

1 ENGROSSED SENATE  
2 BILL NO. 280

By: Simpson of the Senate

3 and

4 McEntire of the House

5  
6 [ long-term care - nursing facility incentive  
7 reimbursement rate plan - reimbursements from Nursing  
8 Facility Quality of Care Fund - - ~~effective date -~~  
9 ~~emergency~~ ]

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

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

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

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

23 ~~2. Quality of care indicators;~~

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

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

2       ~~5. Employee satisfaction survey results;~~

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

4       ~~7. Patient acuity level;~~

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

8       ~~9. Other incentives which include, without limitation,~~  
9 ~~participation in quality initiative activities performed and/or~~  
10 ~~recommended by the Oklahoma Foundation for Medical Quality in~~  
11 ~~capital improvements, in service education of direct staff, and~~  
12 ~~procurement of reasonable amounts of liability insurance~~ focused on  
13 improving resident outcomes and resident quality of life.

14       2. Under the current rate methodology, the Authority shall  
15 reserve Five Dollars (\$5.00) per patient day designated for the  
16 quality assurance component that nursing facilities can earn for  
17 improvement or performance achievement of resident-centered outcomes  
18 metrics. To fund the quality assurance component, Two Dollars  
19 (\$2.00) shall be deducted from each nursing facility's per diem  
20 rate, and matched with Three Dollars (\$3.00) per day funded by the  
21 Authority. Payments to nursing facilities that achieve specific  
22 metrics shall be treated as an "add back" to their net reimbursement  
23 per diem. Dollar values assigned to each metric shall be determined

1 so that an average of the Five Dollars (\$5.00) quality incentive is  
2 made to qualifying nursing facilities.

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

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

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

17 6. The Authority shall establish an advisory group with  
18 consumer, provider and state agency representation to recommend  
19 quality measures to be included in the pay-for-performance program  
20 and to provide feedback on program performance and recommendations  
21 for improvement. The quality measures shall be reviewed annually  
22 and subject to change every four (4) years through the agency's  
23 promulgation of rules. The Authority shall insure adherence to the  
24 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

1 shall be exempt from this fee. Quality of care enhancements  
2 include, but are not limited to, the purposes specified in this  
3 section.

4 B. As a basis for determining the Nursing Facilities Quality of  
5 Care Fee assessed upon each licensed nursing facility, the Authority  
6 shall calculate a uniform per-patient day rate. The rate shall be  
7 calculated by dividing six percent (6%) of the total annual patient  
8 gross receipts of all licensed nursing facilities in this state by  
9 the total number of patient days for all licensed nursing facilities  
10 in this state. The result shall be the per-patient day rate.  
11 Beginning July 15, 2004, the Nursing Facilities Quality of Care Fee  
12 shall not be increased unless specifically authorized by the  
13 Legislature.

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

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

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

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

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

- 13 a. using the daily patient census and patient gross  
14 receipts reports received by the Authority for the  
15 most recent available twelve (12) months, and
- 16 b. annualizing those figures.

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

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

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

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

- 6 a. all monies received by the Authority pursuant to this  
7 section and otherwise specified or authorized by law,
- 8 b. monies received by the Authority due to federal  
9 financial participation pursuant to Title XIX of the  
10 Social Security Act, and
- 11 c. interest attributable to investment of money in the  
12 fund.

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

- 16 a. reimbursement of the additional costs paid to  
17 Medicaid-certified nursing facilities for purposes  
18 specified by Sections 1-1925.2, 5022.1 and 5022.2 of  
19 Title 63 of the Oklahoma Statutes,
- 20 b. reimbursement of the Medicaid rate increases for  
21 ~~intermediate care facilities for the mentally retarded~~  
22 ~~(ICFs/MR)~~ Intermediate Care Facilities for Individuals  
23 with Intellectual Disabilities (ICFs/IID),  
24



- 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

1                    Disabilities (ICFs/IID) from Thirty Dollars (\$30.00)  
2                    to Fifty Dollars (\$50.00) per month per resident.

