HHSC: Long-term Care Facilities Council

June 16, 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.

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 established.

2. Consideration of March 9, 2021, minutes for approval. The minutes were approved as written.

3. Adoption of bylaws. Discussion items from the previous meeting were addressed and included in the bylaws. Voting members are restricted to just 6 voting members who are public members.

MOTION: Approve the bylaws as amended prevailed.

4. Election of vice-chair. The election followed the approved election process. Byron Burris, II was elected vice chair.

5. Report from subcommittees.

Licensing—The committee was awaiting legislative actions before proceeding. They need to look at waivers and online licensing.

Regulatory—The committee was awaiting legislative actions before proceeding.

Reimbursement—They have met several times looking at

- Medicaid reimbursement cycle
- Cost calculation
- HB3523—minimum fee schedule should be extended through September 2023.

MOTION: Approve the recommendation that the Council send a letter recommending to the HHSC to extend the minimum fee schedule through September 2023 to ensure continuity of care for individuals served prevailed,

Intermediate Care Facilities for Individuals with Intellectual Disabilities—The subcommittee has not met yet. There is no update.

6. Nursing facility minimum reimbursement

Allowable and Unallowable Costs

Allowable Costs

- 1 TAC §355.102(f)
- Direct and indirect costs
- Necessary costs incurred during the reporting period for the provision of client care
- Reasonable costs that a prudent and cost-conscious buyer pays for a given item or service

Unallowable Costs

- Unallowable costs are not considered reasonable or necessary or;
- Specifically enumerated in 1 TAC §355.303 Specifications for Allowable and Unallowable Costs

Financial Examination Process

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The Financial Examiner (FE) verifies that the cost reported agrees with the documentation in the Upload Center. The FE will take the following steps if discrepancies are identified.

- FE conducts analysis, then they call or email for a request for information (RFI) for missing or incomplete supporting documentation to validate reported cost. Example of requested information are financial statements, cost allocation (shared cost), payroll summary, etc.
- Allow a maximum of 10 business days per 1 TAC §355.105(b)(2)(B)(xviii) to receive responses to RFI.

1.FE reviews provided responses for acceptability.
2.FE sends a follow up email if responses are deemed incomplete or unacceptable.
3.FE notifies the provider/preparer of needed adjustments by email.
4.The FE makes the required adjustments in STAIRS and uploads the documentation received by the provider/preparer in the Upload Center.
5.The cost report, including adjustments, then proceeds through a supervisory review before it is finalized

The supervisory team may return the cost report back to the FE for further analysis or to request additional documentation to support the adjustments. Once the project is accepted by the supervisory team, then any report requiring reconciliation for spending requirements are forwarded to Provider Finance Department Long Term Services and Supports for their post audit review.

Unallowable Cost Example #1

Cost Allocation Situation: ABC Corporation owns 65 nursing facilities (NF) and 7 Residential Care (RC) facilities and failed to submit an allocation to support the nursing facilities costs.

Result: The FE would perform the following steps to ensure that the shared administrative costs are allocated to business components listed in Steps 3a and 3b in STAIRS:

1. Unallowable costs have been removed prior to allocating.
2. Accurate allocation percentages & mathematical accuracy.
3. Trace the allocated costs to the cost report.
4. If a material difference is noted, FE will contact the provider/preparer to determine why.

Outcome:

1. The Provider/Preparer would need to re-submit a revised allocation work paper.
2. FE will then review the revised allocation work paper to ensure they are accurate and then make the necessary adjustments in STAIRS.
3. If the FE did not receive a revised allocation work paper as requested then shared cost may be disallowed or the report will be returned as unacceptable 1 TAC §355.106(a)(2).

Additional examples were provided and can be accessed by following the link above

Cost Reporting Adjustments

Related-Party Capping Edits-- 1 TAC §355.105(i) General Reporting and Documentation Requirements, Methods, and Procedures

- Related-party owners, administrators and directors, assistant administrators
- 90th percentile of all non-related party annualized compensation

Occupancy Adjustment-- 1 TAC §355.306(b)(2)(C) Cost Finding Methodology

- Facility and administration costs
- The lower of 85% or the overall average occupancy for contracted beds in facilities
- Overall average occupancy represent in the 2018 NF Cost Report was 78.47%

Rate Components-- 1 TAC §355.307 Reimbursement Setting Methodology

- Direct Care Staffing
- Other Recipient Care
- Dietary
- Fixed Capital
- General Administration

Fixed Capital Assets-- 1 TAC §355.307(b)(1)(C) Reimbursement Setting Methodology Lesser of:

- 80th percentile of ALL appraised property values calculation; or
- Inflating the fee from the previous reporting period by Personal Consumption Expenditure (PCE).

