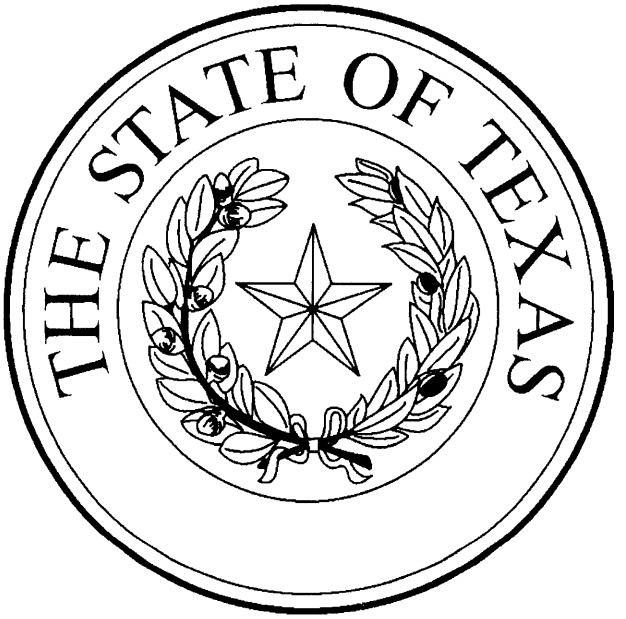
LONG-TERM CARE
LEGISLATIVE OVERSIGHT COMMITTEE

INTERIM REPORT 2004
79TH TEXAS LEGISLATURE



DEBBIE RIDDLE
CHAIR

GINA CHUNG
COMMITTEE CLERK

Joint Legislative Oversight Committee on Long-Term Care

Rep. Debbie Riddle
Chair

November 5, 2004

The Honorable Tom Craddick
Speaker, Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

The Honorable David Dewhurst
Lt. Governor of Texas
Texas State Capitol, Rm. 2E
Austin, Texas 78701

Dear Speaker Craddick and Governor Dewhurst:

The Long-Term Care Legislative Oversight Committee of the Seventy-Eighth Legislature hereby submits its interim report including recommendations for consideration by the Seventy-Ninth Legislature.

Respectfully submitted,

Representative Debbie Riddle
Chair

Senator Robert Duncan

Representative Dan Ellis

Senator Chris Harris

Mr. Jack Gay

Mr. Stan Studer

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INTRODUCTION

The Long-Term Care Legislative Oversight Committee was created by Senate Bill 190, 75th Legislative Session, to monitor the effectiveness and efficiency of the nursing facility regulatory system and to examine other long-term care issues. Under the Health and Safety Code, Section 242.654, the report must include identification of significant problems in the nursing facility regulatory system and an analysis of the continuum of care of long-term care services available in Texas.

As stipulated by the code, the committee is composed of two members of the Senate and two members of the House of Representatives; one public member appointed by the lieutenant governor and one public member appointed by the speaker of the House of Representatives. The lieutenant governor and the speaker are responsible for appointing the presiding officer of the committee on an alternating basis.

On September 11, 2003, Speaker Tom Craddick appointed Representative Debbie Riddle as the presiding officer. Senator Robert Duncan, Senator Chris Harris, and Representative Dan Ellis were appointed as the additional members of the legislature. Mr. Jack Gay and Mr. Stan Studer were appointed as the public members. Mr. Gay, appointed by the Speaker, is currently the President of Tanglewood HealthCare Corporation. Mr. Studer, appointed by the lieutenant governor, is the CEO of Care Inn Properties, Inc.

The committee was not assigned any formal interim charges, therefore, elected to focus on the most pressing issues surrounding long-term care. The committee examined the issues of quality of care, quality assurance, Medicaid reimbursement rates, liability insurance, the effects of tort reform, and possible funding methods such as a quality assurance fee and private long-term care insurance.

The committee held two hearings on September 22, 2004 and October 14, 2004 [See Committee Agendas] in Austin to hear invited and public testimony. At these hearings, it became evident that quality of care directly relates to funding level. Therefore, it was the committee's intent to examine the funding issues that surround long-term care. Furthermore, it was the committee's intent to recommend approaches to alleviate the problems associated with long-term care, so that it may not merely be a short-term fix, but a long-term solution.

BACKGROUND

Over 2.7 million Texans are age 60 and older.[1] By 2040, this number is projected to grow to 8.1 million, a 193 percent increase from 2000.[2] According to AARP, there has been a 38 percent increase within the population age 85 and older since 1993.[3] As the population trend indicates, it is necessary to determine the appropriate policy to address the current and possible future concerns of long-term care.

Long-term care is defined in the Texas Human Resources Code, Section 22.0011 as

> *"...the provision of personal care and assistance related to health and social services, given episodically over a sustained period, to assist individuals of all ages and their families, to achieve the highest level of functioning possible, and regardless of the setting in which the assistance is given..."*

As of July 2004, 3,874 long-term care facilities operated in Texas. Of the 3,874 facilities, 409 were adult-day care facilities[4], 1,391 were assisted living facilities[5], 904 were intermediate care facilities for mental retardation (ICF-MRs)[6], and 1,170 were nursing facilities[7].[8] Care is also available within an individual's home or in an institutional setting. The range of long-term care programs available to individuals addresses and meets most long-term care needs. According to an August 2003 report issued by the Texas Department of Aging and Disability Services, 366,598 individuals participated in over 26 funded programs in Texas.

[1] "Texas Demographics: Older Adults in Texas." Report by the Texas Department on Aging Office of Aging Policy and Information. April 2003, pg. ix.
[2] Ibid., pg. x.
[3] "State Profiles - Texas: Reforming the Health Care System." Report by AARP. April 2004, pg. 4.
[4] Adult day care provides respite to caregivers and may provide therapeutic care.
[5] Assisted living facilities provide assistance with activities of daily living for people who still live on their own in a residential facility.
[6] ICF-MRs include both residential and state facilities.
[7] Nursing facilities offer 24-hour care, with access to physicians, nursing staff, dietary regiments, pharmaceutical services, and daily activity schedules.
[8] Facts provided by Texas Association of Residential Care Communities.

Texas ranks among the top ten states in the country in total spending on nursing home care, with expenditures totaling $1.87 billion in FY2003 and estimated expenditures of $1.95 billion in FY2004.[9] However, in terms of per capita spending on nursing homes, Texas ranks among the bottom ten states. During the 78th Legislative Session, to address a $10 billion budget shortfall, the legislature cut spending across the board including nursing home funding. Nursing home funding was cut by $80 million for the biennium. As a direct result, Medicaid reimbursement rates have become the most pressing issue in the industry.

In its recommendations to the 78th Legislature, dated January 2003, the Long-Term Care Legislative Oversight Committee stated: "At the outset of the 77th Legislature, the nursing home industry was in crisis: liability insurance rates were skyrocketing, lawsuits were on the rise, funding was thought to be inadequate, and the regulatory process was often volatile."

The same description of conditions in the Texas nursing home industry could have been applied to the outset of the 78th Session. The financial conditions in the nursing home industry had continued to deteriorate, and there was no viable market for liability insurance.

By January 2003 it had become clear that there were two major problem areas that overwhelmed institutional long term care providers who contracted with the state to provide nursing home services for its Medicaid[10] program: (1) adequacy of Medicaid reimbursement rates; and (2) availability of affordable liability insurance. While actions by the 78th Session in the area of tort reform laid the groundwork to fix the problem of competitive liability insurance rates, the budgetary requirements that resulted in Medicaid rate reductions increased the already severe provider financial problems.

[9] Presentation by the Health and Human Services Commission on the Department of Aging and Disability Services: Long-Term Care Services, September 14, 2004.

[10] Medicaid is a state-federal entitlement program that pays for medical assistance for low-income individuals who meet certain eligibility requirements. This program became law in 1965 and is jointly funded by the federal and state governments to assist states in providing medical long-term care assistance. Medicaid is the largest source of funding for medical and health-related services for people with limited income.

As a consequence of the extensive testimony provided to the current committee, the committee concludes the following:

- Although there are signs that warrant optimism about the beginnings of a regeneration of the competitive market for liability insurance in Texas, it still has a long way to go.
- The disparity between nursing home providers' costs to provide quality care and the rate at which the state Medicaid program reimburses them has exceeded what could be described as a critical level.
- The funding requirements necessary to close the gap between provider costs and Medicaid reimbursement levels will require the implementation of innovative methods of financing that can substantially increase the state's capacity to draw down previously untapped federal matching funds.

This report discusses each of these conclusions in greater detail as follows.

SECTION 1:

FUNDING

BACKGROUND

Funding for long-term care may come from several different sources. Care funding may come from federal, state, or private sources, or perhaps a mixture of the three. Funding sources may be further divided into Waiver Community Services, Non-Waiver Community Services, Institutional Services, and Acute Care Services. Within Texas, Medicaid is the largest single monetary contributor to long-term care funding in the state. Entitlement programs, such as Medicaid, must serve all persons that meet Medicaid's eligibility requirements and Medicaid must pay for any service included in the state Medicaid program. Non-entitlement services are those that fall outside the Medicaid state plan and/or are funded with general revenue and other federal funds. Unlike entitlement programs, the states have the authority to limit the number of individuals served. Medicare is a non-entitlement program and a large contributor to long-term care funding. Medicare may pay up to one hundred days of care in a nursing facility or home health care after a period of hospital care and in addition to paying for Hospice care. Other sources of funds may be found in various federal and state programs, quality assurance fee, and/or within the pockets of many consumers, their families and friends, or in the form of special/private insurance.[11]

The Texas Department of Aging and Disabilities Services (DADS) FY2004 budget is $4.8 billion and its FY2005 budget is $4.75 billion. The nursing facilities and hospice payments encompass the highest percentage of the total budget at 40.5% in FY2004, $1.95 billion and 37.4% in FY2005, $1.78 billion. The waiver and entitlement programs are a close second with over $1.6 billion combined budgeted in FY2004.[12]

[11] Texas Health and Human Services Commission. A report on Department of Aging and Disability Services: Long-Term Care Services. September 14, 2004.
[12] Ibid.

MEDICAID REIMBURSEMENT

In its report to the 78th Legislature in January 2003, the Long-Term Care Legislative Oversight Committee included the following comment:

> *"Notably, DHS [the Texas Department of Human Services] has concerns that if provider rates are not adequately funded, the quality of service may be reduced because providers will be forced to trim funding in other areas to compensate for inflation."*

Because of budgetary considerations, the 78th Legislature reduced Medicaid reimbursement rates essentially across the board for all providers. In the case of nursing homes, the rate reduction was 1.75% below the level that had been set in September of 2001. That reduced rate level was continued for the state's FY2005 [See Appendix].

In October, the committee heard testimony from the Texas Health and Human Services Commission (HHSC), that a restoration of nursing home base reimbursement rates to a level that reflects the results of methodology calculations that are in its current rules would necessitate an increase of approximately 25% above the rates currently in place. Although this methodology is somewhat complex in its actual formulas, it essentially reflects an average actual spending level of providers as reported on their most recent cost reports, conservatively inflated forward to the current rate year.

This rate setting methodology is commonly referred to as "prospective flat rate". This means that the annual rate is set at the beginning of the fiscal year for payment prospectively, and that the base rate is the same for all providers with a similar mix of resident medical acuities. Higher acuity levels are reimbursed at higher direct care rates based upon eleven acuity levels, or TILEs (Texas Index for Level of Effort). Yet each TILE level is the same statewide.

In addition to the four base rate components, which include a direct care TILE level rate, a general and administrative rate component, a dietary rate component, and a facility use fee, the reimbursement rules also provide opportunities for providers to qualify for two other rate "add-ons": (1) the liability insurance rate add-on referred to above, and (2) an optional rate increment administered as the Nursing Facility Direct Care Staff Enhancement program.

The Nursing Facility Direct Care Staff Enhancement program, implemented in 2000, allows facilities the option to request, additional reimbursement for direct care staff (the RNs, LVNs and Nurse Aides who provide the daily care for residents) within an array of incremental levels in exchange for a contractual obligation to be accountable at the end of the year for having met specific direct care staffing and/or spending requirements for that additional reimbursement.

Failure to meet those obligations results in a "recoupment" of all or a portion of that additional reimbursement. The program is based upon the assumption that quality of care improves when there is an increase in direct care staff.

Funding for the staffing enhancement program was expanded significantly by the 2001 Texas Legislature, and facility participation in the program also expanded. However, there has been no additional funding for expansion of the program since that time. The current rules of the Health and Human Services Commission provide for an annual enrollment for new facilities to participate in the program, or for current participants to increase their levels of participation. But award levels are grandfathered to prior participants and participation levels. As a consequence, the past several years have resulted in a shortfall of funds relative to participation requests. The persistence of this shortfall over time results in inequities between reimbursement levels for contracting providers that has implications for, among others, market competition. The Health and Human Services Commission recently adopted rules that attempt to begin to equalize the annual award disparity, but the better solution for this important program is adequate funding.

METHOD OF FINANCING: QUALITY ASSURANCE FEE

In its legislative appropriations request for FY2006 and FY2007, the Health and Human Services Commission itemized exceptional items totaling approximately $500 million in general revenue, which would be matched with federal funds to restore nursing Medicaid reimbursement rates to a level supported by the state's own methodology calculations. That is a massive number. It is especially big when placed in the context of a legislature that will be faced with budgetary problems driven by the needs of school financing and property tax reform.

The committee received testimony concerning methods that are currently in use, or in the process of being implemented in many other states, to increase the draw down of federal dollars as matching funds for revenues generated from the same providers who will benefit from those matching funds. The implementation of such a funding mechanism in Texas has been previously proposed as a "Quality Assurance Fee (QAF)."

Federal law permits a QAF to be assessed on skilled nursing facility beds as long as the total tax does not exceed six percent of nursing home revenues. A state's imposition of a QAF on nursing facility beds will result in the state receiving additional Medicaid dollars and the cost of the tax going back to providers through an increase in the Medicaid reimbursement rates. With an increase in the Medicaid reimbursement rates, nursing homes can improve the quality of care.

On March 9, 2001, Senator Mike Moncrief introduced to the Texas Legislature Senate Bill 1592,[13] which related to the "imposition of a quality assurance fee on nursing institutions." It would have imposed a QAF on each institution for which a license fee must be paid under the Texas Convalescent and Nursing Home Licensure Act.

Under SB 1592, the fee would have been based on a fixed daily amount that would produce annual revenues equal to six percent of the total annual gross receipts for institutions in Texas multiplied by the number of "patient days." Each institution would determine its number of patient days by adding: 1) the number of patients occupying an institution bed immediately before midnight of that day; 2) the number of beds that are on hold on that day and that have been placed on hold for a period not to exceed five consecutive calendar days during which a patient is in the hospital; and 3) the number of beds that are on hold on that day and that have been placed on hold for a period not to exceed fourteen consecutive calendar days during which a patient is on therapeutic home leave. HHSC would collect the fees in a quality assurance fund and would use the money, together with matching federal money, to offset allowable expenses under the state Medicaid program and increase reimbursement rates paid under the Medicaid program to institutions. The 77th Legislature failed to pass SB 1592 because the broad-based requirement under CMS rules attracted many opponents.

The committee understands that there are certain types of waivers to federal rules that CMS has granted to certain states in the approval of these funding mechanisms that could further mitigate the adverse financial impact on the small number of providers who will not directly benefit. The committee also understands that the Health and Human Services Commission has made inquiries to CMS regarding how certain types of waivers may be applicable to Texas.

[13] SB 1592, 77th Texas Legislature, Reg. Session, available at http://www.capitol.state.tx.us/cgi-bin/tlo/textframe.cmd?LEG=77&SESS=R&CHAMBER=S&BILLTYPE=B&BILLSUFFIX=01592&VERSION=2&TYPE=B.

METHOD OF FINANCING: PRIVATE LONG-TERM CARE INSURANCE

In order to control Medicaid spending, it is necessary for the legislature to increase outside resources. An option in addition to the Quality Assurance Fee is encouraging and incentivizing the purchase of private long-term care insurance. In 2002, private insurance in the United States paid for 11 percent on long-term care and only seven percent on nursing home care.[14]

The Robert Wood Johnson Foundation initiated a public/private partnership between state governments and private insurance companies. This was known as the Program to Promote Long-Term Care Insurance for the Elderly, also known as the Partnership Program. California, Connecticut, Indiana, and New York received grants to implement this program. The Partnership Program allows for the combination of special Medicaid eligibility standards and asset protections with private long-term care insurance coverage. Consumers purchase private insurance policies for a fixed period and then when it expires, continued coverage by Medicaid begins, even though the consumer is ineligible under normal standards.[15]

However, in 1993, the United States Congress passed the Omnibus Budget Reconciliation Act (OBRA). OBRA removed the asset protection component of the program, thereby, preventing transfer of assets.

If long-term care insurance policy is bought at the age of 65, the policy can cost $2,186 per year.[16] This number increases with age. The Urban Institute[17] published a report on November 1, 1997 called "Long-Term Care for the Elderly and State Health Policy." In this report, they state that "only 10 to 20 percent of the elderly can afford private long-term care insurance. Thus, long-term care policies are affordable mostly by people who would not spend down to Medicaid without the insurance."

[14] Ellen O'Brien and Risa Elias, Kaiser Commission on Medicaid and the Uninsured, "Medicaid and Long-Term Care" (May 2004), 1.
[15] Texas Legislative Council. Memorandum to the Legislative Oversight Committee on Long-Term Care, November 5, 2004.
[16] Susan Coronel and Craig Caplan. Long-Term Care Insurance in 1994 (Washington, D.C.: Health Insurance Association of America, 1996).
[17] Urban Institute is a non-partisan economic and social policy research organization located in Washington, D.C.

RECOMMENDATIONS

It is important to note that long-term care is engulfing Medicaid. The committee recommends several methods to reduce this cost and add supplemental funding.

1. If the funds are available, then it is vital that Medicaid reimbursement rates be increased to better meet the needs of the patients so that the expected quality of care is met and exceeded.

2. If the Staff Enhancement Program is to be expanded, it is necessary to provide enough funds so that the discrepancy between funding and expansion coincides.

3. Since additional funding for long-term care is crucial, the state should consider several innovative methods, including Quality Assurance Fee, to draw down federal dollars to supplement Medicaid. The state should also look at ways to increase the awareness and purchasing of private long-term care insurance by incentivizing or communicating effectively to the citizens of Texas the need for less-reliance on state money.

4. The legislature should work with HHSC and provider groups to initiate the draw down of additional federal funds. Currently, a waiver request has been placed with Centers for Medicare and Medicaid Services (CMS) for approval from the broad based requirement as described in 42 CR §433.68(c). If CMS approves this waiver, it is necessary that the state study this issue further with the development of a workgroup. The committee supports compromised legislation that takes into account the burden of taxation of private-pay residents. Funding requirements for Medicaid should mitigate to the greatest extent possible any potential fiscal impact on private-pay residents of nursing homes.

   HHSC should work with CMS to structure an acceptable waiver to reflect this intent. If an acceptable waiver cannot be approved or agreed upon, then the committee does not recommend QAF to be placed on nursing facilities, but instead recommends that the legislature work on alternative methods to fund long-term care.

SECTION 2:

NURSING HOME LIABILITY INSURANCE

BACKGROUND

Nursing home liability insurance has been a perennial issue for the last several sessions of the Texas Legislature. The 77th Legislature recognized the need to address these problems with its passage of Senate Bill 1839, the "Long-Term Care Facility Improvement Act[18]". This legislation was enacted to address what were commonly viewed as some of the root causes of the skyrocketing liability insurance costs facing the nursing home industry. Its provisions attempted to address the question of cost and availability by authorizing the Joint Underwriting Association (JUA)[19], which is the state's insurer of last resort, to offer professional liability insurance for nursing homes - an insurance product not previously offered by the JUA. The legislation also had provisions that addressed certain other legal and regulatory issues thought to be in some way contributing to the litigious nature of institutional long-term care.

For the first time, a nursing home not otherwise eligible for coverage from the association would be eligible if it demonstrated that it had made a "verifiable attempt" to obtain coverage but could not obtain substantially equivalent coverage and rates elsewhere. The JUA alternative would now be available for both profit and non-profit facilities.

Unfortunately, liability insurance costs for physicians, hospitals, and nursing homes reached a crisis point by 2002. Physicians were leaving the state to practice medicine in less litigious states, and nursing homes were simply unable to obtain affordable coverage in any capacity.

By 2003, on average, covered nursing homes were faced with annual premium price increases in excess of 50% for increasingly inferior insurance products[20]. High rate increases were threatening access to care. Physicians in some areas of the state had limited their practices, retired early, or left Texas altogether. Access to OB/GYN Care was hindered, as were the increasing numbers of neurologists no longer performing surgery[21]. An increasing number of nursing homes were "going bare[22]"—making the decision to go without the security of liability insurance coverage because they could not afford it.

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[18] SB 1839 by Senator Robert Duncan and Senator Mike Moncrief was a comprehensive approach to address the quality of care, insurance rates, and damage awards.

[19] JUA is the Texas Medical Liability Insurance Underwriting Association. Coverage can be obtained through the JUA if two insurers in the admitted voluntary market reject application for coverage. The JUA requires evidence of the rejections. The JUA considers a rejection to have occurred if the applicant is accepted in the admitted voluntary market at a rate higher than the rates charged by the JUA. http://www.tdi.state.tx.us/company/jua_facts.html#q1

[20] A.M. Best Company Review, July 1, 2004.

[21] House Research Organization, HB 4.

[22] "Going bare" is a term used to indicate homes without any insurance coverage.

TORT REFORM

In 2003, the 78th Texas Legislature enacted comprehensive tort reform legislation with the passage of House Bill 4[23] and House Joint Resolution 3[24]. Their passage was largely in response to medical professionals' inabilities to continue to provide affordable health care while at the same time having to deal with issues such as protecting themselves from frivolous lawsuits. Also known as the "Medical Liability and Insurance Improvement Act of Texas," HB 4 sought to help ensure patient access to care by capping large jury awards, which had driven up the cost of medical malpractice insurance for years prior.

Texas recognized the need to address these tort issues just as other states had enacted similar reforms to address similar problems. California passed its Medical Injury Compensation Reform Act (MICRA) [25] in 1975. It was considered the nation's most comprehensive set of medical malpractice revision initiatives. A study conducted by the RAND Corporation's Institute of Civil Justice in Santa Monica, California found the MICRA had a significant effect on premium rates in California. In 1976, when California's MICRA law went into effect, the average medical malpractice premium was $24,000, in 2001 dollars. In 2001, the average premium was only $14,000. Premiums in California, adjusted for inflation, are lower than what they were before it was implemented.[26]

House Bill 4 and HJR 3 in November of 2003, became the law in Texas, seeking to limit the liability of insurers and therefore to let them pass on the savings to health care providers, including physicians, hospitals and nursing home facilities.

[23] HB 4 by Representative Joe Nixon, et al. was a comprehensive tort reform bill. HB 4 contains elements addressing medical malpractice, admissibility of evidence regarding nursing homes, and assignment of judges in health care liability claims. It became effective on September 1, 2003.

[24] HJR 3 by Representative Joe Nixon, et al. allowed the voters to approve a constitutional amendment to limit damages, except economic damages. This legislation was in response to the passage of HB 4 and to *Lucas v. U.S.*, 757 S.W.2d 687 (1988) where the high court found that limiting recovery for people injured by medical negligence for the purpose of reducing malpractice premium rates was unconstitutional as violating Texas Constitution, Art.1, sec. 13, the Open Courts Doctrine, which guarantees meaningful access to courts.

