SENATE FLOOR VERSION
March 5, 2025

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 904 By: Rosino of the Senate

and

Stinson of the House

[state Medicaid program - reimbursement rate plan - qualification criteria - allocation - staff retention initiative - payment - reporting - advisory committee - apportionment - effective date - emergency]

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

SECTION 1. AMENDATORY 56 O.S. 2021, Section 1011.5, is amended to read as follows:

Section 1011.5. A. 1. The Oklahoma Health Care Authority shall develop an incentive reimbursement rate plan for nursing facilities focused on improving resident outcomes and resident quality of life.

2. Under the current rate methodology, the Authority shall reserve Five Dollars ($5.00) per patient day designated for the quality assurance component that nursing facilities can earn for ~~improvement or performance~~ achievement of ~~resident-centered outcomes~~

~~metrics~~ the long-stay quality measures ratings specified in paragraph 4 of this subsection. To fund the quality assurance component, Two Dollars ($2.00) shall be deducted from each nursing facility's per diem rate, and matched with Three Dollars ($3.00) per day funded by the Authority. Payments to nursing facilities that ~~achieve specific metrics~~ qualify under paragraph 4 of this subsection shall be treated as an "add back" to their net reimbursement per diem. Dollar values assigned to each ~~metric~~ rating shall be determined so that an average of the ~~five-dollar-quality~~ five-dollar quality incentive is made to qualifying nursing facilities.

3. Pay-for-performance payments may be earned quarterly and based on ~~facility-specific performance achievement of four equally-weighted, Long-Stay Quality Measures as defined by~~ the facility's long-stay quality measures rating in the nursing home Five-Star Quality Rating System of the Centers for Medicare and Medicaid Services (CMS).

4. Contracted Medicaid long-term care providers may earn payment by achieving ~~either five percent (5%) relative improvement each quarter from baseline or by achieving the National Average Benchmark or better for each individual quality metric~~ at least a two-star long-stay quality measures rating. Program funds shall be allocated as follows:

a. facilities with a two-star rating shall receive forty percent (40%) of the per-day amount reserved for the quality assurance component per Medicaid patient day,

b. facilities with a three-star rating shall receive sixty percent (60%) of the per-day amount reserved for the quality assurance component per Medicaid patient day,

c. facilities with a four-star rating shall receive eighty percent (80%) of the per-day amount reserved for the quality assurance component per Medicaid patient day, and

d. facilities with a five-star rating shall receive one hundred percent (100%) of the per-day amount reserved for the quality assurance component per Medicaid patient day.

5. As soon as practicable after receipt of any necessary federal approval, and subject to appropriation of funds for a rate increase to nursing facilities, facilities may earn up to Three Dollars ($3.00) per Medicaid patient day by participating in an optional staff retention initiative for Registered Nurses, Licensed Practical Nurses, and Certified Nurse Aides. Payments shall be allocated at One Dollar and fifty cents ($1.50) per quality measure, subject to the following conditions:

1 a. a minimum of sixty percent (60%), or a percentage
2 determined by the Authority, of Registered Nurses and
3 Licensed Practical Nurses must be retained for not
4 less than twelve (12) months, with compliance measured
5 quarterly,
6 b. a minimum of fifty percent (50%), or a percentage
7 determined by the Authority, of Certified Nurse Aides
8 must be retained for not less than twelve (12) months,
9 with compliance measured quarterly,
10 c. participating facilities must submit an annual
11 retention plan to the Authority by June 30 of each
12 year, and
13 d. participating facilities shall receive incentive
14 payments under this paragraph during the first year to
15 support retention efforts. Beginning in the second
16 year and thereafter, facilities must meet program
17 metrics as provided by this paragraph to remain
18 eligible for payments.
19 6. Pursuant to federal Medicaid approval, any funds that remain
20 ~~as a result of providers failing to meet the quality assurance~~
21 ~~metrics~~ after all the allocations under this subsection have been
22 made shall be pooled and redistributed to those who ~~achieve the~~
23 ~~quality assurance metrics each quarter~~ qualify for payments under
24 this subsection. If federal approval is not received, any remaining

funds shall be deposited in the Nursing Facility Quality of Care Fund authorized in Section 2002 of this title.

