foundation for Medical Quality in~~

~~capital improvements, in-service education of direct staff, and procurement of reasonable amounts of liability insurance~~ focused on improving resident outcomes and resident quality of life.

2. Under the current rate methodology, the Authority shall reserve Five Dollars ($5.00) per patient day designated for the quality assurance component that nursing facilities can earn for improvement or performance achievement of resident-centered outcomes metrics. To fund the quality assurance component, Two Dollars ($2.00) shall be deducted from each nursing facility's per diem rate, and matched with Three Dollars ($3.00) per day funded by the Authority. Payments to nursing facilities that achieve specific metrics shall be treated as an "add back" to their net reimbursement per diem. Dollar values assigned to each metric shall be determined so that an average of the Five Dollars ($5.00) quality incentive is made to qualifying nursing facilities.

3. Pay-for-performance payments may be earned quarterly and based on facility-specific performance achievement of four (4) equally-weighted, Long-Stay Quality Measures as defined by the Centers for Medicare and Medicaid Services (CMS).

4. Contracted Medicaid long-term care providers may earn payment by achieving either five percent (5%) relative improvement each quarter from baseline or by achieving the National Average Benchmark or better for each individual quality metric.

5. Pursuant to federal Medicaid approval, any funds that remain as a result of providers failing to meet the quality assurance metrics shall be pooled and redistributed to those who achieve the quality assurance metrics each quarter. If federal approval is not received, any remaining funds shall be deposited in the Quality of Care fee fund authorized in Section 2002 of this title.

6. The Authority shall establish an advisory group with consumer, provider and state agency representation to recommend quality measures to be included in the pay-for-performance program and to provide feedback on program performance and recommendations for improvement. The quality measures shall be reviewed annually and subject to change every four (4) years through the agency's promulgation of rules. The Authority shall insure adherence to the following criteria in determining the quality measures:

a. direct benefit to resident care outcomes,

b. applies to Medicaid, long-stay residents, and

c. need for quality improvement using the Centers for Medicare and Medicaid Services (CMS) ranking for Oklahoma.

7. The Authority shall begin the pay-for-performance program focusing on improving the following CMS nursing home quality measures:

a. Percentage of High Risk Long-Stay Residents with Pressure Ulcers,

b. Percentage of Long-Stay Residents Who Lose Too Much Weight,

c. Percentage of Long-Stay Residents with a Urinary Tract Infection, and

d. Percentage of Long-Stay Residents who received an Antipsychotic Medication.

B. The Oklahoma Health Care Authority shall negotiate with the Centers for Medicare and Medicaid Services to include the authority to base provider reimbursement rates for nursing facilities on the criteria specified in subsection A of this section.

C. The Oklahoma Health Care Authority shall ~~make refinements to the incentive reimbursement rate plan~~ audit the program to ensure transparency and integrity~~. These refinements shall include, but may not be limited to, the following:~~

~~1. Establishing minimum standard for incentive payments, through higher percentiles using evidence-based criteria or introduction of absolute standards above the current benchmark;~~

~~2. Using state survey results as a threshold metric for determining if facilities should receive incentive payment and suspend facilities falling below the threshold;~~

~~3. Taking steps to strengthen data collection process; and~~

~~4. Establishing an advisory group with consumer, provider and state agency representation to provide feedback on program performance and recommendations for improvements~~.

D. The Oklahoma Health Care Authority shall provide an annual report of the incentive reimbursement rate plan to the Governor, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate by December 31 of each year. The report shall include, but not be limited to, an analysis of the previous fiscal year including incentive payments, ratings, and notable trends.

SECTION 2. AMENDATORY 56 O.S. 2011, Section 2002, as last amended by Section 1, Chapter 183, O.S.L. 2013 (56 O.S. Supp. 2018, Section 2002), is amended to read as follows:

Section 2002. A. For the purpose of providing quality care enhancements, the Oklahoma Health Care Authority is authorized to and shall assess a Nursing Facilities Quality of Care Fee pursuant to this section upon each nursing facility licensed in this state. Facilities operated by the Oklahoma Department of Veterans Affairs shall be exempt from this fee. Quality of care enhancements include, but are not limited to, the purposes specified in this section.

