



Texas Council on Long- Term Care Facilities

As Required by Senate Bill 1519

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2. Executive Summary

Senate Bill 1519 (S.B. 1519), 86th Legislature, Regular Session, 2019, established the Long-Term Care Facilities Council as a permanent advisory council to the Texas Health and Human Services Commission (HHSC) to study and make recommendations for nursing facilities (NFs), assisted living facilities (ALFs), and intermediate care facilities for individuals with an intellectual disability or related condition (ICF-IIDs) regarding:

1. A consistent survey and informal dispute resolution (IDR) process with regard to best practices and protocols to make the survey, inspection, and IDR processes more efficient and less burdensome, as well as to recommend uniform standards for those processes;
2. Medicaid quality-based payment systems with regards to the systems and a rate-setting methodology; and
3. The allocation of and need for Medicaid beds with regards to the effectiveness of rules adopted by the HHSC executive commissioner relating to the procedures for certifying and decertifying Medicaid beds and the need for modifications to those rules to better control the procedures for certifying and decertifying Medicaid beds.

The executive commissioner of HHSC appointed regulatory staff, IDR staff, and long-term care providers to the council. A key council objective is to submit a report no later than January 1, 2021, outlining its recommendations to the executive commissioner, the governor, the lieutenant governor, the speaker of the House of Representatives, and the chairs of the appropriate legislative committees.

Despite the COVID-19 pandemic, the council was able to meet four times and establish three subcommittees that met from five to seven times each to further study and develop individual recommendations for legislative action. The subcommittees also met via conference call as needed to discuss preliminary recommendations. Public comment was accepted at the outset of each scheduled meeting, and written comment was accepted on an ongoing basis.

The council requested information from HHSC as part of its information-gathering and discovery phase. The council asked agency representatives numerous questions about processes and regulations and used this information to form preliminary recommendations within the scope of SB 1519.

This report was prepared by members of the Long-Term Care Facilities Council. The opinions and recommendations expressed in this report are the members' own and do not reflect the views of the Texas Health and Human Services Commission Executive Council or the Texas Health and Human Services Commission.

3. Background

According to the U.S. Census Bureau, in 2010 there were 3.8 million people in Texas age 60 and older; they made up approximately 15 percent of the total Texas population of 25 million. This group is one of the fastest-growing populations in Texas and is expected to more than triple between 2010 and 2050. By 2050, this group is expected to grow to 12 million. (Data source: US Census 2010 and Texas State Data Center, University of Texas at San Antonio)

By 2050, Texans age 60 and older will comprise 22 percent of the total Texas population. As the older adult population increases, Texas will need more health and human services and community engagement activities (Texas State Plan on Aging 2015-2017).

Thirty-five percent of Texans age 60 and older (1.3 million) have one or more disabilities. Certain population groups are more likely to experience disability than others:

- Disability is more common among women than among men age 75 and older. This might reflect the fact that many more women than men live to be this age.
- Among people age 65 and older with incomes below the poverty level, 54 percent have a disability, compared to 39 percent of those with incomes above the poverty level.

In Texas, the growth of the aging population and increased longevity will mean a marked increase in the number of people age 85 and older. In 2010, the population age 85 and older was 305,000; by 2050, it is expected to increase to 1.6 million, an increase of greater than 500 percent. This segment of the population will increase from 1.2 percent to 2.8 percent of the total population. Rates of disability and serious chronic illness tend to increase with age. This rapid increase in the number of the oldest people is expected to increase the need for long-term services and supports. (Source: Texas State Plan on Aging 2015-2017)

Growth of Long-term Services and Supports for an Aging Population

Along with the aging population, the state has seen a steady need for NF and ALF beds, and ICF/IID-type residential settings. The average number of individuals receiving Medicaid-funded NF services per month in FY 2013 was 56,232, and in FY

2018 that number was 58,582 (Source: State Plan on Aging 2015-2017 / 2018 NF Cost Report data).

Medicaid nursing facility beds in Texas are highly regulated, and HHSC controls their allocation. The number of licensed nursing homes changed from 1,223 in 2015 to 1,248 in 2019, as occupancy rates have not exceeded capacity.

The number of ALFs in Texas continues to grow. In 2015, the number of licensed ALFs was 1,829; that grew to 2,003 in 2019 (Source: HHSC Annual Report Regarding Long-term Care Regulatory, 2019).

