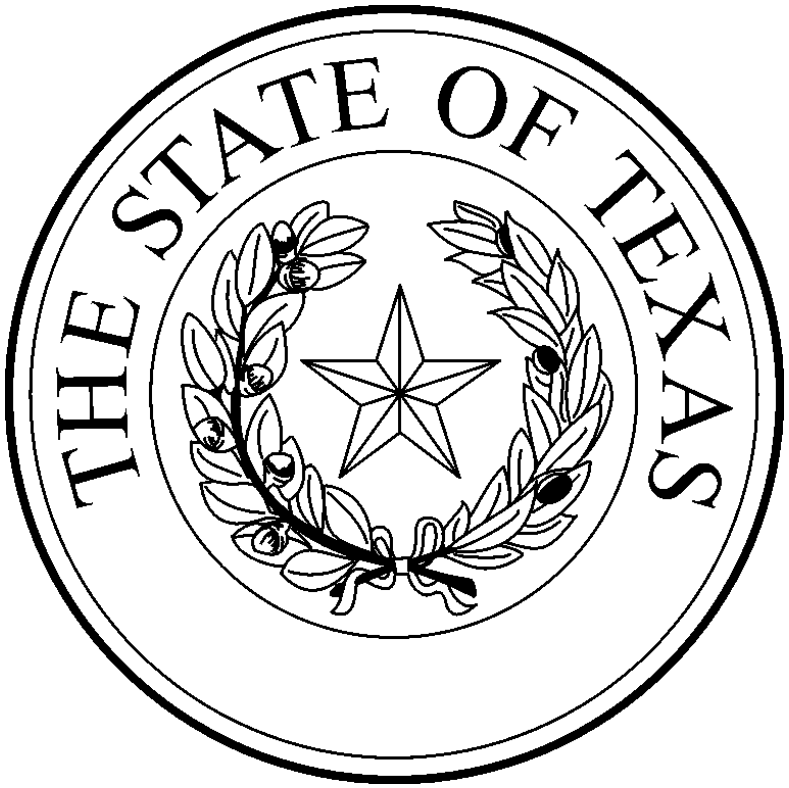
Long Term Care Legislative Oversight Committee



Interim Report

January 2003

Long Term Care
Legislative Oversight Committee

Sen. Robert Duncan
Chairman
Rep. Elliott Naishtat
Vice Chairman

January 9, 2003

The Honorable Bill Ratliff
Lieutenant Governor
Texas State Capitol, Second Floor East
Austin, Texas

Dear Governor Ratliff:

The Long Term Care Legislative Oversight Committee submits this interim report. This Committee was comprised of both elected and public members and was charged with overseeing the implementation of legislation and funding regarding long term care, specifically nursing homes, in Texas.

At the outset of the 77th Legislature, it was feared Texas nursing homes were heading toward a crisis. Liability insurance rates were skyrocketing, lawsuits were on the rise, funding was thought to be inadequate, and the regulatory process was caustic and volatile. In response to these issues, the Legislature passed an omnibus nursing home bill, Senate Bill 1839, to address the problems facing the nursing home industry.

As stated in the legislative intent section of Senate Bill 1839, the measures that passed were intended "as temporary solutions that will facilitate the efficient recovery of both for-profit and not-for-profit private long term care facilities so that, in the future, these facilities will be financially sound and capable of providing high-quality care."

While many of the problems still exist as we proceed into the 78th Legislative Session, it is important that the Legislature consider allowing the solutions ample time to be in effect to truly see the impact. As with many complex issues, time is needed to assess success.

We would like to thank you for providing us this opportunity to address this important matter and to present options that may continue to assist in hopefully solving this situation.

Respectfully submitted,

State Capitol, GE.7 • P.O. Box 12068 • Austin, Texas 78711-2068 • (512) 463-0128 • (800) 322-9538 • Fax: (512) 463-2424

Senator Robert Duncan
Chair

Representative Elliott Naishtat
Vice Chair

Senator Mike Moncrief

Representative Craig Eiland

Senator Chris Harris

Representative Jim McReynolds

Phil Elmore

Pat Karrh, BSN, RN

Long Term Care Legislative Oversight Committee

Interim Report

Table of Contents

Introduction

The Long Term Care Legislative Oversight Committee was created by Senate Bill 190, 75th Legislative Session, by Senator Judith Zaffirini and Representative Elliott Naishtat, to examine the long term care crisis in Texas. Governor Ratliff and Speaker Laney specifically tasked this interim committee to monitor the implementation of nursing home legislation (SB 1839) passed in the 77th Regular Session to address quality of care, nursing home regulation, methods to set Medicaid reimbursement rates, and liability insurance.

On Sept. 2, 2001, Sen. Robert Duncan of Lubbock was named chairman and Rep. Elliott Naishtat of Austin was appointed as vice-chairman. Other senators appointed to the committee include Sens. Chris Harris of Arlington and Mike Moncrief of Fort Worth. Ratliff also named Phil Elmore of Abilene to serve as a public member. Mr. Elmore is the Vice President of Planning for Sears Methodist Retirement System. Speaker Laney appointed Reps. Craig Eiland of Galveston and Jim McReynolds of San Augustine. Laney also named Pat Karrh of Plainview to serve as a public member. Karrh is a registered nurse.

Charges

The Committee shall:

1. Monitor implementation of SB 1839, SB 415, HB 154, and SB 1 provisions regarding nursing homes (77th Legislature), including activities related to quality of care, nursing home regulation, nursing home rate methodologies, liability insurance, and any other relevant issues and legislation; and

2. Make recommendations to the 78th Legislature on any changes needed to improve the quality of nursing home care, assure effective use of public funds for resident care, and improve the affordability of nursing home liability insurance.

Background

Texas currently has approximately 1,223 certified nursing facilities with 126,925 beds.[1] Seventy-two percent of those beds are currently occupied. Although the nursing home industry is privately operated, 86 percent of nursing home residents receive services under Medicaid, the state-federal health benefit program for the poor, elderly and disabled.[2] In addition to the requirements under Medicaid, the nursing-home industry must comply with specific state regulations promulgated by the Texas Department of Human Services (DHS). The state reimburses facilities for Medicaid patients on a per-bed, per-day basis that projects patients' anticipated level of need.

Population trends in Texas highlight the need for nursing home beds.[3] As our population is aging so too is the demand on our state resources to accommodate that population's needs.[4] Texas has the fifth largest elderly population in the United States with more than 1.7 million residents older than 65. One of every 10 Texans is elderly.[5] Although growth in Texas' elderly population mirrors national figures, Texas is distinct in that its elderly population has significant ethnic diversity.[6] Elderly individuals of Hispanic and African-American descent account for 25 percent of the total elderly population in Texas.[7]

---

[1]Facts about Texas Nursing Homes (table) provided by the Texas Department of Human Services.

[2]Id.

[3]State Demographer, Steve Murdock, presented a complete analysis of the effects of the elderly population trends to the Committee at its hearing on December 19, 2001. Mr. Murdock's presentation is attached to this report as Attachment 1.

[4]For fiscal year 2000-01, the Legislature increased payments to nursing facilities (via Medicaid reimbursement) from $3.07 billion to $3.24 billion, an increase of approximately $170 million or $65 million in general revenue. This number reflects a 3.7% inflation increase per annum. Even with this increase, Texas still ranks 49th in the nation for its Medicaid reimbursement rate.

[5]See Findings on Texas Elderly Population by Rogelio Saenz and Edward Murguia, Texas State Data Center, Department of Rural Sociology, Texas Agricultural Experiment Station, The Texas A&M University System (Attachment 2).

[6]Id.

[7]Id.

Texas' elderly population is predominantly female.[8] Elderly Texans tend to live in metropolitan counties with one-third residing in Harris, Dallas, Bexar and Tarrant counties. In rural counties, the elderly population is the largest relative share of the entire population.[9] For example, in Llano, Hamilton, Mills, Hall, Motley, Baylor, Coleman, Coke, Donley, Sabine, Dickens and Foard counties, the elderly population reflects more than one-fifth the total population.[10]

These population totals are particularly troubling given the number of nursing homes in Texas that have closed during the last two years. Since September 2000, 96 nursing homes have closed across the state.[11] Three of those facilities have since reopened. During the last five years, Texas, similar to the rest of the country, has seen several facility chains file for bankruptcy. Four chains owned almost 90 percent of the bankrupt homes; three of those chains are headquartered outside Texas. At the peak of the crisis, almost 500 nursing facilities were bankrupt in Texas. Fortunately, three of those four chains have since come out of bankruptcy. As of September 2002, 132 Texas nursing facilities (11 percent) were still bankrupt.

Solving the nursing home crisis in Texas provides a unique challenge because the root cause of the problem is elusive. From a broad perspective, the crisis appears to be two-fold: the quality of care delivered to the residents; and cost and availability of liability insurance to the nursing homes. On closer examination, however, factors such as Medicaid reimbursement rates, Texas' regulatory environment, and the state's litigious atmosphere contribute to the equation.

Moreover, the proverbial question of "Which came first, the chicken or the egg?" is present in this crisis. No consensus exists as to whether the quality of care issues are the result of increased insurance costs or whether increased insurance costs are the result of quality of care issues. The discussion is circular with the debate centering on whether the lack of quality of care leads to lawsuits, and the lawsuits lead to increased insurance rates; or whether the nursing homes are forced to spend resources on insurance and other aspects of litigation instead of on quality of care.

Issues that motivated passage of SB 1839 are still present today - the crisis did not arise overnight, nor will it be solved overnight. More money is not necessarily the only

[8]Id.

[9]Id.

[10]Id.

[11]Statistical information provided by the Texas Department of Human Services.

answer. The pool of resources Texas can inject into the nursing home industry is limited, and these resources are likely to be stressed even more heavily during the 78th Legislature because a deficit is expected. Time is what is needed to allow the provisions of SB 1839 to take hold and revive this struggling industry.

Key Issues Addressed in Senate Bill 1839

The Omnibus Nursing Home Legislation, SB 1839, was passed by the 77th Legislature to bridge the gap between the current crisis and what is expected to be a rejuvenated, viable industry.

The legislation attempted to approach the crisis on three distinct levels: insurance, legal, and regulatory. This interim report is divided into these same three areas. This report will give a brief history and summary of each area prior to the passage of SB 1839 followed by a synopsis of how remedies have been implemented on each level.

INSURANCE

Availability and Cost of Premiums

Sky-rocketing insurance premiums coupled with the discrepancies of increasing medical costs met by relatively low reimbursement rates is at the root of the nursing home crisis, according to the Texas Heath Care Association.[12]

Data collected by the Texas Department of Insurance indicates that premiums for professional liability insurance for nursing homes has increased dramatically. Premiums for state-regulated insurance companies have increased from $200 per bed in 1998 to $1,971 in 2002.[13] However, the vast majority of nursing homes in Texas are insured through surplus-line insurance companies.[14] The premiums listed by these policies varied from $2,500 to $5,000 per bed, per annum.

The rapid rise in premium rate parallels the rapid drop in regulated insurance carriers in Texas. According to the *Insurance Joumal,* "In 1996, there were eight admitted

[12] The Texas Health Care Association is the trade association that represents most for-profit nursing homes in Texas.

[13] Premium data provided by the Texas Department of Insurance.

[14] Surplus-line companies are unregulated insurance companies conducting business in the State of Texas. Prior to the passage of S.B. 1839, these companies were not required to disclose as much financial information about their companies as regulated companies nor were they required to disclose information about the premiums they charge. Surplus-lines exist to provide insurance to those who cannot acquire insurance in the regular, regulated market. Surplus-line companies cannot advertise in the state and they must show proof that a nursing home was unable to secure regulated insurance rates before writing an insurance policy.

carriers doing business in the state. That number has dwindled to three by the beginning of 2000, and now has dropped to just two."[15] The Texas Department of Insurance reports two regulated carriers and two surplus-line insurers are currently accepting applications for new business for this coverage. However, one of the two admitted carriers requires the insured facility to be part of a hospital; as a result, only a small segment of the market is served.[16]

Identifying the cause or causes leading to the increase in premiums was at the heart of the debate leading to the negotiation and passage of SB 1839. This task was particularly difficult given that no real empirical data existed to justify the increases. Because most nursing home professional liability policies are procured from surplus lines, the Texas Department of Insurance had no regulatory authority to call for that data.

Nursing home owners and administrators contend the increase in premiums is the result of the litigious atmosphere against nursing homes in Texas. They point to the large verdicts being awarded to plaintiffs suing the facilities. Examination of the verdicts awarded against nursing homes in Texas showed that few cases actually go to court and even fewer had large verdicts.

However, Texas recognizes the common-law "Stowers" doctrine has permitted the settling of some claims for more than they may be actually worth. The doctrine arose from a 1929 case, G.A. Stowers Furniture Co. v. American Indemnity Co., 515 S.W. 2d 544 (Commission of Appeals of Texas, Section A, 1929) (Attachment 3). The court said that when an indemnity (insurance) company assumes "the responsibility to act as the exclusive and absolute agent of the assured in all matters pertaining to the questions in the litigation, and, as such agent, it ought to be held to that degree of care and diligence which an ordinarily prudent person would exercise in the management of his own business; and if an ordinarily prudent person, in the exercise of ordinary care, as viewed from the standpoint of the assured, would have settled the case, and failed or refused to do so, then the agent, which in this case is the indemnity company, should respond in damages." (Id. at 549).

The practical application of this doctrine is that when a plaintiff makes a reasonable demand to the defendant's insurance company (i.e., within the policy limits), and the insurance company decides not to settle the case, the insurance company's exposure

[15]Constance Parten, "And Then There Were Two..." *Insurance Journal: The Property and Casualty Magazine of Texas* (November 13, 2000), 1.

[16]Interim legislative report pursuant to S.B. 1839 dated December 1, 2002 from Commissioner of Insurance Jose Montemayor to Governor Rick Perry, Lt. Governor Bill Ratliff and Speaker of the House Pete Laney.

includes any and all damages that might be awarded to the plaintiff. This exposure includes damages above and beyond the policy limits, and may also include - but isn't limited to - exemplary damages typically excluded in most policies. The fear of unknown exposure leads most insurance companies to settle their cases within the policy limits, but for more than the case may be worth. Cases that are resolved at inflated values have caused premiums to rise.

Because very few regulated insurance companies have continued to write professional liability insurance in Texas, most nursing homes have been forced to either purchase expensive policies from surplus-line carriers or they do not carry professional liability insurance at all.[17]

Senator Mike Moncrief, Chair of the Senate Committee on Health and Human Services during the 77th Legislature, directed DHS to survey all certified nursing facilities' liability status. A final report was issued Jan. 31, 2001, based on the 935 (88.1 percent) nursing facilities that responded. Results indicated:

- 619 (66.2 percent) have commercial liability insurance coverage,
- 166 (17.8 percent) were self-insured,
- 139 (14.9 percent) had neither type of coverage, and
- 11 (1.1 percent) did not know their coverage status.

SB 1839 attempted to address both problems -- availability and cost -- by authorizing the state's insurer of last resort, the Joint Underwriting Association (JUA), to write professional liability insurance policies for all nursing homes.[18] Prior to the 77th Legislature, the JUA was only available to health care professionals and non-profit nursing homes. Both SB 1839 and SB 415 (by Sen. John Carona) opened the JUA to writing policies for all nursing homes. Under its authorizing statute, the JUA is not responsible for paying exemplary damages.

The JUA did not write for any nursing homes prior to 2001, and the Legislature wanted to ensure the organization's existing stabilization fund (which covered health care professionals) was not jeopardized by the nursing home business. Accordingly, SB 1839 authorized the Texas Public Financing Authority to issue a $75 million bond package to ensure the stabilization of the fund. Additionally, the bill authorized a maintenance tax surcharge to be assessed against insurance carriers to pay the service debt on the

[17]When a nursing homes does not carry insurance, the term used is "going bare."

[18]The Joint Underwriters Association was created by the Legislature in 1975. Its authorizing statute can be found at 21.49-3, Insurance Code.

bonds.[19]

The JUA's authorizing statute indicates the organization may not be responsible for exemplary damages awarded in a civil cause of action; it may only be liable for compensatory damages. Despite this prohibition, the JUA has been subject to Stowers demands. Because the intent of the Legislature in authorizing the JUA to write insurance was to increase availability and decrease costs, it was important to ensure the uncertainty currently plaguing the commercial market -- and causing the premiums to rise -- was taken out of the equation.

The end result was an unusual statutory provision that trumps the common-law practice arising from Stowers. Under the statute, if the JUA receives a Stowers demand, and does not settle the claim at or under the policy limits, it is still responsible for the cost of litigation and compensatory damages. If the jury awards the plaintiff exemplary damages, the nursing home is responsible for those damages. This provision only applies to coverage under a policy between January 1, 2002, and January 1, 2006. The provision sunsets January 1, 2007.

Mandatory Coverage of Professional Liability Insurance

One of the most contentious issues in the passage of SB 1839 was the provision that required nursing homes in Texas to carry professional liability insurance. The statute requires coverage of $1,000,000 per occurrence/$3,000,000 total per annum. Professional liability insurance may be provided by the JUA, any admitted carriers, or surplus-lines carriers. Currently, self-insurance is not an acceptable method of meeting this requirement. The statute set September 1, 2003, as the implementation date. However, the Department of Human Services may not take any enforcement action prior to September 1, 2004.

Data Reporting

Prior to the passage of SB 1839, only insurance companies that are admitted carriers are required to report claim and settlement data to the Texas Department of Insurance (TDI). SB 1839 requires carriers not "admitted" but that sell surplus lines to report claims and settlement data, as requested by the Commissioner of Insurance. This information was to be reported to the Legislature.

[19]SB 415 also addressed the stabilization fund issue by authorizing an assessment if the fund declined by more than 25%.

Risk Management Issues

During the negotiations of SB 1839, several of the admitted commercial insurance carriers that no longer write plans said Texas should encourage nursing homes to adopt risk management programs and policies to reduce the number of lawsuits. As a result, SB 1839 required the Texas Department of Insurance to create a task force to develop "best practices" for risk management and loss control at nursing homes. The task force consists of representatives from the nursing home industry, insurance industry carriers, Texas Department of Insurance , consumers, the Joint Underwriters Association (JUA) and the Health and Human Services Commission (HSSC). These best practices do not establish "standards of care" in a civil action against a nursing home.

LEGAL

Admissibility of Certain Evidence in Civil Causes of Action

Prior to 1993, documents produced by the Department of Human Services in the survey and regulatory process were admitted into evidence in civil trials. In 1993, the Legislature enacted a provision that made all of these documents inadmissible in a civil cause of action. In 1995, Sen. Judith Zaffirini introduced SB 190, which made the documents admissible in the Human Resources Code, instead of the Health & Safety Code where the other long term care regulations are found. The bill passed, but it was confusing and has been inconsistently applied throughout the state. During the 76th Interim Session, the Human Services Committee chaired by Sen. Zaffirini studied this issue and recommended legislation clarifying SB 190 to allow documents to be admitted but only upon a judicial determination of relevancy under the Texas Rules of Evidence. As a result, Sen. Mike Moncrief filed SB 1590 in the 77th Legislative Session, which passed the Senate on April 19, 2001. This bill was later incorporated, verbatim, into SB 1839.

Notice of Exemplary Damages to the Department of Human Services

Nursing home consumers were especially concerned there was no public record of "bad actors" for other consumers to access. SB 1839 required civil courts to notify the Texas Department of Human Services if exemplary damages are awarded against a nursing home, its employees, officers or agents. Any exemplary award against a nursing home will become part of the nursing home's permanent record at the department.

REGULATORY

Surveyor Training and the Survey Process

Long term care is a highly-regulated industry, and facilities often have difficulty with interpreting and complying with the regulations. This leads to cited violations and administrative money penalties imposed by DHS. Generally the quality of care to the residents is improved if the facility understands the regulatory agency's interpretation. This provision of SB 1839 requires basic education of surveyors to include ten days of observation in a long term care facility. In addition, the section requires biannual joint education of surveyor and provider on one of the ten most commonly cited deficiencies. Surveyors are also required to obtain a certain percentage of their continuing education requirements in gerontology or cognitive or physical disabilities.

Also, the bill creates quality assurance monitors and a rapid response team. The quality assurance monitors will work with the facilities to improve the delivery of care. The rapid response team will be deployed to immediately assist a troubled facility.

Finally, the section transfers the informal dispute resolution process, required by federal law, from DHS to the Health & Human Services Commission, thereby eliminating any potential for bias.

Amelioration of Violations

SB 1839 requires DHS to offer amelioration to a facility when the violation is not categorized as an immediate harm to the facility residents. Amelioration allows the facility to take the penalty money paid to DHS and use it to improve the quality of care and services to the residents.

Implementation of Senate Bill 1839

INSURANCE ISSUES

Availability and Cost

Since the enactment of SB 1839, the JUA has been open to write professional liability insurance for all nursing homes. The JUA is a quasi-state agency required to sustain itself and its operations, but it does not have additional profit margin requirements. The intent of the Legislature was to make professional liability insurance available and affordable to nursing homes in Texas by opening the JUA. Further, an ideal use of the JUA would allow the market to stabilize itself. Ultimately, commercial carriers would be attracted to Texas' reinvigorated market during the next five years.

Effective January 1, 2002, the JUA's rates reflected a 30 percent discount for non-profit nursing homes from the rates with the same coverage provided to for-profit nursing homes. Additionally, effective February 29, 2002, the Commissioner of Insurance, Jose Montemayor, approved a 16 percent across-the-board rate reduction for all nursing homes policies written by the JUA. This reduction was based on the anticipated cost savings relative to the admissibility of evidence in civil causes of action and the exemption from liability of exemplary damages without regard to the Stowers doctrine. This decrease applied in addition to the 30 percent discount for non-profit nursing homes.

Despite these rate reductions, nursing homes use of the JUA was slow to start. Some posture the real reason nursing homes were not using the JUA was the insurance brokers who typically sell insurance to nursing homes do not encourage their clients to approach the JUA. Because the JUA is a quasi-governmental entity, insurance brokers do not receive the same commissions from JUA products as other commercial products.[20]

Others suggest nursing homes are not using the JUA because the it is only authorized to write professional liability insurance and not general liability insurance. Anecdotally, the committee has been told that some insurance carriers refuse to write general liability insurance for a nursing home that has professional liability coverage with a different company.

Another possible explanation for the limited usage of the JUA is that insurance policies have coverage for an entire year and nursing homes only begin looking at

[20]Insurance brokers receive commissions from the JUA on a sliding scale. Specifically, the broker receives 12.5% on the first $2000 worth of premium, 7.5% on the next $3000 worth of premium, 5% on the next $15,000 of premium, and 2% on any premium in excess of $20,000. Typically, commercial carriers pay a flat commission rate of 10-15% of the premium dollar.

insurance rates when their policies are coming up for renewal.

As of December 5, 2002, the JUA has written 40 professional liability policies for nursing homes. Of those, 16 are for non-profit homes and 24 apply to for-profit homes. The average premium per annum, per facility is $110,000. Average cost per occupied bed is $1,083.[21] Sixty-seven percent have a deductible of $25,000. Eighty-two percent have coverage of $1 million per occurrence with a total of $3 million per annum. The JUA has five applications pending, all with for-profit homes and has recently received a request for five more quotes.

Based on low usage of the JUA, no bonds have been issued nor have maintenance charges been assessed. The Board of Directors of the JUA has determined the stabilization fund is sound without having to issue the bonds.

To better understand the nursing homes' use of insurance, TDI and the Department of Human Services are jointly conducting an online survey to ask nursing homes a variety of questions, including: (1) Is the nursing home carrying professional liability insurance? (2) What are the premiums? (3) What is the deductible? (4) What are the coverage limits? (5) Is the nursing home aware of the JUA? (6) Has it asked for a quote from the JUA? (7) If not, why? The entire survey may be viewed at www.dhs.state.tx.us/providers/ltc-policy/index.html . TDI has asked for responses by December 2002.

Mandatory Insurance

Under the provisions of SB 1839, the liability insurance requirements do not go into effect until September 1, 2003. Currently, the cost of insurance is a reimbursable expense under the Medicaid program. However, House Bill 154 required that the Health and Human Services Commission (HHSC) to only reimburse those homes that actually purchased insurance. This provision does not affect those homes that are entirely private-pay facilities.

According to HHSC, 702 (67 percent) of the 1050 contracted nursing facilities that receive Medicaid reimbursement are currently receiving the liability insurance add-on payment. The additional 348 nursing homes that do not receive the add-on payment; these facilities have no insurance coverage.

Of the 702 providers receiving the liability insurance add-on, three are receiving the general liability insurance add-on only (no professional liability insurance add-on), while 17 are receiving the professional liability insurance add-on only (no general liability insurance add-on). The remaining 682 are receiving both the professional and general

[21] The premium cost ranged from $472 to $3,280 per bed.

liability insurance add-ons.

Another provision of SB 1839 instructed TDI to study the implementation of certain provisions of the legislation. TDI completed that study in December 2002.[22]

Data Reporting

To date, the Commissioner of Insurance has not put out a data call on professional liability insurance for nursing homes provided by surplus lines. The department intends to receive this information, analyze it, and report its findings back to the Legislature within the next twelve months.

Risk Management

The Texas Department of Insurance adopted a "best practices" report in December 2001. [23] Adoption of best practices was to encourage commercial carriers to reenter the Texas market. It is too early to determine whether the intentions were well-placed since no commercial carriers have reentered the market since its adoption. However, the JUA does use the best practices guide when it determines its rates.

Additionally, TDI has added questions regarding the use of best practices in its nursing home survey at www.dhs.state.tx.us/providers/ltc-policy/index.html.

LEGAL ISSUES

Admissibility of Certain Evidence in Civil Causes of Action

Although the requirement that Texas Rules of Evidence be applied in determining the admissibility of documents has been in effect a little more than one year, the nursing home industry has proposed to change the statute to make admissible only regulatory documents directly related to the plaintiff's case. The nursing home industry is also proposing that the state's exemplary damage cap may be lifted only when there is a proven criminal conviction against a nursing home employee. This proposal would change existing statutory language that allows the states exemplary damage cap to be lifted when conduct is described as a felony in civil court.

Few, if any, cases have been in the judicial pipeline long enough to have applied the

[22] A copy of that report is included as Attachment 4.

[23] A copy of that report is included as Attachment 5.

statute at all. Moreover, the constant change of law in this area could lead to further judicial confusion, compounding the very issue the statute was intended to address.

Finally, the changes made with respect to admissibility of documents were not made in a vacuum; rather, the legislation was intended to address the nursing home crisis in a cumulative manner Accordingly, the committee believes it would be premature to make additional changes to this portion of the statute at this time.

Notice of Exemplary Damages to the Department of Human Services

The Department of Human Services has not received information on exemplary damages being awarded against a nursing home. The department is in discussions with the Office of Court Administration to establish a formal process of notification.

However, the committee has heard testimony that exemplary damages are being awarded in many long term care jury verdicts. In 2001, three of the top ten jury verdicts in Texas involved exemplary damages against long term care organizations. (Dallas Morning News, July 25, 2002, "Soaring Liability Costs Blamed for Non-Profit Nursing Home Closures)[24]

REGULATORY ISSUES

Joint Surveyor and Provider Training

The Department of Human Services (DHS) was directed by SB 1839 to create and offer a series of joint provider/surveyor training sessions around the state. Historically, the relationship between DHS surveyors and facility providers was contentious, often due to a lack of information sharing and mutual understanding of regulatory standards and provisions. These seminars were established to help ensure the providers and the surveyors were operating under similar regulatory information and training.

To date, DHS has offered 72 joint surveyor and provider training sessions. As delineated in the statute, these sessions focused on the top 10 most commonly cited deficiencies. The topics were identified through input from DHS surveyors and providers. As of December 2002, 1800 providers have received this training alongside 481 DHS

[24]The three long term care cases in the top ten in 2001 include the following punitive damage awards: Fugua v. Horizon?CMS Healthcare Corp. FKA Horizon Healthcare Corp., $310 million punitive damage verdict, settled after verdict for $20 million; Ernst v. Horizon/CMS Horizon Healthcare et. al., $75 million in punitive damages, settled after verdict for $20 million; Copeland v. Dallas Home for the Jewish Aged Inc. $34 million in punitive damages(on appeal).

surveyors. The classes offered are as follows[25]: (1) Abuse and Neglect; (2) Kitchen Sanitation; (3) Focus on Quality; (4) Infection Control; (5) Advance Directives; (6) Incident Reporting; (7) Survey Process; (8) Licensure Process; (9) Pressure Ulcers; (10) Intermediate Care Facility for the Mentally Retarded (ICF/MR) Survey Process; (11) Psychoactive Medications; and (12) Restraint Initiative.

Joint Surveyor and Provider Classes

Topic	# classes offered	Surveyors Trained	Providers Trained	No Designation
Abuse/Neglect	1			20
Kitchen Sanitation	17	15	136	298
Focus on Quality	1	78	247	
Infection Control	15	111	298	
Advance Directives	17	93	254	
Role of Consultant Pharmacist	1	30	54	
Incident Reporting	3	7	47	
Survey Process	2	1	72	
Licensure Process	3	0	92	
Pressure Ulcers	4	26	76	
ICF/MR Survey Process	4	22	90	
Psychoactive Medications	1	0	17	
Restraint Initiative	3	98	430	
Total	**72**	**481***	**1,804**	**318**

**DHS employs 380 surveyors, several surveyors attended multiple sessions*

[25]DHS website http://www.dhs.state.tx.us/programs/ltc/Training/trainingschedule.html

Quality Assurance Monitors and Rapid Response Team

Quality assurance monitors were established to create a state-aided, quality of care improvement program for long term care facilities. Additionally, SB 1839 instituted rapid response teams to be immediately deployed to a troubled facility. DHS was authorized to hire 50 nurses, pharmacists and nutritionists for this program. Forty-three of these 50 employees have been hired. According to testimony from DHS, the focus of this program is to change statewide provider practices regarding the following:

- restraint use
- toileting for incontinent residents
- unnecessary use of bladder catheters
- prevention of avoidable and unintended weigh loss
- prevention of avoidable dehydration
- use of certain psychoactive drugs.

DHS intends to expand the clinical scope of the program to address other issues as additional best practices resources are developed.

The quality monitors began visiting facilities April 15, 2002. Monitors made introductory visits to familiarize providers with the program prior to the onset of the monitoring. As of October 1, 2002, there were 491 monitoring and/or rapid response team visits. Preliminary analysis of the 41 facilities that have had two or more monitoring visits shows these facilities had a slightly higher prevalence of restraint use than the remaining 1000 facilities (19.11 percent versus 18.5 percent). However, in the first quarter of the program's operation, these same 41 facilities showed a restraint reduction rate five to six times greater than facilities that had one or no quality monitor visit.[26]

During DHS testimony regarding this program, members of the committee requested extending Texas Legislative Council research projects to include a survey of this program and its success. The results of this study found that no real quality of care improvements can be seen at this time because of the quality of care monitoring program.[27] However, it is also recommended that the program be continued to allow a greater length of time for the program to realize a possible improvement in quality of care.

[26]DHS testimony, October 8, 2002 hearing.

[27]A copy of that research is included with this report as Attachment ___.

Informal Dispute Resolution Process Changes

SB 1839 moved the long term care informal dispute resolution (IDR) process from DHS to the Health and Human Services Commission (HHSC). States are required to offer informal dispute resolution by the federal government. By moving the informal dispute resolution process from the regulatory agency that cited the violation in question, any potential bias in favor of the violation would be removed from the process.

Informal dispute resolution is available to a nursing facility, an Intermediate Care Facility for the Mentally Retarded (ICF/MR) and an assisted living facility. Prior to IDR, both the facility and DHS are permitted to provide additional information about the citation. Next, the facility submits the rebuttal to the deficiency in question and supporting documentation. Finally, DHS provides further information that may arise from the facility's rebuttal.

In cases that involve a deficiency without a penalty, HHSC will perform a review of the information. In situations that involve a penalty, a provider may request a face-to-face or telephone IDR. At that time, DHS may attend, but no new information may be presented from either side.

HHSC completes its review and issues a decision no later than the thirtieth calendar day after receipt of the IDR request. After its review, HHSC may offer the following decisions:

- delete all or a portion of the deficiency,
- sustain the deficiency,
- move the deficiency from one citation to a more appropriate citation, or
- change the scope and severity of the deficiency for Immediate Jeopardy or Substandard Quality of Care designations.

Currently, the final two options listed above are subject to change as Texas is awaiting review and guidance from the Centers for Medicare and Medicaid Services (CMS). CMS has found those deficiency changes should only be made by the state surveying agency. In Texas, that agency is DHS.

