House
Legislative
Analysis
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NURSING HOME STAFFING REQUIREMENTS

House Bill 4463
Sponsor: Rep. Clarence E. Phillips
Committee: Senior Health, Security and Retirement

Complete to 3-16-01

A SUMMARY OF HOUSE BILL 4463 AS INTRODUCED 3-13-01

House Bill 4463 would amend the Public Health Code (MCL 333.21720a) to increase the required patient to nursing care personnel ratio for nursing homes, and to allow the use of unlicensed nursing personnel to meet those ratios.

Currently, a licensed nursing home must have at least one licensed nurse on duty at all times and must employ additional registered nurses and licensed practical nurses to maintain a patient to nursing care personnel ratio of not more than eight to one for morning shifts, not more than twelve to one for afternoon shifts, and not more than fifteen to one for nighttime shifts. In addition, a nursing home must maintain a nursing home staff sufficient to provide not less than 2.25 hours of nursing care by employed nursing care personnel per patient per day.

The bill would delete these requirements and instead establish a staff-to-patient ratio that would require at least 3.0 hours of direct patient care by a direct patient care provider. The ratio would be computed on a 24-hour basis so that at no time could the ratio fall below one direct patient care provider to 15 nursing home residents. A "direct patient care provider" would be a registered professional nurse (RN) or a licensed practical nurse (LPN) whose primary function was as a nurse, or a competency-evaluated nurse assistant (CENA). The term would exclude the director of nursing, a quality assurance nurse, the staff development nurse, a physical therapist, a certified speech and language therapist, an occupational therapist, an activities director or activities staff, and an individual employed by a resident or his or her family to provide care only for that resident.

Direct Patient Care. The bill would specify that direct patient care would mean one or more of the following activities or services provided by a direct patient care provider:

*Personal care, such as bathing, skin care, routine mouth care, hair and nail care, shaving, dressing, and other matters of personal hygiene.

*Nutrition, including measuring and recording a patient's food intake, and assisting a patient in fluid intake and eating.

*Elimination, including preventing incontinence, catheter care, measuring and recording bladder output, and so on.

*Restoration and rehabilitation, including turning a patient; range of motion exercises; assistance and encouragement with ambulation, walking, and transferring from location to location or position to position; and the use of wheelchairs, walkers, canes, and crutches; and so on.

*Feeding and clothing patients and making and changing beds.

*Administration of medications and treatments.

*Other activities or services performed with or for the care provider's assigned patient to enhance that patient's quality of life.

Staff-to-patient ratios. Between October 1, 2001 and April 1, 2002, the required per-patient-per-day ratio of direct patient care would be at least 2.75 hours, increased from the current 2.25 hours. The required ratio would increase again to at least 2.85 hours between April 2, 2002 and October 1, 2002, and then increase again to at least 3.0 hours after October 1, 2002. Duties other than direct patient care performed by a direct patient care provider could not be counted for the ratio, but time spent in documenting a provider's care for a patient could be used in the computation. A direct patient care provider could not perform duties such as food preparation, housekeeping, laundry, or maintenance (except in an emergency, at which time the hours spent in these activities could be used to compute the ratio). In the case of an emergency, a non-patient care employee could provide patient care, as could RNs and LPNs who primarily perform administrative duties. A nursing home could not use a non-direct patient care provider in computing the ratio, but could use such a person to provide some types of patient care services in the home as long as he or she had received proper training in that service. An aide who had completed the necessary training to become a CENA, but had not yet taken the test, could be used to satisfy the staff-to-patient ratio and the hours-per-patient-per-day ratio, but not for longer than 120 days.

Funding. If the nursing home's costs of operation were increased in order to comply with the new staffing ratios, the home could advise the Department of Consumer and Industry Services in writing of the increased costs and request a reimbursement. The department would have to immediately adjust the home's Medicaid reimbursement sufficient to cover the increased costs, regardless of previously applied cost limits. (Note: the bill contains references to Title XVIII of the federal Social Security Act; apparently the reference should be to Title XIX. Title XVIII governs the Medicare program, while Title XIX governs Medicaid.) If the department did not adjust the Medicaid reimbursement rates, all of the following would occur:

*The home would be exempt from the new staffing ratios until the reimbursement rate was adjusted.

*The home would staff according to the staffing requirements in place before the bill's effective date.

*The home would have to return to the bill's staffing ratios within 30 days of being notified that the reimbursement rate would be adjusted.

If the department failed to increase the reimbursement within the 30-day time period, the department would have to file a written report with the House and Senate Appropriations Committees and appropriate subcommittees that included its reasons for not adjusting the home's reimbursement rate. The department would also have to determine if the home's operating costs were actually increased or not during its audit of the home's annual cost report. If the department determined that the home's costs were not increased, the department could retroactively disallow the increased costs claimed by the home. Such a retroactive disallowance would be considered an "adverse action" as defined under administrative rules (R 400.3401), and would be subject to appeal.

A nursing home could also file a petition for temporary, emergency rate relief from either the new 15 to 1 staffing ratio, or the new 3.0 hours of direct patient care ratio, or both. The department could grant the home's petition if the home demonstrated that the new ratios had a substantial effect on the nursing home's operating costs. A decision on the petition would have to be issued within 90 days. If the petition were denied, the department would have to notify the home in writing of the reasons. A failure to rule on the petition within 90 days would constitute a granting of the petition.

A nursing home could appeal a denial for temporary, emergency relief. The department would also have to hold an informal hearing on the appeal. The department would have to issue a written decision of the appeal within 30 days of the hearing. A denial of an appeal would have the effect of creating an emergency under provisions in the federal Social Security Act.

A nursing home could appeal an adverse decision in response to an appeal to the circuit court for the county in which the home was located, or the circuit court for Ingham County. If the nursing home prevailed in court, the court could award the home compensatory damages for the cost of providing care to its residents during the petition and appeal process, and could also award court costs.

Legislative intent. The bill would state that the exemption was not intended to allow the department to reimburse a home at a rate lower than what was needed to maintain the new 3.0 hours of direct care per patient per day. Further, the bill would state that the intent was for the department to sufficiently increase the Medicaid reimbursement rate so that homes could meet the new staffing requirement.

Patient/family notification. A nursing home would have to post the name of the direct patient care provider assigned to a particular patient either in a conspicuous place near the nurse's station or outside the patient's door near the patient's name.

The bill would take effect July 1, 2001.

Analyst: D. Martens

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.