Fixed Capital Assets-- 1 TAC §355.306(b)(2)(A) Cost Finding Methodology

- Building and building equipment depreciation and lease expense
- Mortgage interest
- Land improvement depreciation
- Leasehold improvement amortization
- Reimbursement as described in 1 TAC §355.307

Provider Finance Department LTSS Center for Information and Training
(512) 424-6637
PFD-LTSS@hhs.texas.gov

7. Approved legislation bills related to long-term care facilities.

Pandemic Response Related Bills:

SB25-- Adds Chapter 260B to the Health and Safety Code to allow for a resident of or the guardian or legally authorized representative of a resident of a nursing facility, assisted living facility, intermediate care facility for individuals with an intellectual disability, and other certain residences to designate an essential caregiver that the facility or residence may not prohibit in-person visitation with. The bill also amends Chapter 555 of the Health and Safety Code to allow for a resident of or the guardian of a resident of a state supported living center to designate an essential caregiver that the center may not prohibit in-person visitation with. The bill requires the executive commissioner of the Health and Human Services Commission (HHSC) to develop guidelines to assist the facility, center, or residence in establishing essential caregiver visitation policies and procedures. The bill requires the executive commissioner of HHSC to establish the guidelines as soon as practicable after the effective date of the bill.

SJR19— Pursuant to SB25, the joint resolution proposes a constitutional amendment to Article I of the Texas Constitution that would establish the right for a resident of a nursing facility, assisted living facility, intermediate care facility for individuals with an intellectual disability, residence providing home and community-based services, or state supported living center, to designate at least one essential caregiver with whom the facility, residence, or center may not prohibit in-person visitation. The cost to the state for publication of the resolution is $178,333 in fiscal year 2022.

The proposed amendment would be submitted to voters at an election to be held November 2, 2021.

SB572--Requires the Health and Human Services Commission (HHSC) to establish rules that require health care facilities to allow religious counselors to visit patients or residents during a public health emergency upon certain request.

SB809— Requires health care institutions who have received federal funding during the coronavirus disease public health emergency, including under the federal Coronavirus Aid, Relief, and Economic Security Act and the federal American Rescue Plan Act of 2021, to provide a monthly report of the funding received to the Health and Human Services Commission (HHSC). HHSC would be required to compile the information received from health care institutions and submit a quarterly written report to the Governor, Lieutenant Governor, Speaker of the House of Representatives, the Legislative Budget Board, and the standing committees of the Legislature with primary jurisdiction over state finance and public health.

Additionally, the bill allows the appropriate licensing agency of a health care institution to take

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disciplinary action against a health care institution that violates reporting requirements as if the health care institution violated an applicable licensing law.

SB930—Clarifies that, unless made confidential under other law, the name or location of a nursing home or similar facility in which residents have been diagnosed with a communicable disease and the number of residents diagnosed is not confidential and is subject to disclosure by state agencies or local health authorities under the Texas Public Information Act.

SB968-- Prohibits the Texas Medical Board (TMB) from limiting nonelective medical procedures and would authorize TMB to temporarily limit other medical procedures during a declared state of disaster.

The bill requires the Texas Department of Emergency Management (TDEM) to enter into a contract that meets certain requirements with a manufacturer or wholesale distributor of personal protective equipment.

The bill requires the Department of State Health Services (DSHS) to consult with the Task Force on Infectious Disease Preparedness and Response during a public health disaster. The bill establishes a civil penalty if a health care facility fails to report as required by DSHS during a public health disaster or emergency.

The bill prohibits a governmental entity from issuing a vaccine passport for a purpose other than healthcare, prohibit businesses in the state from requiring documentation certifying the customer's COVID-19 vaccination or recovery, and require state agencies to ensure businesses in the state comply as a condition for contracting with the state and receiving licenses, permits, or other authorizations.

The bill requires DSHS to establish an Office of Chief State Epidemiologist to provide public health expertise.

The bill requires the Preparedness Coordinating Council advisory committee to conduct a study on the state's response to COVID-19 nine months after the date of the public health disaster related to COVID-19 ends or by September 1, 2023, whichever is earlier.

The bill requires DSHS to develop and implement a disease prevention information system for dissemination of immunization information during a declared state of disaster or local state of disaster.

The bill limits what a presiding officer of the governing body of a political subdivision could limit or prohibit during a declared state of disaster or local disaster.

The bill requires the inclusion of medically fragile individuals in TDEM's emergency assistance registry to allow for wellness checks during certain emergencies.

SB1856— amends the Health and Safety Code to establish that services that are provided by a vocational nursing student in a licensed nursing facility and authorized by a contract or other arrangement with the facility are allowed at all times in Texas, including during a declared state of disaster. The bill authorizes a licensed nursing facility to do the following:

- require a student to comply with the facility's policies regarding health screenings or the use of personal protective equipment; and
- condition the student's provision of services on compliance with those policies.

The bill applies only to a student who is enrolled in an accredited school or program that is preparing the student for licensure as a licensed vocational nurse and who is participating in a clinical program at a licensed nursing facility.

Other Bills

HB1423—Amends Health and Safety Code Chapter 242 to require the Health and Human Services Commission (HHSC), or a representative of HHSC, to conduct one unannounced inspection annually. The bill also allows HHSC, or a representative of HHSC, to conduct a follow-up inspection after conducting the unannounced annual inspection.

Not later than January 31st of each year, HHSC is required to evaluate their capacity to regulate institutions under Chapter 242. Not later than January 1st of each year, HHSC is required to evaluate their compliance with unannounced annual inspections under Chapter 242.