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

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

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

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

23           8.    No nursing facility shall be guaranteed, expressly or  
24   otherwise, that any additional costs reimbursed to the facility will

1 equal or exceed the amount of the Nursing Facilities Quality of Care  
2 Fee paid by the nursing facility.

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

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

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

21 J. 1. If any provision of this section or the application  
22 thereof shall be adjudged to be invalid by any court of last resort,  
23 such judgment shall not affect, impair or invalidate the provisions  
24 of the section, but shall be confined in its operation to the

1 provision thereof directly involved in the controversy in which such  
2 judgment was rendered. The applicability of such provision to other  
3 persons or circumstances shall not be affected thereby.

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

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

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

- 15 1. Submit the Quality of Care Fee;
- 16 2. Submit the fee in a timely manner;
- 17 3. Submit reports as required by this section; or
- 18 4. Submit reports timely.

19 M. As used in this section:

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

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

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

9        4. "Additional costs paid to Medicaid-certified nursing  
10 facilities under Oklahoma's Medicaid reimbursement methodology"  
11 means both state and federal Medicaid expenditures including, but  
12 not limited to, funds in excess of the aggregate amounts that would  
13 otherwise have been paid to Medicaid-certified nursing facilities  
14 under the Medicaid reimbursement methodology which have been updated  
15 for inflationary, economic, and regulatory trends and which are in  
16 effect immediately prior to the inception of the Nursing Facilities  
17 Quality of Care Fee.

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

23        2. Any facilities that made application to the State Department  
24 of Health to become a licensed continuum of care facility no later

1 than January 1, 2012, shall be assessed at the same rate as those  
2 facilities assessed pursuant to paragraph 1 of this subsection;  
3 provided, that any facility making ~~said~~ the application shall  
4 receive the license on or before September 1, 2012. Any facility  
5 that fails to receive such license from the State Department of  
6 Health by September 1, 2012, shall be assessed at the rate  
7 established by subsection C of this section subsequent to September  
8 1, 2012.

9 O. If any provision of this section, or the application  
10 thereof, is determined by any controlling federal agency, or any  
11 court of last resort to prevent the state from obtaining federal  
12 financial participation in the state's Medicaid program, such  
13 provision shall be deemed null and void as of the date of the  
14 nonavailability of such federal funding and through and during any  
15 period of nonavailability. All other provisions of the bill shall  
16 remain valid and enforceable.

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

19 Section 1-1925.2. A. The Oklahoma Health Care Authority shall  
20 fully recalculate and reimburse nursing facilities and ~~intermediate~~  
21 ~~care facilities for the mentally retarded (ICFs/MR)~~ Intermediate  
22 Care Facilities for Individuals with Intellectual Disabilities  
23 (ICFs/IID) from the Nursing Facility Quality of Care Fund beginning  
24 October 1, 2000, the average actual, audited costs reflected in

1 previously submitted cost reports for the cost-reporting period that  
2 began July 1, 1998, and ended June 30, 1999, inflated by the  
3 federally published inflationary factors for the two (2) years  
4 appropriate to reflect present-day costs at the midpoint of the July  
5 1, 2000, through June 30, 2001, 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 Intermediate Care Facilities for Individuals with Intellectual  
12 Disabilities (ICFs/IID).

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

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

- 20 a. from 7:00 a.m. to 3:00 p.m., one direct-care staff to  
21 every eight residents, or major fraction thereof,
- 22 b. from 3:00 p.m. to 11:00 p.m., one direct-care staff to  
23 every twelve residents, or major fraction thereof, and  
24

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

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

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

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

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

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

22          a.     from 7:00 a.m. to 3:00 p.m., one direct-care staff to  
23                every six residents, or major fraction thereof,  
24



