BILL ANALYSIS

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S.B. 1050
By: Hughes
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The Texas nursing home industry has faced closures and consolidations in the last year that are unprecedented. In 2018, the largest nursing home provider in Texas filed for bankruptcy. Also in 2018, one of the largest nursing home operators in the country exited Texas after having come to Texas less than five years ago. Multiple homes in rural Texas closed for various reasons that led to financial losses that could not be overcome. According to data collected from providers across Texas, approximately 25 percent of nursing homes reported annual losses exceeding $250,000. Whereas 75 percent report that Medicaid reimbursements do not cover their costs for providing care.

For frail and elderly individuals whose medical condition regularly requires the skills of licensed nurses, nursing homes are paid a Medicaid daily rate or per diem based on the patient's acute or physical care needs.

Summary:

S.B. 1050 amends the Health and Safety Code to establish the Texas Nursing Home Quality Act (NHQA) and Trust Fund to direct improvements related to quality outcomes in Texas nursing homes. Under authorization in the bill, Texas will utilize a Method of Finance (MOF) currently deployed in 43 other states and the District of Columbia. Under this MOF, nursing facilities make payments to the Health and Human Services Commission (HHSC) to access federal match dollars available and currently used by other states and the District of Columbia. The payments collected are deposited in a Trust Fund within the comptroller of Public Accounts of the State of Texas. These funds would be held with other trusts outside the treasury, but managed by the comptroller.

The funds would be used as a MOF of state match to draw down federal matching funds under Title XIX or Medicaid, not unlike the state's current finance system deployed under managed care and the 1115 Waiver for hospital programs. The additional funds would be directed towards investments improving care delivery and increased payment for providers that achieve improvement in quality outcomes. The bill prohibits these funds from being used to expand Medicaid. The bill exempts certain provider types (State-owned Veteran Homes, Continuous Care Retirement Communitites and Non-profit facilities) from making payments to HHSC. The bill will increase the quality of and stability of nursing home in Texas, especially in rural parts of the state.

As proposed, S.B. 1050 amends current law relating to the creation and operation of a health care quality provider participation program and authorizes an administrative penalty.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 1 (Sections 242.707 and 242.711, Health and Safety Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 242, Health and Safety Code, by adding Subchapter P, as follows:

SUBCHAPTER P. QUALITY PROVIDER PARTICIPATION PROGRAM

Sec. 242.701. PURPOSE. Provides that the purpose of this subchapter is to authorize the Health and Human Services Commission (HHSC) to administer a long-term care quality provider participation program that provides additional compensation to nursing facilities that meet quality requirements and to increase Medicaid reimbursement rates by collecting payments from certain nursing facilities. Requires the payments to be used to pay the nonfederal share of the quality provider participation program and for other purposes authorized by this subchapter.

Sec. 242.702. DEFINITION. Defines "non-Medicare resident day."

Sec. 242.703. APPLICABILITY. Provides that this subchapter does not apply to:

(1) a state-owned veterans nursing facility;

(2) a facility that provides on a single campus a combination of services, which may include independent living services, licensed assisted living services, or licensed nursing facility care services, and that either:

(A) holds a certificate of authority to operate a continuing care retirement community under Chapter 246 (Continuing Care Facilities); or

(B) had during the previous 12 months:

(i) a combined number of non-Medicare resident days of service provided to independent living and assisted living residents, excluding services provided to persons occupying facility beds in a licensed nursing facility, that exceeded the number of non-Medicare resident days of service provided to nursing facility residents; and

(ii) on a contiguous campus of a facility, a minimum ratio of two licensed independent or assisted living beds for each one nursing facility bed; or

(3) a nonprofit corporation governed by Chapter 22 (Nonprofit Corporations), Business Organizations Code.

Sec. 242.704. CALCULATION OF PAYMENTS. (a) Requires each nursing facility to which this subchapter applies to pay a quality provider participation payment. Prohibits the amount of payment from being uniform to satisfy the redistributive requirements of 42 C.F.R. Section 433.68(e)(2)(i).

(b) Requires HHSC to annually calculate the quality provider participation payment. Requires the payment to be set in accordance with the maximum rate allowed under 42 C.F.R. Section 433.68(f)(3)(i).

(c) Authorizes HHSC, if, during the course of the state fiscal year, HHSC determines that the total amount of quality provider participation payment revenue differs significantly from the amount previously estimated, to recalculate and prospectively modify the payment amount to reflect the recalculation.

(d) Prohibits a nursing facility from listing the quality provider participation payment as a separate charge on a resident's billing statement or otherwise directly or indirectly attempting to charge the payment to a resident.

