HOUSE COMMITTEE ON HUMAN SERVICES
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2000

A REPORT TO THE
HOUSE OF REPRESENTATIVES
77TH TEXAS LEGISLATURE

ELLIOTT NAISHTAT
CHAIRMAN

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Committee On
HUMAN SERVICES

December 5, 2000

Elliott Naishtat
Chairman

P.O. Box 2910
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The Honorable James E. "Pete" Laney
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

The Committee on Human Services of the Seventy-Sixth Legislature hereby submits its interim report including recommendations for consideration by the Seventy-Seventh Legislature.

Respectfully submitted,

Elliott Naishtat, Chairman

Glen Maxey

Rick Noriega

Norma Chavez

Barry Telford

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INTRODUCTION

At the beginning of the 75th Legislature, the Honorable James E. "Pete" Laney, Speaker of the Texas House of Representatives, appointed nine members to the House Committee on Human Services. The committee membership included the following: Elliott Naishtat, Chairman; Glen Maxey, Vice-Chairman; Norma Chavez; Wayne Christian; John Davis; Rick Noriega; Barry Telford; Vicki Truitt; and Arlene Wohlgemuth.

During the interim, the committee was assigned four charges by the Speaker: 1) Study issues created by the transition of the TANF Program to federal law when the state's waiver expires in 2002. Include a review of the final TANF regulations and how other states use TANF funds outside the traditional cash assistance program. Consider policies to improve outcomes for people leaving welfare. 2) Study issues surrounding the financial difficulties experienced by some nursing home companies, including the reasons for bankruptcies and closures, state policies and resources for dealing with them, and impacts on residents. 3) Assess the state's responsibilities and policies regarding supports for individuals with disabilities in community-based settings. 4) Study the current public assistance eligibility, application and review processes, and other Department of Human Services' client communications to ensure that clients are getting the supports necessary to make a successful transition to self-sufficiency.

The committee has completed its hearings and research and has filed its report. The committee wishes to express appreciation to all the people who contributed to the development of this report. Thanks to the speakers and citizens who provided testimony at hearings, to the leadership and staff of the Texas Health and Human Services Commission, Texas Department of Human Services, Texas Department of Mental Health and Mental Retardation, Texas Department of Protective and Regulatory Services, Texas Department of Insurance, Office of Public Insurance Counsel, Texas Workforce Commission, Office of the Attorney General, Texas Department on Aging, Legislative Budget Board, the Promoting Independence Advisory Board, Local Workforce Development Boards, and to the staff of the Texas House of Representatives for their time and efforts on behalf of the committee.

HOUSE COMMITTEE ON HUMAN SERVICES

INTERIM STUDY CHARGES

CHARGE Study issues created by the transition of the TANF Program to federal law when the state's waiver expires in 2002. Include a review of the final TANF regulations and how other states use TANF funds outside the traditional cash assistance program. Consider policies to improve outcomes for people leaving welfare.

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CHARGE Study the current public assistance eligibility, application and review processes, and other Department of Human Services' client communications to ensure that clients are getting the supports necessary to make a successful transition to self-sufficiency.

CHARGE 1: Study issues created by the transition of the TANF Program to federal law when the state's waiver expires in 2002. Include a review of the final TANF regulations and how other states use TANF funds outside the traditional cash assistance program. Consider policies to improve outcomes for people leaving welfare.

Introduction

In 1995, the 74th Texas Legislature passed House Bill 1863, and welfare reform was initiated in Texas. The legislation made cash assistance a time-limited benefit, and recipients were required to work or prepare for the workplace. House Bill 1863 was similar, in many ways, to provisions in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), the federal welfare reform measure which was passed by Congress in August of 1996. Both contain time limits, an emphasis on personal responsibility and mandatory work requirements. In other ways, however, HB 1863 differs from federal welfare reform. For instance, there are no lifetime limits on assistance in the Texas legislation as there are in PRWORA.

Rather than immediately conform with federal welfare reform regulations, the state was allowed to take advantage of a waiver option. The waiver authorized a delay in implementing many of the federal provisions. The House Committee on Human Services was charged with examining provisions covered by the waiver that will change once Texas transitions to federal regulations. This report will highlight required changes, as well as the flexibility the state should retain in structuring the TANF program to best meet the needs of those moving from welfare to work.

In many ways, Texas has made a creditable start in moving recipients of Temporary Assistance for Needy Families (TANF), formerly AFDC, off the rolls and into jobs. Since 1994, the caseload has declined by more than 400,000 recipients. Welfare reform in Texas, however, is relatively new, and more needs to be done to make the program work for all who need it. With less of the federal block grant going to cash assistance, the state faces the challenge of deciding how to structure a program that helps people become self-sufficient. Federal regulations allow the state to be innovative, as long as funds go towards the allowable purposes of TANF (see box). The committee was also charged with studying measures the state may take to improve the outcomes of former TANF clients. This report will discuss the major gaps that prevent clients from becoming self-sufficient, including child care, transitional supports and effective case management.

Four Allowable Purposes of Federal TANF Funds and State MOE

1. Provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;
2. End the dependence of needy parents on government benefits by promoting job preparation, work and marriage;
3. Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and
4. Encourage the formation and maintenance of

Challenges Created by the Expiration of the TANF Waiver

The state's waiver expires in January 2002. At that time, the TANF program must be in compliance with federal regulations. This does not mean that Texas should abandon flexibility in determining the best way to achieve its goals. In many cases, the state can choose to retain current policies, alter them according to federal guidelines, or create a separate state program using TANF Maintenance of Effort (MOE) funds.

The chart at right illustrates policies affected by waiver expiration. The state will also need to look closely at work participation rates, exemptions from engaging in work, lifetime limits, and allowable work activities. These will be discussed in greater detail.

HB 1863 Waiver Component	Federal Law	Difference
Penalties for failure to participate in the child support program without good cause: Texas applies a $78 TANF grant reduction for failure to comply with child support requirements.	The state is required to reduce a family's TANF grant by at least 25 percent for failure to comply with child support regulations.	Texas is in compliance with federal law, except for single parent families of seven or more and two-parent families of six or more.
Penalties for drug convictions: A $25 reduction in the TANF grant is applied for six months if a recipient is convicted of an alcohol or drug-related felony or misdemeanor.	States are required to permanently disqualify TANF recipients who are convicted of drug related felony offenses after 8/22/96; however, Texas can apply less severe penalties if state law allows.	Unless Texas passes a law allowing for less severe penalties for drug-related felonies, the state must permanently disqualify those convicted after 8/22/96.
Individual Development Accounts: The state allows TANF recipients to accumulate funds for education, home ownership, small business start-up, medical expenses, and other assets.	Federal law allows IDAs for education, home ownership and business capitalization.	Texas allows the accumulation of assets for purposes not allowed in federal law such as medical expenses.

In 2002, state and local entities responsible for welfare reform will face even greater challenges moving TANF recipients into the workplace. These entities include the Department of Human Services (DHS), Texas Workforce Commission (TWC) and Local Workforce Development Boards (LWDBs). The federal government recognizes only one work exemption for single parents with children under age one and one temporary work exemption for parents with children under age six who cannot locate child care. The remaining work exemptions will no longer be recognized. For a large portion of the caseload, the challenge of entering the workplace will come sooner because the 76th Legislature reduced the child exemption age from four to one by 2001. Hence, a larger percentage of the TANF caseload will be counted in the state's work participation rate calculation whether the family has a state recognized exemption or not. The state is required to pay as much as five percent more in MOE if LWDBs fail to meet work participation goals. The chart on the next page, entitled Work Participation Rate Calculation, describes the formula used to calculate the work participation rate as well as terms commonly used when discussing the rate.

Work Participation Rate Calculation
(After Implementation of SB 666 and Waiver Expiration)

$$\frac{\textit{Numerator}\text{ (all adults receiving assistance who are working in allowable work activities)}}{\textit{Denominator}\text{ (all adults or children not attending school without federally recognized work exemption)}} + \textit{Caseload Reduction Credit} = \textit{Participation Rate}$$

Caseload Reduction Credit
1% credit for each percentage point decline in TANF caseload since FY 1995

Caseload Reduction Credit FY 2000.....51.7% (projected)

Work Participation Rate Goals
Following Implementation of SB 666 and Waiver Expiration

- All Families.....50%
- Two-Parent Families.....90%

Two-Parent Participation Rate

As the chart above indicates, the state must meet higher work participation goals for two-parent families receiving TANF than for all families. Between January and May 2000, the state achieved a two-parent work participation rate of approximately 50 percent before the Caseload Reduction Credit (CRC) was applied.[1] This is based on a numerator of 888 and denominator of 1,809. However, the numerator will need to increase to 1,750 by 2002 if the state hopes to meet federal goals. Even with a CRC, it will be very difficult to achieve this goal.

All states have the option of paying for the assistance of two-parent families with MOE rather than TANF federal funds. When a state uses MOE to fund cash assistance, the state can create its own work participation rate guidelines. Essentially, paying for the assistance of two-parent families with MOE ameliorates the burden of meeting difficult work participation goals for a particularly small portion of the overall TANF caseload, and allows the state to design more innovative approaches for working with clients. Already, 15 states have created a separate state program for two-parent families.[2]

FY 2000 TANF Revenue
(in Millions)

Federal Block Grant	$486.3
Maintenance of Effort (MOE)	$251.3

Exemptions from Work Requirements

Currently, DHS and LWDBs exempt a large portion of the TANF caseload from work requirements. A client will receive an exemption at DHS if, at the time of TANF certification, it is determined that he or she

is unable to work. Also, employed adults and children attending school at the time of certification receive exemptions in order to remove the burden of attending an orientation session to the Choices Program, the state's welfare-to-work program based at LWDBs. Once a client has been to a Choices orientation, he or she may be able to receive a temporary "good cause" exemption if a situation arises that prevents the person from working. Those exempted do not count against work participation rate goals.

