STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

SENATE BILL 1417 By: Rosino

AS INTRODUCED

An Act relating to the state Medicaid program; amending 56 O.S. 2021, Section 1011.5, which relates to the nursing facility incentive reimbursement rate plan; modifying amount of certain reserved funds; removing certain limitations on deductions and payments; adding certain outcomes metrics; modifying terminology; clarifying language; providing for establishment of certain benchmarks; modifying certain method of reporting; authorizing the Oklahoma Health Care Authority to take certain actions depending on certain factors; amending 63 O.S. 2021, Section 1-1925.2, which relates to reimbursements from the Nursing Facility Quality of Care Fund; modifying and adding components in certain payment methodology; requiring certain adjustments; removing certain provisions relating to payment rates; directing certain allocations; requiring development of certain add-on rate; directing certain transition of payment rate methodology; requiring the Authority to implement certain scholarship program subject to available funding; updating statutory language; providing an effective date; and declaring an emergency.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 56 O.S. 2021, Section 1011.5, is amended to read as follows:

Section 1011.5. A. 1. The Oklahoma Health Care Authority shall develop an incentive reimbursement rate plan for nursing

facilities focused on improving resident outcomes and resident quality of life.

2. ~~Under the current rate methodology, the~~ The Authority shall reserve funds above the average of Five Dollars ($5.00) per patient day designated for incentive payment in the currently approved Medicaid state plan for the quality assurance component that nursing facilities can earn for improvement or performance achievement of resident-centered outcomes metrics. ~~To fund the quality assurance component, Two Dollars ($2.00) shall be deducted from each nursing facility's per diem rate, and matched with Three Dollars ($3.00) per day funded by the Authority. Payments to nursing facilities that achieve specific metrics shall be treated as an "add back" to their net reimbursement per diem. Dollar values assigned to each metric shall be determined so that an average of the five-dollar-quality incentive is made to qualifying nursing facilities~~ The Authority shall determine the dollar amount for each resident-centered outcomes metric under the incentive reimbursement rate plan.

3. Pay-for-performance payments to contracted nursing facilities may be earned quarterly and shall be based on the following outcomes metrics:

a. facility-specific performance achievement of four ~~equally-weighted~~ equally weighted, Long-Stay Quality Measures, as defined by the Centers for Medicare and

Medicaid Services (CMS) and as provided by subparagraph a of paragraph 6 of this subsection,

b. completion of required hours of a training component as provided by subparagraph b of paragraph 6 of this subsection,

c. achievement of staffing retention and direct care component benchmarks as provided by subparagraph c of paragraph 6 of this subsection, and

d. achievement of satisfaction survey benchmarks as provided by subparagraph d of paragraph 6 of this subsection.

4. ~~Contracted Medicaid long-term care providers may earn payment by achieving either five percent (5%) relative improvement each quarter from baseline or by achieving the National Average Benchmark or better for each individual quality metric.~~

~~5.~~ Pursuant to federal Medicaid approval, any funds that remain as a result of providers failing to meet the ~~quality assurance~~ benchmarks of the outcomes metrics established by this subsection shall be pooled and redistributed to those who achieve the ~~quality assurance metrics~~ benchmarks each quarter. If federal approval is not received, any remaining funds shall be deposited in the Nursing Facility Quality of Care Fund authorized in Section 2002 of this title.

~~6.~~ 5. The Authority shall establish an advisory group with consumer, provider and state agency representation to recommend ~~quality measures~~ benchmarks for outcomes metrics, other than the benchmarks specified in paragraph 6 of this subsection, to be included in the pay-for-performance program and to provide feedback on program performance and recommendations for improvement. ~~The quality measures~~ Such benchmarks shall be reviewed annually and shall be subject to change every three (3) years through the agency's promulgation of rules. The Authority shall ~~insure~~ ensure adherence to the following criteria in determining the ~~quality measures~~ benchmarks:

a. provides direct benefit to resident care outcomes,

b. applies to long-stay residents, and

c. addresses a need for quality improvement using criteria including, but not limited to, the Centers for Medicare and Medicaid Services (CMS) ranking for Oklahoma.

