Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to the <u>Oklahoma Health Care Authority (OHCA) Proposed</u> Changes Blog.

OHCA COMMENT DUE DATE: February 17, 2017

The proposed policy is a Permanent Rule. The proposed policy was presented at the January 3, 2017 Tribal Consultation and is scheduled to be presented to the Medical Advisory Committee on March 9, 2017 and the OHCA Board of Directors on March 23, 2017.

Reference: APA WF 16-31A

SUMMARY:

Long Term Care Policy Revisions - The proposed Long Term Care policy revisions update rules to align with current business practices and state and federal regulation requirement. In addition, revisions remove references to outdated terminology.

LEGAL AUTHORITY

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 2002 of Title 56 of Oklahoma Statute; 42 CFR 431 Subpart D; 42 CFR 442.15, 42 CFR 442.101, 42 CFR 442.110; 42 CFR Part 483 Subparts B, C, and I

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY

- TO: Tywanda Cox Federal and State Policy
- From: Likita Gunn Federal and State Authorities
- SUBJECT: Rule Impact Statement APA WF # 16-31A
- A. Brief description of the purpose of the rule:

The proposed revisions to Long Term Care policy update requirements for the State Survey Agency when they are

certifying facilities with deficiencies. Revisions also amend the change of ownership process for facilities. Both revisions are necessary to comply with recent changes to Federal and State regulation. Revisions also clarify that nursing facilities will be afforded a hearing pursuant to federal regulation.

For nursing homes that handle trust accounts, the Department of Human Services allows facilities to use electronic ledgers and bank statements as source documents for inspections, accounting, and tracking purposes. Proposed revisions update rules to align with this practice. Other revisions for trust funds revoke language that implies unclaimed funds escheats to the State.

Additional changes revoke rules outlining the necessary requirements for members to obtain a private room. Nursing facilities receive a set reimbursement for room and board regardless of the privacy level so prescriptive rules are not required.

Further revisions amend rules governing quality of care fund requirements to accurately reflect how these funds are calculated and assessed as authorized by Section 2002 of Title 56 of Oklahoma Statutes.

Other revisions update the payment methodology for private nursing facilities to mirror language found in the State Plan, and adds influenza and pneumococcal vaccines as a covered routine service since it is not separately reimbursable.

Finally, revisions throughout amend terminology to correctly identify individuals residing in long term care facilities as those with intellectual disabilities and replaces the term patient with member as appropriate. Other general cleanup of terms include: replacing agreement with the term contract, updating form names, revising the name of divisions, and striking references to policy that has been revoked.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

No classes of persons will be affected by the proposed rule as the changes to policy are only to align rules with current practice and Federal and State regulations, which are already being adhered to by nursing facilities and partner agencies.

C. A description of the classes of persons who will benefit from the proposed rule:

No classes of persons will benefit from the proposed rule.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

The proposed rule should have no economic impact and no fee changes, as the proposed rule change should only require a change in business practice for providers.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

Agency staff has determined that the proposed rule is budget neutral.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less

costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

There are no other legal methods to minimize compliance costs.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

This rule impact statement was prepared on December 8, 2016.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-21. Appeals procedures for nursing facilities

Appeal procedures for denial, failure to renew, or termination of a nursing facility agreement are described at OAC $\frac{317:2-1-8}{317:30-5-124(h)}$. The Oklahoma State Department of Health, by agreement, continues to be responsible for hearings for licensure and certification as the survey agency.

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-43. Services in an Intermediate Care Facility for the <u>Mentally Retarded</u>Individuals with Intellectual <u>Disabilities(ICF/IID)</u>

Services in an <u>ICF/MRICF/IID</u> facility are provided to individuals per OAC 317:30-5-122 and OAC 317:35-9-45.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 4. LONG TERM CARE HOSPITALS

317:30-5-63. Trust funds

When a new <u>recipientmember</u> is admitted to a long term care hospital, the administrator will complete and send to the county office the Management of Recipient's Funds form to indicate whether or not the <u>recipientmember</u> has requested the administrator to handle personal funds. If the administrator agrees to handle the <u>recipient'smember's</u> funds, the Management of Recipient's Funds form will be completed each time funds or other items of value, other than monthly income, are received.

(1) By using the Management of Recipient's Funds form as a source document, the facility personnel will prepare a Ledger Sheet for Recipient's Account in a form acceptable to the Authority, for each recipient for whom they are holding funds or other items of value. This form is used to keep an accurate accounting of all receipts and expenditures and the amount of money on hand at all times. This form is to be available in the facility for inspection and audit. The facility may use electronic ledgers and bank statements as the source documentation for each member for whom they are holding funds or other items of value. This information must be available at all times for inspection and audit purposes. The facility must have written policies that ensure complete accounting of the recipient's member's personal funds. All recipient's member's funds which are handled by the facility must be clearly identified and maintained separately from funds belonging to the facility or to private patients. When the total sum of all funds for all recipients members is \$250.00 or more, they must be deposited by the facility in a local bank account designated as "Recipient's Trust Funds." The funds are not to be commingled with the operating funds facility. of the Each resident in an ICF/MR facility intermediate care facility for individuals with intellectual disabilities (ICF/IID) must be allowed to possess and use money in normal ways or be learning to do so. (2) The facility is responsible for notifying the county office at any time a recipient's member's account reaches or exceeds the maximum reserve by use of the AccountingRecipient's Personal Funds and Property form. This form is also prepared by the facility when the <u>recipientmember</u> dies or is transferred or discharged, and at the time of the county eligibility review of the <u>recipientmember</u>.

(3) The Management of Recipient's Funds form, the Accounting-Recipient's Personal Funds and Property form, and the Ledger Sheets for Recipient's Account can be obtained from the local county DHS officeare available online at www.okdhs.org.

(4) When the ownership or operation of the facility is discontinued or where the facility is sold and the recipients' members' trust funds are to be transferred to a successor facility, the status of all recipient's member's trust funds must be verified by the AuthorityOHCA and/or the be provided with written verification by buyer must an independent public accountant of all residents' monies and properties being transferred, and a signed receipt obtained from the owner. All transfers of recipient's member's trust funds must be acknowledged, in writing, by the transferring facility and proper receipts given by the receiving facility.

(5) Unclaimed funds or other property of deceased recipientsmember's, with no known heirs, must be reported to the Oklahoma Tax Commission. If it remains unclaimed for a certain period, the money or property escheats to the State.

(6) It is permissible to use an individual trust fund account to defray the cost of last illness, outstanding personal debts and burial expenses of a deceased recipientmember of this Authority the OHCA; however, any remaining balance of reported to unclaimed funds must be the Oklahoma Tax Commission. The Unclaimed Property Division, Oklahoma Tax Commission, State Capitol Complex, Oklahoma City, Oklahoma, is to be notified for disposition instructions on any unclaimed funds or property. No money is to be sent to the Oklahoma Tax Commission until so instructed by the Unclaimed Property Division.

(7) Books, records, ledgers, charge slips and receipts must be on file in the facility for a period of six (6) years and available at all times in the facility for inspection and audit purposes.

PART 9. LONG TERM CARE FACILITIES

317:30-5-120. Eligible providers

Long Term Care Facilities may receive payment for the provision of nursing care under the Title XIX Medicaid Program only when they are properly licensed and certified by the Oklahoma Department of Health, meet Federal and State requirements and hold a valid written agreement contract with the Oklahoma Health Care Authority (Agreement to Provide Long Term Care Services under the Medicaid Act (Agreement)(OHCA) to provide long term care services. All long term care facility Agreementscontracts are time limited with specific effective and expiration dates and can be issued for no more than a twelve month period. Whenever possible, the agreement expiration date will correspond with the certification period by the State Survey Agency.