However, in 2002, most adults in the TANF caseload, with the exception of single parents of children under the age of one and parents with children under age six who cannot locate child care, will be counted in the work participation rate calculation regardless of their work exemption. To re-emphasize, this will increase the difficulty in meeting federal goals for two-parent families unless their assistance is paid with MOE. Federal goals for single-parent families, on the other hand, will not be difficult to meet because of the Caseload Reduction Credit.

The TANF caseload has declined nearly 51 percent since FY 1995. Texas can credit this percentage towards its work participation goal. The work participation goal for all families will be 50 percent in 2002. Therefore, as long as the CRC grows or remains the same, the federal work participation goal for the entire welfare-to-work population will be satisfied. The state must continue moving people from welfare to work, but may continue to structure the program according to clients' needs.

Exemptions	Total Clients	Percent of Exempt Clients	Percent of Total Clients
Child age 15 and younger	21	0.08%	0.02%
Certified child; age 16, 17, or 18 attending school	915	3.31%	1.03%
Caring for a disabled child	2,685	9.73%	3.02%
Temporary illness or injury	1,687	6.11%	1.90%
Incapacitated	5,208	18.87%	5.86%
Age 60 or older	530	1.92%	0.60%
Caring for a child under age 1	7,722	27.98%	8.69%
Caring for an ill or disabled adult	3,050	11.05%	3.43%
Too remote to participate	4,024	14.58%	4.53%
Not subject to participation/not TANF eligible	7	0.03%	0.01%
Pending an appeal on TANF denial	71	0.26%	0.08%
Time-limited local economic exemption factor	340	1.23%	0.38%
Time-limited economic hardship exemption	1	0.00%	0.00%
Time-limited severe personal hardship	17	0.06%	0.02%
Caring for a child under age 4 not receiving TANF	105	0.38%	0.12%
VISTA volunteer	71	0.26%	0.08%
3rd to 9th month of pregnancy	231	0.84%	0.26%
Employed or self-employed 30 or more hours	909	3.29%	1.02%

The table above illustrates current exemptions that are applied by DHS at the time of certification for TANF.[3] The bulk of the clients exempted are unable to work because they are caring for very young or

disabled children. For others, major barriers such as incapacitation or geographic distance from employment opportunities prove difficult to overcome. Recipients of TANF are still subject to time limits, so great pressure will remain to assist these individuals in becoming self-sufficient. Texas will need to decide how to serve those with barriers that state resources do not adequately address. Many of the current exemptions need to remain in place. The state can continue to assist families exempted from work requirements even when time limits are surpassed. This will be discussed in the following section.

Time Limits

Changes in welfare policy as a result of the waiver expiration will have an impact on time limits. Texas has already conformed to federal law with regard to the 60-month lifetime limit. In October 1999, the state relinquished its waiver option to delay the lifetime clock from ticking until 2002. As a result, each month of assistance provided since August 1996 has been counted toward recipients' lifetime clocks. An exception was made for clients who were under exemptions between August 1996 and October 1999. Each month of assistance given to individuals who had received work exemptions began to count against their lifetime clocks beginning October 1999. The net effect of this policy decision is that more people will exhaust their lifetime limits earlier than expected.

As the number of TANF recipients declines, more and more of the caseload will be composed of individuals who have serious impediments to work, live in areas of the state with significantly high unemployment rates, or reside in locations with limited transportation.

As the number of TANF recipients declines, more and more of the caseload will be composed of individuals who have serious impediments to work, live in areas of the state with significantly high unemployment rates, or reside in locations with limited transportation. The welfare-to-work system may encounter difficulty in locating the necessary resources that allow certain individuals to obtain and keep work. For instance, a study conducted by Texas A&M University for the Texas Legislative Council demonstrated that adult TANF recipients who care for a physically incapacitated child or second adult in the home are likely to spend the maximum amount of time on the rolls because they are unable to locate the resources necessary to overcome these barriers. [4]

Texas can exempt up to 20 percent of its TANF caseload from lifetime limits, but the state will need to identify the reasons that a person can exceed 60 months. Also, the state can continue assisting individuals facing serious and chronic barriers to work with MOE. If the state were to do this, Texas could create alternative work requirements and time limits for groups that may have significant difficulty transitioning into the workplace.

Allowable Work Activities

Federal law allows states to include in the numerator only those adults engaged in allowable work activities. A state may define the activities it will count as work, but once the waiver expires, some activities may not be counted in the numerator. Federal law limits job searching to six weeks, whereas Texas law does not have a time limit. Under federal law, the state is only allowed to include up to 30 percent of the numerator

in educational activities such as secondary school, GED classes, or vocational education that does not exceed 12 months. Post-secondary education is currently an allowable work activity, but may not be counted in the numerator after the waiver expires.

Again, Texas has enormous flexibility with regard to implementing welfare reform. Despite the fact that post-secondary education and vocational education beyond 12 months cannot be counted in the numerator once the waiver expires, the state may continue to provide assistance with federal or state dollars to anyone engaged in such activities.[5] Research indicates that welfare clients are more likely to remain in their jobs and advance in wages and responsibilities if they have achieved some form of certification beyond a GED.[6]

Type of Work Activity	Percent of Clients Participating in Activity
Vocational Education Training	6.83%
Adult Basic Education	1.38%
On the Job Training	0.21%
Job Search	35.06%
Job Readiness	15.19%
Employment Entry	50.88%
Community Services	0.42%
Job Creation/Subsidized Work	0.86%
English as a Second Language	1.22%
Assessment	28.35%
High School	0.73%
GED	5.73%
Life Skills	0.89%
Post-Secondary	2.63%
Unpaid Work Experience	2.96%
Job Skills	1.18%

Texas emphasizes the "work first" approach to labor market transition. Typically, a TANF recipient will begin a supervised job search immediately. If the individual continues to have problems finding employment, more intensive services may be offered. This is a common approach throughout the nation and is most effective in helping clients with the most serious barriers to work gain some experience in the workforce. However, research suggests that the long-term impacts of "work first" strategies do not help clients to lift themselves out of poverty.[7] In general, clients do not experience an increase in wages over time, nor do they move into positions that offer benefits and increased responsibility. This is a serious deficit in the program, and minimizes the long-term impact of welfare reform because clients still must rely on public supports. More favorable strategies from other states include a combination of workforce attachment with simultaneous training and education.

The Parents as Scholars Program

The State of Maine allows parents to further their education and increase their employment prospects through a separate state program. Parents who are eligible for TANF may enroll in a two- or four-year post-secondary degree program. During the first two years, the adult must be in class or studying for at least 20 hours per week. In the last two years, the client must work 15 hours per week in addition to class time. The state pays for this program with TANF MOE.

Another consideration is the amount of time clients have before they must be engaged in a work activity. Federal law requires all recipients to work when the state determines that the client is ready, but no longer than 24-months from the time of initial certification. The state can continue to allow exempted individuals to receive benefits even if their non-participation has an adverse effect on participation rates. The CRC will alleviate any negative impact on participation goals. Also, the state already applies a grant reduction for anyone who does not comply with the requirements of

welfare reform, including work participation.

Conclusions About the Challenges of Waiver Expiration

With the exception of the two-parent participation rate, it is unlikely there will be a negative impact resulting from waiver expiration. This is true even if the state chooses to retain aspects of HB 1863 not recognized by the federal government. Texas has already defined a variety of exemptions for individuals facing significant barriers in meeting work requirements. The state is doing a good job at meeting work participation goals. When the federal government stops recognizing many of Texas' current exemptions, the Caseload Reduction Credit will help the state meet its work participation goals. Also, funding the two-parent family caseload with MOE will further offset the impact of maintaining current exemptions. Texas is in compliance with federal law because it already reduces TANF grants to recipients for non-compliance with any of the requirements of the program without good cause; therefore, the state may continue to provide assistance to non-working adults who have exceeded the 24-month time limit. Texans in danger of exceeding their lifetime limits because of severe hardship can, if the state chooses, continue to receive assistance as long as they represent 20 percent or less of the entire caseload. The state can also take advantage of the flexibility in the federal law by paying for the assistance of those with severe hardship with MOE. In short, the state can retain aspects of HB 1863, including work exemptions and allowable work activities, that differ from federal law.

Child Care

One of the most serious problems with the welfare-to-work system is the lack of child care assistance. The state dedicated $368.5 million from various federal and state sources this year for child care vouchers for low-income families. Still, these dollars provided child care assistance to little more than five percent of eligible families. Most low-income working parents still rely on family and friends for care, pay a large percentage of their monthly income for child care services, or go without this important resource altogether. If the welfare-to-work system is to help people achieve self-sufficiency, then child care must be expanded in the state.

FY 2000 Child Care Appropriation

Child Care Development Fund	**$247.5 Million**
State Funds	**$61.7 Million**
TANF, Welfare-to-Work and Social Security Block Grant	**$58.2 Million**
Food Stamp Employment and Training Dollars	**$0.2 Million**

Under federal regulations, Texas is allowed to transfer up to 30 percent of the TANF block grant to the Child Care Development Fund (CCDF). In FY 2000, the state transferred about $45.6 million, or 8.7 percent of the TANF block grant.[8] The FY 2001 amount will be $33.5 million, or 6.2 percent. If Texas chose to transfer the entire 30 percent of the block grant to CCDF, the amount for 2001 would be $161.3 million.

As of June 2000, Texas was serving about 95,000 children a day with the allotted funds.[9] There were 29,868 families on the waiting list. The Texas Workforce Commission reports that it would cost about $126 million to serve the number of families on the current waiting list. However, since clients will continue to request child care as they enter the system, eliminating the current waiting list will not prevent a new list from forming.