~~7.~~ 6. The Authority shall ~~begin~~ administer the pay-for-performance program ~~focusing on improving the following CMS nursing home quality measures~~ utilizing the following benchmarks for outcomes metrics:

a. achievement of either five percent (5%) relative improvement each quarter from baseline or by achieving the national average benchmark or better for each of

the following equally weighted CMS Long-Stay Quality Measures:

~~a. percentage of long-stay, high-risk residents with pressure ulcers~~

(1) percentage of long-stay, high-risk residents with falls,

~~b.~~ (2) percentage of long-stay residents who lose too much weight,

~~c.~~ (3) percentage of long-stay residents with a urinary tract infection, and

~~d.~~ (4) percentage of long-stay residents who got an antipsychotic medication,

b. completion of training hours required by the Authority through distance learning or in-person training on:

(1) fall prevention,

(2) mental health care,

(3) techniques to manage care,

(4) pressure ulcer care, or

(5) any other subject approved by the Authority,

c. achievement of the following staffing retention and direct care hour benchmarks:

(1) retention of not less than fifty percent (50%) of registered nurses for twelve (12) months,

(2) retention of not less than sixty percent (60%) of certified nurse aides for twelve (12) months, and

(3) provision of direct care hours every three (3) months in accordance with a benchmark established by the Authority, and

d. achievement of benchmarks established by the Authority for satisfaction surveys of:

(1) residents and families of residents, and

(2) staff of the facility.

B. The Oklahoma Health Care Authority shall negotiate with the Centers for Medicare and Medicaid Services to include the authority to base provider reimbursement rates for nursing facilities on the criteria specified in subsection A of this section.

C. The Oklahoma Health Care Authority shall audit the program to ensure transparency and integrity.

D. The Oklahoma Health Care Authority shall ~~provide~~ electronically submit an annual report of the incentive reimbursement rate plan to the Governor, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate by December 31 of each year. The report shall include, but not be limited to, an analysis of the previous fiscal year including incentive payments, ratings, and notable trends.

E. The Oklahoma Health Care Authority may change, add, or exclude any outcomes metric from the incentive reimbursement rate

plan based on availability of funding, changes to metrics made by the Centers for Medicare and Medicaid Services, and quality needs of nursing facilities in this state as determined by the Authority.

SECTION 2. AMENDATORY 63 O.S. 2021, Section 1-1925.2, is amended to read as follows:

Section 1-1925.2. A. The Oklahoma Health Care Authority shall fully recalculate and reimburse nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) from the Nursing Facility Quality of Care Fund beginning October 1, 2000, the average actual, audited costs reflected in previously submitted cost reports for the cost-reporting period that began July 1, 1998, and ended June 30, 1999, inflated by the federally published inflationary factors for the two (2) years appropriate to reflect present-day costs at the midpoint of the July 1, 2000, through June 30, 2001, rate year.

1. The recalculations provided for in this subsection shall be consistent for both nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).

2. The recalculated reimbursement rate shall be implemented September 1, 2000.

B. 1. From September 1, 2000, through August 31, 2001, all nursing facilities subject to the Nursing Home Care Act, in addition to other state and federal requirements related to the staffing of

nursing facilities, shall maintain the following minimum direct-care-staff-to-resident ratios:

a. from 7:00 a.m. to 3:00 p.m., one direct-care staff to every eight residents, or major fraction thereof,

b. from 3:00 p.m. to 11:00 p.m., one direct-care staff to every twelve residents, or major fraction thereof, and

c. from 11:00 p.m. to 7:00 a.m., one direct-care staff to every seventeen residents, or major fraction thereof.

2. From September 1, 2001, through August 31, 2003, nursing facilities subject to the Nursing Home Care Act and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) with seventeen or more beds shall maintain, in addition to other state and federal requirements related to the staffing of nursing facilities, the following minimum direct-care-staff-to-resident ratios:

a. from 7:00 a.m. to 3:00 p.m., one direct-care staff to every seven residents, or major fraction thereof,

b. from 3:00 p.m. to 11:00 p.m., one direct-care staff to every ten residents, or major fraction thereof, and

c. from 11:00 p.m. to 7:00 a.m., one direct-care staff to every seventeen residents, or major fraction thereof.