~~6. The Authority shall establish an advisory group with consumer, provider and state agency representation to recommend quality measures to be included in the pay-for-performance program and to provide feedback on program performance and recommendations for improvement. The quality measures shall be reviewed annually and shall be subject to change every three (3) years through the agency's promulgation of rules. The Authority shall insure adherence to the following criteria in determining the quality measures:~~

~~a. provides direct benefit to resident care outcomes,~~

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

~~c. addresses a 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 long-stay, high-risk 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 got 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 audit the program to ensure transparency and integrity.

D. The Oklahoma Health Care Authority shall ~~provide~~ electronically submit 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 63 O.S. 2021, 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 Individuals with Intellectual Disabilities~~ intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) from the Nursing Facility Quality of Care

Fund beginning October 1, 2000, the average actual, audited costs reflected in previously submitted cost reports for the cost-reporting period that began July 1, 1998, and ended June 30, 1999, inflated by the federally published inflationary factors for the two (2) years appropriate to reflect present-day costs at the midpoint of the July 1, 2000, through June 30, 2001, rate year.

1. The recalculations provided for in this subsection shall be consistent for both nursing facilities and ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~ intermediate care facilities for individuals with intellectual disabilities (ICFs/IID).

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

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

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

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

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

2. From September 1, 2001, through August 31, 2003, nursing facilities subject to the Nursing Home Care Act and ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~ intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) 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 October 1, 2019, nursing facilities subject to the Nursing Home Care Act and ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~ intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) with seventeen or more beds shall maintain, in addition to other state and federal requirements related to the staffing of nursing facilities, the following minimum direct-care-staff-to-resident ratios:

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

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

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

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

5. a. On and after January 1, 2020, a facility may implement twenty-four-hour-based staff scheduling; provided, however, such facility shall continue to maintain a direct-care service rate of at least two and ~~nine tenths~~ nine-tenths (2.9) hours of direct-care service per resident per day, the same to be calculated based on average direct care staff maintained over a twenty-four-hour period.

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

1 c. As used in this paragraph, ~~"twenty-four-hour-based~~
2 ~~scheduling"~~ "twenty-four-hour-based staff scheduling"
3 means maintaining:
4 (1) a direct-care-staff-to-resident ratio based on
5 overall hours of direct-care service per resident
6 per day rate of not less than ~~two and ninety one~~
7 ~~hundredths (2.90)~~ two and nine-tenths (2.9) hours
8 per day,
9 (2) a direct-care-staff-to-resident ratio of at least
10 one direct-care staff person on duty to every
11 fifteen residents or major fraction thereof at
12 all times, and
13 (3) at least two direct-care staff persons on duty
14 and awake at all times.
15 6. a. On and after January 1, 2004, the State Department of
16 Health shall require a facility to maintain the shift-
17 based, staff-to-resident ratios provided in paragraph
18 3 of this subsection if the facility has been
19 determined by the Department to be deficient with
20 regard to:
21 (1) the provisions of paragraph 3 of this subsection,
22 (2) fraudulent reporting of staffing on the Quality
23 of Care Report, or
24

(3) a complaint or survey investigation that has determined substandard quality of care as a result of 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 twenty-four-hour-based staff scheduling as defined in subparagraph c of paragraph 5 of this subsection.

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

7. a. For facilities that utilize twenty-four-hour-based staff-scheduling privileges, the Department shall monitor and evaluate facility compliance with the twenty-four-hour-based staff-scheduling staffing provisions of paragraph 5 of this subsection through

reviews of monthly staffing reports, results of complaint investigations and inspections.

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

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

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

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

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

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

D. The State Commissioner of Health shall promulgate rules prescribing staffing requirements for ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~ intermediate care facilities for individuals with intellectual disabilities serving six or fewer clients (ICFs/IID-6) and for ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~ intermediate care facilities for individuals with intellectual disabilities serving sixteen or fewer clients (ICFs/IID-16).

