

1 STATE OF OKLAHOMA

2 2nd Session of the 56th Legislature (2018)

3 COMMITTEE SUBSTITUTE
4 FOR

5 HOUSE BILL NO. 2958

By: Thomsen

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8 COMMITTEE SUBSTITUTE

9 An Act relating to public health and safety; amending
10 63 O.S. 2011, Section 1-1925.2, which relates to
11 certain reimbursements from the Nursing Facility
12 Quality of Care Fund; removing Oklahoma Nursing
13 Facility Funding Advisory Committee; removing certain
14 methodology for certain calculation to nursing
15 facilities; requiring Oklahoma Health Care Authority
16 to implement case-mix-adjusted payment to nursing
17 facilities based on certain components; requiring
18 Authority to renew funding levels annually; and
19 providing an effective date.

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

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

25 Section 1-1925.2 A. The Oklahoma Health Care Authority shall
26 fully recalculate and reimburse nursing facilities and intermediate
27 care facilities for the mentally retarded (ICFs/MR) from the Nursing
28 Facility Quality of Care Fund beginning October 1, 2000, the average
29 actual, audited costs reflected in previously submitted cost reports

1 for the cost-reporting period that began July 1, 1998, and ended
2 June 30, 1999, inflated by the federally published inflationary
3 factors for the two (2) years appropriate to reflect present-day
4 costs at the midpoint of the July 1, 2000, through June 30, 2001,
5 rate year.

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

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

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

- 18 a. from 7:00 a.m. to 3:00 p.m., one direct-care staff to
19 every eight residents, or major fraction thereof,
- 20 b. from 3:00 p.m. to 11:00 p.m., one direct-care staff to
21 every twelve residents, or major fraction thereof, and
- 22 c. from 11:00 p.m. to 7:00 a.m., one direct-care staff to
23 every seventeen residents, or major fraction thereof.

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

- 7 a. from 7:00 a.m. to 3:00 p.m., one direct-care staff to
8 every seven residents, or major fraction thereof,
- 9 b. from 3:00 p.m. to 11:00 p.m., one direct-care staff to
10 every ten residents, or major fraction thereof, and
- 11 c. from 11:00 p.m. to 7:00 a.m., one direct-care staff to
12 every seventeen residents, or major fraction thereof.

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

- 20 a. from 7:00 a.m. to 3:00 p.m., one direct-care staff to
21 every six residents, or major fraction thereof,
- 22 b. from 3:00 p.m. to 11:00 p.m., one direct-care staff to
23 every eight residents, or major fraction thereof, and

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

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

7 5. a. On and after January 1, 2004, a facility that has been
8 determined by the State Department of Health to have
9 been in compliance with the provisions of paragraph 3
10 of this subsection since the implementation date of
11 this subsection, may implement flexible staff
12 scheduling; provided, however, such facility shall
13 continue to maintain a direct-care service rate of at
14 least two and eighty-six one-hundredths (2.86) hours
15 of direct-care service per resident per day.

16 b. At no time shall direct-care staffing ratios in a
17 facility with flexible staff-scheduling privileges
18 fall below one direct-care staff to every sixteen
19 residents, and at least two direct-care staff shall be
20 on duty and awake at all times.

21 c. As used in this paragraph, "flexible staff-scheduling"
22 means maintaining:

23 (1) a direct-care-staff-to-resident ratio based on
24 overall hours of direct-care service per resident

per day rate of not less than two and eighty-six
one-hundredths (2.86) hours per day,

(2) a direct-care-staff-to-resident ratio of at least
one direct-care staff person on duty to every
sixteen residents 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,

(3) a complaint and/or survey investigation that has
determined substandard quality of care, or

(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

1 minimum of three (3) months before being considered
2 eligible to implement flexible staff scheduling as
3 defined in subparagraph c of paragraph 5 of this
4 subsection.

5 c. Upon a subsequent determination by the Department that
6 the facility has achieved and maintained for at least
7 three (3) months the shift-based, staff-to-resident
8 ratios described in paragraph 3 of this subsection,
9 and has corrected any deficiency described in
10 subparagraph a of this paragraph, the Department shall
11 notify the facility of its eligibility to implement
12 flexible staff-scheduling privileges.

13 7. a. For facilities that have been granted flexible staff-
14 scheduling privileges, the Department shall monitor
15 and evaluate facility compliance with the flexible
16 staff-scheduling staffing provisions of paragraph 5 of
17 this subsection through reviews of monthly staffing
18 reports, results of complaint investigations and
19 inspections.

20 b. If the Department identifies any quality-of-care
21 problems related to insufficient staffing in such
22 facility, the Department shall issue a directed plan
23 of correction to the facility found to be out of
24 compliance with the provisions of this subsection.

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

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

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

12 (3) the third determination within a two-year period
13 shall require that shift-based, staff-to-resident
14 ratios be maintained for a minimum period of
15 twelve (12) months.

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

19 D. The State Board of Health shall promulgate rules prescribing
20 staffing requirements for intermediate care facilities for the
21 mentally retarded serving six or fewer clients and for intermediate
22 care facilities for the mentally retarded serving sixteen or fewer
23 clients.

