THE SPECIAL TASK FORCE ON THE FUTURE OF LONG TERM HEALTH CARE

Report to the 71st Legislature
January 10, 1989

SPECIAL TASK FORCE ON THE FUTURE OF LONG-TERM HEALTH CARE
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The Honorable William P. Hobby, Jr.
Lieutenant Governor of Texas

The Honorable Gibson D. Lewis
Speaker, Texas House of Representatives

Pursuant to the mandate of HCR 213, the Special Task Force on the Future of Long Term Health Care hereby submits its final report and recommendations. Recommendations contained in this report are the result of careful examination of the long term health care system in Texas, and are intended to address both immediate and far-reaching concerns.

Respectfully submitted,

James M. Martin, Chairman

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* NOTE: Recognizing the fiscal constraints of the 71st Legislative Session, I do not agree with all the recommendations of this report but I do consider the work of the committee to be a great benefit to the legislative process.

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"Prevention constitutes the most vital element in terms of meaningful aging. It is the hardest aspect to measure because it is difficult to show what one has prevented. Studies demonstrate that older people who are neglected subsequently need more of the expensive health services than do those who are active participants in health and mental health programs.

Preventive efforts aimed at keeping older people stimulated, motivated, and focused on living can save the State monies in terms of institutional care and can benefit it in terms of persons who are productive and useful to society."

Bert Kruger Smith
Hogg Foundation for Mental Health

ACKNOWLEDGEMENTS

The Special Task Force on the Future of Long Term Health Care and its staff would like to express its appreciation to the Texas Tech University Health Sciences Center, University of Texas Health Science Center at Houston, University of Texas at Arlington, and Texas State Technical Institute in Harlingen, for allowing the task force to hold public hearings on their campuses.

The task force and its staff would also like to thank the Texas Department of Human Services, Texas Department of Health, Attorney General's Office, Texas Department on Aging, Office of the Lieutanant Governor, Office of the Speaker of the House of Representatives, State Board of Insurance, Texas Education Agency, State Board of Pharmacy, Long Term Care Coordinating Council for the Elderly, Texas Health and Human Services Coordinating Council, and the Texas Legislative Council for their technical assistance in the development of this report.

Thanks also go to the American Association of Retired Persons, United People for Better Nursing Home Care, Gray Panthers, Texas Organization of Residential Care Homes, Texas Health Care Association, Texas Association of Homes for the Aging, Texas Association of Home Health Agencies, Texas Nurses Association, Texas Medical Association, Texas Hospital Association, Alzheimer's Disease and Related Disorders Association, University of Texas Medical Branch at Galveston, and all individuals and organizations which provided testimony and information to the task force in the development of this report.

The task force staff would like to express its sincere gratitude and appreciation to Leslie Lemon, Staff Director, and Linda Christofilis, Committee Clerk, of the Senate Health and Human Services Committee. Their guidance and support were instrumental in the development of this report.

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INTRODUCTION

LEGISLATIVE BACKGROUND

The 70th Legislature created the Special Task Force on the Future of Long Term Health Care through enactment of House Concurrent Resolution 213 (Appendix A). The legislature concluded that the nursing home program in Texas had grown in size, complexity, and cost. Legislative and regulatory attempts to control cost and protect patients had resulted in an inequitable and outdated nursing home program that was costly and burdensome to both state government and providers. The problem was compounded by the lack of an integrated system between the Texas Department of Health (TDH) and the Texas Department of Human Services (TDHS). House Concurrent Resolution 213 mandated the task force to study the current and future status of long term care in Texas with the goal of establishing a system which offers quality care in the most efficient manner.

The twelve members of the task force were appointed by the lieutenant governor and the speaker of the house of representatives and include legislative members, long term care providers, and consumer representatives. Advisory members were assigned to the task force by the Texas Department of Human Services, the Texas Department of Health, and the Office of the Attorney General.

THE SCOPE OF LONG TERM HEALTH CARE

According to the Texas Department on Aging, the population of Texans over the age of 65 is growing faster than any other age group, and the 85+ age group is the fastest growing group of all. According to the Texas Association of Homes for the Aging, elderly people who live beyond the age of 65 face a forty percent chance of needing nursing home care before they die. About thirty percent of these people will need nursing home care for longer than one year. This growing population of elderly people points to the inevitable need for increases in long term care services and improvements in the current long term care system.

Individuals under the age of 65 with physical and/or mental disabilities may also need long term care services ranging from assistance with activities of daily living to intensive medical care. In addition, medical advances have enabled people to live longer, thus allowing the population of young disabled and/or chronically ill people to grow. Therefore, the demand for long term care services for this non-elderly population is increasing.

The task force realized that long term care services must encompass a wide variety of services in a wide variety of settings, and must be designed to care for people of all ages. Long term care can no longer be thought of as institutional care for the elderly; this type of care falls short of providing services to everyone in need. Therefore, the task

force found it necessary to address the long term care needs of both young and old people in settings ranging from custodial care in the home to skilled nursing care in institutional settings.

Although a long term care system should include a variety of services, the task force was guided in its deliberations by the unanimous belief that in order to preserve the highest possible quality of life, long term care should be provided at home or in home-like, community based settings whenever possible. The task force thought that efforts to improve the system should focus on ways to prevent the need for long term institutional care as long as possible, through a combination of education and the provision of quality community based services.

With this philosophy in mind, the task force began its deliberations. However, it was acknowledged that due to time, staff, and budgetary constraints, the broad spectrum of long term care could not be thoroughly covered. Therefore, the task force concentrated on the most critical and far-reaching issues facing the long term care system in Texas today and provided guidance and input in the conclusion of this report for future improvement of the system.

The task force recognized its charge to examine how the state could develop a long term care system that provides a

true continuum of care for elderly and disabled people. The recommendations contained in this report, if implemented, would go a long way toward the establishment of such a system. However, the task force recognizes the fiscal restraints under which the 71st Legislature must operate. If the legislature determines that full funding to support these recommendations is not available, the task force hopes this report will serve as a guide in the decision-making process.

PUBLIC HEARINGS AND WORK SESSIONS

The task force began its deliberations by conducting public hearings in the following cities on the dates designated below:

1. Houston - February 4, 1988,
2. Harlingen - February 17, 1988,
3. Arlington - March 2, 1988,
4. Lubbock - March 16, 1988, and
5. Austin - March 29, 1988.

These hearings provided a framework of issues to be considered by the task force at its work sessions. Work sessions were held in Austin on the following dates:

1. April 12, 1988,
2. May 12, 1988,
3. June 14, 1988,
4. July 13, 1988,
5. August 16, 1988,

6. September 1, 1988,

7. September 19, 1988, and

8. November 29, 1988.

REPORT FORMAT

The recommendations contained in this report reflect and address public concerns brought before the task force throughout this process. Issues of concern are organized into six major categories. Each category is a chapter of the report. The categories covered are: Chapter 1 - Continuum of Care, Chapter 2 - Quality of Life in Nursing Homes, Chapter 3 - Staff Requirements, Chapter 4 - Eligibility, Chapter 5 - Rates, and Chapter 6 - Regulatory Programs.

Chapter 1, Continuum of Care, examines a range of services, from community based services in the home or home-like settings, to institutional services provided in nursing homes. It stresses the need for a continuum of services to meet a wide variety of individual needs, the need to provide community care as an alternative to institutionalization when it is in the individual's best interest, and the need for coordination of services through case management. It also covers the need to increase funding of existing programs, and the need to fill in the "gaps" in community based services. The goal of a continuum of care is to provide services that fit the needs of the individual, rather than shaping the needs of the individual to fit existing services.

Chapter 2, Quality of Life in Nursing Homes, stresses the need to provide the highest quality of services in institutional settings. The task force recognized that people residing in nursing homes are extremely vulnerable because of their age, disability, and/or fragile physical condition. Often these people are too frail to advocate for themselves. Additional safeguards are needed to ensure they are treated in a caring fashion and protected from any wrong-doing. Recommendations discussed in this chapter involve the need to prevent thefts in nursing homes; the need to increase funding for the Texas Department on Aging's ombudsman program, benefits counseling, volunteer services, and advocacy services; and the need to improve pharmaceutical services in nursing homes.

Chapter 3, Staff Requirements, recognizes the critical role that properly trained staff play in the provision of quality care, whether the care is provided in an individual's home or in a nursing home. Appropriate training can not be obtained, nor will well-trained staff remain in the long term care field if adequate funding is not available. It costs money to train people and it costs money to keep people. Recommendations in this chapter involve the need for increases in funding to adequately pay and train long term care staff as required by the federal Omnibus Budget Reconciliation Act of 1987.

Chapter 4, Eligibility, grew out of extensive public testimony, as well as phone calls and letters to the task

force, by people who were at a loss as to how to care for a loved one. These individuals were frustrated because they could not afford to buy long term care, yet their family member did not qualify for state or federal assistance. Many of those people were elderly themselves and/or had exhausted their personal resources. This chapter recommends a statutory amendment which would require the Texas Department on Aging to develop programs to educate the public on the cost of long term care, how it is financed, and eligibility requirements for state and federal programs. The Medicaid eligibility income cap for institutional and community based services is also discussed.

Chapter 5, Rates, examines the current Medicaid rate-setting process at TDHS, and makes recommendations designed to make this process more understandable to the legislature, long term care providers, and the general public. The task force heard a great deal of public testimony concerning both the lack of understanding of how TDHS sets rates, as well as the lack of opportunity for providers to interact with TDHS staff when there is disagreement about a reimbursement rate. Changes in TDHS' rules regarding the ratemaking process and opportunities for public input are presented in this chapter.

Chapter 6, Regulatory Programs, involves recommendations which improve the regulatory system by enabling long term care

providers to provide quality care services in the least costly, most efficient manner. One of the mandates of the task force was to study and find ways to improve the complex, inefficient, long term care regulatory system. The legislature was concerned that previous attempts to improve the regulatory system had resulted in an inequitable and outdated nursing home program that was costly and burdensome to both government and providers. The task force studied the regulatory system for nursing homes, as well as personal care homes, and found that some regulations hindered rather than facilitated quality patient care. Regulatory issues involving nursing facilities, personal care homes, and TDHS' attendant care programs are discussed in this chapter.

This report concludes with a discussion of important issues that the task force was unable to examine. These issues, although not immediately critical to the long term care service delivery system, must be addressed in order to avoid serious problems in the future and to continue to move the state toward an optimal system. The task force hopes that by including them in the report, they will be brought to the attention of other groups involved in long term care. The task force urges the legislature to give these groups the proper direction and authority to examine and resolve these issues.

CHAPTER 1: CONTINUUM OF CARE

This chapter deals with the need to provide a wide variety of long term care services in Texas, both in the community and in institutions. A true continuum of care should range from services provided in a person's home to skilled nursing home care. The goal should be providing services that meet the individual's needs, rather than the availability of services determining what needs are met. In this chapter, recommendations are centered around two primary themes: the need to expand community based programs to allow more people to delay institutionalization for as long as possible and the need for coordination of services between state agencies.

EXPANSION OF COMMUNITY BASED PROGRAMS

BACKGROUND INFORMATION

The task force repeatedly heard testimony about the failure of the state to provide alternatives to institutionalization. It was determined that although many alternative programs exist, there is no true continuum of care due to inadequate funding. Many of the programs that do exist are provided by TDHS through its Community Care for the Aged and Disabled (CCAD) program. These programs, which serve approximately 55,000 clients per month, are described below.

1. Primary Home Care provides medically necessary, long-term maintenance or supportive care supervised by a registered nurse in a client's home. It is a Medicaid program, funded through Title XIX of the Social Security Act, with a state match.

2. Family Care provides personal care, housekeeping, escort services, and meal preparation in a client's home. It is funded by Title XX, a federal program also known as the Social Services Block Grant.

3. The Congregate and Home Delivered Meals program provides nutritious meals, either delivered to a client's home or in a central dining area. It is funded by Title XX.