317:30-5-121. Coverage by category

(a) **Adults.** Payment is made for compensable long term care for adults after the <u>patientmember</u> has been determined medically eligible to receive such care.

(b) Children. Coverage for children is the same as adults.

317:30-5-122. Levels of care

(a) This rule sets forth the criteria used to determine whether an individual who is seeking SoonerCare payment for long term care services needs services at the level of Skilled Nursing Facility, or Intermediate Care Facility for People with Mental Retardation (ICF/MR) Individuals with Intellectual Disabilities (ICF/IID). The criteria set forth in this Section must be used level for individuals when determining of care seeking SoonerCare coverage of either facility-based institutional long term care services or Home and Community Based Services (HCBS) Waivers.

(b) The level of care provided by a long term care facility or through a HCBS Waiver is based on the nature of the person's needs and the care, services, and treatment required from appropriately qualified personnel. The level of care review is a determination of an individual's physical, mental, and social/emotional status to determine the appropriate level of care required. In addition to level of care requirements, other applicable eligibility criteria must be met.

(1) **Skilled Nursing facility.** Payment is made for the Part A coinsurance and deductible for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.

(2) **Nursing Facility.** Care provided by a nursing facility to <u>patientsmembers</u> who require professional nursing supervision and a maximum amount of nonprofessional nursing care due to physical conditions or a combination of physical and mental conditions.

(3) Intermediate Care Facility for the Mentally Retarded Individuals with Intellectual Disabilities. Care for persons with intellectual disabilities or related conditions to provide health and/or habilitative services in a protected residential setting. To qualify for <u>ICF/MRICF/IID</u> level of care, persons must have substantial functional limitations in three or more of the following areas of major life activity:

(A) <u>Self care</u><u>Self-care</u>. The individual requires assistance, training, or supervision to eat, dress, groom, bathe, or use the toilet.

(B) Understanding and use of language Understanding and use of language. The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of request requests, or is unable to follow two-step instructions.

(C) <u>Learning</u>Learning. The individual has a valid diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders.

(D) Mobility Mobility. The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without assistive device.

(E) <u>Self direction</u><u>Self-direction</u>. The individual is 7<u>seven</u> (7) years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical care, personal safety, or for legal, financial, habilitative, or residential issues, and/or has been declared legally incompetent. The individual is a danger to himself or others without supervision.

(F) <u>Capacity for independent living</u>Capacity for independent living. The individual who is 7<u>seven (7)</u> years old or older and is unable to locate and use a telephone, cross the street safely, or understand that it is unsafe to accept rides, food, or money from strangers. <u>orOr</u> an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping, or paying bills.

317:30-5-123. PatientMember certification for long term care (a) Medical eligibility. Initial approval of medical eligibility for long-term care is determined by the Oklahoma Department of Human Services (OKDHS) area nurse, or nurse designee. The certification is obtained by the facility at the time of admission.

(1) **Pre-admission screening.** Federal <u>Regulationsregulations</u> govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) for individuals with mental illness and intellectual disability. PASRR applies to the screening or reviewing of all individuals for mental illness or intellectual disability or related conditions who apply to

reside in Title XIX certified nursing facilities or regardless of the source of payment for the nursing facility(NF) services and regardless of the individual's or resident's known diagnoses. The nursing facility (NF)NF must independently evaluate the Level I PASRR Screen regardless of who completes the form and determine whether or not to admit individual to the facility. Nursing facilities which an inappropriately admit a person without a PASRR Screen are subject to recoupment of funds. PASRR is a requirement for nursing facilities with dually certified (both Medicare and Medicaid) beds. There are no PASRR requirements for Medicare skilled beds that are not dually certified, nor is PASRR required for individuals seeking residency in an intermediate care facility for the mentally retarded (ICF/MR) individuals with intellectual disabilities (ICF/IID).

(2) PASRR Level I screen.

(A) Form <u>LTC 300LTC-300R</u>, Nursing Facility Level of Care Assessment, must be completed by an authorized NF official or designee. An authorized NF official or designee must consist of one of the following:

(i) The nursing facilityNF administrator or coadministrator;

(ii) A licensed nurse, social service director, or social worker from the nursing facilityNF; or

(iii) A licensed nurse, social service director, or social worker from the hospital.

(B) Prior to admission, the authorized NF official must evaluate the properly completed OHCA Form LTC 300LTC-300R and the Minimum Data Set (MDS), if available. Any other readily available medical and social information is also used to determine if there currently exists any indication of mental illness (MI), intellectual disability, or other related condition, or if such condition existed in the applicant's past history. Form LTC-300LTC-300R constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II Assessment is necessary prior to allowing the patientmember to be admitted. The NF is also responsible for consulting with Level the of Care Evaluation Unit (LOCEU) regarding any mental illness/intellectualillness, or an intellectual disability related condition information that becomes known either from completion of the MDS or throughout the resident's stay.

(C) The nursing facility<u>NF</u> is responsible for determining from the evaluation whether or not the patientmember can be admitted to the facility. A "yes" response to any question from Form <u>LTC-300</u>LTC-300R, Section E, will require the nursing facility to contact the LOCEU for a consultation to determine if a Level II Assessment is needed. If there is any question as to whether or not there is evidence of mental illness, an intellectual disability, or condition, related LOCEU should be contacted prior to admission. The original Form LTC-300LTC-300R must be submitted by mail to the LOCEU within 10 days of the resident admission. SoonerCare payment may for resident whose LTC-300LTC-300R not be made а requirements have not been satisfied in a timely manner. (D) Upon receipt and review of the Form LTC-300LTC-300R, the LOCEU may, in coordination with the OKDHS area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II Assessment is not required, the process of determining medical eligibility continues. If a Level II is required, a medical decision is not made until the results of the Level II Assessment are known.

(3) Level II Assessment for PASRR.

(A) Any one of the following three circumstances will allow a <u>patientmember</u> to enter the <u>nursing facilityNF</u> without being subjected to a Level II PASRR Assessment.

(i) The <u>patientmember</u> has no current indication of mental illness or intellectual disability or other related condition and there is no history of such condition in the <u>patient'smember's past</u>.

(ii) The <u>patientmember</u> does not have a diagnosis of intellectual disability or related condition.

(iii) An individual may be admitted to an NF if he/she has indications of mental illness or an intellectual disability or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery (Exempted Hospital Discharge). If an individual is admitted to an NF based on Exempted Hospital Discharge, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. Exempted Hospital Discharge is allowed only if all three of the following conditions are met:

(I) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);

(II) The individual must require NF services for the condition for which he/she received care in the hospital; and

(III) The attending physician must certify in writing before admission to the facility that the individual is likely to require less than 30 days of nursing facility<u>NF</u> services. The NF will be required to furnish this documentation to OHCA upon request.

(B) If the <u>patientmember</u> has current indications of mental illness or intellectual disability or other related condition, or if there is a history of such condition in the <u>patient'smember's</u> past, the <u>patientmember</u> cannot be admitted to the <u>nursing facilityNF</u> until the LOCEU is contacted for consultation to determine if a Level II PASRR Assessment must be performed. Results of any Level II PASRR Assessment ordered must indicate that <u>nursing</u> <u>facilityNF</u> care is appropriate prior to allowing the patientmember to be admitted.

(C) The OHCA-LOCEUauthorizes Advance Group Determinations for the mental illness and intellectual disability Authorities Authorities in the following categories listed in (i) through (iii) of this subparagraph. Preliminary screening by the LOCEU may indicate eligibility for nursing facilityNF level of care prior to consideration of the provisional admission.