3. On and after October 1, 2019, nursing facilities subject to the Nursing Home Care Act and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) with seventeen

or more beds shall maintain, in addition to other state and federal requirements related to the staffing of nursing facilities, the following minimum direct-care-staff-to-resident ratios:

a. from 7:00 a.m. to 3:00 p.m., one direct-care staff to every six residents, or major fraction thereof,

b. from 3:00 p.m. to 11:00 p.m., one direct-care staff to every eight residents, or major fraction thereof, and

c. from 11:00 p.m. to 7:00 a.m., one direct-care staff to every fifteen residents, or major fraction thereof.

4. Effective immediately, facilities shall have the option of varying the starting times for the eight-hour shifts by one (1) hour before or one (1) hour after the times designated in this section without overlapping shifts.

5. a. On and after January 1, 2020, a facility may implement twenty-four-hour-based staff scheduling; provided, however, such facility shall continue to maintain a direct-care service rate of at least two and nine tenths (2.9) hours of direct-care service per resident per day, the same to be calculated based on average direct care staff maintained over a twenty-four-hour period.

b. At no time shall direct-care staffing ratios in a facility with twenty-four-hour-based staff-scheduling privileges fall below one direct-care staff to every

fifteen residents or major fraction thereof, and at least two direct-care staff shall be on duty and awake at all times.

c. As used in this paragraph, "twenty-four-hour-based-scheduling" means maintaining:

(1) a direct-care-staff-to-resident ratio based on overall hours of direct-care service per resident per day rate of not less than two and ninety one-hundredths (2.90) hours per day,

(2) a direct-care-staff-to-resident ratio of at least one direct-care staff person on duty to every fifteen residents or major fraction thereof at all times, and

(3) at least two direct-care staff persons on duty and awake at all times.

6. a. On and after January 1, 2004, the State Department of Health shall require a facility to maintain the shift-based, staff-to-resident ratios provided in paragraph 3 of this subsection if the facility has been determined by the Department to be deficient with regard to:

(1) the provisions of paragraph 3 of this subsection,

(2) fraudulent reporting of staffing on the Quality of Care Report, or

(3) a complaint or survey investigation that has determined substandard quality of care as a result of insufficient staffing.

b. The Department shall require a facility described in subparagraph a of this paragraph to achieve and maintain the shift-based, staff-to-resident ratios provided in paragraph 3 of this subsection for a minimum of three (3) months before being considered eligible to implement twenty-four-hour-based staff scheduling as defined in subparagraph c of paragraph 5 of this subsection.

c. Upon a subsequent determination by the Department that the facility has achieved and maintained for at least three (3) months the shift-based, staff-to-resident ratios described in paragraph 3 of this subsection, and has corrected any deficiency described in subparagraph a of this paragraph, the Department shall notify the facility of its eligibility to implement twenty-four-hour-based staff-scheduling privileges.

7. a. For facilities that utilize twenty-four-hour-based staff-scheduling privileges, the Department shall monitor and evaluate facility compliance with the twenty-four-hour-based staff-scheduling staffing provisions of paragraph 5 of this subsection through

reviews of monthly staffing reports, results of complaint investigations and inspections.

b. If the Department identifies any quality-of-care problems related to insufficient staffing in such facility, the Department shall issue a directed plan of correction to the facility found to be out of compliance with the provisions of this subsection.

c. In a directed plan of correction, the Department shall require a facility described in subparagraph b of this paragraph to maintain shift-based, staff-to-resident ratios for the following periods of time:

(1) the first determination shall require that shift-based, staff-to-resident ratios be maintained until full compliance is achieved,

(2) the second determination within a two-year period shall require that shift-based, staff-to-resident ratios be maintained for a minimum period of twelve (12) months, and

(3) the third determination within a two-year period shall require that shift-based, staff-to-resident ratios be maintained. The facility may apply for permission to use twenty-four-hour staffing methodology after two (2) years.

C. Effective September 1, 2002, facilities shall post the names and titles of direct-care staff on duty each day in a conspicuous place, including the name and title of the supervising nurse.