Studies indicate that the lack of child care vouchers or subsidies is one of the most significant deterrents to work.[10] The cost of child care is prohibitive for most families, even those earning incomes well above the poverty line (100 percent of poverty for a family of four is $17,050). Child care costs in this state are higher than the cost of university tuition. In 1997, the average annual cost of public college tuition in Texas was $2,022, or about three-fifths the average child care cost for a four year old.[11] In contrast with post-secondary education, there are few sources of financial assistance to help families pay for child care.

Typical Child Care Center in Texas
(Infant Care)

Payroll Expenditures - Staff/Infant Ratio 1:4

Hourly Wage	Hours Per Week (12 hours per day)	Total Weekly Payroll
$8.00	60	$480

Revenue from State Child Care Vouchers

Average Weekly Revenue for One Infant	Number of Infants Served	Total Weekly Revenue
$100	4	$400
Balance (Before Facility Costs)		***[$80]***

There are serious gaps in child care in Texas. Most families experience enormous difficulty locating care for infants, programs that remain open in the evenings and weekends, and specialized care for children with disabilities. The lack of specialized or infant care in Texas can be partially attributed to low reimbursement rates and high staff costs. The table at left illustrates the dilemma many centers face when attempting to provide care without experiencing a revenue loss.

In July 1998, TWC took steps to increase access to child care subsidies. Federal regulations allow states to set income limits for child care services at or below 85 percent of State Median Income (SMI) levels. Texas is one of only seven states to set the income level at 85 percent. The Local Workforce Development Boards have the authority to decrease the income guidelines if the TANF population is large, but many boards maintain the 85 percent SMI level. In these areas, many working parents can take advantage of child care assistance not previously available.

All evidence indicates that public dollars dedicated to child care is money well spent. Quality child care, characterized by higher teacher/child ratios, higher wages, appropriately trained or certified staff, developmentally appropriate curriculum, and parental involvement, can result in substantial benefits.[12] Children who attend such programs perform better in school, demonstrate good social adjustment, are less likely to exhibit later delinquency, and are more likely to graduate from high school. Furthermore, public dollars spent on child care subsidies have been shown to pay for themselves almost immediately in dollars

returned to the government in taxes because the parents are able to work.[13]

During the 77th Legislative Session, child care should be a priority. The state needs to create funding and financial strategies to improve the supply, quality and affordability of child care for all working parents, not just TANF clients. Other states have begun addressing this problem aggressively.

A good example is the North Carolina Smart Start Project. This statewide initiative maximized child care funds by blending state and local dollars and increasing private investment. The project addressed serious deficits in quality by emphasizing local innovation, creating a network for information sharing and providing state level technical assistance. Since 1994, North Carolina has increased its child care supply by more than 400 percent, and child care facilities providing care for children with disabilities increased by 19 percent.[14] Over 14,000 more families receive child care subsidies as a result of this initiative. Most important, children experience the greater benefits of early education through a statewide emphasis on quality. The Smart Start Project may be a good model for statewide child care improvements in Texas.

Transitional Supports

In addition to child care, former TANF clients require ongoing support as they transition off cash assistance. The state currently provides Medicaid, child care, limited case management, and transportation assistance to former TANF clients. These supports increase the likelihood that an individual will remain employed, not return to TANF and advance in wages to self-sufficiency.

Adults who leave the TANF rolls because of work are eligible for 12 months of Transitional Medicaid. An additional six months of Transitional Medicaid can be received if a participant was exempted from work requirements but participated in the Choices Program anyway. The use of this benefit is associated with a decreased likelihood that the individual will return to TANF.[15]

In the 76th Legislative Session, TWC was appropriated $4 million to provide grants for transitional supports. The LWDBs that applied for, and were granted, funds provide services that include intensive case management to support job retention; transportation assistance, including help for car ownership in areas without adequate public transportation; computer literacy training; substance abuse counseling; business start-up assistance; mentoring; and apprenticeships. Because there was only a small amount of dollars dedicated to

Allowable Uses of TANF Dollars to Provide Transitional Support for Working Families

Helping Working Families Meet Work Expenses: Transportation, child care, work clothes or uniforms, tools, small business ownership.
Helping Working Families Meet Basic Needs: Expansion of earned-income tax credit, employment subsidies (using MOE).
Helping Working Families Participate in Education or Training: Tuition for post-secondary education or vocational training, stipends for full-time students (using MOE), assistance with the cost of books and supplies.
Helping Working Families Between Jobs: Re-employment assistance including job search, temporary financial aid.

Source: The Center for Law and Social Policy, www.clasp.org/pubs/TANF/markKELLOGG.htm.

this purpose, fewer of the LWDBs received funds than needed them. The Legislature should expand the appropriation for transitional supports. Other transitional needs include assistance with rent or first-time home ownership and substance abuse treatment.

Effective Case Management

Another challenge regarding the welfare-to-work program is structuring the system in such a way that needs and barriers to work are addressed effectively. Case management is the key. Clients work closely with professionals trained to identify barriers and locate necessary supports. Below are aspects of case management that should be strengthened in Texas.

Up-Front Needs Assessment

One of the ways to support effective case management of TANF clients moving into the workforce is to ensure that their strengths and deficits are identified early. Doing so reduces the likelihood that learning disabilities, domestic violence, substance abuse, mental and emotional difficulties among the adults or children in a household, and other barriers go unnoticed. Failure to identify such problems often results in the client being sanctioned for non-compliance. Also, clients are more likely to reapply for TANF if they do not receive appropriate supports early. House Bill 1863 calls for an approach to job training and transitional support that is based on an assessment of family needs.

All LWDBs provide some form of assessment that covers "information about the client's employment and educational history; vocational and educational skills, experiences, and needs; support services needs; and family circumstances that may affect participation."[16] However, the quality of assessment varies among LWDBs. The only standardized assessment tool used widely is a literacy test. Few LWDBs use scales for the assessment of substance abuse or vocational aptitude. Also, many clients do not enter the Choices Program until later. Those who are granted a work exemption by DHS are not assessed until the exemption expires. An initial assessment conducted by DHS will ensure that employability needs and barriers are identified early. This information can then be shared with the LWDBs to improve case management services once the client is referred to the Choices Program.

Family Violence

A particularly vulnerable population that may experience difficulty in achieving self-sufficiency are those living in or leaving a violent relationship. Studies indicate that between 20 and 30 percent of female TANF recipients are currently in abusive relationships.[17] Furthermore, nearly two-thirds have been abused in the past. Work participation is an enormous challenge for these individuals. Many abusers attempt to sabotage their partner's efforts to gain employment. Oftentimes, the physical and emotional strain of such a relationship can prevent an abused partner from taking the necessary steps to become independent of the abuser as well as public assistance. Studies show that this population will

Studies indicate that between 20 and 30 percent of female TANF recipients are currently in an abusive relationship. Furthermore, nearly two-thirds have been abused in the past.

cycle on and off the welfare rolls, experience frequent job turnover and have trouble working the requisite number of hours to avoid sanction.

For these reasons, Texas does not require victims of domestic violence to participate in the Child Support Collections Program. When case managers are made aware of violence in the home, they have the authority to issue a "good cause" work exemption. This gives the abused person time to connect with appropriate resources. Unfortunately, many DHS and LWDB workers are not aware of domestic violence that clients may be experiencing. This may partly be due to a lack of training that prepares workers to deal with these delicate issues. While some LWDBs provide training, and DHS began training its workers this year, the quality and content of training varies. The 77th Legislature should ensure that adequate training on domestic violence is provided to all workers who provide direct services to TANF clients.

Sanction Policies

Currently, clients who are not complying with Choices Program requirements face the risk of losing a portion of their TANF grant. Typically, clients who do not meet requirements will receive a letter indicating they are out of compliance and a sanction is forthcoming. These notices are often confusing and misleading. Letters sent by DHS informing clients of potential sanctions for not complying with TANF requirements were used as an example of confusing and incorrect notices in a report by the federal Department of Health and Human Services.[18] While DHS has changed incorrect statements in the notice, much of the language remains confusing.

Mesa County, Colorado, Sanction and Conciliation Policies

"Mesa County's program is designed to minimize harm to families resulting from sanctions. Called the Intervention Program, it requires that cases be referred to a social worker prior to any sanction action. The social worker makes a home visit and, based on the findings at the first visit, can carry the case for up to 90 days. During this time, the social worker assesses the family needs and provides intensive services to overcome barriers. In practice, such barriers as domestic violence, substance abuse, and child-rearing problems have been discovered during the home visits."

Source: Colorado Works Program, Colorado Sanction & Conciliation Policies.

Knowing that letters are often ineffective, some workforce centers perform home visits or other forms of personal outreach in order to identify and address the reasons individuals are non-compliant. However, this is not a mandatory practice. Advocates assert that home visits or other personal communication with a client, before applying a sanction, often reveals barriers previously unknown to case managers. Centers that perform home visits restructure case management plans in such a way that the client is again able to participate. The 77th Legislature should issue guidance to all LWDBs to attempt to contact non-compliant clients personally before issuing a sanction.

The Employment Retention and Advancement Project - A Texas Innovation

The Employment Retention and Advancement Project (ERA) was implemented by DHS, TWC and LWDBs to focus on wage advancement among current and former TANF recipients. The project was developed by DHS and is based on best practices across the nation, including the New Hope Project in Milwaukee, Wisconsin, which demonstrated success in helping low-income individuals to increase wages and become self-sufficient.[19] There are four pilot sites which provide intensive support to individuals developing the skills and experience necessary to be successful in the workplace. Clients receive intensive case management and are eligible for non-traditional services based on clients'

needs. Further, their transition off cash assistance is closely monitored so they do not lose necessary financial support before they are ready. The program is relatively new, but preliminary evaluations indicate that participating clients are engaged in work activities far more than other Choices clients. This program is being piloted in Houston, Corpus Christi, Abilene and Fort Worth.