4. The Emergency Response System is an electronic monitoring service that permits quick response to emergencies utilizing a network of volunteers and remote telephone calling ability. It too is funded by Title XX.

5. Adult Foster Care provides special services and 24-hour living arrangements in foster homes for persons who cannot live alone, but do not need nursing home care. It is also a Title XX funded program.

6. The Day Activity and Health Services program provides out of home social and nursing services for people unable to remain alone during the day. The

goal is to maintain the person's level of functioning. It is funded by Title XIX and XX.

7. Special Services for the Handicapped provides counseling, personal care, and help with the development of skills needed for independent living. These services are directed toward the adult disabled population. The program is funded by Title XX.

8. The Residential Care program provides services to eligible adults who require access to services on a 24-hour basis, but do not need daily nursing intervention. Services may include board, protective supervision, personal care, social and recreational services, housekeeping, laundry, and transportation. Funding for this program comes from general revenue.

9. Client Managed Attendant Care is a demonstration project. It targets physically handicapped adults who need assistance to live independently, but are capable of directing their care, including the hiring, training, supervision and termination of an attendant. Clients with incomes above $730/month must pay for a portion of their care. This project is funded with general revenue.

10. The In-Home and Family Support Services program is a voucher program designed to assist persons with developmental disabilities and their families in

purchasing services that are conducive to maintaining community living arrangements. It is a demonstration project funded by the Developmental Disabilities Council through a federal grant.

11. The respite program provides short-term care for aged and disabled adults who require care and/or supervision. Services may include personal care, housekeeping, supervision, home-delivered meals and meal preparation, transportation, and nursing services for the client. The client's caregiver may receive training, support, and/or counseling to strengthen his or her coping skills. Funds for this program come from general revenue.

As indicated, TDHS' community care programs are primarily funded by Title XIX (Medicaid) and Title XX (the Social Services Block Grant). Whereas Title XIX programs are funded through a federal/state matching ratio, which in fiscal year 1989 is 59 percent to 41 percent, Title XX programs are limited to a fixed amount of federal funding. Texas is receiving its maximum share for this block grant. Therefore, any additional funds for programs funded by Title XX must come entirely from general revenue.

PROGRAMS REQUIRING INCREASED FUNDING

Four areas were identified where an increase in funding would go a long way toward the establishment of a true

continuum of services. The following paragraphs describe these four areas.

The first area relates to elimination of the waiting list for Title XX services. Because TDHS can only serve a fixed number of clients with Title XX funds, additional clients who are eligible for services must be placed on waiting lists. As of January 1, 1988, there were 2,545 clients on the waiting list for Title XX services. It is estimated that 4,074 people will be on the waiting list for these services in fiscal year 1990, and 5,295 in fiscal year 1991. Many of these individuals have a high level of functional impairment and a critical need for services. If appropriate, community based services were available, they might be able to remain at home or in a home-like setting. However, the critical shortage of community based services may force them to seek nursing home care. General revenue funds are needed to eliminate the waiting list to allow people to avoid unnecessary, more costly institutional care. This will cost approximately $9.9 million in fiscal year 1990 and $13.5 million in fiscal year 1991.

The second area that needs additional funding relates to attendant care. The availability of attendant care can make the difference in a person's ability to remain independent. Attendants come to a client's home and assist him or her in activities of daily living, such as bathing, dressing, and grooming. The Client Managed Attendant Care Demonstration

Project targets physically handicapped adults who need assistance, but are capable of hiring, training, supervising, and firing an attendant. The project incorporates a sliding fee scale, emergency substitute attendants, and attendant service at the client's work place or school.

This pilot was initially funded by the 69th Legislature. Through a competitive procurement process, service providers were chosen in east Texas, south Texas, and Bexar County. The demand for services has resulted in waiting lists of six to eight months in two of the three pilot sites. TDHS is requesting $1.1 million in fiscal year 1990 and $1.2 million in fiscal year 1991 to serve 215 additional clients each month. These funds would come from general revenue.

The third program that helps people stay at home is the In-Home and Family Support Services program. TDHS currently has a federal grant from the Developmental Disabilities Council for $.3 million per year for this program. Although TDHS will seek funding from the Developmental Disabilities Council again in fiscal years 1990 and 1991, additional funds are needed.

This program is intended to help people with developmental disabilities and their families buy services that are conducive to maintaining or encouraging community living arrangements. Services are intended to supplement the existing care being provided by family and/or friends. The client population includes persons with developmental disabilities, regardless of

age, who are not mentally retarded or mentally ill, who meet the federal definition of developmentally disabled. The maximum cap on services is $3600 per year for ongoing services, with a one time maximum amount of $3600 for architectural modification or a capital expenditure. There is a co-payment requirement for clients with an annual income above 200 percent of poverty. To serve an additional 133 clients/year in fiscal year 1990 and 164 clients/year in fiscal year 1991, TDHS is requesting $.3 million each year in general revenue.

The fourth area that needs additional funding relates to respite care services. Currently, TDHS' respite care services provide short-term care for aged and disabled adults who require care and/or supervision. As stated previously, services may include personal care, housekeeping, supervision, meals, transportation, and nursing services for the client. Also, the client's caregiver may receive training, support, and/or counseling to strengthen his or her coping skills. Even a minimal amount of respite care may make the difference in a caregiver's ability to continue. If the family caregiver system that supports these individuals breaks down, it could cost Texas and the federal government approximately $12,640 per year per person for placement in a nursing home.

The Department of Human Services is requesting an increase in funds for respite services of $1.4 million per year over the fiscal year 1989 service level. This will allow them to expand

respite services to disabled children who live with a parent or other caregiver, as well as to the adult aged and disabled population. In fiscal years 1990 and 1991, 4,200 clients would be served. This is an increase of 3,878 each year over the 1988 service level. The cost of respite care can not exceed the cost of institutional care. Therefore, the task force estimated that these funds would provide services for approximately nine and one-half days per year per person, with a maximum of fourteen days for any individual. General revenue funds are requested.

NEW PROGRAMS NEEDED

Strengthening the existing continuum of care not only requires increased funding for existing programs, but additional dollars for new programs. The task force identified three areas where new programs are needed.

The first area involves state supplementation of Supplemental Security Income (SSI) benefits. To qualify for benefits, a person must be over age 65, blind, or disabled, and have an income below the federal SSI benefit level of $354/month for individuals and $554/month for couples.

Many individuals who live in personal care homes have only SSI benefits to pay for their care. It is difficult for personal care homes to meet state licensure standards and provide quality care if they rely solely on the resident's SSI

benefits. State supplementation of SSI benefits would provide low-income individuals with more money to purchase suitable housing. Limiting the supplementation to individuals in licensed personal care homes would encourage providers to be licensed, while holding down the cost of the supplementation. The cost to the state would be $4.2 million in fiscal year 1990 and $4.8 million in fiscal year 1991. Approximately 2,859 clients would be served in the first year of the biennium and about 3,132 would be served in the second.

The second new program needed would fill a hole in the current service delivery system. The task force identified a gap in services between patients requiring acute, often post-hospital, skilled home health care and patients who have little medical need and can be served through Primary Home Care. Patients may be "in between" home health care and Primary Home Care and be forced to enter an institutional setting. One way to avoid this is to provide services in the home which are currently only available in institutional settings.

Some Medicaid recipients currently receiving hyperalimentation services in an institution could be discharged if in-home care was provided. Hyperalimentation refers to an intravenous feeding system which meets the long term nutritional needs of people who cannot ingest food orally. In addition, in-home physical, speech, and

occupational therapies could better meet the needs of certain recipients, and would be less expensive than services rendered as a physician or hospital service. Access to durable medical equipment (DME) can allow a person to function outside a hospital setting. DME is equipment which can withstand repeated use and is suitable for use in the home. Frequently used DME includes hospital beds, wheelchairs, walking devices, and oxygen therapy services.

TDHS is requesting funds to provide these in-home services under its Purchased Health Premiums program. This new program would provide hyperalimentation services, physical, speech, and occupational therapies, and durable medical equipment in the home of clients who need a high level of care. The state's share of the funding would be approximately $8.5 million in fiscal year 1990 and $9.3 million in fiscal year 1991. This would be matched with Title XIX funds, resulting in a total of $20.7 million in the first year of the biennium and $22.7 million in the second.

The third new program needed would serve severely disabled adults who are aging out of TDHS' managing conservatorship. These young adults have on-going needs, but no longer qualify for TDHS' support when they reach their twenty-second birthday. Funds to place them in the type of setting most appropriate to their individual needs are being requested by the Department of Human Services. The funds, if appropriated,

would come from general revenue in the amount of $.9 million in fiscal year 1990 and $1 million in fiscal year 1991. One hundred severely disabled clients would be served each year.

RECOMMENDATIONS

1. The legislature should grant TDHS' request for funding to eliminate the waiting list for community care services, at a state cost of $9.9 million in fiscal year 1990 and $13.5 million in fiscal year 1991.

2. The legislature should grant TDHS' general revenue request for $1.1 million in fiscal year 1990 and $1.2 million in 1991 for increases in the Client Managed Attendant Care program.

3. The legislature should grant TDHS' request for $.3 million in general revenue each year of the biennium to increase the number of people served by the In-Home and Family Support Services program.

4. To provide respite services to people in need, the legislature should grant TDHS' request for additional funds of $1.4 million over the current level of funding, for fiscal years 1990 and 1991. This would provide approximately nine and one-half days per year of respite services to about 4,200 people.

5. The legislature should grant TDHS' request for $4.2 million in fiscal year 1990 and $4.8 million in fiscal year

1991 to provide state supplementation of SSI benefits to individuals living in licensed personal care homes.

6. To fill the gap in services between skilled home health care and Primary Home Care, the legislature should grantfunding for hyperalimentation services, physical, speech, and occupational therapies and durable medical equipment under the Purchased Health Premiums program. This would cost $20.7 million in fiscal year 1990, or approximately $8.5 million in state funds, and $22.7 million in fiscal year 1991, or approximately $9.3 million in state funds.

7. The legislature should grant TDHS' request for $.9 million in fiscal year 1990 and $1 million in fiscal year 1991 to serve severely disabled clients who are aging out of TDHS' managing conservatorship.

COMMUNITY BASED MEDICAID WAIVER PROGRAMS

BACKGROUND INFORMATION

Medicaid waiver programs are another way for states to offer community based care to individuals. Waivers are intended to encourage the use of community based programs by allowing states to receive Medicaid matching funds for these programs. In these programs, certain Medicaid requirements are waived to allow individuals to receive services in the community. Waiver programs benefit both the client and the state because clients can be served in the least restrictive

environment at a reduced cost to the state. There are currently three waivers under TDHS' Community Care for the Aged and Disabled program.

The first of these is one of five waivers granted under Section 1115 of the Social Security Act. It is a research and demonstration waiver and is referred to as Waiver 5. Without this waiver, an individual who needs Primary Home Care has to meet SSI income eligibility requirements, i.e. have an income of $354/month or less. Waiver 5 allows Texas to waive those income eligibility requirements up to the income level for nursing home care or $687/month. This allows Texas to provide community care to clients who, prior to 1979, would have been served in an ICF II nursing home under the old level of care criteria. This waiver was originally obtained when Texas decided to phase out the ICF II level of care in 1979 and wanted to expand funding for alternative care in the community. The Department of Human Services has served approximately 30,000 clients since the program's inception. TDHS expects to serve approximately 4,400 Waiver 5 clients per year in fiscal years 1989 through 1991.

Section 1115 (Waiver 5), expires on January 1, 1990. TDHS is concerned that the waiver will not be renewed due to increasing resistance to renewal over the past eight years. TDHS was denied in its last attempt to get another three year waiver from the federal Health Care Finance Administration.

Since January 1, 1986, TDHS has relied on Congress for extensions of this waiver. The department is concerned that Congress may not continue to provide extensions. If the waiver expires, these clients will go unserved or will need to enter a nursing home.