D. The State Commissioner of Health shall promulgate rules prescribing staffing requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities serving six or fewer clients (ICFs/IID-6) and for Intermediate Care Facilities for Individuals with Intellectual Disabilities serving sixteen or fewer clients (ICFs/IID-16).

E. Facilities shall have the right to appeal and to the informal dispute resolution process with regard to penalties and sanctions imposed due to staffing noncompliance.

F. 1. When the state Medicaid program reimbursement rate reflects the sum of Ninety-four Dollars and eleven cents ($94.11), plus the increases in actual audited costs over and above the actual audited costs reflected in the cost reports submitted for the most current cost-reporting period and the costs estimated by the Oklahoma Health Care Authority to increase the direct-care, flexible staff-scheduling staffing level from two and eighty-six one-hundredths (2.86) hours per day per occupied bed to three and two-tenths (3.2) hours per day per occupied bed, all nursing facilities subject to the provisions of the Nursing Home Care Act and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) with seventeen or more beds, in addition to

other state and federal requirements related to the staffing of nursing facilities, shall maintain direct-care, flexible staff-scheduling staffing levels based on an overall three and two-tenths (3.2) hours per day per occupied bed.

2. When the state Medicaid program reimbursement rate reflects the sum of Ninety-four Dollars and eleven cents ($94.11), plus the increases in actual audited costs over and above the actual audited costs reflected in the cost reports submitted for the most current cost-reporting period and the costs estimated by the Oklahoma Health Care Authority to increase the direct-care flexible staff-scheduling staffing level from three and two-tenths (3.2) hours per day per occupied bed to three and eight-tenths (3.8) hours per day per occupied bed, all nursing facilities subject to the provisions of the Nursing Home Care Act and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) with seventeen or more beds, in addition to other state and federal requirements related to the staffing of nursing facilities, shall maintain direct-care, flexible staff-scheduling staffing levels based on an overall three and eight-tenths (3.8) hours per day per occupied bed.

3. When the state Medicaid program reimbursement rate reflects the sum of Ninety-four Dollars and eleven cents ($94.11), plus the increases in actual audited costs over and above the actual audited costs reflected in the cost reports submitted for the most current cost-reporting period and the costs estimated by the Oklahoma Health

Care Authority to increase the direct-care, flexible staff-scheduling staffing level from three and eight-tenths (3.8) hours per day per occupied bed to four and one-tenth (4.1) hours per day per occupied bed, all nursing facilities subject to the provisions of the Nursing Home Care Act and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) with seventeen or more beds, in addition to other state and federal requirements related to the staffing of nursing facilities, shall maintain direct-care, flexible staff-scheduling staffing levels based on an overall four and one-tenth (4.1) hours per day per occupied bed.

4. The Commissioner shall promulgate rules for shift-based, staff-to-resident ratios for noncompliant facilities denoting the incremental increases reflected in direct-care, flexible staff-scheduling staffing levels.

5. In the event that the state Medicaid program reimbursement rate for facilities subject to the Nursing Home Care Act, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) having seventeen or more beds is reduced below actual audited costs, the requirements for staffing ratio levels shall be adjusted to the appropriate levels provided in paragraphs 1 through 4 of this subsection.

G. For purposes of this subsection:

1. "Direct-care staff" means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility;

2. Prior to September 1, 2003, activity and social services staff who are not providing direct, hands-on care to residents may be included in the direct-care-staff-to-resident ratio in any shift. On and after September 1, 2003, such persons shall not be included in the direct-care-staff-to-resident ratio, regardless of their licensure or certification status; and

3. The administrator shall not be counted in the direct-care-staff-to-resident ratio regardless of the administrator's licensure or certification status.

H. 1. The Oklahoma Health Care Authority shall require all nursing facilities subject to the provisions of the Nursing Home Care Act and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) with seventeen or more beds to submit a monthly report on staffing ratios on a form that the Authority shall develop.

2. The report shall document the extent to which such facilities are meeting or are failing to meet the minimum direct-care-staff-to-resident ratios specified by this section. Such report shall be available to the public upon request.