[25] The law, which was enacted when California was facing an insurance crisis, is being considered as a model for medical malpractice reform in other states.

[26] Daniel P. Kessler and Mark B. McClellan, "The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care," 60 Law and Contemporary Problems 1:81-106 (1997), pg. 105.

In the short time since the passage of tort reform in Texas, rates have slowed their exponential growth upwards. Moreover, we have seen the accessibility for medical malpractice rates for hospitals and physicians becoming more palatable. In addition, several new insurance companies have returned to the Texas marketplace to write professional liability insurance coverage for doctors and hospitals.[27]

The impact on nursing homes, so far, is different. Immediately prior to the passage of HB 4 and HJR 3, the competitive market for nursing liability insurance had effectively disappeared. Although carriers are at least beginning to test the market, the protections of tort reform legislation in Texas have not had the time to take their full effect.

For instance, in the month prior to the effective date of HB 4, a precipitous number of lawsuits were filed.[28] The adjudication of these suits could take years to reach a final resolution, and therefore, prolong the unwillingness of carriers to re-enter the Texas market. In addition, because the caps on economic damages were set higher than that of physicians, nursing homes continue to have the perception of "deeper pockets" to litigate.

EXAMPLES OF LIABILITY INSURANCE COSTS CONFRONTING NURSING HOMES

The following is a real life example of the premiums confronting a Texas nursing home service provider for liability insurance coverage. This is a relatively small home, and consequently reflects lower than average rates, as policy premiums correlate with the total number of nursing home beds in each facility:

Policy Year:	1994/1995	1995/1996	1996/1997	1997/1998	1998/1999	1999/2000	2000/2001
Premium:	$10,117	$10,050	$10,050	$10,050	$12,588	$33,769	$65,000

[27] Long-Term Care Legislative Oversight Committee, Texas Department of Insurance, October 14, 2004.
[28] The number of claims dramatically increased for the month of August 2003 due to the effective date of September 1, 2003. Long-Term Care Legislative Oversight Committee, Texas Association of Homes and Services for the Aging, October 14, 2004.

When the provider was confronted with the $65,000 quote, the decision was made to 'go bare.' Quotes on a current policy with similar coverage limits such as those in earlier years would be between $125,000 and $175,000.[29]

For this facility, had it chosen to purchase a policy at these premium rates, it would be eligible for additional liability insurance reimbursement of approximately $26,000 per year.

The nursing home industry has yet to feel any concrete financial relief. According to TDI, there are eight non-admitted or surplus-line carriers[30] that still offer coverage to nursing homes and assisted living facilities (on a limited basis) but the current premium per bed is well over $1,000. The markets that do offer the coverage are now more willing to entertain lower coverage options. It will take time for the tort limitations to have an effect on the market.

The companies that offered the coverage in the past are still dealing with claims made as late as 2003 for coverage that may have ceased in the year 2001. Prior policies had been
provided on an 'occurrence' basis that allows claims to be made even after the coverage expired or was canceled as long as the trigger to the claim occurred during the policy period.

The state's Medicaid reimbursement rules provide that as long as a facility can demonstrate that it carries liability insurance coverage, it is eligible for a Medicaid rate 'add-on.' Currently, for each Medicaid day of service provided, such a facility receives an additional $1.68 in reimbursement. The total revenue impact of this additional reimbursement is substantially less than it seems, as illustrated by the following example.

A typical Texas nursing home has about 100 licensed beds. Of those, approximately 85% are occupied. Of those 85 occupied beds, the Medicaid program possibly covers 70% of the residents. Consequently, a facility could expect approximately $36,000 in Medicaid reimbursement for carrying insurance, while the cost of minimal coverage for those beds could easily be double that amount.

[29] Colley & Associates, Houston, Texas.

[30] Non-admitted and surplus line carriers are not licensed to sell insurance in Texas. However, to be eligible, they must be licensed in their home state or home country. By law, an agent can place a risk with a surplus lines company only after making a "diligent effort" to find an admitted carrier to issue the policy. http://www.tdi.state.tx.us/consumer/cbo15.html.

Recent information received from Texas Health and Human Services have indicated that the number of nursing homes providing evidence of liability coverage for the purpose of the add-on reimbursement was 694 out of 1,136 Medicaid nursing homes in Texas. This is roughly 60% of the total. However, the overages that are being purchased, and the prices paid for them are a small fraction of the value prior to the Texas insurance crisis.

Additionally, a factor that has to be considered is that a great number of this 694 figure is attributable to large regional or national organizations (chains) that have secured coverage via 'captive' or other non-traditional insurance. Some of these, along with some smaller independent operations, have obtained what is referred to as 'finite' coverage. This is a method under which a nursing home provides evidence of coverage based on a limit for which they have provided collateral, either a line of credit or cash funds to the company. Fees apply in addition to the collateral.

RISK RETENTION GROUPS

There are a number of parties that are either formed, are forming, or are looking into forming 'Risk Retention Groups[31]' to offer general/professional liability coverage to Texas nursing home owners and operators.

For example, the 'Eldercare' RRG is already available and is offered across the United States. There is some participation in Texas. This plan offers a range of limits of liability up to $1,000,000/3,000,000. The deductible is $50,000 per claim. Defense is included within the limit. As the limits increase, so do the costs. Based on recent quotes/indications the premium or cost including the capital contribution is approximately 50% of what it would be on the traditional basis. Risk Management Fees and State taxes apply in addition to the premium charge. In addition to the first year's capital contribution, there will be a capital contribution each year at renewal. Prior acts coverage is available.

In order to legally offer and provide insurance in Texas, the RRG must be filed with the State of Texas and must have provided certain required data including the capitalization plan. Only those RRG's that meet the State's criteria will be approved for the 'reimbursement add-on' and both of these fit that category. (Note: State Guaranty Funds are not available for 'Risk Retention Groups.')

[31] A risk retention group is any corporation or other limited liability association, which is organized for the primary purpose of and whose primary activity consists of assuming and spreading all or any portion of commercial liability exposure of its members; which is chartered and licensed as a liability insurance company.

TEXAS MEDICAL LIABILITY INSURANCE UNDERWRITING ASSOCIATION

The Texas Medical Liability Insurance Underwriting Association, also called the JUA, makes insurance available to physicians, hospitals and nursing homes. There was no reduction in these rates for nursing homes since September 2003. The Texas Department of Insurance denied an increase request of 35% and 68% for doctors and hospitals, respectively. The JUA currently insures about 2,500 doctors, 29 hospitals and 50 nursing homes across the state.

At a recent committee hearing of the Long-Term Care Legislative Oversight Committee, the committee heard testimony on the rates for this insurer of last resort. The premiums are determined on a provider specific basis based upon their classification into one of five risk groups, or 'Tiers.'

The following illustrates the lowest available rate (Tier I Level) based on 1st year claims made and a deductible of $25,000 – professional liability only. Employees may be included as additional insured/scope of duties for the nursing home.

Limit:	$250,000/$750,000	$690*
Limit:	$500,000/$1,500,000	$770*
Limit:	$1,000,000/$3,000,000	$842.50*

*per average occupied bed past 12-months

The highest coverage limits are those that were typical of policies prior to the advent of the current insurance crisis. Few nursing homes in Texas would be eligible for classification in Tier 1. It is more typical that they would be placed in Tier 2 or 3 (higher risk).

Furthermore, for each successive year of coverage, and premium are increased in consideration of the increased exposure due to potential claims for events in a previous covered year. Full coverage is not reflected until the fourth consecutive year.

With this information from the JUA, a clear picture emerges of the market conditions that still confront Texas nursing home operators. The premium cost for a level of coverage typical of the period prior to the current insurance crisis (i.e., $1,000,000/$3,000,000) is at the time when full coverage occurs (i.e., the fourth year and every year thereafter).

In addition, the cost of separate general liability coverage ranges between $300 and $400 per licensed bed per year. This is in addition to any premium that applies with JUA. To qualify for this level of premium, the nursing home has to have point accumulation of less than '0'. Debits and credits are applied based on certain factors. The next level premium increases by 80% (points 0 – 25). After this, the cost is considerably greater.

As the provider of last resort, the JUA admitted to the committee that its rates are not designed with a competitive market in mind. They exist simply to ensure that coverage is available when the market becomes exceedingly dysfunctional as to preclude participation by any other suppliers. Furthermore, the criteria developed to determine how facilities would be classified into the five separate Tiers, or risk groups, should be re-evaluated to determine how well those criteria are meeting the needs of both the JUA and eligible nursing homes.

Availability of general liability is another problem faced by providers. During the October 14, 2004 Long-Term Care hearing, the JUA testified that they do in fact offer general liability. Nevertheless, providers have been unable to obtain general liability coverage through them. If a nursing home only purchases professional liability, it is exceedingly difficult for that facility to acquire general liability elsewhere. Many homes have faced various consequences due to a lack of general liability coverage.

For example, Barbara Duelm, LNFA, with the Sarah Roberts French Home, a not-for-profit Medicaid nursing home, testified that their home could not renew their Medicare Part B provider number[32] because they did not have any general liability coverage. They attempted to purchase general liability coverage from the JUA; however, they would not offer general liability to them. As a result, they lost $2,800 per year on TILE reimbursement[33].

[32] Medicare Part B helps cover your doctors' services and outpatient care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care. Part B also helps pay for these covered services and supplies when they are medically necessary.

[33] TILE reimbursement is the Texas Index for Level of Effort Case Mix Classification System, the reimbursement rates for the direct care staff and other residents. Eleven TILE classes are determined through a statistical analysis of resident resource utilization data.

SUMMARY

The medical malpractice insurance crisis in Texas is healing. Due to the reforms of the 78th Legislature, the expectation is that the climate – and costs to health care providers such as nursing homes and long-term care facilities will eventually result in cost savings. However, we are not there yet. A flood of lawsuits were filed shortly before these reforms took effect. Unfortunately, these will have to wind their way through the previous system of huge jury awards. Insurers will still have to factor the future cost of claims into their new rates.

State regulators are currently rejecting rate hikes in this area. In a presentation to the Long-Term Care Legislative Oversight Committee on October 14, 2004, Texas Department of Insurance Commissioner Jose Montemayor said that during a recent telephone survey of insurers and brokers, TDI staff identified 10 companies writing professional liability insurance for long-term care facilities (nursing home and assisted living), 8 surplus-lines companies, 1 admitted company, and 1 risk retention group. However, two companies reported that they only write renewals and do not accept new nursing home business. According to the testimony, those companies indicated that they are considering writing new business in light of HB 4 and HJR 3's Proposition 12[34] passage. In fact, the three new companies that recently began offering professional liability policies to long-term care facilities specifically cite HB 4 and Proposition 12 as their reason for entry into the Texas market. The state of Texas needs to continue to monitor this progress and work hard toward making liability insurance affordable for long-term care facilities in Texas.

[34] Prop. 12 added sec. 66 to Art. 3 of the Texas Constitution, authorizing the Legislature to set limits on damages, other than economic damages.

RECOMMENDATIONS

It is imperative that the legislature allow the market to continue to re-develop.

1. The Texas Department of Insurance should convene a workshop to investigate the concerns surrounding the parameters used for the five JUA risk tier classifications of facilities before September 1, 2005. The scope of the discussion should include but is not limited to tier escalation against smaller facilities and the need to consider the entire experience of the administrator and not just the amount of time spent at one facility for the purposes of the tenure score.[35]

2. Carriers need to be encouraged to recognize more rapidly in premium rates the precipitous decline in numbers of claims filed, and other manifested impacts of the implementation of HB 4. It is important that the legislature not impose mandatory liability insurance with the current market conditions. Instead, the committee recommends that the state continue to monitor the development of a viable competitive market for liability insurance.

3. The legislature should investigate the means of better informing nursing facilities of the availability of general liability at the JUA.

[35] This relates to Criteria 4 under the JUA's tier rating system.

SECTION 3:

REGULATION AND QUALITY OF CARE

BACKGROUND

The state of Texas is subject to the federal rules governing long-term care facilities. Each individual state, within the United States, is required to follow the federal rules as a minimum standard. The states may pass legislation by creating more stringent guidelines, but may never allow less regulation than the federal rules. The federal regulations can be found in the Code of Federal Regulations (CFR), Title 42, entitled Public Health[36]. Within the Texas statutes resides state specific long-term care legislation. These laws are found in the Texas Health and Safety Code, Title 4, entitled Health Facilities. Title 40, Part 1 of the Texas Administrative Code (TAC) governs state long-term care facilities. The applicable code is as follows:

- Nursing Facilities - Chapter 19, Subchapters A-R and T-AA
- Assisted Living Facilities - Chapter 92, Subchapters A-H
- ICF/MR-RC Facilities - Chapter 90, A-D, F-H, J, and L
- Adult day Care - Chapter 98, Subchapters A-H
- Home and Community Support Services - Chapter 97, A-G

Texas requires that all long-term care providers be licensed or certified and in compliance with all licensure rules to begin and remain in operation. Providers interested in participating in Medicare and/or Medicaid programs must be certified and in compliance with federal regulations under Titles XVIII and/or XIX of the Social Security Act. State owned ICF-MR/RC facilities and skilled hospital units are also required to be certified in order to participate in Medicare and/or Medicaid. The Long-Term Care Regulatory Credentialing Department of the Department of Aging and Disability Services (DADS) includes the Nursing Facility Administrator Licensing and Investigations (NFA), Nurse Aide Registry (NAR), Employee Misconduct Registry (EMR), Medication Aide (MA), and Nurse Aide Training and Competency Evaluation Programs (NATCEP) programs. The agency licenses, certifies, and permits the following people for employment: 2,200 licensed nursing facility administrators; 105,000 active, certified nurse aides; and 8,000 permitted medication aids[37]. DADS is responsible for licensing, surveying, certifying, and regulating the following long-term care providers: 1,170 Nursing Facilities (licensure and certification); 904 ICF-MR/RC Facilities (licensure and certification); 1,384 Assisted Living Facilities (licensure); 414 Adult Day Care Facilities which provide Day Activity and Health Services (DAHS) (licensure and certification); 2,916 Home and Community Support Service agencies, including home health, Hospice, and personal attendant services (licensure and certification); 326 Home and Community-based Service Providers; and 87 Texas Home Living Waiver Authorities.

[36] http://www.capitol.state.tx.us/statutes/hstoc.html
[37] http://www.dads.state.tx.us/business/ltcr/credentialing/index.html

The DADS survey process consists of the following:

- Long-term care facilities and agencies are surveyed on an annual basis via unannounced visits
- Annual surveys last from 2-5 working days, depending on the size of the facility/agency
- Surveys measure compliance with state licensure standards and/or federal regulations
- Facility surveys also measure compliance with Life Safety Code physical plant and fire safety code standards
- If deficiencies or problems are identified, corrective actions are evaluated in follow up visits until all are corrected
- Facility or agency investigations are conducted as needed for self-reported incidents and/or complaints registered with Regulatory Services by consumers, families, etc.
- Lastly, facility or agency visits are also conducted as needed for change of ownership and/or facility/agency relocation

The DADS enforcement process consists of the following measures:

- Appropriate enforcement actions are chosen based on the scope and severity of identified problem areas;
- Enforcement actions include: temporary holds placed on vendor payments pending completion of corrective action(s); administrative (monetary) penalties imposed by the Department of Aging and Disability Services (DADS); and/or civil (monetary) penalties imposed by the Attorney General in conjunction with DADS;
- Amelioration of violations;
- Appointment of a trustee;
- Emergency suspension and closing order;
- Suspension of admissions;
- Denial of a license;
- Revocation of a license;
- Civil monetary penalties;
- Termination of the provider agreement;
- Denial of payment for new admissions, all Medicare and/or Medicaid residents;
- Creation of a temporary management agreement

If a provider disagrees with the findings and/or recommendations made by a survey team, the provider may opt to appeal the findings of the team. The DADS appeals process may consist of any of the following:

- **Informal reconsideration** - This process is conducted by the Enforcement Section of DADS Regulatory Services based on a request from an ICF/MR provider. The review includes an analysis of the deficiencies cited by the survey team and the provider's rebuttal information/evidence. The decision reached from this process is limited to the enforcement action - specific deficiency citations are not changed.
- **Informal dispute resolution** - The IDR is conducted by staff from the Health and Human Services Commission based on a request from a nursing facility, assisted living facility, or ICF/MR provider. The review induces an analysis of the statement of deficiencies cited by the survey team and the provider's rebuttal information/evidence. The decision from this process may delete or change the content of the deficiency (or deficiencies) cited.
- **Informal review of violations** - This review is conducted by staff at the Health and Human Services Commission based on a request from a Home and Community Support Services Agency (HCSSA) to refute licensure.
- **Opportunity to show compliance** - This is a process in which a provider of any type is allowed an opportunity to show compliance with all licensing requirements prior to the institution of proceedings to revoke or suspend a licensure, or to deny an application for renewal of a license.

A Long-term Care Plan for People with Mental Retardation and Relation Conditions was prepared by the Texas Department of Mental Health and Mental Retardation (TDMHMR) pursuant to Section 533.062 of the Texas Health and Safety Code.[38] Dominant legislation relevant to the Long-term Care Plan is as follows:

- 77th Legislature: HB 966, SB 367, and SB 368
- 78th Legislature: HB 2292, HB 1 (MHMR Rider 70), HB 1 (MHMR Rider 12), HB 1 (MMHR Rider 44), and HB 1 (MHMR Rider 45)

[38] The Long-Term Care Plan for People with Mental Retardation and Related Conditions, Fiscal Years 2004-2005 (Adjusted November 2003), Texas Health and Human Services Commission.

Quality of care issues have been the topics of interest for some time. The 1956 Commission on Chronic Illness reported widespread problems in the United States over all quality of care.[39] More recently, HB 2644, passed in the 1995 legislative session, prohibited Texas from establishing nursing home standards different from those the federal government uses for Medicare and Medicaid certification. The nursing home industry, which proposed the bill, contended that the state rules did not add much to quality-of-care regulation, and that the state rules never figured into the federal certification decisions. In September 1996, a committee of the Texas Board of Nursing Facility Administrators developed new, much stronger draft regulations. These rules were proposed after it was reported that the board had failed to discipline any nursing home administrators since 1993, including twenty-three administrators working at homes where conditions were so bad the homes were put under state control. Reacting to the controversy over HB 2644 and the publicity concerning the Texas Board of Nursing Facility Administrators, the legislature passed several new laws in 1997 that strengthened nursing home regulation.[40] The prohibition against more stringent state standards than federal law was repealed, and many new standards were imposed, including a detailed listing of patients' rights.[41]

Texas has already begun instituting quality initiatives with regard to long-term care services. S.B. 1839, 77th Texas Legislature, 2001, established a technical assistance program for long-term care. The program consists of three components that provide a non-regulatory framework for quality improvements in services to long-term care recipients.

[39] U.S. Senate, "Recommendations of the Commission on Chronic Illness on the Care of the Long-Term Care Patient, "*Studies of the Aged and Aging, Vol 2.* Committee on Labor and Public Welfare (Washington DC: Government Printing Office, 1957).

[40] This reform was coupled with the 1987 Congressional Nursing Home Reform Law, which requires that every nursing home resident be given whatever services are necessary to function at their highest possible level. A listing of specific patient rights may be found at http://www.elderlawanswers.com/resoruces/s8/r33568.asp

[41] Joshua M. Weiner et al., *Health Policy for Low-Income People in Texas* (Washington , DC: The Urban Institute, 1997);
Richard C. Ladd et al., *State LTC Profiles Report* (Minneapolis, MN: National LTC Mentoring Program, University of Minnesota School of Public Health, 1995).

These components, and their respective functionalities, are as follows:

- **Quality monitoring** - QM provides problem-oriented, technical assistance (nursing, pharmacy, dietary) to long-term care staff members in all Texas nursing facilities. It focuses on specific clinical problems (such as the use of restraints) that represent statewide opportunities for quality care improvements. The Long-term Care Quality Reporting System (QRS) can help users make a quick comparison among Medicaid-certified nursing facilities of their compliance with the state and federal regulations and potential weaknesses and strengths.[42]
- **Joint training** - This provides an opportunity for providers and regulators to participate in an ongoing educational process that addresses both clinical and regulatory issues.
- **LTC facility liaison function** - The liaison function provides an on-site forum to address regulatory questions and improve performance in long-term care facilities, while furthering open communication between facility, staff and survey staff.

The efforts of these initiatives have been generally successful, although continued work is still needed to both ensure that performance and regulatory success is measured by outcomes, not mere compliance with prescribed procedures, and to ensure the QRS data is as current and accurate as possible.[43]

While state regulations are changing rapidly, most still require "sufficient" staffing to meet residents' needs, 24-hours a day. A study of nursing homes by the U.S. General Accounting Office found that half of the homes surveyed did not meet federal standards for nurse staffing.[44] According to the National Citizens Coalition for Nursing Home Reform (NCCNHR), staffing is the single most critical issues facing residents in long-term care facilities. Most facilities barely meet the minimum guidelines for staff to resident ratios and if one or more staff members are absent, residents simply become neglected.

[42] http://www.facilityquality.dhs.state.tx.us

[43] Long-Term Care Legislative Oversight Committee, Texas Health Care Association, September 22, 2004.

[44] U.S. General Accounting Office, *Problems in Providing Proper Care to Medicaid and Medicare Patients in Skilled Nursing Homes*. Report No. B-164031(3). (Washington, DC: Government Printing Office, 1971).

Long-term care Ombudsman in Texas have documented that requests for assistance go unanswered for long periods of time, extending from 30 minutes to the next shift change. Immediate and common consequences of staffing shortages are incorrect/missed medications, falls from residents trying care for themselves, infections and pressure sores. The majority of care ultimately resides on the shoulders of certified nursing assistants. Sadly, within this group of professionals, there is nearly a one hundred percent turnover rate. Studies confirm that 4.1 nursing hours per resident day is a threshold-staffing ratio below which quality care simply cannot be provided. In a recent staffing survey of facilities in Harris County, the staffing ratios for a given day ranged between 2.3 and 3.6 hours per resident. This data is typical of staffing across the state.

The Texas Legislature took a number of actions in 2001 that affected long-term care, particularly concerning the state's assisted living and nursing home industries. In regard to assisted living providers, the legislature: required state officials to give providers prior notice and an opportunity for a hearing before denying, suspending, or revoking a license for violations of licensing standards; prohibited the state from assessing administrative penalties that exceed $1,000 unless a facility fails to maintain a correction; permitted providers to retain residents whose health conditions have declined if the resident, the resident's physician and the provider agree that the resident can be cared for adequately; and, established an assisted living fund for facilities in emergency situations; prohibited providers from employing individuals with a criminal history indicated on a background check.

State lawmakers also enacted several major nursing home measures in 2001, which include: required nursing homes to carry liability coverage of at least $1 million per occurrence and $3 million aggregate on a claims-made basis, effective September 1, 2003, and provided that for-profit facilities might obtain coverage through the Texas Medical Liability Insurance Underwriting Association if no other coverage is available; approved legislation allowing nursing home residents to monitor their care with electronic monitoring devices, such as video cameras, with the consent of roommates and after alerting others to the monitoring by placing a sign on their door; and, created new training requirements for nursing home inspectors. The legislature also provided for the establishment of pilot centers at two universities for advancing the quality of long-term care. The pilot centers will identify, develop and evaluate consumer-centered clinical and quality-of-life assessment and care protocols. They also will evaluate 1) the role of reimbursement and financial incentives in improving care in long-term care facilities, and 2) the role of telecommunications technology for improving care in remote or undeserved areas.