Conclusion

As waiver expiration nears, the Legislature should take the opportunity to examine the success of welfare reform in Texas. The state has done a good job moving clients from welfare to work, and the focus should now be on moving people out of poverty and into self-sufficiency. There are provisions in HB 1863 that must be changed in order to comply with federal regulations. However, these changes are relatively minor. In general, the state has enormous flexibility in designing its own program. The committee recommends that the Legislature make the appropriate technical changes to bring Texas into compliance with federal regulation, take advantage of the flexibility allowed by federal law, and enhance the supports provided to low-income families.

Recommendations

1. Recommend that the Legislature amend state law to impose a greater penalty for non-compliance with the Child Support Program for families of seven or more (single parent) and six or more (two-parent).

Federal law requires at least a 25 percent reduction in the TANF grant without good cause for failure to comply with child support regulations. Texas meets this requirement except for families of six or more (two-parent) or seven or more (single parent). The state must change its policy for these families, but no other action is federally mandated.

2. Recommend that the Legislature amend state law to limit the use of Individual Development Accounts (IDA) for TANF clients to post-secondary education, first home purchase and business capitalization, to conform to federal regulations.

Current uses of IDAs permitted by the state do not conform to federal guidelines. If uses that fall outside of those specified by the federal government continue, Texas will have to allocate additional funds. However, this will further complicate a program that is already complex and serves very few people in Texas.

3. Recommend that the Legislature amend state law to continue to assess a $25 financial penalty for six months for a drug or alcohol-related misdemeanor conviction. Recommend that the Legislature enact state law to allow TANF/Food Stamp clients with non-trafficking drug felonies who have completed any sentencing, are in compliance with parole/probation requirements and are participating in or have completed a substance abuse treatment program to receive assistance. Include limits on how many times such clients may access benefits under these conditions.

Texas has the option to continue current policies for misdemeanor drug and alcohol offenses, and to establish policies related to felony drug offenses. Only .08 percent of TANF recipients in Texas (104 individuals) were under sanction for drug or alcohol offenses. State law must be amended to avoid default to federal law requiring permanent disqualification for all felony offenses. At least 27 states have elected to modify the federal ban on TANF assistance to persons convicted of felony drug offenses who have taken steps to recover from their addictions.

4. Recommend that the Legislature utilize TANF Maintenance of Effort (MOE) for assistance and services to two-parent families.

The federal work participation goal for two-parent families is 90 percent versus 35 percent for the entire TANF population with mandatory work requirements. The state must pay five percent more in Maintenance of Effort, or about $15 million, if it does not meet the two-parent participation rate. Reliance on TANF MOE will allow the state to develop unique ways of serving two-parent families without the threat of fiscal penalties.

5. Recommend that the Legislature define allowable work exemptions.

Texas can maintain current work exemptions not recognized by the federal government; however, these still count in the work participation rate calculation. The state should examine current exemptions to ensure that 1) those who are working count in the state's work participation rate calculation, and 2) appropriate exemptions remain in place.

6. Recommend that the Legislature maintain current "good cause" exemptions.

"Good cause" exemptions are temporary and last not more than three months. Currently, about six percent of the total TANF caseload receive a "good cause" exemption. Maintaining "good cause" exemptions will not significantly affect work participation rates.

7. Recommend that the Legislature direct HHSC, DHS and TWC to define hardship exemptions.

States are allowed to exempt up to 20 percent of their TANF caseloads from federal time limits. A state must first define the hardship exemptions that will be included in the 20 percent. This allows the state to continue to provide assistance to those with severe hardships beyond their control.

8. Recommend that the Legislature amend state law to require all adults receiving cash assistance to participate in work activities within 24 months. For those clients with significant and continuing barriers to work, direct DHS and TWC to design activities to meet their needs. If barriers to work persist, continue assistance for those unable to work within the allotted 24-month period.

Texas should require participation in work activities after 24 months, but exercise its flexibility by allowing those not ready to work to continue receiving assistance. Very few clients will be incapable of working after 24 months, primarily Tier 3 individuals, but such a policy will help Local Workforce Development Boards create strategies that best meet the needs of their clients.

9. Recommend that the Legislature amend state law to define allowable work activities and to include post-secondary education and vocational education lasting beyond 12 months or more.

States are given the authority to define allowable work activities. Although the federal government does not recognize post-secondary education and vocational education lasting longer than 12 months as allowable work activities, the state may continue to serve individuals engaged in such activities with federal or state dollars. Texas' high Caseload Reduction Credit reduces the impact of such a policy.

10. Recommend that the Legislature increase the supply and capacity of quality child care for current and former TANF clients, including infant care, weekend care and after-hour care.
The lack of quality and affordable child care is one of the most critical unmet needs facing working poor

families. The state must look for ways to maximize public dollars in order to increase supply and quality. Statewide strategies in which partnerships are formed with local communities to address this vital need have proven successful in other states.

11. Recommend that the Legislature direct DHS to continue to provide an additional six months of Transitional Medicaid benefits to exempt Choices Program clients.

Texas currently provides 12 months of Transitional Medicaid for families who exhaust their time limits or lose eligibility due to earnings or child support. Texas can provide an additional six months for individuals who voluntarily participate in Choices, but were exempt from work requirements.

12. Recommend that the Legislature expand transitional supports for participants leaving welfare for jobs. These supports could include educational opportunities, job coaching, emergency cash assistance, transportation assistance, housing assistance, health care, access to child care that meets work hours, and other supports deemed appropriate.

Transitional supports in Texas currently are limited to child care and Transitional Medicaid. The state has great flexibility in the use of TANF, Welfare-to-Work Grant, and Workforce Investment Act funds to include transitional supports. Transitional supports increase the likelihood that clients will remain off TANF assistance, continue to advance in the workplace and become self-sufficient.

13. Recommend that the Legislature continue funding the Employment Retention and Advancement (ERA) pilot program. Direct DHS to deliver evaluation results of the ERA pilot to the Legislature to allow for consideration of statewide expansion.

ERA features intensive case management and a post-employment stipend that promotes job retention and advancement in the labor market, not just job placement. The program is expected to reduce reliance on cash assistance in Texas, lower the TANF recidivism rate and produce strategies that can be replicated in other Texas communities.

14. Recommend that the Legislature direct DHS and TWC to follow best practices in coordination of services as recommended by a DHS/Local Workforce Development Board Coordination Workgroup.

Testimony indicated that comprehensive services could be improved through enhanced coordination between DHS and TWC. Some regions are doing an exceptional job of fostering cooperation between DHS and LWDBs. To build on this foundation, the House Human Services Committee has facilitated a workgroup composed of regional leaders to discuss best practices in coordination. This recommendation is intended to require DHS and TWC to apply the best practices identified within the workgroup to daily operation at the regional level.

15. Recommend that the Legislature direct DHS to investigate why a family may be subject to sanctions.

This recommendation pertains to sanctions imposed for failure to comply with immunization, health

screening and school attendance requirements. A case review and investigation into the sanction before it is imposed could determine if the parents lack access to services or face other problems that could be addressed with available services. The investigation could also determine what resources could assist the family in meeting unfulfilled requirements, leading to appropriate referrals and follow-up to local support services.

16. Recommend that the Legislature support and fund rewards for Local Workforce Development Boards that place and retain TANF Choices participants in jobs providing sufficient wages and hours to lift families above poverty.

Clients who advance beyond low-paying, low-skilled work into jobs with increased responsibility and higher pay are more likely to remain self-sufficient. Currently, Local Workforce Development Boards do not receive incentives to accomplish these goals and often do not design programs that effectively address long-term barriers to self-sufficiency.

17. Recommend that the Legislature fund a pilot project to provide wrap-around services to families by DHS, TWC, the Texas Department of Protective and Regulatory Services (DPRS), and other organizations as needed, that are driven by the families' needs.

The Texas Integrated Funding Initiative is currently piloting wrap-around service arrangements within children's mental health agencies. An example of a wrap-around service arrangement can be found in the children's mental health arena. Some local MHMR centers collaborate with local juvenile justice centers and DPRS as well as other agencies to blend funding in order to serve the multiple needs of parents with special needs children. The family has a voice in the types of services provided and the blended funding allows for non-traditional services such as respite care from a neighbor. Such arrangements increase the likelihood of the child staying with the family, minimize stress and possible abuse, and decrease the overall cost because preventative services tend to eliminate the need for high dollar services later. Texas can apply this model to LWDBs to allow them to serve parents who face multiple barriers.

CHARGE 2: Study issues surrounding the financial difficulties experienced by some nursing home companies, including the reasons for bankruptcies and closures, state policies and resources for dealing with them, and impacts on residents.

Introduction

Prior to and during the 76th Legislative Session, concerns surrounding the financial solvency of some nursing home chains came to the attention of the Legislature. In October 1998, the Texas Department of Human Services (DHS) was contacted by the Health Care Financing Administration of the federal government (HCFA) regarding Medicare billing irregularities in 13 nursing homes operated by Sensitive Care, Inc., of Fort Worth. That was the beginning of a coordinated multi-agency regulatory effort that resulted in the state taking over responsibility for the operation of the homes through the placement of trustees to ensure the safety of the residents.

In the end, Sensitive Care, Inc., entered Chapter 11 and Chapter 7 bankruptcy, over $2 million was expended and later recovered by the state, three facilities were closed and the operations of the remaining ten were assumed by two new companies.[20] Through the experience of responding to the Sensitive Care, Inc. case, the complexity and severity of nursing home financial difficulties and the state's responsibility to address the problem became apparent. Additionally, starting with Chartwell Healthcare, Inc., six more nursing home chains, representing 112 homes, filed for bankruptcy. These filings led to the assignment of this interim study charge.