Finally, if the facility is not satisfied with the results of the IDR, it may file a request with the State Office of Administrative Hearings (SOAH) to dispute the DHS-recommended enforcement action. Following the SOAH hearing, if the facility continues to be unsatisfied with the ruling, it may file a lawsuit in district court.[28]

[28]DHS testimony, October 8, 2002 hearing.

Amelioration of Violations

As previously stated, amelioration allows the facility to take the penalty money paid to DHS for a violation, that is not considered an immediate threat of harm, to use to improve quality of care and services to the residents. The facility may use all or only a portion of the penalty, but may not use the funds for administrative services.

DHS has received seven amelioration requests from nursing facilities.[29] Of those requests, six have been approved. The highest administrative penalty approved for amelioration was $74,000; the lowest penalty was $1,000. Examples of approved amelioration requests provided by DHS include:[30]

- $15,000 request approved for a portion of the cost for a facility planning to create a 26-bed Special Care Unit for behavioral management,
- $1,000 request approved for a facility planning to hire a consultant to provide in-service training on communication, and
- $46,000 request approved for a facility planning to create a restorative dining program.

[29]DHS has yet to publish rules for assisted living facilities and no ICF/MR has requested amelioration.

[30]DHS testimony, October 8, 2002 hearing.

Budget Issues

Most stakeholders agree the state should provide higher levels of funding for long term care facilities. In response to the multi-faceted crisis facing Texas' nursing homes, the Legislature has investigated various funding strategies and increases that may have a positive effect on the care being given to residents.

During negotiations, it was imperative to the authors of SB 1839 that funding be only a portion of the solution. The nursing home crisis stemmed from a variety of issues and it was the general concern that simply granting the nursing facilities' funding requests without addressing the other components of the issue would not solve the problem. The authors did not want funding increases to be lost in a failing system that would not improve quality of care. The approach was to adjust all the elements of the problem - legal, insurance and regulatory - to strengthen the infrastructure. Therefore, the money that was appropriated would go to the services and needs of the residents of a healthy long term care foundation.

As with most medical care services, funding levels have increased. In FY 1998, the funding level for the Nursing Facilities and Hospice Payments Strategy was $1.6 billion, including all funds, and in 2003, $1.9 billion, also including all funds. Nursing homes receive about 90 percent of this strategy amount.[31] The following items are funded under the Nursing Facilities and Hospice Payments Strategy:

- Medicaid nursing facility services;
- Medicaid-funded payment of Medicare co-insurance for Medicare Skilled Nursing Facility care (dual eligibles);
- Medicaid Hospice services;
- physical therapy/occupational therapy/speech therapy services provided to Medicaid-eligible residents of nursing facilities;
- specialized therapy services for Medicaid-eligible nursing facility residents diagnosed with mental illness, mental retardation or related conditions;
- reimbursement of provider costs associated with nurse aide training;
- ventilator support;
- DHS staff that directly support the management of Nursing Facilities; and
- outsourced costs of operating the Claims Management System.

[31] Legislative Budget Board Testimony, December 19, 2001

2002-2003 Funding Issues

During the 77th legislative session, DHS received an increase of $439.9 million, all funds ($175.0 million in general revenue) for the 2002-2003 biennium in the Nursing Facilities and Hospice Payments Strategy. From that funding, $135 million in general revenue was earmarked for inflation-related rate increases and $40.0 million was directed to improve the quality of care in nursing homes.[32] Quality-of-care funding was for direct-care staffing enhancements, which provides increased reimbursement to participating nursing facility providers who have improved direct-care staffing levels and/or their level of compensation. This rider was an early step implemented in the 76th Legislative Session to address the nursing home crisis.

Additionally, $35.6 million was appropriated for the 2002-2003 biennium in response to the passage of House Bill 154 which increased the Personal Needs Allowance from $45 to $60.[33]

The 77th Legislature also addressed quality of care funding with DHS Rider 39. Rider 39 directs DHS to use $10 million, all funds, and 82 full-time-equivalent (FTE) positions during the 2002-2003 biennium to promote best practices, provider education, and enhanced communication in the nursing facility survey process. The rider directed the agency to report on the progress of the transition and implementation of the program.

2004-2005 Funding Issues

DHS has a 2004-2005 biennium baseline increase of $26 million in general revenue from the 2002-2003 funding to address caseload growth in the Nursing Facility and Hospice Payment Strategy. Historical data trends are used to estimate the growth in these services.

The nursing facility client-per-month caseload count is projected to decrease slightly from 59,976 clients in 2003 to 59,919 in 2005. Therefore, a majority of this funding increase is attributed to the growth in hospice clients with some growth in payments of Medicare co-insurance. Agency staff has indicated the growth in hospice spending is based on increased public awareness, acceptance and preference of this type of service

[32]Id.

[33]Personal Needs Allowance are funds retained by the client from their monthly income to purchase personal items.

Unlike the slightly diminishing caseloads, nursing facility costs are projected to increase in the 2004-2005 biennium. These increases are two-fold: the growing acuity level for the clients in nursing facilities and paying for inflation costs for provider services.

First, according to DHS, the rising acuity, in other words, level of care is a significant cost driver. Of the DHS $49.9 million general revenue requested for 2004-2005 acuity increases, $15.2 is related to acuity in nursing facilities. At nursing facilities, changes in acuity are reflected in month-to-month changes in the weighted average nursing facility rate per patient day.

Specifically in nursing facilities, trends indicate that the weighted average daily rate per patient day will increase by .8 percent each year based on increases in the average patient case-mix. Currently, there are eleven different case-mix reimbursement levels. Although reimbursement rates for each case-mix level are constant for the entire biennium, the average rate is trending upward, as the percentage of patients in the heavier care case-mix levels is increasing over time.

DHS suggests the increase in acuity levels may be the result of the diversion of potential nursing facility clients into community care services. A higher proportion of clients at the lower levels are diverted into community care.[34] The clients with fewer and less expensive medical needs may be served in the community, while clients with the greatest medical needs remain in the nursing facilities. As a result, the average daily costs rises.

The second major cost driver is the inflation of rates for provider costs. In creating an appropriation request, agencies are not allowed to include the cost of inflation for services in the baseline budget. Therefore, as an exceptional item, DHS is requesting $108.8 million, (75.2 percent of the $144.6 million general revenue request) for inflation of costs in nursing facilities. General inflation is based upon the Personal Consumption Expenditure (PCE) chain-weighted price index forecast by DRI-WEFA, an economic and financial forecasting company.[35]

This $108.8 million general revenue request is a provider rate increase of 6.05

[34]Department of Human Services Appropriations Request, October 8, 2002

[35]DRI (formerly Data Resources Inc.) and WEFA (formerly Wharton Econometric Forecasting Associates) merged to DRI-WEFA. All client products and services have been fully integrated, the company has changed its name to Global Insight on October 28, 2002. http://www.globalinsight.com

percent, effective from September 2003 to August 2005, based on FY 2000 cost reports inflated to the FY 2004-2005 biennium per rate methodology. Rates for FY 2002-2003 were based on FY 1999 cost reports inflated forward per rate methodology. Actual 2004-2005 rates will be based on FY 2001 cost reports inflated forward. However, final FY 2001 cost report data will not be available until February 2003. Until then, FY 2000 data will be used.[36] Additionally, nurse and nurse aide wages are inflated based on historical trends in cost-report wage data.

Notably, DHS 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.

It is also important to discuss the DHS exceptional item addressing mandatory liability insurance for nursing facilities pursuant to the provisions of SB 1839. As nursing facilities may claim a portion of their daily reimbursement rate to pay for this coverage, DHS is requesting $54.7 million in general revenue to pay for the increased number of insured nursing facilities.[37] This fiscal impact was inadvertently left out of the fiscal note of SB 1839 as it was amended throughout the legislative process.

[36]Department of Human Services Appropriations Request, October 8, 2002

[37]For impact analyses for FY 2004-2005 LAR purposes are based on CY 2002 Texas Joint Underwriting Association (JUA) rates projected to FY 2004-2005, assuming 10% annual increases, with minimum required limits and $25,000 deductible, the highest deductible under the JUA rate structure.

Implementation of House Bill 154

OVERVIEW

The 77th Legislature passed House Bill 154 by Reps. Thompson and Chavez and Sen. Gallegos, relating to the personal needs allowance (PNA) for certain Medicaid recipients who live in long-term care facilities. Prior to the implementation of HB 154, the PNA was $45 per month. HB 154 increased the PNA, for certain Medicaid individuals, to at least $60 per month.

PROVISIONS

HB 154 amended the Human Resources Code to add a new subsection requiring DHS to set a PNA of at least $60 per month for residents who receive medical assistance in convalescent or nursing homes or related institutions licensed under Chapter 242 of the Health and Safety Code; personal care facilities; ICF-MR facilities; or other long term care facilities. In addition, DHS may send the PNA directly to a resident who receives Supplemental Security Income (SSI) pursuant to 42 U.S.C. Section 1381 *et seq.* The PNA does not apply to a resident participating in a medical assistance waiver program administered by DHS.

As a condition of increasing the allowance, the agency was required to develop an early warning system to detect fraud in the handling of these allowances and other funds of residents in long term care facilities.

As stated above, liability insurance is an allowable expense under the Medicaid program. HB 154 mandated that the insurance reimbursement only be paid to those homes which actually purchased liability insurance.

IMPLEMENTATION

Personal Needs Allowance:

HB 154 was effective on Sept. 1, 2001. At that time, the allowance was increased from $45 to $60 each month for certain Medicaid individuals.

For FY 2002, DHS has estimated the total cost of the PNA to be $9,856,652 with the state paying $3,925,904. In DHS regulated ICF-MR facilities, the total FY 2002 estimated cost is $1,368,000 with the state paying $544,874.

Early Warning System for Fraud Detection

As a condition to increasing the allowances, DHS was required to establish an early warning system to detect fraud in the handling of these allowances and other resident funds.

The early warning system is as follows:

- Monitoring of facility trust fund accounts is conducted by Long Term Care Services (LTCS) specialized staff annually;
- More frequent monitoring occurs for facilities (1) filing bankruptcy or (2) voluntarily or involuntarily giving up their Medicaid contract with the department;
- Staff will also monitor if there is anything suspicious during a complaint investigation or a regularly scheduled annual survey as required by Health and Safety Code Chapter 242.

Specialized trust fund monitoring staff receive training from the HHSC and the Attorney General of Texas, Medicaid Fraud Division, to identify and report fraudulent activities. A fiscal note of $500,000 was attached to this requirement of HB154, but it was not funded. Accordingly, DHS used existing resources and activities to ensure better monitoring.

Liability Insurance Add-On in Daily Rate

The HHSC reports currently 702 of the 1050 contracted nursing facility providers (67%) are receiving the liability insurance add-on payment in the daily rate. Of these providers receiving the liability insurance add-on, three are receiving the general liability insurance add-on only (no professional liability insurance add-on) and 17 are receiving the professional liability insurance add-on only (no general liability insurance add-on). The remaining 682 are receiving both the professional and general liability insurance add-on in the daily rates paid to these facilities.

The add-on payment for professional liability insurance is $2.20 per resident, per day and $0.20 per resident per day for general liability insurance. This amount is added to the daily rate for each Medicaid resident in the facility.

Prior to setting the rates for the biennium, HHSC did a survey of nursing facility providers to estimate how many actually had purchased liability insurance coverage. The rate add-on for liability insurance was then set at a level which would expend that part of

the appropriation derived from liability insurance costs, based on the estimated number of facilities with coverage. Thus, the entire appropriation for liability insurance add-on is paid to those facilities with insurance.

In order to obtain the insurance add-on, each facility was required to submit a document certifying insurance coverage and the certificate of insurance from the insurance carrier as evidence of coverage to the HHSC's Rate Analysis Department. Acceptable insurance carriers include admitted carriers authorized to write liability insurance in Texas or an eligible surplus lines insurer in accordance with Article 1.14-2, Insurance Code. Insurance issued by the Texas Medical Liability Insurance Underwriting Association (JUA) is also acceptable. Finally, if the liability insurance was independently procured, the insurance company was referred to the TDI to determine whether the insurance company meets TDI requirements. The review of these insurance companies is currently being conducted by TDI.

Once HHSC has been presented with a valid insurance document and certification, payment of the add-on can be made. A stop date to end the add-on payment is entered. If the policy is renewed and HHSC is given the appropriate documentation, then the stop date on the payment to is extended for the length of the new policy. No further review of policies or certificates is conducted to determine cancellation of coverage after the add-on has been obtained. HHSC does inform providers that it is their responsibility to notify the agency if the policy has been canceled and failure to notify could constitute Medicaid fraud.

Additional Department of Human Services Activities

DHS has initiated changes and programs in response to concerns from the Legislature and the nursing home industry, regarding the regulatory environment for nursing facilities. During the 77th Interim, DHS reorganized its Long Term Care agency structure. The Long Term Care Regulatory Division was transferred under the new Deputy Commission for Long Term Care. This new position is responsible for:

- aligning long term care eligibility services, community care services and contracts;
- policy and staff training; and
- the licensing and regulation of providers.

The agency's goal in this change was to create a seamless system that provides an array of quality services that meet consumer needs.[38] Additionally, oversight and management of the regulatory attorneys and Long Term Care Regulatory Division regional directors was placed under the direction of the Division's regional administrators. This move of administrative duties to the regional administrators is intended to provide Long Term Care Regulatory Division's managers more time to focus on core functions of the agency.[39]

In 2000, DHS created survey comment cards for the nursing facilities to complete, comment and mail to DHS state headquarters about a survey in their facility. These anonymous comment cards allow the facility administrators the freedom to report to the agency how they feel about a survey encounter. The cards are made up of six specific items and administrators are encouraged to add written comments. All negative responses are forwarded to the region so that surveyors and regional administrators are aware of concerns from one of their facilities.

[38]Department of Human Service agency testimony, October 8, 2002

[39]Id.

DHS provided the committee with the following 2002 Third Quarter report:[40]

Facility Type	Number of Responses
Nursing Facility	817
ICF/MR	232
Assisted Living	190
Adult Day Care	44
Did not indicate facility type	117
Total Responses	**1,400**

Below are the results:

Item on Comment Card	Agreed
The conduct of the surveyor(s) during the visit was professional	98.6%
Surveyor(s) followed protocol and considered all pertinent evidence	98.2%
There was minimal disruption to your normal routine due to the surveyor(s) activity	95.6%
The surveyor(s) kept you adequately informed during the course of the survey	97.3%
The surveyor(s) adequately explained the findings or deficiencies	98.6%
The surveyor(s) spent sufficient time to perform an adequate investigation or survey	99.4%

[40] Id.

Finally, Commissioner Jim Hine created the Long Term Care Workgroup composed of consumers, providers, advocates, regulators, an ombudsman, and DHS management to address key issues for the agency. The process addressed four critical areas: contract management, agency infrastructure, Texas Works, and Long Term Care. The Long Term Care Workgroup was given the charge to develop innovative and collaborative models for improved long term care service delivery. Additionally the group was to implement a program that guides the actions and relationships of individual Texas service providers and DHS, so as to:

- provide a broad array of quality services to maximize client choice and independence;
- ensure the health and safety of all long term care clients, and reward those providers who demonstrate exceptional service;
- secure ready access for clients, providers, and client advocates to the long term care delivery system as a whole, as well as to individual service components; and
- facilitate appropriate service delivery to clients with individualized needs and expectations.[41]

The result from this workgroup was the following Vision and Core Values statement:

> Texas is committed to a premier long term care system that provides a comprehensive continuum of services designed to promote independence and effectively balance quality of life, consumer choice, quality service delivery and personal safety.

To that end, the working group created recommendations to enhance the regulatory process experience and improve collaboration and coordination between industry stakeholders and DHS. Efforts, such as these, contribute to the improving infrastructure for the long term care industry.

[41]Department of Human Services testimony, October 8, 2002

Interim Research Projects

In most debates regarding long term care issues, quality of care was the shared goal held by all the stakeholders. While many disagreed on the solutions to the crisis, all involved wanted to ensure that the frail and elderly are offered the highest level of care in Texas facilities. However, there were no real definitions of what is quality of care and what is the best means to achieve such care.

The Long Term Care Legislative Oversight Committee partnered with Texas Legislative Council Statistical & Demographic Research Division to investigate different mechanisms and measurements for quality of care. It was the hope of the committee that the research results would provide common ground from which stakeholders can better evaluate aspects of quality care.

The following research projects were conducted during the interim:

1. **Evaluation of Current Texas Nursing Home Quality Reporting System**

   QUESTION: Can the current Texas nursing home Quality Reporting System (QRS) developed and implemented by the Texas Department of Human Services (TDHS) be improved to assist consumers in selecting a quality nursing home?

   ANSWER: Yes. Our evaluation revealed aspects of the QRS that can be improved.

2. **Does Predictability of Regulatory Surveys Affect Quality of Care?**

   QUESTION: Does an unpredictable survey process affect the quality of care in nursing facilities relative to a partially predictable survey process?

   ANSWER: At this point in our research, the data indicate that survey unpredictability had no measurable effect on the quality of services provided in nursing facilities between April 2000 and February 2002.

3. **Assessing Quality of Care in Nursing Homes**

   QUESTION: Is there evidence that Texas nursing facilities under-report problems relating to quality of care in nursing facilities?

ANSWER: No. An independent assessment of data reported by nursing facilities does not show any pattern of systematic underreporting. On some items, independent review found more problem cases than reported by facilities. On other items, facilities reported more problem cases than were found on independent review.

4. **Adequacy of Numbers of Nursing Home Regulators**

QUESTION: How does the number of nursing home survey and certification personnel in Texas compare to the number in other states?

ANSWER: The number of personnel in Texas compares favorably to the number in other states. In FY2000, Texas had the fifth highest number of survey and certification personnel per 1,000 nursing home residents.

5. **State Comparisons of Nursing Home Reimbursement Methodologies**

QUESTION: Would Texas reduce costs by adopting the reimbursement methodology of another state?

ANSWER: One approach to adopting a different reimbursement methodology addresses only the method of categorizing nursing home residents--for example, using the Resource Utilization Groups (RUGs-III) instead of the Texas Index for Level of Effort (TILE). A change of this type would have no effect on the budget because the existing TILE effort levels (i.e., minutes of attention from nursing staff) would be applied to the RUGs-III categories. However, there might be other non-budgetary implications.

6. **Adequacy of Nursing Home Quality Indicators**

QUESTION: Is there evidence to suggest that certain nursing home Quality Indicators are not adequate to signal some quality of care problems, suggesting that the State of Texas should request the Centers for Medicare & Medicaid Services to revise such indicators?

ANSWER: No. There is no evidence to suggest that Quality Indicators fail to capture problems with quality of care. However, this finding implies that quality of care problems may be concentrated in a persistent subset of "low quality" facilities and are not

randomly distributed throughout all facilities in the state.

7. **Evaluation of the TDHS Quality-of-Care Monitor Program**

QUESTION: Has the Quality-of-Care Monitor Program, as required by Senate Bill 1839, 77th Legislature, Regular Session, improved the quality of care provided to residents of Texas nursing homes?

ANSWER: No. Six separate analyses were undertaken to determine whether there has been programmatic effect, but in no case did the analyses show that the program is producing a net improvement of the quality of care. Since the program has been in effect for less than one year, it seems advisable to reevaluate the program periodically.

The complete results of these research projects are attached as Exhibits 6-12.

Recommendations

- 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. In response, the Legislature passed S.B. 1839, the provisions of which were aimed at addressing the systemic and fundamental problems plaguing the industry. As with most comprehensive and complex pieces of legislation, implementation occurs over time. Additionally, ample opportunity is needed to truly assess the legislation's success. Thus, at this time, the Committee recommends that the 78th Legislature refrain from making dramatic changes to the legislation.

- In choosing the implementation date for mandatory liability insurance of September 1, 2003, the 77th Legislature was mindful that the requirement for insurance was a significant change from the status quo. Moreover, although the Legislature supported the concept that all nursing homes should carry liability insurance, the Legislature did not intend to place an unreasonable financial burden on the nursing homes. The use of September 1, 2003 was specifically chosen to give the Legislature the opportunity to review the fiscal implications of this enactment date again during the 78th Legislative session. Thus, the Committee recommends that the 78th Legislature evaluate whether postponing the implementation date for mandatory insurance would be prudent. The Committee also recommends that the 78th Legislature consider whether different types of insurance (i.e., self-insurance, etc....) which should be permissible under this provision.

- The Committee has heard anecdotally that contributions to the charitable endowments of several faith-based organizations has decreased significantly. The faith-based organizations attribute this reduction, in part, to fear on behalf of the contributors that their donated funds will be used to pay for litigation and settlement expenses rather than for caring for the elderly. In an effort to protect these endowments, the Legislature should consider legislation to shield this money from lawsuits in instances where the charitable organization purchases professional liability insurance.

- The 78th Legislature should consider legislation to allow the Joint Underwriters Association (JUA) to write general liability policies for those nursing homes who also purchase professional liability policies from the JUA.

- In an effort to better implement HB 154, HHSC should require facilities to file with their cost reports a statement, on a form proscribed by HHSC, from the insurance carrier(s) certifying the facility had liability insurance coverage in effect during the relevant time period. If the facility fails to show coverage for the entire relevant time period, HHSC should recoup the State and Federal funds paid for services not provided.

- In an effort to reduce redundancy in paperwork, as well as providing conformity between state and federal agencies, the Legislature should consider a phase out of the TILE(Texas Index for Level of Effort) reporting reimbursement system and substituting with RUGs III (Resource Utilization Groups), if funds become available.

Demographic Implications for the Long-term Care System

by

Steve H. Murdock

Department of Rural Sociology

Texas Agricultural Experiment Station

The Texas A&M University System

Major Demographic Trends Affecting the Future

- Change in Rates and Sources of Population Growth
- Increase in the Non-Anglo Population
- Aging of the Population
- Change in Household Composition

Total Population Change

Total Population and Percent Population Change in Texas and the United States, 1850-2000

Year	Total Population		Percent Change	
	Texas	U.S.	Texas	U.S.
1850	212,592	23,191,8 76	---	---
1860	604,215	31,443,321	184.2	35.6
1870	818,579	39,818,449	35.5	26.6
1880	1,591,749	50,155,783	94.5	26.0
1890	2,235,527	62,947,714	40.4	25.5
1900	3,048,710	75,994,575	36.4	20.7
1910	3,896,542	91,972,266	27.8	21.0
1920	4,663,228	105,710,620	19.7	14.9
1930	5,824,715	122,775,046	24.9	16.1
1940	6,414,824	131,669,275	10.1	7.2
1950	7,711,194	150,697,361	20.2	14.5
1960	9,579,677	179,323,175	24.2	19.0
1970	11,196,730	203,302,031	16.9	13.4
1980	14,229,191	226,545,805	27.1	11.4
1990	16,986,510	248,709,873	19.4	9.8
2000*	20,851,820	281,421,906	22.8	13.2

* All values are for the indicated census year.

Ten Fastest Growing States in Numerical Terms in the United States, 1990-2000

State	1990 Population*	2000 Population*	Numerical Change 1990-2000	Percent Population Change 1990-2000
California	29,760,021	33,871,648	4,111,627	13.8
Texas	16,986,510	20,851,820	3,865,310	22.8
Florida	12,937,926	15,982,378	3,044,452	23.5
Georgia	6,478,216	8,186,453	1,708,237	26.4
Arizona	3,665,228	5,130,632	1,465,404	40.0
North Carolina	6,628,637	8,049,313	1,420,676	21.4
Washington	4,866,692	5,894,121	1,027,429	21.1
Colorado	3,294,394	4,301,261	1,006,867	30.6
Illinois	11,430,602	12,419,293	988,691	8.6
New York	17,990,455	18,976,457	986,002	5.5

* Population values are decennial census counts for April 1 of the year indicated

Ten Fastest Growing States in Percentage Terms in the United States, 1990-2000

State	1990 Population*	2000 Population*	Numerical Change 1990-2000	Percent Population Change 1990-2000
Nevada	1,201,833	1,998,257	796,424	66.3
Arizona	3,665,228	5,130,632	1,465,404	40.0
Colorado	3,294,394	4,301,261	1,006,867	30.6
Utah	1,722,850	2,233,169	510,319	29.6
Idaho	1,006,749	1,293,953	287,204	28.5
Georgia	6,478,216	8,186,453	1,708,237	26.4
Florida	12,937,926	15,982,378	3,044,452	23.5
Texas	16,986,510	20,851,820	3,865,310	22.8
North Carolina	6,628,637	8,049,313	1,420,676	21.4
Washington	4,866,692	5,894,121	1,027,429	21.1

* Population values are decennial census counts for April 1 of the year indicated

Ten Largest States in United States by Population Size in 2000 Ranked by Population Size in 2000

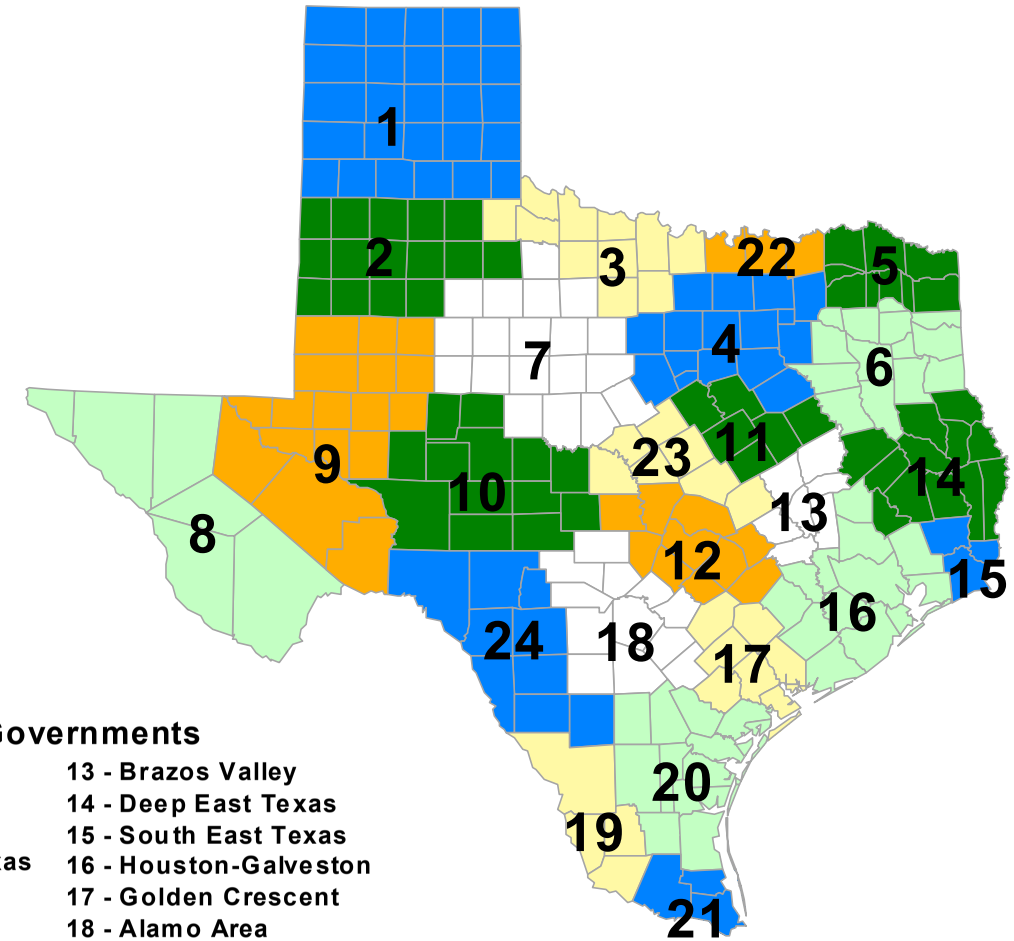
State	1990 Population*	2000 Population*	Numerical Change 1990-2000	Percent Change 1990-2000
California	29,760,021	33,871,648	4,111,627	13.8
Texas	16,986,510	20,851,820	3,865,310	22.8
New York	17,990,455	18,976,457	986,002	5.5
Florida	12,937,926	15,982,378	3,044,452	23.5
Illinois	11,430,602	12,419,293	988,691	8.6
Pennsylvania	11,881,643	12,281,054	399,411	3.4
Ohio	10,847,115	11,353,140	506,025	4.7
Michigan	9,295,297	9,938,444	643,147	6.9
New Jersey	7,730,188	8,414,350	684,162	8.9
Georgia	6,478,216	8,186,453	1,708,237	26.4

* Population values are decennial census counts for April 1 of the year indicated

Number of Areas in Texas with 1990-2000 Population Increases in Total Population and Populations from Each Racial/Ethnic Group

	Total	Anglo	Black	Hispanic	Other
Councils of Governments (N=24)	24 (100.0%)	15 (62.5%)	23 (95.8%)	24 (100.0%)	23 (95.8%)
Metropolitan Areas (N=27)	27 (100.0%)	23 (85.2%)	26 (96.3%)	27 (100.0%)	27 (100.0%)
Counties	186 (73.2%)	143 (56.3%)	165 (68.8%)	227 (89.4%)	201 (80.1%)
N=	(254)	(254)	(240)	(254)	((251)
Places	945 (74.0%)	704 (56.0%)	601 (61.5%)	1,082 (88.0%)	783 (74.1%)
N=	(1,277)	(1,257)	(978)	(1,229)	(1,057)

