HHSC: Long-term Care Facilities Council December 7, 2021

Long-term Care Facilities Council shall study and make recommendations regarding a more consistent survey and informal dispute resolution process for long-term care facilities, the Medicaid quality-based payment systems for these facilities, and the allocation of Medicaid beds in these facilities. Members include:

Ryan Harrington, Chairperson
Assisted Living Services Provider Category
Fort Worth

Allison Levee
State Agency Responsible for Informal Dispute Resolution Category
Austin

Byron Burris, II
For-profit and Non-profit Nursing Facility Provider Category
Victoria

Linda Lothringer
Survey Enforcement within The State Survey and Certification Agency Category
San Antonio

Dr. Michael Fischer
Physician with Expertise in Infectious Disease or Public Health Category
Austin

Michael Gayle
Expert in Medicaid Quality-based Payment Systems for Long-term Care Facilities Category
Austin

Michelle Dionne-Vahalik
Survey and Certification Agency Category
Austin

Dr. Obinna Ogundu
For-profit Nursing Facility Provider Category
Wylie

Patrick Duncan Murray
Non-profit Nursing Facility Provider Category
Manchaca

Steven Nowonty
Practicing Medical Director of a Long-term Care Facility Category
Corpus Christi

Victoria Grady
Expert in Medicaid Quality-based Payment Systems for Long-term Care Facilities Category
Austin

1. Welcome and opening remarks. The meeting was convened by Ryan Harrington, Chair. A quorum was present.

2. Consideration of September 30, 2021, draft meeting minutes The minutes were approved as written.

3. Recommendations from LTCFC Report updates.

HHSC is creating a rule project for Medicaid bed allocation. The rule development will be based on the recommendations from this council

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Senate Bill 1519 (S.B. 1519), 86th Legislature, Regular Session, 2019, established the Long-Term Care Facilities Council as a permanent advisory council to the Texas Health and Human Services Commission (HHSC) to study and make recommendations for nursing facilities (NFs), assisted living facilities (ALFs), and intermediate care facilities for individuals with an intellectual disability or related condition (ICF-IIDs) regarding:
1. A consistent survey and informal dispute resolution (IDR) process with regard to best practices and protocols to make the survey, inspection, and IDR processes more efficient and less burdensome, as well as to recommend uniform standards for those processes;
2. Medicaid quality-based payment systems with regards to the systems and a ratesetting methodology; and
3. The allocation of and need for Medicaid beds with regards to the effectiveness of rules adopted by the HHSC executive commissioner relating to the procedures for certifying and decertifying Medicaid beds and the need for modifications to those rules to better control the procedures for certifying and decertifying Medicaid beds.

The executive commissioner of HHSC appointed regulatory staff, IDR staff, and long-term care providers to the council. A key council objective is to submit a report no later than January 1, 2021, outlining its recommendations to the executive commissioner, the governor, the lieutenant governor, the speaker of the House of Representatives, and the chairs of the appropriate legislative committees. Despite the COVID-19 pandemic, the council was able to meet four times and establish three subcommittees that met from five to seven times each to further study and develop individual recommendations for legislative action. The subcommittees also met via conference call as needed to discuss preliminary recommendations. Public comment was accepted at the outset of each scheduled meeting, and written comment was accepted on an ongoing basis. The council requested information from HHSC as part of its information-gathering and discovery phase. The council asked agency representatives numerous questions about processes and regulations and used this information to form preliminary recommendations within the scope of SB 1519.

This report was prepared by members of the Long-Term Care Facilities Council. The opinions and recommendations expressed in this report are the members' own and do not reflect the views of the Texas Health and Human Services Commission Executive Council or the Texas Health and Human Services Commission.

The following policy recommendations were approved by the council for consideration by the Legislature and HHSC. They are grouped by those that would require legislative action and by those that would require state agency action, based on preliminary research.