In 1999, Governor George W. Bush directed HHSC to conduct a comprehensive review of all services and support systems available to people with disabilities with Executive Order GWB 99-2 [See Appendix]. In January 2001, HHSC issued a comprehensive long-term care reform plan entitled "Promoting Independence."

The lengthy plan includes an inventory of available services, state budget requests and proposed statute changes, and identification of agencies responsible for implementing recommendations, primarily the Department of Human Services and the Department of Mental Health and Mental Retardation. The plan includes recommendations to expand all waiver programs, increase outreach to people with disabilities about community care options, help nursing facility residents make the transition into the community, provide temporary rent subsidies for consumers who are awaiting federal housing assistance, train staff, and implement a data collection system.

Data from the Center for Medicare and Medicaid Services (CMS) reports that the average number of deficiencies in Texas nursing home facilities has dropped from 6.7 in 2000 to 5.1 in 2004. The number of complaints against those same homes has also dropped from 10,048 in 2001, to 7,858 in 2003.[45] Perhaps the decrease in deficiencies is due to recent state legislation tightening the reigns on long-term care facilities. The Department of Aging Disability Services (DADS) offers the information needed for consumers to evaluate the quality of long-term care services. The Quality Reporting System (QRS) can be used to obtain specific information about a particular long-term care provider or to compare providers in a particular area.[46] QRS provides information that can help consumers identify providers that may meet a family member's needs, but is not meant to serve as the only basis for choosing a particular provider.

Facility inspections are a point-in-time snapshot, and most facilities are inspected only once per year. Key to inspectors viewing a "typical" day in a facility is to ensure the element of surprise when conducting a visit. Although there is some variability in the inspection cycles, there also appears to be a measure of predictability. Under current federal law, surveys and inspections of nursing homes, for example, are set to occur approximately once per year. The time between inspections cannot be less than nine months or exceed 15 months. A facility is not notified of the date and time of a survey - surveyors attempt to arrive completely unannounced. States have begun to stagger surveys and conduct visits on weekends, as well as early mornings and evenings, when quality, safety, and staffing problems may be more likely to occur. However, to aid in alleviating this predictability by inspectors, DADS should track the date and location of each facility's federal survey and state licensure inspections to ensure more randomness in the number of days between cycles. Such would allow even greater unpredictability of the surveyor's inspection schedule and a more accurate look at the true day-to-day environment experienced by a nursing home resident.

[45] TDHS LTCR FY 2003 Annual Report

[46] http://facilityquality.dhs.state.tx.us/ltcqrs_public/nq1/jsp3/qrsHome1en.jsp?MODE=P&LANGCD=en

HOUSE BILL 2292

HB 2292, passed during the 78th Legislative Session by Representative Arlene Wohlgemuth, reorganizes the delivery of health and human services. Before HB 2292 was passed, HHSC's purview included the Department of Health (TDH), Department of Human Services (DHS), Department of Mental Health and Mental Retardation (MHMR), Department of Protective and Regulatory Services (DPRS), Rehabilitation Commission, Department on Aging, Commission on Alcohol and Drug Abuse, Commission for the Blind, Commission for the Deaf and Hard of Hearing, and Interagency Council on Early Childhood Intervention. The major programs under HHSC's direction included Medicaid, Children's Health Insurance Program (CHIP), Vendor Drug Program, institutional care and community service for people with mental illness or mental retardation, protective services, and services for the elderly, blind and deaf.

HB 2292 consolidated the health and human services (HHS) activities and established five newly created agencies: Health and Human Services Commission (HHSC), the Department of State Health Services, the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services, and the Department of Family and Protective Services. As a result, DADS now oversees all long-term care regulatory issues.

Provisions related to long-term care includes new language ensuring nursing homes' participation in the Staff Enhancement Program voluntary. It also allowed the state to recoup the costs accrued by Medicaid patients. Finally, it established a nursing home quality assurance team (NFQAT) to study and recommend to DADS on ways to promote high quality care for residents of nursing facilities. NFQAT consists of a nine-member team appointed by the Governor.[47]

[47] HB 2292, 78th Legislative Session, http://www.capitol.state.tx.us/cgi-bin/tlo/textframe.cmd?LEG=78&SESS=R&CHAMBER=H&BILLTYPE=B&BILLSUFFIX=02292&VERSION=5&TYPE=B

NURSING FACILITY QUALITY ASSURANCE TEAM (NFQAT)

The nursing facility quality assurance team (NFQAT) was statutorily required to report the following:

> *(1) Recommendations for improving the quality of information provided to consumers about the facilities;*
> *(2) the minimum standards and performance measures included in the department's contracts with those facilities;*
> *(3) the performance of the facilities with regard to the minimum standards;*
> *(4) the number of facilities with which the department has terminated a contract or to which the department will not award a contract because the facilities do not meet the minimum standards; and*
> *(5) the overall impact of the minimum standards on the quality of care provided by the facilities, consumers' access to facilities, and cost of care.*[48]

The NFQAT submitted to the 79th Legislature on October 1, 2004 its recommendations. [See Appendix]

[48] Ibid. HB 2292 §§ 2.92

RECOMMENDATIONS

Quality of care is the key to successful long-term care. The committee recommends the following:

1. Study alternative models and movements, such as the Eden Alternative®[49], by establishing a task force led by the Texas Long-Term Care Institute.[50] [See Appendix]

2. Attempts should be made to coordinate the efforts of the programs such as the State Quality Monitor Program and the NFQAT as to avoid duplication of time and effort. In areas of duplication, the state should reduce its efforts and allow federal programs to collect data. For Texas, this will provide a cost-savings measure.

3. The state should encourage long-term care facilities to move toward quality improvement over quality assurance. According to the Texas Medical Foundation, evidence suggests that quality of care has improved, but the state should not stop here. It is crucial that long-term care facilities go beyond just assuring quality, but constantly seek to improve quality.

4. It is necessary to achieve sufficient staffing. Staffing continues to be a fundamental issue. Therefore, the committee recommends for the continuation of the Staff Enhancement Program. However, many facilities are unable to provide the residents with supplemental staff due to funding shortages, as mentioned above.

[49] Eden Alternative® is a person-directed care model. This is part of the culture change promoted by CMS. Unlike the medical model which focuses on task-doing, the person-directed model focuses on the whole person. Caregivers are formed into household teams in order to develop a close relationship between caregiver and patient. "The top-down hierarchical model of management is replaced by self-directed teams of caregivers, empowered to meet the daily desires and pleasures of each Elder in their care. Caregivers rediscover the meaning in their work and choose to stay." Testimony of Texas Long-Term Care Institute, Sandy Ransom, RN, MSHP, September 22, 2004

[50] Texas Long-Term Care Institute is a legislative appropriated group charged with studying different methods for improvements in quality of care.

SECTION 4:

STAR+PLUS

BACKGROUND

In 1993, a new Texas Program called State of Texas Access Reform (STAR) began providing Medicaid services through a managed care delivery system. Between 1993 and 1998, only children and pregnant women were included in the implementation of STAR. However, Texas began a pilot project in 1998 called STAR+PLUS, the purpose of which was to integrate acute health services with long-term care services using a managed care delivery system. STAR+PLUS' congressional authority, legislative history, delivery system, clients, benefit package, quality assurance process, cost savings and customer satisfaction data, and proposed expansion to other service areas, as well as areas of dissatisfaction and debate.

In a 1995 report to the 74th (1995) Texas Legislature, the Senate Health and Human Services Committee concluded that cost containment, significant reform and improvement of the Medicaid program could be achieved if the State of Texas obtained waivers to conduct pilot studies of long-term care (as well as mental health and substance abuse and consumer-oriented support for persons with mental retardation). During the same legislative session, the senate issued Concurrent Resolution No. 55 (SCR 55), which stated that a waiver to allow an integrated managed care pilot study of long-term care for the elderly and individuals with disabilities would be advantageous because integration of such services into a statewide managed care program could reduce cost shifting and the need for institutional care, improve access and quality, and create greater accountability for outcomes.[51] However, a pilot study was necessary to accurately estimate potential savings. Accordingly, under SCR 55, the 74th Legislature directed the State Medicaid Office to apply for a federal waiver to allow an integrated managed care pilot program for long-term care for the elderly and for individuals with disabilities. Under SCR 55, the integrated managed care pilot program was to be developed with input from the public and implemented in both urban and rural areas, when possible. Further, SCR 55 required the Texas Health and Human Services Commission (HHSC) to submit a preliminary plan for expansion of sites to the Senate Health and Human Services Committee by November 1, 1996, and to submit a plan for statewide expansion by November 1, 1998.

[51] Senate Concurrent Resolution No. 55, 74th Texas Legislature (1995), available at http://www.capitol.state.tx.us/tlo/74R/billtext/SC00055F.HTM

HHSC submitted a proposal for the integrated managed care pilot program, named STAR+PLUS, on July 23, 1997. STAR+PLUS was approved on January 30, 1998, and implemented in Harris County by April 1, 1998.[52] STAR+PLUS's approval was recently renewed on September 1, 2004, and is scheduled to expire on August 31, 2006.[53] STAR+PLUS operates under all four of the 1915(b) waivers.

Before implementation of the STAR+PLUS program in Harris County, acute care and long-term care were separately provided, administered, and budgeted. There was little coordination of the provision of such services. The response to this lack of coordination was STAR+PLUS, which was designed to integrate delivery of acute and long-term care services through a managed care system for Supplemental Security Income (SSI) and SSI-related recipients.[54]

STAR+PLUS clients choose a health maintenance organization (HMO) or the primary care case management (PCCM) model, which is an option for certain SSI clients under the age of twenty-one. Currently, adult STAR+PLUS clients choose from two different HMOs, AmeriGroup STAR+PLUS[55] and EverCare STAR+PLUS[56].

The STAR+PLUS HMOs are paid based on a fixed per member per month (PMPM) capitation rate,[57] which is determined by averaging the medical and community support service expenses for the STAR+PLUS population in the previous year.[58] HHSC has issued the capitation rates for fiscal year 2005 and the projected capitation rates for the expanded STAR+PLUS service areas.[59]

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[52] Texas Health and Human Services Commission, Department of Aging and Disability Services: Long-Term Care Services, September 14, 2004.

[53] STAR+PLUS operates under waivers set forth at SSA §§ 1915(b)(1), 1915(b)(2), 1915(b)(3), and 1915(b)(4). A copy of the STAR+PLUS 1915(b) waiver is available at http://www.hhsc.state.tx.us/starplus/b_waiver/Renewal_STAR+PLUS_WAIVERB.pdf

[54] Texas Health and Human Services Commission, Testimony to the Long-Term Care Legislative Oversight Committee, September 22, 2004

[55] See AmeriGroup Texas Star, discussed at http://www.amerigroupcorp.com/members/mem_houston.asp.

[56] See EverCare STAR+PLUS, discussed at http://www.evercareonline.com/products/starplus.html. EverCare primary contractor during April 2003. For a PowerPoint presentation authored by EverCare regarding its STAR+PLUS managed care product, see Quality in the Managed Long-Term Care Environment: The Texas Experience (May 2, 2002), available at http://www.hcbs.org/files/4/190/C.Adams.pdf.

[57] The services that are included in the HMO capitation payment are listed at http://www.hhsc.state.tx.us/starplus/star_plus_101/appdxc.htm. The STAR+PLUS covered services are listed at http://www.hhsc.state.tx.us/starplus/star_plus_101/appdxpp.htm
The STAR+PLUS covered services for 1915(c) HBC waiver clients, when determined medically necessary, are listed at http://www.hhsc.state.tx.us/starplus/star_plus_101/appdxll.htm.

[58] The costs for 2003 are available at Appendix D-3 http://www.hhsc.state.tx.us/Medicaid/rfp/52904272/rfp_docs.html.

[59] During the 78th Legislative Session, HB 2292 was passed, which directed HHSC to provide Medicaid services through the most cost-effective managed care model or models and to conduct a study to identify the managed care models that were most cost effective for HHSC's Medicaid program. HHSC contracted with the Lewin Group who recommend for the expansion of STAR+PLUS.

However, the committee heard substantial opposition to the expansion of STAR+PLUS. Among many others, the committee heard the following oppositions: the HMOs are being paid for care coordination but care coordination visits are not made to the facility residents; payment authorization processes are unnecessarily complex with numerous tripwires that result in non-payment for services provided; compared to Medicaid fee-for-service, the HMO's ineffective and inefficient billing procedures have resulted in increased administrative costs that could be used for patient care and providers have had to add administrative staff and shift significant staff time to deal with problems.[60] Other dissatisfactions include the inability of the STAR+PLUS HMOs to understand the key differences in service delivery and administration between acute and long-term care services, which would be exacerbated by the expansion of STAR+PLUS and the concern felt by most committee members is the increase in administrative costs for providers that results from the fact that each STAR+PLUS HMO has its own methods of administration and billing.

In a letter to HHSC by Representative Arlene Wohlgemuth, the author of HB 2292, she explains the intent of Section 2.29(b), relating to Medicaid managed care.

> *(b) Except as otherwise provided by this section and notwithstanding any other law, the commission shall provide medical assistance for* ***acute*** *care through the most cost-effective model of Medicaid managed care as determined by the commission. If the commission determines that it is more cost-effective, the commission may provide medical assistance for acute care in a certain part of this state or to a certain population of recipients using:*
>
> *(1) a health maintenance organization model, including the acute care portion of Medicaid Star + Plus pilot programs;*
>
> *(2) a primary care case management model;*
>
> *(3) a prepaid health plan model;*
>
> *(4) an exclusive provider organization model; or*
>
> *(5) another Medicaid managed care model or arrangement.*

Representative Wohlgemuth explains that "acute care" was deliberately inserted to prevent the Commission from being required to expand managed care for long-term care patients."[61]

[60] Texas Health Care Association, Testimony to the Long-Term Care Legislative Oversight Committee, September 22, 2004.

[61] Representative Arlene Wohlgemuth, Letter to HHSC, April 15, 2004.

RECOMMENDATIONS

The committee recommends that:

1. It is essential that providers' administrative costs be reduced. Numerous reports reveal that providers' administrative costs during the first couple of years of implementation of STAR+PLUS were extremely high because payment authorization processes were unnecessarily complex and that providers have had to add administrative staff and shift significant staff time to deal with problems.

2. It is also necessary to conduct more frequent and timely audits of the HMOs to make certain that they are distributing and spending the money properly.

3. If STAR+PLUS is expanded, it is also the committee's recommendation that all STAR+PLUS clients have access to care coordination. The testimony heard at the September 22, 2004 Long-Term Care hearing indicated that patients have difficulty accessing care coordinators and that care coordinator do not provide services or visit clients. It is necessary to ensure that care coordination is provided to clients.

COMMITTEE AGENDAS

Joint Legislative Oversight Committee on Long-Term Care

Rep. Debbie Riddle
Chair

Texas State Capitol
Wednesday, September 22, 2004
E1.014

Agenda

I. Call to Order - Representative Riddle, Chair

II. Roll Call

III. Opening Remarks

IV. Invited Testimony

- HHSC
- DADS
- Texas Medical Association
- Texas Long-Term Care Institute
- Texas Health Care Association
- Texas Assisted Living Association
- Texas Association of Homes and Services for the Aging
- Texas Association of Residential Care Communities

V. Public Testimony

VI. Other Business

VII. Adjourn

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Joint Legislative Oversight Committee on Long-Term Care

Rep. Debbie Riddle
Chair

Texas State Capitol
Thursday, October 14, 2004
10 am - E1.014

Agenda

I. Call to Order - Representative Riddle, Chair

II. Roll Call

III. Opening Remarks

IV. Invited Testimony

- Texas Department of Insurance
- Joint Underwriting Association
- Marsh USA
- Sarah Roberts French Home
- Texas Association of Homes and Services for the Aging
- Texas Health Care Association
- Texas Assisted Living Association
- Texas Association of Residential Care Communities

V. Public Testimony

VI. Other Business

VII. Adjourn

Capitol Extension, Suite E1.422 • Austin, Texas 78711 • Office: (512) 463-0572 • FAX: (512) 463-1908

APPENDIX A: BACKGROUND

Key Trends*

		State	U.S.
Population age 50-64 (#)	2003	3,135,003	45,794,142
	1993	2,171,239	33,641,651
	% change	44.4	36.1
Population age 85+ (#)	2003	263,545	4,627,543
	1993	190,957	3,446,245
	% change	38.0	34.3
Minority/ethnic population (%)	2002	50.4	30.9
	1991-93	39.5	24.7
	% change	27.6	25.1
Persons under age 65 with family income at or below poverty (%)	2001	15.3	12.1
	1990-92	17.3	14.4
	% change	-11.6	-16.0
Diabetes prevalence among adults (%)	2002	7.0	6.7
	1997	5.9	4.8
	% change	18.6	39.6
Overweight adults (%)	2002	62.8	59.1
	1992	47.2	47.2
	% change	33.1	25.2
Low birth weight infants (%)	2001	7.6	7.7
	1991	7.1	7.1
	% change	7.0	8.5
Persons who didn't visit a doctor due to cost (%)	2000	15.1	9.9
	1995	13.7	11.1
	% change	10.2	-10.8
Population underserved by primary care physicians (%)	2003	15.7	11.8
	1993	8.0	8.8
	% change	96.6	33.3
Emergency unit visits (per 1,000 population)	2001	379	383
	1991	329	376
	% change	15.1	2.0
Total Medicaid enrollment (in 1,000s)	2000	2,701	44,279
	1990	1,759	28,850
	% change	53.6	53.5
Medicaid spending on prescription drugs (%)	2002	11.9	12.1
	1997	7.9	8.1
	% change	50.8	49.7
Nursing home residents age 65+ (% of age 65+)	2001	4.1	4.5
	1996	4.8	4.7
	% change	-15.0	-4.7
Medicare beneficiary enrollment in M+C plans (%)	2003	6.6	12.6
	1998	14.5	16.4
	% change	-54.5	-23.2

*Percent change figures are cumulative for entire time period.

LONG-TERM CARE POLICY CHANGES
78th Legislature, Regular Session, 2003

Nursing Home Provisions-Department of Human Services (DHS)

- Allows JCAHO accreditation and good standing to satisfy the requirements for nursing home license renewal, as a pilot program (Sections 2.57 and 2.146, HB2292)
- Requires development of minimum standards for nursing facilities and contract performance measures (Section 2.92, HB2292)
- Prohibits excluding nursing home residents from receiving medical transportation for renal dialysis treatment (Section 2.87, HB2292)
- Allows HHSC to operate a voluntary incentive program for increasing direct care wages and benefits in nursing facilities (Sections 2.102 and 2.148, HB2292)
- Establishes a gubernatorially-appointed nursing facility quality assurance team to make recommendations for promoting high-quality care for nursing home residents (Section 2.109, HB2292)
- Requires billing Medicare before billing Medicaid for dually-eligible (Medicare/Medicaid) clients, except for home health services provided to a person determined not to be homebound (Section 2.108, HB2292)
- Prohibits payment of Medicare deductible or coinsurance to long term care providers if Medicare reimbursement exceeds Medicaid rate (Section 2.108, HB2292)
- Requires recovery of Medicaid reimbursement from all Medicare fiscal intermediaries (Section 2.05, HB2292)
- Requires suit for temporary restraining order or injunctive relief to be brought in the county of the alleged nursing home violation (Section 2.58, HB2292)
- Deletes specific criteria from the judicial standards for determining the seriousness of a nursing home violation (Section 2.59, HB2292)
- Prohibits multiple monetary penalties for nursing home violations resulting from single action (Section 2.60, HB2292)
- Deletes specific requirements relating to medication administration and storage in nursing homes (Sections 2.61 and 2.62, HB2292)
- Sets the personal needs allowance for nursing home residents at $45 per month (Section 2.207, HB2292)
- Requires DHS to use an average amount in calculating consumer personal funds as a methodology for determining the personal surety bond requirements for nursing homes (Section 2.105 HB 2292)

Mental Health and Mental Retardation Provisions

- Allows private ICF-MR facilities and home and community-based support services flexibility to use Medicaid payments cost-effectively in the event of a rate reduction (Section 2.03, HB2292)
- Imposes a quality assurance fee on state-owned ICF-MR facilities and makes conforming changes for calculation and reporting of patient days (Sections 2.64, 2.65, and 2.66, HB2292)
- Expands uses of money in quality assurance fund to other HHS purposes (Sections 2.67 and 2.156-repeal of Health and Safety Code Sections 252.206(d) and 252.207(b), HB2292)
- Requires privatization of ICF-MRs, but not before August 31, 2006; allows local authorities to serve as a provider only as a last resort (Sections 2.74, 2.82, and 2.82A, HB2292)

- Modifies allocation of the duties of providers, local mental retardation authorities (LMRAs), and the Department of Mental Health and Mental Retardation (TDMHMR) under the LMRA waiver program (Section 2.76, HB2292):
    - Requires the provider of services to develop the plan of care and conduct case management
    - Requires the LMRA to manage waiting lists, perform functions related to consumer choice and enrollment and conduct case management with regard to funding disputes
    - Requires TDMHMR to perform surveying, certification and utilization review functions and manage the appeals process
    - Requires TDMHMR to review screening and assessment of level of care, case management fees paid to a community center and administrative fees paid to a service provider
    - Requires TDMHMR to allocate reimbursement funds related to case management between provider and local authority
- After 8/31/04 and before 9/1/05, allows state schools or state hospitals to be privatized if services can be provided at a 25% reduction in cost and quality levels can be maintained at least at the levels indicated in the most recent ICF-MR survey or JCAHO accreditation determination (Sections 2.77 and 2.78, HB2292)
- Allows telemedicine to be used for psychiatric examination for in-patient admissions (Section 2.83, HB2292)

Home Health and Community Support Services Provisions

- Requires DHS to contact an individual on an interest list and begin the program eligibility determination process at least 30 days before an opening is forecasted to become available within a community services program (SB285)
- Renames the "frail elderly program" the "community attendant services" program for home and community-based services provided to functionally disabled persons (Section 2.101, HB2292)
- Exempts from licensure as a home and community support services agency (HCSSA) persons who provide services under a home and community-based services (HCS) waiver that is funded by TDMHMR (Sections 2.55, 2.56, 2.68, 2.69, 2.73, 2.113, 2.198, and 2.156-repeal of Health and Safety Code Sections 142.009(i), 142.0176, and 142.006(d), (e), and (f), HB2292)
    - Exempt HCSSAs must still check employee misconduct registry and notify employees about registry
    - Employees exempt from licensure are not exempt from being listed on employee misconduct registry
    - DHS may establish initial and renewal compliance fees for providers exempt from licensure
- Exempts from licensure as an HCSSA persons providing home health as the employee of a consumer or entity or employee of an entity acting as a consumer's fiscal agent (Section 2.55, HB2292)
- Defines personal care services as personal assistance services and restricts the use of the term "personal assistance services" by a provider (Sections 2.193 and 2.194, HB2292)
- Allows HCSSA employees who are nurses to purchase, store, and transport flu vaccines (Section 2.195, HB2292)
- Allows investigation of alleged abuse or neglect by an HCSSA to be conducted without an on-site survey (Section 2.197, HB2292)
- Allows home health services in the Medicaid Comprehensive Care Program to be provided by non-Medicare certified providers (Section 2.204, HB2292)