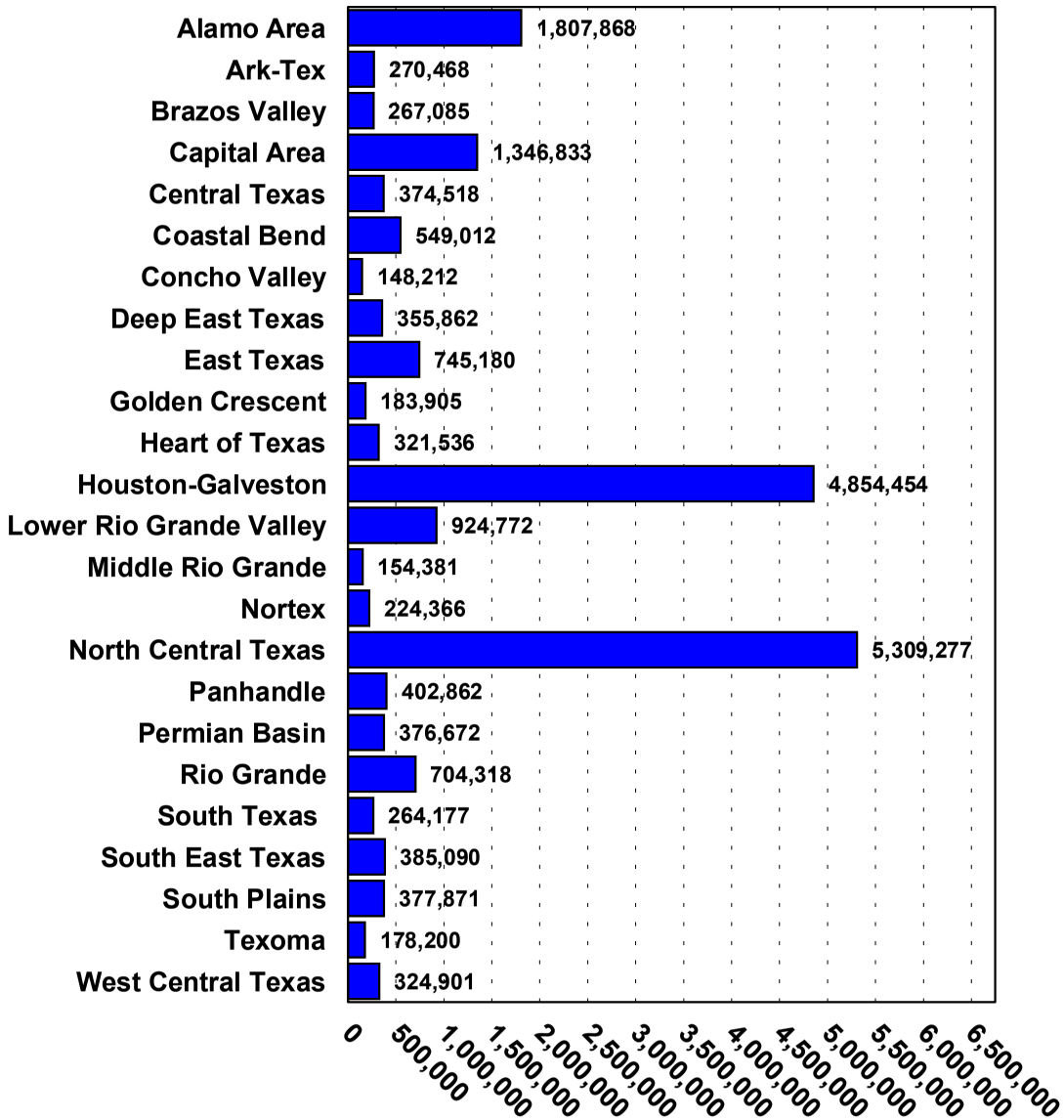
Councils of Governments in Texas



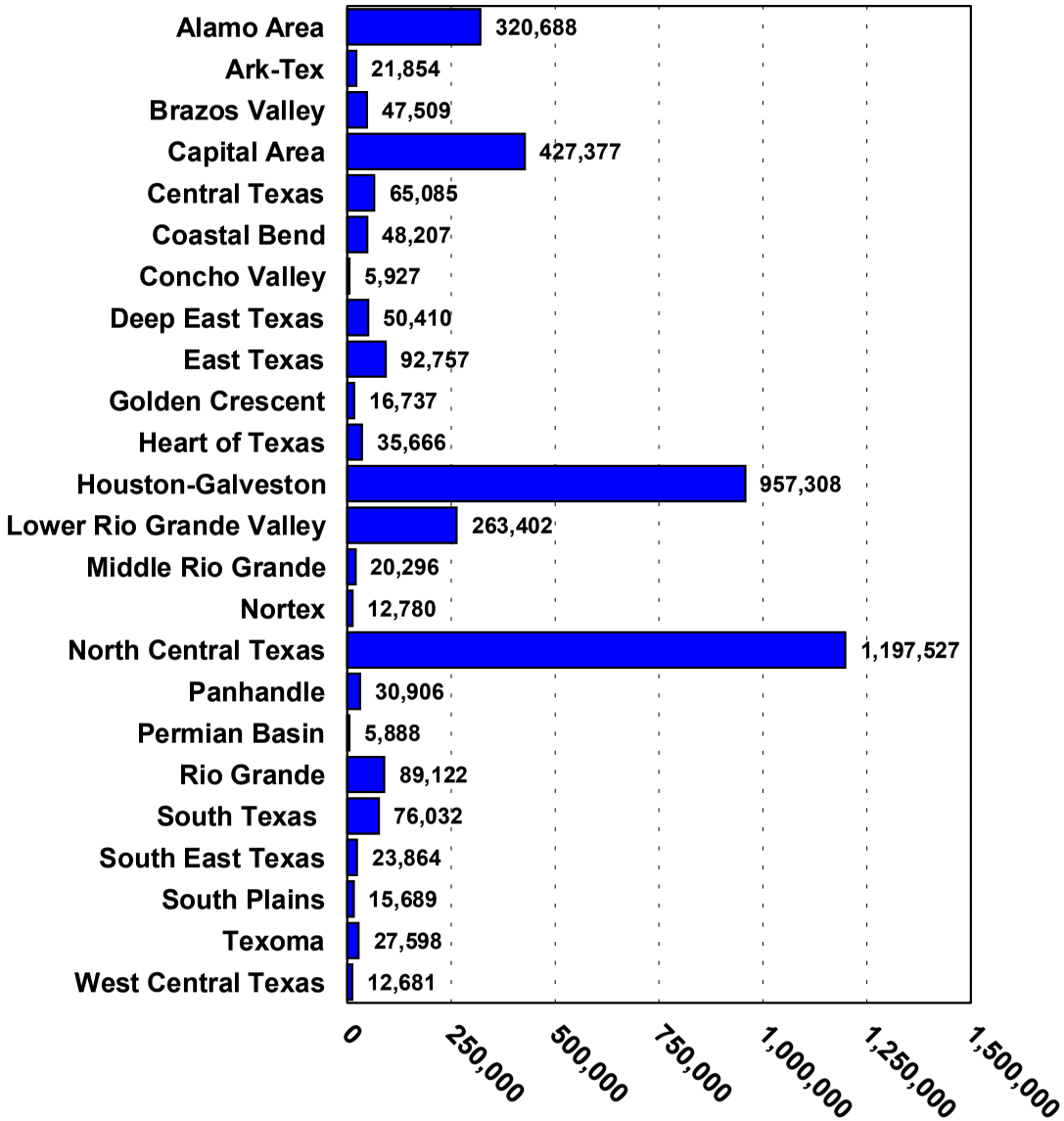
Councils of Governments

1 - Panhandle
2 - South Plains
3 - Nortex
4 - North Central Texas
5 - Ark-Tex
6 - East Texas
7 - West Central Texas
8 - Rio Grande
9 - Permian Basin
10 - Concho Valley
11 - Heart of Texas
12 - Capital Area
13 - Brazos Valley
14 - Deep East Texas
15 - South East Texas
16 - Houston-Galveston
17 - Golden Crescent
18 - Alamo Area
19 - South Texas
20 - Coastal Bend
21 - Lower Rio Grande Valley
22 - Texoma
23 - Central Texas
24 - Middle Rio Grande

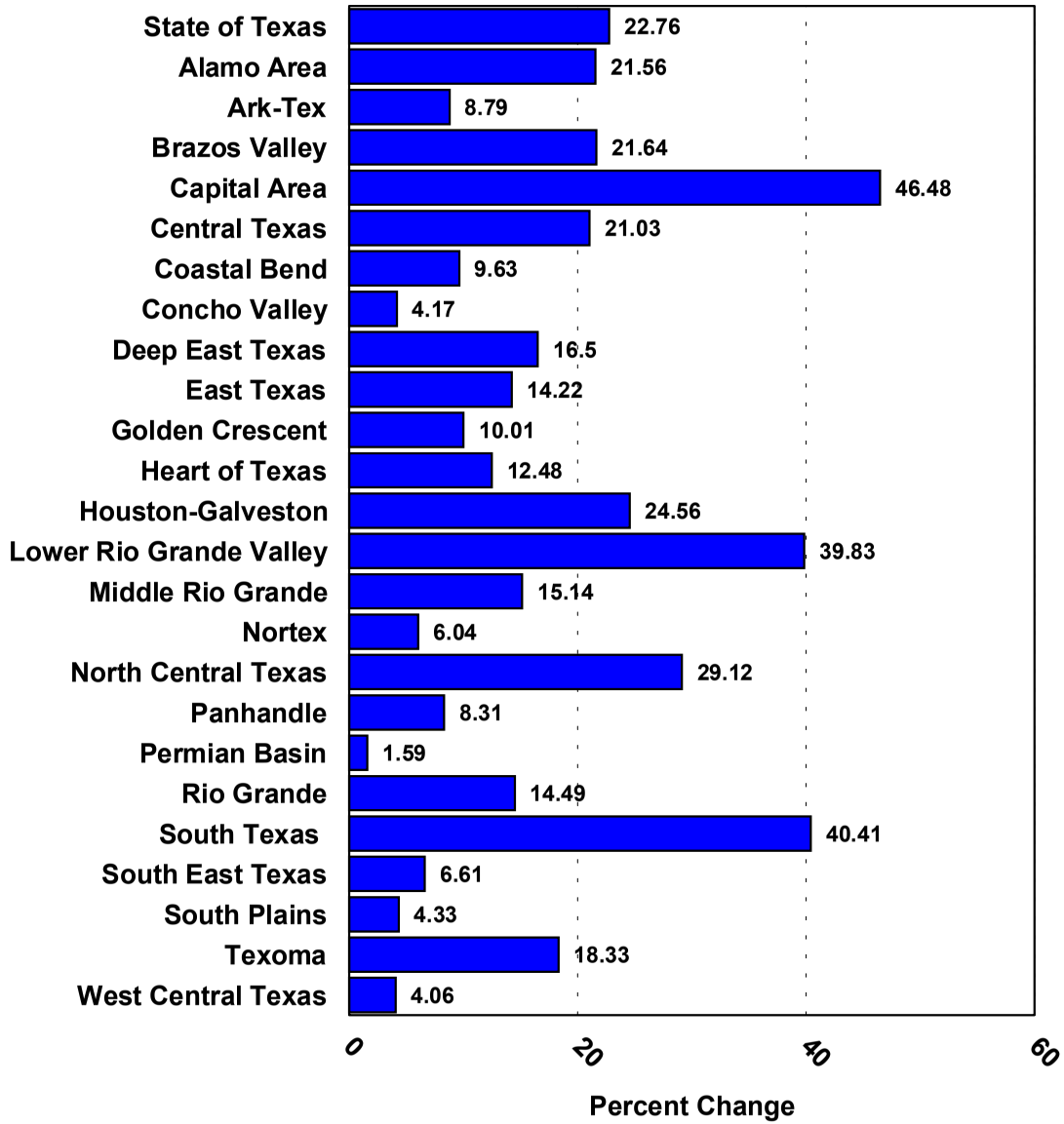
Population in 2000 for Council of Government Regions in Texas



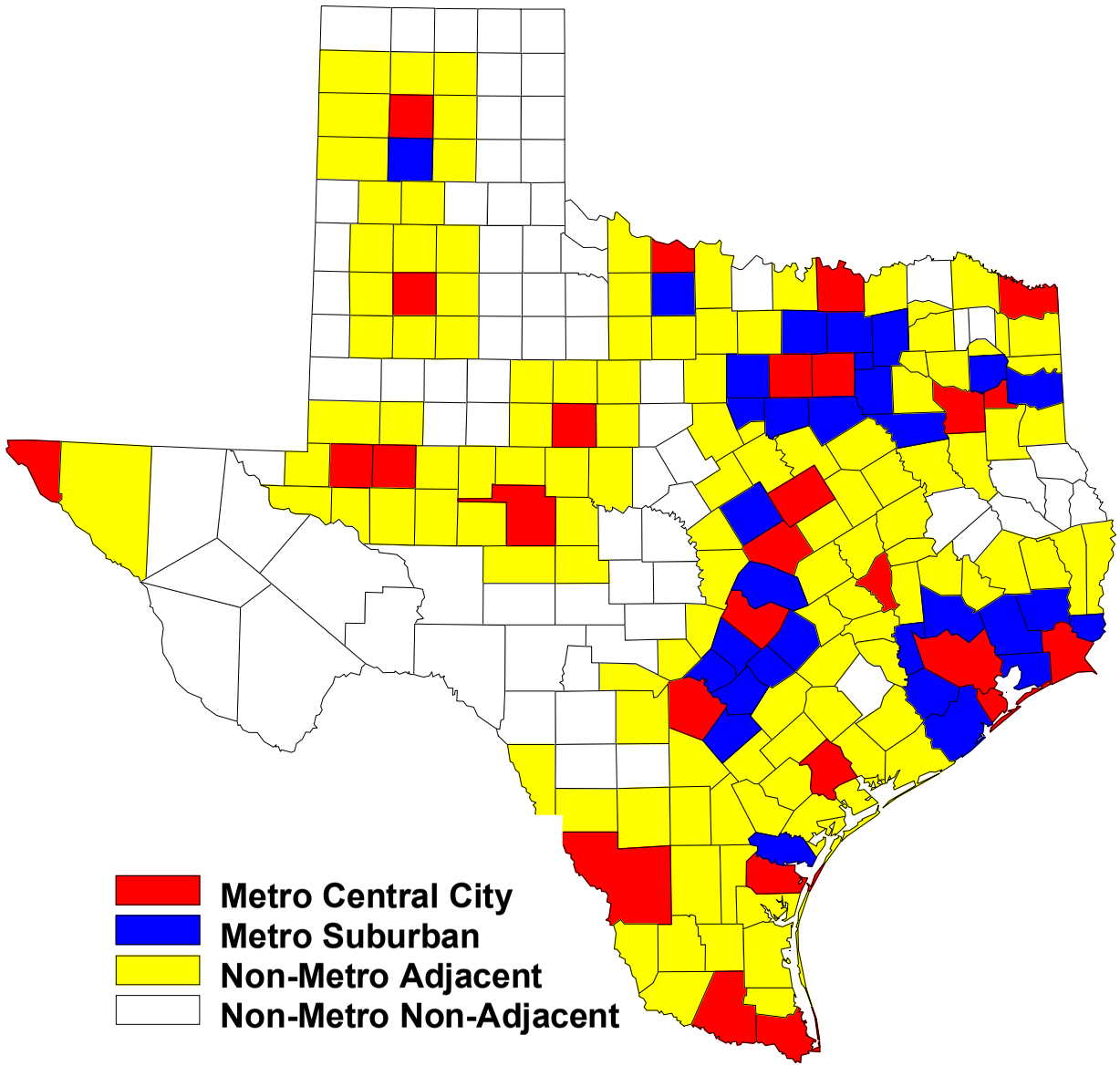
Numerical Change in Population from 1990 to 2000 for Council of Government Regions in Texas



Percent Change in Population from 1990 to 2000 for Council of Government Regions in Texas



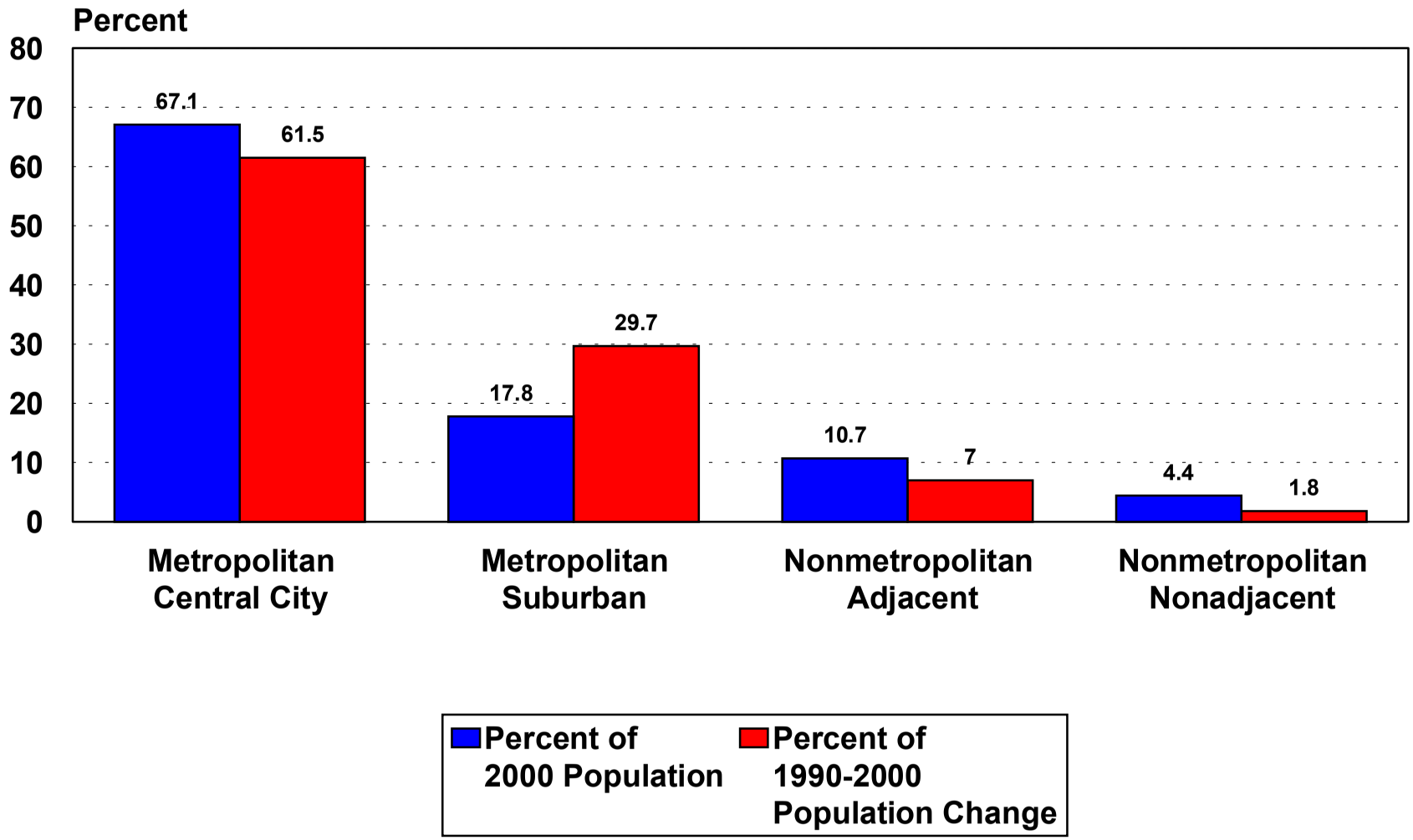
Counties by Metropolitan Status



Population in 1990 and 2000, Numerical and Percent Change in Population 1990 to 2000 in Metropolitan and Nonmetropolitan Areas in Texas

Metropolitan Status	Population		Change in Population	
	1990	2000	Number	Percent
Metropolitan Central City	11,615,291	13,993,705	2,378,414	20.48
Metropolitan Suburban	2,550,367	3,698,175	1,147,808	45.01
Nonmetropolitan Adjacent	1,962,353	2,234,027	271,674	13.84
Nonmetropolitan Nonadjacent	858,499	925,913	67,414	7.85

Percent of Total State Population and Percent of Total State Population Change for 1990 to 2000 by Metropolitan and Nonmetropolitan Status in Texas



Population in 1990 and 2000, Numerical and Percent Change in Population 1990 to 2000 in Counties in Texas Ranked by Population Size, 2000

Rank	County	Population		Change in Population	
		1990	2000	Number	Percent
1	Harris	2,818,199	3,400,578	582,379	20.66
2	Dallas	1,852,810	2,218,899	366,089	19.76
3	Tarrant	1,170,103	1,446,219	276,116	23.60
4	Bexar	1,185,394	1,392,931	207,537	17.51
5	Travis	576,407	812,280	235,873	40.92
6	El Paso	591,610	679,622	88,012	14.88
7	Hidalgo	383,545	569,463	185,918	48.47
8	Collin	264,036	491,675	227,639	86.22
9	Denton	273,525	432,976	159,451	58.29
10	Fort Bend	225,421	354,452	129,031	57.24
11	Cameron	260,120	335,227	75,107	28.87
12	Nueces	291,145	313,645	22,500	7.73
13	Montgomery	182,201	293,768	111,567	61.23
14	Jefferson	239,397	252,051	12,654	5.29
15	Galveston	217,399	250,158	32,759	15.07
16	Williamson	139,551	249,967	110,416	79.12
17	Lubbock	222,636	242,628	19,992	8.98
18	Brazoria	191,707	241,767	50,060	26.11
19	Bell	191,088	237,974	46,886	24.54
20	McLennan	189,123	213,517	24,394	12.90

Population in 1990 and 2000, Numerical and Percent Change in Population 1990 to 2000 in Counties in Texas Ranked by Percent Change, 1990-2000

Rank	County	Population		Change in Population	
		1990	2000	Number	Percent
1	Collin	264,036	491,675	227,639	86.22
2	Williamson	139,551	249,967	110,416	79.12
3	Rockwall	25,604	43,080	17,476	68.25
4	Bandera	10,562	17,645	7,083	67.06
5	Kendall	14,589	23,743	9,154	62.75
6	Montgomery	182,201	293,768	111,567	61.23
7	Denton	273,525	432,976	159,451	58.29
8	Fort Bend	225,421	354,452	129,031	57.24
9	Hartley	3,634	5,537	1,903	52.37
10	Bastrop	38,263	57,733	19,470	50.88
11	Burnet	22,677	34,147	11,470	50.58
12	Comal	51,832	78,021	26,189	50.53
13	Hays	65,614	97,589	31,975	48.73
14	Hidalgo	383,545	569,463	185,918	48.47
15	Llano	11,631	17,044	5,413	46.54
16	Webb	133,239	193,117	59,878	44.94
17	Medina	27,312	39,304	11,992	43.91
18	Wilson	22,650	32,408	9,758	43.08
19	Hood	28,981	41,100	12,119	41.82
20	Blanco	5,972	8,418	2,446	40.96

Racial/Ethnic Change in Texas

Texas Rank Among States on Selected Characteristics of Race/Ethnicity Groups

Group	Texas Value	Texas Rank	Comparison Areas
By Size in 2000			
Anglo	10,291,680	3	California; 17.0 million New York; 12.5 million
Black	2,421,653	2	New York; 2.9 million
Hispanic	6,669,666	2	California; 11.0 million
Other	685,785	4	California; 4.2 million New York; 1.2 million Hawaii; 733,000

Texas Rank Among States on Selected Characteristics of Race/Ethnicity Groups

Group	Texas Value	Texas Rank	Comparison Areas
By Numerical Change, 1990-2000			
Anglo	783,036	2	Florida; 1.1 million
Black	445,293	3	Florida; 665,000 Georgia; 627,000
Hispanic	2,329,761	2	California; 3.3 million
Other	307,220	3	California; 1.2 million New York; 493,000

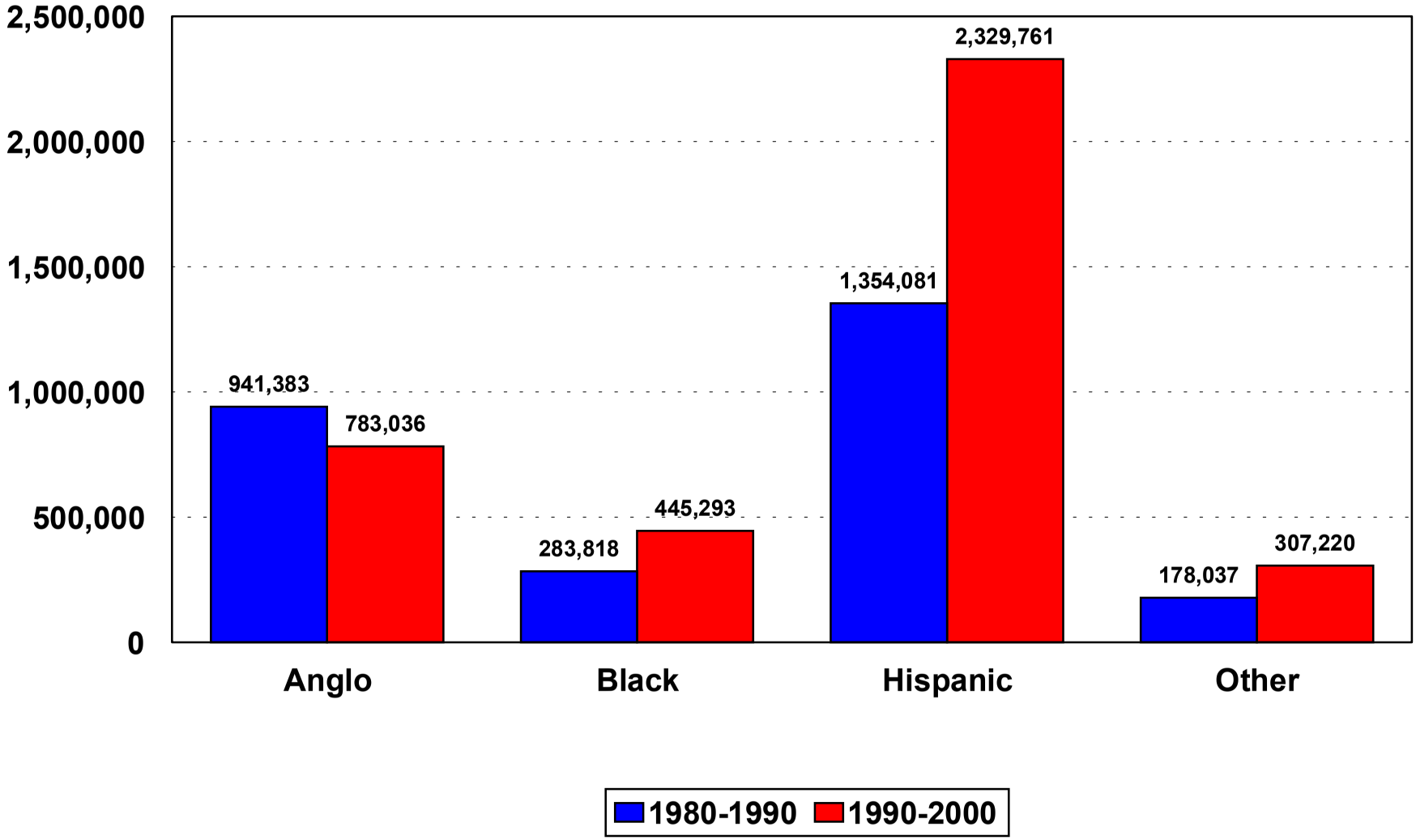
Anglo Population For States in the United States in 1990 and 2000 Ranked by Total Population Size in 2000

State	1990 Anglo Population	2000 Anglo Population	Numerical Change 1990-2000	Percent Change 1990-2000
California	17,029,126	16,393,491	-635,635	-3.73
Texas	10,291,680	11,074,716	783,036	7.61
New York	12,460,189	11,921,371	-538,818	-4.32
Florida	9,475,326	10,568,868	1,093,542	11.54
Illinois	8,550,208	8,514,486	-35,722	-0.42
Pennsylvania	10,422,058	10,373,049	-49,009	-0.47
Ohio	9,444,622	9,604,550	159,928	1.69
Michigan	7,649,951	7,906,629	256,678	3.36
New Jersey	5,718,966	5,625,346	-93,620	-1.64
Georgia	4,543,425	5,170,762	627,337	13.81

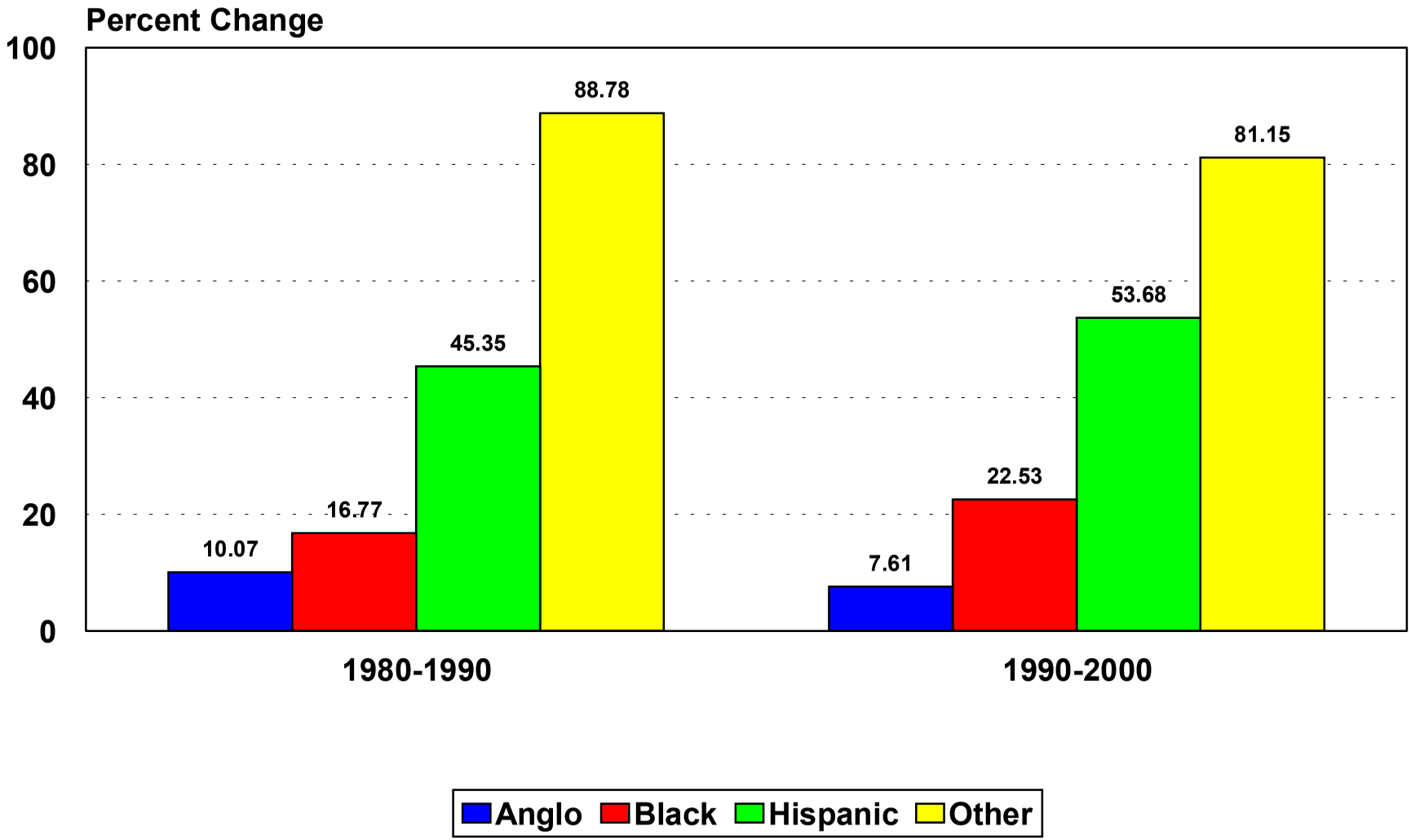
Texas Rank Among States on Selected Characteristics of Race/Ethnicity Groups

Group	Texas Value	Texas Rank	Comparison Areas
By Percent of Total Population in 2000			
Anglo	53.1	47	Ahead of Hawaii; 30.1 Ahead of New Mexico; 45.7 Ahead of California; 48.4
Black	11.6	18	Highest is Mississippi; 36.4 Lowest is Montana; 0.4
Hispanic	32.0	3	New Mexico; 42.1 California; 32.4
Other	3.3	22	Highest is Hawaii; 60.5 Lowest is West Virginia; 0.9

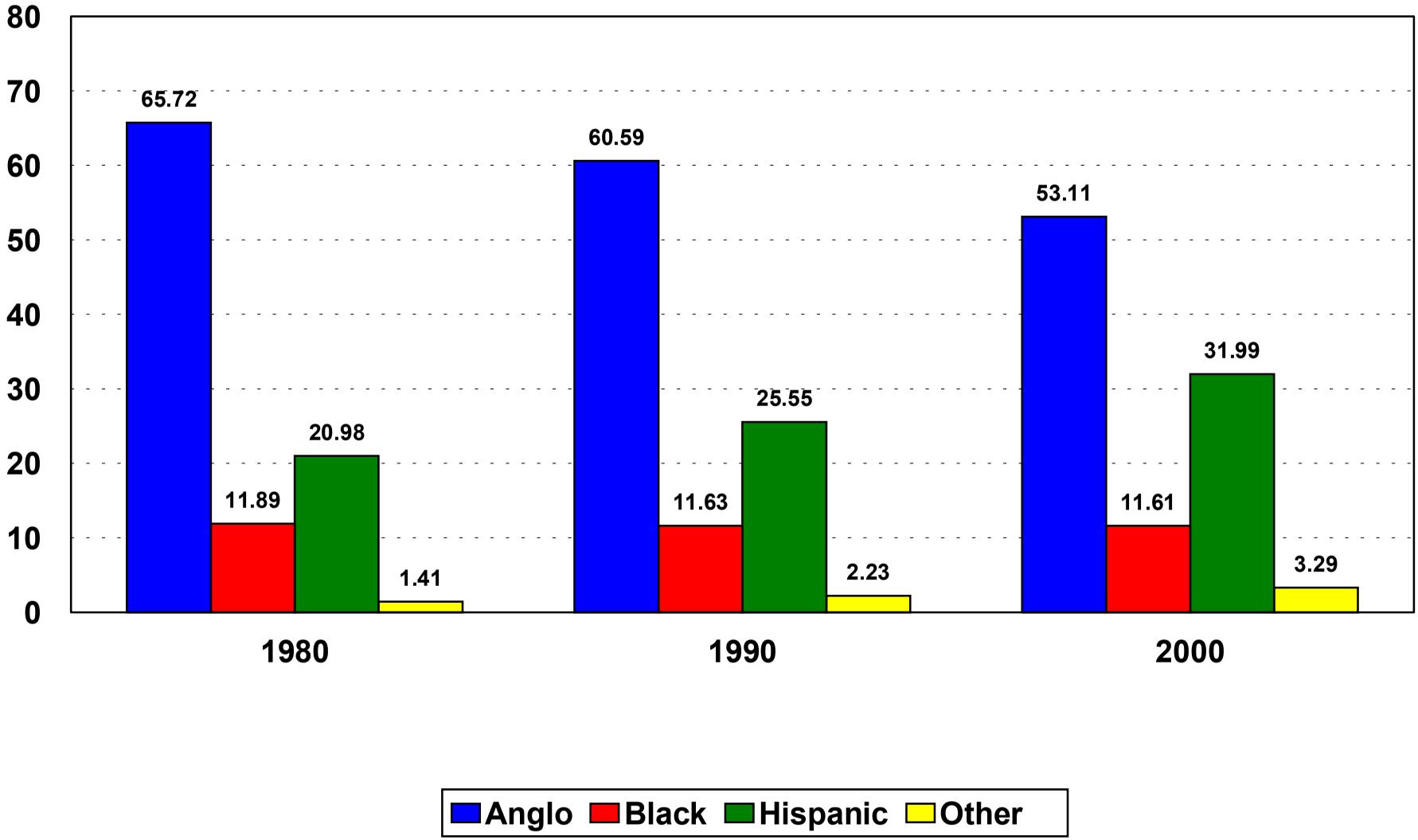
Numerical Change in Population by Race/Ethnicity in Texas for 1980-1990 and 1990-2000