The bill also requires HHSC to conduct a survey on the number of facilities licensed under Health and Safety Code Chapters 242 and 247 that are equipped with an operational emergency generator or comparable emergency power source that is capable of providing continuous electric utility services to the facility during severe weather events or other emergencies. Not later than September 1, 2022, HHSC is required to submit the results of the survey to the members of the House Human

Services Committee and the Senate Health and Human Services Committee, or the successor of those committees.

HB1681— Amends Health and Safety Code Chapter 247 to require the executive commissioner of the Health and Human Services Commission to adopt rules prohibiting the construction of a new assisted living facility within a 100-year floodplain in a county with a population of 3.3 million or more.

HB3720— Requires the Health and Human Services Commission (HHSC), in consultation with the Intellectual and Developmental Disability System Redesign Advisory Committee, State Medicaid Managed Care Advisory Committee, and other stakeholders, to develop a questionnaire for individuals on an interest list for a Medicaid waiver program, including: Community Living Assistance and Support Services (CLASS); Home and Community-based Services (HCS); Deaf-Blind with Multiple Disabilities (DBMD); Texas Home Living (TxHmL); Medically Dependent Children Program (MDCP); and STAR+PLUS Home and Community-Based Services (STAR+PLUS HCBS).
An individual who is on an interest list who does not respond to requests for updates to interest list information or does not maintain contact with HHSC would be considered inactive until they make contact with HHSC. This analysis assumes there would be a minimal cost associated with implementing the provisions that could be absorbed within current resources.

The bill requires the executive commissioner of HHSC to appoint an additional member to the Long-Term Care Facilities Council that meets certain criteria. The bill amends Health and Safety Code Chapter 252 to limit the total amount of administrative penalties that a facility can be assessed. The bill also requires the executive commissioner of HHSC to develop and adopt rules regarding the application of certain administrative penalties no later than December 1, 2021.

HB3961— Requires posting of information regarding the office of the state long-term care ombudsman on certain long-term care facilities' Internet websites.

SB270— Prevents financial abuse of nursing home residents by allowing facilities to pursue debts against responsible payors who have improperly diverted a resident's funds and left them unable to pay for their long-term care and susceptible to discharge and lawsuits.

S.B. 270 applies only to instances where:
(1) a resident has the financial resources to pay for care;
(2) a responsible payor contractually commits those funds to the resident's care; and

(3) the responsible payor misappropriates the resident's funds and breaches his or her contract with the nursing home.

SB383— Provides disclosure requirements of certain facilities that provide care for persons with Alzheimer's disease and related disorders.

SB1103-- makes it explicitly clear in statute that HHSC is the licensing authority for CNAs and therefore allows HHSC to move forward with more comprehensive background checks on these licensed employees.

8. Update on recommendations from the LTCFC Report 2019.

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 rate setting 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 1519.8 | Page 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 legislature did not make recommendations related to bed allocation, but a project will be opened at HHSC. The recommendations to HHSC have not been implemented. The Council had a paper they were working from, but it was not shared with the public.

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 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 The following recommendations were agreed upon by the council during deliberations. Recommendations to HHSC Regulatory Division

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.

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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.

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.

There are protocols in place already and survey staff will be reminded of this requirement

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.

Consulting with Policy and Rules

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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 user-friendly format that requests uniform information and would include guidance to state agency staff and to providers on exactly what information is needed.

Working with Policy and Rules to develop a template

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.

Policy exists and is ongoing

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.).

Details are provided at exit conference and more detail will be provided at the exit conference.

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.

A provider letter addresses this and asks providers to report suspected inconsistencies.

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). 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.

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HHSC is looking for clarity from the Council, A change of liability coverage would require a code change. If it is a process change it would not require a rule change though it would be advised. HHSC is open to us the cost reporting system to address the insurance information. They would not like that to be part of the cost reporting process.

The Chair stated the goal was to address the administrative burden and make it an easier process.

HHSC stated they will proceed with a rule change

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.

Accountability has been added to year five and each quarter there will be a different infection control element.

Q. Since QIPP is going away in 2023… (1115 waiver was not continued---yet) what are we doing to ensure quality measure will continue. A: HHSC stated that they have no plans for the waiver to end.

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.

HHSC has not proceeded to address this. This was not brought up as a problem from stakeholders.

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).

QIPP requires measures and HHSC will be conducting a look back. Actions are being monitored as part of PIP.

The chair stated that hours for leadership development could be included. The Chair stated we can look at these again in December.

Public comment.

Jenny Lestzall, Advocate related a personal experience with a loved one. There were four critical issues not addressed by the Legislature

- Staffing issues and turn over and training
- Facility accountability
- Protection of resident rights
- Cost of care

There were significant failures in the care of her loved one with Alzheimer's.

Review of action items and agenda items for future meeting.

- There are several subcommittee meetings for the morning of September 30th
- HHSC stated that there is no confirmation of allowance of in-person meetings in September

Adjourn and thank you. There being no further business, the meeting was adjourned.

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