SUBJECT: Creation and administration of a nursing facility quality assurance fee

COMMITTEE: Appropriations — committee substitute recommended

VOTE: 18 ayes — Chisum, Guillen, B. Brown, F. Brown, Chavez, Crownover, J. Davis, England, Hopson, Isett, Kolkhorst, Lucio, McReynolds, Menendez, Noriega, Otto, Taylor, Zerwas

3 nays — Branch, Jackson, Riddle

8 absent — Allen, Darby, Dukes, Gattis, Harper-Brown, McClendon, Turner, Van Arsdale

WITNESSES: For — Tim Graves, Texas Health Care Association

Against — George Linial and David Thomason, Texas Association of Homes, Services for the Aging

On — Carlos Higgins, Texas Silver-Haired Legislature; Gordon Taylor, Department of Aging and Disability Services

BACKGROUND: In 2003, the 78th legislature enacted HB 2292 by Wohlgemuth, which, among many other provisions, imposed a quality assurance fee (QAF) on state-owned Intermediate Care Facilities for the Mentally Retarded (ICF-MR).

The 79th Legislature in 2005 approved Art. 2, Department of Aging and Disability Services (DADS), Rider 51 in the general appropriations act for fiscal 2006-07, which would have used quality assurance fees (QAFs) assessed on nursing home facilities to provide Medicaid provider rate increases. Gov. Perry vetoed this rider, noting that the contingent legislation did not pass and citing objections to the imposition of the QAF on certain facilities that would not receive benefit from the fees.

Under federal law — 42 C.F.R. sec. 433.68 — a health-related tax is permissible if it is broad-based and uniform. A state may receive a waiver from either of these two requirements if it can demonstrate that the tax meets a federal definition of being generally redistributive.

DIGEST:

CSHB 3778 would collect a quality assurance fee from nursing homes, convalescent homes, and related institutions licensed under Health and Safety Code, ch. 242. Exemptions from imposition of the nursing facility QAF would include:

- a state-owned veterans' nursing facility;
- an entity that provided multiple services on a single campus and operated under a continuing care retirement community certificate of authority; and
- an entity that provides multiple services on a single campus in which, during the prior year, the combined patient days of service provided to independent and assisted living residents exceeded the patient days of service provided to nursing facility residents.

Assessment of the QAF. The amount of the QAF would be determined by the number of patient days and gross receipts reported to the Health and Human Services Commission (HHSC) for a period of at least six months. Patient days would represent a calculation of the number of patients in care on a given day and the number of beds on hold for patients receiving medical care elsewhere. HHSC would assess the QAF on a per patient, per day basis in an amount that would not produce annual revenues equaling more than 5.5 percent of the facility's total annual gross receipts. The amount of the QAF could vary according to the number of patient days provided by an institution to make the QAF sufficiently generally redistributive to obtain the appropriate federal waiver. The executive commissioner of HHSC would adopt rules to administer the QAF and could define exceptions from the QAF if appropriate federal waivers were obtained.

Payment of the QAF. The nursing facility would pay the QAF monthly. A nursing facility could not list the QAF as a separate charge on a patient's or resident's billing statement or indirectly charge the QAF to a patient. The nursing facility would report the total number of patient days for the month and pay the QAF to HHSC or DADS by the 25th day of the following month. The administrative penalty for violations associated with the QAF could not exceed the greater of one-half of the amount of the outstanding QAF or $20,000.

Use of QAF funds. The comptroller would deposit QAFs in a dedicated general revenue fund. HHSC could use the money in the nursing home QAF account together with federal matching funds to offset an

institution's allowable Medicaid expenses and to increase reimbursement rates paid under Medicaid to institutions. HHSC would devise the formula by which reimbursement rates would be increased.

If for any reason it was determined that QAF funds could not draw down federal matching dollars, HHSC immediately would cease collection of the QAF and would return any collected QAFs to the appropriate institutions within 30 days.

General provisions. HHSC could revise the state plan amendments and waiver requests associated with the QAF if the Centers for Medicaid and Medicare Services disapproved of the QAF plan. The executive commissioner could adopt definitions, rates, or calculations not expressly provided for to accomplish the intent of the QAF.

CSHB 3778 would take effect September 1, 2007.