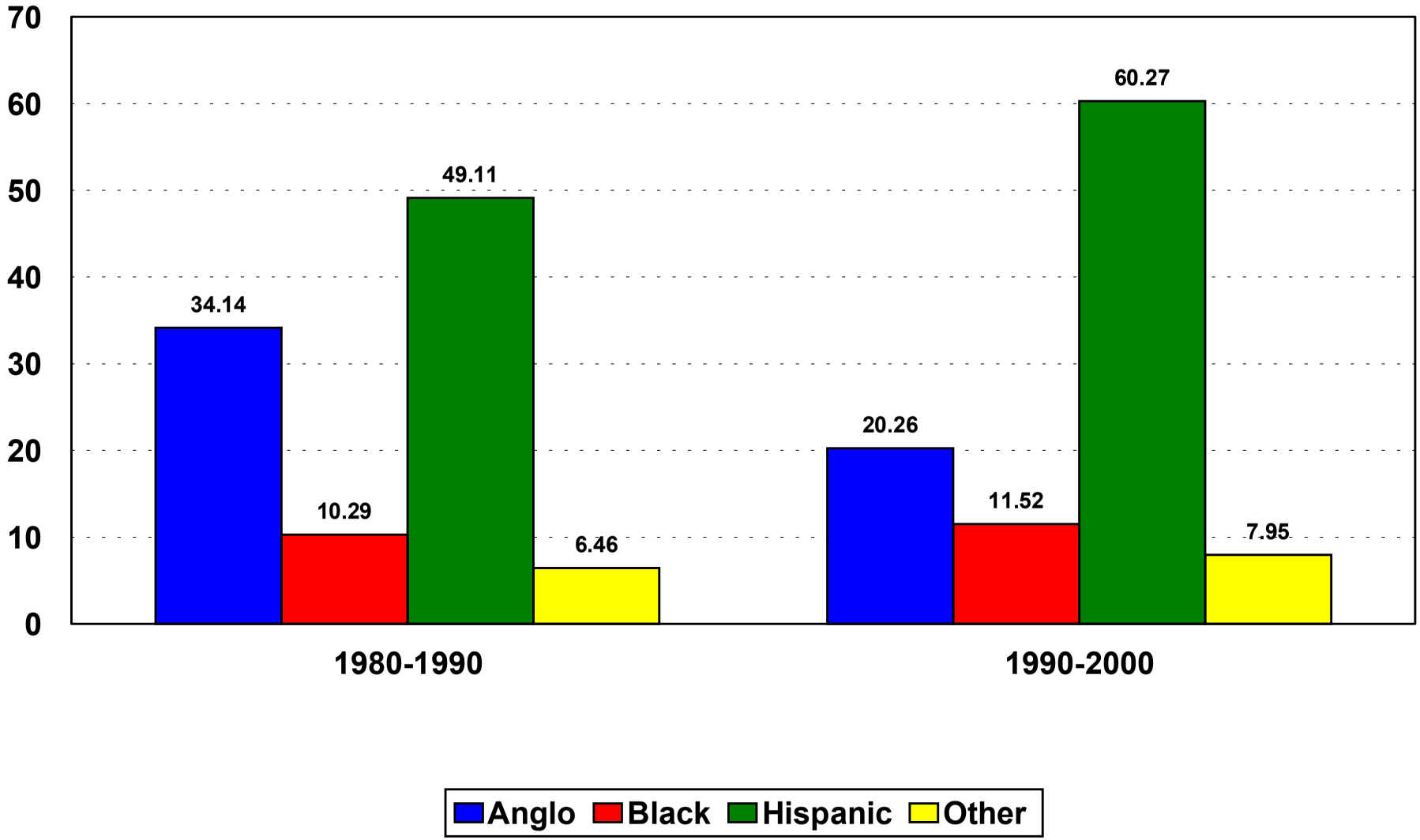
Percent Change in Population by Race/Ethnicity for 1980-1990 and 1990-2000 in Texas



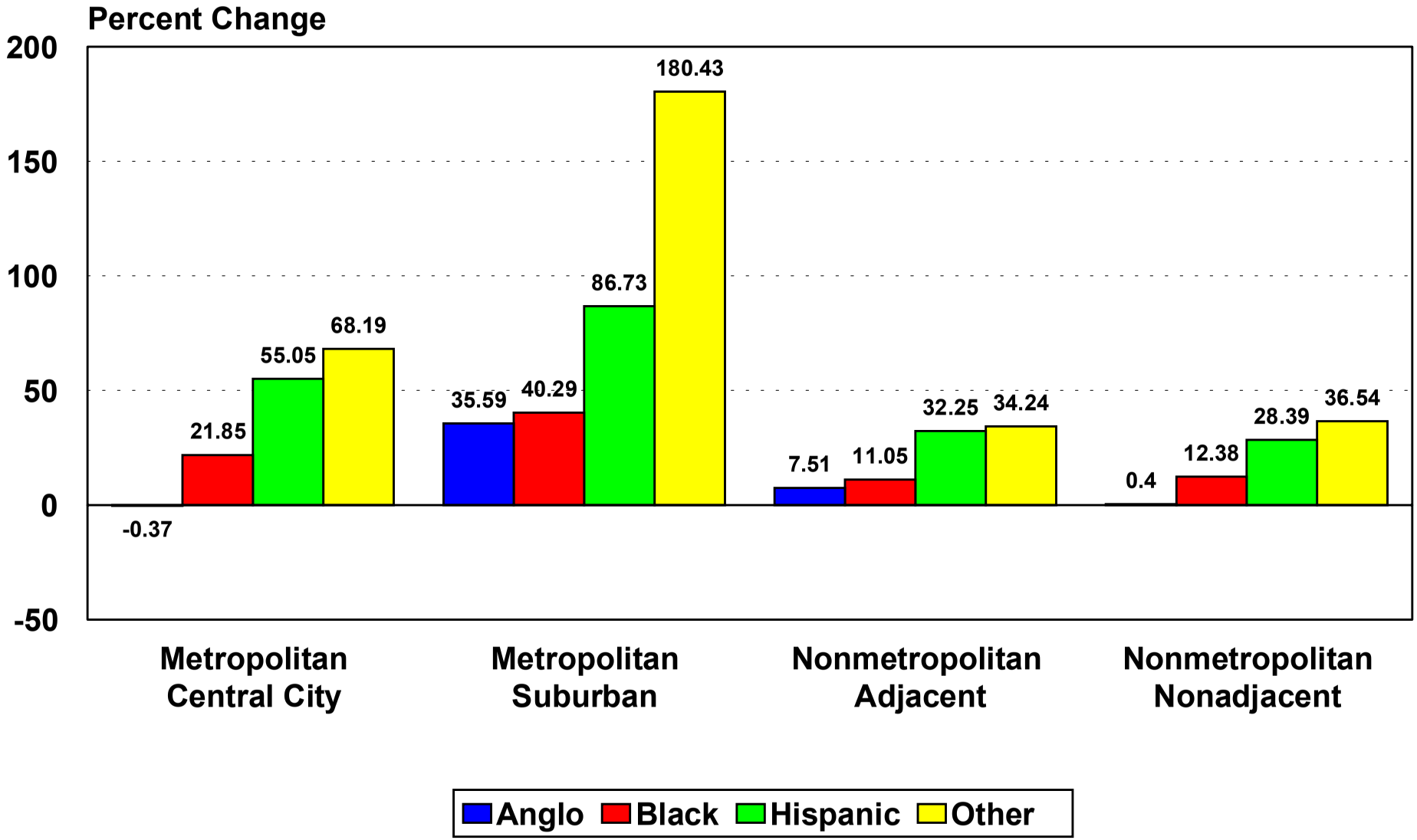
Proportion of Population by Race/Ethnicity in Texas in 1980, 1990 and 2000



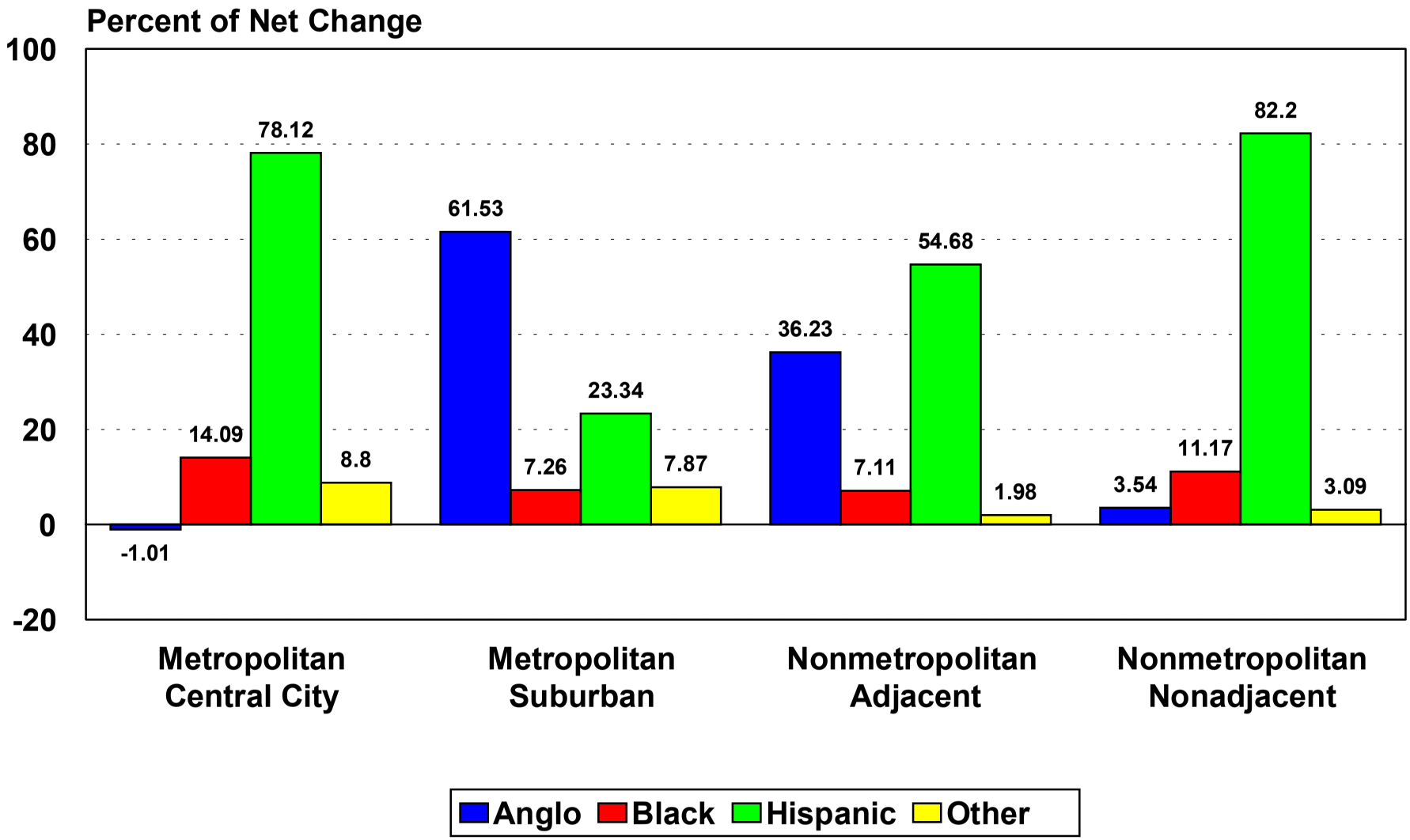
Proportion of Net Population Change Attributable to Each Race/Ethnicity Group in Texas for 1980-1990 and 1990-2000



Percent Change in Population from 1990 to 2000 by Race/Ethnicity by Metropolitan Status in Texas



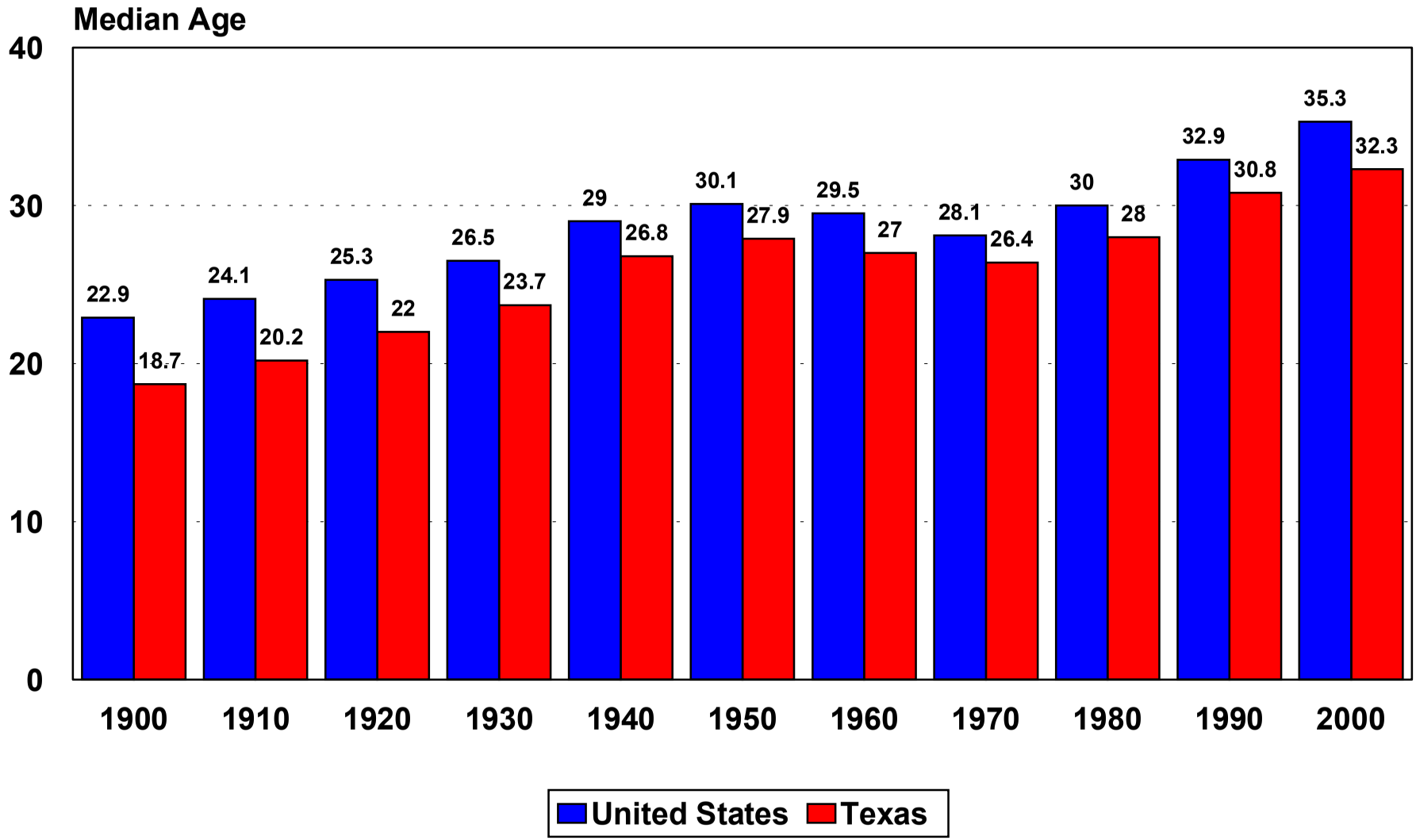
Proportion of Net Population Change from 1990 to 2000 Attributable to Each Racial/Ethnic Group by Each Metropolitan Status Type in Texas



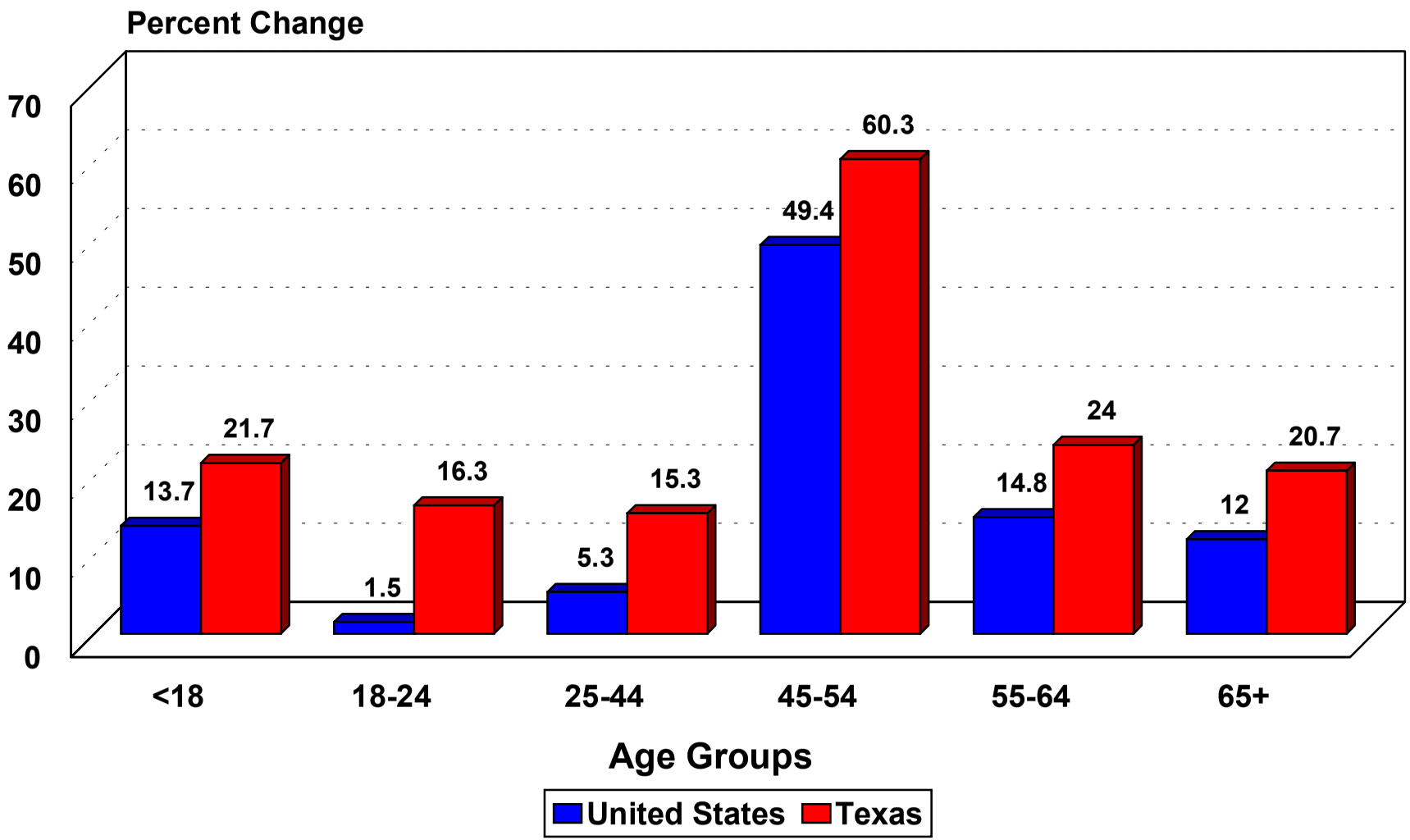
Major Changes in Population Composition (Characteristics)

- **Age**

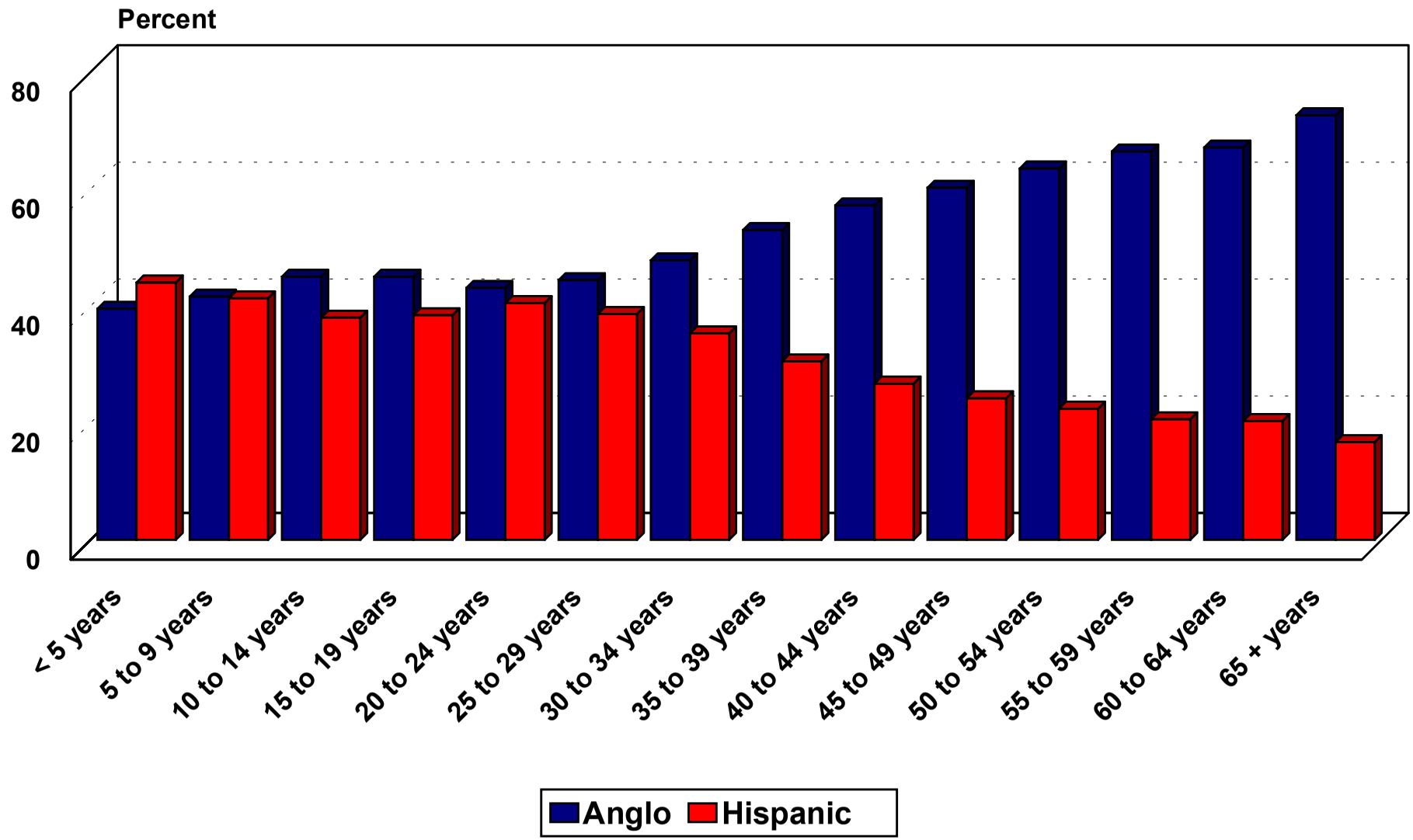
Median Age in the United States and Texas, 1900-2000



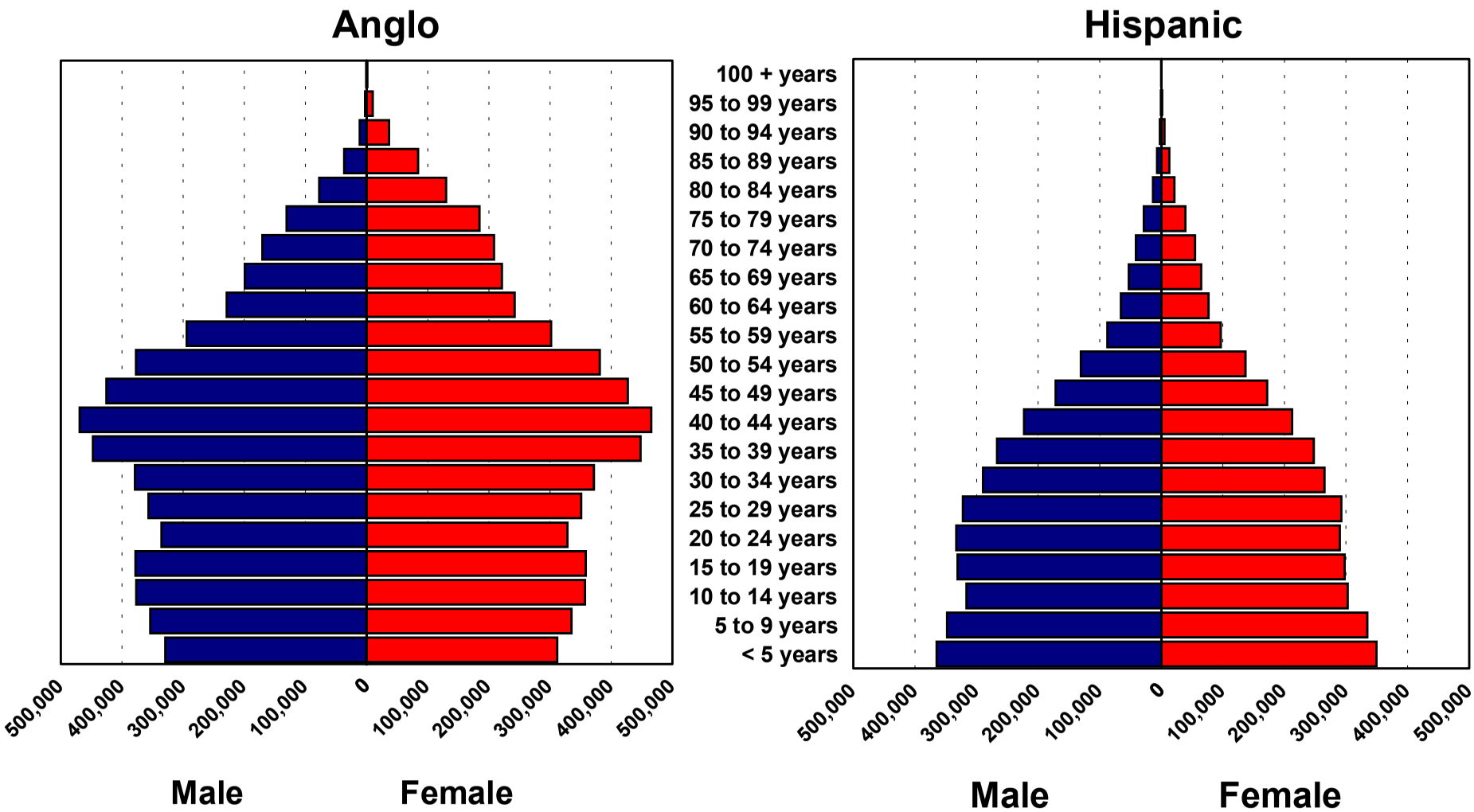
Percent Change in Population by Age Group in the United States and Texas, 1990-2000



Percent of Texas Population By Age Group and Ethnicity, 2000



Population Pyramids for Anglo and Hispanic Ethnic Groups in Texas, 2000



Major Changes in Population Composition (Characteristics)

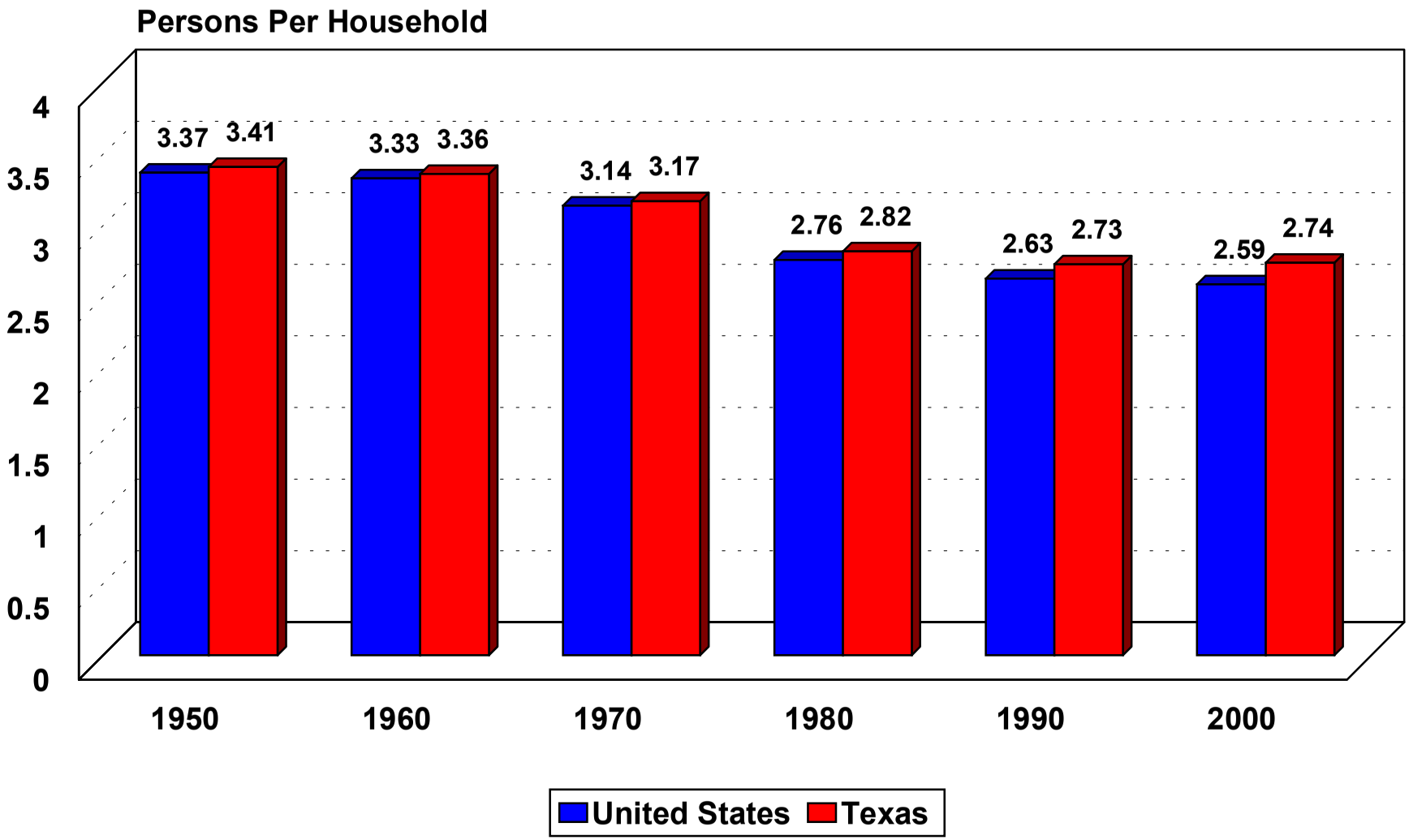
- **Household and Family Characteristics**

Number of Households in the United States and Texas in 1970, 1980, 1990, and 2000

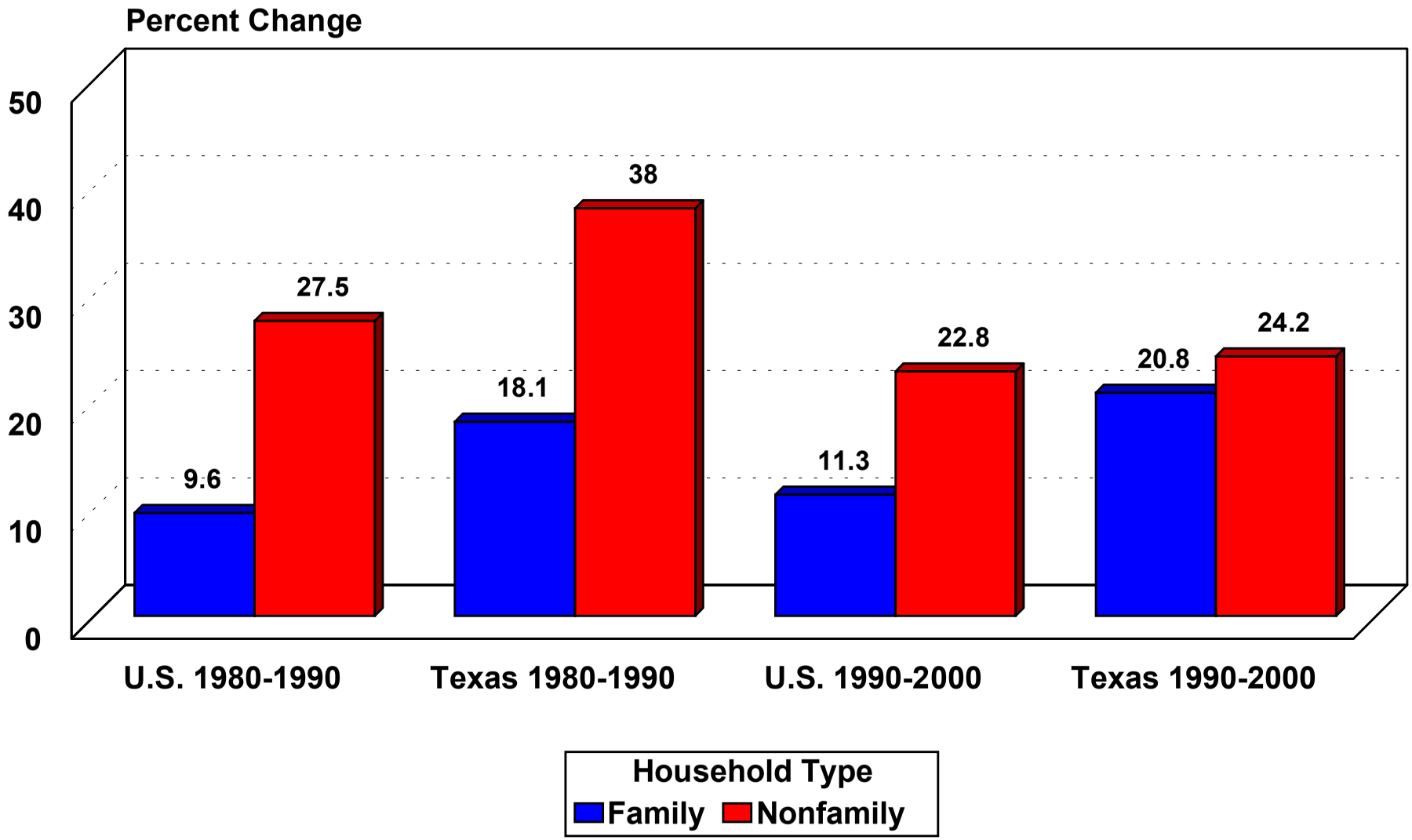
	Number of Households				Percent Change in Households		
	1970	1980	1990	2000	1970-80	1980-90	1990-2000
U.S.	63,616,135	80,467,427	91,947,410	105,480,101	26.5	14.3	14.7
Texas	3,440,366	4,934,936	6,070,937	7,393,354	43.4	23.0	21.8

Source: Data for 1970-2000 from the decennial censuses for the respective years.

