

1 STATE OF OKLAHOMA

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

3 COMMITTEE SUBSTITUTE

4 FOR ENGROSSED

HOUSE BILL 2958

By: Thomsen of the House

5 and

6 Paxton of the Senate

7
8
9 COMMITTEE SUBSTITUTE

10 [public health and safety - requiring Oklahoma
11 Health Care Authority to implement case-mix-adjusted
12 payment to nursing facilities - effective date]
13

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

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

17 Section 1-1925.2. A. The Oklahoma Health Care Authority shall
18 fully recalculate and reimburse nursing facilities and intermediate
19 care facilities for the mentally retarded (ICFs/MR) from the Nursing
20 Facility Quality of Care Fund beginning October 1, 2000, the average
21 actual, audited costs reflected in previously submitted cost reports
22 for the cost-reporting period that began July 1, 1998, and ended
23 June 30, 1999, inflated by the federally published inflationary
24 factors for the two (2) years appropriate to reflect present-day

1 costs at the midpoint of the July 1, 2000, through June 30, 2001,
2 rate year.

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

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

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

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

21 2. From September 1, 2001, through August 31, 2003, nursing
22 facilities subject to the Nursing Home Care Act and intermediate
23 care facilities for the mentally retarded with seventeen or more
24 beds shall maintain, in addition to other state and federal

1 requirements related to the staffing of nursing facilities, the
2 following minimum direct-care-staff-to-resident ratios:

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

9 3. On and after ~~September 1, 2003, subject to the availability~~
10 ~~of funds~~ January 1, 2020, nursing facilities subject to the Nursing
11 Home Care Act and intermediate care facilities for the mentally
12 retarded with seventeen or more beds shall maintain, in addition to
13 other state and federal requirements related to the staffing of
14 nursing facilities, the following minimum direct-care-staff-to-
15 resident ratios:

- 16 a. from 7:00 a.m. to 3:00 p.m., one direct-care staff to
17 every six residents, or major fraction thereof,
- 18 b. from 3:00 p.m. to 11:00 p.m., one direct-care staff to
19 every eight residents, or major fraction thereof, and
- 20 c. from 11:00 p.m. to 7:00 a.m., one direct-care staff to
21 every fifteen residents, or major fraction thereof.

- 22 4. a. Effective immediately, facilities shall have the
23 option of varying the starting times for the eight-
24 hour shifts by one (1) hour before or one (1) hour

1 after the times designated in this section without
2 overlapping shifts.

3 b. the administrator shall not be counted in the direct-
4 care-staff-to-resident ratio regardless of his or her
5 licensure or certification status.

6 5. a. On and after January 1, ~~2004~~ 2021, a facility that has
7 been determined by the State Department of Health to
8 have been in compliance with the provisions of
9 paragraph 3 of this subsection since the
10 implementation date of this subsection, may implement
11 flexible staff scheduling; provided, however, such
12 facility shall continue to maintain a direct-care
13 service rate of at least two and eighty-six one-
14 hundredths (2.86) hours of direct-care service per
15 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.
24

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-

24

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~~ implement a case-mix-adjusted payment methodology.

7 a. No later than January 1, 2019, the Oklahoma Health
8 Care Authority shall implement a direct care focused
9 payment methodology. The methodology shall be
10 implemented in accordance with the provisions of this
11 paragraph. For the purpose of this paragraph, terms
12 as used herein shall have the following definitions
13 and the identified methodologies shall follow the
14 procedures and utilize the information as identified:

15 (1) "direct care component cost" shall consist of two
16 (2) subcomponents: direct care labor costs and
17 care related costs. "Direct care labor costs"
18 shall be defined as and include all wages,
19 benefits, contract labor and related costs for
20 direct care staff as that term is currently
21 defined in 63 O.S. Section 1-1925(G) subject to
22 case mix adjustment as defined in division 2 of
23 this subparagraph. "Care related costs" shall be
24 defined as and include nursing training, nursing

1 and pharmacy consulting, medical director costs,
2 food, supplements, drugs, medical supplies and
3 incontinence supplies,

4 (2) "case mix adjustment" shall be defined as the
5 acuity adjustment for all residents using
6 weighted average RUGS 66 nursing case mix data to
7 be calculated not less often than annually,

8 (3) "direct care component rate" shall be defined as
9 one hundred ten percent (110%) of the acuity-
10 adjusted and inflation adjusted median per diem
11 cost of the direct care components cost for all
12 facilities,

13 (4) "direct care component floor" shall be defined
14 and established as ninety percent (90%) of the
15 direct care component rate,

16 (5) "indirect care and administrative component
17 costs" shall be defined as all other inflation
18 adjusted allowable costs not identified as direct
19 care component costs, capital component costs or
20 quality of care fee costs,

21 (6) "capital component" shall consist of two
22 subcomponents: fair market rental and cost of
23 ownership. "Fair market rental" shall be defined
24 as the fair market rental value of the utilized

facility, assuming seventy-five percent (75%)
occupancy, irrespective of actual cost or lease
payments on land, buildings, fixed equipment and
major movable equipment used in providing
resident care. "Cost of ownership" shall be
defined as the actual cost of property taxes and
insurance premiums for property, general and
professional liability insurance; provided,
allowable professional liability insurance
premiums shall be limited to the ninetieth
percentile of premium expenses reported for all
facilities carrying coverage,