Recommendations for Legislative Action:

A. Formalize authority to temporarily increase Medicaid beds during a state of emergency. Statutory authority is needed to increase bed allocation during a state of emergency (i.e. public health

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emergency, natural disaster, etc.). Currently, an increase can only be achieved through waivers/exemptions. For example, there were six NFs provided temporary Medicaid bed increases during 2020 due to COVID19.

B. Nursing facility providers should be fully funded for care provided to Medicaid residents based on median costs. The base Medicaid reimbursement rate in Texas currently ranks 49th lowest in the country and has not been adjusted since 2014. The expense of a Medicaid nursing home resident is approximately $10 per day more than the reimbursement based on the allowable cost in 1 TAC §355.307 Reimbursement Setting Methodology. In addition, the nursing facility providers absorb an additional $22 per day of cost that are not eligible for reimbursement through Medicaid (Source: 2018 NF Cost Report data).

C. CMS changed to a Patient Driven Payment Model (PDPM) for nursing facility reimbursement for Medicare in October 2019 and potentially will no longer support data required for the current nursing facility Medicaid rate methodology used in Texas. The current Medicaid reimbursement model is based on the prior Medicare resource utilization group methodology and any future changes to the Medicaid model should be based upon PDPM.

D. Remove waiver programs that are seldom used, specifically including the waiver for a facility that serves as a teaching facility for physicians and related health care professionals (Human Resource Code 32.0213). The waiver has only been approved once since the waivers were established.

E. Remove the waiver to allow for Medicaid spend-down beds. This waiver provides a temporary Medicaid bed for residents who have “spent down” their resources to become eligible for Medicaid, but for whom no Medicaid bed is available in the current facility. From October 2019 to November 2020, there were 27 requests, of which 14 were approved, eight denied and five withdrawn under this waiver. This high-volume waiver requires a significant amount of HHSC staff time and is requested by a limited number of facilities. There are an adequate number of Medicaid licensed beds in each county to provide an alternate location for Medicaid residents without having to expand Medicaid licensed beds in an existing facility.

F. Provide a cost adjustment to nursing facility providers to account for the incremental cost related to specific types of care, including tracheostomy, pediatric, ventilator, autism, and complex behaviors. These specialty care services require significantly more than what the current Medicaid rate methodology allows.

Recommendations to HHSC Regulatory Division

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G. Delay a requirement to decertify beds for a period of 24 months following the end of a state of emergency, by county. This allows for recovery and normal resumption of business for entities that were affected by an emergency, including the COVID-19 pandemic, and provides a better basis to evaluate the true need for beds in those communities. Industry estimates of the current COVID-19 reductions in census project it will take 18 to 24 months for facilities to stabilize following the pandemic. A similar period of time is required to plan and rebuild facilities following natural disasters that result in a state of emergency. We recommend this delay be limited to counties actually affected and therefore included in a state of emergency.

H. Allow replacement status for Medicaid beds in existing buildings to be used for renovation and/or expansion. Currently a provider can request that Medicaid beds be placed in replacement status only for one or more new facilities. This option would provide flexibility to providers seeking to increase their Medicaid beds in existing facilities when renovating or expanding capacity with an addition.

I. Require a nursing facility provider to be identified in a waiver application prior to approval. Currently only the property owner must be identified in the initial application, and after approval the new Medicaid beds can be sold to another developer. The nursing facility provider is of great significance to the project and should be identified during the waiver or exemption application and not be allowed to be changed, except through a change of ownership process after the new facility is constructed.

J. Medicaid beds for facilities in good standing that voluntarily closed for reasons other than extensive damage to the facility should be returned to HHSC and not be eligible for replacement status. Facilities typically close due to regulatory concerns or poor financial performance driven by low census. Allowing closed nursing facilities to sell its Medicaid beds exacerbates the problem by allowing a new provider to build a facility, which also results in too great of a supply of Medicaid beds.

K. Delay approval for new waivers by 12 months after the end of the state of emergency by county. This delay will allow time for occupancy to normalize after the impact of COVID-19 or any other natural disaster, and then any waivers not currently approved can be resubmitted with updated information that reflects the impact of new demographic trends.