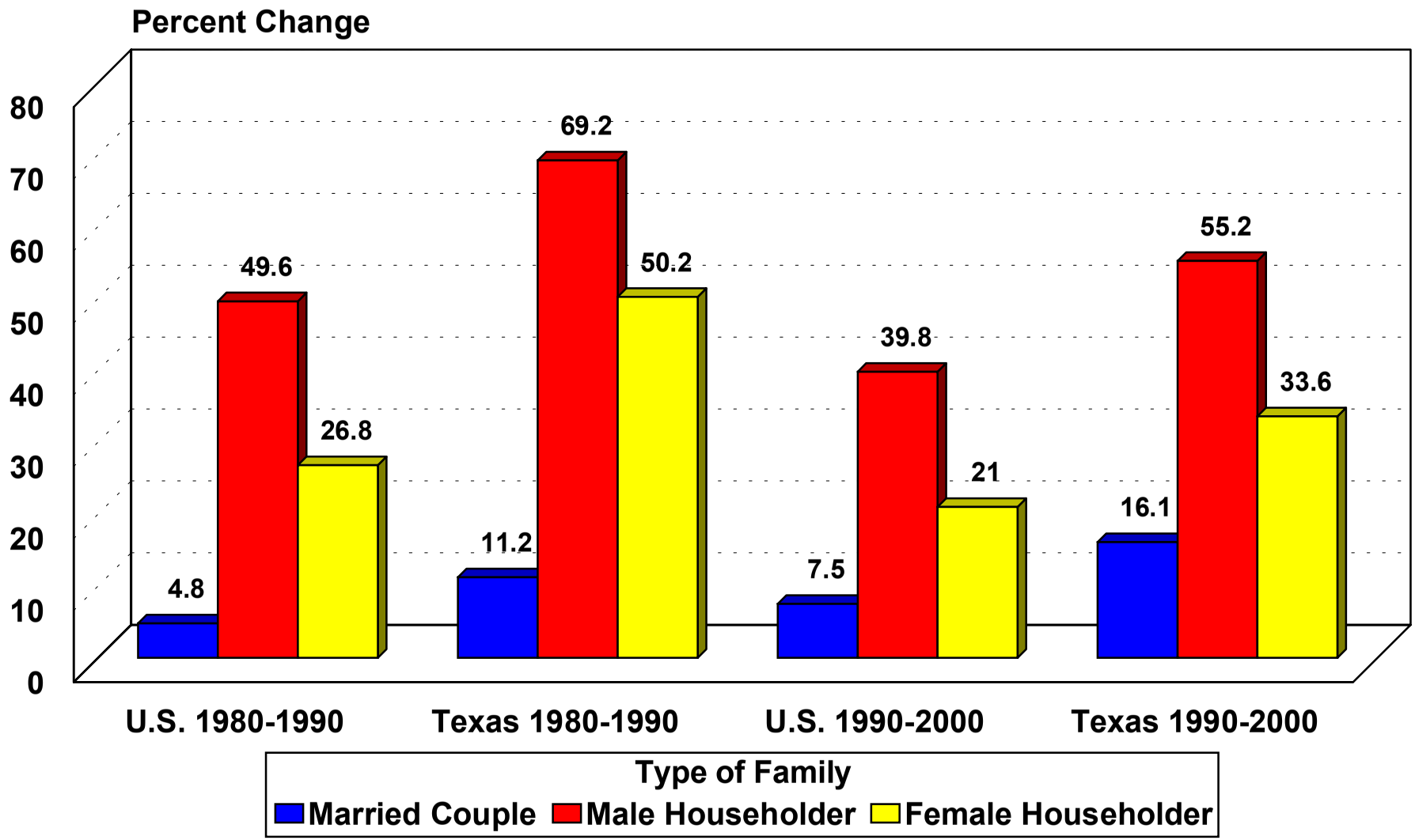
Average Persons Per Household in the United States and Texas, 1950-2000



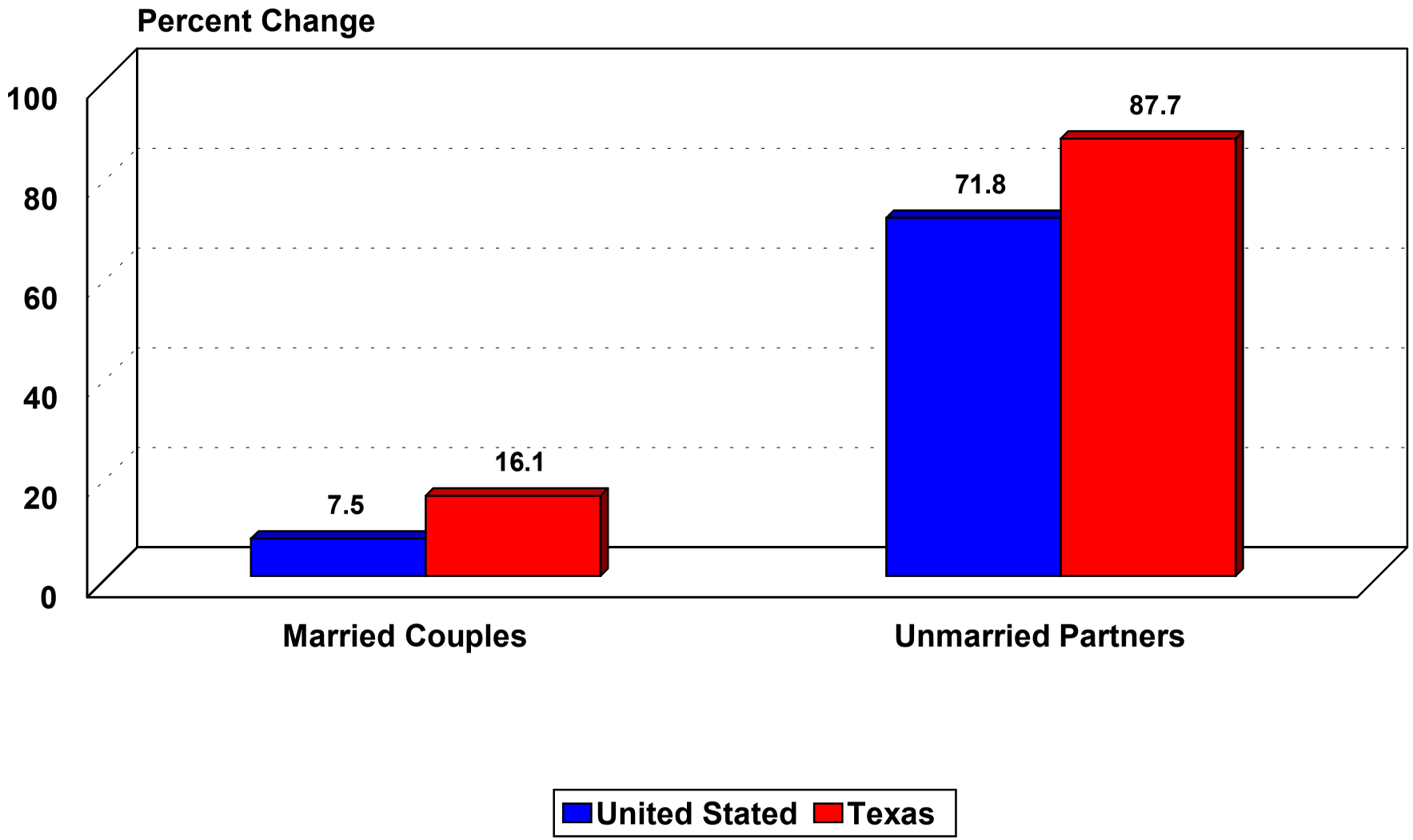
Percent Change for Households by Type for the United States and Texas, 1980-2000



Percent Change for Family Households for the United States and Texas 1980-2000

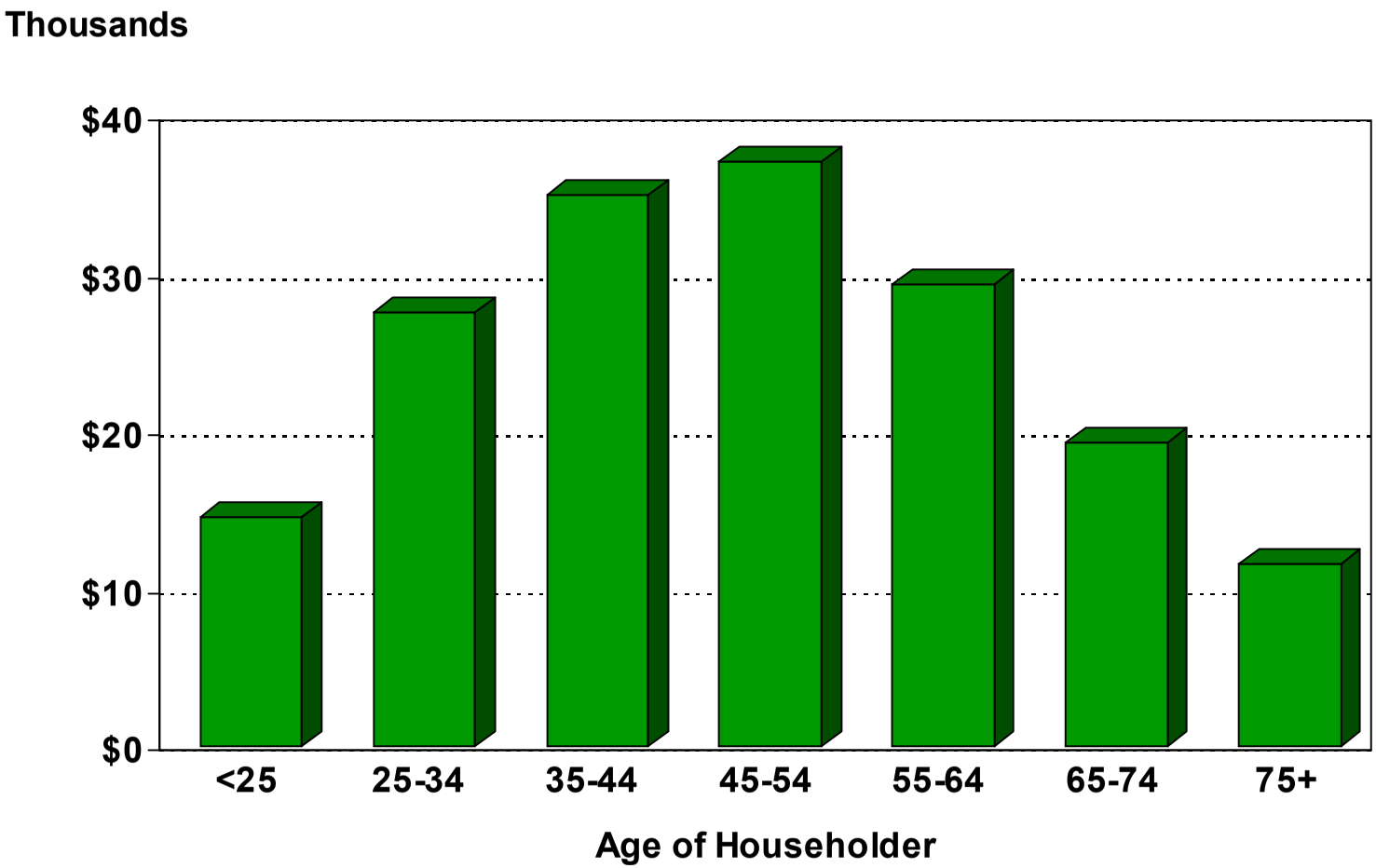


Percent Change in Partners by Type in the United States and Texas, 1990-2000

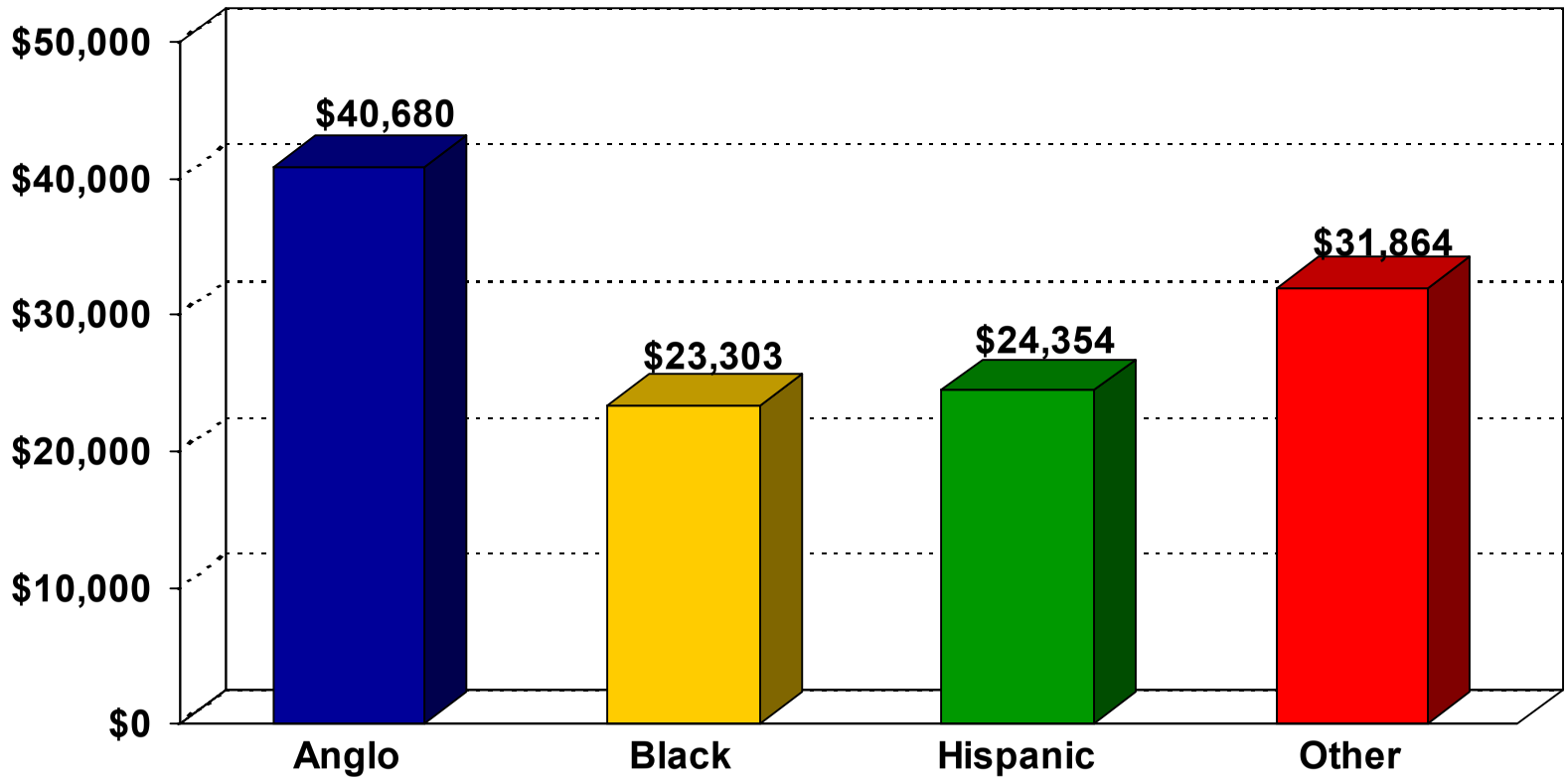


POPULATION CHARACTERISTICS AND SOCIOECONOMIC CONDITIONS

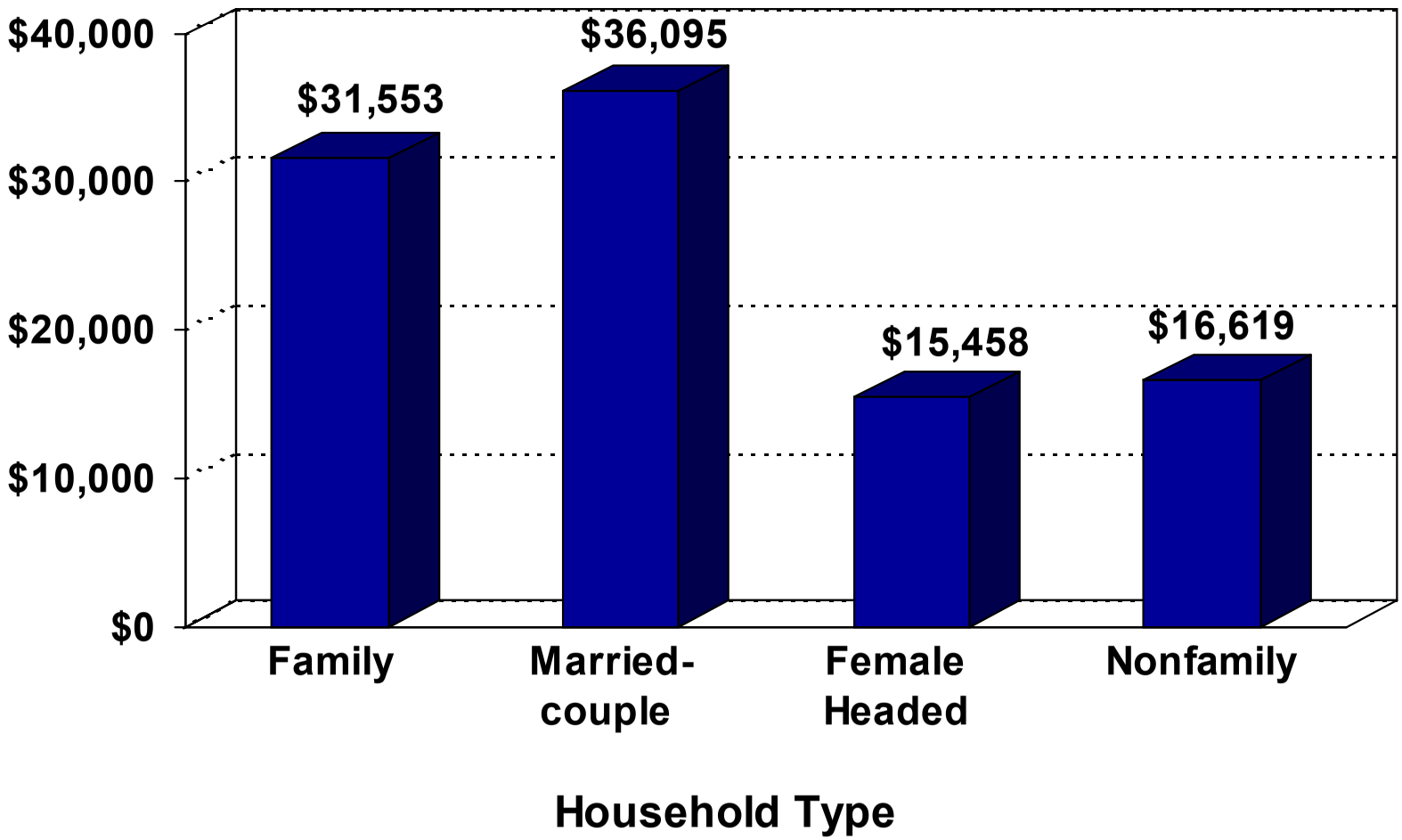
Median Household Income in Texas by Age of Householder, 1990



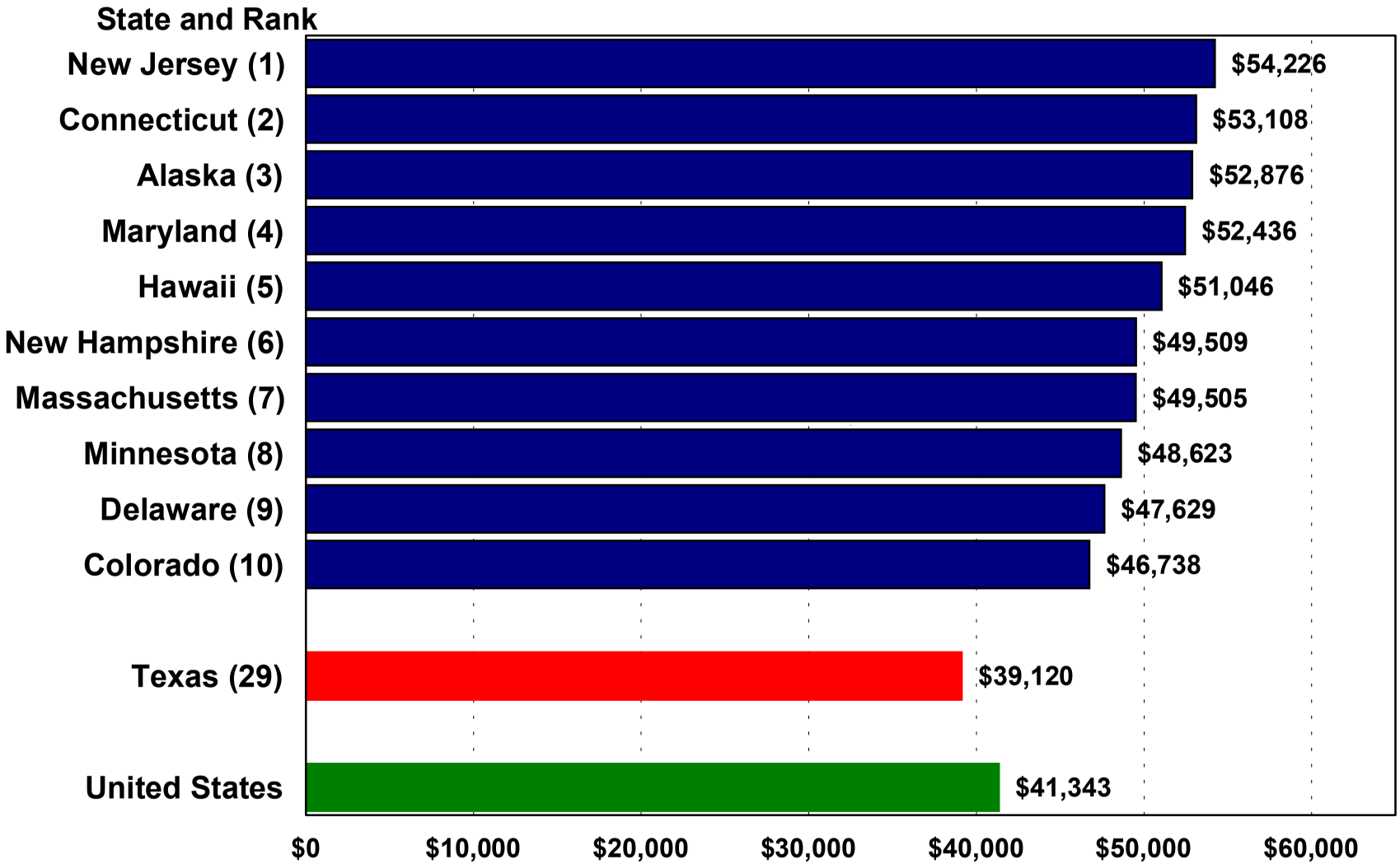
Mean Household Income In Texas by Race/Ethnicity in 1989



Median Income in Texas by Household Type in 1989

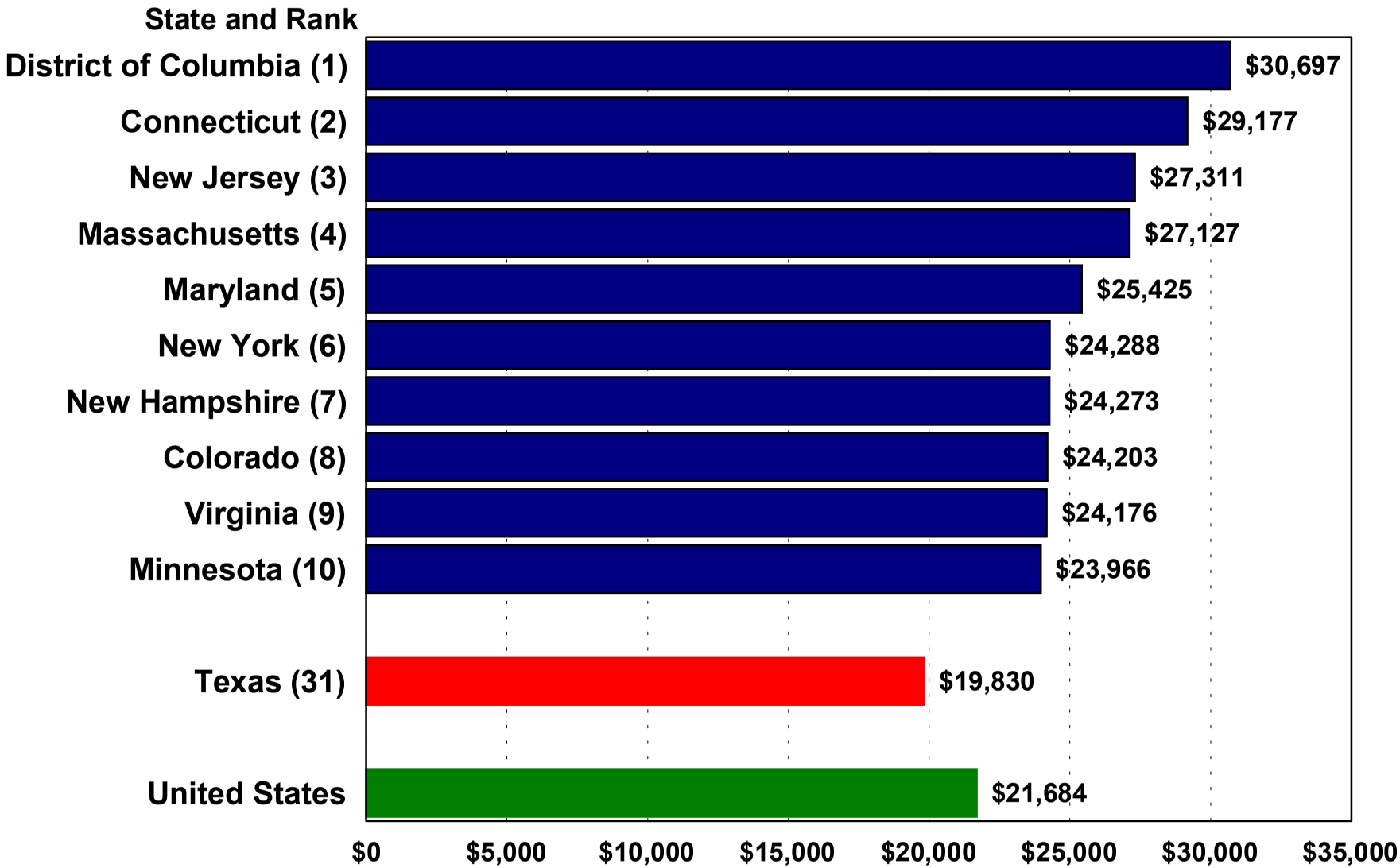


States Ranked by Median Household Income in Past 12 Months, 2000*



* Values reflect data from the Census 2000 Supplementary Survey (C2SS), they are not based on the 2000 Decennial Census.

States Ranked by Per Capita Income in Past 12 Months, 2000*



* Values reflect data from the Census 2000 Supplementary Survey (C2SS), they are not based on the 2000 Decennial Census.