SUPPORTERS SAY:

CSHB 3778 would allow Texas nursing facilities and other state health care providers to capitalize upon a QAF collected from nursing facilities similar to legislation enacted in at least 30 other states. Texas already has successfully implemented a QAF on ICF-MRs, and the bill would confer the same benefits on nursing facilities and the health care industry at large. HHSC estimates that nursing homes need a 20 percent increase to cover costs incurred to provide services to Medicaid patients despite nearly a 12 percent rate increase over the interim. This need will only be enhanced as the baby-boom generation begins to enter nursing facilities.

The state would use the QAF to draw down matching federal funds, first apportioning funds back to nursing facilities and then providing these facilities with rate increases as proposed in the House engrossed version of HB 1 by Chisum, Art. 9, sec. 10.09. This appropriations rider, contingent upon enactment of CSHB 3778 or other QAF legislation, would provide a 17 percent rate increase to nursing facilities and significant rate increases to physicians, dentists, and other health care professionals. Provider rate increases desperately are needed to increase the number of providers taking new Medicaid patients before the state reaches a critical provider shortage. Only 38 percent of physicians currently are accepting new Medicaid patients. Those not accepting new Medicaid patients frequently cite inadequate reimbursement rates as the major reason.

Assuming Texas received the appropriate federal waivers, CSHB 3778 would prohibit the collection of QAFs from continuing care retirement communities and other facilities that predominately provided services to independent and assisted living patients. This would minimize the number of facilities that would pay the QAF yet not be fully reimbursed for their contribution.

Quality assurances fees are an all-or-nothing venture, because federal regulation governing permissible health care-related taxes would not allow a tax to be imposed only on Medicaid beds. While this federally imposed limitation inevitably would create some cost to private pay facilities, this fee would be for the greater good of the nursing home community and the Medicaid health care community at large. The bill includes a prohibition on passing on the QAF to nursing facility residents, so no private payor would be adversely affected. Administrative penalties would be imposed for violating this provision. The bill also would provide the protection that if federal matching funds were ever to cease, the QAF would cease as well.

OPPONENTS SAY:

Imposition of the nursing facility QAF proposed in CSHB 3778 would represent yet another example of the state's unwillingness to support important services through the use of existing general revenue. The QAF would place a monthly fee on all eligible nursing-home beds, with the exception of certain facilities exempted through federal waiver. This QAF assessment would include nursing homes that did not take Medicaid patients.

Forty-nine out of Texas' 1,100 nursing homes contain a significant number of private-pay beds, and 22 contain purely private-pay beds. These homes are not connected with any health care system that could benefit from QAF reimbursements. A QAF on these nursing homes would be a "granny tax" passed on by the nursing home to elderly, private payors. Even though facilities could not pass on the QAF to a private payor directly on a billing statement, the private facility's increased costs inevitably would cause a private payor's bills to increase. Such increases could be masked as cost increases related to other facility overhead. Gov. Perry highlighted the objectionable practice of imposing taxes that would adversely impact the elderly population through his veto of "granny tax" appropriations in 2005.

OTHER OPPONENTS SAY:

The amount of rate increases in the contingent appropriations rider would not provide for the additional funds HHSC estimates nursing facilities would need to cover the cost of providing Medicaid services. If CSHB 3778 assesses a QAF against nursing facilities, only nursing facilities should receive the benefit of this fee.

NOTES:

According to the fiscal note, the comptroller estimates CSHB 3778 would generate annual gross revenue of $111.3 million for general revenue-dedicated funds in fiscal 2008 and $225.5 million in fiscal 2009. Because of anticipated expenditures of the new revenue, including offsets to the general revenue-dedicated nursing home QAF account, the net fiscal impact of the bill would be a negative general revenue-related impact of $642,880 for developing supporting technology to administer the QAF in 2008, and there would be no estimated net impact thereafter. The QAF would draw $57.9 million in federal funds in 2008 and $112.2 million in 2009. These funds would be expended for purposes allowable by CSHB 3778 in the year in which they were obtained.

The House engrossed version of HB 1 by Chisum includes Art. 9, sec. 10.09, making appropriations contingent on enactment of HB 3778 or another bill authorizing a nursing facility QAF. Sec. 10.09 would reimburse eligible nursing facilities for the QAF funds contributed and would appropriate an additional $72.8 million in general revenue for nursing facility rate increases over the biennium. The rider would appropriate $281 million in general revenue for additional provider rate increases for physicians, dentists, and other health care professionals.