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

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

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

9           5.     a.     On and after January 1, ~~2004~~ 2020, a facility ~~that has~~  
10                 ~~been determined by the State Department of Health to~~  
11                 ~~have been in compliance with the provisions of~~  
12                 ~~paragraph 3 of this subsection since the~~  
13                 ~~implementation date of this subsection,~~ may implement  
14                 ~~flexible~~ twenty-four (24) hour-based staff scheduling;  
15                 provided, however, such facility shall continue to  
16                 maintain a direct-care service rate of at least ~~two~~  
17                 ~~and eighty-six one hundredths (2.86)~~ two and nine  
18                 tenths (2.9) hours of direct-care service per resident  
19                 per day, the same to be calculated based on average  
20                 direct care staff maintained over a twenty-four (24)  
21                 hour period.

22           b.     At no time shall direct-care staffing ratios in a  
23                 facility with ~~flexible~~ twenty-four (24) hour-based  
24                 staff-scheduling privileges fall below one direct-care

1 staff to every ~~sixteen~~ fifteen residents or major  
2 fraction thereof, and at least two direct-care staff  
3 shall be on duty and awake at all times.

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

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

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

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

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

22 (1) the provisions of paragraph 3 of this subsection,  
23 (2) fraudulent reporting of staffing on the Quality  
24 of Care Report, or

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

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

7 b. The Department shall require a facility described in  
8 subparagraph a of this paragraph to achieve and  
9 maintain the shift-based, staff-to-resident ratios  
10 provided in paragraph 3 of this subsection for a  
11 minimum of three (3) months before being considered  
12 eligible to implement ~~flexible~~ twenty-hour (24) based  
13 staff scheduling as defined in subparagraph c of  
14 paragraph 5 of this subsection.

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

- 1        7.    a.    For facilities that ~~have been granted flexible~~ utilize  
2                    twenty-four (24) hour based staff-scheduling  
3                    privileges, the Department shall monitor and evaluate  
4                    facility compliance with the ~~flexible~~ twenty-four (24)  
5                    hour based staff-scheduling staffing provisions of  
6                    paragraph 5 of this subsection through reviews of  
7                    monthly staffing reports, results of complaint  
8                    investigations and inspections.
- 9        b.    If the Department identifies any quality-of-care  
10                   problems related to insufficient staffing in such  
11                   facility, the Department shall issue a directed plan  
12                   of correction to the facility found to be out of  
13                   compliance with the provisions of this subsection.
- 14       c.    In a directed plan of correction, the Department shall  
15                   require a facility described in subparagraph b of this  
16                   paragraph to maintain shift-based, staff-to-resident  
17                   ratios for the following periods of time:
- 18                   (1)   the first determination shall require that shift-  
19                   based, staff-to-resident ratios be maintained  
20                   until full compliance is achieved,
- 21                   (2)   the second determination within a two-year period  
22                   shall require that shift-based, staff-to-resident  
23                   ratios be maintained for a minimum period of ~~six~~  
24                   ~~+6+~~ twelve (12) months, and

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

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

10          D. The State ~~Board~~ Commissioner of Health shall promulgate  
11 rules prescribing staffing requirements for intermediate care  
12 facilities for the mentally retarded serving six or fewer clients  
13 and for intermediate care facilities for the mentally retarded  
14 serving sixteen or fewer clients.

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

18          F. 1. When the state Medicaid program reimbursement rate  
19 reflects the sum of Ninety-four Dollars and eleven cents (\$94.11),  
20 plus the increases in actual audited costs over and above the actual  
21 audited costs reflected in the cost reports submitted for the most  
22 current cost-reporting period and the costs estimated by the  
23 Oklahoma Health Care Authority to increase the direct-care, flexible  
24 staff-scheduling staffing level from two and eighty-six one-

1 hundredths (2.86) hours per day per occupied bed to three and two-  
2 tenths (3.2) hours per day per occupied bed, all nursing facilities  
3 subject to the provisions of the Nursing Home Care Act and  
4 intermediate care facilities for the mentally retarded with  
5 seventeen or more beds, in addition to other state and federal  
6 requirements related to the staffing of nursing facilities, shall  
7 maintain direct-care, flexible staff-scheduling staffing levels  
8 based on an overall three and two-tenths (3.2) hours per day per  
9 occupied bed.