(i) **Provisional admission in cases of delirium.** Any person with mental illness, intellectual disability, or related condition that is not a danger to self and <u>orand/or</u> others, may be admitted to a Title XIX certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

(I) A Level II evaluation is completed immediately after the delirium clears. The LOCEU must be provided with written documentation by a physician that supports the individual's condition which allows provisional admission as defined in (i) of this subparagraph.

(II) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(ii) **Provisional admission in emergency situations.** Any person with a mental illness, <u>an</u> intellectual disability, or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified nursing facilityNF for a period not to exceed

seven days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. The LOCEU must be provided with written documentation from OKDHS Adult Protective Services which supports the individual's emergency admission. Payment NF for services will not be made beyond the emergency admission ending date.

(iii) **Respite care admission.** Any person with mental illness, intellectual disability, or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified nursing facilityNF to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted up to 15 consecutive days per stay, not to exceed 30 days per calendar year.

(I) In rare instances, such as illness of the caregiver, an exception may be granted to allow 30 consecutive days of respite care. However, in no instance can respite care exceed 30 days per calendar year.

(II) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(4) Resident Review.

(A) The nursing facility's routine resident assessment will identify those individuals previously undiagnosed as intellectally disaled disabled or mentally ill. А new condition of intellectual disability or mental illness must be referred to LOCEU by the NF for determination of the need for the Level II Assessment. The facility's failure to refer such individuals for а Level ΙI Assessment may result in recoupment of funds.

(B) A Level II Resident Review may be conducted the following year for each resident of a nursing facilityNF who was found to experience a serious mental illness with no primary diagnosis of dementia on his or her preadmission Level II, to determine whether, because of the resident's physical and mental condition, the resident requires the level of services provided by a nursing facilityNF and whether the resident requires specialized
services.

(C) A significant change in a resident's mental condition could trigger a Level II Resident Review. If such a change should occur in a resident's condition, it is the responsibility of the <u>nursing facilityNF</u> to notify the LOCEU of the need to conduct a resident review.

(5) Results of Level II Pre-Admission Assessment and Resident Review. Through contractual arrangements between the OHCA and illness/intellectualillness mental or intellectual the disability assessments authorities, individualized are conducted and findings presented in written evaluations. The evaluations determine if nursing facilityNF services are specialized services or less than specialized needed, if services are needed, and if the individual meets the federal PASRR definition of mental illness or intellectual disability or related conditions. Evaluations are delivered to the LOCEU to process formal, written notification to patientmember, guardian, NF, and interested parties.

Readmissions, interfacility (6) and transfers. The Preadmission Screening process does not apply to readmission of an individual to ana NF after transfer for a continuous hospital stay, and then back to the NF. There is no specific limit on the length of absence from the nursing time facilityNF for the hospitalization. Inter-facility transfers are also subject to preadmission screening. In the case of transfer of a resident from ana NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the resident's most recent LTC 300LTC-300R and any PASRR evaluations accompany the transferring resident. The receiving NF must submit an updated LTC-300LTC-300R that reflects the resident's current status to LOCEU within 10ten (10) days of the transfer. Failure to do so could result in possible recoupment of funds. LOCEU should also be contacted prior to admitting out-of-state NF applicants with mental illness or intellectual disability or related condition, so that PASRR needs can be ascertained. Any PASRR evaluations previously completed by the referring state should be forwarded to LOCEU as part of this PASRR consultation.

(7) PASRR appeals process.

(A) Any individual who has been adversely affected by any PASRR determination made by the State in the context of either a preadmission screening or an annual resident review may appeal that determination by requesting a fair hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county OKDHS office to discuss a hearing. Forms for requesting a fair hearing (OKDHS Form 13MP001E, Request for a Fair Hearing), as well as assistance in completing the forms, can be obtained at the local county OKDHS office. Any request for a hearing must be made no later than 20 days following the date of written notice. Appeals of these decisions are available under OAC 317:2-1-2. All individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal. (B) When the individual is found to experience mental illness, an intellectual disability, or related condition through the Level II Assessment, the PASRR determination made by the intellectual disability/mental illnessmental illness or intellectual disability authorities cannot be countermanded by the Oklahoma Health Care AuthorityOHCA, either in the claims process or through other utilization control/review processes, or by the Oklahoma State Department of Health. Only appeals determinations made through the fair hearing process may overturn a PASRR determination made by the intellectual disability /mental illness or intellectual disability authorities.

(b) **Determination of Title XIX medical eligibility for long term care.** The determination of medical eligibility for care in a <u>nursing facilityNF</u> is made by the OKDHS area nurse, or nurse designee. The procedures for determining <u>Nursing Facility (NF)NF</u> program medical eligibility are found in OAC 317:35-19. Determination of <u>ICF/MRICF/IID</u> medical eligibility is made by LOCEU. The procedures for obtaining and submitting information required for a decision are outlined below.

(1) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ICF/MRICF/IID care is based of a results current comprehensive psychological on evaluation by a licensed psychologist state or staff psychologist, documentation of intellectual disability or related condition prior to age 22, and the need for active treatment according to federal standards. Pre-approval is made by LOCEU analysts.

(2) Medical eligibility for ICF/MRICF/IID services. Within 30 calendar days after services begin, the facility must submit the original of the Nursing Facility Level of Care Assessment (Form LTC-300)(Form LTC-300R) to LOCEU. Required attachments include current (within 90 days of requested approval date) medical information signed by a physician, a current (within 12 months of requested approval date) psychological evaluation, a copy of the pertinent section of the Individual Developmental Plan other appropriate documentation or

relative to discharge planning and the need for <u>ICF/MRICF/IID</u> level of care, and a statement that the member is not an imminent threat of harm to self or others (i.e., suicidal or homicidal). If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on MEDATS.

(3) **Categorical relationship.** Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship to disability has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances, LOCEU will render a decision on categorical relationship using the same definition as used by the Social Security Administration (SSA). A follow-up is required by the OKDHS worker with SSA to be sure that their disability decision agrees with the decision of LOCEU.

317:30-5-124. Facility licensure

(a) **Nursing home license required.** A nursing facility<u>NF</u> must meet state nursing home licensing standards to provide, on a regular basis, health related care and services to individuals who do not require hospital care.

(1) In order for long term care facilities to receive payment from the <u>AuthorityOHCA</u> for the provision of nursing care, they must be currently licensed under provisions of Title 63 O.S., Nursing Home Care Act, <u>1995</u>, Section <u>1–1901</u>1–1900.1, et seq.

(2) The State Department of Health is responsible for the issuance, renewal, suspension, and revocation of a facility's license in addition to the enforcement of the standards. The denial, suspension, or revocation of a facility's license is subject to appeal to the State Department of Health. All questions regarding a facility's license should be directed to the State Department of Health.

(b) **Certification** survey. The Oklahoma State Department of Health is designated as the State Survey Agency and is responsible for determining а long term care facility's compliance with Title XIX requirements. The results of the survey are forwarded to the OHCA by the State Survey Agency.

(c) **Certification period.** The certification period of a long term care facility is determined by the State Survey Agency. In the event the facility's deficiencies are found to be of such serious nature as to jeopardize the health and safety of the <u>patientmember</u>, the State Survey Agency may terminate (decertify) the facility's certification period and notify the <u>AuthorityOHCA</u>. Upon notification by the State Survey Agency, the <u>AuthorityOHCA</u> will notify the facility by certified letter that the Agreement<u>contract</u> is being terminated. The letter will indicate the effective date and specify the time period that payment may continue in order to allow orderly relocation of recipient/patientsthe members. The decision to terminate a facility's certification by the State Survey Agency is subject to appeal to the State Department of Health. The decision to terminate a facility's Agreement by the Authority (for a reason other than the facility decertification or suspension/revocation of the facility license) is subject to appeal to the Oklahoma Health Care Authority (see OAC 317:2-1-8 for grievance procedures and process).