The state also has seen a slow decline in the number of ICFs/IID. Both federal and state initiatives, such as Money Follows the Person (MFP) funding, have led to a reduction of individuals residing in large private and state-operated ICFs/IID in Texas (Source: Legislative Budget Board Staff report to 82nd Legislature, January 2011). The Legislature in the early 1990s put a moratorium on new ICFs/IID and implemented three-person group homes under the Home and Community Services (HCS) waiver program. In the mid-90's, the Legislature allowed HCS programs to serve four individuals, in part due to an impending 27 percent rate reduction per individual per day. In 2015, 8,401 individuals lived in ICFs/IID; in 2019, that number had declined to 7,464 (Source: HHSC Annual Report Regarding Long-term Care Regulatory, 2019).

Facility Counts by Program Type

Program	Count	% of all Facilities
Assisted Living	2,003	49.4%
ICF/IID	805	19.8%
Nursing	1,248	30.8%
Total	4,056	

Source: HHSC Regulatory Services FY 2019 Annual Report.

Regulation of Nursing Facilities, Assisted Living Facilities, and ICF/IID Facilities

HHSC oversees long-term care services and supports that help more than a million older Texans and those with disabilities to lead dignified, independent, and productive lives (Source: DADS Sunset Report 2014). HHSC oversees multiple complex programs, facilities, and provider types with multiple funding streams and reporting / accountability

requirements. HHSC regulates more than 10,000 providers that serve these populations. For long-term care, HHSC regulates the following facilities, agencies, and programs:

- Day activity and health services facilities;
- ALFs;
- Home and community support services agencies, which includes home health agencies and hospices;
- NFs and skilled NFs;
- Publicly and privately-operated HCS waiver providers;
- Publicly and privately-operated Texas Home Living (TxHmL) waiver providers; and
- Publicly and privately-operated ICFs/IID, including those operating as state supported living centers (SSLCs).

In addition, HHSC operates 12 SSLCs and the ICF unit at the Rio Grande State Center. These centers house about 2,800 individuals, which is significantly lower than in decades past, and many of them have complex medical and behavioral needs. (Note: The Regulatory Services division of HHSC, which regulates and certifies the SSLCs, is intentionally separated from the facility operations division within the HHSC organizational structure.)

HHSC Regulatory Services also licenses and surveys all nursing facilities, ALFs, and ICF/IID providers in Texas. HHSC also certifies NFs on behalf of the Centers for Medicare and Medicaid Services (CMS) for participation in the Medicaid and Medicare programs. In FY 2020, Texas had 1,220 licensed NFs.

Informal Dispute Resolution

The HHSC IDR unit acts as a neutral third party in cases where NFs, ALFs, and ICFs/IID decide to informally dispute survey findings cited by HHSC Regulatory.

Senate Bill 304, 84th Legislature, Regular Session, 2015, requires HHSC to contract with an appropriate, disinterested non-profit organization to perform IDRs for NFs. Although it was specific only to NF providers, HHSC released a Request for Proposal (RFP) to include all three facility types. Michigan Peer Review Organization was awarded the contract and is the current entity conducting IDRs in Texas.

4. Bill Requirements and Report Development Process

SB 1519 created the Long-term Care Facilities Council to make recommendations regarding the development of more consistent survey and IDR processes for long-term care facilities, Medicaid quality-based payment systems and rate-setting methodology, and the allocation of Medicaid beds. The council has 11 members, including HHSC Regulatory staff, HHSC IDR staff, and long-term care facility providers and must submit a report to the Legislature by January 1 of each odd-numbered year, beginning in 2021.

An open application process was developed and posted to the HHSC website to receive applications for external members to the council. The application period closed November 29, 2019. Staff from HHSC reviewed both the external and internal (state agency) applicants and made recommendations to then-Executive Commissioner Courtney Phillips. She then appointed members to the council, which held its first meeting on March 3, 2020, in Austin, Texas. HHSC Regulatory Services staff provide administrative support to the council.

Duties of the Council

The more specific duties of the Council are as follows:

1. Study and make recommendations regarding best practices and protocols to make survey, inspection, and informal dispute resolution processes more efficient and less burdensome on long-term care facilities;
2. Recommend uniform standards for those processes;
3. Study and make recommendations regarding Medicaid quality-based payment systems and a rate-setting methodology for long-term facilities; and
4. Study and make recommendations relating to the allocation of and need for Medicaid beds in long-term care facilities, including studying and making recommendations relating to:
 - a. The effectiveness of rules adopted by the executive commissioner relating to the procedures for certifying and decertifying Medicaid beds in long-term care facilities; and
 - b. The need for modifications to those rules to better control the procedures for certifying and decertifying Medicaid beds in long-term care facilities.