- 15% reduction in hours for DHS attendant services (HB1)
  (note: this reduction has been restored for FY04)
- Limits annual individual cost of care for clients who have left institutions for DHS waiver programs (Formerly, the cost of care could not be limited, once the individual entered the waiver program) (Rider 7 DHS Appropriations)
- Requires that money, which "follows the consumer" from the nursing facility to the community, return to the nursing facility budget strategy upon termination of waiver services (Rider 28 DHS Appropriations)
- Allows the DHS to consider expansion of consumer directed services to other community care programs (Section 2.202, HB2292)

Miscellaneous Provisions

- Requires authorized respiratory therapy services for ventilator-dependent to be provided by a respiratory therapist if practicable and cost-neutral (SB245)
- If cost-effective, requires call centers to be used for determining, certifying or re-certifying eligibility for health and human services, including long-term care programs; allows HHSC to contract with one to four private entities for operation of call centers (Section 2.06, HB2292)
- Requires HHS agencies to contract with TxDOT for client transportation services; makes contracting with TxDOT optional for the Department of Protective and Regulatory Services (Sections 2.127-2.134, HB2292)

APPENDIX B:
FUNDING

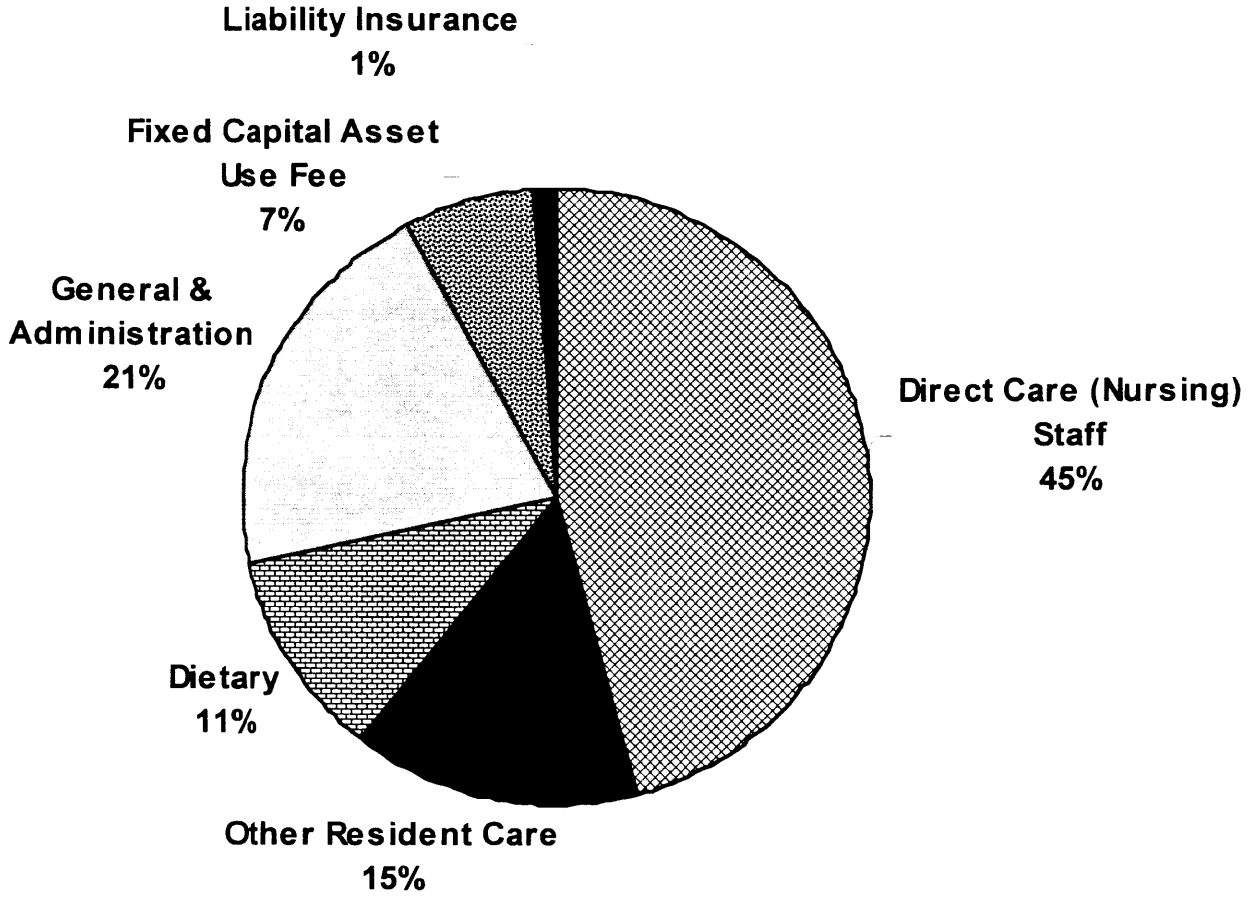
TEXAS
Health and Human
Services Commission

DADS FY 2004-05 Budget

Strategy (or Objective*)	% FY04	FY04	% FY05	FY05
Access & Intake	0.0	$ 36.3	1.0	$ 37.4
LTC Functional Eligibility	1.3	64.5	1.4	66.9
Entitlement Programs*	16.5	793.5	18.7	891.7
Waiver Programs*	17.3	831.7	18.0	855.9
Non-Medicaid Programs*	5.2	251.3	4.8	231.4
PACE	0.0	20.1	0.0	24.6
NF & Hospice	40.5	1,945.7	37.4	1,778.3
ICF-MR	7.8	374.6	7.7	368.3
State Schools	8.1	388.7	8.1	385.3
Capital Repairs	0.0	2.4	0.0	19.0
LTC- Regulatory	1.0	47.3	1.1	52.5
Credentialing	0.0	0.9	0.0	1.0
Quality Outreach	0.0	4.7	0.0	4.8
Indirect Admin*	1.0	40.7	1.0	40.9
Capital Budget	-	-	-	-
TOTAL		**$ 4,802.3**		**$ 4,757.9**

TEXAS
Health and Human
Services Commission

Estimated Average FY 2005 Nursing Facility Rate



NURSING FACILITY MEDICAID RATES: 10 YEAR HISTORY *

DATA ITEM	1995	1996	1997 **	1998	1999	2000	2001	2002 ***	2003 ****	2004****
AVERAGE MEDICAID REVENUE PER RESIDENT DAY	$ 63.15	$ 66.48	$ 71.90	$ 75.28	$ 78.47	$ 83.06	$ 87.78	$ 95.68	$ 95.68	$ 94.00
ANNUAL % CHANGE	N/A	5.27%	8.14%	4.71%	4.24%	5.85%	5.68%	8.99%	0.00%	-1.75%
AVERAGE MEDICAID ALLOWABLE EXPENSES PER RESIDENT DAY	$ 65.22	$ 69.28	$ 73.43	$ 79.19	$ 83.12	$ 89.44	$ 94.73	$ 99.41	$ 104.32	$ 109.48
ANNUAL % CHANGE	N/A	6.23%	5.99%	7.83%	4.97%	7.61%	5.91%	4.94%	4.94%	4.94%
FACILITIES IN DATABASE	1,050	1,067	1,044	1,022	1,032	1,014	1,020	1,010	1,010	1,010
FACILITIES LOSING MONEY ON MEDICAID	541	583	549	605	611	638	635	561	698	841
% FACILITIES LOSING MONEY ON MEDICAID	51.5%	54.6%	52.6%	59.2%	59.2%	62.9%	62.3%	55.5%	69.1%	83.3%

* Source: 1995 - 2002, Medicaid cost report databases

** Litigation / Minimum Wage Increase

*** Rates set on a biennial basis

**** 2003, 2004 expenses assumes lowest average annual increase from 1996-2002 (4.94%). Revenue assumes 1.75% decrease mandated by legislature.

Regulatory Trends

Number of Inspections Completed Per Year	FY 2003 Expended	FY 2004 Estimated	FY 2005 Budgeted
Nursing Facilities	1449	1434	1434
Assisted Living Facilities	1505	1541	1541
Adult Day Care Facilities	387	366	366
ICFs-MR/RC	891	933	933
Home and Community Support Services Agencies	1592	1684	1635
Total	5824	5958	5909

Regulatory Trends

Number of Complaint and Incident Investigations Per Year	FY 2003 Expended	FY 2004 Estimated	FY 2005 Budgeted
Nursing Facilities	11,315	12,033	12,033
Assisted Living Facilities	1,856	1,926	1,926
Adult Day Care Facilities	373	402	402
ICFs-MR/RC	1,811	1,625	1,625
Home and Community Support Services Agencies	1,053	951	997
Total	16,408	16,937	16,983

Regulatory Trends

	FY 2003 Expended	FY 2004 Estimated	FY 2005 Budgeted
MOF			
General Revenue	**$15,477,586**	**$13,561,662**	**$16,850,621**
Federal Funds			
Survey & Certification	**$34,533,098**	**$34,889,805**	**$36,735,827**
Medicaid	**$2,999,547**	**$3,223,141**	**$2,981,065**
Other Funds	**$1,751,015**	**$1,230,142**	**$1,690,142**
TOTAL	**$54,761,246**	**$52,904,750**	**$58,257,655**

Nursing Facility Trends

Fiscal Year	Number of Facilities	Number or Licensed or Certified Beds	Number of Occupants	Occupancy Rates	Number of Occupants; Percent Growth/Loss
2000	1,274	129,595	94,092	73.0%	-2.9%
2001	1,223	126,925	91,987	72.0%	-2.2%
2002	1,194	124,448	91,595	74.0%	-0.4%
2003	1,176	123,637	90,319	73.0%	-1.0%
2004*	1,165	123,755	91,612	74.0%	+1.4%
Percent Change in 5 Years	- 8.6%	- 4.5%	-2.6%	---	-2.6%

- Preliminary data for Fiscal Year 2004

ICF-MR/RC Facility Trends

Fiscal Year	Number of Facilities	Number or Licensed or Certified Beds	Number of Occupants	Occupancy Rate	Number of Occupants; Percent Growth/Loss
2000	898	14,171	13,140	98.0%	-0.2%
2001	905	13,916	12,876	93.0%	-2.0%
2002	902	13,699	12,510	91.0%	-2.8%
2003	907	13,647	12,477	91.0%	-0.3%
2004*	904	13,621	12,247	90.0%	-1.8%
Percent Change in 5 Years	+0.7%	- 3.9%	-6.8%	---	-6.8%

- Preliminary data for Fiscal Year 2004

Assisted Living Facility Trends

Fiscal Year	Number of Facilities	Number or Licensed or Certified Beds	Number of Occupants	Occupancy Rate	Number of Occupants; Percent Growth/Loss
2000	1,355	40,368	21,428	53.0%	+20.0%
2001	1,298	40,259	23,594	59.0%	+10.0%
2002	1,324	41,424	26,157	63.0%	+11.0%
2003	1,385	42,253	26,989	64.0%	+3.0%
2004*	1,403	42,850	27,979	65.0%	+4.0%
Percent Change in 5 Years	+3.5%	+6.1%	+30.5%	—	+30.5%

- Preliminary data for Fiscal Year 2004

Home and Community Support Services Agencies Trends

Fiscal Year	Number of Parent Agencies	Percent Change	Number of Branches *	Percent Change	Total Number of Agencies	Percent Change
2001	1,833	-----	471	-----	2,304	-----
2002	1,922	+4.9%	476	+1.1%	2,398	+4.1%
2003	2,090	+8.7%	507	+6.5%	2,597	+8.3%
2004*	2,415	+15.6%	560	+10.5%	2,975	+14.6%
Percent Change	-----	+31.8%	-----	+18.9%	-----	+29.1%

- Preliminary data for Fiscal Year 2004
* Includes alternate delivery site (hospice)

TEXAS LEGISLATIVE COUNCIL

P.O. Box 12128, Capitol Station
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DAVID DEWHURST
Lieutenant Governor
Joint Chair

TOM CRADDICK
Speaker of the House
Joint Chair

MEMORANDUM

TO: Legislative Oversight Committee on Long-Term Care
Ms. Gina Chung

FROM: Carey Eskridge
Research Specialist

DATE: November 5, 2004

SUBJECT: The Program to Promote Long-Term Care Insurance for the Elderly

This memorandum is in response to your request for information relating to the Robert Wood Johnson Foundation (RWJF) Partnership for Long-Term Care Program to Promote Long-Term Care Insurance for the Elderly. The memorandum includes background information relating to the origins, development, and current status of the program and concludes with answers to your specific questions regarding the effect of the program on Medicaid reimbursement costs in each state in which the program is operating and incentives for public participation in those states.

Background

In 2000, an estimated six million elderly in the United States required long-term care.[1] But while most Americans have at least some insurance coverage to protect them against medical care costs, the private insurance plans available for long-term care generally provide limited coverage and, often, only for "post-acute" care that immediately follows hospitalization. Consequently, many of these citizens rely on publicly funded programs like Medicaid to help pay for their care. In 2002, Medicaid accounted for 43 percent of the $139 billion spent on long-term care and 50 percent of the $103 billion spent on nursing home care in the United States.[2] In fact, nearly 60 percent of those in nursing homes use Medicaid as their primary source of payment.[3] By contrast, private insurance accounted for 11 percent of national spending on long-term care and only seven percent of national spending on nursing home care in 2002.[4]

With Medicaid representing such a substantial portion of state budgets, exceeding 21 percent in 2003,[5] there is growing concern in state government over the financing of long-term care. In Texas, 32 percent ($4.366 million) of total Medicaid spending for federal fiscal year 2002 was distributed for long-term care services,[6] of which $1.8 million was spent for care administered in nursing facilities and nearly $1.7 million for home health and personal care.[7] Projections relating to the impending long-term care needs of the "baby boom" generation demonstrate the potential impact of these obligations. Estimates indicate that of the 77 million Americans expected to retire beginning in 2011,[8] 45 percent will require care in a nursing facility, with 33 percent spending at least three months and nine percent spending five years or longer in a nursing home.[9] Moreover, care administered in nursing facilities is expensive. The national average cost of a year in a nursing home is approximately $40,000 and is expected to rise to more than $83,000 by 2010.[10]

The Program to Promote Long-Term Care Insurance for the Elderly

Prompted by policy analysis suggesting an imminent need for solutions to financing long-term care, the Robert Wood Johnson Foundation developed a public/private partnership initiative between state governments and private insurance companies known as the Program to Promote Long-Term Care Insurance for the Elderly. The partnerships combine special Medicaid eligibility standards and asset protections with private long-term care insurance coverage. Under the program, consumers purchase private insurance policies for a predetermined period of coverage. When the private policy expires, the consumer is then eligible for continued coverage under Medicaid, without being required to qualify under standard eligibility criteria relating to income and asset limits. In 1987, the foundation provided development resources to potential programs in eight states coordinated through a national office located at the University of Maryland Center on Aging. Four states were awarded implementation grants: California, Connecticut, Indiana, and New York. The programs continue to operate in these states.

A state seeking to make changes to its Medicaid program must first gain federal approval either through a waiver or through an amendment to the state's Medicaid plan. Several sections of the Social Security Act authorize the secretary of the United States Department of Health and Human Services to waive certain federal Medicaid requirements, thereby allowing state Medicaid programs to offer alternative services, expand services to certain populations, and develop new initiatives. The most common waivers, administrative waivers granted by the Centers for Medicaid and Medicare Services (CMS), fall into one of three categories: (1) freedom-of-choice waivers; (2) home and community-based services waivers; and (3) research and demonstration waivers. Waiver programs are usually time limited, require special reporting, and can waive requirements statewide or for targeted groups within the Medicaid eligible population. State plan amendments must also be approved by CMS, but the modifications are not limited in duration. Although some states participating in the development of the partnership programs initially sought to modify their Medicaid programs by employing waivers, models were ultimately established as state plan amendments.

As a means-tested program, Medicaid restricts eligibility for long-term care coverage to the elderly who meet rigorous income and asset limitations. As a result, many elderly citizens and their families, lacking private long-term care insurance, exhaust personal assets by paying for care out-of-pocket until they become poor enough to qualify for Medicaid. The partnership programs are designed to protect consumers against the loss of nonhousing assets by excluding them from the qualification requirements for Medicaid.

During the development of the partnership programs, two models emerged: the dollar-for-dollar model and the total assets model. Each model requires the consumer to purchase a minimum amount of private insurance coverage for a minimum length of time. The programs in California and Connecticut are based on the dollar-for-dollar model. Under this model, for every dollar of long-term care coverage purchased from a private insurer participating in the program, a dollar of assets is protected from Medicaid eligibility requirements. The amount of coverage purchased is the amount that will be paid out in benefits if the purchaser requires care at a nursing home. Once the private policy benefits are exhausted, Medicaid assumes coverage for the participants' care. Although consumers' assets are protected, participants must contribute any income to Medicaid as a condition of coverage. In addition, if at the time the private policy expires and Medicaid is scheduled to assume coverage the purchaser's assets are greater than when the policy was purchased, the policyholder must "spend down" those assets to the amount covered by the private policy.

The New York program adopted the total assets model. The total assets model requires the purchase of private long-term care insurance policies that cover a minimum of three years of care administered in a nursing home and a minimum of six years of home health care. When these benefits are exhausted, Medicaid assumes coverage and assets are not considered at all for eligibility. As in the dollar-for-dollar model, however, the participant's income must be contributed to the cost of care.

Indiana originally adopted the dollar-for-dollar model. In 1998, however, Indiana began offering both total asset protection and dollar-for-dollar protection to consumers. A participant who purchases a policy of a minimum amount prescribed by the state receives total asset protection. Policies purchased for less than the minimum amount entitle the purchaser to dollar-for-dollar asset protection. In 1998, Indiana set the minimum coverage amount for total asset protection at $140,000. Each year on January 1 the amount increases for policies newly purchased during that year. In 2000, the minimum coverage amount was set at $154,350.

The Omnibus Budget Reconciliation Act of 1993

In 1993, the United States Congress passed the Omnibus Budget Reconciliation Act (OBRA) to require states approved for a Medicaid state plan amendment to develop partnership programs after May 14, 1993, to recover assets from the estates of all beneficiaries of Medicaid. This meant the asset protection component of the program is effective only while the participant is alive and effectively eliminated the primary incentive for participation in partnership

programs—passing one's assets to one's heirs. Although OBRA grandfathered the asset protection of the four RWJF programs operating in California, Connecticut, Indiana, and New York, only two states, Illinois and Washington, implemented long-term care partnerships after the May 14, 1993, deadline. Several other states have passed legislation to facilitate partnerships, but no action has been taken by the states' Medicaid agencies.

Conclusion

In 1989, the RWJF commissioned an evaluation of the Partnership for Long-Term Care Program to Promote Long-Term Care Insurance for the Elderly. The evaluation included "monitoring methods to measure cost-savings in partnership states." But it was recognized that "any effect the partnerships will have on Medicaid spending will not occur until a much later date." Indeed, to this date, there has been no formal study of cost-savings across the four original partnership states. Program administrators in Indiana, California, and Connecticut responded to requests for general information regarding the effect of their programs on state Medicaid expenditures, but were only able to offer primarily anecdotal results.

Indiana provided a "cost-effectiveness formula" that included a "total potential savings" figure and a quarterly report for the second quarter of 2004 (see attached). Although the data does not appear to reflect actual Medicaid program savings, the Indiana administrator indicated that "only a few" of the policyholders in that state had exhausted their private policy benefits and accessed Medicaid. Similarly, California responded with information from an informal study that indicated possible savings for 19 participants of $1.35 million, but it was not clear if this figure was savings applied exclusively to the state's Medicaid program and the information did not include the duration of participation for these policyholders. In 1991, before the partnership programs were adopted, the national program office at the University of Maryland Center on Aging conducted cost-effectiveness estimates based on a number of models simulating possible program scenarios. The Connecticut program administrator provided this report, but, again, there is no data demonstrating actual cost savings (see attached).

Clearly, the principal enticement for public participation in the partnership programs is asset protection. But further incentive is provided by the fact that certain private long-term care policies sold through the programs meet the criteria for "tax-qualified" policies under the Health Insurance Portability and Accountability Act. Certain participants covered by a tax-qualified policy may deduct premiums from their income taxes up to a maximum limit.

This memorandum is intended to provide a brief overview of the Robert Wood Johnson Foundation Partnership for Long-Term Care Program to Promote Long-Term Care Insurance for the Elderly and to answer your specific request for information relating to Medicaid program cost-savings and incentives for participation. If you have any questions or need further assistance, please contact me at 463-1143.

Notes

1. Ellen O'Brien and Risa Elias, Kaiser Commission on Medicaid and the Uninsured, "Medicaid and Long-Term Care" (May 2004), 1.
2. Ibid, 3.
3. Ibid, 3.
4. Ibid, 3.
5. National Association of State Budget Officers, "2003 State Expenditure Report," 46.
6. The Henry J. Kaiser Family Foundation, "Distribution of Medicaid Spending (Federal and State) by Service, FFY2002," *State Health Facts Online*, www.statehealthfacts.org.
7. The Henry J. Kaiser Family Foundation, "Distribution of Medicaid Spending (Federal and State) on Long-Term Care, FFY2002," *State Health Facts Online*, www.statehealthfacts.org.
8. Erin Madigan, "Long-term health care costs loom large for governors," *Stateline.org* (July 16, 2004), www.stateline.org.
9. Congressional Budget Office, "Financing Long-Term Care for the Elderly" (April 2004), 14.
10. The Robert Wood Johnson Foundation, National Program Report, The Program to Promote Long-Term Care Insurance for the Elderly (February 2001), www.rwjf.org/reports/npreports/elderlye.htm.

04R868

Attachments

State of Indiana Cost Effectiveness Formula
(Data as of 9/15/04)

Savings

The percentage of survey respondents who fall into the potential savings category (25%) will be applied to the amount of ILTCIP benefits that have been paid out ($8,022,986.27).

(25%) ($8,022,986.27) = $2,005,747.00

This amount will need to be reduced to reflect that Medicaid would have paid at a lower rate – approximately 15% less – so the savings should be 85% of the above number.