The Department of Human Services is asking Congress to add a provision to the Medicaid portion of the Social Security Act to give any state the option to phase out its current minimum level of institutional care, like Texas did, and provide funding for community based services as an alternative. This would allow Texas to continue to do what it has been doing with Waiver 5, without needing to continually seek renewal of a waiver.

Cost savings reports prepared by TDHS support the need for this type of program. The agency estimates that approximately $1 billion were saved through community based waivers and the phasing out of the ICF II level of nursing home care. Without the waiver, Texas would have approximately 84,000 Medicaid patients in nursing homes in 1988, as opposed to the current 55,000. This is based on an annual increase of four percent in the nursing home population. The task force wrote a letter to the Texas congressional delegation supporting this amendment to the Medicaid portion of the Social Security Act which would give any state the option to phase out its current minimum level of institutional care and receive federal funding to serve those clients in the community.

The second waiver available in Texas is based on Section 1915(c) of the Social Security Act. It is a waiver for medically dependent children. It provides skilled nursing care for a limited number of severely disabled children who are eligible for institutional care but would be ineligible for Medicaid benefits because of their parents' income if served at home. The waiver was expanded to serve 120 children, as of June 29, 1988. TDHS is also requesting $.4 million in fiscal years 1990 and 1991 to serve 70 additional clients each year.

The third waiver is also based on Section 1915(c) of the Social Security Act and is a waiver for mentally retarded clients. It provides in-home and out-of-home services for a limited number of SSI eligible, mentally retarded clients who qualify for ICF-MR institutional care. In fiscal year 1988, 358 clients were served. TDHS is requesting federal permission to continue this waiver program and to expand it to serve 450 clients in fiscal year 1989, 690 clients in fiscal year 1990, 930 clients in fiscal year 1991, 1,170 clients in fiscal year 1992, and 1,350 clients in fiscal year 1993. The Texas Department of Mental Health and Mental Retardation is requesting $1.4 million in fiscal year 1990 and $3.0 million in fiscal year 1991 to expand the program.

A 1915(c) waiver for the elderly existed in Potter and Randall counties as a pilot project from January 1, 1983 through December 31, 1986. The Department of Human Services

did not request a renewal of this waiver because it was not widely utilized by those communities. According to TDHS staff, it was difficult to show cost effectiveness due to Texas' high level of care criteria and low reimbursement rates. To be in the waiver program, an individual had to meet the eligibility requirements for nursing home care. The costs of services under the waiver program could not exceed the state's reimbursement rate for nursing homes. Providers found it difficult to serve this population, in the community, at that rate. However, consideration to the benefits of this type of waiver should be considered in the future, as the rates change.

RECOMMENDATIONS

8. The legislature should grant TDHS' request for $.4 million in fiscal years 1990 and 1991 for the expansion of the 1915(c) waiver for medically dependent children.

9. The legislature should grant TDMHMR's request for $1.4 million of fiscal year 1990 and $3.0 million in fiscal year 1991 for the expansion of the 1915(c) waiver for mentally retarded clients.

10. The statute should require TDHS to review, on a biennial basis, the feasibility of requesting a 1915(c) waiver for the elderly, if an increase in Medicaid reimbursement rates occurs.

COORDINATION OF SERVICES BETWEEN STATE AGENCIES

BACKGROUND INFORMATION

The second major issue in this chapter is the need for coordination between state agencies providing health and human services. Several of these agencies are requesting funds to perform case management services. Agencies usually offer a variety of services, and potential clients need someone to help them find the services that would best meet their needs. Although case management within agencies helps clients figure out what services that agency can provide, it does not help them learn about services that are available at other agencies. If interagency case management was available, clients could get assistance in accessing services that they need, regardless of the agency that offers the services. Through case management, clients can obtain the best possible array of services and agencies can efficiently utilize limited public dollars.

The Texas Department of Human Services currently offers some case management services for its Community Care for the Aged and Disabled (CCAD) clients. According to the department, CCAD staff are funded at seventy-seven percent of need. This means that each case manager is responsible for about 150 cases per month. The workers perform eligibility determination, identification of needed services among the CCAD service array, authorization of services, case monitoring, and case

follow-up. For fiscal year 1990, TDHS is requesting funding for 353.5 additional CCAD staff above the fiscal year 1989 level, at an increased cost of $8.6 million; and 397.5 additional staff above the fiscal year 1989 level for fiscal year 1991, at an increased cost of $9.1 million. If appropriated, funding will come from Title XIX and general revenue.

The Texas Department on Aging (TDoA) is proposing statewide expansion of its "Options for Independent Living" demonstration projects as the primary focus of its 1990-1991 legislative appropriations request. This expansion would provide case management services to approximately 45,000 non-Medicaid eligible, elderly people per year. TDoA is requesting that in-home/health services funding be increased from $1.7 million in 1989 to $8.1 million in 1990 and $14 million in 1991. Funding requested is from general revenue.

The Texas Commission for the Deaf (TCD) is requesting general revenue funding of $82,000 to develop a case management model in fiscal year 1990 and $1.7 million to perform case management services in fiscal year 1991 at local councils for the deaf.

The Texas Department of Mental Health and Mental Retardation (TDMHMR) is providing case management to individuals with long-term mental illness and/or mental retardation who are at risk of state hospital or state school

placement. During fiscal year 1989, approximately $15.5 million is budgeted for the operation of 77 case management units. Eighty percent of the funding for these units comes from general revenue, and the remainder is from local funding of the community mental health and mental retardation centers. TDMHMR is requesting $21.5 million for fiscal year 1990 and $26.7 million for 1991. The state and local match will remain at the eighty percent to twenty percent level. This will provide additional case managers plus one new case management unit.

Although there are many benefits to the case management services currently being provided in the state, there is one major drawback. These agencies "manage" the services they provide. Staff of one agency is rarely knowledgeable of services provided by other agencies, and there is no statewide case management system in Texas. Many people do not know how to find out about the services they need and if they are eligible for those services. They often go from agency to agency, repeatedly being required to fill out forms to determine if they qualify for a certain type of service. If they do not qualify, or the service is not what they really need, there is no organized method for getting them to the appropriate services.

The Texas Department of Health (TDH), prior to the 70th session, employed social workers to help individuals who were

ineligible for nursing home care access community based services. These positions were eliminated by cuts in the department's budget, and now people who are denied a level of nursing home care by TDH receive no further assistance.

RECOMMENDATIONS

11. The statute should require any health and human services agency which receives funding for case management to train their staff about services provided at other agencies.This will enable them to develop the best service plan for clients, eliminate the need for individuals to go from agency to agency in search of help, and reduce the time spent by agency staff on inappropriate applications for services.

12. The statute should require TDH to inform people who are denied a level of care that there are community services available under TDHS' Community Care for the Aged and Disabled program. TDH should provide these people with a descriptive list of CCAD services and a local phone number to call for more information.

13. As the first step toward a statewide case management approach, the statute should require a thorough study into the best way to implement this type of case management system. The study should include, but not be limited to, examining how the program can best be administered, what the fiscal impact will be, the number of clients that will be served, the number of

case managers needed, projected program increases needed to meet the needs of new clients, and the development of a single assessment instrument that can be used by participating agencies. Participation in the study should include TDHS, TDH, TCD, TDoA, TDMHMR, the Texas Rehabilitation Commission, and the Texas Commission for the Blind. The study should be completed by August 31, 1990.

To test the effectiveness of a case management system that crosses agency lines, a pilot project should begin September 1, 1990. The pilot project should include a case management system that will help people in hospitals as well as in the community. It should include the use of a single assessment instrument to determine needs and appropriate placement. An individualized plan of service should be developed for each client served through the pilot project, as well as a system for regularly scheduled client monitoring.

CHAPTER TWO: QUALITY OF LIFE IN NURSING HOMES

This chapter stresses the need to provide the highest quality of services in institutional settings. Nursing home residents should be able to live in a comfortable environment where their social and emotional needs, as well as their physical needs, are met. They should not have to worry about theft of their money or property. Often a nursing home resident's age, disability, or physical condition makes him or her vulnerable to abuse and incapable of defending themselves. Recommendations discussed in this chapter examine ways to prevent abusive situations, as well as how to establish a system of advocates which can speak out for residents who may be too frail to advocate for themselves. Also included are recommendations to improve pharmaceutical services in nursing homes.

PREVENTING THEFTS IN NURSING HOMES

BACKGROUND INFORMATION

During public hearings, the task force heard testimony concerning the high incidence of theft among nursing home residents. It was suggested that searches of nursing home employees might be a way to cut down on theft. According to the Texas Legislative Council, no state has a statutory provision that authorizes the search of a nursing home employee as he or

she leaves work; however, any employer has at least a limited right to conduct reasonable searches of an employee and the employee's belongings as he or she enters or leaves the work place. A search is reasonable if the procedure is clearly understood by all workers [K. Decker, Employee Privacy Law and Practice (1987)].

The task force also found that the Omnibus Budget Reconciliation Act of 1987 may help address the issue of theft. It requires each state, by January 1, 1989, to establish and maintain a nurse aide registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program. The registry must also include specific documented findings by the state against a nurse aide accused of resident neglect or abuse or misappropriation of the recipient's property, and any statement by the aide disputing the findings. This information should prove helpful when screening applicants for nurse aide positions.

RECOMMENDATION

14. Since nursing home administrators may not be aware of their right to conduct reasonable searches of employees, the task force recommends that the Texas Association of Homes for the Aging, the Texas Health Care Association, and the Texas Independent Nursing Home Association inform their members of this right. If needed, the associations should offer training on what constitutes a "reasonable search."

The task force also recommends that the associations encourage the use of the nurse aide registry. If thefts are properly reported, the registry can serve as a screening device in the hiring process.

OMBUDSMAN PROGRAMS, ADVOCACY, VOLUNTEERISM, AND LEGAL SERVICES FOR NURSING HOME RESIDENTS

BACKGROUND INFORMATION

The ombudsman program operated by the Texas Department on Aging (TDoA), is mandated by the Older Americans Act of 1965. Ombudsmen act as a "go-between" between nursing home residents and staff to resolve conflicts and open the lines of communication. The program is organized around the agency's twenty-eight Area Agencies on Aging. These agencies carry out the mandate of TDoA and are located throughout the state. A full or part-time Area Agency on Aging staff person coordinates the efforts of the volunteer ombudsmen in their region. About forty percent of Texas nursing homes are served by an ombudsman. Ombudsman volunteers are assigned to predominantly Medicaid facilities and focus on residents who do not have family, friends, or others to advocate for them.

One of TDoA's primary concerns is inadequate funding of the ombudsman program. Few Area Agencies on Aging can afford a full-time staff position to adequately develop and supervise the program. Also, funding for volunteer expenses such as

mileage and meals, especially in rural areas, is frequently not available. TDoA is requesting $290,000 for the 1990-1991 biennium to address these problems.

Another way to insure the needs of nursing home residents are met is through an active volunteer program. In testimony before the task force, TDoA staff stated that nursing homes have consistently used community volunteers to improve the quality of life and care of residents, and an active volunteer program is one indication of a well-run facility. However, legal services have typically not been accessible to the average nursing home resident who is on Medicaid.

Currently Area Agencies on Aging contract with regional Legal Services Centers to provide legal services to elderly people in the community. Legal Services Centers receive federal funding to provide legal assistance to low income people, but do not have sufficient funds to serve nursing home residents. Due to a lack of funds, Area Agencies on Aging also have been unable to contract for legal services for these residents.

In addition, the availability of benefits counseling, assistance in appealing denials of level of care determinations, and advocacy for quality services are inconsistent across the state. The Department on Aging is requesting $202,580 in fiscal year 1990 and $405,080 in fiscal year 1991 for benefits counseling, advocacy, and legal assistance.