3. The Authority may assess administrative penalties for the failure of any facility to submit the report as required by the Authority. Provided, however:

a. administrative penalties shall not accrue until the Authority notifies the facility in writing that the report was not timely submitted as required, and

b. a minimum of a one-day penalty shall be assessed in all instances.

4. Administrative penalties shall not be assessed for computational errors made in preparing the report.

5. Monies collected from administrative penalties shall be deposited in the Nursing Facility Quality of Care Fund and utilized for the purposes specified in the Oklahoma Healthcare Initiative Act.

I. 1. All entities regulated by this state that provide long-term care services shall utilize a single assessment tool to determine client services needs. The tool shall be developed by the Oklahoma Health Care Authority in consultation with the State Department of Health.

2. a. The Oklahoma Nursing Facility Funding Advisory Committee is hereby created and shall consist of the following:

(1) four members selected by the Oklahoma Association of Health Care Providers,

(2) three members selected by the Oklahoma Association of Homes and Services for the Aging, and

(3) two members selected by the State Council on Aging.

The Chair shall be elected by the committee. No state employees may be appointed to serve.

b. The purpose of the advisory committee will be to develop a new methodology for calculating state Medicaid program reimbursements to nursing facilities by implementing facility-specific rates based on expenditures relating to direct care staffing. No nursing home will receive less than the current rate at the time of implementation of facility-specific rates pursuant to this subparagraph.

c. The advisory committee shall be staffed and advised by the Oklahoma Health Care Authority.

d. The new methodology will be submitted for approval to the Board of the Oklahoma Health Care Authority by January 15, 2005, and shall be finalized by July 1, 2005. The new methodology will apply only to new funds that become available for Medicaid nursing facility reimbursement after the methodology of this paragraph has been finalized. Existing funds paid to nursing homes will not be subject to the methodology of this paragraph. The methodology as outlined in this paragraph will only be applied to any new funding

for nursing facilities appropriated above and beyond the funding amounts effective on January 15, 2005.

e. The new methodology shall divide the payment into two components:

(1) ~~direct care which~~ the nursing rate component, which shall consist of direct care and a nurse aide wage and promotion scale if utilized.

(a) Direct care includes allowable costs for registered nurses, licensed practical nurses, certified medication aides and certified nurse aides. The direct care component of the rate shall be a facility-specific rate, directly related to each facility's actual expenditures on direct care.

(b) Effective July 1, 2025, the Authority shall design and implement an optional nurse aide wage and promotion scale for nursing facilities. This program shall provide qualifying facilities with a subsidy payment, and

(2) other costs.

f. The Oklahoma Health Care Authority, in calculating the base year prospective direct care rate component, shall use the following criteria:

(1) to construct an array of facility per diem allowable expenditures on direct care, the Authority shall use the most recent data available. The limit on this array shall be no less than the ninetieth percentile,

(2) each facility's direct care base-year component of the rate shall be the lesser of the facility's allowable expenditures on direct care or the limit,

(3) effective July 1, 2025, the direct care payment amount of each facility shall be adjusted to reflect the resident case mix of each facility using a percentage of funds in the direct care pool as determined by the Authority,

(4) other rate components shall be determined by the Oklahoma Nursing Facility Funding Advisory Committee of the Authority in accordance with federal regulations and requirements,

~~(4)~~ (5) prior to July 1, 2020, the Authority shall seek federal approval to calculate the upper payment limit under the authority of CMS

utilizing the Medicare equivalent payment rate, ~~and~~

~~(5)~~ (6) if Medicaid payment rates to providers are adjusted, nursing home rates and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) rates shall not be adjusted less favorably than the average percentage-rate reduction or increase applicable to the majority of other provider groups~~.~~

~~g. (1) Effective October 1, 2019, if sufficient funding is appropriated for a rate increase, a new average rate for nursing facilities shall be established. The rate shall be equal to the statewide average cost as derived from audited cost reports for SFY 2018, ending June 30, 2018, after adjustment for inflation. After such new average rate has been established, the facility specific reimbursement rate shall be as follows:~~

~~(a) amounts up to the existing base rate amount shall continue to be distributed as a part of the base rate in accordance with the existing State Plan, and~~