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 Individuals with Intellectual Disabilities~~ intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) 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 Individuals with Intellectual Disabilities~~ intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) 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 Individuals with Intellectual Disabilities~~ intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) 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 Commissioner 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 Individuals with Intellectual~~

1 ~~Disabilities~~ intermediate care facilities for individuals with
2 intellectual disabilities (ICFs/IID) having seventeen or more beds
3 is reduced below actual audited costs, the requirements for staffing
4 ratio levels shall be adjusted to the appropriate levels provided in
5 paragraphs 1 through 4 of this subsection.

6 G. For purposes of this ~~subsection~~ section:

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

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

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

18 H. 1. The Oklahoma Health Care Authority shall require all
19 nursing facilities subject to the provisions of the Nursing Home
20 Care Act and ~~Intermediate Care Facilities for Individuals with~~
21 ~~Intellectual Disabilities~~ intermediate care facilities for
22 individuals with intellectual disabilities (ICFs/IID) with seventeen
23 or more beds to submit a monthly report on staffing ratios on a form
24 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 established in Section 2002 of Title 56 of the Oklahoma Statutes and utilized for the purposes specified in ~~the Oklahoma Healthcare Initiative Act~~ such section.

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~~ Care Providers Oklahoma or its successor organization,

(2) three members selected by ~~the Oklahoma Association of Homes and Services for the Aging~~ LeadingAge Oklahoma or its successor organization, and

(3) two members selected by the ~~State Council on Aging~~ State Council on Aging and Adult Protective Services.

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

b. The purpose of the advisory committee ~~will~~ shall be to:

(1) 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, and

1 (2) recommend changes to the incentive reimbursement
2 rate plan created under Section 1011.5 of Title
3 56 of the Oklahoma Statutes.
4 No nursing home ~~will~~ shall receive less than the
5 current rate at the time of implementation of
6 facility-specific rates pursuant to division 1 of this
7 subparagraph.
8 c. The advisory committee shall be staffed and advised by
9 the Oklahoma Health Care Authority.
10 d. The new methodology ~~will~~ shall be submitted for
11 approval to the ~~Board of the~~ Oklahoma Health Care
12 Authority Board by January 15, 2005, and shall be
13 finalized by July 1, 2005. The new methodology ~~will~~
14 shall apply only to new funds that become available
15 for Medicaid nursing facility reimbursement after the
16 methodology of this paragraph has been finalized.
17 Existing funds paid to nursing homes ~~will~~ shall not be
18 subject to the methodology of this paragraph. The
19 methodology as outlined in this paragraph ~~will~~ shall
20 only be applied to any new funding for nursing
21 facilities appropriated above and beyond the funding
22 amounts effective on January 15, 2005.
23 e. The new methodology shall divide the payment into two
24 components:

1 (1) direct care which includes allowable costs for ~~registered nurses~~ <u>Registered Nurses</u>, ~~licensed practical nurses~~ <u>Licensed Practical Nurses</u>, ~~certified medication aides~~ <u>Certified Medication Aides</u> and ~~certified nurse aides~~ <u>Certified Nurse Aides</u>. 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) <u>as soon as practicable after receipt of any necessary federal approval, and subject to</u>

1 appropriation of funds for a rate increase to
2 nursing facilities, the Authority shall
3 incorporate a case-mix component into the payment
4 rate methodology for nursing facilities. The
5 inclusion of the case-mix component shall occur
6 upon the availability and analysis of the
7 necessary data by the Authority. Appropriated
8 funds shall be allocated as follows:
9 (a) fifty percent (50%) of funds shall be
10 designated for the case-mix component, and
11 (b) the remaining fifty percent (50%) of funds
12 shall be allocated to the base rate
13 component,
14 (4) other rate components shall be determined by the
15 Oklahoma Nursing Facility Funding Advisory
16 Committee or the Authority in accordance with
17 federal regulations and requirements,
18 ~~(4)~~ (5) prior to July 1, 2020, the Authority shall
19 seek federal approval to calculate the upper
20 payment limit under the authority of ~~CMS~~ the
21 Centers for Medicare and Medicaid Services (CMS)
22 utilizing the Medicare equivalent payment rate,
23 and
24