RECOMMENDATIONS

15. The legislature should grant TDoA's request for $290,000 per year for the 1990-1991 biennium to expand the ombudsman program.

16. The legislature should grant TDoA's request for $202,580 in fiscal year 1990 and $405,080 in fiscal year 1991 for benefits counseling, advocacy services, and legal assistance. The Area Agencies on Aging, should contract with the eleven legal services programs in Texas to develop outreach programs for nursing home residents.

ADVERSE DRUG REACTIONS IN NURSING HOMES

BACKGROUND INFORMATION

To qualify for nursing home care in Texas, potential patients must meet rather high level of care criteria set by the Health Department. This means they require a substantial amount of daily nursing care. It is common for elderly patients who are ill enough to meet this criteria to be taking multiple prescription drugs to treat multiple medical conditions. Obviously, taking several medications at one time greatly increases the occurrence of adverse drug reactions. Concern was expressed that patients in nursing homes sometimes suffer adverse drug reactions due to inadequate monitoring of multiple prescriptions. This is supported by the following statement from a report by the National Council on Patient Information and Education.

> Multiple, chronic illnesses are common among older people, and like any other population the elderly will have occasional acute problems as well. In many cases, it is necessary to see a variety of specialists to obtain needed treatment. Thus, individual physicians unknowingly may prescribe a drug that counteracts the benefits of a medication ordered by another doctor or that interacts adversely with a third prescription medicine.
>
> Older people are more prone [than the general population] to drug interactions and adverse drug effect. The U.S. General Accounting Office reports that 40 percent of those suffering adverse drug reactions are over 60 years old. One-sixth of all U.S. hospital admissions of patients over age 70 have been attributed to adverse drug reaction. By comparison, adverse drug reactions account for only one in 35 admissions in the rest of the population. Health care costs for such admissions among elder people are estimated at $21 billion annually.

It is difficult for nursing home staff to monitor the drugs that patients are taking because the Minimum Licensing Standards for Nursing Homes give each resident the right to choose and change their pharmacy at any time. A nursing home is prohibited from interfering in this choice as long as the pharmacy meets a few basic requirements. This approach is based on the "freedom of choice" requirements in the Medicaid portion of the Social Security Act. To assist nursing home staff in dealing with this situation,it was suggested that a software package be developed to help detect adverse drug reactions. This would enable nursing home staff to detect drug reactions themselves and remedy the situation in a timely manner. Similar software has been developed and is frequently used in many hospitals.

RECOMMENDATION

17. The Texas Department of Health should be appropriated $50,000 for the development and testing of a software package for detecting and recording adverse drug reactions in nursing homes and for a pilot project to test the patient care benefits and cost effectiveness of using this software in nursing homes. TDH should solicit requests for proposals from the pharmacy colleges at the University of Texas Health Science Center at San Antonio/the University of Texas at Austin, the University of Houston, and Texas Southern University for this project by September 1, 1989. A contract should be awarded to a pharmacy school by November 1, 1989. By March 1, 1989, the software package should be developed. At this time, TDH should identify five nursing homes which will be used to test the benefits of the software package. The college of pharmacy should train the nursing home staff in these five homes in the use of the software and should monitor the pilot project for an eight month period. By January 15, 1990, a report should be submitted to the 72nd Legislature which includes findings from the pilot project, estimated cost of statewide use of the software package, and recommendations.

THE ROLE OF CONSULTING PHARMACISTS IN NURSING HOMES

BACKGROUND INFORMATION

Drug monitoring in nursing facilities is addressed in the State Standards of Participation for the Medicaid program.

Section 16.3204 outlines the requirements for consulting pharmacists in nursing facilities. A consulting pharmacist must be licensed by the State of Texas. His or her responsibilities are to review the drug regimen of each patient in a nursing home at least monthly, and report any irregularities to the director of nursing. The director of nursing then reports these findings to the administrator andthe attending physician. State standards also require a consulting pharmacist to spend a minimum number of hours per month at each nursing facility according to the number of patients in the facility. These requirements follow.

HOURS	FACILITY POPULATION
4	60 patients or less
5	61-150 patients
6	over 150 patients

Many nursing homes use these minimum requirements as the maximum amount of time they will pay their consulting pharmacist. Therefore, these consultants are often unable to adequately carry out their responsibilities because they cannot spend enough time on each patient's case. Because a consultant is only required to examine a facility one time per month, he or she may not detect an adverse drug reaction until several weeks after its onset.

To better utilize consulting pharmacists, it was suggested that requirements for consultant pharmacy hours be geared

toward number of minutes per patient rather than the current breakdown. Also, requiring a pharmaceutical assessment when patients are admitted to a nursing facility would provide the pharmacist an opportunity to review a patient's current drug regimen and allow detection of potential problems before they occur. Using the consulting pharmacist for prevention rather than detection after an adverse drug reaction has occurred would result in better patient care. Another way to encourage this, in skilled nursing facilities, would be requiring the consulting pharmacist to be a member of a Utilization Review Committee. In intermediate care facilities, a consulting pharmacist could be involved in the development of a patient's care plan. This should enable him or her to detect problems before they occur.

The potential benefits of these changes appear to be significant; however, information was not available to the task force that indicated that these changes would reduce drug interactions and/or adverse drug effects. Also, the costs of implementing these changes need to be investigated. The task force did not want to add requirements for nursing homes that would increase costs without a corresponding improvement in the quality of life for these patients.

RECOMMENDATION

18. The Texas Department of Health, the Texas Department of Human Services, the State Board of Pharmacy, and the three

pharmacy schools in Texas should conduct a study on ways to better utilize consulting pharmacists. The study should include, but not be limited to, the need for modifying the minimum time requirements for consulting pharmacists in nursing homes, the costs and benefits of including consulting pharmacists on Utilization Review Committees and in the development of patient care plans, and the effectiveness of assessing patient drug regimens upon admittance. The study should be completed by August 31, 1990, and findings and recommendations should be submitted to the 72nd Legislature.

Staff support for the study should be provided by TDH. Also, the Board of Health should consider the findings and recommendations of this study in the preparation of its appropriations request for the 1992-1993 biennium.

WASTED MEDICATIONS IN NURSING HOMES

BACKGROUND INFORMATION

Another concern identified by the task force is the waste of medications in long term care facilities. Currently, nursing facilities purchase drugs in bottle form, usually containing a 30-day supply of medication. If a patient needs to change medication during that period, or if a patient dies, the unused prescription must be disposed of according to federal and state laws. It was suggested that converting to a unit dose method of dispensing would prevent this type of waste from occurring.

Unit dose medications are dispensed for a short period of time, and each day's medications are pre-measured. Unit doses may be dispensed for a one-day, three-day, or seven-day period. This means that if a patient no longer needs a medication, only a few doses are wasted.

This method also helps reduce two forms of drug misuse. First, it cuts down on errors that occur when medications are dispensed. Every day's drug regimen is pre-measured by the pharmacist, which makes it easier for the nursing home staff to administer the correct amount at the correct time. According to the Department of Health, the current error rate for drug administration sometimes reaches fifty percent. Second, it helps eliminate drug abuse that is reportedly occurring in nursing homes through theft of unused prescriptions. Reducing the amount of unused medications reduces the opportunity for those who may be tempted to steal and sell a drug on the street.

RECOMMENDATION

19. The Board of Health should appoint a task force to compare the costs and benefits of the current method of dispensing medications in nursing facilities with a unit dose method. The study should examine, under each method, the estimated cost of the medication, the amount of nursing time needed to administer medication, the amount of pharmacy time needed to prepare medication, the level of drug wastage, the

medication error rates, and the level of drug abuse from thefts. The unit dose dispensing method should be examined at 1-day, 3-day, and 7-day intervals. The study should be completed by August 31, 1990, and findings and recommendations should be reported to the 72nd Legislature.

The task force should include a consulting pharmacist, a pharmacist who fills prescriptions for a nursing home or homes, a representative of the pharmaceutical manufacturing industry, a director of nursing for a licensed nursing home, and three representatives of consumer groups representing elderly and/or disabled persons. Staff support should be provided by the Texas Department of Health. The Texas Department of Human Services, the Texas State Board of Pharmacy, and the pharmacy colleges at the University of Texas Health Science Center at San Antonio/the University of Texas at Austin, the University of Houston, and Texas Southern University, should cooperate and assist the task force in the performance of its duties, as requested.

CHAPTER THREE: STAFF REQUIREMENTS

This chapter involves the need for increases in funding to adequately train and pay long term care staff as required by the federal Omnibus Budget Reconciliation act of 1987 (OBRA). This act requires substantial increases in training requirements for nurse aides, as well as staffing requirements for professional nurses in long term institutional settings.

NURSE AIDE TRAINING

BACKGROUND INFORMATION

The task force found that most of the patient care in institutional settings is provided by nurse aides. A great deal of public testimony was given involving serious concerns about the low quality of care, as well as possible patient abuse and neglect, that occurs in nursing homes due to the lack of training and supervision, low payment, and high turnover of nurse aides.

The Department of Health has rules governing the training of nurse aides as well as other nursing home staff. These rules require an orientation within ten working days of employment. The remainder of the required training must be completed within the following 120 days. In addition, nurse aides must have at least two hours per quarter of continuing education.

OBRA contains significant changes to the way nursing homes operate. Those related to the training of nurse aides are as follows:

1) the Secretary of Health and Human Services is required to establish by July 1, 1988, federal requirements for the approval of nurse aide training and competency evaluation programs;

2) the Texas Department of Health must specify by September 1, 1988, the training and competency evaluation programs the state approves;

3) TDH, by January 1, 1989, must establish and maintain a nurse aide registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program;

4) newly hired nurse aides must complete training and pass a competency evaluation as of October 1, 1989;

5) effective January 1, 1990, nurse aides employed by a facility before July 1, 1989, must also complete training and pass a competency evaluation; and

6) TDH must provide for review and approval of the training programs by September 1, 1990.

The act also requires states to amend their state plan to provide for an appropriate adjustment in payment rates for nursing homes to reflect the cost of complying with these requirements. OBRA provides a federal match of 61.25 percent

in fiscal year 1990 and 62.03 percent in fiscal year 1991 for the training of nurse aides. Administrative costs of implementing this requirement are matched at a 50/50 state/federal ratio. States must pay the entire cost of training nurse aides that do not care for Medicaid patients.

The following chart shows the fiscal impact of the training and competency evaluation, per preliminary estimates by the Department of Human Services and the Texas Department of Health. These figures are estimated to cover nursing homes' cost of hiring additional staff who will work during the aides' two week training period as well as the cost of the training itself. It does not cover any increases in salaries for properly trained aides.

	Fiscal Year 1990	Fiscal Year 1991
State	$41,431,802	$41,431,802
Federal	30,663,021	30,663,021
Total	$72,094,823	$72,094,823

The new federal requirements will address the primary concerns regarding the inadequate training of nurse aides. However, the key is adequate funding of nursing homes that employ properly trained and certified aides. Therefore, the task force will send letters to the Legislative Budget Board, the Senate Finance Committee, and the House Appropriations Committee supporting TDH's request for additional funds in this area. The letter will also request funds to cover salary increases for certified aides.

RECOMMENDATION

20. The legislature should appropriate to the Texas Department of Health adequate funds to increase nursing home reimbursement rates to cover all aspects of the training of nurse aides, including payment of additional staff during the training process, actual training costs, and salary increases for certified aides.

INCREASED REQUIREMENTS FOR RNs IN NURSING HOMES

BACKGROUND INFORMATION

The task force also found the shortage of professional nurses in nursing homes to be a critical issue. According to public testimony, fewer nurses are seeking employment in nursing homes at the same time the demand for long term care professionals is increasing. This problem is largely the result of low payment of nurses in nursing homes. Nurses in this setting are among the lowest paid in their profession, while long term care nursing is one of the hardest types of nursing care.

