

Oklahoma Health Care Authority

The Oklahoma Health Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's [Proposed Changes Blog](#).

OHCA COMMENT DUE DATE: November 11, 2020

The proposed policy is an Emergency Rule. The proposed policy was presented at the November 3, 2020 Tribal Consultation. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on November 12, 2020 and the OHCA Board of Directors on November 12, 2020.

Reference: APA WF 20-19B

SUMMARY:

Appeals and Incorrect References Language Cleanup - The proposed revisions will revise certain sections of policy that have references to incorrect or outdated sections.

LEGAL AUTHORITY

The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 20-19B

A. Brief description of the purpose of the rule:

The proposed rule changes will replace incorrect rule section references with the appropriate references. Additionally, revisions will remove appeals language for programs that no longer exist and will involve minor cleanup to fix grammatical and formatting errors.

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:

SoonerCare members and providers will be affected by the proposed rule. This rule should not place any cost burden on private or public entities. No information on any cost impacts were received from any entity.

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

SoonerCare members and providers will benefit from the proposed rule changes that update incorrect references, as they will now have the proper reference cited when filing an appeal or researching appropriate policies.

- 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:

There is no probable economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

- 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 effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

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

- 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 agency does not anticipate that the proposed rule changes will have an adverse effect on small businesses.

- H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there are no other legal methods to achieve the purpose of the proposed rule. Measures included a formal public comment period and tribal consultation.

- 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 proposed rule changes are not designed to reduce any significant risks to the public health, safety, and environment.

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

The agency anticipates that in the absence of these rule changes, there would not be any detrimental effect on the public health, safety, and environment.

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

Prepared: October 13, 2020

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

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) **"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 Statutes, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.

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

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

(6) **"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.

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

(8) **"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.

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

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

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

(12) **"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.

(13) **"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 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) 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 (12) months and annualizing those figures. Also, the fee will be monitored to never surpass the federal maximum.

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

(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.

(5) The method of collection is as follows:

(A) The OHCA assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two (2) 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 OHCA 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 OHCA 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 percent (10%) of the amount and interest of 1.25 percent (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 (CST), 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 OHCA 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 OHCA cost reporting purposes.

(E) The Quality of Care fund, which contains assessments collected 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) All nursing facilities and intermediate care facilities for 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-care-staff-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; and
- (J) Therapy Aide/Assistant.

(3) The hours of direct care rendered by persons filling non-direct 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 ICFs/IID must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

(d) **Quality of care reports.** All nursing facilities and ~~intermediate care facilities for individuals with intellectual disabilities~~ ICFs/IID must submit a monthly report developed by the OHCA, 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.

(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 documentation within five (5) business days following the submission deadline. Any documentation received after the five (5) business day period will not be considered in determining compliance and for reporting purposes by the OHCA.

(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 OHCA 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 percent (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 considered for OHCA 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 certified nursing assistants, nurses, directors of nursing, and administrators.

(10) Audits may be performed to determine compliance pursuant to subsections (b) and (c) 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 OSDH 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 OSDH informs the OHCA of all final penalties as required in order to deduct from the Medicaid facility's payment. Imposed penalties are not considered for OHCA 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 wage for hours worked. Additionally, an administrative penalty of \$25.00 is imposed for each non-compliant staff hour worked. For Medicaid facilities, a deduction is made to their payment. Imposed penalties for non-compliance with minimum wage requirements are not considered for OHCA cost reporting purposes.~~

~~(13)~~ (12) Under OAC 317:2-1-2, long-term care facility providers may appeal the administrative penalty described in (b) (5) (B) and ~~(c) (8) and (c) (12) (d) (8)~~ of this section.

~~(14)~~ (13) Facilities that have been authorized by the 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 Report. The owner, authorized corporate

officer, or administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH authorization for flexible staff scheduling.

PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH-RELATED SERVICES

317:30-5-1020. General provisions

(a) School-based services are medically necessary health-related and rehabilitative services that are provided by a qualified school provider to a student under the age of ~~21~~twenty-one (21) pursuant to an Individualized Education Program (IEP), in accordance with the Individuals with Disabilities Education Act (IDEA). Payment is made to qualified school providers for delivery of school-based services, provided that such services are, among other things, medically necessary and sufficiently supported by medical records and/or other documentation, as explained below.