L. Remove waiver programs that are seldom used, specifically including the small house waiver designed to promote the construction of smaller nursing facilities (40 TAC §19.2322 (h)(9)). This waiver has only been approved once since it was established.

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M. Allow regulatory surveyors to continue with their more collaborative and consultative role that has occurred during the pandemic. For example, providers expressed an interest in receiving real-time feedback on noncompliance situations, while the surveyors are still onsite.

N. Ensure a list of requested information that could not be found by the provider during a regulatory visit is delivered by the surveyor to the facility leadership prior to exit. This affords providers an additional opportunity to ensure they understand what records have been requested and that the correct staff/department has searched for them.

O. Implement a uniform plan of removal template for immediate threat situations that lists the requirements a provider must meet to get the immediate threat lifted. This will enhance consistency throughout the state. The template would be in a userfriendly format that requests uniform information and would include guidance to state agency staff and to providers on exactly what information is needed.

P. Ensure daily debriefings are conducted consistently statewide. Surveyors would provide information to facility leadership regarding issues of any non-compliance found daily during their onsite visits.

Q. Ensure exit conferences provide thorough, detailed information regarding noncompliance so providers can easily understand the deficient practices and resolve the issues while awaiting the report of findings. For example, if infection control is cited – which can cover a wide variety of processes/procedures – describe the deficient practice (e.g. hand-washing techniques were not in line with CDC guidance, etc.).

R. Ensure consistency when citing noncompliance for licensure requirements on Form 3724. There should be consistency statewide when deciding which regulations to cite for noncompliance and how many areas in which to cite. Citations should be such that the provider corrects any system and individual issues that contributed to the noncompliance.

Recommendations to HHSC Financial Division For Provider Finance.

S. Confirmation of General Liability coverage should be included in the provider's cost report rather than requiring a certificate of liability coverage.

Recommendations to HHSC Medicaid Division For Quality Incentive Payment Process (QIPP).

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QIPP is a performance-based program that encourages nursing facilities to improve the quality and innovation of their services through implementation of program-wide improvement processes, which facilities are compensated for if they meet or exceed certain goals. The following recommendations should be considered for future QIPP programs:

T. Maintain focus on infection prevention and control. Specifically, consideration should be given to including infection control prevention, antibiotic stewardship, pharmacy safety, and incentives for containment of infectious disease based on the percentage of a facility's resident population.

U. Provide funds to encourage compatibility of electronic medical records. A multi-year approach should be developed to strengthen the level of electronic medical records to industry standards and allow for improved flow of information between health care providers.

V. The council believes that quality leaders in a nursing facility are a significant indicator of quality care. QIPP should encourage facilities to develop a comprehensive leadership development program, with the goal to drive broad improvements based on clear quality measures. Specifically, this program should require 16 hours of continuing education leadership training for licensed nursing facility administrators (LNFA).

Status:
The regulatory rule update will not finalize until 2023 because of the complexity of stakeholder input. The council requested to see the changes before they get recommended. This will be well into 2022.

Regarding survey operations the following is occurring:

M. Surveyors cannot move to be consultants with providers. Form 3701 lists noncompliance. A second return visit can occur with noncompliance. Joint training is looking at additional training areas.

N. This is already part of the survey process.

O. This is being reviewed with the policy and review area. There is already computer based training.

P. This is part of current survey protocol and is being evaluated

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Q. Form 3701 is being reviewed to expand the directions on the form. Joint training is being considered.

R. Provider letter on inconsistencies was revised and sent out. Providers can identify inconsistent feedback. Providers already are taking advantage of this. The system is evolving. A review process internally has been implemented to guarantee with consistency.

Long Term Services and supports

An amendment is being proposed to address liability insurance costs:

- Streamlines the add-on rates with an annual provider attestation
- Increase the time limit for add on rates
- Defines eligibility criteria
- Describes the circumstance under which HHSC can recoup the add-on payment

The rule will be published in the Texas Register in January 2022 to be effective June 2022.