10       2. When the state Medicaid program reimbursement rate reflects  
11 the sum of Ninety-four Dollars and eleven cents (\$94.11), plus the  
12 increases in actual audited costs over and above the actual audited  
13 costs reflected in the cost reports submitted for the most current  
14 cost-reporting period and the costs estimated by the Oklahoma Health  
15 Care Authority to increase the direct-care flexible staff-scheduling  
16 staffing level from three and two-tenths (3.2) hours per day per  
17 occupied bed to three and eight-tenths (3.8) hours per day per  
18 occupied bed, all nursing facilities subject to the provisions of  
19 the Nursing Home Care Act and intermediate care facilities for the  
20 mentally retarded with seventeen or more beds, in addition to other  
21 state and federal requirements related to the staffing of nursing  
22 facilities, shall maintain direct-care, flexible staff-scheduling  
23 staffing levels based on an overall three and eight-tenths (3.8)  
24 hours per day per occupied bed.

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

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

20        5. In the event that the state Medicaid program reimbursement  
21 rate for facilities subject to the Nursing Home Care Act, and  
22 intermediate care facilities for the mentally retarded having  
23 seventeen or more beds is reduced below actual audited costs, the  
24 requirements for staffing ratio levels shall be adjusted to the

1 appropriate levels provided in paragraphs 1 through 4 of this  
2 subsection.

3 G. For purposes of this subsection:

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

7 2. Prior to September 1, 2003, activity and social services  
8 staff who are not providing direct, hands-on care to residents may  
9 be included in the direct-care-staff-to-resident ratio in any shift.  
10 On and after September 1, 2003, such persons shall not be included  
11 in the direct-care-staff-to-resident ratio, regardless of their  
12 licensure or certification status; and

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

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

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



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

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

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

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

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

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

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

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

- 1                   (2)   three members selected by the Oklahoma  
2                   Association of Homes and Services for the Aging,  
3                   and  
4                   (3)   two members selected by the State Council on  
5                   Aging.

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

8           b.   The purpose of the advisory committee will be to  
9           develop a new methodology for calculating state  
10           Medicaid program reimbursements to nursing facilities  
11           by implementing facility-specific rates based on  
12           expenditures relating to direct care staffing. No  
13           nursing home will receive less than the current rate  
14           at the time of implementation of facility-specific  
15           rates pursuant to this subparagraph.

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

18           d.   The new methodology will be submitted for approval to  
19           the Board of the Oklahoma Health Care Authority by  
20           January 15, 2005, and shall be finalized by July 1,  
21           2005. The new methodology will apply only to new  
22           funds that become available for Medicaid nursing  
23           facility reimbursement after the methodology of this  
24           paragraph has been finalized. Existing funds paid to

1 nursing homes will not be subject to the methodology  
2 of this paragraph. The methodology as outlined in  
3 this paragraph will only be applied to any new funding  
4 for nursing facilities appropriated above and beyond  
5 the funding amounts effective on January 15, 2005.

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

8 (1) direct care which includes allowable costs for  
9 registered nurses, licensed practical nurses,  
10 certified medication aides and certified nurse  
11 aides. The direct care component of the rate  
12 shall be a facility-specific rate, directly  
13 related to each facility's actual expenditures on  
14 direct care, and

15 (2) other costs.

