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 (LTCFC) 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, 2023, 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.

The council has met 8 times since our 2021 report and has established 4 subcommittees that 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 S.B. 1519.

This report was prepared by members of the LTCFC. The opinions and recommendations expressed in this report are the members' own and do not reflect the views of the HHSC Executive Council or HHSC.

3. Background

According to the 2020 U.S. Census Bureau, in 2019 there were 3.8 million people in Texas age 65 and older; they made up approximately 13% of the total Texas population of 29.5 million. The Texas Demographic Center (TDC) projects that by 2030, Texas' older population will reach 5.6 million (16% of the population) and 8.3 million by 2050 (18% of the population). (Source: US Census 2020, Texas State Plan on Aging 2023-2025, Texas Demographic Center: https://demographics.texas.gov/11.21.22)

In addition, 37% of the population age 65 and older 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.

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 2022, the population age 85 and older was 442,000; by 2050, it is expected to increase to 1.5 million, an increase of greater than 300%. 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 2023-2025)

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

Along with the aging population, the state has seen a steady and continuing need for NF and ALF beds, as well as ICF/IID-type residential settings.

Medicaid NF beds in Texas are highly regulated and HHSC controls their allocation. The number of licensed nursing homes in Texas has decreased from 1,248 (2019 data) to 1,199 as of 11/2/2022, and occupancy rates are well below capacity. Data from CMS indicates an increase in occupancy of licensed SNF beds to 62% from a pandemic low of 57% in 2021.

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) and to 2,025 in 2021 (Source: HHSC Annual Report, 2021).

The state has also 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). In the early 1990s the Legislature put a moratorium on new ICFs/IID and implemented three-person group homes under the Home and Community-based Services (HCS) waiver program. In the mid-90's, the Legislature allowed HCS programs to serve 4 individuals, in part due to an impending 27% 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). There are 13 State Supported Living Centers (SSLCs) in Texas dedicated to serve persons with intellectual and developmental disabilities (IDD) who are medically fragile or have severe behavioral problems.

Facility Counts by Program Type

Program	Count	% of all Facilities
Assisted Living	2,025	50%
ICF/IID	787	20%
Nursing	1,199	30%
Total	**4,011**	

Source: HHSC October 2022

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, including 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 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 NFs, 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.

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 Services.

Senate Bill 304, 84th Legislature, Regular Session, 2015, requires HHSC to contract with an appropriate, disinterested 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

S.B. 1519 created the LTCFC 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 Services 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. Opening that have occurred since the first meeting have followed a similar process with a posting to the HHSC website, HHSC staff review of the applicants, and recommendations made to the current Executive Commissioner.

Duties of the Council

The more specific duties of the LTCFC 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.

The LTCFC is further provided the authority to receive informational updates from the ex-officio member of the Nursing Facility Payment Methodology Advisory Committee established under Texas Government Code, §531.012.

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. Funding should be appropriated to hold harmless providers from losing revenue resulting from changes in the Medicaid model recommendations made during the biennium period. In addition, HHSC should create options and mechanisms to address the structural integrity of the program and ensure that providers are not negatively impacted financially due to the transition.

B. NF providers should be fully funded for care provided to Medicaid residents based on median costs. The base Medicaid reimbursement rate in Texas currently ranks 50th lowest in the country and has not been adjusted since 2014. The expense of a Medicaid nursing home resident is approximately $89.26 per day more than the average reimbursement rate based on the allowable cost in 1 TAC §355.307 Reimbursement Setting Methodology (Source: 2018 NF Cost Report data inflated to 2024-2025 biennium).

C. Provide a cost adjustment to nursing home providers to account for the incremental cost related to specific care needs of persons with IDD (these might including tracheostomy, ventilator, autism, and complex behavioral issues). These specialty care services require significantly more expense than what the current Medicaid rate methodology allows.

D. Offer funding to encourage the establishment of specialty providers and to assist existing providers ready to offer specialty services to more effectively care for persons with IDD. Persons with IDD, and especially those with certain behavioral issues, often remain in levels of care that are inappropriate for their needs due to the lack of ability to provide care in more traditional environments. The IDD population requires a higher-level service than many traditional nursing homes offer using a rehabilitation-only model. Skilled NFs capable of complex care of persons with IDD are rare and some have a waitlist. ICF and group home providers often find themselves unable to assist in the placement of residents as they require higher levels of care and are unable to upgrade their in-house services or offerings.

E. Provide funds to assist providers with the purchase of specialty medical equipment that is often needed for persons with IDD but is an expense beyond the normal room and board funding through Medicaid. Specialty beds and power wheelchairs that need repairs go well beyond the expenses to purchase or replace more standard “hospital beds” and manual wheelchairs found in traditional environments.

F. Seek ways to provide additional funding for day programming needs of persons in group homes or ICF level facilities. For example, persons in ICFs are required to spend 6-8 hours, Monday through Friday, engaged in various day programs such as skills training and job coaching for employment. Current funding levels do not support required staffing and programming needs.

Recommendations to HHSC

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

G. HHSC should eliminate any occupancy adjustment from the Medicaid cost report expenses to determine allowable cost. There is currently a Texas Administrative Code (TAC) requirement that allowable Medicaid cost be adjusted if the occupancy is below 85% or the overall average occupancy rate for contracted beds in facilities included in the rate base during the cost reporting periods included in the base. Specifically, the average nursing home occupancy in Texas is currently 62.8% (based on December 18, 2022 data from the CDC - National Healthcare Safety Network). Occupancy adjustments to Medicaid cost are not a federal requirement and result in the reporting of artificially low Medicaid cost compared to actual costs.