4. Report from subcommittees

Licensing and Regulatory—no report

Reimbursement—The subcommittee is meeting monthly and is looking at the Medicaid reimbursement cost formula. They also looked at the Medicaid revenue cycle and the work reimbursement process to make it more fluid. Also, will be looking at dental and DME.

Intermediate Care Facilities for Individuals with Intellectual Disabilities—a new member will be joining.

5. Quality Incentive Payment Program (QIPP) status update.

Year 5 (2022) approval was retroactively approved to September. The primary change was to a methodology was setting performance targets. Even with late approval, the program is back on schedule.

Year 6 proposed an identical plan as for approved year 5. (Components 1,2,3 and 4) There will be a public hearing on proposed measures. Final Proposed metrics will be published February 1.

6. Update on Senate Bill 8, 87th Legislature, Third Called Session, 2021 Section 33.

SECTION 33. HEALTH AND HUMAN SERVICES COMMISSION: STAFFING NEEDS. (a) Provides that the amount of $378,300,000 is appropriated to HHSC from money received by this state from the Coronavirus State Fiscal Recovery Fund (42 U.S.C. Section 802) established under the American Rescue Plan Act of 2021 (Pub. L. No. 117-2) and deposited to the credit of the Coronavirus Relief Fund No. 325 for the purpose of providing funding during the two-year period beginning on the effective date of this Act for HHSC to administer one-time grants related to providing critical staffing needs resulting from frontline health care workers affected by COVID-19, including recruitment and retention bonuses for staff:

(1) of nursing facilities, assisted living facilities, home health agencies, and facilities that serve persons with intellectual or developmental disabilities in an intermediate care facility for individuals with intellectual disabilities or related conditions (ICF/IID); or

(2) who provide community attendant services.

(b) Provides that it is the intent of the legislature that HHSC prioritize grants to grantees that comply with the reporting requirements prescribed by Rider 143 (Health and Human Services Commission), Chapter 1053 (S.B. 1), Acts of the 87th Legislature, Regular Session, 2021 (the General Appropriations Act), the reporting requirements established by Chapter 588 (S.B. 809), Acts of the 87th Legislature, 2021, or equivalent reporting requirements established by HHSC.

(c) Requires HHSC to annually report to the LBB the grants awarded under this section. Requires that the report include, for the year covered by the report, the amount of grants awarded, the award recipients, and the total amount of each grant used by the recipient. Requires that the report be submitted to the LBB not later than December 1 of the year in which the report is due.

(d) Provides that of the amount appropriated under Subsection (a) of this section:

(1) $200,000,000 is required to be used only for grants for nursing facilities; and

(2) $178,300,000 is required to be used only for grants for assisted living facilities, home health agencies, community attendants, and facilities that serve persons with intellectual or developmental disabilities in an intermediate care facility for individuals with intellectual disabilities or related conditions (ICF/IID).

(e) Provides that it is the intent of the legislature that HHSC consider federal COVID-19 relief money received by providers when allocating the money described by Subsection (d)(2) of this section.

All appropriations must be distributed as grants. An RFA process will be used and aiming for it to be a five-month procurement process. HHSC is also exploring a direct grant award through a noncompetitive process.

For the $200 million identified above, HHSC is proposing an initial direct award of $75,000 for 1200 facilities. Then an RFA process can be used for the rest of the money with a minimal grant award of $50,000 and max of $1 million.

For the $178.3 million HHSC looked at a direct grant award but it was found there would be 35,000 eligible providers and the amount would be minimal. HHSC determined that it would use an RFA process with five distinct sub pools by provider type. Various priorities will be developed to allocate the funds and a max of $25,000.

The RFA process would be significant and HHSC is working internally to determine how to streamline the RFA processing. ARPA funding will be examined so duplication of funding will not occur.

Questions/Answers/Comments

Who determines the levels of grant? The criteria would be driven by SB8

7. Public Comment. No public comment was offered

8. Adjourn. There being no further business, the meeting was adjourned.

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