Texas Nursing Homes in Bankruptcy

Nursing Home Chain	Date Filed	# of homes
Chartwell Healthcare, Inc.	10/05/98	8
King-Walters, Inc.	02/24/99	4
Sensitive Care, Inc.	02/24/99	13
Tx. Health Enterprises, Inc.	08/03/99	56
Vencor, Inc.	09/13/99	4
Sun Healthcare Group, Inc.	10/14/99	26
New Hope Health Care, Inc.	12/09/99	1
Mariner Post-Acute Net., Inc	01/18/00	101
Integ. Health Services, Inc.	02/02/00	66

Since this charge was issued, three more nursing home chains, including two of the largest operating in Texas, have filed for bankruptcy. At the time this report went to print, ten nursing home chains, representing 279 facilities, or 24 percent of Texas facilities, had filed for bankruptcy between October 1998 and July 1, 2000 (see chart[21]). Notably, nearly 90 percent of these bankrupt homes are owned by four large chains, three of which are national chains based outside of Texas: Mariner Post-Acute Network, Inc., Integrated Health Services, Inc., Texas Health Enterprises, Inc., and Sun Healthcare Group, Inc.

Factors Affecting Nursing Home Financial Status

Studies by HCFA, the U.S. General Accounting Office, nursing home industry associations and advocate groups have produced a variety of possible explanations for nursing homes' financial difficulties. Contributing factors that have been cited include the new Medicare payment system, increased fraud detection in the Medicare program, Medicaid rates, liability insurance cost increases, civil lawsuits, fluctuations in stock prices, high and escalating lease payments, the assisted living industry pulling away private pay residents, and the weight of upper management in nursing home chains.

Through interim public hearings and other deliberations, the committee has heard primarily about the low Medicaid reimbursement rates, the liability insurance crisis and the increased civil judgments that are affecting insurance rates. However, further research has suggested that in addition to those three issues, the other cited factors have played a role in the crisis in Texas.

The financial crisis discussed in this report is not unique to Texas. Nationwide, the nursing home industry is experiencing financial difficulties. According to the American Health Care Association, 11 percent of the nursing homes in this country are in bankruptcy.[22] Difficulties Sun Healthcare, Inc., is experiencing elsewhere affect the company's overall solvency, and thus affect Texas nursing home residents as well. Therefore, as this report reviews factors that affect Texas nursing homes' financial status, much of the discussion will be from a state and national perspective.

Acronyms used throughout this Report

DHS	Texas Department of Human Services
HHSC	Texas Health and Human Services Commission
OAG	Texas Office of the Attorney General
TDI	Texas Department of Insurance
JUA	The Joint Underwriting Association
HCFA	U.S. Health Care Financing Administration
GAO	U.S. General Accounting Office
OIG	Office of the Inspector General (An office of the U.S. Department of Health and Human Services)
SNF	(Medicare) skilled nursing facility
BBA	Balanced Budget Act (of 1997)
THCA	Texas Health Care Association
TAHSA	Texas Association of Homes and Services for the Aging
PPS	Medicare's Prospective Payment System

Medicare Rates and the Medicare Payment System

Nearly all nursing home chains operating in Texas provide skilled nursing facility (SNF) services, including rehabilitative services, which are covered by Medicare. Out of 1,154 nursing homes in Texas, all but 38 are certified to provide SNF services.[23] The Medicare Program accounts for approximately 12 percent of Texas nursing facility revenues.[24]

Since the mid-1980s, the Medicare SNF benefit has been one of the fastest-growing components of Medicare spending, increasing an average of 30 percent annually, to $13.6 billion nationwide in 1998.[25]

This spending growth is attributed to an increase in the number and types of services provided to SNF patients and the rising number of beneficiaries using these services. In addition, the cost-reimbursement method used by Medicare as well as a lack of appropriate program oversight, contributed to the growth in Medicare spending for SNF services. In effect, there were no reimbursement caps on "ancillary" services such as respiratory, physical and occupational rehabilitative therapies. One business journal, *Business Week*, noted that provision of such services could yield 30 percent profit margins.[26] Many large nursing home chains invested heavily in the infrastructure to provide these ancillary services, often paying exorbitant sums for nursing home beds in order to market ancillary services. Aggressive expansion involving numerous acquisitions often meant taking on significant debt, which seemed safe because of the revenue SNF services brought in and the influx of capital from stock-market successes.

In response to this almost un-checked expenditure growth, Congress, in the Balanced Budget Act of 1997, directed HCFA to phase in a new prospective payment system (PPS) for SNF services. Prior to implementation of this system, nursing homes were paid the reasonable costs they incurred in providing Medicare-covered services. Payments for ancillary services were virtually unlimited. Under the PPS, which HCFA began phasing in in July 1998, facilities receive a fixed payment for each day of care provided to a Medicare-eligible beneficiary. This change, which represented an estimated statewide reduction of approximately $1 billion in Medicare payments, has had a significant effect on the nursing home industry.[27] According to *Business Week*, the daily price cap reduced the profit margin for ancillary services by nearly 50 percent, almost overnight.[28]

Sun Healthcare Group, Inc., and Vencor, Inc., which both operate in Texas, filed for bankruptcy in 1999. Many nursing home industry studies blame the new Medicare payment system for the financial troubles of both companies. Sun Healthcare and Vencor experienced significant increases in capital-related costs and took on considerable debt as they invested in the equipment and staff needed to provide the more complex SNF services.[29] Providing these services, at the time, generated higher payments at an almost unlimited frequency. The new fixed-rate system and the rates assigned to the more complex rehabilitative services, limited cash-flow that the corporations had relied on to cover their capital investments. Vencor, Inc., depended heavily on Medicare clients and served a comparatively low number of Medicaid residents. Medicaid residents made up 43 percent of Vencor's census, as compared to the approximately 70 percent average Medicaid census in nursing homes statewide.[30]

> In reference to Vencor, Inc., seeking Chapter 11 bankruptcy, Chairman Edward L. Kuntz said it "was necessary because of the dramatic changes impacting the long-term care industry, most notably decreased Medicare reimbursement."
>
> *Source: Kuntz, Edward L. Vencor Press Release. September 1999.*

The key factor in the bankruptcy of Integrated Health Services, Inc. (IHS), with 66 bankrupt homes in Texas, also appears to be its extremely aggressive acquisition strategy, resulting in a highly leveraged balance sheet reliant on Medicare revenues. In November 1999, IHS experienced what financial analysts called "the largest bottom-line loss in nursing home history."[31] The loss of $1.8 billion included a $1.4 billion charge for asset impairment, which is essentially an admission of overpaying for acquisitions,

according to healthcare industry analyst Sheryl Skolnick of BancBoston Robertson Stephens.[32] IHS also runs the industry's largest contract rehabilitation division, one of the areas most severely affected by the Medicare changes.[33]

Sun Healthcare, Inc., which operates 26 of the bankrupt homes in Texas, IHS with 66 bankrupt facilities, Texas Health Enterprises, Inc., with 56 homes in bankruptcy and Vencor, Inc., with four bankrupt facilities in Texas, claim Medicare rates and the reimbursement method are the primary causes of their financial difficulties. Whether Medicare changes are primarily to blame for these companies' problems can be debated. But with almost all nursing homes in Texas certified to provide some SNF services, the Balanced Budget Act changes are playing a significant role in the nursing home financial crisis in Texas, where Medicare funds have historically been used to compensate for chronically low Medicaid reimbursement rates.

Increased Fraud and Overpayment Detection in Medicare

The federal government's increased vigilance in reducing overpayments in the Medicare program is cited as a factor that has placed a strain on the financial condition of the nursing home industry.

The federal crackdown on Medicare waste began in 1993, when Congress became concerned with skyrocketing Medicare expenditures and evidence of high rates of overpayment. The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services began developing official "error-rate" estimates in Fiscal Year 1996 to track reductions in overpayments. Based on a statistical sample, the OIG estimated that improper Medicare benefits payments made during FY 99 totaled $13.5 billion, or 7.97 percent of the $169.5 billion in processed fee-for-service payments reported by HCFA. The FY 99 and the FY 98 overpayment estimates are not statistically different, but the FY 99 estimate is significantly less than the estimates of previous years. The FY 99 estimate is $6.8 billion less than the FY 97 estimate of $20.3 billion, and $9.7 billion less than the FY 96 estimate of $23.2 billion, which represented 14 percent of processed payments.[34] The OIG attributes the reductions in overpayments to HCFA's vigilance in monitoring the error rate and developing appropriate corrective action plans. Health care providers' due diligence in complying with Medicare billing requirements is also a recognized reason for the reductions.

> **W**ithout referring to a particular company, John T. Bentivoglio, special counsel for health-care fraud at the Justice Department, as quoted in the *Washington Post*, said that federal enforcement efforts have added a financial strain to some nursing home chains and noted that "a number of highflying nursing home chains appear to have incorporated defrauding Medicare as part of their business strategy."
>
> *Source: Hilzenrath, David S. Nursing Home Settles Fraud Case. Washington Post, February 4, 2000.*

While the OIG is unable to differentiate between inadvertent mistakes and outright fraud in developing its estimates, it is clear that Medicare patients in nursing homes are prime targets for certain operators to fraudulently bill Medicare. According to the U.S. Department of Justice, fraudulent billing and the subsequent crackdown are factors in Texas. Vencor, Inc., is accused of defrauding the government since 1992, in the amount of $1 billion.[35]

Due to Vencor's Chapter 11 bankruptcy status, it is unclear whether taxpayers will recover any of the fraudulent payments, even if the Department of Justice prevails. The Department of Justice has also joined one of several whistle-blower suits against Sun Healthcare, Inc., accusing the company of making fraudulent claims. These two companies own 30 of the bankrupt homes in Texas.

