STATE OF OKLAHOMA

2nd Session of the 56th Legislature (2018)

COMMITTEE SUBSTITUTE
FOR ENGROSSED
HOUSE BILL 2958 By: Thomsen of the House

and

Paxton of the Senate

COMMITTEE SUBSTITUTE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

after the times designated in this section without overlapping shifts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

G. For purposes of this subsection:

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

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

H. 1. The Oklahoma Health Care Authority shall require all nursing facilities subject to the provisions of the Nursing Home

Care Act and intermediate care facilities for the mentally retarded with seventeen or more beds to submit a monthly report on staffing ratios on a form that the Authority shall develop.

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

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

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

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

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

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

I. 1. All entities regulated by this state that provide long-term care services shall utilize a single assessment tool to determine client services needs. The tool shall be developed by the

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

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

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

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

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

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

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

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

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

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

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

~~(2) other costs.~~

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

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

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

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

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

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

~~4.~~ 3. The Oklahoma Health Care Authority shall develop a nursing facility cost-reporting system that reflects the most current costs experienced by nursing and specialized facilities. The Oklahoma Health Care Authority shall ~~utilize the most current cost report data to estimate costs in determining daily per diem rates~~ implement a case-mix-adjusted payment methodology.

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

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

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

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

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

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

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

(6) "capital component" shall consist of two subcomponents: fair market rental and cost of ownership. "Fair market rental" shall be defined 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

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

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

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

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

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

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

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

(1) in determining the direct care component rate, a direct care component floor shall be established. All facilities whose inflation adjusted direct care labor plus inflation adjusted care related costs are above the direct care component floor shall receive the direct care component rate. All facilities whose inflation adjusted direct care labor plus inflation adjusted care related costs are below the direct care component floor shall receive actual facility specific allowable direct care component cost plus ten percent (10%) of the direct care component rate,

(2) in determining the indirect care and administrative component costs, all facilities shall be reimbursed at one hundred ten percent (110%) of the inflated median indirect and administrative costs of all Medicaid facilities and paid as a class per-diem rate to all Medicaid contracted facilities,

(3) in determining the capital component, all facilities shall be reimbursed at a rate which combines the fair market rental plus the cost of ownership. The capital component shall be determined by multiplying a facility's licensed beds by the per bed value (PBV), then adjusted by the facility's age factor to determine the current asset value (CAV). The age-adjusted CAV is then multiplied by the capital component multiplier to determine the gross fair rental component. The allowable costs of ownership are added to the gross fair rental component, then the total divided by the greater of the facility's actual census days or their equivalent days at minimum occupancy to determine the facility's capital component per diem,

(4) in determining the quality of care fee component, all facilities shall be reimbursed at actual per-day cost of the quality of care fee,

(5) in determining reimbursement with respect to Focus on Excellence, the Focus on Excellence methodologies currently utilized shall continue and reimbursement amounts shall represent an add-on to combined per diem rate of the direct care component, indirect care and administrative component, capital component, and quality of care fee component, and

(6) in addition to the reimbursement rates established in this paragraph, nursing facility services for residents receiving care for Acquired Immune Deficiency Syndrome (AIDS), ventilator-dependent residents and any other categories identified as high intensity services shall be paid an additional add-on or enhanced rates, to be determined by the Oklahoma Health Care Authority, as reasonable compensation representing the additional cost of providing these services.

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

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

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

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

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

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