B. As a basis for determining the Nursing Facilities Quality of Care Fee assessed upon each licensed nursing facility, the Authority shall calculate a uniform per-patient day rate. The rate shall be calculated by dividing six percent (6%) of the total annual patient gross receipts of all licensed nursing facilities in this state by the total number of patient days for all licensed nursing facilities in this state. The result shall be the per-patient day rate.

Beginning July 15, 2004, the Nursing Facilities Quality of Care Fee shall not be increased unless specifically authorized by the Legislature.

C. Pursuant to any approved Medicaid waiver and pursuant to subsection N of this section, the Nursing Facilities Quality of Care Fee shall not exceed the amount or rate allowed by federal law for nursing home licensed bed days.

D. The Nursing Facilities Quality of Care Fee owed by a licensed nursing facility shall be calculated by the Authority by adding the daily patient census of a licensed nursing facility, as reported by the facility for each day of the month, and by multiplying the ensuing figure by the per-patient day rate determined pursuant to the provisions of subsection B of this section.

E. Each licensed nursing facility which is assessed the Nursing Facilities Quality of Care Fee shall be required to file a report on a monthly basis with the Authority detailing the daily patient census and patient gross receipts at such time and in such manner as required by the Authority.

F. 1. The Nursing Facilities Quality of Care Fee for a licensed nursing facility for the period beginning October 1, 2000, shall be determined using the daily patient census and annual patient gross receipts figures reported to the Authority for the calendar year 1999 upon forms supplied by the Authority.

2. Annually the Nursing Facilities Quality of Care Fee shall be determined by:

a. using the daily patient census and patient gross receipts reports received by the Authority for the most recent available twelve (12) months, and

b. annualizing those figures.

Each year thereafter, the annualization of the Nursing Facilities Quality of Care Fee specified in this paragraph shall be subject to the limitation in subsection B of this section unless the provision of subsection C of this section is met.

G. The payment of the Nursing Facilities Quality of Care Fee by licensed nursing facilities shall be an allowable cost for Medicaid reimbursement purposes.

H. 1. There is hereby created in the State Treasury a revolving fund to be designated the "Nursing Facility Quality of Care Fund".

2. The fund shall be a continuing fund, not subject to fiscal year limitations, and shall consist of:

a. all monies received by the Authority pursuant to this section and otherwise specified or authorized by law,

b. monies received by the Authority due to federal financial participation pursuant to Title XIX of the Social Security Act, and

c. interest attributable to investment of money in the fund.

3. All monies accruing to the credit of the fund are hereby appropriated and shall be budgeted and expended by the Authority for:

a. reimbursement of the additional costs paid to Medicaid-certified nursing facilities for purposes specified by Sections 1-1925.2, 5022.1 and 5022.2 of Title 63 of the Oklahoma Statutes,

b. reimbursement of the Medicaid rate increases for ~~intermediate care facilities for the mentally retarded (ICFs/MR)~~ Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID),

c. nonemergency transportation services for Medicaid-eligible nursing home clients,

d. eyeglass and denture services for Medicaid-eligible nursing home clients,

e. ~~ten additional~~ fifteen ombudsmen employed by the Department of Human Services,

f. ten additional nursing facility inspectors employed by the State Department of Health,

g. pharmacy and other Medicaid services to qualified Medicare beneficiaries whose incomes are at or below one hundred percent (100%) of the federal poverty

level; provided however, pharmacy benefits authorized for such qualified Medicare beneficiaries shall be suspended if the federal government subsequently extends pharmacy benefits to this population,

h. costs incurred by the Authority in the administration of the provisions of this section and any programs created pursuant to this section,

i. durable medical equipment and supplies services for Medicaid-eligible elderly adults, and

j. personal needs allowance increases for residents of nursing homes and ~~Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)~~ Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) from Thirty Dollars ($30.00) to Fifty Dollars ($50.00) per month per resident.