(d) Certification with deficiencies.

(1) When an ICF/MR facility is certified to be in compliance with the Title XIX requirements but has deficiencies which must be corrected, an Agreement may be executed, subject to the facility's resolution of deficiencies according to the approved plan of correction. Following the visit by the State Survey Agency, one of two actions may occur:

(A) The State Survey Agency will notify the Authority that all deficiencies have been corrected or acceptable progress has been made toward correction. The Authority, by letter, will notify the facility of the action and the Agreement may run to the expiration date; or

(B) The State Survey Agency will notify the Authority that some or all of the deficiencies have not been corrected and circumstances require that the **automatic cancellation date** be invoked. The Authority, by certified letter, will notify the facility, owners of the facility and regulatory agencies when the automatic cancellation date is invoked.

(2) The Agreement will terminate as a result of the automatic cancellation date being invoked. In accordance with federal regulations, payment for current residents of the facility can continue for no more than thirty (30) days from the date the automatic cancellation date is invoked, to permit an orderly relocation of patients. Payment cannot be made for patients admitted after the automatic cancellation date is invoked. The decision to invoke a facility's automatic cancellation date is subject to appeal to the State Department of Health.

(d) **Certification with deficiencies.** Certification of any facility that has been found to have deficiencies by the State Survey Agency will be governed by 42 CFR 442.110 (Certification period for ICF/IID with standard-level deficiencies) or 42 CFR 442.117 (Termination of certification for ICFs/IID whose deficiencies pose immediate jeopardy).

(e) AgreementContract procedures.

(1) A facility participating in the Medicaid program will be

notified by letter from the AuthorityOHCA 6075 days prior to the expiration of the existing Agreement<u>contract</u>. New Agreement forms will be sent to be completed if the facility wishes to continue participation in the Medicaid Program. The facility must complete a new contract to continue participation in the SoonerCare program.

(2) Two copies of the Agreement to Provide Long Term Care Services under the Medicaid Act (Agreement) will be sent to the facility for completion. Both signed copies of the Agreement (signed with original signature only of owner, operator or administrator and properly notarized) must be returned to the OHCA.

(3)(2) When the Agreement<u>contract</u> is received, approved by the <u>AuthorityOHCA</u>, and the HCFA-1539 has been received from the State Department of Health indicating the facility's certification period, the <u>Agreementcontract</u> will be completed. A copy of the executed Agreement will be returned to the facility where it must be maintained for a period of six years for inspection purposes.

(4)(3) Intermediate care facilities for the mentally retarded Individuals with Intellectual Disabilities(ICF/IID) wishing to participate in the ICF/MRICF/IID program must be approved and certified by the State Survey Agency as being in compliance with the ICF/MRICF/IID regulations (42 CFR 442 Subpart C). It is the responsibility of a facility to request the State Survey Agency perform a survey of compliance with ICF/MRICF/IID regulations.

(A) When the <u>AuthorityOHCA</u> has received notification of a facility's approval as an <u>ICF/MRICF/IID</u> and the Title XIX survey of compliance has begun, the <u>Agreementcontract</u> will be sent to the facility for completion.

facility which has been certified (B) Α as an ICF/MRICF/IID and has an Agreementa contract with the AuthorityOHCA will be paid only for recipient/patients whomembers that have been approved for ICF/MRICF/IID level When the facility is originally certified to of care. provide ICF/MRICF/IID services, payment for recipient/patients
member's currently residing in the facility who are approved for a NF level of care will be made if such care appropriate the is to recipient/patient's member's needs.

(f) **New facilities.** Any new facility in Oklahoma must receive, from the State Department of Health, a Certificate of Need. When construction of a new facility is completed and licensure and certification is imminent, facilities wishing to participate in the Title XIX Medicaid Program should request, by letter, an Agreement form When the Authority has received notification from the State Department of Health of the new facility's licensure, the Agreement will be sent to the facility for completion, if not previously sent.

(1) It is the responsibility of the new facility to request the State Survey Agency to perform a survey for Title XIX compliance.

(2) The effective date of the provider Agreement will be subsequent to completion of all requirements for participation in the Medicaid Program. In no case can payment be made for any period prior to the effective date of the facility's certification.

(f) **New facilities.** Any new facility in Oklahoma must receive a Certificate of Need from the State Department of Health. It is the responsibility of the new facility to request the State Survey Agency to perform a survey for Title XIX compliance.

(1) When construction of a new facility is completed and licensure and certification is imminent, facilities wishing to participate in the Title XIX Medicaid Program may apply electronically to become a Medicaid contracted provider.

(2) In no case can payment be made for any period prior to the effective date of the facility's certification.

(g) **Change of ownership.** The acquisition of a facility operation, either whole or in part, by lease or purchase, or if a new FEINFederal Employer Identification Number is required, constitutes a change of ownership. The new owner must follow provisions of the Nursing Home Care Act at Title 63 O.S. Section 1-1905 (D) (relating to transfers in ownership) and OAC 310:675-3-8 (relating to notice of change), as applicable. When such change occurs, it is necessary that a new Agreement<u>contract</u> be completed between the new owner and the <u>AuthorityOHCA</u> in order that payment can continue for the provision of nursing care.—If there is any doubt about whether a change of ownership has occurred, the facility owner should contact the State Department of Health for a final determination.

(1) License changes due to change of ownership. State Law prescribes specific requirements regarding the transfer of ownership of a nursing facilityNF from one person to another. transfer of ownership is When а contemplated, the buyer/seller or lessee/lessor must notify the State Department of Health, in writing, of the forthcoming transfer at least thirty (30) days prior to the final transfer and apply for a new facility license.

(2) **Certificate of Need.** A change of ownership is subject to review by the Oklahoma State Department of Health. Any person contemplating the acquisition of a nursing facility<u>NF</u> should contact Certificate of Need Division of the State Department of Health for further information regarding Certificate of

Need requirements.

(A) When a long term care facility changes ownership, federal regulations require automatic assignment of the Agreement to the new owner. An assigned Agreement is subject to all applicable statutes and regulations under which it was originally issued. This includes but is not limited to:

(i) any existing plan of correction,

(ii) any expiration date,

(iii) compliance with applicable health and safety regulations, and

(iv) compliance with any additional requirements imposed by the Medicaid agency.

(B) The new owner must obtain a Certificate of Need as well as a new facility license from the State Department of Health. Pending notification of licensure of the new owner, no changes are made to the Authority's' facility records (i.e., provider number) with the exception of change in administrator or change in name, if applicable.

(C) When notification and licensure from the State Department of Health is received, procedures for transmitting forms to the facility and completing the Agreement, as described in Agreement Procedures for New Facilities, will be followed.

(D) The effective date of a facility's change of ownership is the date specified on the new license issued by the State Department of Health to the new owner or lessee.

(A) The new owner must obtain a Certificate of Need as well as a new facility license from the State Department of Health. Pending notification of licensure, no changes will be made to the OHCA's facility records with the exception of change in administrator or change in name, if applicable.

(B) When a change in ownership does occur, the OHCA will automatically assign the contract to the new owner per federal regulation. By signing the contract, the new owner is representing to the OHCA that they meet the requirements of the contract and the requirements for participation in the Medicaid program. The new owner's contract is subject to the prior owner's contract terms and conditions that were in effect at the time of transfer of ownership, including compliance with all appropriate federal regulations.