Sec. 242.705. RESIDENT DAYS. Requires a nursing facility, for each calendar day, to determine the number of non-Medicare resident days by adding the number of

non-Medicare residents occupying a bed in the nursing facility immediately before midnight of that day plus the number of residents admitted that day, less the number of residents discharged that day, except that a resident is included in the count under this section if the resident is admitted and discharged on the same day or the resident is discharged that day because of the resident's death.

Sec. 242.706. COLLECTION AND REPORTING. (a) Requires HHSC to impose and collect the quality provider participation payment.

(b) Requires each nursing facility, not later than the 25th day after the last day of a month, to file with HHSC a report stating the total non-Medicare resident days for the month and pay the quality provider participation payment.

Sec. 242.707. RULES; ADMINISTRATIVE PENALTY. (a) Requires the executive commissioner of HHSC (executive commissioner) to adopt rules to administer this subchapter, including rules related to imposing and collecting the quality provider participation payment.

(b) Prohibits an administrative penalty assessed under Section 242.066 for a violation of this subchapter, notwithstanding that section, from exceeding the greater of one-half of the amount of the nursing facility's outstanding quality provider participation payment or $20,000.

(c) Provides that an administrative penalty assessed for a violation of this subchapter is in addition to the nursing facility's outstanding quality provider participation payment.

(d) Provides that a facility described by Section 242.703 is not subject to an administrative penalty under this subchapter.

Sec. 242.708. QUALITY PROVIDER PARTICIPATION PROGRAM TRUST FUND. (a) Provides that the quality provider participation payment trust fund is established as a trust fund to be held by the comptroller of public accounts of the State of Texas (comptroller) outside of the state treasury and administered by HHSC as trustee. Requires interest and income from the assets of the trust fund to be credited to and deposited in the trust fund. Authorizes HHSC to use money in the fund only as provided by Section 242.709.

(b) Requires HHSC to remit the quality provider participation payment collected under this subchapter to the comptroller for deposit in the trust fund.

Sec. 242.709. REIMBURSEMENT OF FACILITIES. (a) Requires the comptroller to use money in the quality provider participation payment trust fund, along with any corresponding federal matching funds, only for the following purposes:

(1) paying any reasonable and necessary HHSC cost to develop and administer systems for managing the quality provider participation payment;

(2) reimbursing the Medicaid share of the payment as an allowable cost in the Medicaid daily rate; and

(3) allocating the remainder to improve resident care and quality of life and to be distributed as follows:

(A) 50 percent of the remainder is required to be distributed through increased reimbursement rates to nursing facilities that participate in the state Medicaid program and demonstrate historical expenditures for capital improvements, renovations, or

other enhancements designed to create a more home-like environment, wages and benefits, or other direct care services; and

(B) 50 percent of the remainder is required to be distributed to nursing facilities based on the following order of importance:

(i) performance under the Centers for Medicare and Medicaid Services five-star quality rating system;

(ii) increases in direct care staffing and revenue enhancements program funding for participating facilities under Sections 32.028(g) (relating to requiring the executive commissioner to ensure that rules governing the determination of rates paid for nursing facilities improve the quality of care) and (i) (relating to requiring the executive commissioner to ensure rules governing the incentives program meet certain standards), Human Resources Code, to the maximum level achieved and allowed for those facilities on September 1, 2019; and

(iii) development and funding of additional quality provider participation payments for unique, long-term care needs that are not funded separately, including Alzheimer's disease, dementia, obesity, and other conditions or initiatives identified by HHSC.

(a-1) Requires HHSC, notwithstanding Subsection (a)(3), before September 1, 2020, to allocate 100 percent of the remainder of the money described by that subsection for distribution to nursing facilities that participate in the state Medicaid program.

(a-2) Prohibits the programs described by Subsection (a)(3) from beginning earlier than September 1, 2020. Provides that this subsection and Subsection (a-1) expire September 1, 2023.

(b) Requires HHSC, in consultation with the advisory committee established under Section 242.712, to devise a formula by which amounts received under this subchapter increase the reimbursement rates paid to nursing facilities under the state Medicaid program consistent with Subsection (a)(3) and with the goal of improving resident care and quality. Requires HHSC, in consultation with the advisory committee, to develop a weighted formula for distributing the money described by Subsection (a)(3)(B).

(c) Requires HHSC to distribute unearned money for the program described by Subsection (a)(3) to all nursing facilities that qualify for a distribution in proportion to the amount of the total earned money each qualifying nursing facility receives.

(d) Prohibits money in the quality provider participation payment trust fund from being used to expand Medicaid eligibility under the Patient Protection and Affordable Care Act (Pub. L. No. 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111–152).