4. Expenditures from the fund shall be made upon warrants issued by the State Treasurer against claims filed as prescribed by law with the Director of the Office of Management and Enterprise Services for approval and payment.

5. The fund and the programs specified in this section funded by revenues collected from the Nursing Facilities Quality of Care Fee pursuant to this section are exempt from budgetary cuts, reductions, or eliminations.

6. The Medicaid rate increases for ~~intermediate care facilities for the mentally retarded (ICFs/MR)~~ Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) shall not exceed the net Medicaid rate increase for nursing facilities including, but not limited to, the Medicaid rate increase for which Medicaid-certified nursing facilities are eligible due to the Nursing Facilities Quality of Care Fee less the portion of that increase attributable to treating the Nursing Facilities Quality of Care Fee as an allowable cost.

7. The reimbursement rate for nursing facilities shall be made in accordance with Oklahoma's Medicaid reimbursement rate methodology and the provisions of this section.

8. No nursing facility shall be guaranteed, expressly or otherwise, that any additional costs reimbursed to the facility will equal or exceed the amount of the Nursing Facilities Quality of Care Fee paid by the nursing facility.

I. 1. In the event that federal financial participation pursuant to Title XIX of the Social Security Act is not available to the Oklahoma Medicaid program, for purposes of matching expenditures from the Nursing Facility Quality of Care Fund at the approved federal medical assistance percentage for the applicable fiscal year, the Nursing Facilities Quality of Care Fee shall be null and void as of the date of the nonavailability of such federal funding, through and during any period of nonavailability.

2. In the event of an invalidation of this section by any court of last resort under circumstances not covered in subsection J of this section, the Nursing Facilities Quality of Care Fee shall be null and void as of the effective date of that invalidation.

3. In the event that the Nursing Facilities Quality of Care Fee is determined to be null and void for any of the reasons enumerated in this subsection, any Nursing Facilities Quality of Care Fee assessed and collected for any periods after such invalidation shall be returned in full within sixty (60) days by the Authority to the nursing facility from which it was collected.

J. 1. If any provision of this section or the application thereof shall be adjudged to be invalid by any court of last resort, such judgment shall not affect, impair or invalidate the provisions of the section, but shall be confined in its operation to the provision thereof directly involved in the controversy in which such judgment was rendered. The applicability of such provision to other persons or circumstances shall not be affected thereby.

2. This subsection shall not apply to any judgment that affects the rate of the Nursing Facilities Quality of Care Fee, its applicability to all licensed nursing homes in the state, the usage of the fee for the purposes prescribed in this section, and/or the ability of the Authority to obtain full federal participation to match its expenditures of the proceeds of the fee.

K. The Authority shall promulgate rules for the implementation and enforcement of the Nursing Facilities Quality of Care Fee established by this section.

L. The Authority shall provide for administrative penalties in the event nursing facilities fail to:

1. Submit the Quality of Care Fee;

2. Submit the fee in a timely manner;

3. Submit reports as required by this section; or

4. Submit reports timely.

M. As used in this section:

1. "Nursing facility" means any home, establishment or institution, or any portion thereof, licensed by the State Department of Health as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes;

2. "Medicaid" means the medical assistance program established in Title XIX of the federal Social Security Act and administered in this state by the Authority;

3. "Patient gross revenues" means gross revenues received in compensation for services provided to residents of nursing facilities including, but not limited to, client participation. The term "patient gross revenues" shall not include amounts received by nursing facilities as charitable contributions; and

4. "Additional costs paid to Medicaid-certified nursing facilities under Oklahoma's Medicaid reimbursement methodology"

means both state and federal Medicaid expenditures including, but not limited to, funds in excess of the aggregate amounts that would otherwise have been paid to Medicaid-certified nursing facilities under the Medicaid reimbursement methodology which have been updated for inflationary, economic, and regulatory trends and which are in effect immediately prior to the inception of the Nursing Facilities Quality of Care Fee.