(b) An IEP and all relevant supporting documentation, including, but not limited to, the documentation required by ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-1020(c), below, serves as the plan of care for consideration of reimbursement for school-based services. The plan of care must contain, among other things, the signatures, including credentials, of the provider(s) and the direct care staff delivering services under the supervision of the professional; as well as a complete, signed, and current IEP which clearly establishes the type, frequency, and duration of the service(s) to be provided, the specific place of services if other than the school (e.g., field trip, home), and measurable goals for each of the identified needs. Goals must be updated to reflect the current therapy, evaluation, or service that is being provided and billed to SoonerCare.

(1) Except for those services, referenced in ~~Oklahoma Administrative Code (OAC)~~OAC 317:30-5-1023(b) ~~(42)~~ (H), a plan of care that meets the requirements of OAC 317:30-5-1020(b), above, shall serve as a prior medical authorization for the purpose of providing medically necessary and appropriate school-based services to students.

(2) For the purposes of occupational therapy services, and services for members with speech, hearing, and language disorders, a plan of care that meets the requirements of OAC 317:30-5-1020(b), above, may also, in accordance with sections (§§) 725.2(H) and 888.4(C) of Title 59 of the Oklahoma Statutes (O.S.) serve as a valid prescription or referral for an initial evaluation and any subsequent services, as is required by Title 42 of Code of Federal Regulations (C.F.R.), § 440.110.

(3) Physical therapy services, by contrast, shall require a signed and dated prescription from the student's physician

prior to that student's initial evaluation, in accordance with OAC 317:30-5-291(1). Prescriptions for school-based physical therapy must be reauthorized at least annually, and documented within Oklahoma State Department of Education's (OSDE) online IEP system, as set forth in subsection (c), below.

(c) Qualified school providers must ensure that adequate documentation is maintained within the OSDE online IEP system in order to substantiate that all school-based services billed to SoonerCare are medically necessary and comply with applicable state and federal Medicaid law. Such documentation shall include, among other things:

(1) Documentation establishing sufficient notification to a member's parents and receipt of adequate, written consent from them, prior to accessing a member's or parent's public benefits or insurance for the first time, and annually thereafter, in accordance with 34 C.F.R. § 300.154;

(2) Any referral or prescription that is required by state or federal law for the provision of school-based services, or for the payment thereof, in whole or in part, from public funds, including, but not limited to, 42 C.F.R. § 440.110. However, any prescription or referral ordered by a physician or other licensed practitioner of the healing arts who has, or whose immediate family member has, a financial interest in the delivery of the underlying service in violation of Section 1395nn, Title 42 of United States Code shall not be valid, and services provided thereto shall not be eligible for reimbursement by the Oklahoma Health Care Authority (OHCA);

(3) An annual evaluation located in or attached to the IEP that clearly demonstrates, by means of the member's diagnosis and any other relevant supporting information, that school-based services are medically necessary, in accordance with OAC 317:30-3-1(f). Evaluations completed solely for educational purposes are not compensable. Evaluations must be completed annually and updated to accurately reflect the student's current status. Any evaluation for medically necessary school-based services, including but not limited to, hearing and speech services, physical therapy, occupational therapy, and psychological therapy, must include the following information:

(A) Documentation that supports why the member was referred for evaluation;

(B) A diagnosis that clearly establishes and supports the need for school-based services;

(C) A summary of the member's strengths, needs, and interests;

(D) The recommended interventions for identified needs, including outcomes and goals;

(E) The recommended units and frequency of services; and

- (F) A dated signature and the credentials of the professional completing the evaluation; and
- (4) Documentation that establishes the medical necessity of the school-based services being provided between annual evaluations, including, for example, professional notes or updates, reports, and/or assessments that are signed, dated, and credentialed by the rendering practitioner.
- (d) All claims related to school-based services that are submitted to OHCA for reimbursement must include any numeric identifier obtained from OSDE.