As stated previously, Texas nursing homes have historically used Medicare revenues to compensate for low Medicaid rates. Therefore, reductions in Medicare revenues can leave homes financially vulnerable because of the inadequacy of Medicaid as a revenue stream. Whether the over-billing in Texas was intentional or not, HCFA's cutting of nearly $9.7 billion in revenue to Medicare providers nationwide, over the last three years, has clearly affected the nursing home industry. However, the committee has been unable to determine conclusively what specific effect the overpayment reductions have had on the homes in crisis in Texas.

Medicaid Reimbursement Rates

Both industry representatives and nursing home resident advocate groups point to low Medicaid rates and the rate methodology itself as underlying causes for much of the industry's problems. The Fiscal Year 2000 Texas Medicaid Nursing Facility rates paid by the state rank 45th in the nation. The national average is a daily rate of $103.27 per resident. Texas' daily rate is $81 per resident, more than $20 per day less than the national average.[36] Medicaid dollars constitute 70 percent of Texas nursing home revenues.[37] In addition to being below the national average, the Texas Health Care Association (THCA), which represents the majority of the for-profit homes in the state, claims that Texas' daily rate underfunds nursing home spending for residents by $6 per day, or more than $130 million per year.[38]

Critics of the low Medicaid rate have claimed for years that the methodology itself is inadequate. The nursing home rate-setting methodology is based on two-year-old cost reports of resident care costs, administrative and dietary expenses, and fixed capital expenses. Consequently, significant increases in any given year in nursing home staffing costs and liability insurance premiums are not accounted for in the rate in a timely manner. Further, appropriations for nursing home Medicaid rates have been made without the benefit of the cost reports, which in the past were not submitted and analyzed until after the legislative session. Therefore, rates have been set based on predictions of expenditures that two-year-old cost reports would reflect. It should be noted that recent rule changes will provide legislators, beginning in the 77th Session, with the cost report analysis prior to the appropriations process. Additionally, the flat-rate system pays the same rate for all nursing home residents in each level of need category, failing to account for regional differences in the cost of providing care. An urban nursing home

Status of Texas Nursing Homes

45th in the nation in reimbursement rates;
46th in the nation in the number of nurse aides per nursing home;
47th in the nation in the number of registered nurses per nursing home;
Over 150 percent turnover for direct care staff .

may have to offer much higher wages to attract adequate staff than a rural home. The uniform rate does not provide for these differences.

In response to the limitations of the flat-rate system, the 76th Legislature directed DHS, by means of Appropriations Rider 38, to provide incentives for nursing facilities to increase direct care staffing and direct care wages and benefits through the development of a new reimbursement methodology.
To implement the rider, the Health and Human Services Commission adopted rules establishing a voluntary program through which nursing homes could obtain additional funds for increased staffing of registered nurses, licensed vocational nurses, medication aides, and certified nurse aides. Providers who choose to participate in the enhancement program and receive additional funds must demonstrate compliance with the enhanced staffing requirements. Those homes that choose not to participate will be limited to only routine inflationary rate increases each year. The enhancement program made $48 million available to nursing homes for the 2000-2001 biennium.[39]

For the Fiscal Year 2000 component of the program, over 900 homes, or approximately 88 percent of Texas homes, applied for the enhanced rate. However, due to budget constraints, only about half of the enhanced funding requested by the 900 homes was awarded.[40] The reimbursement enhancement system is a move in the right direction, but more funding must be made available in order to truly meet the demand for increased staffing in nursing homes.

Effects on Staffing: The strong Texas economy has actually had an adverse effect on nursing homes. Low unemployment rates and increased wages for traditionally lower paying fields have made it more difficult to adequately staff nursing homes. Not being dependent on state reimbursement rates for revenue, competing employers in many other settings can offer a more competitive wage for much less stressful work. Nursing home operators find it increasingly difficult to recruit and retain enough quality staff. Quality care in nursing homes is dependent on staff, and low reimbursement rates negatively affect the staffing situation in many homes.

The consequences of these staffing problems are significant. According to THCA, turnover for direct care staff exceeds 150 percent. Texas is 46th in the nation in the number of nurse aides per nursing home and 47th in the number of registered nurses.[41] While low Medicaid rates have a direct effect on the industry's financial situation by keeping that revenue source low, the low rates also have an indirect effect. As staffing remains inadequate and quality suffers, deficiencies occur and increased regulatory and civil actions become another potential financial burden.

The State of Texas, through regulatory means, demands a high level of quality from those who care for elderly persons and provides for consequences when that high level of quality is not achieved. If high standards are demanded, however, it is incumbent upon Texas to reimburse that care at a commensurate level. Low reimbursement rates, the care reimbursement methodology, and the need for greater funding for the rate enhancement system are all significant contributing factors to the current financial crisis in the Texas nursing home industry.

Liability Insurance Cost Increases

Affordability and availability of long-term care liability insurance for nursing homes has become a serious problem in Texas. The nursing home industry is experiencing considerable premium increases at the same time many insurers have departed Texas. According to Texas Department of Insurance (TDI) officials, the problem is more serious in the for-profit segment of the industry.[42]

Availability: At a February 2000 hearing conducted by TDI, rate filings submitted to TDI suggested that only three insurance companies were writing nursing home coverage through the admitted, or licensed, market at that time, compared with eight in November 1996.[43] It is now known that fewer companies are writing coverage in the licensed market. This lack of licensed insurers suggests that much of the nursing home industry is purchasing liability coverage from the surplus market, while some homes are opting to forego coverage altogether. While Texas nursing homes may not be seeing an "availability crisis," as some coverage is available, the problem is that coverage is primarily available through the surplus market. The surplus market's lack of protections should the insurer become insolvent, coupled with higher than average rates, may not offer a favorable option for the insured.

> ***Surplus Insurance Market***
> Surplus market insurers are allowed to do business in Texas, but are not licensed by the state and, aside from minimal solvency requirements, are not subject to any regulation by the state. Only companies unable to obtain coverage in the licensed market can purchase coverage from the surplus market.

Affordability: Since the majority of the nursing home industry is purchasing coverage from insurance companies that do not have to submit their rates to TDI, reliable data on premium rate increases industry-wide is difficult to obtain. For-profit nursing homes, which include over 80 percent of the state's nursing homes, can not purchase from the rate-regulated insurance market.[44] As stated earlier, many for-profit homes are purchasing coverage from the surplus market, making it even more difficult to obtain reliable rate information. Non-profit homes, the only segment of the industry that may purchase from the regulated insurance market, account for only about 18 percent of Texas homes. However, many of the non-profits also purchase coverage from the unregulated surplus market. Therefore, only about five to ten percent of the Texas nursing home market purchases coverage from the regulated market which, since subject to rate controls, must submit rates to TDI.[45]

THCA conducted its own limited survey of its membership. The association's survey of about a quarter of the number of beds in Texas showed that premiums had increased between 1998 and 1999 from about $650 per bed, per year, to over $1,800 a bed. THCA indicated that some homes have been faced with premiums of $2,800 or more per bed, with some homes experiencing increases in quoted premiums ten times higher than in previous years.[46] THCA claims the industry-wide impact of liability insurance cost increases could be over $100 million dollars for the year 2000.[47] These costs are reimbursable, but the reimbursement method, which does not account for such costs for nearly two years, provides no immediate

relief. Committee staff stress that this survey was conducted by THCA and no validation of methodology has been conducted.

TDI Provides Relief: On February 1, 2000, TDI Commissioner Jose Montemayor approved a TDI staff proposal seeking to ease the growing liability insurance crisis for non-profit homes. The commissioner's approval allowed non-profit nursing homes to purchase liability coverage from the Texas Medical Liability Insurance Underwriting Association (commonly referred to as the "joint underwriting association" or JUA), a state-created insurer of last resort. According to TDI staff, while there appears to be a more serious problem of affordable and available liability insurance coverage for the for-profit segment of the industry, for-profit homes are currently not eligible to apply for coverage through the JUA. The ability to purchase from the JUA addresses availability concerns, providing a guaranteed insurer of last resort. However, JUA coverage will not necessarily provide any affordability relief for nursing homes. At the time this report went to print, the JUA and TDI were in the process of developing rates for the non-profit nursing home industry.

In 1975, the 64th Texas Legislature established the JUA to provide medical liability insurance to physicians and health care providers who could not find coverage in the voluntary licensed insurance market. The JUA is made up of all insurers authorized to write, and engaged in writing, automobile and other liability insurance in Texas, and is governed by a board of nine directors representing member insurers, physicians, hospitals and the public. Currently there are approximately 500 members.

Source: Hamilton, Marilyn. Texas Department of Insurance. Oral Testimony.

Within parameters set forth in Texas statute, the commissioner of insurance has the discretion to determine whether coverage is reasonably available to specific, eligible providers and whether these providers should receive coverage from the JUA. In 1977, the JUA board of directors expanded eligibility to include non-profit nursing homes. However, by 1982, it was determined that an adequate market of nursing home liability underwriters was reasonably available to non-profit nursing homes, and JUA eligibility was rescinded. Since that time, non-profit nursing homes have not been eligible for coverage through the JUA, although they continued to be listed in statute as an industry that could be granted eligibility.[48] Again, for-profit nursing homes are not statutorily eligible for coverage under the JUA, nor can they purchase from the medical malpractice insurance market that is regulated by TDI. Eligibility to purchase JUA coverage for for-profit nursing homes would require legislative action.

Industry Solutions: Both major nursing home industry associations, THCA, representing primarily the for-profits, and the Texas Association for Homes and Services for the Aging (TAHSA), representing the non-profits, are in various stages of exploring the creation of shared-

Purchasing and Risk Retention Groups

A purchasing group is defined as any group whose purposes include the purchase of liability insurance on a group basis, and whose members, business or activities are similar or related with respect to the nature of their liability.