N. 1. As per any approved federal Medicaid waiver, the assessment rate subject to the provision of subsection C of this section is to remain the same as those rates that were in effect prior to January 1, 2012, for all state-licensed continuum of care facilities.

2. Any facilities that made application to the State Department of Health to become a licensed continuum of care facility no later than January 1, 2012, shall be assessed at the same rate as those facilities assessed pursuant to paragraph 1 of this subsection; provided, that any facility making ~~said~~ the application shall receive the license on or before September 1, 2012. Any facility that fails to receive such license from the State Department of Health by September 1, 2012, shall be assessed at the rate established by subsection C of this section subsequent to September 1, 2012.

O. If any provision of this section, or the application thereof, is determined by any controlling federal agency, or any

court of last resort to prevent the state from obtaining federal financial participation in the state's Medicaid program, such provision shall be deemed null and void as of the date of the nonavailability of such federal funding and through and during any period of nonavailability. All other provisions of the bill shall remain valid and enforceable.

SECTION 3. AMENDATORY 63 O.S. 2011, Section 1-1925.2, is amended to read as follows:

Section 1-1925.2. A. The Oklahoma Health Care Authority shall fully recalculate and reimburse nursing facilities and ~~intermediate care facilities for the mentally retarded (ICFs/MR)~~ Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) from the Nursing Facility Quality of Care Fund beginning October 1, 2000, the average actual, audited costs reflected in previously submitted cost reports for the cost-reporting period that began July 1, 1998, and ended June 30, 1999, inflated by the federally published inflationary factors for the two (2) years appropriate to reflect present-day costs at the midpoint of the July 1, 2000, through June 30, 2001, rate year.

1. The recalculations provided for in this subsection shall be consistent for both nursing facilities and ~~intermediate care facilities for the mentally retarded (ICFs/MR), and shall be calculated in the same manner as has been mutually understood by the long-term care industry and the Oklahoma Health Care Authority~~

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).

2. The recalculated reimbursement rate shall be implemented September 1, 2000.

B. 1. From September 1, 2000, through August 31, 2001, all nursing facilities subject to the Nursing Home Care Act, in addition to other state and federal requirements related to the staffing of nursing facilities, shall maintain the following minimum direct-care-staff-to-resident ratios:

a. from 7:00 a.m. to 3:00 p.m., one direct-care staff to every eight residents, or major fraction thereof,

b. from 3:00 p.m. to 11:00 p.m., one direct-care staff to every twelve residents, or major fraction thereof, and

c. from 11:00 p.m. to 7:00 a.m., one direct-care staff to every seventeen residents, or major fraction thereof.

2. From September 1, 2001, through August 31, 2003, nursing facilities subject to the Nursing Home Care Act and intermediate care facilities for the mentally retarded with seventeen or more beds shall maintain, in addition to other state and federal requirements related to the staffing of nursing facilities, the following minimum direct-care-staff-to-resident ratios:

a. from 7:00 a.m. to 3:00 p.m., one direct-care staff to every seven residents, or major fraction thereof,

b. from 3:00 p.m. to 11:00 p.m., one direct-care staff to every ten residents, or major fraction thereof, and

c. from 11:00 p.m. to 7:00 a.m., one direct-care staff to every seventeen residents, or major fraction thereof.

3. On and after ~~September 1, 2003, subject to the availability of funds~~ October 1, 2019, nursing facilities subject to the Nursing Home Care Act and intermediate care facilities for the mentally retarded with seventeen or more beds shall maintain, in addition to other state and federal requirements related to the staffing of nursing facilities, the following minimum direct-care-staff-to-resident ratios:

a. from 7:00 a.m. to 3:00 p.m., one direct-care staff to every six residents, or major fraction thereof,

b. from 3:00 p.m. to 11:00 p.m., one direct-care staff to every eight residents, or major fraction thereof, and

c. from 11:00 p.m. to 7:00 a.m., one direct-care staff to every fifteen residents, or major fraction thereof.