(h) A nursing facility or ICF/IID dissatisfied with an action taken by the OHCA that is appealable as a matter of right pursuant to Subpart D of Part 431 of Title 42 of the Code of Federal Regulations, shall be afforded a hearing as provided by 42 CFR 431.153 or 431.154.

317:30-5-125. Trust funds

When a new <u>recipientmember</u> is admitted to a nursing facility, the administrator will complete and send to the county office the Management of Recipient's Funds form to indicate whether or not the <u>recipientmember</u> has requested the administrator to handle personal funds. If the administrator agrees to handle the <u>recipient'smember's</u> funds, the Management of Recipient's Funds form will be completed each time funds or other items of value, other than monthly income, are received.

(1) By using the Management of Recipient's Funds form as a source document, the facility personnel will prepare a Ledger Sheet for Recipient's Account in a form acceptable to the Authority, for each recipient for whom they are holding funds or other items of value. This form is used to keep an accurate accounting of all receipts and expenditures and the amount of money on hand at all times. This form is to be available in the facility for inspection and audit. The facility may use electronic ledgers and bank statements as the source documentation for each member for whom they are holding funds or other items of value. This information must be available at all times for inspection and audit purposes. The facility must have written policies that ensure complete accounting of the recipient's personal funds. All recipient'smember funds which are handled by the facility must be clearly identified and maintained separately from funds belonging to the facility or to private patients. When the total sum of all funds for all recipients members is \$250.00 or more, they must be deposited by the facility in a local bank account designated as "Recipient's Trust Funds." The funds are not to be commingled with the operating funds of the facility. Each resident in an ICF/MRICF/IID facility must be allowed to possess and use money in normal ways or be learning to do so.

(2) The facility is responsible for notifying the county office at any time a recipient'smember's account reaches or exceeds the maximum reserve by use of the Accounting-Recipient's Personal Funds and Property form. This form is also prepared by the facility when the recipientmember dies or is transferred or discharged, and at the time of the county eligibility review of the recipientmember.

(3) The Management of Recipient's Funds form, the Accounting-Recipient's Personal Funds and Property form, and the Ledger Sheets for Recipient's Account can be obtained from the local county DHS officeare available online at www.okdhs.org.

(4) When the ownership or operation of the facility is

discontinued or where the facility is sold and the recipients' members' trust funds are to be transferred to a successor facility, the status of all recipient'smembers' trust funds must be verified by the AuthorityOHCA and/or the buyer must be provided with written verification by an independent public accountant of all residents' monies and properties being transferred, and a signed receipt obtained from the owner. All transfers of recipient's a member's trust funds must be acknowledged, in writing, by the transferring facility and proper receipts given by the receiving facility. property of (5) Unclaimed funds or other deceased recipients members, with no known heirs, must be reported to the Oklahoma Tax Commission. If it remains unclaimed for a certain period, the money or property escheats to the State. (6) It is permissible to use an individual trust fund account to defray the cost of last illness, outstanding personal debts and burial expenses of a deceased recipientmember of this Authority the OHCA; however, any remaining balance of unclaimed funds must be reported to the Oklahoma Tax Commission. The Unclaimed Property Division, Oklahoma Tax Commission, State Capitol Complex, Oklahoma City, Oklahoma, is to be notified for disposition instructions on any unclaimed funds or property. No money is to be sent to the Oklahoma Tax Commission until so instructed by the Unclaimed Property Division.

(7) Books, records, ledgers, charge slips and receipts must be on file in the facility for a period of six (6) years and available at all times in the facility for inspection and audit purposes.

317:30-5-127. Notification of nursing facility changes

It is important that the nursing facility keep the Authority's Service Contracts Operations UnitOHCA Provider Enrollment and Contracts Unit informed of any change in administrator, operator, mailing address, or telephone number of the facility. Inaccurate information can cause a delay in receipt of payments or correspondence. The facility should also report all changes to the Oklahoma State Department of Health and the Oklahoma State Board of Nursing Homes.

317:30-5-128. Private rooms [REVOKED]

A private room may be provided for a recipient only on the written order of the patient's attending physician and only if the long term care facility agrees to collect any additional cost from someone other than the patient or spouse. The determination by the attending physician that a private room is needed will be on an individual patient basis and be for a period of not more than thirty (30) days. The physician's signed written order, must give full medical reasons for the need of this special service and the order must be included as a part of the individual patient's record in the facility. A redetermination in writing, by the patient's attending physician must be made for this special service each subsequent thirty (30) days to support a charge for a private room.

317:30-5-129. Required monthly notifications

(a) The Notification Regarding Patient in a Nursing Facility or <u>ICF/MRICF/IID</u> form is completed and forwarded to the local DHS office by the facility each time a <u>recipientmember</u> is admitted to or discharged from the facility <u>except for therapeutic leave</u> or hospital leave.

(b) A Computer Generated Notice or the Notice to Client Regarding Long-Term Medical Care form is used by the county office to notify the <u>recipientmember</u> and the facility of the amount of money, if any, the <u>recipientmember</u> is responsible for paying to the facility and the action taken with respect to the <u>patient'smember's</u> eligibility for nursing facility care. This form reflects dates of transfer between facilities and termination of eligibility for any reason.

317:30-5-131.2. Quality of care fund requirements and report

(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise:

(1) "Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities" means any home, establishment, or institution or any portion thereof, licensed by the State Department of Health as defined in Section 1 1902 of Title 63 of the Oklahoma Statutes.

(2) **"Quality of Care Fee"** means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in this State.

(3) "Quality of Care Fund" means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(4) **"Quality of Care Report"** means the monthly report developed by the Oklahoma Health Care Authority to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in the State.

(5) **"Staffing ratios"** means the minimum direct-care-staff-toresident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(6) **"Peak In-House Resident Count"** means the maximum number of in-house residents at any point in time during the applicable shift.

(7) **"Staff Hours worked by Shift"** means the number of hours worked during the applicable shift by direct care staff.

(8) "Direct-Care Staff" means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for individuals with intellectual disabilities pursuant to Section 1 1925.2 of Title 63 of the Oklahoma Statues, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.

(9) **"Major Fraction Thereof"** is defined as an additional threshold for direct care staff to resident ratios at which another direct care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct care staff to resident ratio pursuant to Section 1 1925.2 of Title 63 of the Oklahoma Statutes.

(10) "Minimum wage" means the amount paid per hour to specified staff pursuant to Section 5022.1 of Title 63 of the Oklahoma Statutes.

(11) "Specified staff" means the employee positions listed in the Oklahoma Statutes under Section 5022.1 of Title 63 and as defined in subsection (d) of this Section.

(12) **"Total Patient Days"** means the monthly patient days that are compensable for the current monthly Quality of Care Report.

(13) **"Total Gross Receipts"** means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, Private Pay and Insurance_including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.

(14) **"Service rate"** means the minimum direct-care-staff-toresident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(1) "Annualize" means that the calculations, including, for example, total patient days, gross revenue, or contractual allowances and discounts, is divided by the total number of applicable days in the relevant time period.

(2) **"Direct-Care Staff"** means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for individuals with intellectual disabilities pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statues, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.

(3) "Major Fraction Thereof" is defined as an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.

(4) "Minimum wage" means the amount paid per hour to specified staff pursuant to Section 5022.1 of Title 63 of the Oklahoma Statutes.

(5) "Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities" means any home, establishment, or institution or any portion thereof, licensed by the State Department of Health (OSDH) as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.