5. Recommendations

The following policy recommendations were approved by the council for consideration by the Legislature and HHSC. They are grouped by those that would require legislative action and by those that would require state agency action, based on preliminary research.

Recommendations for Legislative Action:

- A. Formalize authority to temporarily increase Medicaid beds during a state of emergency. Statutory authority is needed to increase bed allocation during a state of emergency (i.e. public health emergency, natural disaster, etc.). Currently, an increase can only be achieved through waivers/exemptions. For example, there were six NFs provided temporary Medicaid bed increases during 2020 due to COVID-19.
- B. Nursing facility providers should be fully funded for care provided to Medicaid residents based on median costs. The base Medicaid reimbursement rate in Texas currently ranks 49th lowest in the country and has not been adjusted since 2014. The expense of a Medicaid nursing home resident is approximately \$10 per day more than the reimbursement based on the allowable cost in 1 TAC §355.307 Reimbursement Setting Methodology. In addition, the nursing facility providers absorb an additional \$22 per day of cost that are not eligible for reimbursement through Medicaid (Source: 2018 NF Cost Report data).
- C. CMS changed to a Patient Driven Payment Model (PDPM) for nursing facility reimbursement for Medicare in October 2019 and potentially will no longer support data required for the current nursing facility Medicaid rate methodology used in Texas. The current Medicaid reimbursement model is based on the prior Medicare resource utilization group methodology and any future changes to the Medicaid model should be based upon PDPM.
- D. Remove waiver programs that are seldom used, specifically including the waiver for a facility that serves as a teaching facility for physicians and related health care professionals (Human Resource Code 32.0213). The waiver has only been approved once since the waivers were established.

- E. Remove the waiver to allow for Medicaid spend-down beds. This waiver provides a temporary Medicaid bed for residents who have “spent down” their resources to become eligible for Medicaid, but for whom no Medicaid bed is available in the current facility. From October 2019 to November 2020, there were 27 requests, of which 14 were approved, eight denied and five withdrawn under this waiver. This high-volume waiver requires a significant amount of HHSC staff time and is requested by a limited number of facilities. There are an adequate number of Medicaid licensed beds in each county to provide an alternate location for Medicaid residents without having to expand Medicaid licensed beds in an existing facility.
- F. Provide a cost adjustment to nursing facility providers to account for the incremental cost related to specific types of care, including tracheostomy, pediatric, ventilator, autism, and complex behaviors. These specialty care services require significantly more than what the current Medicaid rate methodology allows.

Recommendations to HHSC

The following recommendations were agreed upon by the council during deliberations.

Recommendations to HHSC Regulatory Division

- G. Delay a requirement to decertify beds for a period of 24 months following the end of a state of emergency, by county. This allows for recovery and normal resumption of business for entities that were affected by an emergency, including the COVID-19 pandemic, and provides a better basis to evaluate the true need for beds in those communities. Industry estimates of the current COVID-19 reductions in census project it will take 18 to 24 months for facilities to stabilize following the pandemic. A similar period of time is required to plan and rebuild facilities following natural disasters that result in a state of emergency. We recommend this delay be limited to counties actually affected and therefore included in a state of emergency.
- H. Allow replacement status for Medicaid beds in existing buildings to be used for renovation and/or expansion. Currently a provider can request that Medicaid beds be placed in replacement status only for one or more new facilities. This option would provide flexibility to providers seeking to increase their Medicaid beds in existing facilities when renovating or expanding capacity with an addition.

- I. Require a nursing facility provider to be identified in a waiver application prior to approval. Currently only the property owner must be identified in the initial application, and after approval the new Medicaid beds can be sold to another developer. The nursing facility provider is of great significance to the project and should be identified during the waiver or exemption application and not be allowed to be changed, except through a change of ownership process after the new facility is constructed.
- J. Medicaid beds for facilities in good standing that voluntarily closed for reasons other than extensive damage to the facility should be returned to HHSC and not be eligible for replacement status. Facilities typically close due to regulatory concerns or poor financial performance driven by low census. Allowing closed nursing facilities to sell its Medicaid beds exacerbates the problem by allowing a new provider to build a facility, which also results in too great of a supply of Medicaid beds.
- K. Delay approval for new waivers by 12 months after the end of the state of emergency by county. This delay will allow time for occupancy to normalize after the impact of COVID-19 or any other natural disaster, and then any waivers not currently approved can be resubmitted with updated information that reflects the impact of new demographic trends.
- L. Remove waiver programs that are seldom used, specifically including the small house waiver designed to promote the construction of smaller nursing facilities (40 TAC §19.2322 (h)(9)). This waiver has only been approved once since it was established.
- M. Allow regulatory surveyors to continue with their more collaborative and consultative role that has occurred during the pandemic. For example, providers expressed an interest in receiving real-time feedback on noncompliance situations, while the surveyors are still onsite.
- N. Ensure a list of requested information that could not be found by the provider during a regulatory visit is delivered by the surveyor to the facility leadership prior to exit. This affords providers an additional opportunity to ensure they understand what records have been requested and that the correct staff/department has searched for them.
- O. Implement a uniform plan of removal template for immediate threat situations that lists the requirements a provider must meet to get the immediate threat lifted. This will enhance consistency throughout the state. The template would be in a user-friendly format that requests uniform information and would include guidance to state agency staff and to providers on exactly what information is needed.