4. Effective immediately, facilities shall have the option of varying the starting times for the eight-hour shifts by one (1) hour before or one (1) hour after the times designated in this section without overlapping shifts.

5. a. On and after January 1, ~~2004~~ 2020, a facility ~~that has been determined by the State Department of Health to have been in compliance with the provisions of~~

~~paragraph 3 of this subsection since the implementation date of this subsection,~~ may implement ~~flexible~~ twenty-four (24) hour-based staff scheduling; provided, however, such facility shall continue to maintain a direct-care service rate of at least ~~two and eighty-six one-hundredths (2.86)~~ two and nine tenths (2.9) hours of direct-care service per resident per day, the same to be calculated based on average direct care staff maintained over a twenty-four (24) hour period.

b. At no time shall direct-care staffing ratios in a facility with ~~flexible~~ twenty-four (24) hour-based staff-scheduling privileges fall below one direct-care staff to every ~~sixteen~~ fifteen residents or major fraction thereof, and at least two direct-care staff shall be on duty and awake at all times.

c. As used in this paragraph, "~~flexible staff~~ twenty-four (24) hour-based~~-~~scheduling" means maintaining:

(1) a direct-care-staff-to-resident ratio based on overall hours of direct-care service per resident per day rate of not less than ~~two and eighty-six one-hundredths (2.86)~~ two and ninety one-hundredths (2.90) hours per day,

(2) a direct-care-staff-to-resident ratio of at least one direct-care staff person on duty to every ~~sixteen~~ fifteen residents or major fraction thereof at all times, and

(3) at least two direct-care staff persons on duty and awake at all times.

6. a. On and after January 1, 2004, the Department shall require a facility to maintain the shift-based, staff-to-resident ratios provided in paragraph 3 of this subsection if the facility has been determined by the Department to be deficient with regard to:

(1) the provisions of paragraph 3 of this subsection,

(2) fraudulent reporting of staffing on the Quality of Care Report, or

(3) a complaint and/or survey investigation that has determined substandard quality of care~~, or~~ as a result of insufficient staffing

~~(4) a complaint and/or survey investigation that has determined quality-of-care problems related to insufficient staffing~~.

b. The Department shall require a facility described in subparagraph a of this paragraph to achieve and maintain the shift-based, staff-to-resident ratios provided in paragraph 3 of this subsection for a

minimum of three (3) months before being considered eligible to implement ~~flexible~~ twenty-hour (24) based staff scheduling as defined in subparagraph c of paragraph 5 of this subsection.

c. Upon a subsequent determination by the Department that the facility has achieved and maintained for at least three (3) months the shift-based, staff-to-resident ratios described in paragraph 3 of this subsection, and has corrected any deficiency described in subparagraph a of this paragraph, the Department shall notify the facility of its eligibility to implement ~~flexible~~ twenty-four (24) hour based staff-scheduling privileges.

7. a. For facilities that ~~have been granted flexible~~ utilize twenty-four (24) hour based staff-scheduling privileges, the Department shall monitor and evaluate facility compliance with the ~~flexible~~ twenty-four (24) hour based staff-scheduling staffing provisions of paragraph 5 of this subsection through reviews of monthly staffing reports, results of complaint investigations and inspections.

b. If the Department identifies any quality-of-care problems related to insufficient staffing in such facility, the Department shall issue a directed plan

of correction to the facility found to be out of compliance with the provisions of this subsection.

c. In a directed plan of correction, the Department shall require a facility described in subparagraph b of this paragraph to maintain shift-based, staff-to-resident ratios for the following periods of time:

(1) the first determination shall require that shift-based, staff-to-resident ratios be maintained until full compliance is achieved,

(2) the second determination within a two-year period shall require that shift-based, staff-to-resident ratios be maintained for a minimum period of ~~six (6)~~ twelve (12) months, and

(3) the third determination within a two-year period shall require that shift-based, staff-to-resident ratios be maintained for a minimum period of ~~twelve (12) months~~. The facility may apply for permission to use twenty-four (24) hour staffing methodology after two (2) years.