A risk-retention group is a liability insurance company that is owned by its members.

risk purchasing groups. TAHSA has officially formed a risk-retention group.[49] THCA is still conducting research and considering this option, but the capitalization requirements are so substantial that the association has not taken any action at this time.[50] The formation of this type of purchasing arrangement is commonly explored when any particular group is experiencing an availability and/or affordability crisis regarding insurance coverage. One advantage to this approach is that, in theory, it promotes aggressive "self-policing" of the group in question.

Questions About the Liability Insurance Issue: In order to accurately assess the extent of the liability insurance crisis and respond with responsible solutions, policymakers need more information. As stated earlier, reliable data on premium increases and the closed claim experience of the insurance companies writing coverage for nursing homes is not readily available. However, as a result of a TDI survey of insurance companies writing this kind of coverage, data that may help with the assessment of the liability crisis has been obtained from TDI. At the time this report went to print, the committee was having an analysis performed that may provide answers to many of the questions raised in this section of the report.

Based on research and testimony to the committee, it is clear that the nursing home industry is experiencing significant premium increases. Since the companies writing coverage for nursing homes are not required to "justify" their rates to TDI, it is unknown whether the premium increases are justified based on the claims experience for the entire nursing home industry. If the rates are justified in terms of overall industry claims experience, is it because of one or two extraordinarily large claims that skew the average for the entire industry? Further, even if the rates are justified based on overall claims experience for the entire industry, it is not known if the rates are justified on a home by home basis. Testimony received by the committee suggests that for the majority of "good" homes, that is, homes with no judgments against them and a clean operating history, unjustified premium increases are occurring.

Questions to be Answered

Are the increased rates justified in terms of closed claims experience?
Are one or two extraordinarily large claims driving up those closed claims figures?
Are the increased rates justified on a home-by-home basis?
What are the causes behind all the closed claims?

While the insurance industry may be treating all homes the same, regardless of individual operating history, there is certainly a precedent for determining rates based on an individual home's "experience." The system for auto insurance, and many other lines of commercial liability coverage, utilizes an "experience rating" system to establish tiered rates. The use of this type of system is not required for any insurer writing coverage for nursing homes.

Further, when the nursing home industry and the insurance industry testify about the increased closed claims experience for the nursing home industry, it is unknown what the cause is behind the claims. Often, the claims are discussed in the context of civil judgments, but claims do not necessarily have to result from civil judgments. Closed claims can include fraud claims by the government, which is an issue with some of the larger chains nationwide. Knowing what is driving all the claims is key to determining what solutions may

apply.

In summary, more information is needed to appropriately address the liability insurance issue and the committee may obtain such information prior to the session. If assistance is needed in getting additional information, there are recommendations related to this issue later in the report. Nevertheless, even without the data that will help policymakers better assess the situation and respond accordingly, it is clear to the committee that increased liability insurance premiums are one of the significant factors in the current financial crisis.

Increased State Regulatory Action and Civil Litigation

The committee heard a significant amount of testimony about the role of civil litigation in the current nursing home financial crisis. To a lesser extent, the role of increased state regulatory fines has also been cited as a contributing factor. The role of litigation has been discussed both as a source of direct costs to nursing home companies and as the influencing factor behind the liability insurance crisis. As with the liability insurance issue, the lack of readily available and objective sources of information makes an analysis of this subject, and the development of solutions, difficult.

Nursing home industry representatives testified to the committee that increases in civil monetary penalties, which are pursued by the Office of the Attorney General (OAG), and administrative fines levied by the state that have emerged since the passage of SB 190, 75th Session, are direct contributing factors to nursing homes filing for Chapter 11 bankruptcy protection.[51] There is data to assess the direct effect state regulatory fines against nursing home chains have had on the financial crisis in Texas (see chart [52] [53]).

NURSING HOME BANKRUPTCIES

Company	Short Term Debt	Maximum OAG Claims	Administrative Penalties Outstanding*	Total Penalties
Texas Health Enterprises	$40 million (unsecured claims)	$19 million	$559,550	$19,559,550
Mariner	$1.7 billion	$8,197,000	$1,179,150	$9,376,150
Integrated Health Services	$3.7 billion	$3,200,000	$212,950	$3,412,950

Again, there are currently four major companies representing the majority of homes operating under Chapter 11 bankruptcy in Texas. They include Mariner Post-Acute Network, Inc., Integrated Health Services, Inc., Texas Health Enterprises, Inc., and Sun Healthcare Group, Inc. The chart shows that DHS administrative penalties and OAG civil penalties, with the exception of penalties assessed against Texas Health Enterprises, make up a very small fraction of the total short term debt of each nursing home company.

The nursing home industry also testified that judgments levied against nursing homes as a result of civil litigation have imposed a direct financial burden on nursing home chains, exacerbating the financial crisis. It has been difficult to obtain data on civil losses of the chains in financial turmoil.

Several large verdicts have made headlines, and nursing home and insurance industry representatives testified about various large verdicts. The *Auld* case from Fort Worth is one such case. The jury awarded the estate $2.37 million in actual damages and $90 million in punitive damages for the wrongful death of a resident of a Horizon/CMS Healthcare facility. This significant award received much attention. However, the trial judge, based on statutory caps, reduced the actual damages to $1.5 million and the punitive damages to $9.48 million. No money has been paid out in the case.
Source: Auld, Lexa. Oral Testimony to the House Committee on Human Services. May 2000.

A February Austin *American - Statesman* article about the increase in civil judgment claims stated that, "In 1997, Texas nursing homes paid 86 claims worth $10.4 million. Two years later, 92 claims were filed, costing a total of $26.1 million."[54] Those figures raise certain questions. If only six more claims were paid during 1998, did one or two claims, perhaps in response to some egregious mistake ending in tragedy, increase the number precipitously? Or did the amount of all claims increase slightly, spreading the nearly $16 million in increased costs evenly among the 92 claims? What is known is that the average amount of a claim paid in Texas is $230,000 compared to a national average of $47,900.

While more data on the dollar amounts of civil judgments imposed on troubled nursing homes in Texas is needed, it appears that a litigious environment has contributed to financial burdens on some Texas nursing homes. However, it also appears that the financial burden of civil judgments actually paid by nursing home chains has not been a major factor in the bankruptcies in Texas. Three of the large chains in bankruptcy have between $1 billion and nearly $4 billion in short-term debt each. Paid civil judgment awards appear to be a minor part of that debt. A representative of Mariner Post-Acute Network, Inc., testified to the committee that Mariner, with approximately $1.7 billion in short-term debt, had no major civil judgments against the company.[55] Mariner has 101 bankrupt homes in Texas.

While fines levied by the state and civil tort awards may not be direct contributing factors in nursing home filings for bankruptcy protection, fines appear to be a major catalyst in another key area related to the financial status of nursing homes: the liability insurance crisis. Whether judgments are summarily reduced or not, the insurance industry takes note of the headlines. As previously reported, there has been no definitive evidence presented to the committee to prove that significant rate increases are justified by insurance company losses. However, to be fair, it does appear that closed claims experience is increasing in severity and frequency in Texas. It is also true that insurance companies, both as a wise business practice and, to some extent, a requirement of law, must keep enough reserves on hand to cover potential losses, even if a judgment is never actually paid. Premium costs are driven by the need to build reserves. Therefore, the need to raise premiums for some Texas nursing homes, to some degree, may be justified. Whether the magnitude of the premium increases is justified has yet to be determined.

In summary, it appears that the heightened litigious environment surrounding nursing homes is playing a role in the financial crisis. Determining the reasons for the existence of this environment, the extent and nature of its effects on the crisis, and appropriate policy solutions represent complex issues subject to debate.

Other Influencing Factors

Other contributing causes of the financial crisis in the nursing home industry include fluctuations in stock prices, high and escalating lease payments, the assisted living industry's pulling away private pay residents, low censuses, and the weight of upper management in nursing home chains. With regard to large publically traded nursing home chains, fluctuating stock prices have played a role in the current crisis (see chart[56]). Of the bankrupt homes in Texas, Vencor, Sun Healthcare, Mariner Post-Acute, and Integrated Health Services are all publically traded.[57] Prior to the Balanced Budget Act of 1997, nursing home chains realized the nearly unlimited potential revenue source that ancillary Medicare services represented. Chains that seized the opportunity by rapidly expanding their infrastructure to provide more ancillary services were rewarded on the stock market. Such expansions often meant taking on significant debt, which analysts deemed to be a manageable risk because of the significant revenue stream from those services and the influx of capital from stock market investors. Those homes that did not exploit Medicare's reimbursement system were, in effect, punished by investors. It appears that Wall Street analysts and investors encouraged the aggressive expansion that, after the Balanced Budget Act, eventually damaged much of the industry. Further, as the same nursing home chains that were once favored on the stock market began to struggle, investors began to pull their support, causing stock prices to plummet.

Nursing Home Stock Price Decreases

Company	Stock Price as 6/22/99	% Decline from 6/22/97
Vencor	$0.19	-99%
Sun Healthcare	$0.34	-98%
Integrated Health	$8.31	-78%
Mariner Post-Acute	$0.56	-96%

Another factor in some of the bankruptcies in Texas is high and escalating lease arrangements. Again, in light of the potential revenue that Medicare ancillary services could generate, some homes agreed to costly and escalating leases in order to acquire more nursing home beds. Such arrangements seemed financially sound because of the money that could be generated from the additional nursing home beds. Some landlords have been known to receive between 11 and 28 percent of overall operator revenues, at times requiring the operator to pay for insurance, maintenance, and taxes on the leased property.[58] Texas Health Enterprises, Inc., cited some of the lease arrangements for its nursing homes as one of the major reasons for its bankruptcy.