In Texas there is one registered nurse for every 413 people. The national average is one per every 199 persons. Enrollment in RN educational programs is declining while the competition for registered nurses is increasing. Hospitals are employing more registered nurses and fewer LVNs and nurse aides due to the increasingly complex care required in hospitals. To

meet their needs, hospitals have increased nurses' salaries which makes it more difficult for long term care providers to compete. Information from the Texas Hospital Association's 1988 Hospital Employees Salary Survey indicates an average starting salary for a staff RN between $9.38 and $10.32/hour, depending on the size of the hospital, its location and type of ownership. The average maximum salary falls between $12.55 and $16.03/hour. This increases to a range between $13.64 and $18.74/hour for a head nurse.

Less precise information is available on the salaries of registered nurses in nursing homes. However, according to the Texas Nurses Association, the range appears to fall between $7 and $15/hour with few people at either extreme. For a registered nurse to receive the higher range salary in a nursing home, he or she must be the training coordinator, assistant director of nursing, or the director of nursing.

OBRA includes requirements that, as of October 1, 1990, a nursing facility must provide 24-hour licensed practical nurse care seven days a week, with at least one registered nurse employed for eight consecutive hours a day, seven days a week. This will require some nursing homes to hire additional registered nurses or increase the hours of the RNs that are currently working in their nursing homes. To calculate the cost, TDHS used an average hourly wage of $9.60, a figure near the bottom of the range for average starting salaries in

hospitals. Even using this low figure, TDHS indicates a need to increase funding in this area by $9.5 million for fiscal year 1991. The state's share of this cost is approximately $3.6 million.

An increase in reimbursement rates will be needed for nursing homes to recruit and retain the professional nurses required by federal legislation. Therefore, the task force will write letters to the Legislative Budget Board, the Senate Finance Committee and the House Appropriations Committee identifying the range of salaries of registered nurses in hospitals and ask for adequate funding to allow nursing homes to compete with hospitals in the hiring process.

RECOMMENDATION

21. The legislature should appropriate adequate funds to TDHS to increase nursing home reimbursement rates to allow providers to comply with federal requirements for employment of one registered nurse, eight hours a day, seven days a week. The funds should be sufficient to allow nursing homes to effectively compete with hospitals in the hiring of nurses. To ensure the increase in funds is applied toward improved patient care, the legislature should prohibit nursing homes from spending these funds on anything other than patient care.

CHAPTER FOUR: ELIGIBILITY

Issues discussed in this chapter are the result of extensive public testimony, as well as phone calls and letters to the task force, by people who were at a loss as to how to care for their loved one. These individuals were frustrated because they could not afford to buy long term care, yet their family member did not qualify for state or federal assistance. Many of those people were elderly themselves and/or had exhausted their personal resources. This chapter addresses problems of accessibility to long term care services, as well as the lack of information available about the cost of long term care. A statutory amendment which requires the Department on Aging to develop programs to educate the public on the cost of long term care, financing options for long term care, and the Medicaid eligibility income cap for institutional and community based services are discussed.

WHAT DOES LONG TERM CARE COST? WHO PAYS?

BACKGROUND INFORMATION

There is currently little information available to the public about the cost of long term care and how it is financed. This causes many people to make the assumption that, although they are not familiar with the system, some mechanism must be in place to pay for care. According to the Texas

Association of Homes for the Aging, recent studies indicate that sixty to eighty percent of elderly people believe that Medicare and/or private insurance will cover all or most of an extended nursing home stay. Other studies show that most people do not want to consider the fact that they might one day need such care.

In truth, many elderly people will never need nursing home care. Only five percent of the population age 65 and over are in nursing homes. However, twenty-two percent of the population age 85 and over are. The significance of this fact is magnified when facts and projections of the Bureau of the Census are considered. For example, in 1980, there were 25.5 million people age 65 and over; 2.2 million of these were age 85 and over. By the year 2030, there will be 64.3 million people age 65 and over; approximately 8.8 million of these will be in the 85 and over age bracket.

How the care for these individuals is paid for is not understood by most people. About fifty percent of the money spent on long term care will come directly out of the pocket of the recipient. About forty-five percent will come from Medicaid, less than two percent from Medicare and the remaining three percent from the Veteran's Administration and other programs.

The Ad Hoc Committee on Medicaid Liens and Estate Recovery recommended that the legislature ask TDoA to develop and

implement educational programs to increase awareness of the growing need for long term care and the fact that it is not covered by Medicare nor by most private health insurance policies. According to TDoA staff, they are very concerned and interested in moving into the area of public education. They feel that they are in an excellent position to disseminate this type of information due to their network of twenty-eight Area Agencies on Aging and hundreds of senior centers throughout the state.

One way the Department on Aging has tried to educate the public on the cost of long term care is through a two year grant from the federal Administration on Aging. The grant requires TDoA to establish a business advisory group. It is to study ways to inform corporations of the long term care needs of their employees after retirement, as well as family members who may currently have such needs. The aim of the group is to discuss ways to have long term care insurance coverage available under employee group benefit programs. The Department on Aging staff and the advisory group plan to work closely with the State Board of Insurance on this issue.

RECOMMENDATION

22. TDoA's statute should be amended to require that agency to develop programs to educate the public on the cost of long term care, the limits on Medicaid eligibility, and the

inadequacy of other financing options. This statutory directive should not only require TDoA to encourage the development of group insurance policies, but to disseminate information on long term care financing to individuals as well.

MEDICAID ELIGIBILITY

BACKGROUND INFORMATION

Throughout the public hearing phase of the task force's work, testimony was frequently submitted which stressed the need for Texas to increase its Medicaid eligibility income cap to allow more people access to much needed long term care. Twenty-two states use the federal maximum income cap of $1,062/month. Nine states have an income level below the federal maximum. Nineteen states have a medically needy program. This program allows people to qualify for Medicaid if a large proportion of their income is used for medical expenses.

In Texas, the current Medicaid income cap for institutional care is $687.15/month. This means that for an individual to qualify for Medicaid to pay for long term care, he or she must have a monthly income of no more than this amount plus $20.00, or a total of $707.15 per month. (Medicaid disregards the first $20.00 of income when calculating nursing home eligibility.) The average cost of nursing home care is $1,800/month. Therefore, there is a significant gap between

those who qualify for Medicaid and those who can afford to payfor their care. During public testimony, many people urged the task force to recommend that the state adopt the federal maximum for the Medicaid income cap. The implications of this increase in terms of additional clients served and costs are as follows.

	FISCAL YEAR 1990	FISCAL YEAR 1991
Additional clients served	4,973	6,126
State Share	$ 15.3 million	$ 21.1 million
Federal Share	$ 23.9 million	$ 34.4 million
Total Cost	$ 39.2 million	$ 55.5 million

For Title XX Community Care for the Aged and Disabled (CCAD) programs administered by TDHS, the income cap is $707.15 per month. The CCAD programs were discussed in detail in Chapter One. They are designed to help people and their families delay institutionalization for as long as possible by allowing them to receive services in their homes and in the community. For people to qualify for these services, their income must not exceed $707.15.

The task force realized that if the income cap for institutional care was raised and the community care income cap was not, an incentive would be created for institutional care. Individuals whose income level exceeded the community care income cap might be able to get financial assistance for nursing home care. The task force felt very strongly that the

long term care system should encourage people to remain in the community if their needs could be met there. TDHS is requesting an increase in funding to allow the income cap for community based care to be raised to $1,062/month, which is the same as the federal maximum for nursing home care. These additional funds would come entirely from general revenue. Implications of this increase are as follows.

	FISCAL YEAR 1990	FISCAL YEAR 1991
Additional clients served	10,413	10,839
Cost to General Revenue Fund	$29.8 million	$32.2 million

RECOMMENDATIONS

23. The Medicaid eligibility income cap for institutional care should be raised to the federal maximum of $1,062/month.

24. The income eligibility cap for TDHS' Title XX funded CCAD programs should be raised to the same level as the nursing home cap.

CHAPTER FIVE: RATES

This chapter examines the current Medicaid rate-setting process at the Department of Human Services and offers recommendations to make this process more understandable to long term care providers, the legislature, and the general public. There was a great deal of public testimony concerning the lack of understanding of how TDHS sets rates. Providers were also concerned about the lack of opportunity to interact with TDHS' staff when there is confusion or a disagreement about a reimbursement rate. Providers find it very difficult to allocate scarce financial resources efficiently and provide quality care when they are not sure what expenses will be reimbursed.

This chapter involves the need to change TDHS' rules regarding the Medicaid ratemaking process for nursing facilities so the public has a clear understanding of the process. It also includes establishment of a process whereby interested persons have an opportunity, through a public hearing, to present comments concerning TDHS' proposed Medicaid rates.

BACKGROUND INFORMATION

According to testimony from the Texas Association of Homes for the Aging, Medicaid is second only to private pay as the

method of payment for nursing home care. It covers about forty-five percent of the cost. This year over $530 million in Medicaid funds will be spent on nursing home care for over 55,000 elderly and disabled Texans. Texas ranks close to the bottom of all states in terms of the reimbursement rate paid to nursing home providers. The low rate may have an adverse impact on the quality of care because fixed costs cannot be adjusted and a nursing facility may be forced to reduce variable costs, such as patient care. The need for adequate rates becomes more critical when one considers recent federal legislation. The Omnibus Budget Reconciliation Act of 1987 imposes higher standards on nursing homes and requires states to adequately reimburse providers who comply with those standards.

The Texas Department of Human Services establishes the Medicaid rate of reimbursement for physician services, primary home care, nursing homes and hospitals. This is done in the department's Economic Analysis Division with a staff of fifteen people. This staff is responsible for developing prospective rates, not only for Medicaid-funded services, but for a total of eighteen programs.

For nursing homes, rates are calculated on a flat rate basis, i.e., every nursing home providing the same level of care receives the same reimbursement per patient. Although many other states' reimbursement system is based on a facility

by facility cost, the flat rate approach was adopted in Texas for three primary reasons. These include simplifying the payment methodology, controlling the cost of the program, and encouraging economical and efficient operations. Although the flat rate system was intended to simplify the process, the reverse has been true. The current system is difficult to understand. The situation is complicated by TDHS' failure to fully describe, in their rules, the process used to establish rates. This has allowed TDHS to adjust rates without providers understanding the process by which they are adjusted, or having an opportunity for input on all aspects of the rate methodology.

The lack of a clearly defined ratemaking process in TDHS' rules has resulted in providers who do not know what cost of living indexes are used for inflation adjustments, the criteria used for desk audits, or other critical factors used in establishing rates. The failure to define these through the rulemaking process precludes any input from providers. Also, there is very limited opportunity for a provider to challenge the decisions of TDHS staff in the rate making process. The following rule, Section 16.9801(b)(12)(E), describes the limited "due process" provided.

> "Reviews of cost reports disallowances. A provider who disagrees with disallowances of the items in a cost report and wishes to appeal them is entitled to a review with TDHS staff according to the following procedure. Within 30 calendar days of notification of the disallowances by TDHS Audit Division, the provider

must contact the Economic Analysis Division and request a review. Reviews are intended to encourage open discussion between providers and TDHS staff to promote resolution of matters in dispute. At the earliest possible date which is convenient for all parties concerned, Economic Analysis Division staff arrange a review at which the provider may present all pertinent information supporting his disagreement with any disallowances in question. Three TDHS staff members designated by the executive responsible for the Economic Analysis Division consider the provider's case and give a written decision within 30 days of the review."

Generally, the state requires a ratemaking process to comply with the requirements of the Administrative Procedures and Texas Register Act (Article 6252-13a, V.T.C.S.). This provides a very structured system for appeals, but it does not apply to TDHS' rate setting process. The task force determined that an alternative was needed to allow more input into the ratemaking process.