C. Effective September 1, 2002, facilities shall post the names and titles of direct-care staff on duty each day in a conspicuous place, including the name and title of the supervising nurse.

D. The State ~~Board~~ Commissioner of Health shall promulgate rules prescribing staffing requirements for intermediate care

facilities for the mentally retarded serving six or fewer clients and for intermediate care facilities for the mentally retarded serving sixteen or fewer clients.

E. Facilities shall have the right to appeal and to the informal dispute resolution process with regard to penalties and sanctions imposed due to staffing noncompliance.

F. 1. When the state Medicaid program reimbursement rate reflects the sum of Ninety-four Dollars and eleven cents ($94.11), plus the increases in actual audited costs over and above the actual audited costs reflected in the cost reports submitted for the most current cost-reporting period and the costs estimated by the Oklahoma Health Care Authority to increase the direct-care, flexible staff-scheduling staffing level from two and eighty-six one-hundredths (2.86) hours per day per occupied bed to three and two-tenths (3.2) hours per day per occupied bed, all nursing facilities subject to the provisions of the Nursing Home Care Act and intermediate care facilities for the mentally retarded with seventeen or more beds, in addition to other state and federal requirements related to the staffing of nursing facilities, shall maintain direct-care, flexible staff-scheduling staffing levels based on an overall three and two-tenths (3.2) hours per day per occupied bed.

2. When the state Medicaid program reimbursement rate reflects the sum of Ninety-four Dollars and eleven cents ($94.11), plus the

increases in actual audited costs over and above the actual audited costs reflected in the cost reports submitted for the most current cost-reporting period and the costs estimated by the Oklahoma Health Care Authority to increase the direct-care flexible staff-scheduling staffing level from three and two-tenths (3.2) hours per day per occupied bed to three and eight-tenths (3.8) hours per day per occupied bed, all nursing facilities subject to the provisions of the Nursing Home Care Act and intermediate care facilities for the mentally retarded with seventeen or more beds, in addition to other state and federal requirements related to the staffing of nursing facilities, shall maintain direct-care, flexible staff-scheduling staffing levels based on an overall three and eight-tenths (3.8) hours per day per occupied bed.

3. When the state Medicaid program reimbursement rate reflects the sum of Ninety-four Dollars and eleven cents ($94.11), plus the increases in actual audited costs over and above the actual audited costs reflected in the cost reports submitted for the most current cost-reporting period and the costs estimated by the Oklahoma Health Care Authority to increase the direct-care, flexible staff-scheduling staffing level from three and eight-tenths (3.8) hours per day per occupied bed to four and one-tenth (4.1) hours per day per occupied bed, all nursing facilities subject to the provisions of the Nursing Home Care Act and intermediate care facilities for the mentally retarded with seventeen or more beds, in addition to

other state and federal requirements related to the staffing of nursing facilities, shall maintain direct-care, flexible staff-scheduling staffing levels based on an overall four and one-tenth (4.1) hours per day per occupied bed.

4. The Board shall promulgate rules for shift-based, staff-to-resident ratios for noncompliant facilities denoting the incremental increases reflected in direct-care, flexible staff-scheduling staffing levels.

5. In the event that the state Medicaid program reimbursement rate for facilities subject to the Nursing Home Care Act, and intermediate care facilities for the mentally retarded having seventeen or more beds is reduced below actual audited costs, the requirements for staffing ratio levels shall be adjusted to the appropriate levels provided in paragraphs 1 through 4 of this subsection.

G. For purposes of this subsection:

1. "Direct-care staff" means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility; ~~and~~

2. Prior to September 1, 2003, activity and social services staff who are not providing direct, hands-on care to residents may be included in the direct-care-staff-to-resident ratio in any shift. On and after September 1, 2003, such persons shall not be included

in the direct-care-staff-to-resident ratio, regardless of their licensure or certification status; and

3. The administrator shall not be counted in the direct-care-staff-to-resident ratio regardless of the administrator's licensure or certification status.