H. HHSC should biennially review the TAC and federal cost reporting rules to evaluate any differences and determine if any TAC modifications should be made to provide consistency with federal requirements and cost report rules. Medicaid allowable costs are occasionally different in TAC compared to federal requirements and this change would result in improved uniformity and streamline cost reporting.

I. HHSC should develop a mechanism to eliminate or reduce burden on NF providers who participate in rate enhancement and are required to complete an accountability report each year the providers’ cost report is not required, typically on a biennial basis. This mechanism could include modifying TAC requirements pertaining to rate enhancement program or developing tools to automatically determine if staff enhancement levels are achieved by using data that is readily available. This would eliminate the burden of providers who are required to complete biennial staff reporting and HHSC staff needing to review and approve the reporting.

J. The Medicare Patient Driven Payment Model (PDPM) replaced the Resource Utilization Group (RUG) as the federal case-mix classification system for the Skilled Nursing Facility payment methodology in October 2019. As a result, Texas may no longer be able to use RUG based case-mix methodology for Medicaid NF payments and must find a suitable alternative. The NF-PMAC was formed in October 2019 to recommend potential alternatives and issued an official report with recommendations in August 2022.

   The NF-PMAC was presented with 4 alternative proposals and recommended HHSC proceed with implementation of PDPM-LTC. PDPM-LTC purports to operate within the current Federal Medicare PDPM platform, but only utilizes 3 of the 6 classification components (Nursing Component, Non-therapy Ancillaries, and Brief-Interview for Mental Status/Cognitive Impairment Score).

   This recommendation explicitly excludes the 3 components of the current Federal PDPM methodology: physical therapy, occupational therapy, and speech therapy. The report noted "recognizing that daily therapy services is typically not why a Medicaid long-term care resident is receiving benefits in a long-term care facility, long-term care residents do experience functional decline and need rehab services from time to time". However, according to 2020 billing data, 41% of NF residents were reimbursed based on therapy being provided, indicating that therapy services are a significant component of care provided to NF residents and therefore vital to their health and well-being.

   The report further noted "reimbursement funding will continue to be available for the qualified beneficiaries with traditional Medicare Part B, Medicare Advantage, or specialty Medicaid plans approval". However, Medicaid does not reimburse a NF for the 20% copay portion of Medicare Part B which could result in a significant loss when therapy services are provided if therapy services are excluded from the Medicaid reimbursement. Multiple states currently reimburse NFs for the 20% copay and any new Medicaid rate methodology should include reimbursement for therapy services to account for this gap in payment.

   HHSC should continue with implementation of a new Medicaid rate methodology that is consistent with PDPM, however to achieve comparable results the methodology should include all 6 components. Furthermore, the LTCFC should continue have the opportunity to provide feedback on any further changes to the Medicaid rate methodology proposed by HHSC.

K. HHSC should evaluate eliminating the Long-term Care Medicaid Information (LTCMI) form through the identification of alternate data sources in an effort to reduce the administrative burden on long-term care facility providers. The LTCMI form is not federally mandated and results in an additional burden on providers in order to receive reimbursement.

L. Advocate for additional waivers from CMS to expand CNA training sites. Currently, NFs designated with an immediate jeopardy are prohibited from hosting NATCEP students for a two-year period. A third-party NATCEP should be allowed to perform training in a NF with an immediate jeopardy and the NATCEP must be responsible for providing the preceptor instructor and accept responsibility for students.

M. Recommend that CMS and HHSC develop and pilot a virtual program to satisfy the required 40 hours of CNA clinical training.

N. Recommend that HHSC evaluate the use of non-certified and non-skilled staff to supplement direct care that is not required to be performed by certified or licensed staff. HHSC should further evaluate the current training requirements for paid feeding assistants.

O. Texas Workforce Commission (TWC) should expand funding to include CNA programs. TWC has indicated that there are no statutory limitations to funding CNA training, except that any such training must lead to self-sufficient wages. HHSC and TWC should further study the current prevailing wage for CNAs to validate that the average wage meets this requirement.

P. HHSC should reevaluate the cost for training program reimbursement found in §355.307(3). The most recent assessment and cost ceiling level ($250) is calculated based on 2008 rates. Any cost that exceeds the HHSC cost ceiling must have prior approval from Provider Billing Services before costs can be reimbursed, which creates an administrative burden on providers to pursue reimbursement.

Q. HHSC should work with the Texas Board of Nursing to strengthen the requirements for geriatric clinical rotations that include long-term care settings.

R. Allow long-term care facility providers to assume an existing Medicaid contract and all associated liabilities during the CHOW process without requiring a vendor hold.

S. HHSC should continue to streamline and evaluate requirements for licensure of Licensed Nursing Facility Administrator (LNFA) and Executive Director positions in long-term care facilities. Specific suggestions for LNFA include:

    a. Reduce the requirements from a Bachelor’s degree to an Associates degree;

    b. Allow reciprocity from any state with at least 2 years of experience as an LNFA;

c. Waive internship requirements for any individual that has been licensed by HHSC to run a long-term care facility, hospice, health home, or similarly licensed operation for at least two years; and

d. Update the LNFA exam.

T. Implement a uniform plan of removal template for immediate threat situations that list 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 providers on exactly what information is needed.

U. Ensure consistency when citing noncompliance on infection control. 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.

V. If a noncompliance is at the level of Immediate Jeopardy, surveyors should ensure that the facility has a plan to address the issue before leaving the facility. This will help to ensure that more residents or people are not affected by the noncompliance.

W. For changes in regulations/rules regarding infection control, allow facilities a 30-day grace period for implementation. This process will enhance precise, adequate, and effective implementation of new policies or processes by facilities. During this grace period, facilities may not be cited unless it is something that will put the residents/facility in immediate risk.

6. Conclusion

The LTCFC allowed members, 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 – Subcommittee Participants

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