RECOMMENDATIONS

25. The statute should require TDHS to expand its rules regarding the Medicaid ratemaking process, so the public has a clear understanding of the process. The expansion of rules should include, but not be limited to, a description of the cost of living index(es) to be used to calculate inflation rates and how the department decides what level of inflation to use in its calculations, the criteria for desk audits, the procedure for notifying providers, if requested, of exclusions of and adjustments to reported expenses, and a method for

adjusting rates if new legislation, regulations, or economic factors will impact costs.

26. TDHS rules should establish a process whereby interested persons have an opportunity, through a public hearing, to present comments concerning TDHS' proposed Medicaid rates. The public should be provided with clear notification of the subject matter, and the process for achieving these proposed rates should be disclosed to providers, consumers, the Legislative Budget Board, and the Governor's Office of Budget and Planning. The rules establishing this process must not conflict with any provisions of the Administrative Procedures Act.

CHAPTER SIX: REGULATORY PROGRAMS

One of the mandates of the task force was to study and find ways to improve the long term care regulatory system, which has been described as complex and inefficient. The 70th Legislature was concerned that previous attempts to improve the regulatory system had resulted in an inequitable and outdated nursing home program that was costly and burdensome to both government and providers. The task force studied the regulatory system for nursing homes as well as personal care homes and found that some regulations hindered rather than facilitated quality patient care. In other areas, the task force determined that statutory requirements needed to be clarified or expanded to encourage provision of quality care in a cost effective manner.

This chapter involves recommendations to improve the regulatory system by enabling long term care providers to provide quality care services in the least costly, most efficient manner. Regulatory issues involving nursing facilities, personal care homes, and TDHS' attendant care programs.

INCENTIVES FOR SUPERIOR CARE IN NURSING HOMES

BACKGROUND INFORMATION

During the public hearing phase of the task force's work, much testimony was presented involving the punitive nature of

the nursing home regulatory process and the lack of incentives to encourage provider performance above the minimum. There was concern that in Texas, the system is quick to punish those who fall below minimum standards for care, but does very little to reward those who exceed them.

Currently, only one incentive is offered for facilities to provide superior care. Under Section 7(a)(9), Article 4442c, V.T.C.S., the Department of Health may issue a superior grade to facilities that go beyond the minimum level of services and personnel. The superior grade must be prominently displayed for public view and facilities may advertise that they have received it. A facility cannot be awarded a superior grade if it has violated state or federal laws or regulations during the twelve months prior to the inspection. The task force decided that this incentive program was insufficient, and sought a way to develop another incentive that would encourage superior care without costing the state additional funds to implement.

The task force found that state law requires nursing facilities to undergo two unannounced licensing inspections per year, one certification survey per year (if the facility participates in the Medicaid program), one inspection of care per year involving ten percent of each facility's residents, one inspection of care per year involving 100 percent of the Medicaid recipients, and complaint investigations and follow-up visits when necessary. Each visit costs the state in terms of

staff time and travel expenses. However, there are also costs to the nursing home, especially in terms of staff time that would otherwise be focused on patient care.

The task force examined decreasing the number of inspections per year if certain criteria were met, thereby encouraging nursing facilities to meet those criteria. The result would be better care for the residents and reduced cost to the state and the nursing home provider. However, in consultations with the regulatory agencies, the task force learned that ownership changes or changes in personnel involved in administration or management often have a dramatic impact on patient care. The task force was also advised that the person serving as director of nursing has a significant impact on patient care, and any changes in that position also could affect the quality of care.

RECOMMENDATION

27. The statute should require the Department of Health to eliminate one licensure survey per year if:

- **a. there have been no punitive actions against the nursing facility in the past three years; and**
- **b. there has been no change in the ownership, administration, or management of the facility, or in the person serving as director of nursing in the last year.**

The exemption of one licensure survey each year should continue as long as the above conditions are met and no punitive actions occur. If the facility is subject to punitive action, it will again be required to undergo two licensing inspections per year until no punitive action is cited for three consecutive years.

This provision should expire on August 31, 1991, unless continued by the 72nd Legislature. Prior to the 72nd Session, the Department of Health should determine the effectiveness of the program and make appropriate recommendations to the 72nd Legislature.

THE NURSING HOME SURVEY PROCESS

BACKGROUND INFORMATION

During the 70th Legislative Session, the budget of TDH's Bureau of Long Term Care was cut, resulting in the loss of twenty-two positions and approximately $320,000 in state appropriations. However, the full impact of these cuts should be viewed in terms of the state/federal match. For every twenty-five percent of state funding, the federal government matches it with seventy-five percent of federal funds. In these terms, the $320,000 funding cut resulted in a loss of $1.25 million.

Subsequently, the bureau had to revise its priorities, and the following mandated responsibilities related to the regulation of nursing homes are no longer being performed:

1. annual open hearings,
2. grading evaluations which can result in the awarding of superior rating certificates,
3. the second of two annual licensure inspections, and
4. a full life safety code survey annually.

Of great concern to the Department of Health staff is the inability of the bureau to respond rapidly to complaints and serious incidents, to perform timely follow-up inspections, and to maintain flexibility in the scheduling of regulatory activities. To reverse this, TDH is requesting a total of $5.1 million in state and federal funds for the next fiscal year. This represents an increase from the current $4.3 million. If approved, it would result in a staffing level of 458 positions, up from the current level of 402. This would enable the bureau to perform surveys with full teams, to complete in-depth complaint investigations in a timely manner, and generally restore a level of regulatory activity appropriate to the department's legislative mandate.

In addition to state mandated responsibilities, TDH will also be required to incorporate new procedures into the survey process due to the Omnibus Budget Reconciliation Act of 1987. This act requires nursing facilities to meet a variety of new standards, including requirements for professional staffing and nurse aide training. Increased funding for TDH will be needed to enforce these new federal regulations.

RECOMMENDATION

28. The legislature should grant TDH's request for $5.1 million for the next fiscal year to enable it to comply with state mandates regarding the survey process. The task force also supports appropriate funding to allow TDH to comply with federal mandates for this process.

OPEN HEARINGS IN NURSING HOMES

BACKGROUND INFORMATION

At the request of the task force, TDH presented testimony about the effectiveness of its current mandate to conduct annual open hearings in all nursing home facilities. TDH testified that this may not be the most effective use of staff time and travel dollars. It is common for no one to attend an open hearing for well run facilities that are under no punitive action. Often when people do attend a hearing, they only have positive remarks to make about the facility. It appears that few people use the open hearings to express their concerns. This may be because there are other ways for this information to be shared. First, TDH has a toll free "800" number for people to call to report complaints. This is a quick, easy way for people to let TDH know that there is a problem in a nursing home. Second, when conducting a survey, TDH staff are required to post notices on the door of the facility and at the nurses' station. These notices state that anyone may have a private

conference with a member or members of the survey team. Some people may be more comfortable airing their concerns in a private conference rather than in a public hearing.

The task force considered several ways to make the open hearings process more efficient, including regional hearings, sub-office hearings, or hearings according to complaint level, special requests, or problems within facilities. TDH advised the task force that regional hearings would not be practical because some regions are very large and too many nursing facilities would be covered at one hearing. There might not be enough time to adequately address concerns for every nursing home, and people would often have to travel long distances to testify. TDH also said that holding open hearings outside the nursing home would make it difficult for residents to testify because many of them are too frail to leave the facility. The regional staff of TDH suggested that open hearings be conducted only in facilities where an advocate, ombudsman, relative or resident has requested a hearing during the past twelve months. This would be an effective way to alert TDH to unacceptable conditions and prevent them from conducting hearings where they are unnecessary.

RECOMMENDATION

29. The statute should be amended to delete the current requirement for an annual hearing. Instead it should require

TDH to conduct open hearings only in facilities where an advocate, ombudsman, relative, or resident has requested a hearing.

USING ADVOCATES FOR THE ELDERLY DURING LICENSURE SURVEYS

BACKGROUND INFORMATION

As stated in the previous recommendation, state statute requires nursing homes that participate in the Medicaid program to undergo two unannounced licensure surveys per year. However, due to budget cuts, TDH can only conduct one per year. To stretch limited state dollars further, TDH combines licensing inspections with other mandated functions, such as the examination of staff/patient ratios and inspections of patient care.

According to Article 4442c, V.T.C.S, the Health Department must invite at least one person as a citizen advocate to accompany the survey team on licensing inspections. The advocate may be a member of any statewide organization for the elderly, including the American Association of Retired Persons, the Texas Senior Citizen Association, the Texas Retired Federal Employees, or the Texas Department on Aging's Certified Long Term Care Ombudsman program. However, because TDH performs several mandated functions during one visit to a facility, citizen advocates have not been invited to attend in recent years. Reinstating the practice of including an advocate in

the survey would add credibility to the process and help to insure quality care in Texas nursing homes.

RECOMMENDATION

30. The task force urges Health Department staff to invite a senior citizen's advocate to accompany them on licensure surveys.

ESTABLISHING A SINGLE SET OF STANDARDS FOR NURSING HOMES

BACKGROUND INFORMATION

Nursing facilities currently must comply with the following sets of standards in order to be licensed and care for Medicaid patients:

1. Federal Standards of Participation for Medicaid Reimbursement, promulgated by the federal Department of Health and Human Services;
2. State Standards of Participation for Medicaid Reimbursement promulgated by the Texas Department of Human Services; and
3. Texas Minimum Licensing Standards, promulgated by the Texas Department of Health .

Many nursing home providers, as well as staff from the Department of Health, testified that effective administration of quality long term care is difficult under multiple sets of standards. Providers often cannot determine which standard to

follow when the language is vague or in direct conflict with another standard. It is also difficult for TDH surveyors to survey under both sets of standards.

State licensure and Medicaid standards were developed in Texas because the two regulatory agencies believed that the Federal Standards of Participation were not stringent enough to protect patients and ensure quality care. However, passage of the Omnibus Budget Reconciliation Act of 1987 will require the development of new, more stringent Federal Standards of Participation. Representatives of TDH and TDHS advised the task force that these new federal standards will be as stringent, if not more stringent, than the current state standards. They think that the Federal Standards of Participation will be sufficient for the regulation of nursing facilities and a separate set of state standards will no longer be necessary. The task force recognized the benefit of one set of standards, but would not endorse a set of federal standards, that have not been published yet.

RECOMMENDATION

31. The statute should require TDHS and TDH to jointly develop and adopt as rules a single set of standards to be used in place of the current State Standards of Participation and Minimum Licensing Standards. Requiring these standards to comply with new federal law and any federal guidelines that

are available would result in a single set of standards for nursing facilities in Texas. However, if the new federal standards are less stringent than any current state standard, TDHS and TDH must adopt the higher state standard.

In addition, if TDH or TDHS find in the future that a change is needed in the licensing standards or standards of participation, the statute should require the change(s) be adopted jointly by the board of each agency. This would insure that a single set of standards is maintained.

ALLOWING NEW NURSING HOME OWNERS TO BEGIN WITH A "CLEAN SLATE"

BACKGROUND INFORMATION

This issue involves the carry-over of punitive actions against a nursing facility when ownership changes. Federal rules require new owners to be re-certified as Medicaid providers upon change of ownership. Sanction provisions of the State Standards for Participation require that new owners assume the compliance history of the previous owner. Currently, if a provider is put on vendor hold three times in eighteen months, the Medicaid contract is automatically cancelled and the facility is decertified. This is true even if ownership of the facility has changed during the eighteen months.

During the task force's public hearings, it was recommended that when a new owner takes over a facility that has been on

vendor hold within the last 18 months, the new owner should not be "punished" for the previous owner's problems. Instead, it was suggested that the new owner should begin with a clean slate. However, the clean slate would in no way effect the federal rules requiring the facility to be re-certified by TDH upon change of ownership. In other words, a new owner would have to comply with all state and federal standards of participation in order to be certified. The new owner would not, however, be held responsible for prior vendor holds that occurred under the previous owner.