H. 1. The Oklahoma Health Care Authority shall require all nursing facilities subject to the provisions of the Nursing Home Care Act and intermediate care facilities for the mentally retarded with seventeen or more beds to submit a monthly report on staffing ratios on a form that the Authority shall develop.

2. The report shall document the extent to which such facilities are meeting or are failing to meet the minimum direct-care-staff-to-resident ratios specified by this section. Such report shall be available to the public upon request.

3. The Authority may assess administrative penalties for the failure of any facility to submit the report as required by the Authority. Provided, however:

a. administrative penalties shall not accrue until the Authority notifies the facility in writing that the report was not timely submitted as required, and

b. a minimum of a one-day penalty shall be assessed in all instances.

4. Administrative penalties shall not be assessed for computational errors made in preparing the report.

5. Monies collected from administrative penalties shall be deposited in the Nursing Facility Quality of Care Fund and utilized for the purposes specified in the Oklahoma Healthcare Initiative Act.

I. 1. All entities regulated by this state that provide long-term care services shall utilize a single assessment tool to determine client services needs. The tool shall be developed by the Oklahoma Health Care Authority in consultation with the State Department of Health.

2. a. The Oklahoma Nursing Facility Funding Advisory Committee is hereby created and shall consist of the following:

(1) four members selected by the Oklahoma Association of Health Care Providers,

(2) three members selected by the Oklahoma Association of Homes and Services for the Aging, and

(3) two members selected by the State Council on Aging.

The Chair shall be elected by the committee. No state employees may be appointed to serve.

b. The purpose of the advisory committee will be to develop a new methodology for calculating state Medicaid program reimbursements to nursing facilities

by implementing facility-specific rates based on expenditures relating to direct care staffing. No nursing home will receive less than the current rate at the time of implementation of facility-specific rates pursuant to this subparagraph.

c. The advisory committee shall be staffed and advised by the Oklahoma Health Care Authority.

d. The new methodology will be submitted for approval to the Board of the Oklahoma Health Care Authority by January 15, 2005, and shall be finalized by July 1, 2005. The new methodology will apply only to new funds that become available for Medicaid nursing facility reimbursement after the methodology of this paragraph has been finalized. Existing funds paid to nursing homes will not be subject to the methodology of this paragraph. The methodology as outlined in this paragraph will only be applied to any new funding for nursing facilities appropriated above and beyond the funding amounts effective on January 15, 2005.

e. The new methodology shall divide the payment into two components:

(1) direct care which includes allowable costs for registered nurses, licensed practical nurses, certified medication aides and certified nurse

aides. The direct care component of the rate shall be a facility-specific rate, directly related to each facility's actual expenditures on direct care, and

(2) other costs.

f. The Oklahoma Health Care Authority, in calculating the base year prospective direct care rate component, shall use the following criteria:

(1) to construct an array of facility per diem allowable expenditures on direct care, the Authority shall use the most recent data available. The limit on this array shall be no less than the ninetieth percentile,

(2) each facility's direct care base-year component of the rate shall be the lesser of the facility's allowable expenditures on direct care or the limit,

(3) other rate components shall be determined by the Oklahoma Nursing Facility Funding Advisory Committee in accordance with federal regulations and requirements, ~~and~~

(4) ~~rate components in divisions (2) and (3) of this subparagraph shall be re-based and adjusted for~~

~~inflation when additional funds are made available~~

(a) If, at any time, reimbursement rates are determined to be below ninety-five percent (95%) of statewide average cost as determined by the most recently available audited cost reports, after adjustment for inflation, the Authority shall restore rates to a level in excess of such amount. The required incremental increase shall be no less than the Consumer Price Index – Medical for the relevant year; provided, at no time shall the reimbursement rate be increased to a level which would exceed one hundred percent (100%) of the upper payment limit established by the Medicare rate equivalent established by the federal Centers for Medicare and Medicaid Services (CMS).