(85%) ($2,005,747.00) = $1,704,885 = potential savings

Assume 3% interest generated from additional applied income generated from protected assets: (total amount of assets protected for people who have accessed Medicaid):

(3%) ($845,481.87) = $25,364.45 = interest generated

Potential Savings + Interest Generated
$1,704,885 + $25,364 = $1,730,249 = Total Potential Savings

Cost Components

Looking at the percentage of survey respondents who fall into the potential cost category (8%), how many actually had a benefit amount less than the average claim amount for claimants who received payments other than case management and who are now deceased: 1 policyholder = 0.09 % This amount will be applied to the total amount of benefits paid out from above:

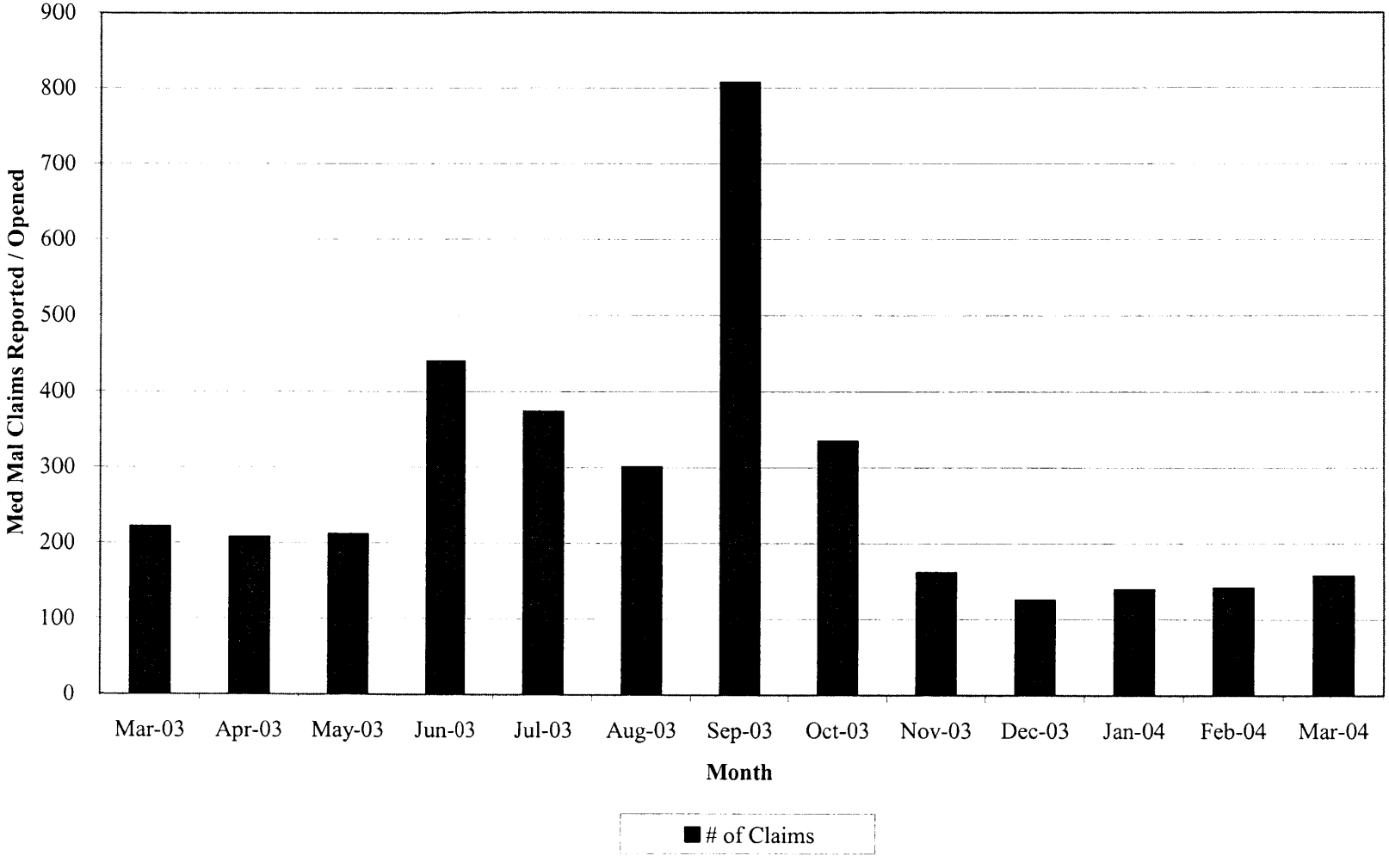
(.002) ($8,022,986.27) = $17,000

Total Potential Savings – Cost Component
$1,730,249 - $17,000. = $1,713,249 Potential Savings

APPENDIX C:
LIABILITY INSURANCE

TEXAS MEDICAL MALPRACTICE

TMLT AND THE TEXAS MEDICAL LIABILITY INS UNDERWRITING ASSOC (JUA) COMBINED MEDICAL MALPRACTICE CLAIMS BY MONTH



Long-Term Care Insurance Experience Report
Cumulative Texas Experience

Experience Year	Cumulative Earned Premiums from Inception through Experience Year ($000)	Cumulative Incurred Claims from Inception through Experience Year ($000)	Number of Covered Lives at End of Experience Year
1999	$479,944	$154,722	136,884
2000	$858,148	$267,289	164,393
2001	$1,176,365	$384,719	212,727
2002	$1,441,794	$471,842	242,373
2003	$1,979,935	$678,253	623,957

Notes:

- *The data elements used to prepare the report were extracted from exhibits filed with the NAIC and TDI cannot guarantee their accuracy.*
- *The required NAIC exhibit from which the data was extracted originated with the 1991 annual statement filing in 1992. As a result, data associated with years prior to 1991 may not have been reported by some carriers.*

Long Term Care Insurers with greater than $2 Million in 2003 Texas Earned Premium

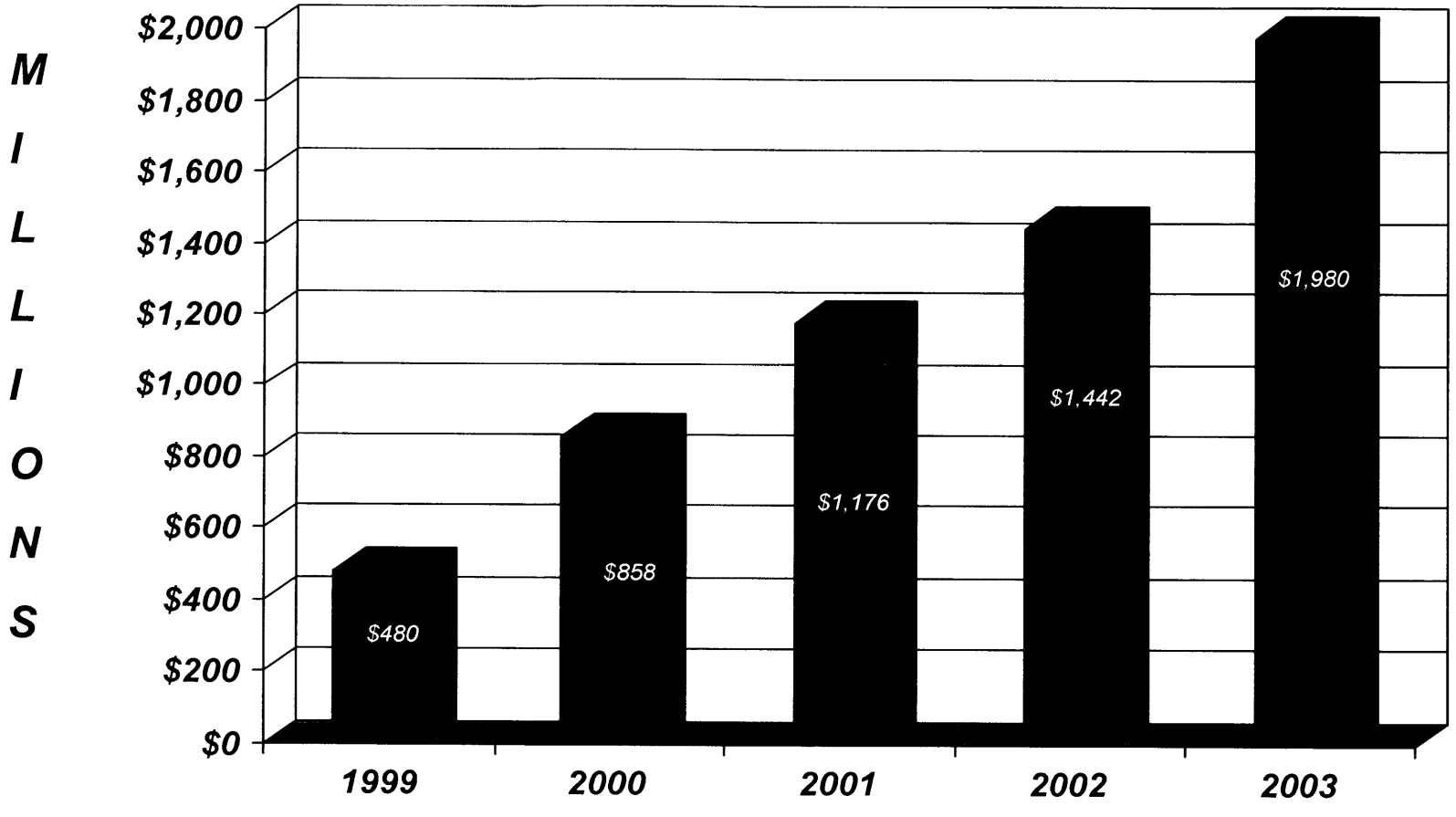
Rank	COMPANY NAME	2002 Weighted Avg. Increase	2003 Weighted Avg. Increase	2004 Weighted Avg. Increase
1	General Electric Capital Assurance Co.	-	-	-
2	United Teacher Associates Ins. Co.	-	-	-
3	Penn Treaty Network America Ins. Co.	37.57%	25.00%	26.41%
4	Conseco Senior Health Ins. Co.	23.62%	14.16%	15.00%
5	UNUM Life Ins. Co. of America**	-	-	-
6	John Hancock Life Ins. Co	-	-	-
7	Life Investors Ins. Co. of America	-	35.00%	-
8	Thrivent Financial for Lutherans	-	-	-
9	Fortis Ins. Co.	-	-	-
10	Aetna Life Insurance Co.	-	-	-
11	Equitable Life and Casualty Ins. Co.	-	-	-
12	Stonebridge Life Ins. Co.	25.00%	20.00%	20.95%
13	Washington National Ins. Co.	-	-	25.00%
14	State Farm Mutual Automobile Ins. Co.	-	-	-
15	AF&L Insurance Co.	15.30%	-	21.91%
16	IDS Life Ins. Co.	-	-	-
17	Physicians Mutual Ins. Co.	-	-	-
18	Allianz Life Insurance Co. of North America	-	-	-
19	American Family Life Assurance Co. of Columbus	-	-	-
20	Continental Casualty Co.	-	34.10%	-
21	Valley Forge Life Ins. Co.	-	-	-
22	New York Life Ins. Co.	-	-	-
23	Mutual of Omaha Ins. Co.	-	-	23.57%
24	Southern Farm Bureau Life Ins. Co.	-	-	-
25	Medico Life Ins. Co.	-	20.00%	-
26	Fortis Benefits Ins. Co.	-	-	-
27	Kanawha Ins. Co.	-	-	-
28	Lincoln Benefit Life Co.	-	-	-
29	Massachusetts Mutual Life Ins. Co.	-	-	-
30	Northwestern Long Term Care Ins. Co.	-	-	-

Notes:
Companies are ranked based on 2003 earned premium.
Weights are based on earned premium supporting the increase.

Texas Department of Insurance
Life/Health Division
October 13, 2004

Long Term Care Insurance

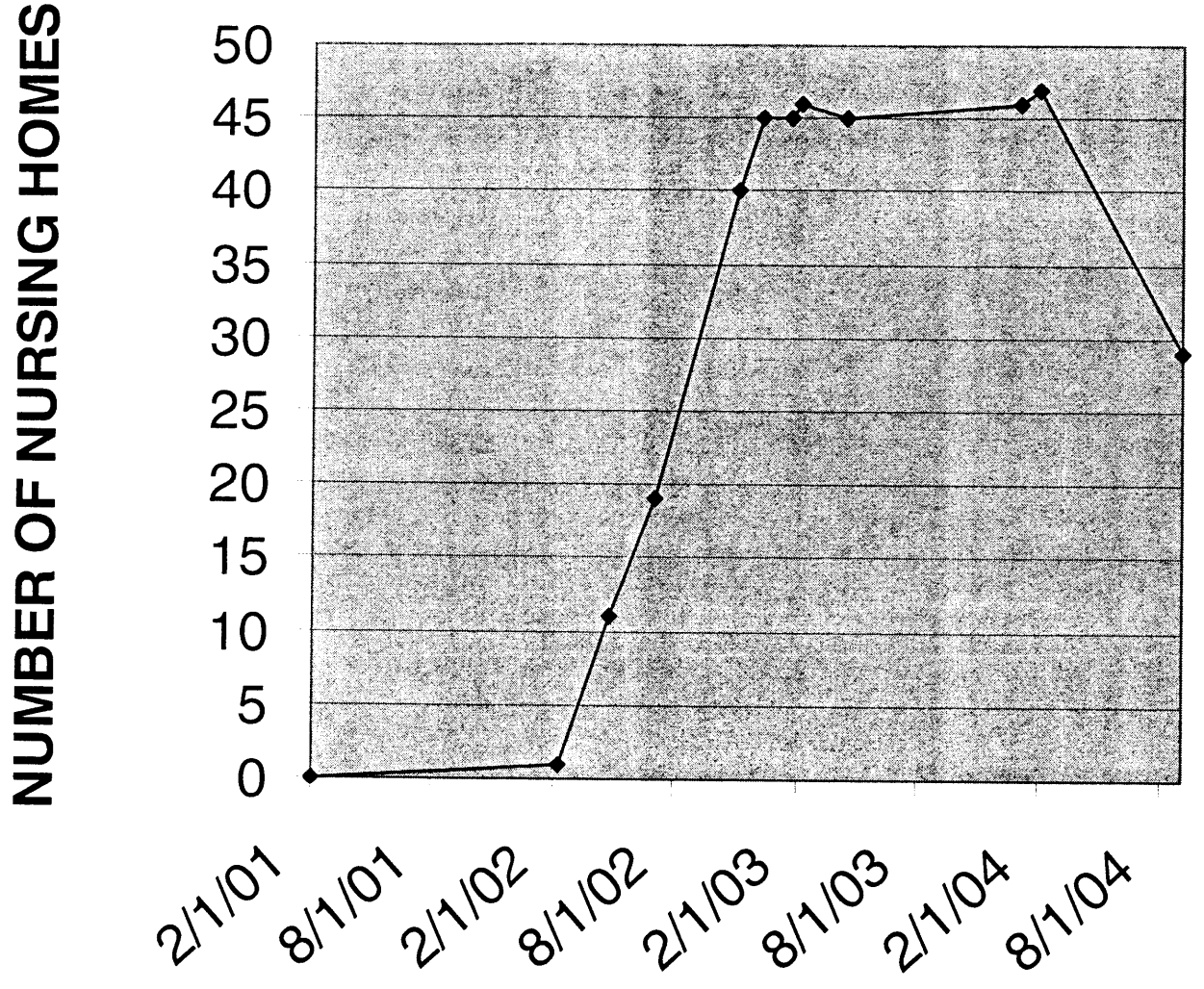
Cumulative Texas Earned Premium*



** Amounts represent cumulative earned premium from inception through experience year, reported to the NAIC. This reporting requirement originated with the 1991 annual statement filing in 1992 and as a result, data associated with years prior to 1991 may not have been reported by some carriers.*

Texas Department of Insurance
Life/Health Division
October 13, 2004

TEXAS JUA INSURED NURSING HOMES



Nursing Facilities Receiving Medicaid Reimbursement for Professional Liability Insurance

- There are 1162 total nursing facilities in Texas[1].

- 1135 homes (98%) are certified nursing facilities eligible to collect Medicaid reimbursement for Professional Liability Insurance.
  - 461 (41%) of these nursing facilities are not receiving reimbursement.
  - 674 nursing facilities (59%) applied for and are receiving reimbursement.

- The homes receiving Medicaid reimbursement for Professional Liability Insurance include the following classes:
  - 477 (71%) nursing facilities with insurance from insurers that are Texas admitted, eligible, registered, or the Texas JUA.
  - 163 (24%) nursing facilities reporting independently procured insurance plans with Independently Procured Tax paid to the Texas Comptroller of Public Accounts, and
  - 34 (5%) nursing facilities reporting captive insurers with Independently Procured Tax (insurance procured out-of-state) paid to the Texas Comptroller of Public Accounts.

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[1]This data compiled through cooperation with the Health and Human Services Commission (HHSC) and the Department of Aging and Disability Services (DADS). HHSC collects liability information on Medicaid-licensed facilities for the purpose of providing reimbursement for liability insurance coverage in accordance with HB 154, 77th Legislative Session of 2001 and 1 TAC 355.312, Reimbursement Setting Methodology--Liability Insurance Costs. DADS is the licensing authority for Texas nursing facilities. This data includes facilities assumed to be in the process of renewing coverage.

TEXAS MEDICAL LIABILITY INSURANCE UNDERWRITING ASSOCIATION HOSPITALS AND OTHER INSTITUTIONAL HEALTH CARE PROVIDERS

NURSING HOMES

A. CLASSIFICATIONS

	Code Number	Territories
Governmental	92212	entire state
For-Profit	99002	entire state
Not-for-Profit	80924	entire state

These classifications do not apply to risks with surgical operating room facilities, laboratory or medical departments, or X-ray equipment.

B. DEFINITIONS

Assisted Living Facility Beds. Beds associated with a resident receiving personal care services other than acute, skilled, or semi-skilled care. Three Assisted Living Beds in or affiliated with a licensed nursing facility equals one occupied Nursing Home bed. An Assisted Living Facility is defined by §247.002 of the Health and Safety Code.

Not-for-Profit Nursing Home. A nursing home, no part of whose net earnings inures to the benefit of any private individual or entity. The term not-for-profit includes governmental institutions.

Nursing Home. A skilled, convalescent, acute, or general care nursing facility licensed by the Texas Department of Human Services, Long Term Care – Regulatory Division.

Nursing Home Beds. Beds associated with a resident receiving varying degress of treatment under the direction and supervision of a physician in a nursing home as defined by §242.002 of the Health and Safety Code.

Outpatient visit. A day visit to a nursing home without an overnight stay. A thousand (1,000) day visits equals one occupied Nursing Home bed.

C. TEXAS JUA TIER RATING, NURSING HOMES

1. **Past Claims Experience.** Upon initial application, the nursing home applicant shall submit a loss experience run of all liability claims involving patients for the immediately preceding three years. An updated run shall be provided at the first and second renewals. A claim shall consist of a third party claim for negligence brought by or on behalf of a patient resulting in the bodily injury to, or death of, that patient. The loss experience run shall include all claims, whether open or closed, or whether or not indemnity or expense is paid.

   For the purposes of rating, a closed claim with a payment to a plaintiff, or an open claim, shall constitute a claim. Multiple claims brought on account of bodily injury to, or death of, an individual patient, and arising from the same occurrence, shall be considered to be one claim for the purposes of rating.

   For the initial rating, count the number of claims in the immediately preceding three-year period from the date of the application. For renewals, count the number of claims in the three-year period ending 120 days prior to the effective date of the renewal policy. Refer to the chart, Nursing Homes Assignment to Point Interval, Based on Numbers of Claims in Most Recent Three Years, to determine the point interval that applies to the applicant.

   Changes in ownership interest may affect the continued use of an entity's loss experience in future ratings. Based on the provisions of this section, when a change in ownership occurs, a determination shall be made by the JUA to use or exclude an acquired entity's past loss experience. The past loss experience of any entity that has a change in ownership may be excluded only if the conditions of both Paragraphs a and b are met:

   a. The change in ownership must be a material change such that the:

      (1) Entity which obtains entire ownership interest after the change must have had no ownership interest before the change, or

      (2) The collective ownership of those having an interest in an entity both before the change and after the change amounts to either:

         (a) An ownership increase from less than 50% to more than 50% ownership interest, or

         (b) An ownership decrease from more than 50% to less than 50% ownership interest.

b. The material change in ownership is accompanied by a substantial change in operations within 90 days of the ownership change.

If the past loss experience of an entity is excluded under conditions a and b above, and if that entity is acquired by an entity that has existing Texas loss experience, then the loss experience of the acquiring entity may be used in the rating at the discretion of the JUA.

In the case of an entity that has been in existence more than twelve months but less than three and a half years and is not a successor to a pre-existing nursing home, use the entire loss experience of the entity, not to exceed a three-year period.

In the case of an entity that has been in existence for less than twelve months and is not a successor to a pre-existing nursing home, assign zero rating points on account of past claims experience.

In the case of an entity that has been in existence for less than three and a half years and is a successor to a pre-existing nursing home, the loss experience of the pre-existing nursing home may be used to supplement the entity's own loss experience at the discretion of the JUA.

In the case of an entity that has been in existence for less than three and a half years, is not a successor to a pre-existing nursing home, whose owners contract with a third party vendor to provide operational management services in operating the entity, and that third party vendor has existing Texas loss experience, then the loss experience of that third party vendor may be used in the rating at the discretion of the JUA.

Claims Point Intervals	1	2	3	4	5
Rating Points	-7	0	10	20	30

Nursing Homes Assignment to Point Interval,
Based on Numbers of Claims in Most Recent Three Years

Average Annual Occupied Beds	Number of Claims Over Most Recent Three Years																			Greater Than
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	18
0-30	2	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
31-40	2	3	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
41-50	2	3	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
51-60	2	3	3	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
61-70	2	2	3	4	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
71-80	2	2	3	3	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
81-90	1	2	3	3	4	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5
91-100	1	2	2	3	3	4	4	5	5	5	5	5	5	5	5	5	5	5	5	5
101-110	1	2	2	3	3	4	4	5	5	5	5	5	5	5	5	5	5	5	5	5
111-120	1	2	2	3	3	3	4	4	5	5	5	5	5	5	5	5	5	5	5	5
121-130	1	2	2	2	3	3	4	4	4	5	5	5	5	5	5	5	5	5	5	5
131-140	1	2	2	2	3	3	4	4	4	5	5	5	5	5	5	5	5	5	5	5
141-150	1	2	2	2	3	3	3	4	4	4	5	5	5	5	5	5	5	5	5	5
151-160	1	1	2	2	3	3	3	4	4	4	5	5	5	5	5	5	5	5	5	5
161-170	1	1	2	2	2	3	3	3	4	4	4	5	5	5	5	5	5	5	5	5
171-180	1	1	2	2	2	3	3	3	4	4	4	4	5	5	5	5	5	5	5	5
181-190	1	1	2	2	2	3	3	3	3	4	4	4	5	5	5	5	5	5	5	5
191-200	1	1	2	2	2	2	3	3	3	4	4	4	4	5	5	5	5	5	5	5
201-225	1	1	2	2	2	2	3	3	3	3	4	4	4	4	5	5	5	5	5	5
226-250	1	1	1	2	2	2	2	3	3	3	3	4	4	4	4	4	5	5	5	5
251-275	1	1	1	2	2	2	2	2	3	3	3	3	3	4	4	4	4	4	5	5
276-300	1	1	1	1	2	2	2	2	2	3	3	3	3	3	4	4	4	4	4	5
301-325	1	1	1	1	2	2	2	2	2	2	3	3	3	3	3	4	4	4	4	5
326-350	1	1	1	1	2	2	2	2	2	2	3	3	3	3	3	3	4	4	4	5
>350	1	1	1	1	1	2	2	2	2	2	2	2	3	3	3	3	3	3	4	5

Insert Chart. Use for determining points for # 1. Past Claims Experience

2. **Quality of Care Rating (Discrepancy list based).** Nursing homes shall receive points in accord with the accompanying table.

If the home is new, opened within the 12 months immediately preceding application, or new ownership has been deemed to have no applicable quality rating, then the points rating for this category shall be zero

Add the points generated by the Quality of Care rating to the cumulative rating point subtotal.

CareScout™ Rating	AAA & AA	A	B	C	D
Rating Points	-10	0	10	15	20

3. **Staff Ratios.** The number of hours nursing staff is available for patient care per patient per day based on a seven-day average for the month immediately preceding the application. Nursing staff means the director of nursing, assistant directors of nursing, nursing department directors, licensed nursing personnel, and certified nurse assistants. Nursing directors may be counted only for the time spent on a shift providing direct resident care.