Testimony indicated that the current system discourages individuals from buying a "bad" facility, i.e. one that has had two vendor holds in less that eighteen months. These prospective owners recognize that if, after purchasing the facility and being certified, they were to receive one vendor hold within eighteen months of the previous owner's first vendor hold, they would lose their certification and Medicaid funding. The risk is often more than they are willing to assume.

Concern was expressed, however, that the potential for abuse existed if providers knew that a change in ownership meant a new owner was given a clean slate. It was feared that the owner of a facility with two vendor holds on his record might change ownership in name only, while maintaining the same stock holders, management, and staff. The task force agreed

that safeguards must be developed to prevent this type of paper shuffling facade.

Safeguards against this type of abuse are included in federal rules for participation in Medicare and Medicaid. Federal regulations carefully define related parties in terms of partnerships, corporations, proprietorships, trusts, estates, or any other form of business organization. Immediate family relationships also constitute relatedness. The following persons are considered immediate family for Medicare program purposes: husband and wife, natural parent, child and sibling, adoptive child and adoptive parent, step-parent, step-child, step-sister and step-brother, father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, and grandparent and grandchild. Prohibiting the granting of a clean slate to a new owner, if he or she is a related party or if a related party re-acquires the property, should provide an adequate safeguard against any potential abuse of the system.

RECOMMENDATION

32. The statute should require the Department of Human Services to allow a new owner to begin with a clean slate if he or she is not a related party as defined by Medicaid and/or Medicare rules. However, if within three years of the sale, the former owner or a related party re-acquires the property, the former sanctions would apply.

USING THE "TEXAS REGISTER" TO INCREASE AWARENESS OF PROGRAM AND POLICY CHANGES

BACKGROUND INFORMATION

The task force learned that most people, including members of the legislature and health care providers, are largely unaware of state agencies' efforts to amend the Medicaid state plan, pursue pilot projects, or pursue Medicaid waivers. The task force believes that public input in these situations is very important. People should be given ample opportunity to express their concerns about state level decisions that may have a profound impact on their lives, their family, or their business. In some cases, new waiver programs or pilot projects may mean the difference between receiving or not receiving services. In other situations, changes to the state plan may have a dramatic impact on how a provider offers services.

Currently, interested persons are only able to offer their input at TDHS board meetings. According to TDHS, the board must approve amendments to the state plan, as well as authorize the pursuit of pilot projects or waiver programs. Therefore, they are announced in the "Texas Register" as board agenda items, and the public has a chance to testify at these meetings. However, the TDHS board may have an extensive agenda to cover, and limited amounts of time may be devoted to these topics. In addition, TDHS board agenda items listed in the "Texas Register" are very brief, and interested persons may not

be aware of the type of change that is being proposed. Requiring a more detailed announcement would insure a greater awareness of proposed changes. With this awareness should come an increase in public input.

RECOMMENDATION

33. TDHS should be required to announce in the "Texas Register" its intentions to pursue Medicaid waivers, Title XIX funding for pilot projects, or an amendment of the Medicaid state plan. The announcement should include a name and phone number to call for specific information on these activities. The designated contact person should be able to describe the impact of the proposed change, including the cost, the possible cost savings, the criteria for receiving services, and the number of people served.

PERSONAL CARE HOME LICENSURE STANDARDS

BACKGROUND INFORMATION

Personal care homes provide a way for individuals who do not need nursing home care, yet need help with activities of daily living or help with medication regimens, to live in a residential setting. They often provide boarding home or apartment-like living arrangements with staff available at all times to provide personal care assistance to residents.

These homes developed in the late 1970's when Texas began to phase out its ICF II (or custodial) level of nursing home care. Because fewer people were being admitted to nursing homes, alternatives in less restrictive settings were needed. Personal care services became a viable option for community based care. The Department of Human Services asked TDH to develop personal care licensing standards to regulate this new industry. TDH asked its Nursing Home Advisory Committee to assist in the development of the standards. At that time, it appeared that nursing home regulations could be appropriately applied to personal care homes. Therefore, minimum licensing standards for personal care homes were developed which reflect an institutional, medical model, rather than a residential model. As the personal care industry has developed, these standards have not been revised.

Personal care providers testified that the current institutional standards are inappropriate because personal care homes provide services in a residential setting. Residents of personal care homes may need some assistance, but are able to remain somewhat independent. This is very unlike the situation in nursing facilities, where residents require a great deal of daily nursing care. Frequently, regulations that are intended to protect the health and safety of nursing home residents are unnecessary in personal care homes. For example, furniture in personal care apartments must conform to the same regulations

as furniture in institutions. This means that residents of personal care homes may not be able to pick out their own curtains, rugs, or wastebaskets because they are not made of fire-retardant materials. These regulations are applicable to institutions because residents may be unable to escape quickly if a fire breaks out in their room. However, residents of personal care homes must be ambulatory, so they would have little difficulty leaving their rooms in case of fire.

The providers stated that changes in the licensing standards for personal care homes are needed to improve this type of situation, and that the standards should provide an incentive to license rather than the current disincentive. There are numerous facilities that are choosing not to be licensed as personal care homes. They do not oppose the concept of regulation; rather, they oppose the current institutionally based standards. These standards, in addition to being costly, reduce the quality of life and limit the personal decisions a resident can make in a personal care home.

Personal care homes serve people who have a wide variety of financial resources. While some homes provide services to clients on SSI benefits alone (about $354 per month), other homes charge as much as $2,000 per month for services. It is extremely difficult for a provider who must rely solely on SSI checks to meet current licensure regulations. It is

particularly difficult for these providers to meet the strict standards of the 1985 Life Safety Code. As illustrated by the previous example, residents of personal care homes are able to protect themselves in case of fire, whereas a bedridden nursing home resident is not. Therefore, many facilities which view these standards as unnecessary or overly restrictive, remain unlicensed and unregulated. The development of more reasonable standards should result in more providers seeking licensure, which in turn should help insure the quality of care in personal care homes. Although this approach was recommended by a previous interim committee, no legislative action was taken. The task force determined that efforts to increase licensure should be undertaken again.

RECOMMENDATIONS

34. The statute should require the Board of Health to appoint a nine member advisory body by September 1, 1989, to revise the current licensing standards for personal care homes. The standards should clearly differentiate personal care settings from nursing home settings. They should require facilities to meet licensure requirements that insure quality care and protection of the health and safety of the residents without excessive costs.

The advisory body should review the findings and recommendations of the Task Force on Personal Care Homes,

established by the 69th Legislature. They should consider the feasibility of adopting less restrictive, less costly life safety code standards for personal care homes. Also, the advisory group should consider a multi-tiered system with different requirements for facilities that serve ambulatory and non-ambulatory clients.

The advisory body should be made up of a balanced representation of personal care providers and consumers, including a member with expertise in life safety code regulations. The Licensing Officer of the Bureau of Long Term Care at TDH should serve as a non-voting, advisory member. This advisory group should be authorized to elect its chairperson.

Recommendations of the advisory group should be submitted to the Board by May 1, 1990. The Board should adopt rules for the regulation of personal care homes by September 1, 1990. Consideration should be given to the recommendations of the advisory body.

35. Article 4442c, V.T.C.S., should be amended to delete all references to personal care homes. A separate section under Article 4442, V.T.C.S., should be developed specifically for the regulation of personal care homes to clearly differentiate them from institutional settings.

TDHS' ATTENDANT CARE PROGRAMS

BACKGROUND INFORMATION

The attendant care programs administered by the Department of Human Services are designed to allow disabled people to receive care in their homes to help them avoid or delay institutionalization. Attendants assist in routine activities of daily living, such as dressing, bathing, and assistance with meals. The programs are designed to provide basic services to the greatest number of clients at the lowest possible cost. Because of this, most attendants are part-time employees receiving minimum wage and few, if any, benefits. They may be family members or friends of the client who are trying to help in any way they can.

Usually, home services of this nature must be performed by a home health agency licensed by the Department of Health. However, because of the special nature of TDHS' attendant care programs, TDH and TDHS have entered into a written agreement stating that these providers of attendant care services do not have to be licensed home health agencies. TDHS reports that this agreement needs to be formalized in statute. This would prevent any confusion about the ability of these attendants to provide services without a license, and eliminate the possibility of a delay in services due to unclear licensing regulations.

RECOMMENDATION

36. The statute should be amended to clarify that persons providing attendant care services under TDHS' attendant care programs are exempted from the Health Department's home health agency licensure requirements.

CONCLUSION

As stated in the introduction of this report, the task force was unable to thoroughly cover the broad spectrum of long term care due to time, staff, and budgetary constraints. Therefore, the committee's efforts were focused on the most critical issues. This report is intended to serve as a starting point for improving the long term care system in Texas, with continued efforts in the future.

As the deliberations of the task force came to a close, it was recognized that several areas of concern had not received adequate study. Although most of these issues are not immediately critical to the long term care service delivery system at this time, the task force believed that they are nevertheless important topics that must be addressed in order to develop an optimal long term care service delivery system. In addition, if these issues are not addressed in the future, serious shortfalls in the long term care system will result due to the failure of the state and/or private sector to recognize their importance. These issues are as follows.

1. There is no clear definition of what a long term care system includes. Traditionally, long term care is viewed as institutional care for the elderly. However, the task force learned early in this study that long term care encompasses a wide variety of health care settings, services, and client populations. In addition, the population in need of these services continuously changes. As mentioned in the introduction, medical advances have enabled chronically ill and disabled individuals to live longer, thus creating an increase in the number of

individuals below the age of 65 who need long term care services. The task force believes that continued study of long term care and attempts to improve the system should examine the needs of this population, as well as those of elderly persons. That examination should include development of a common definition of the system as a whole.

2. The continuing disparity that exists between Medicaid reimbursement and the cost to private-pay patients in the long term care system must stop. Testimony indicated that nursing facilities currently must depend upon income from private pay patients to make ends meet due to the inadequacy of the Medicaid reimbursement rate. This situation is complicated by the growing number of facilities which only accept private pay patients. There is a great deal of concern that these facilities will attract private pay patients away from facilities that also serve Medicaid recipients, therefore causing a shortfall in revenue. It is feared that this lack of revenue will result in a lower quality of nursing home care for Medicaid recipients than for private pay patients.

3. The legislature must fully address all of the new requirements mandated by the Omnibus Budget Reconciliation Act of 1987. Although the requirements on staffing and training regulations are addressed in Chapter 3 of the report, there are a number of additional requirements in this Act which are not specifically discussed. According to preliminary estimates by an interagency work group comprised of TDHS, TDH, and TDMHMR, implementation of requirements mandated by this Act will cost the state approximately $71.9 million in fiscal year 1990 and $117.2 million in fiscal year 1991. The task force urges the 71st Legislature to provide sufficient funding to meet the new federal requirements.

4. There must be continuity between different long term care environments to provide a true continuum of care. Currently regulations, licensure requirements, and reimbursement systems inhibit the development of a true continuum of care because they do not allow continuity or coordination between long term care settings. There are various sets of licensure standards and regulations for nursing homes, home health agencies, personal care homes, and hospitals. The inability of patients to transition smoothly among these settings according to their needs creates a fragmented, uncoordinated long term care system. As discussed in Chapter 1, modifications to the system should continue to ensure that services are provided that meet an individual's needs, rather than the availability of services determining what needs are met.

5. Long term care providers who contract with the state to provide services are required to comply with state and federal laws on program accessibility. This means that these services must be accessible to individuals with physical and/or mental disabilities. The task force was concerned that those providing long term care in institutional settings, such as ICF-MR facilities and nursing homes, do not always comply with these laws. For example, some facilities do not have ramps, restrooms accessible to handicapped people, or special services for blind or deaf people. This lack of services prevents people with disabilities from participating in the activities around them. If long term care providers and contracting state agencies do not ensure that facilities are in compliance with all laws related to program accessibility, the legislature should address this issue.