(6) **"Peak In-House Resident Count"** means the maximum number of in-house residents at any point in time during the applicable shift.

(7) "Quality of Care Fee" means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in this State.

(8) **"Quality of Care Fund"** means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(9) "Quality of Care Report" means the monthly report developed by the Oklahoma Health Care Authority (OHCA) to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in the State.

(10) **"Service rate"** means the minimum direct-care-staff-toresident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(11) "Specified staff" means the employee positions listed in the Oklahoma Statutes under Section 5022.1 of Title 63 and as defined in subsection (d) of this Section.

(12) "Staff Hours worked by Shift" means the number of hours worked during the applicable shift by direct-care staff.

(13	3) "S	taff	ing r	atios"	mean	s t	the	minin	num	direc	t-ca	ire-sta:	ff-
to-	resid	lent	ratio	s purs	uant	to	Sec	ction	1-1	925.2	of	Title	63
of	the	Okla	homa	Statute	es ai	nd	pur	suant	to	OAC	310	:675-1	et

seq.

(14) "Total Gross Receipts" means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, private pay, and insurance including the receipts for items not in normal per diem rate. Charitable contributions received by the nursing facility are not included.

(15) **"Total Patient Days"** means the monthly patient days that are compensable for the current monthly Quality of Care Report.

(b) Quality of care fund assessments.

(1) The Oklahoma Health Care Authority (OHCA)OHCA was mandated by the Oklahoma Legislature to assess a monthly service fee to each Licensed Nursing Facility in the State. The fee is assessed on a per patient day basis. The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for each facility type.

(2) In determination of the fee for the time period beginning October 1, 2000, a survey was mailed to each licensed nursing facility requesting calendar year 1999 Total Patient Days, Gross Revenues and Contractual Allowances and Discounts. This data is used to determine the amount of the fee to be assessed for the period of 10 01 00 through 06 30 01. The fee is determined by totaling the "annualized" gross revenue and dividing by the "annualized" total days of service. "Annualized" means that the surveys received that do not cover the whole year of 1999 are divided by the total number of days that are covered and multiplied by 365.

(3) The fee for subsequent State Fiscal Years is determined by using the monthly gross receipts and census reports for the six month period October 1 through March 31 of the prior fiscal year, annualizing those figures, and then determining the fee as defined above. As per 56 O.S. Section 2002, as amended, the fees are frozen at the amount in effect at July 1, 2004. Also, the fee will be monitored to never surpass the federal maximum.

(2) Annually the Nursing Facilities Quality of Care Fee shall be determined by using the daily patient census and patient gross receipts report received by the OHCA for the most recent available twelve months and annualizing those figures. Also, the fee will be monitored to never surpass the federal maximum.

(4) (3) The fee is authorized through the Medicaid State Plan and by the Centers for Medicare and Medicaid Services (CMS) regarding waiver of uniformity requirements related to the fee.

(5)(4) Monthly reports of Gross Receipts and Census are included in the monthly Quality of Care Report. The data required includes, but is not limited to, the Total Gross Receipts and Total Patient Days for the current monthly report.

(6) (5) The method of collection is as follows:

(A) The Oklahoma Health Care AuthorityOHCA assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two months prior to the month of the fee assessment billing. As defined in this subsection, the total assessment is the fee times the total days of service. The Oklahoma Health Care AuthorityOHCA notifies the facility of its assessment by the end of the month of the Quality of Care Report submission date.

(B) Payment is due to the Oklahoma Health Care AuthorityOHCA by the 15th of the following month. Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of 10% of the amount and interest of 1.25% per month. The Quality of Care Fee must be submitted no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m. (Central Standard Time) of the following business day (Monday-Friday).

(C) The monthly assessment, including applicable penalties and interest, must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the <u>AuthorityOHCA</u> the assessment within the time frames noted on the second invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. Adjustments to prior months' reported amounts for gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

(D) The Quality of Care fee assessments excluding penalties and interest are an allowable cost for Oklahoma Health Care AuthorityOHCA Cost Reporting purposes.

(E) The Quality of Care fund, which contains assessments collected excluding including penalties and interest as described in this subsection and any interest attributable to investment of any money in the fund, must be deposited in a revolving fund established in the State Treasury. The

funds will be used pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(c) Quality of care direct-care-staff-to resident-ratios.

(1) Effective September 1, 2000, allAll nursing facilities for and intermediate care facilities individuals with intellectual disabilities (ICFs/IID) subject to the Nursing Home Care Act, in addition to other state and federal staffing requirements, must maintain the minimum direct-carestaff-to-resident ratios or direct-care service rates as cited in Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(2) For purposes of staff-to-resident ratios, direct-care staff are limited to the following employee positions:

- (A) Registered Nurse
- (B) Licensed Practical Nurse
- (C) Nurse Aide
- (D) Certified Medication Aide

(E) Qualified Intellectual Disability Professional (ICFs/IID only)

- (F) Physical Therapist
- (G) Occupational Therapist
- (H) Respiratory Therapist
- (I) Speech Therapist
- (J) Therapy Aide/Assistant

(3) The hours of direct care rendered by persons filling nondirect care positions may be used when those persons are certified and rendering direct care in the positions listed in OAC 317:30-5-131.2(c)(2) when documented in the records and time sheets of the facility.

(4) In any shift when the direct-care-staff-to-resident ratio computation results in a major fraction thereof, direct-care staff is rounded to the next higher whole number.

(5) To document and report compliance with the provisions of this subsection, nursing facilities and intermediate care facilities for individuals with intellectual disabilities must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

(d) **Quality of care minimum wage for specified staff.** Effective November 1, 2000, all<u>All</u> nursing facilities and private intermediate care facilities for individuals with intellectual disabilities receiving Medicaid payments, in addition to other federal and state regulations, must pay specified staff not less than in the amount of \$6.65 per hour. Employee positions included for purposes of minimum wage for specified staff are as follows:

- (1) Registered Nurse
- (2) Licensed Practical Nurse

(3) Nurse Aide

(4) Certified Medication Aide

(5) Other Social Service Staff

(6) Other Activities Staff

(7) Combined Social Services/Activities

(8) Other Dietary Staff

(9) Housekeeping Supervisor and Staff

(10) Maintenance Supervisor and Staff

(11) Laundry Supervisor and Staff

(e) Quality of care reports. Effective September 1, 2000, allAll nursing facilities and intermediate care facilities for individuals with intellectual disabilities must submit a monthly report developed by the Oklahoma Health Care AuthorityOHCA, the Quality of Care Report, for the purposes of documenting the extent to which such facilities are compliant with the minimum direct-care-staff-to-resident ratios or direct-care service rates.

(1) The monthly report must be signed by the preparer and by the Owner, authorized Corporate Officer, or Administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b which states, in part, "Whoever...(2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefit or payment...shall (i) in the case of such statement, representation, concealment, failure, or conversion by any person in connection with furnishing (by that person) of items or services for which payment is or may be made under this title (42 U.S.C. '1320 et seq.), be quilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be quilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both.".

(4) The Quality of Care Report must be submitted by 5 p.m. (CST) on the 15th of the following month. If the 15th falls upon a holiday or a weekend (Saturday-Sunday), the report is due by 5 p.m. (CST) of the following business day (Monday - Friday).

(5) The Quality of Care Report will be made available in an

electronic version for uniform submission of the required data elements.

(6) Facilities must submit the monthly report through the OHCA Provider Portal.

(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the Long Term Care Financial Management Unit written notification with adequate, objective, and substantive five business days documentation within following the submission deadline. Any documentation received after the day period will not be five business considered in determining compliance and for reporting purposes by the Oklahoma Health Care AuthorityOHCA.