Determine the total number of full-time equivalent (FTE) nursing staff. A full-time equivalent is the work one full-time nurse or nursing assistant gives to the nursing home during one thirty-five hour workweek. For part-time and split shifts, the work of more than one nurse or nursing assistant may constitute one FTE. Calculate the average hours per patient per day according to the following formula:

Total # of Nursing Staff (FTE)	x 35 (hrs/week)	= total staff hours in a week
Total Staff hours in a week	÷ 7 (days/week)	= Staff hours per day
Staff hours per day	÷ Avg. # of residents	= Hours per patient per day

Determine the number of points on the accompanying table and add it to the cumulative rating point subtotal.

Hrs. per Patient per Day	R>3.4	3.3-2.9	2.8-2.3	R<2.3
Rating Points	-5	0	5	15

4. Tenure and Credentials of Key Personnel.

a. The key personnel of the applying nursing home shall consist of the Administrator, Director of Nursing, and Medical Director. Tenure shall be measured as the longevity of the key person with the shortest time of employment at the applying home. Determine the number of points from the accompanying table. The lowest number of points is awarded to homes with the longest tenure. Tenure of 3 key people will not apply to a new home opened within the 12 month period immediately preceding application or for a home under new ownership within the 12 month period immediately preceding application deemed to have no applicable tenure. The points rating for such new homes, or ownership, for this category shall be zero.

Tenure of 3 key people – Employee with Least Amount of Experience	Yrs.>6	2-6	Yrs.<2
Rating Points	-3	0	5

b. The nursing home shall be assigned points on the basis of the table below using the following credentials.

- Administrator is Certified by or a Fellow of the American College of Health Care Administrators.
- Director of Nursing has an RN and certification in Gerontology by the American Nurses Credentialing Center, RN, C (Diploma, Associate) or RN, BC (Bachelors or higher) or current equivalent.
- Medical Director is a licensed physician (MD/DO) and a Certified Medical Director in Long Term Care (CMD) by the American Medical Directors Certification Program (AMDCP), or other recognized certification in Geriatrics or Gerontology.

Credentials of 3 Key People	All 3	2	1	None
Rating Points	-1	2	4	5

Combine the number of points on accompanying tables 4(a) and 4(b) and add them to the cumulative rating point subtotal.

5. **Best Practices for Risk Management and Loss Control.** Determine point total from the accompanying table based on the utilization of the Best Practices for Risk Management and Loss Control for For-Profit and Not-For-Profit Nursing Homes. See the Texas Administrative Code, 28 TAC §§5.1740 – 5.1741, for information on implementation of an effective loss control program. Nursing homes must submit a copy of the program for each exposure area including the name of the designated exposure area leads at the time of application in order to receive credit.

a. Falls,
b. Resident Abuse,
c. Pressure Ulcers,
d. Nutrition and Hydration,
e. Medication Management,
f. Restraints (if used),
g. Infection Control,
h. Burns and Scalds, and
i. "Elopement."

Risk Management/Loss Control and General Safety	a-e and any 2 of f-i	Any 3 of a-e and any 1 of f-i	Any 3 of a-e	All other combinations
Rating Points	-10	0	+10	+20

Determine the number of points on the accompanying table and add it to the cumulative rating point subtotal.

6. **Ombudsman Program**

Determine point total in accordance with which of the following describes the applicant's operations.

a. Nursing home has ombudsman professional funded directly by, and reports to, an entity independent of the nursing home operator and is essentially a full-time position (30 or more hours a week at duties).

b. Nursing home has ombudsman volunteer who is not on nursing home payroll, possesses Texas Department on Aging Certification Card (as evidence of completion of certification process), and spends two hours or more on site per week.

c. Ombudsman present, but not independent of home.

d. No ombudsman.

Ombudsman Program	(a)	(b)	(c)	(d)
Rating Points	-5	-2	0	5

Determine the number of points on the accompanying table and add it to the cumulative rating point subtotal.

Final Step

Select the appropriate rating tier from the table below based on the total rating points assigned above.

Rating Points	Tier
< 0	I
0-25	II
26-50	III
51-75	IV
75-100	V

Exceptions

- If the home has been without professional liability insurance for more than one year in the three-year period prior to application, the minimum tier shall be Tier II.
- If the nursing home is in bankruptcy or under Texas Department of Human Services supervision (such as Appointment of Trustee), then the minimum tier shall be Tier II.

Deductibles

- A deductible is not available for nursing homes in bankruptcy, or if financially insolvent as defined by Generally Accepted Accounting Principles.
- The maximum deductible allowed is $25,000 per occurrence.

Premium Basis

The premiums listed in the Claims-Made Coverage Rates table are on the basis of per occupied bed.

D. ACCOMPANYING RATE TABLES

D. RATE TABLES

1. Claims Made Coverage Rates, Tiers I through V

Texas Medical Liability Insurance Underwriting Association
Claims Made Coverage Rates
Tier I
For-Profit Nursing Homes

Deductible	Limit of Liability (in Thousands of Dollars) 100/300	200/600	250/750	300/900	500/1,500	1,000/3,000
			First Year Claims Made			
$0	$537	$573	$595	$609	$659	$717
$5,000	$523	$559	$580	$595	$645	$702
$10,000	$516	$552	$573	$588	$638	$695
$15,000	$509	$545	$566	$580	$631	$688
$20,000	$502	$537	$559	$573	$623	$681
$25,000	$494	$530	$552	$566	$616	$674
			Second Year Claims Made			
$0	$609	$650	$674	$690	$747	$812
$5,000	$593	$633	$658	$674	$731	$796
$10,000	$585	$625	$650	$666	$723	$788
$15,000	$577	$617	$642	$658	$715	$780
$20,000	$569	$609	$633	$650	$707	$772
$25,000	$560	$601	$625	$642	$698	$763
			Third Year Claims Made			
$0	$674	$719	$745	$763	$826	$898
$5,000	$656	$701	$728	$745	$808	$880
$10,000	$647	$692	$719	$736	$799	$871
$15,000	$638	$683	$710	$728	$790	$862
$20,000	$629	$674	$701	$719	$781	$853
$25,000	$620	$665	$692	$710	$772	$844
			Fourth Year Claims Made			
$0	$695	$741	$769	$788	$853	$927
$5,000	$677	$723	$751	$769	$834	$908
$10,000	$667	$714	$741	$760	$825	$899
$15,000	$658	$704	$732	$751	$816	$890
$20,000	$649	$695	$723	$741	$806	$880
$25,000	$640	$686	$714	$732	$797	$871
			Mature Claims Made			
$0	$709	$757	$785	$804	$870	$946
$5,000	$691	$738	$766	$785	$851	$927
$10,000	$681	$728	$757	$776	$842	$918
$15,000	$672	$719	$747	$766	$832	$908
$20,000	$662	$709	$738	$757	$823	$899
$25,000	$653	$700	$728	$747	$814	$889

Texas Medical Liability Insurance Underwriting Association
Claims Made Coverage Rates
Tier II
For-Profit Nursing Homes

Deductible	Limit of Liability (in Thousands of Dollars) 100/300	200/600	250/750	300/900	500/1,500	1,000/3,000
			First Year Claims Made			
$0	$967	$1,032	$1,071	$1,096	$1,187	$1,290
$5,000	$942	$1,006	$1,045	$1,071	$1,161	$1,264
$10,000	$929	$993	$1,032	$1,058	$1,148	$1,251
$15,000	$916	$980	$1,019	$1,045	$1,135	$1,238
$20,000	$903	$967	$1,006	$1,032	$1,122	$1,225
$25,000	$890	$955	$993	$1,019	$1,109	$1,213
			Second Year Claims Made			
$0	$1,096	$1,170	$1,213	$1,243	$1,345	$1,462
$5,000	$1,067	$1,140	$1,184	$1,213	$1,316	$1,433
$10,000	$1,053	$1,126	$1,170	$1,199	$1,301	$1,418
$15,000	$1,038	$1,111	$1,155	$1,184	$1,286	$1,403
$20,000	$1,023	$1,096	$1,140	$1,170	$1,272	$1,389
$25,000	$1,009	$1,082	$1,126	$1,155	$1,257	$1,374
			Third Year Claims Made			
$0	$1,213	$1,293	$1,342	$1,374	$1,487	$1,617
$5,000	$1,180	$1,261	$1,310	$1,342	$1,455	$1,584
$10,000	$1,164	$1,245	$1,293	$1,326	$1,439	$1,568
$15,000	$1,148	$1,229	$1,277	$1,310	$1,423	$1,552
$20,000	$1,132	$1,213	$1,261	$1,293	$1,407	$1,536
$25,000	$1,116	$1,196	$1,245	$1,277	$1,390	$1,520
			Fourth Year Claims Made			
$0	$1,251	$1,335	$1,385	$1,418	$1,535	$1,668
$5,000	$1,218	$1,301	$1,351	$1,385	$1,501	$1,635
$10,000	$1,201	$1,285	$1,335	$1,368	$1,485	$1,618
$15,000	$1,184	$1,268	$1,318	$1,351	$1,468	$1,602
$20,000	$1,168	$1,251	$1,301	$1,335	$1,451	$1,585
$25,000	$1,151	$1,235	$1,285	$1,318	$1,435	$1,568
			Mature Claims Made			
$0	$1,277	$1,362	$1,413	$1,447	$1,566	$1,703
$5,000	$1,243	$1,328	$1,379	$1,413	$1,532	$1,669
$10,000	$1,226	$1,311	$1,362	$1,396	$1,515	$1,652
$15,000	$1,209	$1,294	$1,345	$1,379	$1,498	$1,635
$20,000	$1,192	$1,277	$1,328	$1,362	$1,481	$1,618
$25,000	$1,175	$1,260	$1,311	$1,345	$1,464	$1,601

Texas Medical Liability Insurance Underwriting Association
Claims Made Coverage Rates
Tier III
For-Profit Nursing Homes

Deductible	Limit of Liability (in Thousands of Dollars) 100/300	200/600	250/750	300/900	500/1,500	1,000/3,000
			First Year Claims Made			
$0	$1,612	$1,720	$1,784	$1,827	$1,978	$2,150
$5,000	$1,569	$1,677	$1,741	$1,784	$1,935	$2,107
$10,000	$1,548	$1,655	$1,720	$1,763	$1,913	$2,085
$15,000	$1,526	$1,634	$1,698	$1,741	$1,892	$2,064
$20,000	$1,505	$1,612	$1,677	$1,720	$1,870	$2,042
$25,000	$1,483	$1,591	$1,655	$1,698	$1,849	$2,021
			Second Year Claims Made			
$0	$1,827	$1,949	$2,022	$2,071	$2,242	$2,437
$5,000	$1,779	$1,900	$1,974	$2,022	$2,193	$2,388
$10,000	$1,754	$1,876	$1,949	$1,998	$2,169	$2,363
$15,000	$1,730	$1,852	$1,925	$1,974	$2,144	$2,339
$20,000	$1,706	$1,827	$1,900	$1,949	$2,120	$2,315
$25,000	$1,681	$1,803	$1,876	$1,925	$2,095	$2,290
			Third Year Claims Made			
$0	$2,021	$2,156	$2,236	$2,290	$2,479	$2,695
$5,000	$1,967	$2,102	$2,183	$2,236	$2,425	$2,641
$10,000	$1,940	$2,075	$2,156	$2,209	$2,398	$2,614
$15,000	$1,913	$2,048	$2,129	$2,183	$2,371	$2,587
$20,000	$1,886	$2,021	$2,102	$2,156	$2,344	$2,560
$25,000	$1,859	$1,994	$2,075	$2,129	$2,317	$2,533
			Fourth Year Claims Made			
$0	$2,085	$2,224	$2,308	$2,363	$2,558	$2,781
$5,000	$2,030	$2,169	$2,252	$2,308	$2,502	$2,725
$10,000	$2,002	$2,141	$2,224	$2,280	$2,475	$2,697
$15,000	$1,974	$2,113	$2,197	$2,252	$2,447	$2,669
$20,000	$1,946	$2,085	$2,169	$2,224	$2,419	$2,641
$25,000	$1,919	$2,058	$2,141	$2,197	$2,391	$2,614
			Mature Claims Made			
$0	$2,128	$2,270	$2,355	$2,412	$2,611	$2,838
$5,000	$2,072	$2,214	$2,299	$2,355	$2,554	$2,781
$10,000	$2,043	$2,185	$2,270	$2,327	$2,526	$2,753
$15,000	$2,015	$2,157	$2,242	$2,299	$2,497	$2,724
$20,000	$1,986	$2,128	$2,214	$2,270	$2,469	$2,696
$25,000	$1,958	$2,100	$2,185	$2,242	$2,441	$2,668

Texas Medical Liability Insurance Underwriting Association
Claims Made Coverage Rates
Tier IV
For-Profit Nursing Homes

Deductible	Limit of Liability (in Thousands of Dollars) 100/300	200/600	250/750	300/900	500/1,500	1,000/3,000
First Year Claims Made						
$0	$2,472	$2,637	$2,736	$2,802	$3,033	$3,296
$5,000	$2,406	$2,571	$2,670	$2,736	$2,967	$3,231
$10,000	$2,373	$2,538	$2,637	$2,703	$2,934	$3,198
$15,000	$2,340	$2,505	$2,604	$2,670	$2,901	$3,165
$20,000	$2,308	$2,472	$2,571	$2,637	$2,868	$3,132
$25,000	$2,275	$2,439	$2,538	$2,604	$2,835	$3,099
Second Year Claims Made						
$0	$2,802	$2,989	$3,101	$3,176	$3,437	$3,736
$5,000	$2,727	$2,914	$3,026	$3,101	$3,362	$3,661
$10,000	$2,690	$2,877	$2,989	$3,064	$3,325	$3,624
$15,000	$2,653	$2,839	$2,951	$3,026	$3,288	$3,587
$20,000	$2,615	$2,802	$2,914	$2,989	$3,250	$3,549
$25,000	$2,578	$2,765	$2,877	$2,951	$3,213	$3,512
Third Year Claims Made						
$0	$3,099	$3,305	$3,429	$3,512	$3,801	$4,132
$5,000	$3,016	$3,223	$3,347	$3,429	$3,718	$4,049
$10,000	$2,975	$3,181	$3,305	$3,388	$3,677	$4,008
$15,000	$2,933	$3,140	$3,264	$3,347	$3,636	$3,966
$20,000	$2,892	$3,099	$3,223	$3,305	$3,594	$3,925
$25,000	$2,851	$3,057	$3,181	$3,264	$3,553	$3,884
Fourth Year Claims Made						
$0	$3,198	$3,411	$3,539	$3,624	$3,922	$4,263
$5,000	$3,112	$3,325	$3,453	$3,539	$3,837	$4,178
$10,000	$3,070	$3,283	$3,411	$3,496	$3,794	$4,136
$15,000	$3,027	$3,240	$3,368	$3,453	$3,752	$4,093
$20,000	$2,984	$3,198	$3,325	$3,411	$3,709	$4,050
$25,000	$2,942	$3,155	$3,283	$3,368	$3,667	$4,008
Mature Claims Made						
$0	$3,264	$3,481	$3,612	$3,699	$4,003	$4,351
$5,000	$3,176	$3,394	$3,525	$3,612	$3,916	$4,264
$10,000	$3,133	$3,351	$3,481	$3,568	$3,873	$4,221
$15,000	$3,089	$3,307	$3,438	$3,525	$3,829	$4,177
$20,000	$3,046	$3,264	$3,394	$3,481	$3,786	$4,134
$25,000	$3,002	$3,220	$3,351	$3,438	$3,742	$4,090

Texas Medical Liability Insurance Underwriting Association
Claims Made Coverage Rates
Tier V
For-Profit Nursing Homes

Deductible	Limit of Liability (in Thousands of Dollars) 100/300	200/600	250/750	300/900	500/1,500	1,000/3,000
			First Year Claims Made			
$0	$3,547	$3,784	$3,926	$4,020	$4,351	$4,730
$5,000	$3,453	$3,689	$3,831	$3,926	$4,257	$4,635
$10,000	$3,405	$3,642	$3,784	$3,878	$4,209	$4,588
$15,000	$3,358	$3,595	$3,736	$3,831	$4,162	$4,541
$20,000	$3,311	$3,547	$3,689	$3,784	$4,115	$4,493
$25,000	$3,264	$3,500	$3,642	$3,736	$4,068	$4,446
			Second Year Claims Made			
$0	$4,020	$4,288	$4,449	$4,556	$4,932	$5,360
$5,000	$3,913	$4,181	$4,342	$4,449	$4,824	$5,253
$10,000	$3,859	$4,127	$4,288	$4,395	$4,771	$5,200
$15,000	$3,806	$4,074	$4,235	$4,342	$4,717	$5,146
$20,000	$3,752	$4,020	$4,181	$4,288	$4,664	$5,092
$25,000	$3,699	$3,967	$4,127	$4,235	$4,610	$5,039
			Third Year Claims Made			
$0	$4,446	$4,742	$4,920	$5,039	$5,454	$5,928
$5,000	$4,327	$4,624	$4,802	$4,920	$5,335	$5,809
$10,000	$4,268	$4,564	$4,742	$4,861	$5,276	$5,750
$15,000	$4,209	$4,505	$4,683	$4,802	$5,217	$5,691
$20,000	$4,150	$4,446	$4,624	$4,742	$5,157	$5,632
$25,000	$4,090	$4,387	$4,564	$4,683	$5,098	$5,572
			Fourth Year Claims Made			
$0	$4,588	$4,894	$5,077	$5,200	$5,628	$6,117
$5,000	$4,465	$4,771	$4,955	$5,077	$5,505	$5,995
$10,000	$4,404	$4,710	$4,894	$5,016	$5,444	$5,934
$15,000	$4,343	$4,649	$4,833	$4,955	$5,383	$5,872
$20,000	$4,282	$4,588	$4,771	$4,894	$5,322	$5,811
$25,000	$4,221	$4,527	$4,710	$4,833	$5,261	$5,750
			Mature Claims Made			
$0	$4,682	$4,995	$5,182	$5,307	$5,744	$6,243
$5,000	$4,558	$4,870	$5,057	$5,182	$5,619	$6,118
$10,000	$4,495	$4,807	$4,995	$5,119	$5,556	$6,056
$15,000	$4,433	$4,745	$4,932	$5,057	$5,494	$5,994
$20,000	$4,370	$4,682	$4,870	$4,995	$5,432	$5,931
$25,000	$4,308	$4,620	$4,807	$4,932	$5,369	$5,869

D. RATE TABLES (continued)

2. Claims Made Reporting Endorsement Coverage Rates, Tiers I through V

Texas Medical Liability Insurance Underwriting Association
Claims Made Reporting Endorsement Coverage Rates
Tier I
For-Profit Nursing Homes

Deductible	Limit of Liability (in Thousands of Dollars) 100/300	200/600	250/750	300/900	500/1,500	1,000/3,000
			First Year Claims Made			
$0	$339	$361	$375	$384	$415	$452
$5,000	$330	$352	$366	$375	$406	$442
$10,000	$325	$348	$361	$370	$402	$438
$15,000	$321	$343	$357	$366	$397	$433
$20,000	$316	$339	$352	$361	$393	$429
$25,000	$312	$334	$348	$357	$388	$424
			Second Year Claims Made			
$0	$457	$487	$505	$518	$560	$609
$5,000	$445	$475	$493	$505	$548	$597
$10,000	$438	$469	$487	$499	$542	$591
$15,000	$432	$463	$481	$493	$536	$585
$20,000	$426	$457	$475	$487	$530	$579
$25,000	$420	$451	$469	$481	$524	$572
			Third Year Claims Made			
$0	$499	$532	$552	$565	$612	$665
$5,000	$485	$519	$539	$552	$598	$652
$10,000	$479	$512	$532	$545	$592	$645
$15,000	$472	$505	$525	$539	$585	$638
$20,000	$465	$499	$519	$532	$578	$632
$25,000	$459	$492	$512	$525	$572	$625
			Fourth Year Claims Made			
$0	$515	$549	$570	$583	$631	$686
$5,000	$501	$535	$556	$570	$618	$673
$10,000	$494	$528	$549	$563	$611	$666
$15,000	$487	$522	$542	$556	$604	$659
$20,000	$480	$515	$535	$549	$597	$652
$25,000	$474	$508	$528	$542	$590	$645
			Mature Claims Made			
$0	$515	$549	$570	$583	$631	$686
$5,000	$501	$535	$556	$570	$618	$673
$10,000	$494	$528	$549	$563	$611	$666
$15,000	$487	$522	$542	$556	$604	$659
$20,000	$480	$515	$535	$549	$597	$652
$25,000	$474	$508	$528	$542	$590	$645

Texas Medical Liability Insurance Underwriting Association
Claims Made Reporting Endorsement Coverage Rates
Tier II
For-Profit Nursing Homes

Deductible	Limit of Liability (in Thousands of Dollars) 100/300	200/600	250/750	300/900	500/1,500	1,000/3,000
			First Year Claims Made			
$0	$610	$650	$675	$691	$748	$813
$5,000	$593	$634	$658	$675	$731	$796
$10,000	$585	$626	$650	$666	$723	$788
$15,000	$577	$618	$642	$658	$715	$780
$20,000	$569	$610	$634	$650	$707	$772
$25,000	$561	$601	$626	$642	$699	$764
			Second Year Claims Made			
$0	$822	$877	$910	$932	$1,009	$1,096
$5,000	$800	$855	$888	$910	$987	$1,074
$10,000	$789	$844	$877	$899	$976	$1,063
$15,000	$778	$833	$866	$888	$965	$1,052
$20,000	$767	$822	$855	$877	$954	$1,041
$25,000	$756	$811	$844	$866	$943	$1,030
			Third Year Claims Made			
$0	$898	$957	$993	$1,017	$1,101	$1,197
$5,000	$874	$933	$969	$993	$1,077	$1,173
$10,000	$862	$921	$957	$981	$1,065	$1,161
$15,000	$850	$910	$945	$969	$1,053	$1,149
$20,000	$838	$898	$933	$957	$1,041	$1,137
$25,000	$826	$886	$921	$945	$1,029	$1,125
			Fourth Year Claims Made			
$0	$926	$988	$1,025	$1,050	$1,136	$1,235
$5,000	$902	$964	$1,001	$1,025	$1,112	$1,211
$10,000	$889	$951	$988	$1,013	$1,099	$1,198
$15,000	$877	$939	$976	$1,001	$1,087	$1,186
$20,000	$865	$926	$964	$988	$1,075	$1,174
$25,000	$852	$914	$951	$976	$1,062	$1,161
			Mature Claims Made			
$0	$926	$988	$1,025	$1,050	$1,136	$1,235
$5,000	$902	$964	$1,001	$1,025	$1,112	$1,211
$10,000	$889	$951	$988	$1,013	$1,099	$1,198
$15,000	$877	$939	$976	$1,001	$1,087	$1,186
$20,000	$865	$926	$964	$988	$1,075	$1,174
$25,000	$852	$914	$951	$976	$1,062	$1,161

Texas Medical Liability Insurance Underwriting Association
Claims Made Reporting Endorsement Coverage Rates
Tier III
For-Profit Nursing Homes