- P. Ensure daily debriefings are conducted consistently statewide. Surveyors would provide information to facility leadership regarding issues of any non-compliance found daily during their onsite visits.
- Q. Ensure exit conferences provide thorough, detailed information regarding noncompliance so providers can easily understand the deficient practices and resolve the issues while awaiting the report of findings. For example, if infection control is cited – which can cover a wide variety of processes/procedures – describe the deficient practice (e.g. hand-washing techniques were not in line with CDC guidance, etc.).
- R. Ensure consistency when citing noncompliance for licensure requirements on Form 3724. There should be consistency statewide when deciding which regulations to cite for noncompliance and how many areas in which to cite. Citations should be such that the provider corrects any system and individual issues that contributed to the noncompliance.

Recommendations to HHSC Financial Division

For Provider Finance.

- S. Confirmation of General Liability coverage should be included in the provider's cost report rather than requiring a certificate of liability coverage.

Recommendations to HHSC Medicaid Division

For Quality Incentive Payment Process (QIPP). QIPP is a performance-based program that encourages nursing facilities to improve the quality and innovation of their services through implementation of program-wide improvement processes, which facilities are compensated for if they meet or exceed certain goals. The following recommendations should be considered for future QIPP programs:

- T. Maintain focus on infection prevention and control. Specifically, consideration should be given to including infection control prevention, antibiotic stewardship, pharmacy safety, and incentives for containment of infectious disease based on the percentage of a facility's resident population.
- U. Provide funds to encourage compatibility of electronic medical records. A multi-year approach should be developed to strengthen the level of electronic medical records to industry standards and allow for improved flow of information between health care providers.
- V. The council believes that quality leaders in a nursing facility are a significant indicator of quality care. QIPP should encourage facilities to develop a

comprehensive leadership development program, with the goal to drive broad improvements based on clear quality measures. Specifically, this program should require 16 hours of continuing education leadership training for licensed nursing facility administrators (LNFA).

6. Conclusion

The Long-term Care Facilities Council's effort in 2020 afforded long-term care industry stakeholders the opportunity to share their concerns and suggestions regarding the regulatory environment and the processes for Medicaid reimbursement and allocation of Medicaid beds. HHSC staff gained further insight into the industry's challenges, as well as a reinforced understanding that they share a common goal with providers – positive outcomes for residents in Texas long-term care facilities.

The Long-term Care Facilities Council also allowed regulatory state staff, industry providers, and IDR staff to share information and gain new insights into the critical roles they all play in providing quality long-term care to a growing aging population and to individuals with disabilities. These robust, constructive discussions led to recommendations that the council is confident will directly improve the quality of care on which these vulnerable Texans depend.

It is the hope of this Council that our state leadership will take these recommendations, review them fully, and implement them in a manner that will best serve the citizens of the State of Texas.

7. Appendix A - Public Comment Submissions

- Ms. Sonja Burns
- Ms. Maribeth Fleniken
- Ms. Vickie Goodman
- Ms. Ginger Mitchell
- Ms. Susan Miller
- Ms. Claudia Smith
- Ms. Sally Daniels
- Ms. Norma Frick
- Ms. Susan Avera Thompson
- Ms. Karen Richardson Stokes
- Mr. Trey Evans

8. Appendix B – Subcommittee Participants

1. Survey and Informal Dispute Resolution Processes
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 - c. Linda Lothringer
 - d. Obinna Ogundu
 - e. Steven Nowonty
2. Medicaid Quality Based Reimbursement
 - a. Michael Fischer
 - b. Michael Gayle
 - c. Victoria Grady
 - d. Ryan Harrington
3. Allocation of Medicaid Beds
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 - b. Michelle Dionne-Vahalik
 - c. Michael Gayle
 - d. Ryan Harrington