(8) An initial administrative penalty of \$150.00 is imposed upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the AuthorityOHCA notifying the facility in writing that the report was not complete or not timely submitted as required. The \$150.00 daily administrative penalty accrues for each calendar day after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For 100% private pay facilities, the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not Oklahoma Health Care AuthorityOHCA considered for Cost Reporting purposes.

(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information includes, but is not limited to: total gross receipts, patient days, available bed days, direct care hours, Medicare days, Medicaid days, number of employees, monthly resident census, and tenure of <u>Certified Nursing</u> <u>Assistantscertified nursing assistants</u>, nurses, directors of nursing, and administrators.

(10) Audits may be performed to determine compliance pursuant to subsections (b), (c), and (d) of this Section. Announced/unannounced on-site audits of reported information may also be performed.

(11) Direct-care-staff-to-resident information and on-site audit findings pursuant to subsection (c), will be reported to the Oklahoma State Department of HealthOSDH for their review in order to determine "willful" non-compliance and assess penalties accordingly pursuant to Title 63 Section 1-1912 through Section 1-1917 of the Oklahoma Statutes. The Oklahoma State Department of HealthOSHD informs the Oklahoma Health Care AuthorityOHCA of all final penalties as required in order to deduct from the Medicaid facility's payment. Imposed penalties are not considered for Oklahoma Health Care AuthorityOHCA Cost Reporting purposes.

(12) If a Medicaid provider is found non-compliant pursuant to subsection (d) based upon a desk audit and/or an on-site audit, for each hour paid to specified staff that does not meet the regulatory minimum wage of \$6.65, the facility must reimburse the employee(s) retroactively to meet the regulatory waqe for hours worked. Additionally, an administrative penalty of \$25.00 is imposed for each noncompliant staff hour worked. For Medicaid facilities, а deduction is made to their payment. Imposed penalties for non-compliance with minimum wage requirements are not considered for Oklahoma Health Care AuthorityOHCA Cost Reporting purposes.

(13) Under OAC 317:2-1-2, Long Term Care facility providers may appeal the administrative penalty described in (b)(5)(B) and (e)(8) and (e)(12) of this section.

(14) Facilities that have been authorized by the Oklahoma State Department of Health (OSDH)OSDH to implement flexible staff scheduling must comply with OAC 310:675-1 et seq. The authorized facility is required to complete the flexible staff scheduling section of Part A of the Quality of Care Owner, authorized Corporate Report. The Officer or Administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH authorization for Flexible Staff Scheduling.

317:30-5-132. Cost reports

Each Medicaid-participating long term care facility is required to submit an annual uniform cost report, designed by OHCA, for the state fiscal year just completed. The state fiscal year is July 1 through June 30. The reports must be submitted to the OHCA on or before the last day of October of the subsequent year.

(1) The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions.

(2) The cost report must be filed using the Secure Website. The instructions and data entry screen simulations will be made available on the OHCA public website<u>under</u> the <u>Provider/Long Term Care Facility/Cost Reporting options</u>.

(3) When there is a change of operation or ownership, the selling or closing ownership is required to file a cost

report for that portion of the fiscal year it was in operation. The successor ownership is correspondingly required to file a cost report for that portion of the fiscal year it was in operation. These "Partial Year Reports" must be filed on paper or electronically by e-mail (not on the secure website system) to the Finance Division of the OHCA on the forms and by the instructions found on the OHCA public website (see directions as noted above).

(4) Cost report instructions are available on the public website at OKHCA.org/Provider/Opportunitiesforliving life/longtermcarefacilities.

(5)(4) Normally, all ordinary and necessary expenses net of any offsets of credits incurred in the conduct of an economical and efficiently operated business are recognized as allowable. Allowable costs include all items of Medicaidcovered expense which nursing facilities incur in the provision of routine services. "Routine services" include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-thecounter medications, transportation, dental examinations, dentures and related services, eye glasses, routine eye examinations, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. (The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.) Ancillary items reimbursed outside the nursing facility rate are not included in the cost report and are not allowable costs.

 $\frac{(6)}{(5)}$ All reports are subject to on-site audits and are deemed public records.

317:30-5-133. Payment methodologies

(a) Private Nursing Facilities.

(1) Facilities. Private Nursing Facilities include:

(A) Nursing Facilities serving adults (NF),

(B) Nursing Facilities serving Aids Patients (NF-Aids),

(C) Nursing Facilities serving Ventilator Patients (NF-Vents),

(D) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID),

(E) Intermediate Care Facilities with 16 beds or less serving <u>Severelyseverly</u> or <u>Profoundlyprofoundly</u> intellectually disabled Patients (Acute ICF/IID), and

(F) Payment will be made for non-routine nursing facility services identified in an individual treatment plan prepared by the State MRIntellectual Disabilities (ID) Authority. Services are limited to individuals approved for NF and specialized services as the result of a PASRR/MRPASRR/ID Level II screen. The per diem add-on is calculated as the difference in the statewide average standard private MRID base rate and the statewide facility base rate. If the standard private ID average base rate falls below the standard NF base rate or equals the standard facility base rate for regular NFs, the payment will not be adjusted for specialized services.

(2) **Reimbursement calculations.** Rates for Private Nursing FacilitiesNFs will be reviewed periodically and adjusted as necessary through a public process. Payment will be made to Private Nursing FacilitiesNFs pursuant to the methodology described in the Oklahoma Title XIX State Plan.

(b) **Public Nursing Facilities.** Reimbursement for public Intermediate Care Facilities for Individuals with Intellectual Disabilities(ICFs/IID)ICFs/IID shall be based on each facility's reasonable cost and shall be paid on an interim basis with an annual retroactive adjustment. Reasonable costs shall be based on Medicare principles of cost reimbursement as set forth in the provider reimbursement manual.

317:30-5-133.1. Routine services

(a) Nursing facility care includes routine items and services be provided directly or through that must appropriate facility required by arrangement by the when SoonerCare residents. Charges for routine services may not be made to resident's personal funds or to resident family members, guardians, or other parties who have responsibility for the resident. If reimbursement is available from Medicare or another public or private insurance or benefit program, those programs are billed by the facility. In the absence of other available reimbursement, the facility must provide routine services from the funds received from the regular SoonerCare vendor payment and the SoonerCare resident's applied income, or spend down amount.

(b) The Oklahoma Health Care AuthorityOHCA will review the listing periodically for additions or deletions, as indicated. Routine services are <u>patientmember</u> specific and <u>provided</u> in accordance with standard medical care. Routine Services include, but are not limited to:

- (1) Regular room $\dot{\tau}$.
- (2) Dietary Services:
 - (A) regular diets,

- (B) special diets-;
- (C) salt and sugar substitutes;
- (D) supplemental feedings-;
- (E) special dietary preparations;
- (F) equipment required for preparing and dispensing tube and oral feedings $_{\tau}$; and
- (G) special feeding devices (furnished or arranged for) \div .

(3) Medically related social services to attain or maintain the highest practicable physical, mental and psycho social<u>psycho-social</u> well-being of each resident, nursing care, and activities programs (costs for a private duty nurse or sitter are not allowed)÷.

(4) Personal services - personal laundry services for residents (does not include dry cleaning) \div .

(5) Personal hygiene items (personal care items required to be provided does not include electrical appliances such as shavers and hair dryers, or individual personal batteries), to include:

- (A) shampoo, comb, and brush;
- (B) bath soap;

(C) disinfecting soaps or specialized cleansing agents when indicated to treat or prevent special skin problems or to fight infection;

- (D) razor and/or shaving cream;
- (E) nail hygiene services; and

(F) sanitary napkins, douche supplies, perineal irrigation equipment, solutions, and disposable douches+.