6. There is a great need for alternative financing of long term care, such as long term care insurance. The task force received testimony from the Texas Association of Homes for the Aging (TAHA) stating that fifty percent of the cost of long term care services is paid by the recipient. About forty-five percent comes from Medicaid, less that two percent from Medicare, and the remaining three percent from the Veteran's Administration and other programs. TAHA also reported that recent studies indicate that sixty to eighty percent of the elderly population believe that Medicare and/or private insurance will cover all or most of an extended nursing home stay. These statistics clearly point to the need for alternative ways of financing long term care costs.

7. There is a lack of formal education in the fields of geriatrics and gerontology for nurses, nurse aides, and physicians. These individuals, particularly physicians, should receive training specific to the care and treatment of elderly people. Courses in this area should be blended into current curriculums in such a way that the physiology of aging, the pharmacokinetics and pharmacology of aging, and the psychological and social aspects of aging can be studied. In addition, physicians that are already caring for patients in long term care settings should be offered continuing medical education courses in this area.

8. There should be a career ladder for entry level workers in the long term care arena. Manpower shortages are critical and the turnover rate for nurse aides is so significant that various licensure and certification requirements seem futile and expensive. The state could encourage retention through such incentives as the

provision of scholarships, day care, or Medicaid coverage for entry level workers. This might motivate entry level workers to pursue a career where nurse aides could progress to LVNs and a few might progress to registered nurse status.

9. Although the issue of AIDS is being addressed by the Special Task Force on AIDS, this task force wants to add its voice in making the legislature aware of the need for long term care and dementia care for AIDS and AIDS Related Complex patients. One way to meet a portion of this need is through the use of Medicaid waivers for home and community based services. The Department of Human Services has applied for one such waiver. This and other efforts to establish a true continuum of long term care for AIDS patients should be addressed by the legislature.

The task force urges the legislature to enable groups involved in long term health care, particularly the Long Term Care Coordinating Council for the Elderly, to effectively address these issues by providing them with clear direction and the proper authority to impact the system. As the need for long term care services increases, it will be necessary to continually refine and improve the long term care system in Texas to create an effective, accessible, array of services both in the community and in institutional settings.

H.C.R. No. 213

HOUSE CONCURRENT RESOLUTION

WHEREAS, Long-term health care is an increasingly important need for our aging society; and

WHEREAS, The nursing home program in Texas has grown in size, complexity, and cost since its inception under the Title XIX Program in 1967; and

WHEREAS, Continually changing legislative and regulatory attempts to control cost and protect patients have resulted in the current nursing home program in Texas which is inequitable, outdated, costly, and burdensome to both the government and providers; and

WHEREAS, There is an ever-increasing need for an integrated system between the Texas Department of Health and the Texas Department of Human Services; and

WHEREAS, There is a need to enhance quality care through a system based on incentives; now, therefore, be it

RESOLVED, That the 70th Legislature of the State of Texas hereby create and establish a Special Task Force on the Future of Long-Term Health Care; and, be it further

RESOLVED, That it shall be the purpose of this special task force to study the current and future status of long-term health care in Texas and to analyze all current laws and regulations that affect long-term health care, with the goal of providing quality care for residents in the most efficient manner; and, be it further

RESOLVED, That the study include:

(1) a cost-efficient, simple, and completely integrated regulatory system between the Texas Department of Health and the Texas Department of Human Services;

(2) a regulatory system that focuses on enhancing quality care through an incentive program with sanctions and penalties carefully defined;

(3) a long-term care reimbursement process designed to foster cost containment, good patient access, and quality of care; and

(4) defining and streamlining the certification process, as well as Medicaid eligibility; and, be it further

RESOLVED, That the special task force shall consist of 12 members; three members shall be appointed from the house of representatives by the speaker of the house; three members shall be appointed from the senate by the lieutenant governor; and the remaining six members shall be appointed jointly by the speaker and lieutenant governor and shall represent the interests of the industry and the consumer, including advocacy groups and providers, the public, and physicians interested in long-term health care; the chair shall be appointed jointly by the speaker and the lieutenant governor; and, be it further

RESOLVED, That the Texas Department of Human Services, the Texas Department of Health, and the Texas Attorney General's Office shall assign advisory, nonvoting members to the special task force; and, be it further

RESOLVED, That the special task force shall hold such hearings to assist in identifying issues affecting long-term health care and shall make recommendations regarding the creation of an economically operated, quality health care system in the future; and, be it further

RESOLVED, That the Texas Department of Human Services, Texas Department of Health, and Texas Attorney General's Office, the Legislative Budget Board, Texas Legislative Council, Schools of Allied Health Sciences, Texas Health and Human Services Coordinating Council, Long-Term Care Coordinating Council for the Elderly, Texas Department on Aging, Texas Department of Mental Health/Mental Retardation, and the Texas Board of Licensure for Nursing Home Administrators shall assign such staff support to assist the special task force in its deliberations as may be required; and, be it further

RESOLVED, That all agencies of state and local governments shall cooperate with and assist the special task force in the performance of its duties; and, be it further

RESOLVED, That the special task force shall be funded as approved by the lieutenant governor and speaker of the house of representatives from the budget of the Texas Legislative Council; and, be it further

RESOLVED, That on or before November 1, 1988, the special task force make a complete written report, including findings and recommendations and drafts of any legislation considered necessary regarding the status and needs for the long-term health care system in Texas, to the 71st Legislature when it convenes in January 1989; five copies of the completed report shall be filed in the Legislative Reference Library; five copies shall be filed with the Texas Legislative Council; two copies shall be filed with the secretary of the senate; and two copies shall be filed with the speaker of the house; following official distribution of the committee report, all remaining copies shall be deposited with the legislative reference librarian.

Smith of Harris

Adopted by the House on May 27, 1987, by a non-record vote and that the House concurred in Senate amendments to H.C.R. No. 213 on June 1, 1987, by a non-record vote. Adopted by the Senate, as amended, on May 30, 1987.

Approved June 5, 1987.

Filed with the Secretary of State, June 5, 1987.

APPENDIX B

ISSUES REFERRED TO OTHER ENTITIES

Senate Subcommittee on Health Services

1. the need for a reimbursement system for ICF-MR facilities that more adequately reflects current, actual costs

2. the inequity between state school and community based client's services and reimbursement rates

3. the long term care needs of mentally retarded people

Tax Equity Committee

1. the need for a tax break for care givers in their home

Commission on Health Care Reimbursement Alternatives and Long Term Care Coordinating Council for the Elderly

1. the need for access to health insurance for disabled people and Alzheimer's victims

2. the need to encourage the private insurance industry to enter the long term care field

House Submcommittee on Direct Voucher Payments for In Home Care of Nursing Home Candidates

1. the need to support families who care for family members in their homes

Special Task Force on Rural Health Care Delivery

1. the lack of long term care services in rural areas

Texas Council on Alzheimer's Disease and Related Disorders

1. the need for access to health insurance for disabled people and Alzheimer's victims

Gray Panthers,
Silver Haired Legislature, and
American Association of Retired Persons

1. the lack of available, reliable persons to serve as guardians for persons who become incompetent and have few familial or financial resources

Long Term Care Coordinating Council for the Elderly and Health and Human Services Coordinating Council

1. transportation problems of mobility impaired individuals who must travel to receive care (a particular problem in rural areas)

Legislative Task Force on AIDS

1. long term care needs of AIDS victims

Coalition for Children with Unmet Health Needs

1. the lack of a nurturing environment in large pediatric nursing homes and the need for small facilities for children that are close to their homes

2. the lack of adequate space in pediatric nursing homes for school personnel to come into the facility and teach students who are too medically fragile to leave the facility

3. the lack of state standards governing the size of skilled nursing facilities with respect to the number of children housed in relationship to the number of community resources

Committee on Post-Secondary Medical, Dental, and Allied Health Education

1. the lack of trained medical professionals in long term care, resulting in a heavy reliance on nurse aides

2. the need for a change in educational systems to train long term care professionals

3. the need for teaching nursing homes

4. the need for recruitment incentives for students who want to work in long term care (scholarships, fellowships)

5. the need to upgrade the public's perception of long term care careers

6. continuing education needs on all levels for long term care personnel

Senate Health and Human Services Committee

1. the lack of compliance with state and federal laws dealing with program accessibility

SPECIAL TASK FORCE ON THE FUTURE OF LONG-TERM HEALTH CARE
ESTIMATED COST OF RECOMMENDATIONS

RECOMMENDATION #	PROGRAM		PROPOSED INCREASE IN GENERAL REVENUE (Millions) FY '90	FY '91	PROPOSED INCREASE IN PEOPLE SERVED FY '90	FY '91
	Texas Department of Human Services					
23.	Increase the Medicaid income cap for nursing homes to the federal maximum (p. 54)	NH	$ 11.8	$ 16.5		
		Drugs	1.3	1.6		
		PHC	1.7	2.3		
		Adm	.5	.7		
		Total	$ 15.3	$ 21.1	4973/mo	6126/mo
24.	Increase the income cap for community care to the federal maximum (p. 54)	GIB	$ 25.4	$ 27.6		
		Adm	4.4	4.6		
		Total	$ 29.8	$ 32.2	10,314/mo	10,839/mo
5.	Provide state supplementation of SSI benefits to help people purchase higher quality care (p. 19) .		$ 4.2	$ 4.9	2859/mo	3132/mo
1.	Deplete the waiting list for Community Care for Aged and Disabled clients (p. 19)		$ 9.9	$ 13.5	4074/mo	5295/mo
2.	Expand the Client Managed Attendant Care program (p. 19)		$ 1.1	$ 1.2	215/mo	215/mo
3.	Expand the In-home and Family Support Project to help persons with disabilities purchase home-based services (p. 19)		$ .3	$ .3	133/yr	164/yr
7.	Place severely disabled adults who are aging out of TDHS' managing conservatorship program (p. 20)		$ .9	$ 1.0	100/mo	100/mo

6.	Fill the gap in home care between skilled home health care and primary home care (p. 20)	$ 7.1	$ 7.6	97,236/yr	99,795/yr
4.	Increase respite services (p. 19)	$ 1.4	$ 1.4	2750/yr	2750/yr
8.	Expand the 1915(c) waiver for medically dependent children to allow them to remain at home or to be served in home-like settings (p. 24)	$ .4	$ .4	70/yr	70/yr
21.	Increase reimbursement rates to help nursing homes compete with hospitals in the hiring of professional nurses and comply with federal staffing requirements (p. 48)	-0-	$ 12.7 to $ 19.2	_____	_____
13.	Implement case management project (p. 28)	$ **	$ **	_____	_____
	Texas Department of Mental Health & Mental Retardation				
9.	Expand the 1915(c) waiver for mentally retarded clients to allow them to remain at home or to be served in home-like settings (p. 24)	$ 1.4	$ 3.0	240/yr	480/yr
	Texas Department on Aging				
15.	Increase funding for the Ombudsman Program (p. 35)	$ .3	$ .3	_____	_____

16.	Increase funding for benefits counseling, advocacy, and legal services (p. 35)	$ .2	$ .4	_____	_____
	Texas Department of Health				
20.	Training and certification of nurse aides (p. 46)	$ 41.4*	$ 41.0*	_____	_____
28.	Increase funding to improve the survey process (p. 66)	$ .4	$ .5	_____	_____
34.	Development of an advisory body to update licensing standards for personal care homes (p. 78)	(in thousands) $ 14.4	-0-	_____	_____
17.	Require TDH to develop and test a software package to detect adverse drug reactions in nursing homes (p. 37)	(in thousands) $ 25.0	$ 25.0	_____	_____
18.	Require TDH, TDHS, the State Board of Pharmacy, and the three pharmacy schools in Texas to conduct a study on ways to better utilize consulting pharmacists (p. 39)	$ **	$ **	_____	_____
19.	Require the Board of Health to appoint a task force to compare the costs and benefits of the current method of dispensing medications in nursing facilities with a unit dose method (p. 41)	$ **	$ **	_____	_____
	TOTAL	$114.1	$141.5 to $148.0		