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

19 (1) to construct an array of facility per diem  
20 allowable expenditures on direct care, the  
21 Authority shall use the most recent data  
22 available. The limit on this array shall be no  
23 less than the ninetieth percentile,  
24

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

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

9 ~~(4) rate components in divisions (2) and (3) of this~~  
10 ~~subparagraph shall be re-based and adjusted for~~  
11 ~~inflation when additional funds are made~~  
12 ~~available~~

13 (a) If, at any time, reimbursement rates are  
14 determined to be below ninety-five percent  
15 (95%) of statewide average cost as  
16 determined by the most recently available  
17 audited cost reports, after adjustment for  
18 inflation, the Authority shall restore rates  
19 to a level in excess of such amount. The  
20 required incremental increase shall be no  
21 less than the Consumer Price Index - Medical  
22 for the relevant year; provided, at no time  
23 shall the reimbursement rate be increased to  
24 a level which would exceed one hundred

1                   percent (100%) of the upper payment limit  
2                   established by the Medicare rate equivalent  
3                   established by the federal Centers for  
4                   Medicare and Medicaid Services (CMS).

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

9           (5) if Medicaid payment rates to providers are  
10           adjusted, nursing home rates and Intermediate  
11           Care Facilities for Individuals with Intellectual  
12           Disabilities (ICFs/IID) rates shall not be  
13           adjusted less favorably than the average  
14           percentage-rate reduction or increase applicable  
15           to the majority of other provider groups.

16           g. (1) Effective July 1, 2019, if new funding is  
17           appropriated for a rate increase, a new average  
18           rate for nursing facilities shall be established.  
19           The rate shall be equal to the statewide average  
20           cost as derived from audited cost reports for SFY  
21           2018, ending June 30, 2018, after adjustment for  
22           inflation. After such new average rate has been  
23           established, the facility specific reimbursement  
24           rate shall be as follows:

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

5           (b) to the extent the new rate exceeds the rate  
6           effective before the effective date of this  
7           act, fifty percent (50%) of the resulting  
8           increase on July 1, 2019, shall be allocated  
9           toward an increase of the existing base  
10           reimbursement rate and distributed  
11           accordingly. The remaining fifty percent  
12           (50%) of the increase shall be allocated in  
13           accordance with the currently approved 70/30  
14           reimbursement rate methodology as outlined  
15           in the existing State Plan.

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

23           h. Effective January 1, 2021, and annually thereafter,  
24           under the currently approved methodology, a new rate

1           shall be established based on the audited cost reports  
2           for SFY 2020, ending June 30, 2020.

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

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

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

21          (2) effective January 1, 2020, all clinical employees  
22          working in a licensed nursing facility shall be  
23          required to receive at least four (4) hours  
24

1                   annually of Alzheimer's or Dementia training, to  
2                   be provided and paid for by the facilities.

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

7           4.   The Oklahoma Health Care Authority shall develop a nursing  
8 facility cost-reporting system that reflects the most current costs  
9 experienced by nursing and specialized facilities. The Oklahoma  
10 Health Care Authority shall utilize the most current cost report  
11 data to estimate costs in determining daily per diem rates.

12           5.   The Oklahoma Health Care Authority shall provide access to  
13 the detailed Medicaid payment audit adjustments and implement an  
14 appeal process for disputed payment audit adjustments.

15 Additionally, the Oklahoma Health Care Authority shall make  
16 sufficient revisions to the nursing facility cost reporting forms  
17 and electronic data input system so as to clarify what expenses are  
18 allowable and appropriate for inclusion in cost calculations.

19           J.   1.   When the state Medicaid program reimbursement rate  
20 reflects the sum of Ninety-four Dollars and eleven cents (\$94.11),  
21 plus the increases in actual audited costs, over and above the  
22 actual audited costs reflected in the cost reports submitted for the  
23 most current cost-reporting period, and the direct-care, flexible  
24 staff-scheduling staffing level has been prospectively funding at



1 four and one-tenth (4.1) hours per day per occupied bed, the  
2 Authority may apportion funds for the implementation of the  
3 provisions of this section.

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

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

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

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

1 Passed the Senate the 12th day of March, 2019.

2  
3 \_\_\_\_\_  
4 Presiding Officer of the Senate

5 Passed the House of Representatives the \_\_\_\_ day of \_\_\_\_\_,  
6 2019.

7  
8 \_\_\_\_\_  
9 Presiding Officer of the House  
10 of Representatives