PROJECTIONS

Population in Texas by Race/Ethnicity in 2000 and Projections of the Population in Texas by Race/Ethnicity from 2001 to 2040

Year	Anglo	Black	Hispanic	Other	Total
2000	11,074,716	2,421,653	6,669,666	685,785	20,851,820
			Assuming Zero Migration		
2010	11,292,858	2,604,162	7,986,640	776,088	22,659,748
2020	11,320,857	2,727,365	9,220,971	828,786	24,097,979
2030	11,086,475	2,756,470	10,406,060	856,437	25,105,442
2040	10,599,190	2,697,888	11,408,456	856,047	25,561,581
			Assuming Rates of Net Migration Equal to One-Half of 1990-2000		
2010	11,494,673	2,730,659	8,999,827	953,348	24,178,507
2020	11,735,043	3,004,173	11,742,820	1,256,342	27,738,378
2030	11,701,065	3,191,230	14,900,692	1,596,578	31,389,565
2040	11,382,992	3,283,413	18,391,333	1,954,592	35,012,330
			Assuming Rates of Net Migration Equal to 1990-2000		
2010	11,700,471	2,863,397	10,164,378	1,168,772	25,897,018
2020	12,165,004	3,309,068	15,056,028	1,897,182	32,427,282
2030	12,350,427	3,694,283	21,533,219	2,960,361	40,538,290
2040	12,225,486	3,995,349	29,926,210	4,435,916	50,582,961

Percent Change for Selected Time Periods for Projected Population in Texas by Racial/Ethnic Status Under Alternative Assumptions of Migration Scenarios

Year	Anglo	Black	Hispanic	Other	Total
Assuming Zero Migration					
2000-2010	2.0	7.5	19.7	13.2	8.7
2010-2020	0.2	4.7	15.5	6.8	6.3
2020-2030	-2.1	1.1	12.9	3.3	4.2
2030-2040	-4.4	-2.1	9.6	-0.0	1.8
2000-2040	-4.3	11.4	71.0	24.8	22.6
Assuming Rates of Net Migration Equal to One-Half of 1990-2000					
2000-2010	3.8	12.8	34.9	39.0	16.0
2010-2020	2.1	10.0	30.5	31.8	14.7
2020-2030	-0.3	6.2	26.9	27.1	13.2
2030-2040	-2.7	2.9	23.4	22.4	11.5
2000-2040	2.8	35.6	175.7	185.0	67.9
Assuming Rates of Net Migration Equal to 1990-2000					
2000-2010	5.7	18.2	52.4	70.4	24.2
2010-2020	4.0	15.6	48.1	62.3	25.2
2020-2030	1.5	11.6	43.0	56.0	25.0
2030-2040	-1.0	8.1	39.0	49.8	24.8
2000-2040	10.4	65.0	348.7	546.8	142.6

Percent of Population in Texas by Race/Ethnicity in 2000 and Projections of the Percent of the Population in Texas by Race/Ethnicity from 2001 to 2040

Year	Anglo	Black	Hispanic	Other
2000	53.1	11.6	32.0	3.3
	Assuming Zero Migration			
2010	49.9	11.5	35.2	3.4
2020	47.0	11.3	38.3	3.4
2030	44.2	11.0	41.4	3.4
2040	41.5	10.6	44.6	3.3
	Assuming Rates of Net Migration Equal to One-Half of 1990-2000			
2010	47.6	11.3	37.2	3.9
2020	42.4	10.8	42.3	4.5
2030	37.2	10.2	47.5	5.1
2040	32.5	9.4	52.5	5.6
	Assuming Rates of Net Migration Equal to 1990-2000			
2010	45.2	11.1	39.2	4.5
2020	37.5	10.2	46.4	5.9
2030	30.5	9.1	53.1	7.3
2040	24.1	7.9	59.2	8.8

Percent of the Projections of the Population by Race/Ethnicity and Age Groups in Texas from 2000-2040 Under Alternative Migration Scenarios

Age Group	Anglo	Black	Hispanic	Other	Total
			All Scenarios		
2000					
<18	23.0	31.7	35.8	26.1	28.2
18-24	8.8	11.2	13.2	11.2	10.6
25-44	30.1	32.1	31.8	37.7	31.1
45-64	24.4	17.7	14.0	20.1	20.2
65+	13.7	7.3	5.2	4.9	9.9
			Assuming Zero Migration		
2020					
<18	19.9	24.1	31.4	20.7	24.8
18-24	8.1	10.2	11.1	9.1	9.6
25-44	24.9	29.8	27.2	24.4	26.3
45-64	27.6	25.3	21.8	30.2	25.1
65+	19.5	10.6	8.5	15.6	14.2
2040					
<18	17.4	19.8	27.4	17.0	22.1
18-24	7.7	8.9	10.1	6.7	8.8
25-44	24.0	27.3	26.7	23.8	25.6
45-64	25.2	27.0	20.8	22.9	23.3
65+	25.7	17.0	15.0	29.6	20.2

(Continued)

Percent of Net Change in the Number of Texas Population from 2000-2040 Due to Each Race/Ethnicity Group Population

Race	Number	Percent
Assuming Zero Migration		
Anglo	-475,526	-10.1
Black	276,235	5.9
Hispanic	4,738,790	100.6
Other	170,262	3.6
Total	4,709,761	100.0
Assuming Rates of Net Migration Equal to One-Half of 1990-2000		
Anglo	308,276	2.1
Black	861,760	6.1
Hispanic	11,721,667	82.8
Other	1,268,807	9.0
Total	14,160,510	100.0
Assuming Rates of Net Migration Equal to 1990-2000		
Anglo	1,150,770	3.9
Black	1,573,696	5.3
Hispanic	23,256,544	78.2
Other	3,750,131	12.6
Total	29,731,141	100.0

Population in Texas 75+ Years of Age by Race/Ethnicity in 2000 and Projections of the Population in Texas 75+ Years of Age by Race/Ethnicity from 2001 to 2040

Year	Anglo	Black	Hispanic	Other	Total
2000	711,077	74,993	132,808	11,046	929,924
			Assuming Zero Migration		
2010	761,888	82,068	202,733	24,030	1,070,719
2020	886,983	94,662	282,976	46,663	1,311,284
2030	1,253,671	150,286	481,724	90,898	1,976,579
2040	1,537,347	212,811	767,248	133,125	2,650,531
			Assuming Rates of Net Migration Equal to One-Half of 1990-2000		
2010	777,487	84,129	205,598	27,410	1,094,624
2020	925,271	101,677	300,477	63,790	1,391,215
2030	1,331,583	168,207	542,829	149,422	2,192,041
2040	1,658,315	247,975	928,252	266,837	3,101,379
			Assuming Rates of Net Migration Equal to 1990-2000		
2010	793,563	86,315	208,864	31,173	1,119,915
2020	965,440	109,462	320,140	87,433	1,482,475
2030	1,414,631	188,693	613,624	245,837	2,462,785
2040	1,789,177	289,593	1,126,466	533,327	3,738,563

Percent Change for Selected Time Periods for Projected Population in Texas by Racial/Ethnic Status Under Alternative Assumption of Migration Scenarios Population 75+ Years of Age

Year	Anglo	Black	Hispanic	Other	Total
Assuming Zero Migration					
2000-2010	7.1	9.4	52.7	117.5	15.1
2010-2020	16.4	15.3	39.6	94.2	22.5
2020-2030	41.3	58.8	70.2	94.8	50.7
2030-2040	22.6	41.6	59.3	46.5	34.1
2000-2040	116.2	183.8	477.7	1105.2	185.0
Assuming Rates of Net Migration Equal to One-Half of 1990-2000					
2000-2010	9.3	12.2	54.8	148.1	17.7
2010-2020	19.0	20.9	46.1	132.7	27.1
2020-2030	43.9	65.4	80.7	134.2	57.6
2030-2040	24.5	47.4	71.0	78.6	41.5
2000-2040	133.2	230.7	598.9	2315.7	233.5
Assuming Rates of Net Migration Equal to 1990-2000					
2000-2010	11.6	15.1	57.3	182.2	20.4
2010-2020	21.7	26.8	53.3	180.5	32.4
2020-2030	46.5	72.4	91.7	181.2	66.1
2030-2040	26.5	53.5	83.6	116.9	51.8
2000-2040	151.6	286.2	748.2	4728.2	302.0

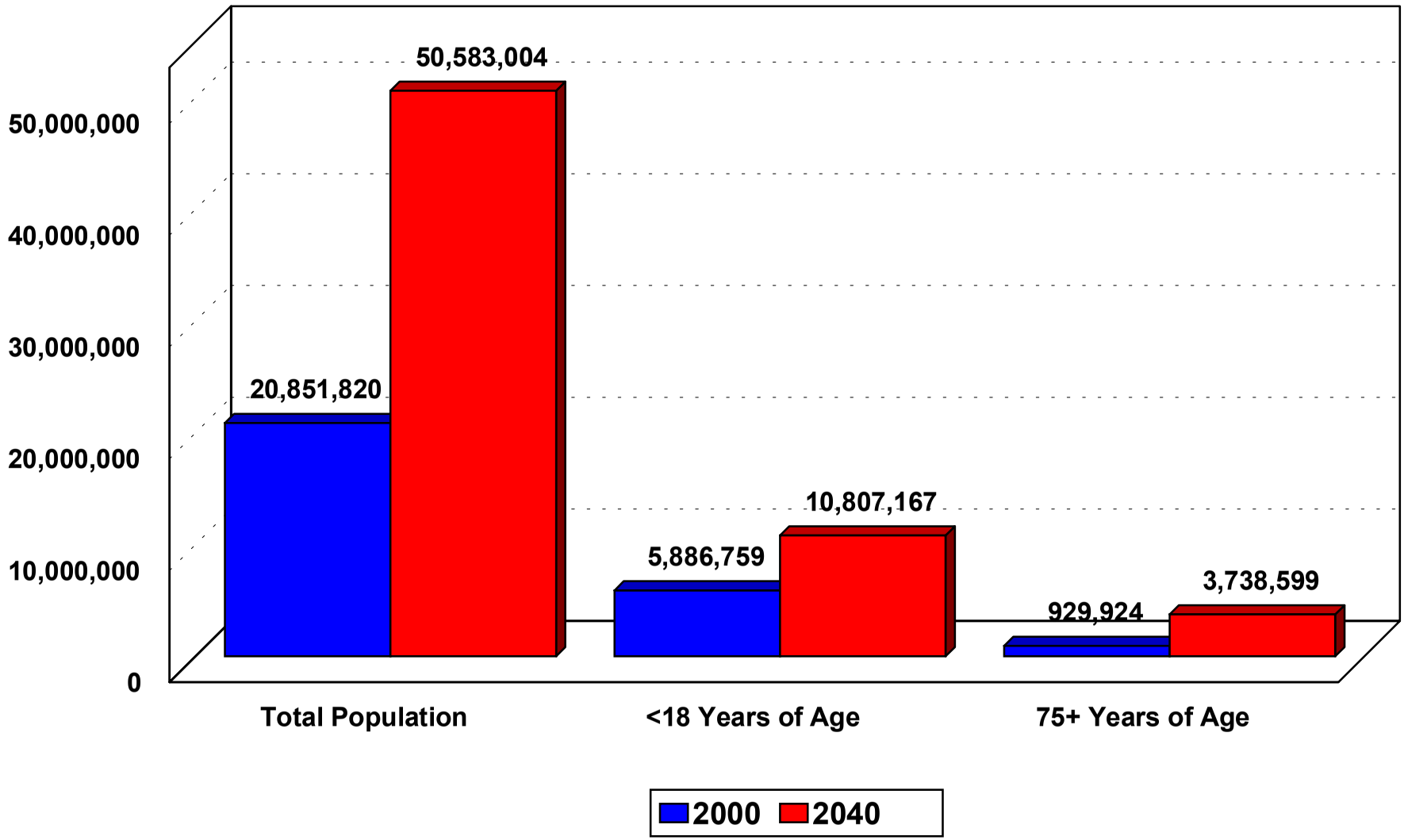
Percent of Population 75+ Years of Age in Texas by Race/Ethnicity in 2000 and Projections of the Percent of the Population 75+ Years of Age in Texas by Race/Ethnicity from 2001 to 2040

Year	Anglo	Black	Hispanic	Other
2000	76.4	8.1	14.3	1.2
Assuming Zero Migration				
2010	71.2	7.7	18.9	2.2
2020	67.6	7.2	21.6	3.6
2030	63.4	7.6	24.4	4.6
2040	58.1	8.0	28.9	5.0
Assuming Rates of Net Migration Equal to One-Half of 1990-2000				
2010	71.0	7.7	18.8	2.5
2020	66.5	7.3	21.6	4.6
2030	60.7	7.7	24.8	6.8
2040	53.5	8.0	29.9	8.6
Assuming Rates of Net Migration Equal to 1990-2000				
2010	70.9	7.7	18.6	2.8
2020	65.1	7.4	21.6	5.9
2030	57.4	7.7	24.9	10.0
2040	47.9	7.7	30.1	14.3

Percent of Net Change in the Number of Texas Population from 2000-2040 Due to Each Race/Ethnicity Group Population 75+ Years of Age

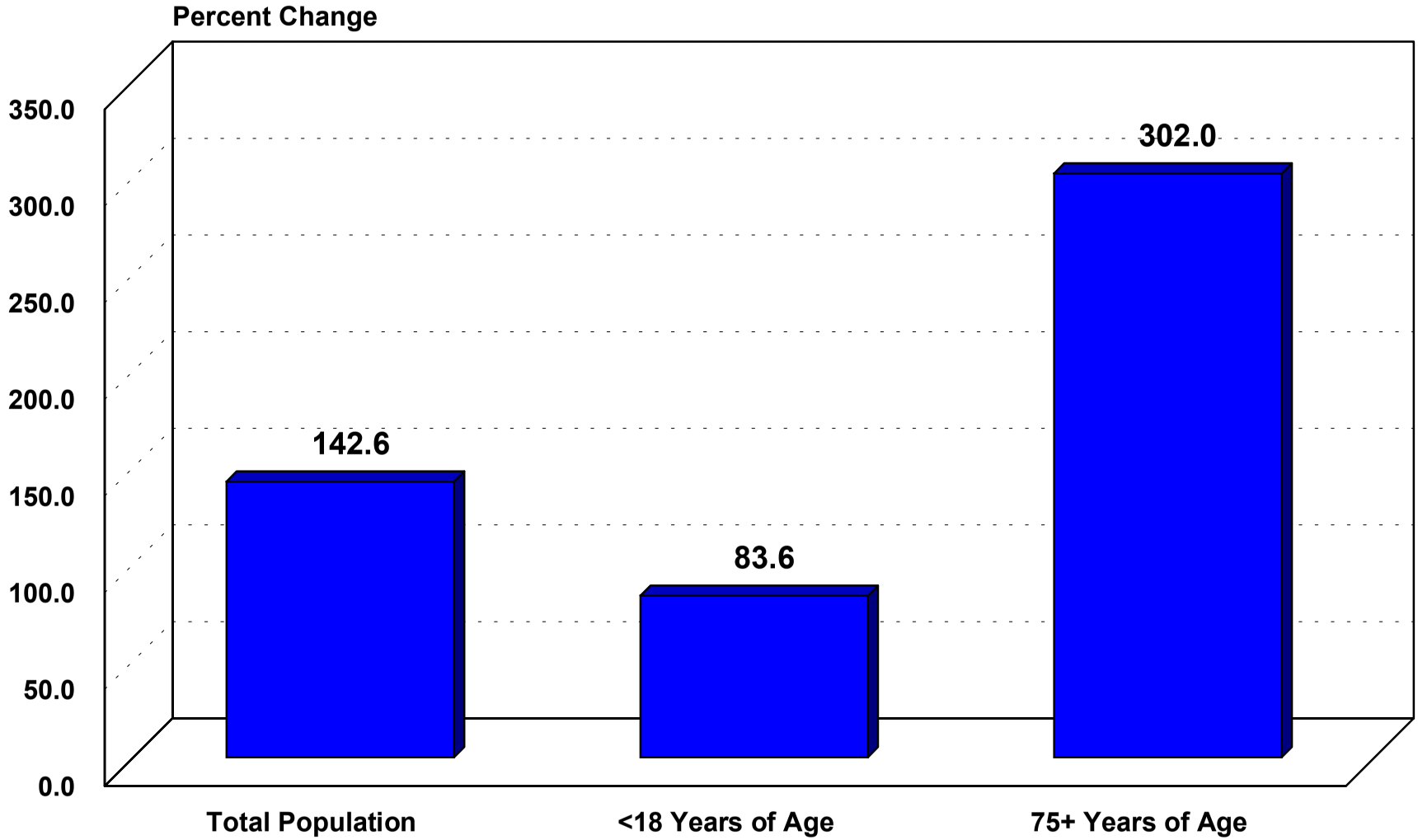
Race	Number	Percent
Assuming Zero Migration		
Anglo	826,270	48.0
Black	137,818	8.0
Hispanic	634,440	36.9
Other	122,079	7.1
Total	1,720,607	100.0
Assuming Rates of Net Migration Equal to One-Half of 1990-2000		
Anglo	947,238	43.6
Black	172,982	8.0
Hispanic	795,444	36.6
Other	255,791	11.8
Total	2,171,455	100.0
Assuming Rates of Net Migration Equal to 1990-2000		
Anglo	1,078,100	38.4
Black	214,600	7.6
Hispanic	993,658	35.4
Other	522,281	18.6
Total	2,808,639	100.0

Provisional Population Projections* for Selected Age Groups in Texas, 2000 to 2040



*Population projections shown use the provisional 1.0 projection scenario

Percent Change in Provisional Population Projections* for Selected Age Groups in Texas, 2000 to 2040



*Population projections shown use the provisional 1.0 projection scenario

The Center for
Demographic and
Socioeconomic
Research and Education

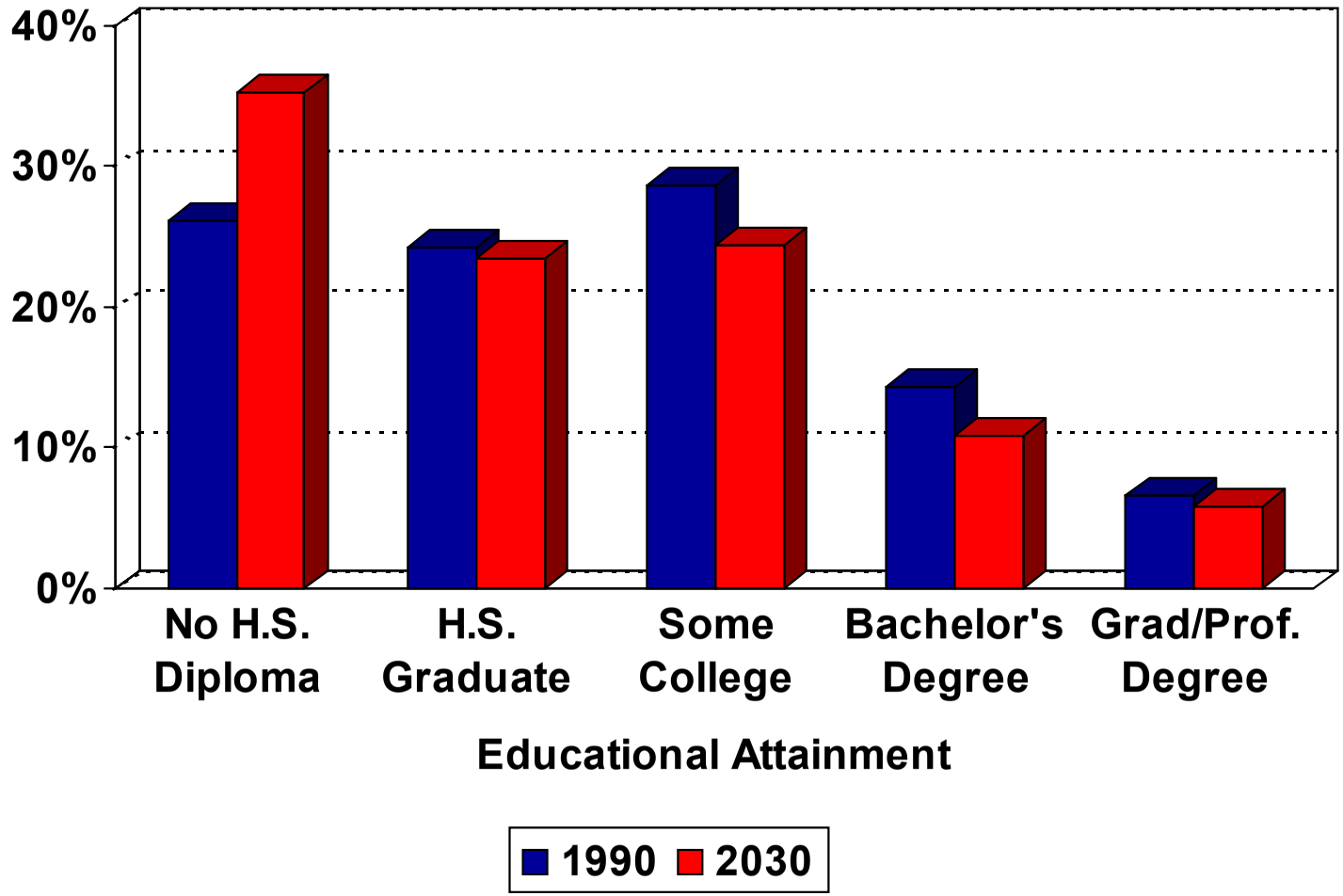
Texas Challenged: Implications of Population Change for Public Service Demand in Texas

A report prepared for
The Texas Legislative Council

by
Steve H. Murdock

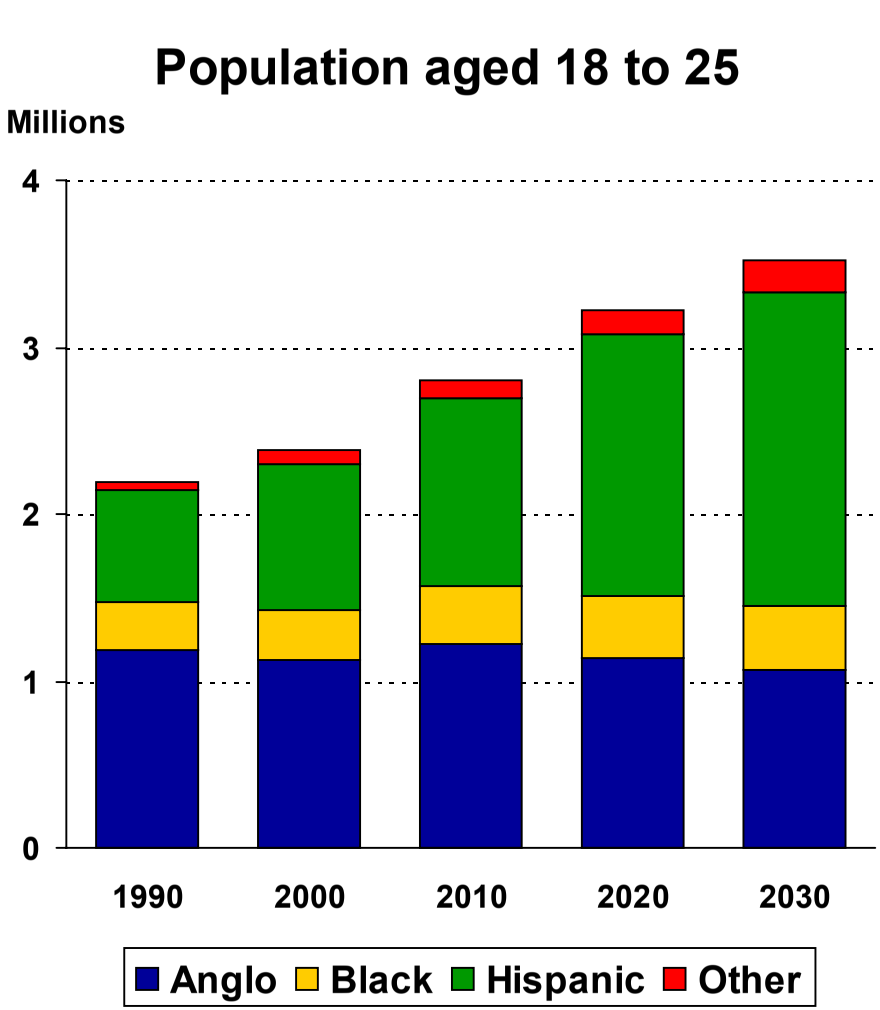
The Center for Demographic and
Socioeconomic Research and Education
Department of Rural Sociology
Texas A&M University

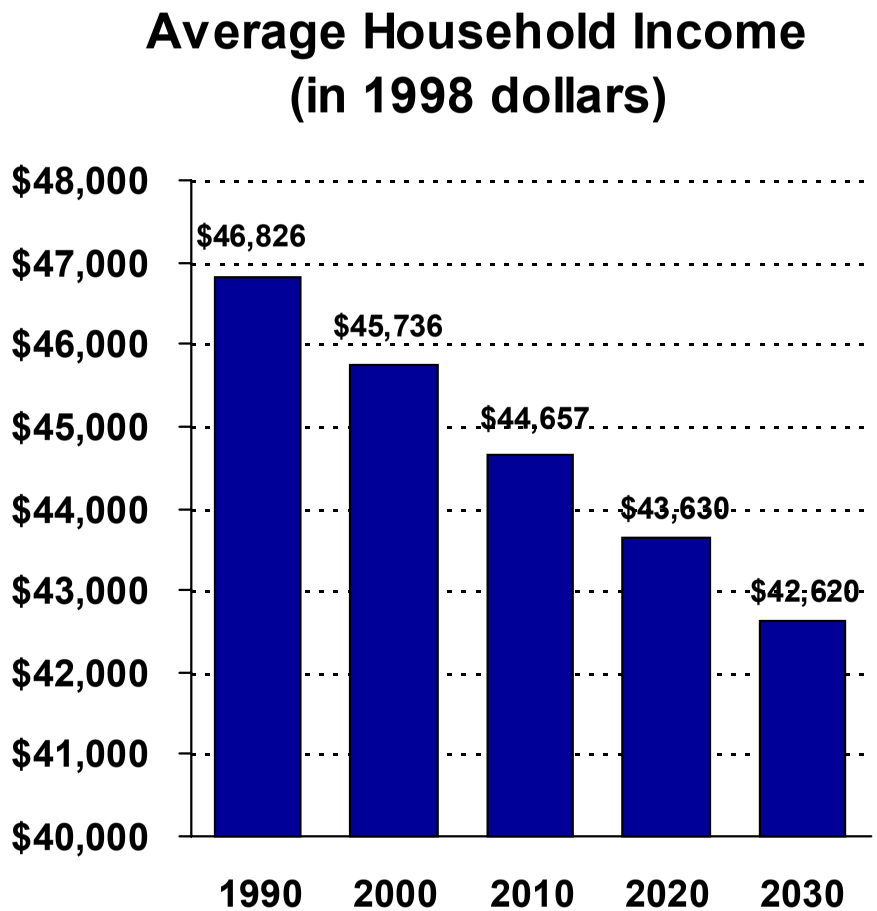
Projected Percent of Labor Force by Educational Attainment for 1990 and 2030*



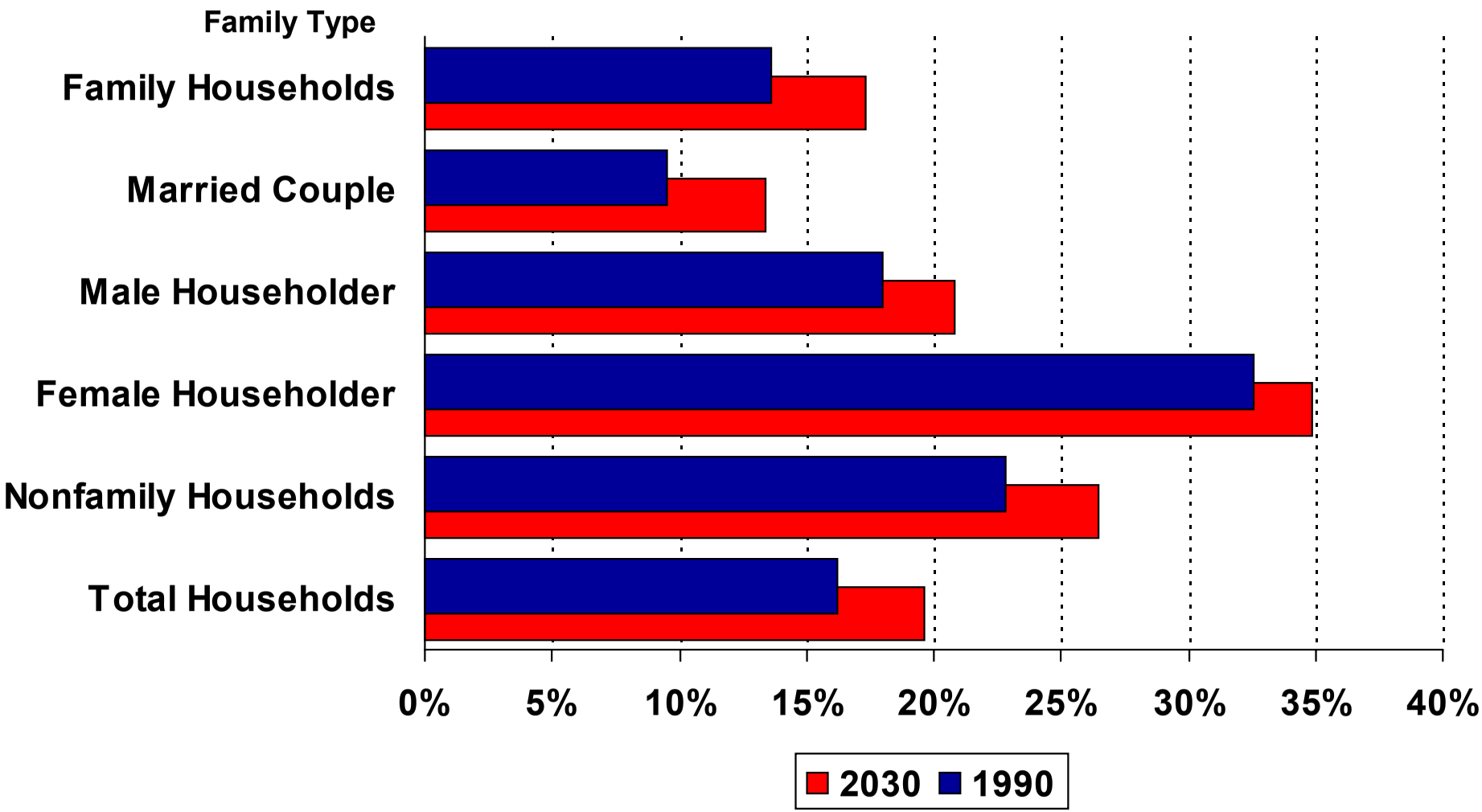
* Projections are shown for the 1.0 scenario

Projected Texas Population Aged 18-25 by Race/Ethnicity and Average Household Income in Texas, 1990-2030



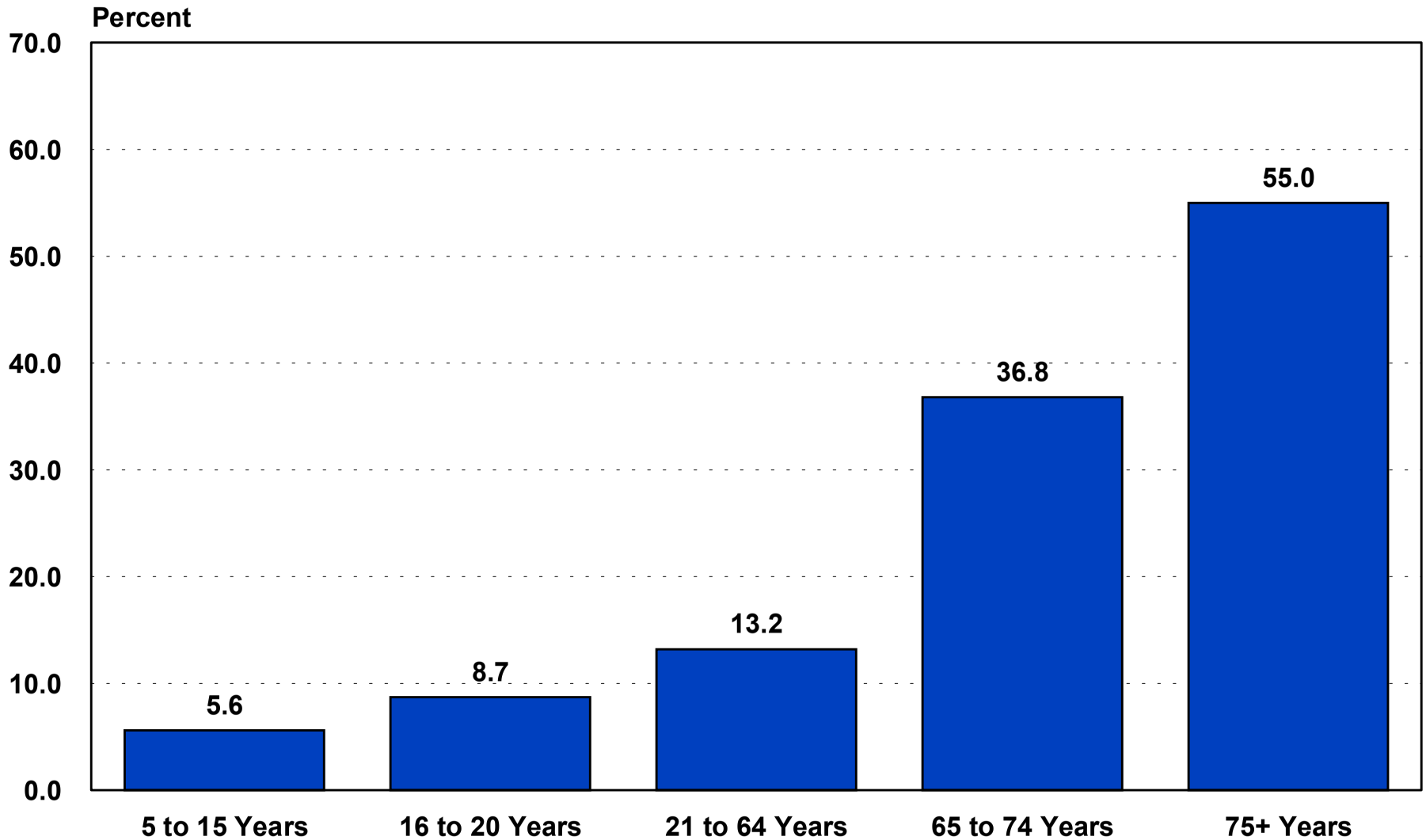


Percent of Households in Poverty by Family Type in 1990 and 2030*



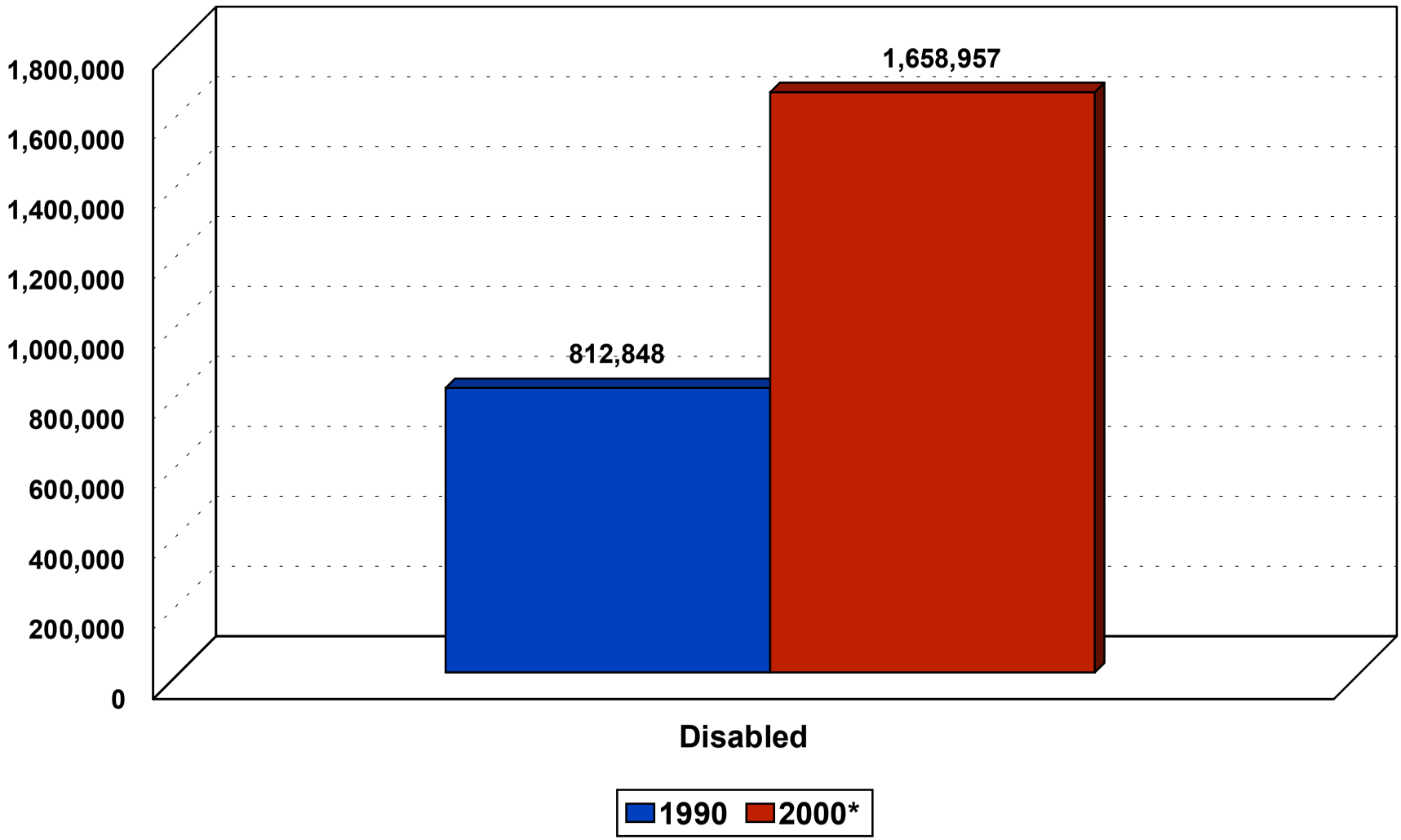
* Projections are shown for the 1.0 scenario