~~(b) to the extent the new rate exceeds the rate effective before the effective date of this~~

~~act, fifty percent (50%) of the resulting increase on October 1, 2019, shall be allocated toward an increase of the existing base reimbursement rate and distributed accordingly. The remaining fifty percent (50%) of the increase shall be allocated in accordance with the currently approved 70/30 reimbursement rate methodology as outlined in the existing State Plan.~~

~~(2) Any subsequent rate increases, as determined based on the provisions set forth in this subparagraph~~,

(7) effective July 1, 2025, the base rate of each facility shall be adjusted by a percentage determined by the Authority based on the facility's performance in the CMS Five-Star Quality Rating System or similar program if the CMS Five-Star Quality Rating System is discontinued,

(8) subsequently, for any new funds, seventy percent (70%) shall be allocated ~~in accordance with the currently approved 70/30 reimbursement rate methodology~~ to the direct care component of the nursing rate and thirty percent (30%) shall be

allocated for other costs under the nursing rate. The rate shall not exceed the upper payment limit established by the Medicare rate equivalent established by the federal CMS,

(9) upon the effective date of this act, subject to the availability of funds, the Authority shall develop an add-on rate for nursing facilities serving residents who have received a tracheostomy. The Authority shall establish eligibility requirements for the add-on rate, and

(10) the Authority shall transition the payment rate methodology of nursing facilities to a price-based methodology when data for such a methodology becomes available and has been analyzed by the Authority.

~~h.~~ g. Effective October 1, 2019, in coordination with the rate adjustments identified in the preceding section, a portion of the funds shall be utilized as follows:

(1) effective October 1, 2019, the Oklahoma Health Care Authority shall increase the personal needs allowance for residents of nursing homes and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) from Fifty Dollars ($50.00) per month to Seventy-five

Dollars ($75.00) per month per resident. The increase shall be funded by Medicaid nursing home providers, by way of a reduction of eighty-two cents ($0.82) per day deducted from the base rate. Any additional cost shall be funded by the Nursing Facility Quality of Care Fund, and

(2) effective January 1, 2020, all clinical employees working in a licensed nursing facility shall be required to receive at least four (4) hours annually of Alzheimer's or dementia training, to be provided and paid for by the facilities.

3. The Department of Human Services shall expand its statewide toll-free, Senior-Info Line for senior citizen services to include assistance with or information on long-term care services in this state.

4. The Oklahoma Health Care Authority shall develop a nursing facility cost-reporting system that reflects the most current costs experienced by nursing and specialized facilities. The Oklahoma Health Care Authority shall utilize the most current cost report data to estimate costs in determining daily per diem rates.

5. The Oklahoma Health Care Authority shall provide access to the detailed Medicaid payment audit adjustments and implement an appeal process for disputed payment audit adjustments to the provider. Additionally, the Oklahoma Health Care Authority shall

make sufficient revisions to the nursing facility cost reporting forms and electronic data input system so as to clarify what expenses are allowable and appropriate for inclusion in cost calculations.

J. 1. When the state Medicaid program reimbursement rate reflects the sum of Ninety-four Dollars and eleven cents ($94.11), plus the increases in actual audited costs, over and above the actual audited costs reflected in the cost reports submitted for the most current cost-reporting period, and the direct-care, flexible staff-scheduling staffing level has been prospectively funded at four and one-tenth (4.1) hours per day per occupied bed, the Authority may apportion funds for the implementation of the provisions of this section.

2. The Authority shall make application to the United States Centers for Medicare and Medicaid Service for a waiver of the uniform requirement on health-care-related taxes as permitted by Section 433.72 of 42 C.F.R.

3. Upon approval of the waiver, the Authority shall develop a program to implement the provisions of the waiver as it relates to all nursing facilities.

K. Subject to the availability of funds, the Authority shall design and implement a scholarship program for nurse aides who work in Medicaid-certified nursing facilities or Intermediate Care

Facilities for Individuals with Intellectual Disabilities (ICFs/IID).

SECTION 3. This act shall become effective July 1, 2024.

SECTION 4. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

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