(b) Effective July 1, 2019, the Authority shall calculate the upper payment limit under the authority of CMS utilizing the Medicare equivalent payment rate, and

(5) if Medicaid payment rates to providers are adjusted, nursing home rates and Intermediate

Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) rates shall not be adjusted less favorably than the average percentage-rate reduction or increase applicable to the majority of other provider groups.

g. (1) Effective July 1, 2019, if new funding is appropriated for a rate increase, a new average rate for nursing facilities shall be established. The rate shall be equal to the statewide average cost as derived from audited cost reports for SFY 2018, ending June 30, 2018, after adjustment for inflation. After such new average rate has been established, the facility specific reimbursement rate shall be as follows:

(a) amounts up to the existing base rate amount shall continue to be distributed as a part of the base rate in accordance with the existing State Plan, and

(b) to the extent the new rate exceeds the rate effective before the effective date of this act, fifty percent (50%) of the resulting increase on July 1, 2019, shall be allocated toward an increase of the existing base reimbursement rate and distributed

accordingly. The remaining fifty percent (50%) of the increase shall be allocated in accordance with the currently approved 70/30 reimbursement rate methodology as outlined in the existing State Plan.

(2) Any subsequent rate increases, as determined based on the provisions set forth in this subparagraph, shall be allocated in accordance with the currently approved 70/30 reimbursement rate methodology. The rate shall not exceed the upper payment limit established by the Medicare rate equivalent established by the federal CMS.

h. Effective January 1, 2021, and annually thereafter, under the currently approved methodology, a new rate shall be established based on the audited cost reports for SFY 2020, ending June 30, 2020.

i. Subsequent rate changes shall occur each January 1 utilizing the most currently filed audited cost reports from the preceding fiscal year, adjusted for inflation.

j. Effective July 1, 2019, in coordination with the rate adjustments identified in the preceding section, a portion of the funds shall be utilized as follows:

(1) effective July 1, 2019, The Oklahoma Health Care Authority shall increase the personal needs allowance for residents of nursing homes and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) from Fifty Dollars ($50.00) per month to Seventy-five Dollars ($75.00) per month per resident. The increase shall be funded by Medicaid nursing home providers, by way of a reduction of eighty-two cents ($0.82) per day deducted from the base rate, and

(2) effective January 1, 2020, all clinical employees working in a licensed nursing facility shall be required to receive at least four (4) hours annually of Alzheimer's or Dementia training, to be provided and paid for by the facilities.

3. The Department of Human Services shall expand its statewide toll-free, Senior-Info Line for senior citizen services to include assistance with or information on long-term care services in this state.

4. The Oklahoma Health Care Authority shall develop a nursing facility cost-reporting system that reflects the most current costs experienced by nursing and specialized facilities. The Oklahoma

Health Care Authority shall utilize the most current cost report data to estimate costs in determining daily per diem rates.

5. The Oklahoma Health Care Authority shall provide access to the detailed Medicaid payment audit adjustments and implement an appeal process for disputed payment audit adjustments. Additionally, the Oklahoma Health Care Authority shall make sufficient revisions to the nursing facility cost reporting forms and electronic data input system so as to clarify what expenses are allowable and appropriate for inclusion in cost calculations.

J. 1. When the state Medicaid program reimbursement rate reflects the sum of Ninety-four Dollars and eleven cents ($94.11), plus the increases in actual audited costs, over and above the actual audited costs reflected in the cost reports submitted for the most current cost-reporting period, and the direct-care, flexible staff-scheduling staffing level has been prospectively funding at four and one-tenth (4.1) hours per day per occupied bed, the Authority may apportion funds for the implementation of the provisions of this section.

2. The Authority shall make application to the United States Centers for Medicare and Medicaid Service for a waiver of the uniform requirement on health-care-related taxes as permitted by Section 433.72 of 42 C.F.R.

3. Upon approval of the waiver, the Authority shall develop a program to implement the provisions of the waiver as it relates to all nursing facilities.

SECTION 4. This act shall become effective July 1, 2019.

SECTION 5. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

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