Disabled Civilian NonInstitutionalized Population Proportioned by Age Group in Texas, 2000*



*Values reflect data from the Census 2000 Supplementary Survey (C2SS), they are not based on the 2000 Decennial Census

Civilian NonInstitutionalized Population 16 to 64 Years of Age With a Work Disability in Texas, 1990 and 2000*



*Values reflect data from the Census 2000 Supplementary Survey (C2SS), they are not based on the 2000 Decennial Census

Provisional Projections of the Disabled Population of Texas from 2000-2040 Under Alternative Projection Scenarios

Year	Population		
	Total	Disabled	Percent
2000	19,227,192	2,848,435	14.8
	Assuming Zero Migration		
2010	20,984,424	3,186,148	15.2
2020	22,470,119	3,656,513	16.3
2030	23,516,649	4,205,017	17.9
2040	24,025,961	4,533,627	18.9
	Assuming Rates of Net Migration Equal to One-Half of 1990-2000		
2010	22,369,797	3,373,824	15.1
2020	25,820,335	4,124,505	16.0
2030	29,369,157	5,072,011	17.3
2040	32,859,830	5,934,455	18.1
	Assuming Rates of Net Migration Equal to 1990-2000		
2010	23,939,821	3,585,405	15.0
2020	30,137,487	4,722,041	15.7
2030	37,911,104	6,312,565	16.7
2040	47,458,891	8,199,752	17.3

Provisional Projections of Percent Change for Selected Time Periods of the Disabled Population of Texas Under Alternative Projection Scenarios

Time	Total
Assuming Zero Migration	
2000-2010	11.9
2010-2020	14.8
2020-2030	15.0
2030-2040	7.8
2000-2040	59.2
Assuming Rates of Net Migration Equal to One-Half of 1990-2000	
2000-2010	18.4
2010-2020	22.3
2020-2030	23.0
2030-2040	17.0
2000-2040	108.3
Assuming Rates of Net Migration Equal to 1990-2000	
2000-2010	25.9
2010-2020	31.7
2020-2030	33.7
2030-2040	29.9
2000-2040	187.9

Projected Number of Nursing Home Residents and Total Monthly Costs (in 1990 dollars) in Texas by Age of Resident and Year Under the Assumption of 1980-90 Rates of Net Migration

Age of Resident	Residents	Total Costs
	1990	
65-74	15,499	22,179,069
75+	85,233	121,768,423
Total	100,732	144,147,492
	2000	
65-74	17,500	25,042,500
75+	108,825	155,728,575
Total	126,325	180,771,075
	2030	
65-74	52,452	75,058,812
75+	283,099	405,114,669
Total	335,551	480,173,481

Steve Murdock
Texas State Data Center

Phone **979 - 845 - 5115**
Fax **979 - 862 - 3061**
Website **txsdc.tamu.edu**

Findings on Texas Elderly Population

1. by
Rogelio Saenz and Edward Murguia

One of the most significant demographic trends affecting the United States is the aging of the population. Results from the 1990 census document the rapid expansion of this segment of the population.

Growth of the Texas elderly population follows the general pattern observed nationally. Median age climbed from 20.2 in 1910 to 27.9 in 1950 to 30.8 in 1990. During the last decade, the elderly population increased 25.2 percent, compared to an overall population growth rate of 19.4 percent.

The age structure in Texas shows significant differences from the national picture as well. Persons age 65 or older accounted for 12.6 percent of the United States population in 1990 but only 10.1 percent of the Texas population. With a median age of 30.8, Texas ranks as the third youngest state behind Utah (26.2) and Alaska (29.4).

In absolute size of population, however, Texas holds the fifth largest elderly population. More than 1.7 million Texans are age 65 or older. Only California and Florida gained more elderly persons between 1980 and 1990 than Texas, which saw its elderly population increase by more than 345,000 people. The growth of the elderly population in the state helped this group increase its proportional representation of the state's population from 9.6 percent in 1980 to 10.1 percent in 1990.

One distinction of the Texas elderly population is its racial and ethnic diversity. Hispanic and Black individuals account for close to one in four of the state's elderly. Persons age 65 or older from these two race/ethnic groups were responsible for about 27 percent of the growth in the Texas elderly population during the decade before the 1990 census. Minority elderly are concentrated in certain parts of the state, including selected metropolitan areas.

Metro areas tend to have the largest concentration of elderly, with approximately 71 percent of the state population of persons age 65 or older. Nonmetro areas, while having smaller absolute numbers of elderly persons, have greater portions of elderly among their residents.

A report detailing the demographics of the Texas elderly population, entitled Demography of the Texas Elderly Population, will soon be available from the authors in the Department of Rural Sociology at Texas A&M University. For more information, contact them at 979-845-5115.

Findings from 1990 census data cited in Demography of the Texas Elderly Population:

- Texas has more than 1.7 million persons age 65 or older, making one of every ten Texans an elderly individual.

- The Texas elderly population is predominantly female, with about 68 elderly males per 100

elderly females.

In Texas, the elderly comprised nearly 12 percent of the White population, 7.8 percent of the Black population, and 5.3 percent of the Hispanic population.

Four of the state's largest metropolitan counties contained approximately one-third of the state's elderly population: Harris, Dallas, Bexar, and Tarrant.

The elderly population accounts for the largest relative share of the population in nonmetropolitan counties.

Twelve counties had populations with more than one-fifth age 65 or older: Llano, Hamilton, Mills, Hall, Motley, Baylor, Coleman, Coke, Donley, Sabine, Dickens, and Foard.

Attachment 3

39 S.W.2d 956, American Indem. Co. v. G.A. Stowers Furniture Co., (Tex.Civ.App.-Galveston 1931)

***956** 39 S.W.2d 956

AMERICAN INDEMNITY CO.

v.

G. A. STOWERS FURNITURE CO.

No. 9529.

Court of Civil Appeals of Texas, Galveston.

April 16, 1931.

Rehearing Denied May 21, 1931.

Appeal from District Court, Harris County; Chas. E. Ashe, Judge.

Action by the G. A. Stowers Furniture Company against the American Indemnity Company. Judgment for plaintiff, and defendant appeals.

Affirmed.

1. INSURANCE k3382
   217 ----
   217XXVII Claims and Settlement Practices
   217XXVII(C) Settlement Duties; Bad Faith
   217k3378 Actions
   217k3382 Questions of law or fact.

Formerly 217k514.22

Tex.Civ.App.-Galveston 1931

Evidence did not raise issue that insured waived right to recover for insurer's negligent failure to settle for injuries caused by automobile.

2. INSURANCE k3379

217 ----

217XXVII Claims and Settlement Practices

217XXVII(C) Settlement Duties; Bad Faith

217k3378 Actions

217k3379 In general.

Formerly 217k514.5(4)

Tex.Civ.App.-Galveston 1931

In action against liability insurer for alleged negligence in failing to settle cause of action against insured, suggested definition of "ordinary care" as applied to settlement held properly refused.

King, Wood & Morrow, Fouts, Amerman, Patterson & Moore, and Joe Moore, all of Houston, for appellant.

Fulbright, Crooker & Freeman, and Atkinson & Gaugler, all of Houston, for appellee.

GRAVES, J.

This is the second appeal of this cause; the result in both appellate courts of the first one, in which the position of the parties as litigants was the reverse of that now appearing, being reported through this court's opinion in 295 S. W. 257, and the Supreme Court's in 15 S.W. (2d) 544, respectively. The suit is between the same two private corporations on the same $5,000 policy of automobile indemnity insurance as applied to the same transaction; that is, to the prior payment by the Stowers Company, the insured, of a judgment in excess of $14,000 Miss Mamie Bichon had obtained against it as the result of a collision with one of its autotrucks that the policy covered. The sole

issue involved is whether or not the appellant indemnity company is liable to the appellee insured company for the claimed consequence of the former's alleged negligence in failing to make a $4,000 settlement of her cause of action Miss Bichon offered during the pendency of but before judgment in the suit thereon that so terminated.

This court on the former appeal construed the policy as importing no such legal liability, and limited the indemnity company's obligation thereunder to a faithful defense of the Bichon suit. G. A. Stowers Furniture Co. v. American Indemnity Co., 295 S. W. 257, at page 261 (2). The Supreme Court, however, disapproved that, and remanded the cause, holding that, as a matter of law under the terms of the policy, the insurer should respond in such damages as proximately resulted, "if an ordinarily prudent person, in the exercise of ordinary care, as viewed from the standpoint of the assured, would have settled the case, and failed or refused to do so." G. A. Stowers Furniture Co. v. American Indemnity Co. (Tex. Com. App.) 15 S.W. (2d) 544, 547.

On the trial from which the present appeal proceeds, the learned and experienced trial judge tracked that decision by submitting the fact inquiry therein pointed out to a jury, under the likewise presented definition of ordinary care, and, on the return of a finding upon sufficient evidence that such a person would have made the $4,000 settlement, entered judgment against appellant in appellee's favor for the full amount it had so finally paid Miss Bichon.

[1] [2] We think that verdict finally settled this controversy, and that appellant's present contentions (1) that appellee waived the right to recover for its negligent failure to make the settlement by thereafter accepting the benefits of its defense of the suit, (2) that the court should have defined ordinary care to mean in this instance "such care as a reasonable, prudent, and cautious attorney in this locality would have exercised in the circumstances," cannot be sustained. Aside from the fact that the claim of waiver appears to have been adversely adjudicated in the former cause, the evidence this time wholly fails to support it, in that it conclusively appears, on the one hand, that, when appellant was negotiating concerning the settlement, ***957.** it did not think appellee had any such right under the contract to waive, rather was then insisting otherwise, and, on the other, that appellee's manager at that time told

appellant's attorney they were going to hold it responsible in event of more than a $5,000 verdict, and "ridiculed him for not making a settlement." Such a situation did not raise an issue of "an intentional relinquishment of a known right." Missouri, K. & T. Ry. Co. v. Hendricks, 49 Tex. Civ. App. 314, 108 S. W. 745, 749, writ of error refused; 40 Cyc. pages 261 and 269.

Obviously, too, the suggested definition of ordinary care would have been directly contrary to the quoted holding of the Supreme Court on the subject.

So that, the law of this case having been so clearly declared upon the former appeal and so conformably administered below in the present trial, an affirmance should follow. It will be so ordered.

Affirmed.

Attachment 6

TEXAS LEGISLATIVE COUNCIL

P.O. Box 12128, Capitol Station
Austin, Texas 78711-2128
Telephone: 512/463-1151

BILL RATLIFF
Lieutenant Governor
Chairman

STEVEN R. COLLINS
Chief Legislative Counsel
Executive Director

JAMES E. "PETE" LANEY
Speaker of the House
Vice Chairman

MEMORANDUM

TO: The Honorable Robert Duncan

FROM: Don R. Warren
Program Director, Research Division

DATE: September 5, 2002

SUBJECT: Evaluation of Current Texas Nursing Home Quality Reporting System

BRIEF QUESTION

Can the current Texas nursing home Quality Reporting System (QRS) developed and implemented by the Texas Department of Human Services (TDHS) be improved to assist consumers in selecting a quality nursing home?

BRIEF ANSWER

Yes. Our evaluation revealed aspects of the QRS that can be improved.

Discussion

The QRS score used for comparing quality among nursing facilities is composed of four axes:

- the most recent survey rating, a score that reflects a facility's compliance with federal regulations and requirements;
- the investigation rating, a score that indicates the severity of deficiencies in a facility;
- the potential disadvantage score (PDS), the number of quality indicators that suggest relative performance problems for a facility; and
- the potential advantage score (PAS), the number of quality indicators that suggest relative performance superiority for a facility.

Our analysis revealed some areas for improvement:

1. The most recent survey rating might have been conducted as recently as a few days before

the QRS posting date or as much as 15 months before the posting date; as a result, the ratings may not reflect whether the facility currently complies with federal regulations. Also, because these ratings would not be updated until the next survey certification measurement, a low score would limit a facility's ability to achieve a high rating for as long as 15 months even if the facility improved its quality of care since the last survey. Likewise, a high initial survey score could mask a subsequent drop in performance. To compensate for the time lags, the effect of the survey rating on the overall score could be "dampened" or "decayed" by how much time had elapsed since it was conducted. For example, a 15-month-old rating would contribute less to the overall QRS score than would a one-month-old rating.

2. For the investigation rating, the score is based on the severity of the deficiencies found from complaints, rather than on the number of deficiencies found. Therefore, the best possible investigation score does not necessarily mean that a facility had no deficiencies; it means only that the facility did not have any moderate or severe deficiencies. There is no distinction in the QRS scoring system between a facility with an investigation finding of no deficiencies and a facility with mild deficiencies because the measurement procedure converts both ratings to the same score. A consumer might think that a facility is in total compliance when there actually are some deficiencies that may be of concern. A distinction could be made in the scoring system between no deficiencies and minor deficiencies.

3. As mentioned above, TDHS produces a QRS score for each nursing facility by calculating the simple average of the scores from the following four axes: the survey rating, the investigation rating, the PAS rating, and the PDS rating. TDHS claims that calculating this average causes the four axes to contribute equally, each 25 percent, to the QRS statistic. However, we found that these axes differ on a set of statistical properties that cause them to contribute unequally to the QRS statistic. TDHS can modify its method of calculation to guarantee that each axis does contribute equally to the QRS statistic.

The QRS is a useful assessment tool because it includes both facility compliance and quality of resident care, but improvements such as those discussed above could make it a better tool for helping consumers compare facilities.

Please let me know if you want us to further explore this issue. For more details, please feel free to call me at (512) 463-1143, ext. 1330.

02Y1360

Attachment 7

TEXAS LEGISLATIVE COUNCIL

P.O. Box 12128, Capitol Station
Austin, Texas 78711-2128
Telephone: 512/463-1151

BILL RATLIFF
Lieutenant Governor
Chairman

STEVEN R. COLLINS
Chief Legislative Counsel
Executive Director

JAMES E. "PETE" LANEY
Speaker of the House
Vice Chairman

MEMORANDUM

TO: The Honorable Robert Duncan
State Senator

FROM: Don R. Warren DRW
Program Director, Research Division

DATE: August 21, 2002

SUBJECT: Does Predictability of Regulatory Surveys Affect Quality of Care?

Brief Question

Does an unpredictable survey process affect the quality of care in nursing facilities relative to a partially predictable survey process?

Brief Answer

At this point in our research, the data indicate that survey unpredictability had no measurable effect on the quality of services provided in nursing facilities between April 2000 and February 2002.

Discussion

We used data from the federal Online Survey Certification and Report (OSCAR) system and the Minimum Data Set (MDS) database. We analyzed the monthly number of quality indicator (QI) "flags" (i.e., potential problems) for each active nursing facility six months prior to, during, and six months following a visit to the facility by the Texas Department of Human Services (TDHS) survey staff that occurred between April 2000 and February 2002. We then tested for any statistically significant difference in the quality of care (i.e., the number of QIs) between the facilities that received on-hour surveys (i.e., workweek starts) versus those that received off-hour surveys (i.e., evening, early morning before 8 a.m., or weekend starts). Descriptively, the average number of QI flags for the off-hour group dropped after the survey relative to the on-hour group, but this initial change was not statistically significant and did not persist. This methodology also involved statistically equating the two comparison groups as part of the analysis.

The original plan was to equate the two groups beforehand by randomly assigning each nursing facility to one of the groups. With the control group, we would have continued the traditional system of partially predictable surveys, and, for the experimental group, we would have introduced a system of no predictability. However, this study would have taken three to five years to complete and would have required a waiver from the responsible federal agency. To accommodate the committee's schedule, we used existing historical data to approximate such a test. Nevertheless, the test as originally planned would best answer this research question.

Please let me know if you need us to further explore this issue. For further details, please feel free to call me at 463-1143, ext. 1330.

02Y1202

Attachment 8

TEXAS LEGISLATIVE COUNCIL

P.O. Box 12128, Capitol Station
Austin, Texas 78711-2128
Telephone: 512/463-1151

BILL RATLIFF
Lieutenant Governor
Chairman

STEVEN R. COLLINS
Chief Legislative Counsel
Executive Director

JAMES E. "PETE" LANEY
Speaker of the House
Vice Chairman

MEMORANDUM

TO: The Honorable Robert Duncan

FROM: Don R. Warren
Program Director, Statistical & Demographic Research

DATE: August 23, 2002

SUBJECT: Assessing Quality of Care in Nursing Homes

Brief Question

Is there evidence that Texas nursing facilities underreport problems relating to quality of care in nursing facilities?

Brief Answer

No. An independent assessment of data reported by nursing facilities does not show any pattern of systematic underreporting. On some items, independent review found more problem cases than reported by facilities. On other items, facilities reported more problem cases than were found on independent review.

Discussion

Background on MDS Quality Indicators

OBRA 1987 required the Department of Health and Human Services to gather certain data, known as the Minimum Data Set (MDS), to use in conducting comprehensive assessments of patient conditions and care needs. Since 1991, these data have been collected in all nursing facilities serving Medicaid and Medicare residents. An MDS assessment is conducted for all nursing home residents within 14 days of admission and at quarterly and yearly intervals unless there is a significant change in condition. The MDS contains individual assessment items covering 17 areas, such as mood and behavior, physical functioning, and skin conditions. This information is used to develop a care plan

for each resident, to focus attention during the nursing home survey process, and in some states it serves as the basis for adjusting payments.[1]

The quality indicators are a subset of 32 data items taken from the larger MDS. The indicators are not direct measures of quality, but their presence indicates potential problem areas that may require further review and investigation. Examples of quality indicators include falls, bed sores, inappropriate medication, and dehydration. The percentage of these events in a facility is compared to the percentage of such events in all facilities in the state. If a facility has a percentage that is higher (or "worse") than 9 out of 10 facilities in general, it could be subject to an investigation to determine whether the facility has a problem with quality of care. Also, some quality indicators are identified as "sentinel events," which means that they are so serious that a single occurrence in any size facility may be sufficient to suggest a potential quality-of-care problem.[2]

In theory, the use of the same data elements for both reimbursement and quality reporting should lessen the incentive to underreport quality issues, since underreporting serious problems would reduce a facility's reimbursement level.[3] The State of Texas, however, bases reimbursement on the TILE system, and there is no mechanism, in theory, to lessen the incentive to underreport issues relating to quality of care. Since neither federal nor state agencies audit the MDS data for accuracy, the question arises as to whether nursing facilities in Texas systematically underreport quality-of-care issues.

Previous Research

State and federal agencies have attempted in various ways to assess the accuracy of the MDS data as a basis for reimbursement. The general consensus is that there are widespread inaccuracies in reporting but no evidence of systematic bias that would tend to raise reimbursement rates.[4] To our knowledge, there have been only three previous efforts to validate the accuracy of the MDS data as a basis for quality-of-care assessments. Two studies, both at the federal level, failed to detect any evidence of systematic bias in the reporting of quality indicators by nursing facilities.[5]

The third study was undertaken by the Texas Department of Human Services (DHS) and The University of Texas at Austin in response to Rider 32 of House Bill 1, 76th Legislature, Regular Session, 1999 (the General Appropriations Act).[6] Among other provisions, Rider 32 of the act authorized DHS to develop quality measurement tools to assess the quality of care in Texas nursing facilities. A secondary goal of the agency was to compare facility-reported MDS data to the findings of independently conducted on-site resident assessments. In general, the authors found that some MDS items reported by facilities appeared to agree with independent assessments and others did not: there was agreement on items that were easily observed and unlikely to change between observations, and there was lack of agreement on items that were "technically complex" and more likely to change between observations.[7] Among the recommendations included in the report, the

authors assert that, "[n]ursing facilities must address the widespread lack of accuracy in their responses to particular MDS assessment items . . . the current lack of MDS accuracy constitutes not only a data quality problem but also a regulatory compliance issue."[8]

Methodology

To assess whether the recognized inaccuracy in the MDS data reflects biased reporting by nursing facilities, the Texas Legislative Council entered into an agreement with the Utilization Review Department of the Health and Human Services Commission's Office of Investigations and Enforcement to independently verify the accuracy of a sample of MDS assessments. Utilization review nurses are stationed throughout the state and charged with the responsibility of reviewing the reimbursement claims submitted by Texas facilities. Thus, they are experienced in resident assessment and provide the most reliable standard available for performing an unbiased, independent assessment.

To ensure that our results could be generalized to all facilities in the state, we drew a random sample of roughly 900 residents from approximately 450 nursing facilities in all geographic areas of the state. We contacted the sampled facilities and requested that they identify the two residents: (1) who had been the subject of an annual, quarterly, or significant change in status assessment that already had been transmitted electronically to Centers for Medicare & Medicaid Services (CMS); and (2) whose assessment completion dates were the nearest to May 31, 2002. During the month of June 2002, each resident who had been previously assessed by a sampled facility was independently assessed by a utilization review nurse.

Once the data were gathered, the group of original assessments and the group of independent assessments were each coded as a "facility," and quality indicator scores for each "facility" and a statewide comparison group were generated using software provided by the Texas Department of Human Services. The differences between the quality indicators reported by the two "facilities" were then compared to estimate bias.

Results

No systematic pattern of underreporting was detected after comparing the two sets of quality indicator scores. On some items, the independent review found serious problems that were not reported by the facilities; but on other items, the facilities had reported serious problems that were not found on independent review. These preliminary results are encouraging because they suggest that there was no underreporting of cases where healthier residents developed unexpected problems relating to quality of care and no underreporting of the "sentinel event" of bed sores. At the same time, there may be a separate cause for concern because facilities reported fewer "sentinel events"

relating to elimination and dehydration, and they also reported fewer cases where a resident was incontinent or depressed but did not have a care plan to treat the condition. A more detailed analysis has proven difficult because of irregularities in the data transmitted by the facilities and made available through CMS.

In conclusion, there was no evidence of systematic bias in the MDS data, but there is clear evidence that the data are unreliable and that poor data quality continues to be a "regulatory compliance issue." At a minimum, it can be inferred from these results that enhanced training is needed for nursing facility personnel who are responsible for MDS data reporting.

NOTES

1 General Accounting Office, "Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities," GAO-02-279 (2002). Available on the Internet at http://frwebgate.access.gpo.gov/cgi-bin/useftp.cgi?IPaddress=162.140.64.21&filename=d02279.pdf&directory=/diskb/wais/data/gao p. 1, ff.

2 David Zimmerman, et al., "Development and Testing of Nursing Home QIs." *Health Care Financing Review*. (1995) 16(4): p. 122.

3 Ibid., p. 118.

4 See J. N. Morris, et al., "Designing the National Resident Assessment Instrument for Nursing Homes" (1990). Available on the Internet at http://gerontologist.gerontologyjournals.org/cgi/content/abstract/30/3/293; Catherine Hawes, "Reliability Estimates for Minimum Data Set for Nursing Facility Resident Assessment and Care Screening (MDS)" Research Triangle Institute (1995). Available on the Internet at http://www.rti.org/publications/pubfull.cfm?PUB_ID=26; Office of Inspector General, "Nursing Home Resident Assessment Resource Utilization Groups" (2001). Available on the Internet at www.hhs.gov/oig/oei/reports/a504.pdf p. 8-9; Jane Straker, et al., "Comparing case-mix scores derived by facility MDS assessors and independent raters" (2002). Unpublished paper released by the author; General Accounting Office (2002) p. 17.

5 Zimmerman, et al., (1995); J. N. Morris, et al., "Validation of Long-Term and Post-Acute Care Quality Indicators" Abt Associates, HRCA Research and Training Insititute, and Brown University (2002). Available on the Internet at http://cms.gov/providers/nursinghomes/nhi/validation_fd_082002.pdf. See also Alyssa Chomiak, et al., "Development and Testing of a Minimum Data Set Accuracy Verification Protocol" Abt Associates Inc. (2001).

6 Cortes, et al., "A Statewide Assessment of Quality of Care, Quality of Life and Consumer Satisfaction in Texas Medicaid Nursing Facilities", Texas Department of Human Services (2000).

7 Ibid., p. 71 ff.

8 Ibid., p. 8.

02Y1224

Attachment 9

TEXAS LEGISLATIVE COUNCIL

P.O. Box 12128, Capitol Station
Austin, Texas 78711-2128
Telephone: 512/463-1151

BILL RATLIFF
Lieutenant Governor
Chairman

STEVEN R. COLLINS
Chief Legislative Counsel
Executive Director

JAMES E. "PETE" LANEY
Speaker of the House
Vice Chairman

MEMORANDUM

TO: The Honorable Robert Duncan

FROM: Don Warren
Program Director

DATE: September 6, 2002

SUBJECT: Adequacy of Numbers of Nursing Home Regulators

Brief Question

How does the number of nursing home survey and certification personnel in Texas compare to the number in other states?

Brief Answer

The number of personnel in Texas compares favorably to the number in other states. In FY2000, Texas had the fifth highest number of survey and certification personnel per 1,000 nursing home residents.

Discussion

Survey and certification personnel are responsible for certifying that nursing homes meet the standards for Medicare and Medicaid programs and for licensing nursing homes that meet state requirements. Nursing homes must meet federal certification requirements in order to qualify for Medicaid and Medicare payments and must be licensed to operate in their respective states. The federal government pays 100 percent of the cost of certifying Medicare facilities and 75 percent of the cost of certifying Medicaid facilities. State licensing activities are the fiscal responsibility of the state government.

Nursing facilities generally are surveyed annually, but can be investigated whenever complaints are received. In its *State Operations Manual*[1], the Center for Medicare and Medicaid

[1] U.S. Health Care Financing Administration, (2000), "Medicaid Nursing Facilities: State Operations Manual," Provider Certification, Baltimore, MD.

Services sets guidelines for surveying nursing homes and delineates procedures for keeping records of deficiencies. When a nursing home is not in compliance with a federal guideline, survey personnel issue a notice and make judgments as to the severity of the noncompliance.

Tables 1 and 1b display, for the 50 states and the District of Columbia, for fiscal year 2000, the total number of nursing facility residents, the total number of survey and certification full-time equivalent personnel (SC FTEs), and the number of survey and certification personnel per 1,000 residents. They also include the total number of nursing facilities, the number of SC FTEs per facility, and the number of residents per nursing facility. Table 1 sorts the information alphabetically by state. Table 1b sorts the information by the number of SC FTEs per 1,000 residents.

Texas has the fifth highest number of survey and certification personnel per 1,000 nursing facility residents, following Alaska, Nevada, Montana, and Wyoming, and is tied with Wyoming for the sixth highest number of survey and certification personnel per nursing facility, after Alaska, Nevada, Delaware, Montana, and New Mexico. Texas has the fifth highest number of nursing facility residents in the country. Only four states have more nursing facility residents than Texas: New York, California, Illinois, and Pennsylvania. Only California has a higher number of nursing facilities.

The number of Texas survey and certification personnel was reduced for FY2002 and FY2003 by 82 FTE (full-time equivalent) positions. These positions were reallocated: 15 to work as liaisons between survey and certification personnel and nursing home staff, 16 to conduct joint training sessions of nursing home staff and survey and certification personnel, and 51 to monitor the 10 most commonly received complaints.