Deductible	Limit of Liability (in Thousands of Dollars) 100/300	200/600	250/750	300/900	500/1,500	1,000/3,000
			First Year Claims Made			
$0	$1,016	$1,084	$1,124	$1,151	$1,246	$1,355
$5,000	$989	$1,057	$1,097	$1,124	$1,219	$1,327
$10,000	$975	$1,043	$1,084	$1,111	$1,206	$1,314
$15,000	$962	$1,029	$1,070	$1,097	$1,192	$1,300
$20,000	$948	$1,016	$1,057	$1,084	$1,178	$1,287
$25,000	$935	$1,002	$1,043	$1,070	$1,165	$1,273
			Second Year Claims Made			
$0	$1,370	$1,462	$1,516	$1,553	$1,681	$1,827
$5,000	$1,334	$1,425	$1,480	$1,516	$1,644	$1,790
$10,000	$1,315	$1,407	$1,462	$1,498	$1,626	$1,772
$15,000	$1,297	$1,389	$1,443	$1,480	$1,608	$1,754
$20,000	$1,279	$1,370	$1,425	$1,462	$1,589	$1,736
$25,000	$1,261	$1,352	$1,407	$1,443	$1,571	$1,717
			Third Year Claims Made			
$0	$1,496	$1,596	$1,656	$1,695	$1,835	$1,995
$5,000	$1,456	$1,556	$1,616	$1,656	$1,795	$1,955
$10,000	$1,436	$1,536	$1,596	$1,636	$1,775	$1,935
$15,000	$1,416	$1,516	$1,576	$1,616	$1,755	$1,915
$20,000	$1,396	$1,496	$1,556	$1,596	$1,735	$1,895
$25,000	$1,376	$1,476	$1,536	$1,576	$1,715	$1,875
			Fourth Year Claims Made			
$0	$1,544	$1,647	$1,709	$1,750	$1,894	$2,059
$5,000	$1,503	$1,606	$1,668	$1,709	$1,853	$2,018
$10,000	$1,482	$1,585	$1,647	$1,688	$1,832	$1,997
$15,000	$1,462	$1,565	$1,626	$1,668	$1,812	$1,976
$20,000	$1,441	$1,544	$1,606	$1,647	$1,791	$1,956
$25,000	$1,421	$1,524	$1,585	$1,626	$1,771	$1,935
			Mature Claims Made			
$0	$1,544	$1,647	$1,709	$1,750	$1,894	$2,059
$5,000	$1,503	$1,606	$1,668	$1,709	$1,853	$2,018
$10,000	$1,482	$1,585	$1,647	$1,688	$1,832	$1,997
$15,000	$1,462	$1,565	$1,626	$1,668	$1,812	$1,976
$20,000	$1,441	$1,544	$1,606	$1,647	$1,791	$1,956
$25,000	$1,421	$1,524	$1,585	$1,626	$1,771	$1,935

Texas Medical Liability Insurance Underwriting Association
Claims Made Reporting Endorsement Coverage Rates
Tier IV
For-Profit Nursing Homes

Deductible	Limit of Liability (in Thousands of Dollars) 100/300	200/600	250/750	300/900	500/1,500	1,000/3,000
			First Year Claims Made			
$0	$1,558	$1,662	$1,724	$1,765	$1,911	$2,077
$5,000	$1,516	$1,620	$1,682	$1,724	$1,869	$2,035
$10,000	$1,495	$1,599	$1,662	$1,703	$1,848	$2,015
$15,000	$1,475	$1,578	$1,641	$1,682	$1,828	$1,994
$20,000	$1,454	$1,558	$1,620	$1,662	$1,807	$1,973
$25,000	$1,433	$1,537	$1,599	$1,641	$1,786	$1,952
			Second Year Claims Made			
$0	$2,101	$2,241	$2,325	$2,381	$2,577	$2,801
$5,000	$2,045	$2,185	$2,269	$2,325	$2,521	$2,745
$10,000	$2,017	$2,157	$2,241	$2,297	$2,493	$2,717
$15,000	$1,989	$2,129	$2,213	$2,269	$2,465	$2,689
$20,000	$1,961	$2,101	$2,185	$2,241	$2,437	$2,661
$25,000	$1,933	$2,073	$2,157	$2,213	$2,409	$2,633
			Third Year Claims Made			
$0	$2,294	$2,447	$2,538	$2,600	$2,814	$3,058
$5,000	$2,233	$2,386	$2,477	$2,538	$2,753	$2,997
$10,000	$2,202	$2,355	$2,447	$2,508	$2,722	$2,967
$15,000	$2,171	$2,324	$2,416	$2,477	$2,691	$2,936
$20,000	$2,141	$2,294	$2,386	$2,447	$2,661	$2,905
$25,000	$2,110	$2,263	$2,355	$2,416	$2,630	$2,875
			Fourth Year Claims Made			
$0	$2,368	$2,526	$2,620	$2,683	$2,904	$3,157
$5,000	$2,305	$2,462	$2,557	$2,620	$2,841	$3,094
$10,000	$2,273	$2,431	$2,526	$2,589	$2,810	$3,062
$15,000	$2,241	$2,399	$2,494	$2,557	$2,778	$3,031
$20,000	$2,210	$2,368	$2,462	$2,526	$2,746	$2,999
$25,000	$2,178	$2,336	$2,431	$2,494	$2,715	$2,967
			Mature Claims Made			
$0	$2,368	$2,526	$2,620	$2,683	$2,904	$3,157
$5,000	$2,305	$2,462	$2,557	$2,620	$2,841	$3,094
$10,000	$2,273	$2,431	$2,526	$2,589	$2,810	$3,062
$15,000	$2,241	$2,399	$2,494	$2,557	$2,778	$3,031
$20,000	$2,210	$2,368	$2,462	$2,526	$2,746	$2,999
$25,000	$2,178	$2,336	$2,431	$2,494	$2,715	$2,967

Texas Medical Liability Insurance Underwriting Association
Claims Made Reporting Endorsement Coverage Rates
Tier V
For-Profit Nursing Homes

Deductible	Limit of Liability (in Thousands of Dollars) 100/300	200/600	250/750	300/900	500/1,500	1,000/3,000
			First Year Claims Made			
$0	$2,235	$2,384	$2,473	$2,533	$2,742	$2,980
$5,000	$2,175	$2,324	$2,414	$2,473	$2,682	$2,920
$10,000	$2,146	$2,295	$2,384	$2,444	$2,652	$2,891
$15,000	$2,116	$2,265	$2,354	$2,414	$2,622	$2,861
$20,000	$2,086	$2,235	$2,324	$2,384	$2,593	$2,831
$25,000	$2,056	$2,205	$2,295	$2,354	$2,563	$2,801
			Second Year Claims Made			
$0	$3,015	$3,216	$3,336	$3,416	$3,698	$4,019
$5,000	$2,934	$3,135	$3,256	$3,336	$3,617	$3,939
$10,000	$2,894	$3,095	$3,216	$3,296	$3,577	$3,899
$15,000	$2,854	$3,055	$3,175	$3,256	$3,537	$3,859
$20,000	$2,814	$3,015	$3,135	$3,216	$3,497	$3,818
$25,000	$2,773	$2,974	$3,095	$3,175	$3,457	$3,778
			Third Year Claims Made			
$0	$3,291	$3,510	$3,642	$3,730	$4,037	$4,388
$5,000	$3,203	$3,423	$3,554	$3,642	$3,949	$4,300
$10,000	$3,159	$3,379	$3,510	$3,598	$3,905	$4,256
$15,000	$3,116	$3,335	$3,467	$3,554	$3,862	$4,213
$20,000	$3,072	$3,291	$3,423	$3,510	$3,818	$4,169
$25,000	$3,028	$3,247	$3,379	$3,467	$3,774	$4,125
			Fourth Year Claims Made			
$0	$3,397	$3,624	$3,759	$3,850	$4,167	$4,529
$5,000	$3,306	$3,533	$3,669	$3,759	$4,077	$4,439
$10,000	$3,261	$3,488	$3,624	$3,714	$4,031	$4,394
$15,000	$3,216	$3,442	$3,578	$3,669	$3,986	$4,348
$20,000	$3,171	$3,397	$3,533	$3,624	$3,941	$4,303
$25,000	$3,125	$3,352	$3,488	$3,578	$3,895	$4,258
			Mature Claims Made			
$0	$3,397	$3,624	$3,759	$3,850	$4,167	$4,529
$5,000	$3,306	$3,533	$3,669	$3,759	$4,077	$4,439
$10,000	$3,261	$3,488	$3,624	$3,714	$4,031	$4,394
$15,000	$3,216	$3,442	$3,578	$3,669	$3,986	$4,348
$20,000	$3,171	$3,397	$3,533	$3,624	$3,941	$4,303
$25,000	$3,125	$3,352	$3,488	$3,578	$3,895	$4,258

E. NURSING HOMES: NOT-FOR-PROFIT

RATES

The Coverage Rates and the Reporting Endorsement Coverage Rates appearing in Section D. of this manual for For-Profit Nursing Homes shall be reduced thirty percent (30%) for eligible Not-For-Profit Nursing Homes.

ASSISTED LIVING FACILITIES

F. CLASSIFICATIONS

	Code Number	Territories
Governmental	99430	Entire State
For-Profit	99431	Entire State
Not-For-Profit	99432	Entire State

G. DEFINITIONS

ASSISTED LIVING FACILITY

A facility providing personal care services other than acute, skilled or semi-skilled care and as defined by §247.002 of the Health and Safety code.

Not-for-Profit Assisted Living Facility. An Assisted Living Facility, no part of whose net earnings inures to the benefit of any private individual or entity. The term not-for-profit includes governmental facilities.

H. TEXAS JUA TIER RATING, ASSISTED LIVING FACILITIES

ALL RULES IN THIS MANUAL APPLY TO ASSISTED LIVING FACILITIES EXCEPT THAT PORTION OF RULE C. WHICH PERTAINS TO THE DEVELOPMENT OF RATING POINTS USED IN DETERMINING RATING TIERS. THIS PORTION OF RULE C. SHALL BE DISREGARDED.

RATES

Only Tier I rates appearing in this manual for primary claims made coverage, including claims made reporting endorsement coverage rates, shall be used in the rating of assisted living facilities.

I. No JUA insured shall be eligible for consecutive first year claims made rating unless an extended reporting period endorsement (tail coverage) was purchased on the previously held JUA policy.

APPENDIX D: REGULATION AND QUALITY OF CARE

Recommendations to Promote High-Quality Care for Residents of Texas Nursing Facilities

As Required by House Bill 2292, 78th Legislature

Report to the 79th Texas Legislature

October 1, 2004

INTRODUCTION and BACKGROUND

Legislative Mandate

The Nursing Facility Quality Assurance Team (NFQAT) was established by HB 2292, 78th Legislature and charged with 1) developing and recommending clearly defined minimum standards to be considered for inclusion in contracts between the Texas Department of Human Services (DHS) and nursing facilities (NFs), and 2) developing and recommending improvements to consumers' access to information regarding quality of care in NFs. The latter charge was to include types and amounts of information available, DHS data systems of NF inspection/survey data, and other NF quality-of-care data.

The NFQAT was also to consider Texas Department of Insurance (TDI) risk factors contributing to NF lawsuits. This charge included considering the practices TDI recommends NFs adopt to reduce lawsuits, as well as other standards to improve quality of care. The NFQAT was to develop a minimum number of critical standards needed to identify NFs with poor quality services that should not be awarded contracts. Together with DHS, the NFQAT was to assess potential financial impact of these standards to providers as well as the fiscal impact to the State.

Recommendations contained in this report are designed to ensure care provided by NFs to residents meets or exceeds minimum acceptable standards of care and encourages the highest quality of care.

Charge deliverables included:

1) Developing and making recommendations required by Section 32.060k, Human Resources Code, **not later than May 1, 2004***; and
2) Reporting on its work and recommendations to the Governor and the Legislative Budget Board no later than October 1, 2004, for consideration by the 79th Legislature.

* Governor's Office appointments were not completed until the last week of April 2004. (All appointments were to be made in January; a final, ninth member was appointed in late May but was not able to participate.)

CONTRACT RECOMMENDATIONS: Additional Contract Standards

Recommendation #1

Require facility to document participation in a formal quality assessment, assurance and improvement program with measurable and sustainable outcomes as a condition for Medicaid contract renewal.

Discussion:

- Facility staff, residents and family members are encouraged to participate in identifying quality improvement goals.

- Each facility will have access to a provider letter that provides guidance on what constitutes a *meaningful* quality improvement process. To have a *meaningful* quality improvement process, a facility must demonstrate the presence of the following components or processes:

  1. **Use rational process for choosing goals.**
     - Identify quality concerns related to facility operations and practices, not only those that can cause negative outcomes, but also those that enhance quality of care and quality of life for residents.
     - Identify at least one area for action in the coming 24 months.
     - Seek input/involvement from the local ombudsman program.

  2. **Develop action plans.**
     When a quality deficiency or opportunity for improvement is identified, the facility should use a systematic process to develop and implement an action plan similar to the following:
     - Identify the problem and root cause(s), (e.g., What is the problem? How extensive is it? What caused it?);
     - Determine the sources of information, (e.g., medical records, facility departments);
     - If necessary, designate a task force or ad hoc committee;
     - Determine disciplines to be involved based on the nature and cause of the problem and on professional expertise and responsibilities;
     - Identify a proven care process/approach;
     - Develop a written plan specifying the tools, approaches, and evaluation of outcomes;
     - Determine goals and timelines;
     - Set timelines for completion of tasks;
     - Review existing policies and procedures; compare to evidence-based and reliable consensus-based approaches such as those in references and web sites;
     - Review literature and consult the medical director and other experts, (e.g., nurse consultant, consultant pharmacist); and

- When an opportunity for improvement is identified, identify the extent of the problem, which may include the number of residents, units, and departments/professionals involved.

3. **Implement action plans.**
   - Create a team to provide leadership.
   - Develop a statement about the team's understanding of the scope, the root cause of the problem, and the plan.
   - Provide education and in-services on the defined topic.
   - If leadership fails to implement the Quality Assessment and Assurance (QA&A) initiatives for which they were responsible, or if the initiatives are not effective (do not meet measurable goals), the administrator or designated supervisor reevaluates the approach and implementation and recommends changes.

4. **Monitor and evaluate.**
   - Data Collection/Measurability: Collect and analyze data to be reviewed at the quarterly QA&A meeting. Revise interventions as needed if goals are not being met.
   - The facility's QA&A program includes methods for monitoring and evaluating the successful implementation of quality processes and practices. There must be evidence that the facility's QA&A plans, strategies, and goals are reflected in the provision of aspects of care, as identified through facility policies and procedures, staff interviews, resident interviews, and other sources of information. The facility should demonstrate that it reviews its plans or strategies and revises them as necessary when desired outcomes are not achieved.
   - Can the direct care staff, particularly Certified Nurse Aides (CNAs), identify the goals of the QA&A initiatives and key elements of the implementation strategy?
   - Is there evidence that the facility is sustaining the progress on the indicator/measure?

- There must be quantifiable evidence that the facility has made measurable improvement in achieving the specified goal for a quality initiative over a 24-month period (or a span of two standard annual surveys). Progress reports shall be posted prominently in the facility. Evidence must be collected and analyzed at least quarterly at the Facility Quality Assurance Meeting.

- Examples of programs which would meet these requirements include the following:
  1. Quality First, or
  2. Texas Medical Foundation Quality Initiatives, or
  3. Implementation of at least two American Medical Directors Association (AMDA) Clinical Practice guidelines appropriate to the identified need of the facility, per the QA&A process, or
  4. Implementation of a quality risk management plan as developed by the Texas Department of Insurance, or
  5. Participation in the Quality Monitoring initiative.

Current Quality Monitoring Program Initiatives:

1. Restraint elimination
2. Effective use of toileting for continence promotion
3. Appropriate indications for indwelling bladder catheters
4. Improving Influenza vaccination rates among residents and staff
5. Improving Pneumococcal vaccination rate among residents
6. Managing fall risk
7. Improving pain assessment (validity and frequency)
8. Improving pain treatment (appropriate use of World Health Organization pain ladder recommendations)
9. Appropriate indications for and clinical monitoring of antipsychotic therapy
10. Appropriate indications for and clinical monitoring of anxiolytic therapy
11. Appropriate use of sleep hygiene measures and duration of hypnotic use
12. Medication regimen simplification
13. Improving hydration risk assessment and hydration practices
14. Improving detection of and intervention for unintended weight loss
15. Improving indications for artificial nutrition and hydration
16. Improving the Advance Care Planning process (Advance Directives)

- If at the time of the next survey, the facility has not shown compliance with its QA&A plan, it has a period of 180 days to cure the compliance failure prior to initiation of contract termination.

Recommendation #2

- Terminate the provider agreement for any facility demonstrating a history of poor quality of care for two-out-of-three years. Prohibit these licensees from obtaining a Medicaid contract for this facility for a set time.

- DADS should ensure that any sale of the facility under this recommendation should not be to the parties controlling the facility at the time of Medicaid contract termination.

Discussion:

- A history of poor quality of care is defined as deficiencies related to CFR 483.13, 483.15, and 483.25 at Level H or above in two-out-of-three years.

Illustration of Patterns of Repeat Offender That Would Be Barred			
Year 1	**Year 2**	**Year 3**	**Decision**
Poor Quality of Care	**Poor Quality of Care**	**No contract**	
Poor Quality of Care		**Poor Quality of Care**	**No contract**
	Poor Quality of Care	**Poor Quality of Care**	**No contract**

- A long-term care facility classified as a *"historically poor quality-of-care facility"* or *"repeat offender"* for two-out-of-three consecutive years shall not be granted a new provider agreement.

- The determination of history of quality of care for this contract provision shall begin with a new provider's first year of control at a facility.

Projected Impact:

Had the above criterion been applied to the most recent three years of regulatory compliance history, 17 facilities would have had their Medicaid contracts terminated for *poor quality of care*. This standard would have required a change of ownership for these facilities to continue operating as certified facilities and/or relocating their residents, an estimated 1200 persons.

Rationale for Performance Criterion for Facilities with a History of Poor Quality of Care:

In a 1999 report, the General Accounting Office (GAO) [now known as the U.S. Government Accountability Office, also GAO], noted that "one in four of the nation's nursing homes had deficiencies so serious that they harmed residents or placed them at serious risk of death or injury." Of those facilities cited for serious deficiencies, 40 % were cited for repeat deficiencies. Thus, a total of 10 % of all certified facilities had deficiencies that actually harmed residents or placed them at serious risk of death or injury *and* had repeat deficiencies. GAO also reviewed the deficiency citations of these facilities and found that "[m]ost of the repeat violators were cited for the same deficiency, and about one-third were cited for closely related problems."

Moreover, using the Centers for Medicare & Medicaid Services (CMS) definition of "poor performing homes," GAO found that "[t]wo-thirds of the poor-performing nursing homes GAO surveyed had repeated violations." Despite this fact, these poor performing facilities remained licensed and certified to participate in Medicare or Medicaid.[10] Indeed, in several earlier reports for the U.S. Senate Special Committee on Aging, GAO criticized state and federal regulatory approaches because they had allowed facilities to continue participating in Medicare and Medicaid despite "yo-yo" patterns of compliance. This pattern is described as one in which a facility comes into compliance long enough to get a new provider agreement but then returns to a pattern of substandard care and significant deficiencies, year after year.[10, 11]

Thus, the issue of poor performing facilities, particularly those with a pattern of repeated deficiencies and poor performance, has been and remains an issue of great concern to the GAO and to Congress, as well as to others interested in improving nursing home quality.[9] This group includes the National Academy of Sciences; Institute of Medicine (IOM), in its recommendations on improving nursing home quality (IOM, 1986); consumer advocacy groups, such as the National Citizens Coalition for Nursing Home Reform (NCCNHR), and the Consumers Union, which publishes a Nursing Home Watch List that identifies "repeat offenders; and researchers concerned with the quality of nursing home care.[1, 3, 4, 5, 6, 7, 8] State survey directors and CMS have also expressed growing concern about how to enhance enforcement and address problems identified with the pattern of "yo-yo" compliance.[2]

Several state survey agency directors noted the difficulty of dealing with facilities with a "yo-yo" pattern of enforcement, even when those facilities have a long history of providing very poor care (Carman, Hawes and Phillips, personal communication, 2004). Data from CMS and the states bears that out. Between 1992 and 2000, a total of only 2.4% of all facilities participating in Medicare and Medicaid were involuntarily terminated from provider participation (Angelelli, Mor, Intrator, Fen & Zinn, 2003).

Recommendation #3

Require that each facility in the bottom 10% for case-mix adjusted nurse staffing, and that is not spending 100% of the direct-care component of the nursing home rate, develop a quality improvement initiative aimed at improving its staffing levels in terms of licensed nursing staff and certified nursing assistants.

- Each such facility shall report quarterly on its progress regarding staffing improvement initiatives until its case-mix-adjusted staffing rate rises above the bottom 10th percentile.

- Unless a facility exceeds the lowest 10th percentile within 12 months of being determined below this threshold, or can demonstrate it is making progress and no residents have been harmed or are at risk because of inadequate quality of care, *its provider contract shall be terminated*.

- There will be a review of progress at nine months with a final warning letter if there is no quantifiable evidence that the facility has made measurable improvement in achieving the specified goal of rising above the 10% threshold.

Discussion:

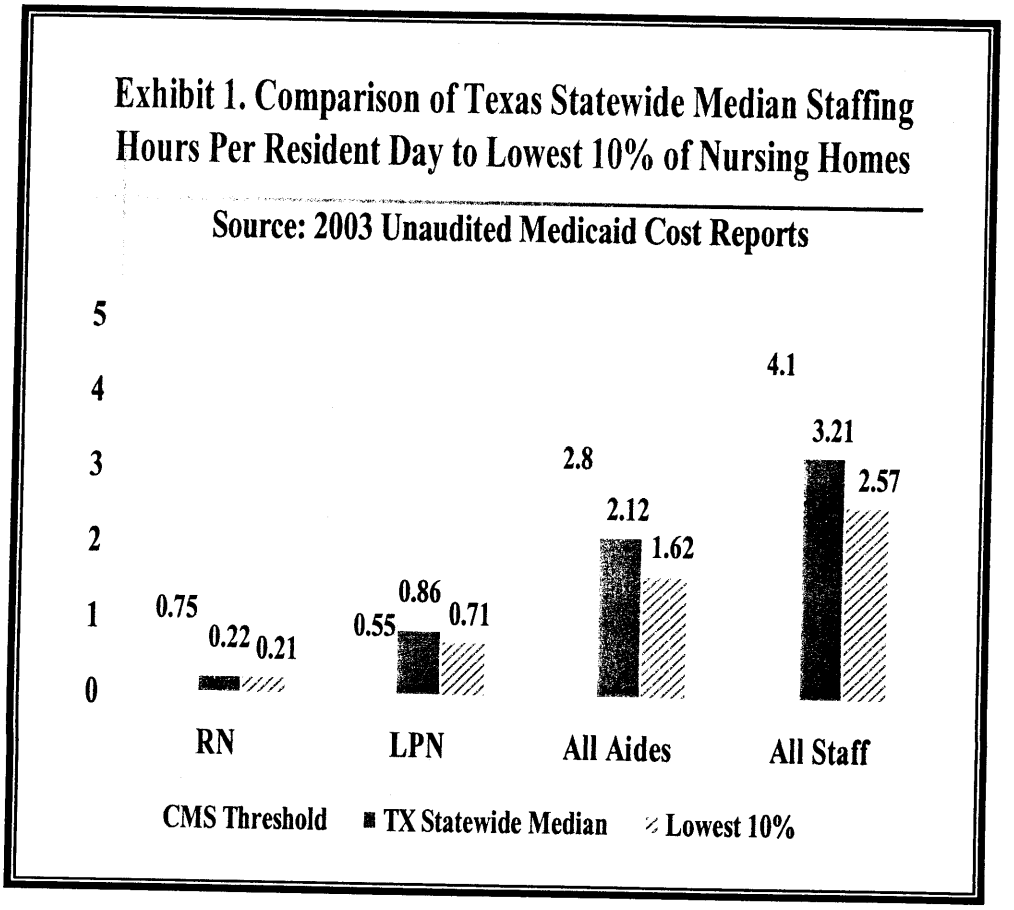
There is widespread agreement that nurse staffing levels are related to nursing home quality. This agreement is based on expert opinion and qualitative and quantitative research findings. As a result, several groups and organizations have made recommendations recently about increasing nurse staffing levels in nursing homes, including the National Academy of Sciences, the National Citizens Coalition for Nursing Home Reform (NCCNHR), and a symposium of experts convened by the Hartford Institute for Geriatric Nursing. [5, 8, 20, 21]

RN Staffing. The most persuasive support for the relationship between staffing and quality comes from a plethora of studies over the last 25 years that have categorically demonstrated the positive relationship between Registered Nurse (RN) staffing and improved quality. [1, 2, 3, 4, 6, 7, 9, 12, 13, 14,15, 16,17, 18, 19, 20, 21] These studies have found a wide range of benefits from higher levels of RN staffing in nursing homes, including lower mortality rates and reduced morbidity. Indeed, higher levels of RN staffing were associated with better process quality *and* better resident outcomes, such as improved physical functioning, lower prevalence of pressure ulcers, lower rates of indwelling catheter use, fewer urinary tract infections, lower rates of dehydration and unintended weight loss, and lower rates of hospital use.