Sec. 242.710. INVALIDITY; FEDERAL FUNDS. Requires HHSC, if any provision of or any procedure under this subchapter is held invalid by a final court order that is not subject to appeal, or if HHSC determines that the imposition of the quality provider participation payment and the expenditure of amounts collected as prescribed by this subchapter will not entitle the state to receive federal matching funds under the Medicaid program or will be inconsistent with the objectives described by Section 537.002 (b)(7) (relating to flexibility in the use of state funds used to obtain federal matching funds), to:

(1) stop collection of the payment; and

(2) not later than the 30th day after the date collection is stopped, return to each nursing facility, in proportion to the total amount paid by each facility compared to the total amount paid by all facilities, any unspent money deposited to the credit of the quality provider participation payment trust fund.

Sec. 242.711. AUTHORITY TO ACCOMPLISH PURPOSES OF SUBCHAPTER. (a) Authorizes the executive commissioner by rule, subject to Subsection (b), to adopt a definition, a method of computation, or a rate that differs from those expressly provided by or expressly authorized by this subchapter to the extent the difference is necessary to accomplish the purposes of this subchapter.

(c) Prohibits the executive commissioner from modifying the applicability of this subchapter under Section 242.703.

Sec. 242.712. ADVISORY COMMITTEE. (a) Requires HHSC to establish an advisory committee of interested persons to make recommendations to HHSC before the adoption of a rule, policy, or procedure affecting persons regulated under this subchapter. Provides that the advisory committee has the purposes, powers, and duties prescribed by HHSC.

(b) Provides that Chapter 2110 (State Agency Advisory Committees), Government Code, does not apply to the advisory committee.

(c) Requires HHSC to appoint to the advisory committee individuals who are selected from a list provided by the executive commissioner, have knowledge about and interests in the work of the advisory committee, and represent a broad range of viewpoints on the work of the advisory committee.

(d) Requires the advisory committee to include a member of the public if HHSC determines that is appropriate and beneficial.

(e) Prohibits a member of the advisory committee from receiving compensation for serving on the advisory committee and from being reimbursed for travel expenses incurred while conducting the business of the advisory committee.

(f) Provides that meetings of the advisory committee are subject to Chapter 551 (Open Meetings), Government Code.

Sec. 242.713. EXPIRATION. Provides that this subchapter expires August 31, 2029.

SECTION 2. (a) Requires the executive commissioner, not later than January 1, 2020, to establish the advisory committee as required by Section 242.712, Health and Safety Code, as added by this Act.

(b) Requires the executive commissioner, as soon as practicable after the effective date of this Act, to:

(1) in consultation with the advisory committee established under Section 242.712, Health and Safety Code, as added by this Act, adopt the rules necessary to implement Subchapter P, Chapter 242, Health and Safety Code, as added by this Act; and

(2) notwithstanding Section 242.704, Health and Safety Code, as added by this Act, establish the amount of the initial payment imposed under Subchapter P, Chapter 242, Health and Safety Code, as added by this Act, based on available revenue and resident day information.

(c) Provides that the amount of the initial payment established under Subsection (b) of this section remains in effect until HHSC obtains the information necessary to set the amount of the payment under Section 242.704, Health and Safety Code, as added by this Act.

SECTION 3. Requires the agency affected by any provision of this Act, if before implementing the provision Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, to request the waiver or authorization and to delay implementing that provision until the waiver or authorization is granted. Requires the agency to begin implementing the provision on the date the waiver or authorization is granted.

SECTION 4. Prohibits a payment, notwithstanding any other law, from being imposed under Section 242.704, Health and Safety Code, as added by this Act, or collected under Section 242.706, Health and Safety Code, as added by this Act, until an amendment to the state Medicaid plan that increases the rates paid to long-term care facilities licensed under Chapter 242 (Convalescent and Nursing Facilities and Related Institutions), Health and Safety Code, for providing services under the state Medicaid program is approved by the Centers for Medicare and Medicaid Services or another applicable federal government agency.

SECTION 5. Requires HHSC to retroactively compensate long-term care facilities licensed under Chapter 242, Health and Safety Code, at the increased rate for services provided under the state Medicaid program beginning on the date the state Medicaid plan amendment is approved by the Centers for Medicare and Medicaid Services or another applicable federal government agency and only for the period for which the payment has been imposed and collected.

SECTION 6. Requires HHSC to discontinue the payment imposed under Subchapter P, Chapter 242, Health and Safety Code, as added by this Act, if HHSC reduces Medicaid reimbursement rates below the sum of the rates in effect on September 1, 2019, and the rates that increased due to funds from the quality provider participation payment trust fund and federal matching funds.

SECTION 7. Effective date: upon passage or September 1, 2019.