Table 1

Number of Nursing Facilities, Residents, and Survey and Certification (SC) Personnel for the States in Fiscal Year 2000

(sorted by state abbreviation)

State	Nursing Facility Residents*	SC FTEs (rounded)	SC FTEs per 1,000 Residents	Nursing Facilities*	SC FTEs per Nursing Facility	Ratio of Residents to Facility (rounded)
AK	559	8	14.31	13	0.62	43
AL	18,966	30	1.58	187	0.16	101
AR	18,815	50	2.66	250	0.20	75
AZ	12,186	39	3.20	137	0.28	89
CA	85,221	279	3.27	1,084	0.26	79
CO	14,766	23	1.56	199	0.12	74
CT	27,389	40	1.46	241	0.17	114
DC	2,308	5	2.17	17	0.29	136
DE	3,563	16	4.49	39	0.41	91
FL	64,584	128	1.98	677	0.19	95
GA	33,075	64	1.93	328	0.20	101
HI	2,747	10	3.49	39	0.25	70
IA	24,199	24	0.99	392	0.06	62
ID	3,931	14	3.56	75	0.19	52
IL	78,474	185	2.36	819	0.23	96
IN	39,024	117	3.00	528	0.22	74
KS	21,391	70	3.27	378	0.19	57
KY	20,011	65	3.25	271	0.24	74
LA	28,903	39	1.35	322	0.12	90
MA	44,016	65	1.48	467	0.14	94
MD	23,240	38	1.64	230	0.17	101
ME	6,579	21	3.19	112	0.19	59
MI	40,417	113	2.80	424	0.27	95
MN	34,873	38	1.09	389	0.10	90
MO	37,079	21	0.57	531	0.04	70
MS	14,937	44	2.95	182	0.24	82
MT	5,103	34	6.66	90	0.38	57
NC	35,013	81	2.31	396	0.20	88
ND	6,090	22	3.61	85	0.26	72
NE	11,933	23	1.93	189	0.12	63
NH	6,155	13	2.11	70	0.19	88
NJ	39,776	56	1.41	314	0.18	127
NM	5,290	26	4.91	69	0.38	77
NV	3,426	27	7.88	45	0.60	76
NY	92,960	143	1.54	562	0.26	165
OH	70,431	167	2.37	858	0.19	82

OK	16,726	30	1.79	290	0.10	58
OR	9,608	37	3.85	147	0.25	65
PA	77,488	113	1.46	708	0.16	109
RI	7,712	21	2.72	85	0.25	91
SC	14,878	28	1.88	169	0.17	88
TN	31,363	14	0.45	315	0.04	100
TX	70,849	351	4.95	1,026	0.34	69
UT	5,241	15	2.86	88	0.17	60
VA	25,526	38	1.49	262	0.15	97
VT	3,122	12	3.84	42	0.29	74
WA	19,455	83	4.27	259	0.32	75
WI	36,310	100	2.75	389	0.26	93
WV	9,514	21	2.21	129	0.16	74
WY	2,556	13	5.09	38	0.34	67

*Harrington, C., Carillo, H., Wellin, V., "Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1994 Through 2000," available on the Internet at: **http://nccnhr.newc.com/public/50_155_2409.CFM**

Harrington, C., Department of Social and Behavioral Sciences, School of Nursing, University of California, San Francisco, 3333 California St., San Francisco, Ca., Unpublished research for the Henry J. Kaiser Family Foundation

Table 1b

Number of Nursing Facilities, Residents, and Survey and Certification (SC) Personnel for the States in Fiscal Year 2000

(sorted by SC FTEs per 1,000 Residents)

State	Nursing Facility Residents*	SC FTEs (rounded)	SC FTEs per 1,000 Residents	Nursing Facilities*	SC FTEs per Nursing Facility	Ratio of Residents to Facility (rounded)
AK	559	8	14.31	13	0.62	43
NV	3,426	27	7.88	45	0.60	76
MT	5,103	34	6.66	90	0.38	57
WY	2,556	13	5.09	38	0.34	67
TX	70,849	351	4.95	1,026	0.34	69
NM	5,290	26	4.91	69	0.38	77
DE	3,563	16	4.49	39	0.41	91
WA	19,455	83	4.27	259	0.32	75
OR	9,608	37	3.85	147	0.25	65
VT	3,122	12	3.84	42	0.29	74
ND	6,090	22	3.61	85	0.26	72
ID	3,931	14	3.56	75	0.19	52
HI	2,747	10	3.49	39	0.25	70
KS	21,391	70	3.27	378	0.19	57
CA	85,221	279	3.27	1,084	0.26	79
KY	20,011	65	3.25	271	0.24	74
AZ	12,186	39	3.20	137	0.28	89
ME	6,579	21	3.19	112	0.19	59
IN	39,024	117	3.00	528	0.22	74
MS	14,937	44	2.95	182	0.24	82
UT	5,241	15	2.86	88	0.17	60
MI	40,417	113	2.80	424	0.27	95
WI	36,310	100	2.75	389	0.26	93
RI	7,712	21	2.72	85	0.25	91
AR	18,815	50	2.66	250	0.20	75
OH	70,431	167	2.37	858	0.19	82
IL	78,474	185	2.36	819	0.23	96
NC	35,013	81	2.31	396	0.20	88
WV	9,514	21	2.21	129	0.16	74
DC	2,308	5	2.17	17	0.29	136
NH	6,155	13	2.11	70	0.19	88
FL	64,584	128	1.98	677	0.19	95
GA	33,075	64	1.93	328	0.20	101
NE	11,933	23	1.93	189	0.12	63
SC	14,878	28	1.88	169	0.17	88
OK	16,726	30	1.79	290	0.10	58
MD	23,240	38	1.64	230	0.17	101
AL	18,966	30	1.58	187	0.16	101
CO	14,766	23	1.56	199	0.12	74
NY	92,960	143	1.54	562	0.26	165
VA	25,526	38	1.49	262	0.15	97
MA	44,016	65	1.48	467	0.14	94
CT	27,389	40	1.46	241	0.17	114

PA	77,488	113	1.46	708	0.16	109
NJ	39,776	56	1.41	314	0.18	127
LA	28,903	39	1.35	322	0.12	90
MN	34,873	38	1.09	389	0.10	90
IA	24,199	24	0.99	392	0.06	62
MO	37,079	21	0.57	531	0.04	70
TN	31,363	14	0.45	315	0.04	100

*Harrington, C., Carillo, H., Wellin, V., "Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1994 Through 2000," available on the Internet at: **http://nccnhr.newc.com/public/50_155_2409.CFM**

Harrington, C., Department of Social and Behavioral Sciences, School of Nursing, University of California, San Francisco, 3333 California St., San Francisco, Ca., Unpublished research for the Henry J. Kaiser Family Foundation

Tables 2 and 2b show the number of nursing home residents, the numbers of complaints received and complaints investigated, and the ratios of complaints received and complaints investigated per 100 nursing home residents for 1999. Table 2 is sorted alphabetically by state, and Table 2b is sorted by number of complaints invesigated per 100 residents. Survey and certification personnel in Texas received and investigated more nursing facility complaints than any other state. Texas had the fifth largest number of complaints received per 100 residents and the third largest number of complaints investigated per 100 residents.

Table 2
1999 Nursing Home Residents and Complaints
(sorted by state abbreviation)

State	Nursing Facility Residents*	Complaints Received	Complaints per 100 Residents	Complaints Investigated	Complaints Investigated per 100 Residents
AK	597	44	7.37	30	5.03
AL	20,365	771	3.79	447	2.19
AR	16,058	1,548	9.64	1,063	6.62
AZ	7,046	635	9.01	537	7.62
CA	87,165	7,213	8.28	7,213	8.28
CO	16,159	397	2.46	328	2.03
CT	27,210	967	3.55	829	3.05
DC	1,801	114	6.33	114	6.33
DE	2,973	221	7.43	127	4.27
FL	64,700	1,709	2.64	1,665	2.57
GA	33,796	1,513	4.48	1,513	4.48
HI	3,224	61	1.89	60	1.86
IA	25,526	1,228	4.81	1,112	4.36
ID	4,459	n/a	n/a	n/a	n/a
IL	81,459	5,547	6.81	5,547	6.81
IN	38,949	2,314	5.94	2,328	5.98
KS	21,777	3,610	16.58	3,610	16.58
KY	20,658	n/a	n/a	n/a	n/a
LA	31,678	860	2.71	860	2.71
MA	42,803	1,281	2.99	664	1.55
MD	13,790	1,013	7.35	556	4.03
ME	6,676	975	14.60	596	8.93
MI	39,226	2,400	6.12	2,400	6.12
MN	35,526	558	1.57	194	0.55
MO	35,330	975	2.76	596	1.69
MS	14,573	240	1.65	240	1.65
MT	5,609	72	1.28	72	1.28
NC	33,625	1,765	5.25	1,625	4.83
ND	6,241	52	0.83	52	0.83
NE	14,491	473	3.26	353	2.44
NH	5,631	786	13.96	312	5.54
NJ	25,453	2,062	8.10	1,431	5.62
NM	6,258	389	6.22	389	6.22
NV	3,100	182	5.87	101	3.26
NY	90,930	4,268	4.69	2,632	2.89
OH	66,696	2,728	4.09	2,728	4.09
OK	17,335	1,126	6.50	1,229	7.09
OR	9,382	2,736	29.16	26	0.28
PA	81,108	2,446	3.02	2,446	3.02
RI	8,326	716	8.60	715	8.59
SC	12,673	665	5.25	500	3.95
SD	5,103	8	0.16	11	0.22
TN	34,668	1,871	5.40	1,821	5.25
TX	79,898	12,522	15.67	11,923	14.92
UT	4,300	741	17.23	517	12.02
VA	24,934	916	3.67	665	2.67

VT	3,091	100	3.24	100	3.24
WA	19,978	8,715	43.62	3,817	19.11
WI	37,778	n/a	n/a	n/a	n/a
WV	9,880	225	2.28	200	2.02
WY	2,303	140	6.08	140	6.08

*Harrington, C., Carillo, H., Wellin, V., "Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1994 Through 2000," available on the Internet at: **http://nccnhr.newc.com/public/50_155_2409.CFM**

Harrington, C., Department of Social and Behavioral Sciences, School of Nursing, University of California, San Francisco, 3333 California St., San Francisco, Ca., Unpublished research for the Henry J. Kaiser Family Foundation

Table 2b

1999 Nursing Home Residents and Complaints

(sorted by complaints investigated per 100 Residents)

State	Nursing Facility Residents*	Complaints Received	Complaints Received per 100 Residents	Complaints Investigated	Complaints Investigated per 100 Residents
WA	19,978	8,715	43.62	3,817	19.11
KS	21,777	3,610	16.58	3,610	16.58
TX	79,898	12,522	15.67	11,923	14.92
UT	4,300	741	17.23	517	12.02
ME	6,676	975	14.60	596	8.93
RI	8,326	716	8.60	715	8.59
CA	87,165	7,213	8.28	7,213	8.28
AZ	7,046	635	9.01	537	7.62
OK	17,335	1,126	6.50	1,229	7.09
IL	81,459	5,547	6.81	5,547	6.81
AR	16,058	1,548	9.64	1,063	6.62
DC	1,801	114	6.33	114	6.33
NM	6,258	389	6.22	389	6.22
MI	39,226	2,400	6.12	2,400	6.12
WY	2,303	140	6.08	140	6.08
IN	38,949	2,314	5.94	2,328	5.98
NJ	25,453	2,062	8.10	1,431	5.62
NH	5,631	786	13.96	312	5.54
TN	34,668	1,871	5.40	1,821	5.25
AK	597	44	7.37	30	5.03
NC	33,625	1,765	5.25	1,625	4.83
GA	33,796	1,513	4.48	1,513	4.48
IA	25,526	1,228	4.81	1,112	4.36
DE	2,973	221	7.43	127	4.27
OH	66,696	2,728	4.09	2,728	4.09
MD	13,790	1,013	7.35	556	4.03
SC	12,673	665	5.25	500	3.95
NV	3,100	182	5.87	101	3.26
VT	3,091	100	3.24	100	3.24
CT	27,210	967	3.55	829	3.05
PA	81,108	2,446	3.02	2,446	3.02
NY	90,930	4,268	4.69	2,632	2.89
LA	31,678	860	2.71	860	2.71
VA	24,934	916	3.67	665	2.67
FL	64,700	1,709	2.64	1,665	2.57
NE	14,491	473	3.26	353	2.44
AL	20,365	771	3.79	447	2.19
CO	16,159	397	2.46	328	2.03
WV	9,880	225	2.28	200	2.02
HI	3,224	61	1.89	60	1.86
MO	35,330	975	2.76	596	1.69

MS	14,573	240	1.65	240	1.65
MA	42,803	1,281	2.99	664	1.55
MT	5,609	72	1.28	72	1.28
ND	6,241	52	0.83	52	0.83
MN	35,526	558	1.57	194	0.55
OR	9,382	2,736	29.16	26	0.28
SD	5,103	8	0.16	11	0.22
ID	4,459	n/a	n/a	n/a	n/a
KY	20,658	n/a	n/a	n/a	n/a
WI	37,778	n/a	n/a	n/a	n/a

*Harrington, C., Carillo, H., Wellin, V., "Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1994 Through 2000," available on the Internet at: **http://nccnhr.newc.com/public/50_155_2409.CFM**

Harrington, C., Department of Social and Behavioral Sciences, School of Nursing, University of California, San Francisco, 3333 California St., San Francisco, Ca., Unpublished research for the Henry J. Kaiser Family Foundation

02Y1283

Attachment 10

TEXAS LEGISLATIVE COUNCIL

P.O. Box 12128, Capitol Station
Austin, Texas 78711-2128
Telephone: 512/463-1151

BILL RATLIFF
Lieutenant Governor
Chairman

STEVEN R. COLLINS
Chief Legislative Counsel
Executive Director

JAMES E. "PETE" LANEY
Speaker of the House
Vice Chairman

MEMORANDUM

TO: The Honorable Robert Duncan

FROM: Don Warren
Program Director

DATE: September 9, 2002

SUBJECT: State Comparisons of Nursing Home Reimbursement Methodologies

Brief Question

Would Texas reduce costs by adopting the reimbursement methodology of another state?

Brief Answer

One approach to adopting a different reimbursement methodology addresses only the method of categorizing nursing home residents--for example, using the Resource Utilization Groups (RUGs-III) instead of the Texas Index for Level of Effort (TILE). A change of this type would have no effect on the budget because the existing TILE effort levels (i.e., minutes of attention from nursing staff) would be applied to the RUGs-III categories. However, there might be other non-budgetary implications.

A second approach would involve adopting not only the method of categorizing residents but also the effort levels that the other state assigned to each category of residents. Because most states assign higher effort levels than does Texas, adopting the other state's levels would increase Texas' costs.

Discussion

The formulas and methods that states use to reimburse nursing homes are varied and complex. This is because state reimbursement policies fulfill the sometimes competing purposes of constraining costs, ensuring quality of care, providing fair treatment for nursing home residents, and assuring equitable payment to providers.

The method for paying nursing facility reimbursement rates traditionally has been based on

five categories of reimbursements, i.e., direct care, ancillaries, dietary, general and administrative, and fixed capital. Direct care reimbursements are paid for registered nurses (RNs), licensed vocational nurses (LVNs), and nurse aides (NAs) who are directly involved in resident care. Ancillary reimbursements are paid for drugs, supplies, and various therapies. Dietary reimbursements cover residents' food supplies and preparation. General and administrative reimbursements cover business supplies and personnel responsible for business operations that are not primarily involved in direct nursing care of residents. Capital reimbursements cover expenditures related to the physical plant, e.g., buildings and equipment.

Over the years, states have been moving to case-mix reimbursement methodologies for the direct care category of expenses. Case-mix systems reimburse a facility's direct care component based on the distribution of categories of residents in that nursing home.

Increasingly, states are basing their case-mix assessments on RUGs-III, an assessment system developed by the former Health Care Financing Administration (HCFA), now renamed the Centers for Medicare and Medicaid Services (CMS). Nineteen states have developed a Medicaid payment system based on the RUGs-III categories[1], and an additional five states are planning to adopt that system. States that do not use the RUGs-III classification have developed their own case-mix system, reimburse for all residents equally, base payments on facility cost, or still use the RUGs-II classification.

RUGs-III was designed to improve the measurement characteristics of the assessment, reflect changes in resident types, and account for residents requiring "high-tech" procedures. The RUGs-III system places nursing home residents in categories based on their scores on the Minimum Data Set (MDS) assessment instrument. Nursing home personnel are required to assess residents using the MDS, which contains items covering 17 sets of resident characteristics, e.g., mood, behavior, skin conditions, and physical functioning.

The RUGs-III system assigns residents to one of seven major categories, i.e., Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Behavior Functions (Reduced). These categories are then subdivided into either 34 or 44 classifications of nursing staff need, depending on the system that is seen as most appropriate for a state's particular needs.

Texas adopted the TILE for nursing home resident reimbursement in 1989. Nursing home residents are assessed with a Client Assessment, Review, and Evaluation (CARE) form in order to determine their TILE rates. Each resident is assigned to one of 11 standard TILE reimbursement rates, plus a default rate that is used when diagnostic information is not available and, if applicable, one of three supplemental rates--two for residents on ventilators and one for pediatric tracheotomy residents.

In addition to providing nursing home reimbursement based on resident characteristics, in June of 2000, Texas introduced a plan for providing increased direct care reimbursement "awards" for nursing homes that voluntarily increase their nursing staffs over minimum levels. Nine levels of staffing were established for fiscal year 2001; the number of levels was increased to 29 for fiscal year 2002.

If Texas opted to move to a reimbursement methodology based on the RUGs-III system, it could take one of two basic approaches. One approach would be to adopt only the RUGs-III categories and adjust the staffing levels for those categories to the staffing levels used by Texas in the TILE system. This approach would not change Texas' overall nursing home budget. However, individual nursing homes in Texas would be reimbursed differently because the mixes of their resident categories would change.

The second approach would be to adopt not only the RUGs-III categories but also to adopt the accompanying staffing levels--for example, the HCFA time study recommendations. The HCFA time study recommendation averages 4.17 nursing hours per resident-day[2] (1.15 RN, .7 LVN, and 2.32 NA). In contrast, the 2000 average nursing hours per resident-day for facilities with Medicaid-only beds in Texas was 3.2[3] (.3 RN, .7 LVN, and 2.2 NA). Using the most recent available data for estimation (2000 staffing ratios, pre-audit 2001 resident days, 2001 salaries), adoption of the HCFA time study recommendation would cost considerably more than current estimates of FY 2001 direct care expenditures.

There could be benefits to Texas in moving from the TILE system to a RUGs-III based classification system. The RUGs-III allows a finer discrimination of nursing needs than the TILE system, i.e., 34 or 44 categories versus 11. RUGs-III also incorporates more recent knowledge of nursing protocols and reflects more current awareness of resident needs and technological advances.

Moving from the TILE system to a RUGs-III based system would impact nursing home staffing in ways that cannot be determined at the present time. Before the effect on staffing can be determined, four preliminary tasks must be performed. First, the audit of FY 2001 cost reports must be completed to determine the staffing ratios of nursing homes.

Second, the RUGs-III database that is derived from a database that Texas is required by federal law to maintain must be corrected for errors and omissions. It has been subject to little data checking and verification, and there are omissions in identifying information, assessment dates, and possibly the MDS data that is used for RUGs-III classification. Information as to the nature of the errors and omissions could be useful for future training purposes.

Third, staff training in conducting assessments for RUGs-III categorization must be expanded. The United States Department of Health and Human Services (HHS) Office of Inspector General conducted a study[4] on a sample of 640 nursing home residents. After HHS reviewers

categorized the residents using the RUGs-III system, they found 76 percent of their assigned categories were different than those assigned by the nursing home staff. For 30 percent of the residents, the nursing home staff placed the residents in a lower RUGs-III category. For 46 percent of the residents, the nursing home staff placed the residents in a higher RUGs-III category. The study also found a 39 to 45 percent difference between the amount of therapy that was logged for the resident and the amount that was coded on the MDS. Training for MDS assessment is important to ensure accuracy due to the high turnover rate of the assessors. The previously referenced USGAO report stated that 60 percent of MDS coordinators had worked one year or less in that role and more than 65 percent had no prior experience in that capacity.[5]

The fourth task necessary for adopting a RUGs-III reimbursement system would be to develop an on-site review program. In an analysis of the 50 states and the District of Columbia[6], only 11 states were found to carry out separate on-site reviews of the accuracy of MDS assessments. (See Table 1.) Ten states with long-standing MDS review procedures reported that the assessment process by itself was inadequate for ensuring accuracy and maintained that a separate review process was necessary to achieve accurate assessment of nursing home residents.

Table 1[7]: States with and without MDS review programs as of January 2001

Type of payment system	State	State Totals
States with separate MDS review programs		
MDS-based payment system	Indiana, Iowa, Maine, Mississippi, Ohio, Pennsylvania, South Dakota, Vermont, Washington, West Virginia	10
Planning to adopt MDS-based payment system	Virginia (reviews began April 2001)	1
States planning separate MDS review programs		
MDS-based payment system	Idaho, Kentucky, New Hampshire	3
Planning to adopt MDS-based payment system	Georgia, Minnesota[8], New Jersey, Utah	4
Subtotal		**18**
States with no plans to establish separate MDS review programs		
MDS-based payment system	Colorado[9], Florida[10], Kansas, Nebraska, North Dakota	5
No MDS-based payment system	Alaska, Alabama, Arkansas, Arizona, California, Connecticut, District of Columbia, Delaware, Hawaii, Illinois[8], Louisiana, Massachusetts[8 11], Maryland[9], Michigan, Missouri, Montana[8], North Carolina, New Mexico, Nevada, New York[8], Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas[8], Wisconsin, Wyoming	28
Subtotal		**33**
Total		**51**

Note: States' decisions regarding whether to adopt an MDS-based payment system and MDS review program may have changed since this reference (January 2001). For example, a Kentucky official told us that it implemented a separate MDS review program in October 2001, and Montana has shifted to an MDS-based payment system.

Table 2 illustrates the MDS assessment error rates of five states before and after initiating the on-site review process. They found that on-site reviews of MDS assessments reduced error rates, reinforced the states' emphasis on accuracy, and provided an opportunity for training assessment staff.

Table 2
Percentage of MDS Errors in Five States
Before and After On-Site Review

State	Initial MDS Error Rate	Subsequent MDS Error Rate
Indiana	75%	30%
Iowa	32%	22%
Maine	21%	10%
Pennsylvania	20%	15%
South Dakota	85%	10%

In a review of national MDS records and the residents' corresponding medical records[12], the HHS Office of the Inspector General found an average of 17 percent of the MDS items differed from the medical record. In Section G of the MDS, "Physical Functioning and Structural Problems," a disparity between the MDS and medical records was found in 31 percent of records reviewed. In the section "Discharge Potential & Overall Status," 37 percent of the items were different from the information that was recorded in the medical records. The same study found that differences in these two sources of resident information were significant enough to affect the planning of nursing home resident care.

Only after completion of these four tasks would it be feasible to determine with accuracy how the RUGs-III reimbursement method would impact nursing home staffing in Texas. With accurate records regarding the number of nursing home residents in each RUGs-III category for every nursing home in Texas, it would then be possible to examine whether the RUGs-III method of classification is a more effective method of nursing home reimbursement than the TILE method.

END NOTES

1. U.S. General Accounting Office (USGAO). (2002). "Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities" (GAO-02-279). Report to the Special Committee on Aging, U.S. Senate. Washington, D.C.

2. Burke, B., and Cornelius, B. "Analysis of Staff Time Based on HCFA's Multistate Case-Mix and Quality Demonstration and HCFA's Staff Time Measurement Study for National SNF System." Baltimore, MD: Health Care Financing Administration, 1998.

3. Harrington, C.; Carillo, H.; Wellin, V. "Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1994 Through 2000," available on the Internet at: http://nccnhr.newc.com/public/50_155_2409.cfm

4. Department of Health and Human Services, Office of the Inspector General. (2001). "Nursing Home Resident Assessment, Resource Utilization Groups," available on the Internet at: http://oig.hhs.gov/oei/reports/oei-02-99-00041.pdf

5. U.S. General Accounting Office (USGAO). (2002). "Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities" (GAO-02-279). Report to the Special Committee on Aging, U.S. Senate. Washington, D.C.

6. U.S. General Accounting Office (USGAO). (1999). "Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards" (GAO/HEHS-99-46). Report to the Special Committee on Aging, U.S. Senate. Washington, D.C.

7. U.S. General Accounting Office (USGAO). (2002). "Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities" (GAO-02-279). Report to the Special Committee on Aging, U.S. Senate. Washington, D.C.

8. Although these states do not conduct a separate review of MDS data, they do conduct separate reviews of data that are linked to their state's Medicaid payment system. For example, Texas has a non-MDS-based case-mix payment system called the Texas Index for Level of Effort that is based on a recipient's condition, ADLs, and the level of staff intervention.

9. Colorado and Maryland officials volunteered that they had conducted onetime reviews of MDS data, but are not planning to regularly continue these reviews. Colorado's state survey agency conducted an MDS review of 90 nursing homes (40 percent of homes) in the summer of 2000 and Maryland officials participated in an HCFA-funded project to conduct on-site reviews from May through July 2000 at five percent of its nursing homes.

10. Florida experimented with MDS-based payment systems for a small portion of Medicaid reimbursement, but is now using a facility-based reimbursement method.

11. Massachusetts adopted an MDS-based payment system after the GAO report.

12. Department of Health and Human Services, Office of the Inspector General. (2001). "Nursing Home Resident Assessment: Quality of Care," available on the Internet at: http://oig.hhs.gov/oei/reports/oei-02-99-00040.pdf

Attachment 11

TEXAS LEGISLATIVE COUNCIL

P.O. Box 12128, Capitol Station
Austin, Texas 78711-2128
Telephone: 512/463-1151

BILL RATLIFF
Lieutenant Governor
Chairman

STEVEN R. COLLINS
Chief Legislative Counsel
Executive Director

JAMES E. "PETE" LANEY
Speaker of the House
Vice Chairman

MEMORANDUM

TO: The Honorable Robert Duncan

FROM: Don R. Warren
Program Director

DATE: September 3, 2002

SUBJECT: Adequacy of Nursing Home Quality Indicators

BRIEF QUESTION

Is there evidence to suggest that certain nursing home Quality Indicators are not adequate to signal some quality of care problems, suggesting that the State of Texas should request the Centers for Medicare & Medicaid Services to revise such indicators?

BRIEF ANSWER

No. There is no evidence to suggest that Quality Indicators fail to capture problems with quality of care. However, this finding implies that quality of care problems may be concentrated in a persistent subset of "low quality" facilities and are not randomly distributed throughout all facilities in the state.

DISCUSSION

Background

Quality Indicators (QIs) are a subset of 32 data items taken from the larger Minimum Data Set (MDS) that is reported by all nursing facilities serving Medicare and Medicaid beneficiaries. The QIs are not direct measures of quality, but their presence indicates potential problem areas that may require further review and investigation.

The way that the QIs signal a potential problem is based on the percentage of residents in a facility who experience the problem. This percentage is compared to the percentage of such events in all facilities in the state, and if a facility ranks higher than 9 out of 10 other facilities, it could be subject to an investigation to determine whether the facility has a problem with quality of care.

Estimates for certain QIs tend to cluster near zero percent, where almost no one experiences the problem, while others cluster near 100 percent, where almost everyone experiences the problem. For example, dehydration is so infrequent that the percentage of residents experiencing the problem is invariably close to zero. At the other extreme, incontinence is so common among residents who are at high risk for the condition that the rate of occurrence is around 94 percent. Surprisingly, the occurrence of incontinence without a plan by the facility to deal with the condition is also unusually high at 82 percent.

However, it is a well-established principle of statistics that as percentage estimates approach zero or one, the estimates tend to have a shorter range than estimates that cluster around the midrange.[1] As a practical matter, this tendency should cause facilities that have estimates clustered at the extremes to change frequently from a low quality status (that is flagged by a QI) to an acceptable status (with no flag). For example, if it only takes one resident to raise a flag for dehydration, then it would only require an improvement in that one resident to improve the status of the facility as a whole.

If this pattern were indeed present it would impose an unnecessary burden on survey staff, who must chase after problems that will change rapidly in any case, whether they are investigated or not. The purpose of this study was to determine whether such a pattern exists in the historical data and whether certain Quality Indicators should be measured differently to provide more useful information to survey staff.

Results

QI calculations, based on Quality Indicator data from the Minimum Data Set for 2001, were generated using software provided by the Texas Department of Human Services. The incidence of a quality problem among individuals was compared to the number of transitions from flagged to nonflagged status for facilities. These data provide no evidence that very high or very low incidence of a quality of care problem is associated with more frequent transitions from flagged to nonflagged status. This result suggests that the QIs in question are stable measures of the conditions they indicate and should not be ignored by survey staff or recalculated by CMS.

---

[1] See William G. Cochran, *Sampling Techniques*, John Wiley & Sons, New York, 1977, pp. 53-55.

This finding also has an important corollary. If the expected pattern does not exist, as these results indicate, it means that facilities with extreme quality problems do not address those problems quickly and move quickly from flagged to nonflagged status. The evidence suggests that high quality facilities simply do not allow such problems to arise and that a persistent subset of low quality facilities consistently fail to address quality of care problems even when they are brought to light.

02Y1353

Attachment 12

TEXAS LEGISLATIVE COUNCIL

P.O. Box 12128, Capitol Station
Austin, Texas 78711-2128
Telephone: 512/463-1151

BILL RATLIFF
Lieutenant Governor
Chairman

STEVEN R. COLLINS
Chief Legislative Counsel
Executive Director

JAMES E. "PETE" LANEY
Speaker of the House
Vice Chairman

MEMORANDUM

TO: The Honorable Robert Duncan

FROM: Don Warren
Program Director

DATE: December 16, 2002

SUBJECT: Evaluation of TDHS Quality-of-Care Monitor Program

BRIEF QUESTION

Has the Quality-of-Care Monitor Program, as required by S.B. 1839, 77th Legislature, Regular Session, improved the quality of care provided to residents of Texas nursing homes?

BRIEF ANSWER

No. Six separate analyses were undertaken to determine whether there has been a programmatic effect, but in no case did the analyses show that the program is producing a net improvement of the quality of care. Since the program has been in effect for less than one year, it seems advisable to reevaluate the program periodically.

DISCUSSION

Background

Section 7.03 of Senate Bill 1839, 77th Legislature, Regular Session, requires the Texas Department of Human Services (TDHS) to establish a quality assurance early warning system, along with rapid response teams, to improve the quality of care provided to residents of nursing institutions, assisted living facilities, and intermediate care facilities for the mentally retarded. The goal of the early warning system is to detect conditions that could be detrimental to the health, safety, and welfare of residents or that would predict the need for the department to take action on behalf of residents of a facility.

To that end, quality-of-care monitors are required to conduct regular, unannounced, aperiodic visits to facilities, giving priority to those with a history of patient care deficiencies. Findings of a monitoring visit are provided to facility administrators with recommendations for improvement, but if the findings suggest an immediate threat to the health or safety of a resident, the monitor is required to report to the department, law enforcement, or other responsible agencies. After a facility has been identified through the early warning system, it is subject to follow-up visits by rapid response teams. The department is required to evaluate the effectiveness of the quality assurance early warning system and report annually to the governor and legislative leaders. The department began implementing these provisions in April 2002.

Methodology

Using data extracted from the minimum data set, quality-indicator scores were compiled for all Medicaid nursing facilities in the state for the six months prior to the beginning of the program by TDHS in April 2002. These scores were then compared to scores reported by facilities for the six months following the start of the program. If the program were effective in improving quality of care, one would expect to find a pattern of improving quality-indicator scores when comparing data from before and after the program intervention.

The program may have been in operation for too short a time to produce a large, statewide effect. Consequently, the evaluation does not stop with a rough statewide comparison but undertakes a range of more targeted comparisons and uses a variety of analytical techniques that are designed to detect any effect, however minor, that the program may have had.

Results

Analysis 1. The most basic criterion to use in evaluating the program is whether or not it has improved quality of care, as measured by the composite across all the quality indicators, for all residents of Medicaid nursing facilities throughout the state. The program had no measurable effect at the broadest, statewide level.

Analysis 2. It is possible that there was statewide improvement on some quality indicators but not on others, and that the beneficial effect was masked in Analysis #1 when all indicators were combined. Therefore, a second analysis was undertaken to examine scores for each of the 32 quality indicators before and after the program intervention. This analysis provided mixed results: six of the indicators showed a significant change from before the intervention to after, but half of these indicators showed a significant improvement in quality while the other half showed a significant deterioration in quality.

Analysis 3. A third analysis of statewide scores was undertaken to determine whether these significant changes were likely to have established a trend for better or worse that could be expected to continue into the future. It is possible, for example, that one result could be likely to continue into the future while another result could be unlikely to persist. The analysis of trend indicated that future results are likely to remain mixed for the same six indicators in the previous analysis that did show a significant change, with equal numbers of positive and negative outcomes continuing into the future.

Analysis 4. Since no effect was discovered when analyzing all facilities, the next approach was to analyze individual quality indicators but distinguish between facilities that had a history of patient care deficiencies and others that did not. Since S.B. 1839 directs the department to focus on problem facilities, it is plausible that an effect that would be apparent for this group would be masked by looking at all facilities together. Accordingly, analyses were undertaken that focused on the group of facilities rated with the lowest performance scores by the TDHS quality-reporting system as compared to the remaining, better performing facilities. When scores from the period before the program began were compared to scores from the subsequent period when the program was in operation, no difference was found between better and worse performing facilities.

Analysis 5. Once again, it is possible that only some of the 32 quality indicators showed improvement in the facilities with a history of patient care deficiencies, and that this improvement was masked by grouping all the indicators together for these facilities. Therefore, we conducted a more refined analysis of the quality indicators that flag the most serious or "sentinel" events in the facilities that had a history of patient care deficiencies as compared to facilities that did not. These indicators were chosen for study because S.B. 1839 requires the department "to detect conditions that could be detrimental to the health, safety, and welfare of residents. . . . [or] that would predict the need for the department to take action" on behalf of residents of a facility. These two characteristics--conditions detrimental to the health and safety of a resident and conditions that predict the need for the department to take action--virtually define the subset of quality indicators known as "sentinel events." Once again, there was no change in these indicator scores from before and after the program intervention.

Analysis 6. The sixth and final evaluation estimated future trends for facilities with a history of deficiencies as compared to facilities without such a history, as was done for the statewide results. Only one of these quality indicators had a relevant difference in trend; the results suggest for that quality indicator that poor-performing facilities are likely to perform worse at a faster rate, as compared to better performing facilities which are likely to perform worse at a slower rate.

Conclusion

It is almost certain that if the Quality-of-Care Monitor Program had a measurable, systematic

effect on quality of care, that effect would have been detected in some way by these analyses. However, we could find no evidence to suggest that the program has had any measurable net effect to date.

Since the program has been in effect for less than one year, it seems advisable to revisit this analysis periodically to ensure a fair evaluation of the program.

02Y1837