- (6) Routine oral hygiene items, including:
 - (A) toothbrushes ;
 - (B) toothpaste ;
 - (C) dental floss ;
 - (D) lemon glycerin swabs or equivalent products ; and

(E) denture cleaners, denture adhesives, and containers

for dental prosthetic appliances such as dentures and partial dentures.

(7) Necessary items furnished routinely as needed to all patientsmembers, e.g., water pitcher, cup and tray, towels, wash cloths, hospital gowns, emesis basin, bedpan, and urinal.

(8) The facility will furnish as needed items such as alcohol, applicators, cotton balls, tongue depressors. Also and, first aid supplies, including small bandages, ointments and preparations for minor cuts and abrasions, and enema supplies, including disposable enemas, gauze, 4 x 4's ABD pads, surgical and micropore tape, telfa gauze, ace bandages, etc.

(9) Over the counter drugs (non-legend) not covered by the

prescription drug program (PRN or routine). In general, nursing facilities are not required to provide any particular brand of non-legend drugs, only those items necessary to ensure appropriate care.

(A) If the physician orders a brand specific non-legend drug with no generic equivalent, the facility must provide the drug at no cost to the <u>patientmember</u>. If the physician orders a brand specific non-legend drug that has a generic equivalent, the facility may choose a generic equivalent, upon approval of the ordering physician;

(B) If the physician does not order a specific type or brand of non-legend drug, the facility may choose the type or brand;

(C) If the member, family, or other responsible party (excluding nursing facility)(excluding the nursing facility) prefers a specific type or brand of non-legend drug rather than the ones furnished by the facility, the member, family or responsible party may be charged the difference between the cost of the brand the resident requests and the cost of the brand generally provided by the facility. (Facilities are not required to provide an unlimited variety of brands of these items and services. It is the required assessment of resident needs, not resident preferences, that will dictate the variety of products facilities need to provide);

(D) Before purchasing or charging for the preferred items, the facility must secure written authorization from the member, family member, or responsible party indicating his or her desired preference, as well as the date and signature of the person requesting the preferred item. The signature may not be that of an employee of the facility. The authorization is valid until rescinded by the maker of the instrument;

(10) The facility will furnish or obtain any necessary equipment to meet the needs of the <u>patientmember</u> upon physician order. Examples include: trapeze bars and overhead frames, foot and arm boards, bed rails, cradles, wheelchairs and/or geriatric chairs, foot stools, adjustable crutches, canes, walkers, bedside commode chairs, hot water bottles or heating <u>padpads</u>, ice bags, sand bags, traction equipment, IV stands, etc.

(11) Physician prescribed lotions, ointments, powders, medications and special dressings for the prevention and treatment of decubitus ulcers, skin tears and related conditions, when medications are not covered under the Vendor Drug Program or other third party payer \div .

(12) Supplies required for dispensing medications, including

needles, syringes including insulin syringes, tubing for IVs, paper cups, medicine containers, etc.+

(13) Equipment and supplies required for simple tests and examinations, including scales, sphygmomanometers, stethoscopes, clinitest, acetest, dextrostix, pulse oximeters, blood glucose meters and test strips, etc.;

(14) Underpads and diapers, waterproof sheeting and pants, etc., as required for incontinence or other care.

(A) If the assessment and care planning process determines that it is medically necessary for the resident to use diapers as part of a plan to achieve proper management of incontinence, and if the resident has a current physician order for adult diapers, then the facility must provide the diapers without charge;

(B) If the resident or the family requests the use of disposable diapers and they are not prescribed or consistent with the facility's methods for incontinent care, the resident/family would be responsible for the expense;

(15) Oxygen for emergency use, or intermittent use as prescribed by the physician for medical necessity *i*.

(16) Other physician ordered equipment to adequately care for the <u>patientmember</u> and in accordance with standard patient care, including infusion pumps and supplies, and nebulizers and supplies, etc.

(17) Dentures and Related Services. Payment for the cost of dentures and related services is included in the daily rate for routine services. The projected schedule for routine denture services must be documented on the Admission Plan of Care and on the Annual Plan of Care. The medical records must also contain documentation of steps taken to obtain the services. When the provision of denture services is medically appropriate, the nursing facility must make timely arrangements for the provision of these services by licensed dentists. In the event dentures denture services are not medically appropriate, the treatment plan must reflect the reason the service isservices are not considered appropriate, the patientmember is solid i.e.e.g., unable to ingest nutrition-or is comatose, etc. When the need for dentures is identified, one set of complete dentures or partial dentures and one dental examination is considered medically appropriate every three years. One rebase and/or one reline is considered appropriate eachevery three years. It is the responsibility of the nursing facility to ensure that the has adequate assistance in the member proper care, maintenance, identification and replacement of these items. The nursing facility cannot set up payment limits which

result in barriers to obtaining denture services. However, the nursing facility may restrict the providers of denture services to providers who have entered into payment arrangements with the facility. The facility may also choose to purchase a private insurance dental coverage product for each SoonerCare member. TheAt a minimum, the policy must cover at a minimum all denture services included in routine services. The member cannot be expected to pay any copayments and/or deductibles. If a difference of opinion occurs between the nursing facility, member, and/or family regarding the provision of dentures services, the OHCA will be the final authority. All members and/or families must be informed of their right to appeal at the time of admission and yearly thereafter. The member cannot be denied admission to a facility because of the need for denture services.

(18)Vision Services. Routine eye examinations for the purpose of medical screening or prescribing or changing glasses and the cost of glasses are included in the daily rate for routine services. This does not include follow-up or treatment of known eye disease such as diabetic retinopathy, conjunctivitis, corneal ulcers, qlaucoma, iritis, etc. known Treatment of eye disease is a benefit of the patient's medical plan. The projected schedule for routine vision care must be documented on the Admission Plan of Care and on the Annual Plan of Care. The medical record must contain documentation of the steps that have been taken vision to access the service. When services are not appropriate, documentation of why vision services are not medically appropriate must be included in the treatment plan. For example, patient the member is comatose, unresponsive, etc. Nursing Home providers may contract blind, with individual eye care providers, providers groups or a vision plan to provide routine vision services to their members. The member cannot be expected to pay any co-payments and/or deductibles.

(A) The following minimum level of services must be included:

(i) Individuals 21 to 40 years of age are eligible for one routine eye examination and one pair of glasses every 36 months (three years).

(ii) Individuals 41 to 64 years of age are eligible for one routine eye examination and one pair of glasses every 24 months (2 years).

(iii)<u>Individuals</u> Individuals 65 years of age or older are eligible for one routine eye examination and one pair of glasses eachevery 12 months (yearly).

(B) It is the responsibility of the nursing facility to

ensure that the member has adequate assistance in the proper care, maintenance, identification and replacement of these items. When vision services have been identified as a needed service, nursing facility staff will make timely arrangements for provision of these services by licensed ophthalmologists or optometrists. If a difference of opinion occurs between the nursing facility, member, and/or family regarding the provision of vision services, the OHCA will be the final authority. All members and/or families must be informed of their right to appeal at admission and yearly thereafter. The member cannot be denied admission to the facility because of the need for vision services.

(19) An attendant to accompany SoonerCare eligible members during SoonerRide Non-Emergency Transportation (NET). Please refer to OAC 317:30-5-326 through OAC 317:30-5-327.9 for SoonerRide rules regarding members residing in a nursing facility. And

(20) Influenza and pneumococcal vaccinations.