CNA Staffing. Research also indicated that higher levels of CNA staffing are associated with better quality. [6, 17] In one study, lower levels of staffing were associated with higher rates of urinary catheter use, lower rates of skin care, and lower resident participation in activities. In

other studies, lower staffing levels were associated with poor care practices, including inadequate assistance with eating during meals, poor skin care, lower activity participation, less toileting assistance, higher rates of quality-of-life deficiencies, and higher rates of total deficiencies. [6, 10, 11, 16, 17] Research also suggests that low CNA staffing (and poor staff training) are major factors in abuse and neglect of residents.[8]

Staffing Threshold. What has been unknown is the threshold at which additional staffing does not necessarily produce improvements in quality. However, CMS recently completed a two-phase study that addressed this issue. What the study and its many component parts found was that quality improved as the staffing levels in facilities increased up to the threshold levels shown below, with no measurable increase in quality as staffing rose above those levels. [18]



The thresholds established by the CMS study are 0.75 RN hours per resident day, 0.55 LPN/LVN hours per resident day, and 2.8 CNA hours, as shown in Exhibit 1. Median staffing levels for Texas facilities and staffing levels for the Texas facilities in the lowest 10 % of total nursing staff are also displayed in Exhibit 1. Exhibit 2 provides greater detail, comparing the Texas statewide average staffing levels with those in facilities in the lowest decile (bottom 10%) for RN staffing, CNA staffing, and total nursing staff.[1]

[1] The NFQAT gratefully acknowledges the assistance of Dr. Leslie Cortes of the Texas Department of Aging and Disability Services for his work in producing these data and for other staff in the Texas Health and Human Services Commission for verifying the accuracy of our estimates.

These exhibits show significant differences in staffing levels of the average nursing home and of those in the lowest tenth of all Texas facilities.

- In 2003, the total nurse and aide (all staff) staffing level in the median Texas nursing home was 0.64 hours per-resident, per-day, (or 25%) *higher* than comparable staff hours in the average facility in the bottom 10% of all Texas nursing homes.

- In 2003, the total *aide* staffing level in the median Texas nursing home was 0.5 hours per-resident, per-day, or 31% *higher* than aide staffing in the average facility in the bottom 10% of all Texas nursing homes.

Exhibit 2. *Revised* Staffing Level of Hours per- Resident/Day (HPRD) – Based on Facility Reports in 2002 Audited and 2003 Unaudited Medicaid Cost Reports

	RN	LVN	MA	RA	CNA	All Aides	All Staff
Statewide							
Average – 2002	0.25	0.86	.017	0.04	1.91	2.12	3.23
Median – 2002	0.23	0.85	.015	0.00	1.89	2.07	3.18
Average – 2003	0.24	0.86	0.20	0.05	1.92	2.17	3.28
Median – 2003	0.22	0.86	0.19	0.01	1.89	2.12	3.21
10% with lowest combined staffing							
Median – 2002	0.20	0.72	0.14	0.00	1.41	1.56	2.53
Median – 2003	0.21	0.71	0.14	0.0	1.46	1.62	2.57
10% with lowest RN staffing							
Median – 2002	0.11	0.89	0.17	0.01	1.90	2.11	3.10
Median – 2003	0.11	0.92	0.22	0.06	1.85	2.10	3.14
10% w/ lowest staffing for all aides							
Median – 2002	0.26	0.84	0.05	0.00	1.37	1.52	2.60
Median – 2003	0.24	0.84	0.06	0.00	1.42	1.57	2.66

All staff (Medicaid contracted and non-contracted beds; permanent and contract staff; RN hours include DON hours)
MA = Medication Aide; RA = Restorative Aide; All Aides = MA + RA + CNA hours per resident day

The relationship between staffing levels and quality of care has been illustrated in research, literature, and practice. Increasing staff levels for both licensed nurses and nurse aides in facilities currently ranked in the bottom 10% of Exhibit 2 will help assure a higher level of care.

RECOMMENDATIONS—Consumer Access

1. Improve public awareness of Quality Reporting System.

- Reach out to surrogate decision-makers or those who assist them, such as primary care physicians (and/or their offices), ombudsmen and hospital discharge planners.
- Conduct a widespread consumer education campaign, e.g., "Planning for Your Future."
- Require the caseworker who determines eligibility for Medicaid and nursing home level of care to give the consumer and/or family a brochure on how to select a nursing home and how to access QRS.
- Explore other mechanisms, (e.g., senior citizen groups), or methods (e.g., distribution of brochures in hospitals, physician offices or senior centers), for publicizing information about how to select a nursing home.
- Develop an annual public awareness campaign using radio, television, and billboards to publicize resources for consumers.

2. Improve access to QRS from other DADS web pages.

- Create a direct link from the DADS home page, marked by a prominent icon, to QRS.
- Increase consumer awareness of how to choose a nursing home and access other available resources; include a method of evaluating the campaign for effectiveness.
- Provide a section on how to navigate the long-term care process in all DADS publications, and list the two web sites—CMS (Nursing Home Compare) and QRS.

3. Increase consumer confidence in understanding and navigation of QRS.

- In the QRS NF Profile pages, change "dual certification" to "Medicare/Medicaid beds," and the glossary (g) icon to "Read More."
- Indicate Deficiency Severity using text and a color code for harm levels: levels one and two, *green*; level three, *yellow*; level four (IJ), *red*.
- Bold the entire last sentence in the QRS yellow Caution Box to stress the importance of visiting the nursing facility.
- In the QRS NF Profile pages, provide a link to Nursing Home Compare.
- Add a bar graph comparison showing facility percentile for staffing and case mix.
- Provide a list of questions concerning staffing that consumers should ask.

- Add the AAA Ombudsmen 1-800-252-2412 to the Caution Box on the QRS web site.
- Create a link at the QRS homepage that points to the DADS web page and gives alternatives to nursing homes.
- In the QRS NF Profile pages, include the number of complaints, number of allegations, and number of substantiated allegations by calendar year for three years.

4. **Evaluate usability of QRS web site and validity of Quality Indicators.**

- Have a Usability Expert conduct a formal evaluation of the QRS web site after all the DHS web sites have been converted successfully to DADS.
- Contract with a third party to evaluate the validity of the Quality Indicators (QIs).

Current Consumer Access initiatives:

The Texas QRS system as it currently exists has many positive qualities. It is superior, in many professionals' view, to the CMS website. Issues of note are echoed in the Castle and Lowe manuscript: Castle, N.G. and Lowe, T. 2004. "Report cards and nursing homes." *The Gerontologist*, (in press). QRS is effective because it:

- Allows consumers to compare multiple facilities and provides useful benchmarks in a geographic area (e.g., comparative performance for all NFs in a given zip code – which is how consumers typically shop – that is, in a given location);
- Is accessible to consumers through the Texas Department of Aging and Disability Services (DADS) web site (and fairly easily through the State of Texas homepage); it also provides access to guides on how to select a nursing home;
- Includes a wide diversity of QIs. This is important since quality is a multidimensional concept, and different consumers have different values and preferences;
- Uses QI data collected each quarter, which dramatically improves timeliness; and
- Cautions users on the limitations of the QIs.

As Castle and Lowe note, only three states (MD, OH, and TX) "attempted to help consumers understand how and why to use quality information."

ADDITIONAL LEGISLATIVE and ADMINISTRATIVE RECOMMENDATIONS

1. Require all licensed facilities to transmit Minimum Data Set (MDS) resident assessments on all residents, not just those in Medicare/Medicaid beds. This requirement would provide a better representation of the status of Texas facilities and a larger denominator in the Quality Indicators/Quality Measures reports for facilities with only a few certified beds. States can opt to make this requirement.

2. Require RN staffing to be 16 hours a day.

3. Appropriate sufficient funding for DADS to examine owner history and comply with legislative mandates regarding assessment of licensure applications related to financial viability and history of care.

4. Examine history of care for owners, and encourage DADS to apply best practices gleaned from other states.

5. Request that the legislature identify factors that may help attract and retain good nursing home providers/owners.

6. Track feeding assistant hours and wages as a separate line item on cost reports.

7. Establish a requirement that providers spend no less than 85% of the nursing home rate component for direct care on allowable direct care expenses – independent of participation in the staffing enhancement program.

8. Retire each expiring Medicaid contract on its anniversary and replace it with a new contract that incorporates the newly defined minimum standards.

ADDITIONAL ISSUES to STUDY

The NFQAT also identified the following issues as important to a discussion of the charge, but there was not sufficient time or resources to develop them:

1. Overall Funding Issues
2. Direct-Care Salaries
3. Career Ladders
4. Facility Financial Viability.

NFQAT recommendations address the charge of developing additional contract standards for the purpose of improving quality. It is clear that inadequate staffing is associated with poor quality. While the recommended contract standards will ensure that direct care funds are spent on direct care, these standards do not ensure that direct care funding will be sufficient to ensure the level of staffing that will lead to improved resident care.

That providers are committed to improving staffing is demonstrated by the fact that 85% of providers participate in the state's staffing enhancement program. However, that program does not have the funding required to meet provider's existing requests for additional staffing. The NFQAT recommends the State address the existing gap in direct care funding so recommended contract standards can have the desired effect.

LITERATURE CITED on POOR QUALITY of CARE—Recommendation #2

1. Consumers Union (2001). *Consumer Reports Complete Guide to Health Services for Senior.* See also www.consumers.org.

2. Dunbar, D. & Sandlin, J. (2004, April). Barriers to effective enforcement. A paper presented at the 2004 CMS Leadership Summit. Washington, DC: US Department of Health and Human Services, Centers for Medicare & Medicaid Services.

3. Edelman, T. (1997). An Unpromising Picture: Implementation of Reform Law's Enforcement Provisions Troubles Advocates. *Quality Care Advocate.* March.

4. Edelman, T. (1998). What Happened to Enforcement? *Nursing Home Law Letter.* 1-2:1-46.

5. Edelman, T. (1997-98, Winter). The politics of long-term care at the federal level and implications for quality. Generations, 21 (4), 37-41.

6. Harrington, C. & Carillo, H. (1999). The regulation and enforcement of federal nursing home standards. *Medical Care Research and Review 56*: 471-494.

7. Hawes, C. (1997-98). Regulation and the politics of long-term care. *Generations* 21(4): 5-9.

8. Institute of Medicine. (1986). *Improving The Quality of Care In Nursing Homes.* Washington, DC: National Academy of Sciences Press.

9. US Office of the Inspector General (1999). *Nursing Home Survey and Certification: Deficiencies Trends.* Washington, DC: DHHS-OIG (OEI-02-98-00331).

10. United States General Accounting Office (1999). *Nursing Homes: Proposal To Enhance Oversight of Poorly Performing Homes Has Merit.* Washington, DC: GAO HEHS-99-157, June 30, 1999.

11. United States General Accounting Office (1999). *Nursing Homes: Additional Steps needed to Strengthen Enforcement of Federal Quality Standards.* Report to the Special Committee on Aging, U.S. Senate. GAO/HEHS-99-46. Washington, DC: U.S. General Accounting Office.

12. Carman, K., Hawes, C. & Phillips, C. (2004). Personal communication from researchers who interviewed state survey agency staff for a CMS project on The Effectiveness of Enforcement. Washington, DC: AIR, Inc.

13. Angelelli, J., Mor, V., Intrator, O., Fen, Z. & Zinn, J. (2003). Oversight of nursing homes: pruning the tree or just spotting bad apples? *Gerontologist* Apr; 43 Special Issue No. 2: 67-75.

LITERATURE CITED on STAFFING—Recommendation #3

1. Aaronson, WE, Zinn JS & Rosko, MD (1994). Do for-profit and not-for-profit nursing homes behave differently? *Gerontologist 34*(6): 775-886.

2. Bliesmer, M.M., Smayling, M., Kane, R.L., & Shannon, I. (1998). The relationship between nursing staffing levels and nursing home outcomes. *Journal on Aging and Health, 10* (3), 351-371.

3. Cherry, RI (1991). Agents of nursing home quality of care: ombudsmen and staff revisited. *Gerontologist June: 31*(3): 302-308.

4. Cohen, JW and Spector, WD (1996). The effect of Medicaid reimbursement on quality of care in nursing homes. *Journal of Health Economics Feb:15*(1) 23-48.

5. Harrington, C., Kovner, C., Mezey, M., Kayser-Jones, J., Burger, S., Mohler, M., Burke, B., and Zimmerman, D. (2000). Experts recommend minimum nurse staffing standards for nursing facilities in the U.S. *The Gerontologist 40*(1):5-16.

6. Harrington, C., Zimmerman, D., Karon, S.L., Robinson, J. and Beutel, P. (2000). Nursing home staffing and its relationship to deficiencies. *Journal of Gerontology: Social Sciences 55B*: (5): S278-S287.

7. Harrington, C. and Swan, J.H. (2003). Nursing home staffing, turnover, and casemix. *Medical Care Research and Review 60* (2):366-392.

8. Hawes, C, Blevins D, Shanley, L (2001). *Preventing Abuse and Neglect of Nursing Home Residents: The Role of the Nurse Aide Registries*. Final report to the Centers for Medicare & Medicaid Services. College Station, TX: School of Rural Public Health, Program on Aging and Long-Term Care Policy.

9. Institute of Medicine (1986). *Improving the Quality of Care in Nursing Homes*. Washington, DC: National Academy Press.

10. Kayser-Jones, J. (1997). Inadequate staffing at mealtime: implications for nursing and health policy. *Journal of Gerontological Nursing* Aug; 23(8); 14-21. See also, Kayser-Jones J & Schell E. (1997). The effect of staffing on the quality of care at mealtime. *Nursing Outlook* Mar-Apr; 45(2): 64-72.

11. Kayser-Jones, J, Schell, ES, Porter, C, Barbaccia, JC, Shaw H. (1999). Factors contributing to dehydration in nursing homes: inadequate staffing and lack of professional supervision. *Journal of the American Geriatrics Society* Oct; 47(10): 1187-94.

12. Linn, MW, Gurel, L, & Linn, BS (1977). Patient outcomes as a measure of quality of nursing home care. *American Journal of Public Health* Apr:67(4): 37-44.

13. Munroe, DJ (1990). The influence of registered nurse staffing on the quality of nursing home care. Res Nursing Health Aug:13(4): 263-270.

14. Nyman, J.A. (1988). Improving the Quality of Nursing Home Outcomes: Are Adequacy- or Incentive-Oriented Policies More Effective. *Medical Care*. 26 (12):1158-1171.

15. Ohio General Assembly Nursing Home Commission (1978). *A Program in Crisis: An Interim Report*. Columbus, OH.

16. Schnelle, J.F., Simmons S.F., Harrington, C., Cadogan, M., Garcia, E., and Bates-Jensen, B. (2004). Relationship of nursing home staffing to quality of care? *Health Services Research 39* (2):225-250.

17. Spector, WD & Takada, HA (1991). Characteristics of nursing homes that affect resident outcomes. *Journal of Aging and Health* Nov;3(4): 427-454.

18. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (2001). Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Phase II Report. Baltimore, MD: Report to Congress (December 2001).

19. Virginia Joint Legislative Audit and Review Commission (1978). *Long-Term Care in Virginia*. Richmond, VA.

20. Wunderlich, GS, Sloan, F. & Davis, CK, Eds. (1996). Nursing Staff in Hospitals and Nursing Homes: Is It Adequate? Washington, DC: National Academy Press.

21. Wunderlich, G.S. and Kohler, P., Eds., Institute of Medicine (IOM). 2000. *Improving the Quality of Long-Term Care*. Washington, DC: National Academy Press.

We, the undersigned members of the Governor's **Nursing Facility Quality Assurance Team**, offer the recommendations in this report for consideration by the 79th Texas Legislature.

Judy Mosley Day — 10-01-04

Judy Mosley Day, Chair
President, Mary E. Bivins Foundation

Kendra Belfi — 10-1-04

Kendra Jensen Belfi, M.D., CMD, FACP

Date

Cindy Norgan — 10-1-04

Cindy Norgan, RN, MSN
Clinical Services Consultant
HCR-ManorCare

Date

Ramona Kennedy — 10-1-04

Ramona Dover Kennedy
Nursing Facility Administrators Advisory Committee

Date

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Professor of Health Policy and Management,
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Chief Executive
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Date

Victoria Gradel-Madrigal — 10/1/04

Victoria Gradel-Madrigal
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Date

Charles E. Miller MD — 01 Oct 04

Charles E. Miller, M.D., CMD
President, Texas Medical Directors Association.
Member, Geriatrics Associates of America

Date

A

1999 STATISTICAL REPORT SUMMARY
of
Eden Alternative® Outcomes in Texas

The Texas Long Term Care Institute (Institute) conducted a two-year study (1996 - 1998) on quality outcomes in nursing homes adopting the Eden Alternative philosophy and operative principles. Five Texas nursing homes were provided with small grants ($5,000 to $30,000) to implement the Eden Alternative. Beds in the participating facilities totaled 734. A task force of academicians, providers, and consumers developed the conceptual model for Texas. Principle Investigator for the project was Sandy Ransom, RN, MSHP and Executive Director of the Institute. The Institute is located within the College of Health Professions at Texas State University-San Marcos.

Outcomes were analyzed with each home and cumulatively. A summary of significant CUMULATIVE findings:

60% decrease in Behavioral Incidents
57% decrease in Stage I - Stage II Pressure Sores
25% decrease in Bedfast Residents
18% decrease in Restraints
11% increase in Census
48% decrease in Staff Absenteeism
11% decrease in Employee Injuries

Most outstanding significant outcomes with individual facilities:

Facility A
80% decrease Decubitus Ulcers
49% decrease Restraints

Facility B
62% decrease Urinary Tract Infections

Facility C
58% decrease Restraints

Facility E
35% decrease Polypharmacy (resident on 5 or more meds)
76% decrease Contractures
96% decrease Decubitus Ulcers
67% decrease Resident Complaints
86% decrease Behavior Incidents

This 110 page, bound report may be obtained for $10 plus shipping & handling by ordering through our online store at http://edenalt.safeshopper.com/

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San Marcos, Texas 78666
(512) 245-8234 / Fax: (512) 245-7803
Email: LTC-Institute@txstate.edu
Visit our website at: http://ltc-institute.health.txstate.edu

B

From BEAM (Bringing Eden Alternative to Michigan)
The Benefits of Eden Alternative

FACT: It costs approximately $3,000 to train a new frontline caregiver in the mid-west. According to the AHCA 2001 report of February 7, 2002, the annualized turnover rate for C.N.A.'s in the state of Michigan is 72.2%. This translates into a cost of $210,000 for every 100 C.N.A.'s that a home employs. This is considered by many to be an unavoidable cost of doing business in long-term care.

FACT: Edenizing homes report reductions in staff turnover rates leading to improved retention. Not only does the bottom line improve with such figures but more importantly, the care for the elders improves because of consistent staffing based on long-term relationships between elder and caregiver.

Lapeer CMCF began their Eden journey in 2000 and became a Registered Eden Home in 2001. They have reported a 75 % decrease in staff turnover as well as dramatic decreases in absenteeism.

- 75% decrease in staff turnover 60% decrease in absenteeism

Oak Crest Manor of Holland began their Eden journey in 2000 and became a Registered Eden Home in 2001, reports a decrease in staff turnover from 104% to 42% over a 1 ½ year period of time. Agency use for the same period of time dropped from $60,435.oo in the year of 2000 to $247.00 from January 2002 to present!

- Outside agency use: 2000 $61,000, 2001 $54,000, 2002 $ 250
- Staff Turnover 2000 104%, 2001 119%, 2002 42%

Lakeland Specialty Hospital began their Eden journey in 1999 and became a Registered Eden Home in 2001, reports decrease turnover rates of 87.26% in 1999 to 32.58% in 2001. There has been no outside agency use in the past two years.

- Turnover C.N.A. 1998: 87.26%
  2002: 22%

Leelanau Memorial Health Center started their Eden journey in 1996 and became an Eden Registered Home in 1998. They experienced a drop in turnover of 72% in 1997 to 17% in 2001. Staff absenteeism over the same period improved from 451 call ins to 276 in 2001

- Turnover all Staff 1996: 78%
  2002: 9.5%

Lenawee CMCF began their Eden journey in 1998 and became a Eden Registered home in 1999. Staff retention rates have climbed to 78%, allowing them to hold onto experienced caregivers leading to improved care

- Turnover C.N.A staff 1998: 58%
  2002: 16%

APPENDIX E:
STAR+PLUS

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Burleson, Texas 76028-4726
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(800) 615-1906

Capitol Office:
P.O. Box 2910
Austin, Texas 78768-2910
(512) 463-0518

State of Texas
House of Representatives

Arlene Wohlgemuth
Representative

April 15, 2004

Albert Hawkins, Commissioner
Health and Human Services Commission
4900 Lamar
Austin, TX 78751

Dear Commissioner Hawkins,

I am writing regarding the implementation of Section 2.29 of HB 2292, relating to Medicaid managed care. As you know, this section allows the Health and Human Service Commission (Commission) to provide acute care through the most cost effective managed care model. The use of the term "acute care" was deliberately inserted to prevent the Commission from being required to expand managed care for long term care patients.

Given that fact, I encourage you to reexamine the inclusion of long term care services, both community and institutional based, in the Medicaid managed care program. If you would like to discuss this matter further, feel free to contact me.

Sincerely,

Arlene Wohlgemuth

Arlene Wohlgemuth
AW/ab