(7) "statewide per bed valuation (PBV)" shall be
defined as the current cost of constructing and
equipping one nursing facility bed based upon
average construction cost of recently constructed
facilities. The PBV shall be adjusted for
inflation annually to reflect changes in
construction costs as indicated per the Marshall
Valuation Service, or the R.S. Means Building
Construction Cost Data, or other comparable
service. The PBV shall be rebased every five (5)
years to reflect the actual current average cost

of constructing and equipping recently
constructed facilities,

(8) "current asset value (CAV)" of a facility shall
be defined as value calculated by multiplying the
number of beds in a facility by the PBV less an
aging index of one percent (1%)for each year, or
partial year of age, not to exceed a fifty
percent (50%) reduction in PBV. The CAV of a
facility shall be recalculated and an appropriate
adjustment to the per diem shall be made when
additional beds are placed in operation.
Additionally, the CAV of a facility shall be
adjusted in the event of any major renovations
made to an existing facility which would impact
and therefore reduce the facility's aging index.
The initial age of each nursing facility
participating in the Medicaid program shall be
derived based on a statewide survey to determine
each facility's year of construction and date of
entry into the Medicaid program. The age shall
be reduced for replacements, renovations and
additions which have occurred since the facility
was built. These changes shall be utilized in
calculating the age of the facility. Facilities

1 who do not submit a completed survey shall be
2 assigned the oldest maximum age,

3 (9) facility rental factor as used in calculating
4 fair market rental shall be two and five tenths
5 percent (2.5%),

6 (10) return on equity as utilized in establishing
7 equity for purpose of fair market rental shall be
8 calculated by multiplying the CAV of a facility by
9 the sum of the June 30th, thirty-year U.S.
10 Treasury Bond Yield plus a risk premium of one and
11 five tenths percent (1.5%),

12 (11) capital component multiplier shall consist of the
13 facility rental factor plus the return on equity,
14 and

15 (12) inflation indicators shall be calculated annually
16 based upon the economic indicators published by
17 Global Insight for the Department of Health and
18 Human Services. Inflation indicators are derived
19 from the Market Basket Index of Operating Costs -
20 Skilled Nursing Facility, which is published
21 quarterly. The inflation index for a rate period
22 is the Global Insight Index for the twelve-month
23 period ending on the most recent calendar quarter
24

1 for which the index has been published prior to
2 rate setting.

3 b. No later than January 1, 2019, the Oklahoma Health
4 Care Authority shall implement a direct care focused
5 payment methodology which includes reimbursement
6 components for each of the following categories:
7 direct care component, indirect care and
8 administrative component, capital component, quality
9 of care fee component and Focus on Excellence. With
10 respect to the component reimbursements identified,
11 the following methodologies and procedures shall be
12 utilized:

13 (1) in determining the direct care component rate, a
14 direct care component floor shall be established.
15 All facilities whose inflation adjusted direct
16 care labor plus inflation adjusted care related
17 costs are above the direct care component floor
18 shall receive the direct care component rate.
19 All facilities whose inflation adjusted direct
20 care labor plus inflation adjusted care related
21 costs are below the direct care component floor
22 shall receive actual facility specific allowable
23 direct care component cost plus ten percent (10%)
24 of the direct care component rate,

- 1 (2) in determining the indirect care and
2 administrative component costs, all facilities
3 shall be reimbursed at one hundred ten percent
4 (110%) of the inflated median indirect and
5 administrative costs of all Medicaid facilities
6 and paid as a class per-diem rate to all Medicaid
7 contracted facilities,
- 8 (3) in determining the capital component, all
9 facilities shall be reimbursed at a rate which
10 combines the fair market rental plus the cost of
11 ownership. The capital component shall be
12 determined by multiplying a facility's licensed
13 beds by the per bed value (PBV), then adjusted by
14 the facility's age factor to determine the
15 current asset value (CAV). The age-adjusted CAV
16 is then multiplied by the capital component
17 multiplier to determine the gross fair rental
18 component. The allowable costs of ownership are
19 added to the gross fair rental component, then
20 the total divided by the greater of the
21 facility's actual census days or their equivalent
22 days at minimum occupancy to determine the
23 facility's capital component per diem,
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1 (4) in determining the quality of care fee component,
2 all facilities shall be reimbursed at actual per-
3 day cost of the quality of care fee,
4 (5) in determining reimbursement with respect to
5 Focus on Excellence, the Focus on Excellence
6 methodologies currently utilized shall continue
7 and reimbursement amounts shall represent an add-
8 on to combined per diem rate of the direct care
9 component, indirect care and administrative
10 component, capital component, and quality of care
11 fee component, and
12 (6) in addition to the reimbursement rates
13 established in this paragraph, nursing facility
14 services for residents receiving care for
15 Acquired Immune Deficiency Syndrome (AIDS),
16 ventilator-dependent residents and any other
17 categories identified as high intensity services
18 shall be paid an additional add-on or enhanced
19 rates, to be determined by the Oklahoma Health
20 Care Authority, as reasonable compensation
21 representing the additional cost of providing
22 these services.

1 c. The Oklahoma Health Care Authority shall revise and
2 amend facility cost report forms to reflect and comply
3 with the provisions of this paragraph.

4 J. 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
7 actual audited costs reflected in the cost reports submitted for the
8 most current cost-reporting period, and the direct-care, flexible
9 staff-scheduling staffing level has been prospectively funding at
10 four and one-tenth (4.1) hours per day per occupied bed, the
11 Authority may apportion funds for the implementation of the
12 provisions of this section.

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

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

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

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