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

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

20 2. When the state Medicaid program reimbursement rate reflects
21 the sum of Ninety-four Dollars and eleven cents (\$94.11), plus the
22 increases in actual audited costs over and above the actual audited
23 costs reflected in the cost reports submitted for the most current
24 cost-reporting period and the costs estimated by the Oklahoma Health

1 Care Authority to increase the direct-care flexible staff-scheduling
2 staffing level from three and two-tenths (3.2) hours per day per
3 occupied bed to three and eight-tenths (3.8) hours per day per
4 occupied bed, all nursing facilities subject to the provisions of
5 the Nursing Home Care Act and intermediate care facilities for the
6 mentally retarded with seventeen or more beds, in addition to other
7 state and federal requirements related to the staffing of nursing
8 facilities, shall maintain direct-care, flexible staff-scheduling
9 staffing levels based on an overall three and eight-tenths (3.8)
10 hours per day per occupied bed.

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

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1 scheduling staffing levels based on an overall four and one-tenth
2 (4.1) hours per day per occupied bed.

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

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

14 G. For purposes of this subsection:

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

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

23 H. 1. The Oklahoma Health Care Authority shall require all
24 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

1 Oklahoma Health Care Authority in consultation with the State
2 Department of Health.

3 2. a. ~~The Oklahoma Nursing Facility Funding Advisory~~

4 ~~Committee is hereby created and shall consist of the~~
5 ~~following:~~

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

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

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

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

15 b. ~~The purpose of the advisory committee will be to~~
16 ~~develop a new methodology for calculating state~~
17 ~~Medicaid program reimbursements to nursing facilities~~
18 ~~by implementing facility-specific rates based on~~
19 ~~expenditures relating to direct care staffing. No~~
20 ~~nursing home will receive less than the current rate~~
21 ~~at the time of implementation of facility-specific~~
22 ~~rates pursuant to this subparagraph.~~

23 c. ~~The advisory committee shall be staffed and advised by~~
24 ~~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.~~

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

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

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

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

17 ~~(4) rate components in divisions (2) and (3) of this~~
18 ~~subparagraph shall be re-based and adjusted for~~
19 ~~inflation when additional funds are made~~
20 ~~available.~~

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

1 4. 3. The Oklahoma Health Care Authority shall develop a
2 nursing facility cost-reporting system that reflects the most
3 current costs experienced by nursing and specialized facilities.
4 ~~The Oklahoma Health Care Authority shall utilize the most current~~
5 ~~cost report data to estimate costs in determining daily per diem~~
6 ~~rates.~~ The Oklahoma Health Care Authority shall implement a case-
7 mix-adjusted payment methodology. The case-mix-adjusted payment
8 methodology shall include reimbursement components for each of the
9 following categories: direct care component, indirect care and
10 administrative component, capital component and pass-through-cost
11 component.

12 a. The direct care component shall include direct care
13 labor and benefits, direct care contract labor and
14 consultant costs (to include but not be limited to
15 medical directors, direct care training, drug and
16 medical supplies, food and supplements). Direct care
17 costs shall be reimbursed at actual audited costs
18 using acuity-based case-mix weighting not including
19 Medicare acuity. Provided, direct care reimbursement
20 shall be limited to one hundred ten percent (110%) of
21 the median of Medicaid direct care costs of all
22 licensed facilities and is subject to a floor of
23 direct care cost plus ten percent (10%) of the ceiling
24 of Medicaid direct care costs of all facilities.

1 b. The indirect care and administrative component costs
2 shall be reimbursed at one hundred ten percent (110%)
3 of the median cost of all licensed facilities and paid
4 as a class rate to all Medicaid contracted facilities.

5 c. Capital component costs for rent, interest and
6 depreciation shall be reimbursed under a fair-market-
7 value reimbursement methodology. Fair market value
8 shall be reimbursed based on depreciated replacement
9 cost as established by an independent appraisal to
10 determine the fair market rental rate.

11 d. Pass through components shall include, but not be
12 limited to, Quality of Care fees, property taxes,
13 property insurance, and professional and general
14 liability insurance with a limit up to the 90th
15 percentile of all facilities' liability insurance
16 premium cost.

17 The Oklahoma Health Care Authority shall annually review the
18 funding levels established by this subsection to confirm they
19 adequately and appropriately meet the intended purposes of
20 implementation; provided, beginning on July 1, 2021, any increases
21 in this reimbursement methodology shall not exceed the Consumer
22 Price Index for Medical Care plus one percent (1%).

23 J. 1. When the state Medicaid program reimbursement rate
24 reflects the sum of Ninety-four Dollars and eleven cents (\$94.11),

1 plus the increases in actual audited costs, over and above the
2 actual audited costs reflected in the cost reports submitted for the
3 most current cost-reporting period, and the direct-care, flexible
4 staff-scheduling staffing level has been prospectively funding at
5 four and one-tenth (4.1) hours per day per occupied bed, the
6 Authority may apportion funds for the implementation of the
7 provisions of this section.

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

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

15 SECTION 2. This act shall become effective November 1, 2018.

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