1 ~~(5)~~ <u>(6)</u> if Medicaid payment rates to providers are
2 adjusted, nursing home rates and ~~Intermediate~~
3 ~~Care Facilities for Individuals with Intellectual~~
4 ~~Disabilities~~ <u>intermediate care facilities for</u>
5 <u>individuals with intellectual disabilities</u>
6 (ICFs/IID) rates shall not be adjusted less
7 favorably than the average percentage-rate
8 reduction or increase applicable to the majority
9 of other provider groups.
10 g. (1) Effective October 1, 2019, if sufficient funding
11 is appropriated for a rate increase, a new
12 average rate for nursing facilities shall be
13 established. The rate shall be equal to the
14 statewide average cost as derived from audited
15 cost reports for SFY 2018, ending June 30, 2018,
16 after adjustment for inflation. After such new
17 average rate has been established, the facility
18 specific reimbursement rate shall be as follows:
19 (a) amounts up to the existing base rate amount
20 shall continue to be distributed as a part
21 of the base rate in accordance with the
22 existing <u>Medicaid</u> State Plan, and
23 (b) to the extent the new rate exceeds the rate
24 effective before ~~the effective date of this~~

1 ~~act~~ October 1, 2019, fifty percent (50%) of
2 the resulting increase on October 1, 2019,
3 shall be allocated toward an increase of the
4 existing base reimbursement rate and
5 distributed accordingly. The remaining
6 fifty percent (50%) of the increase shall be
7 allocated in accordance with the currently
8 approved 70/30 reimbursement rate
9 methodology as outlined in the existing
10 Medicaid State Plan.
11 (2) Any subsequent rate increases, as determined
12 based on the provisions set forth in this
13 subparagraph, shall be allocated in accordance
14 with the currently approved 70/30 reimbursement
15 rate methodology. When the case-mix component is
16 included in the rate methodology, fifty percent
17 (50%) of the amount allocated to direct care
18 shall be apportioned to the case-mix component.
19 The rate shall not exceed the upper payment limit
20 established by the Medicare rate equivalent
21 established by the federal CMS.
22 h. Effective October 1, 2019, in coordination with the
23 rate adjustments identified in the preceding section,
24 a portion of the funds shall be utilized as follows:

1 (1) effective October 1, 2019, the Oklahoma Health
2 Care Authority shall increase the personal needs
3 allowance for residents of nursing homes and
4 ~~Intermediate Care Facilities for Individuals with~~
5 ~~Intellectual Disabilities~~ intermediate care
6 facilities for individuals with intellectual
7 disabilities (ICFs/IID) from Fifty Dollars
8 ($50.00) per month to Seventy-five Dollars
9 ($75.00) per month per resident. The increase
10 shall be funded by Medicaid nursing home
11 providers, by way of a reduction of eighty-two
12 cents ($0.82) per day deducted from the base
13 rate. Any additional cost shall be funded by the
14 Nursing Facility Quality of Care Fund, and
15 (2) effective January 1, 2020, all clinical employees
16 working in a licensed nursing facility shall be
17 required to receive at least four (4) hours
18 annually of Alzheimer's or dementia training, to
19 be provided and paid for by the facilities.
20 3. The Department of Human Services shall expand its statewide
21 toll-free, ~~Senior-Info Line~~ Senior Info-line for senior citizen
22 services to include assistance with or information on long-term care
23 services in this state.
24

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

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

J. 1. When the state Medicaid program reimbursement rate reflects the sum of Ninety-four Dollars and eleven cents ($94.11), plus the increases in actual audited costs, over and above the actual audited costs reflected in the cost reports submitted for the most current cost-reporting period, and the direct-care, flexible staff-scheduling staffing level has been prospectively funded 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~~ Services for a waiver of

1 the uniform requirement on health-care-related taxes as permitted by
2 ~~Section 433.72 of~~ 42 C.F.R.<u>, Section 433.72</u>.
3 3. Upon approval of the waiver, the Authority shall develop a
4 program to implement the provisions of the waiver as it relates to
5 all nursing facilities.
6 SECTION 3. This act shall become effective July 1, 2025.
7 SECTION 4. It being immediately necessary for the preservation
8 of the public peace, health or safety, an emergency is hereby
9 declared to exist, by reason whereof this act shall take effect and
10 be in full force from and after its passage and approval.
11 COMMITTEE REPORT BY: COMMITTEE ON APPROPRIATIONS
March 5, 2025 - DO PASS AS AMENDED BY CS
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