There is reason to believe that competition from the assisted living industry for private-pay residents has also placed a financial strain on nursing homes. Various articles and studies have pointed to this as a

contributing factor in the current nursing home crisis.[59] The *Wall Street Journal* cited Vencor Inc.'s financial troubles as partly "the result of increased use of assisted-living."[60] Further, between 1995 and 2000, assisted living occupancy rates increased 210 percent, while nursing home occupancy decreased about 5 percent over the same period.[61] The loss of private-pay residents can be especially burdensome, as the nursing home industry has historically used private-pay residents to compensate for low Medicaid rates.

The underlying factor in many of Texas Health Enterprises, Inc.'s (THE) problems was its extremely low census. At the time of bankruptcy, THE had a statewide occupancy rate of 60.6 percent, with some facilities having occupancy rates as low as 40 percent. It is difficult to remain solvent with such low occupancy rates.[62] It appears that THE overexpanded because the company believed there would be a significant influx of elderly persons to fill its beds. For THE, that influx never materialized.

The weight of upper-management in some nursing home chains, specifically executive compensation, also appears to have been a factor in some chains' financial difficulties. According to *Business Week*, Robert N. Elkins, former chief executive and founder of Integrated Health Services, Inc. (IHS), made over $14 million in compensation in 1997, the same year his company's stock dropped 78 percent. Elkins also received corporate loans from IHS to buy stock, which he does not have to pay back if he stays for five years. He also has a retirement trust to which the company must make "irrevocable" payments. By 2001, the trust will be valued at $23.9 million.[63] IHS has 66 bankrupt homes in Texas.

> According to *Business Week*, Robert N. Elkins, former chief executive and founder of Integrated Health Services, Inc. (IHS), made over $14 million in compensation in 1997, the same year his company's stock dropped 78 percent.
>
> *Source: Sparks, Debra (2000). "On the Sick List." Business Week, July 5.*

State Policies and Resources for Dealing with the Crisis

Through DHS, the Office of the Attorney General, state court appointed trustees, and the Nursing and Convalescent Home Trust Fund, the state has significant resources to deal with the nursing home crisis. Over time, the officials charged with monitoring and responding to financially troubled nursing homes are becoming more adept.

The Department of Human Services process begins once the agency receives information of financial instability of a facility, or one or more facilities, in a chain. DHS may obtain this information from its survey process, resident family members' concerns that suggest instability, or other outside sources. Upon receipt of this information, DHS conducts an investigation to determine if there is sufficient information to indicate financial instability. DHS also surveys the potentially affected regions for additional information to determine sufficient evidence of a pattern of problems across the regions. SB 1292, 76th Session, allows DHS to investigate the financial soundness of a licensed nursing home by providing the agency with access to all of the home's financial records. SB 1292 also allows for criminal prosecution of a person who knowingly provides false information to DHS.

In other instances, the nursing home operator may contact DHS directly to inform the agency of financial problems. SB 1292 requires nursing homes to notify DHS of a significant change in the institution's financial condition that could adversely affect the delivery of essential services to residents, including nursing services, dietary services or utilities.

Once financial instability is confirmed, a strict monitoring process is begun. Regional staff are assigned to conduct unannounced monitoring visits to each affected facility and complete a monitoring report that includes information about the availability of food, medicine and other supplies. Staff also gather information about vendor payments, payment of utilities, payroll status and other financial responsibilities.

Frequent follow-up monitoring occurs, often by telephone, depending on the rapport between the facility administration and DHS. In the monitoring process, focus is placed on tracking the effect of the financial problem on the home's residents. DHS makes weekly reports to HCFA on the status of the financially troubled operators and weekly conference calls to other states in the HCFA region to share information about financially troubled operators.

Once a home enters bankruptcy, the Office of the Attorney General brings considerable resources and expertise to bear on the situation. The OAG Bankruptcy and Collections Division, in consultation with DHS and OAG Elder Law Division attorneys, represents the state to protect it from losses associated with the bankruptcy. During the bankruptcy, DHS regional staff continue to closely monitor the affected homes to ensure the bankruptcy does not adversely impact resident care. The state also works to process any change of ownership as quickly as possible to expedite a return to stability for the residents.

If conditions appear to be degenerating, DHS works with the nursing home industry to develop a contingency plan for the state to take over operations and relocate the residents. Often, a detailed transfer plan for each potentially affected resident is developed long before a home is taken over.

When a home or a chain of homes is taken over, a trustee is appointed to oversee the facility operations. Often, because DHS has determined there is an immediate threat to the health and safety of residents, DHS requests that the OAG bring an action on behalf of the state for an involuntary court appointment of a trustee. A trusteeship is similar to a receivership, except that the purpose of the trustee is to protect the health and safety of residents, not to protect the

Trustees typically have extensive background in medical facility administration. DHS recommends individuals holding a current Texas nursing facility administrator's license and who have completed specialized trustee training. Trustees are paid reasonable fees as determined by the court. These fees, plus any operating expenses not covered by the home's revenue, are paid from the Nursing and Convalescent Home Trust Fund. The licensee is responsible for reimbursing the state for amounts distributed from the fund. Thanks to the work of the OAG, the state, through bankruptcy proceedings, has recovered all of the approximately $2.1 million in state funds expended during the Sensitive Care, Inc., crisis. Those funds represent the $915,000 advanced from the trust fund and the approximately $1.1 million in additional emergency Medicaid funds appropriated by the Legislature.

Source: Attorney General John Cornyn. Sensitive

assets of the home. In most cases, the court orders the trustee to assume the operation of the facility and to report to the court on its status. Statutes give the trustee authority to move any or all residents for health and safety reasons, and to close the facility.

The Nursing and Convalescent Home Trust Fund, Chapter 242, Health and Safety Code, acts as a source of emergency funds should the state be forced to take over the operation of a nursing home or nursing home chain when resident health and safety is endangered. Prior to the 76th Session, DHS could collect fees from nursing facilities to deposit in the Nursing and Convalescent Home Trust Fund, but the fund was capped at $500,000. Any accumulated money over $500,000 was swept into general revenue at the end of the fiscal year. The financial demands of the state "takeover" of 13 nursing homes in the Sensitive Care, Inc., case shed light on the inadequacies of the trust fund as originally established, when DHS had to seek additional appropriations to cover the costs associated with placing trustees in the 13 homes.

In response, HB 2909, 76th Session, strengthened the fund by raising the cap from $500,000 to $10 million. HB 2909 also authorized DHS to charge and collect an annual fee, if necessary, to ensure that the amount in the Nursing and Convalescent Home Trust Fund is sufficient to cover trustee costs. This legislation did not require DHS to immediately collect $10 million from the nursing homes. Rather, DHS is assessing a reasonable fee that will increase the fund over a five-year period. Currently, the fund balance is $2.4 million.

To further address financial accountability, the concept of requiring nursing homes to be bonded was proposed through SB 1198. This legislation met opposition and the authors agreed that if HB 2909 passed, which increased fees charged to the homes, the "surety bill" would be unnecessary as well as unduly burdensome to nursing homes. Also, SB 1292, which originally proposed to require homes to submit audited financial reports to DHS, was modified when it was determined that this requirement would be even more costly than the surety bond requirement.

Impact on Residents

The foremost concern of this committee and the primary reason for this charge is the health and safety of Texas nursing home residents. A financial crisis in any nursing home can increase the potential for harm and trauma for the residents who rely on the care provided by that home. While the potential for resident harm would seem high in the midst of such a crisis, the actual harm to residents thus far has been minimal. This minimized effect on residents can be attributed to the attention and efforts of both the state and the nursing home operators.

When a home files for Chapter 11 bankruptcy protection, the residents are not immediately in any more jeopardy. In fact, the relief provided by Chapter 11 status and the infusion of more investors' financial resources can often improve conditions in the home. If and when the Chapter 11 bankruptcy evolves into a Chapter 7 bankruptcy, the situation may become more tenuous for residents. However, in the few cases of Chapter 7 bankruptcy in Texas, changes of ownership occurred for nearly all the homes and residents experienced no related physical harm.[64]

In some bankruptcy cases, if an appropriate buyer for the home is not found, the state must eventually close the home and transfer the residents. This occurred with the closing of three of the Sensitive Care, Inc., homes. Even with the most well-planned and executed transfers, the potential for resident harm exists. "Transfer trauma" refers to the negative effects that the moving of residents inevitably has, often in the form of physical and mental harm. Even under the best circumstances, it is not uncommon for some residents in any transferred group to experience transfer trauma. However, resident transfers have been necessary in a limited number of bankruptcies and, with the exception of some anxiety as residents learn of the nursing home's instability, negative impacts on residents have been minimal. According to DHS, no known deaths have occurred as a result of the financial crisis.

Impacts on Residents

In the Sensitive Care, Inc., case three of the 13 homes were closed and residents were transferred to nearby homes. According to the Department of Human Services, of those residents transferred, there were no reports of related deaths or negative physical outcomes.

Source: Texas Department of Human Services. Personal Communication. September 2000.

Nevertheless, the state continues to closely monitor the struggling nursing home chains. As financial conditions worsen for a particular home, the state actively plans for the protection and possible transfer of the residents. While conditions appear to be relatively stable at this point, the state is acting wisely and responsibly in its preparations to ensure the health and safety of residents if conditions in any nursing homes should change.

Recommendations

1. Recommend that the Legislature increase base reimbursement rates for nursing home care.

Low reimbursement rates are a significant contributing factor to the current financial crisis in the Texas nursing home industry. Texas remains 45th in the nation in Medicaid funding for nursing home care. The Legislature should ensure that the base rate adequately reflects the costs of providing quality care and takes into account inflationary increases. If a high standard of care for residents is demanded, it is incumbent upon Texas to reimburse care at a commensurate level. At this time, the committee is not endorsing a specific appropriations amount, but believes increased funding for nursing home rates is an important part of the solution to this crisis.

2. Recommend that the Legislature increase funding for additional rate enhancement through a funding methodology that provides incentives for increased direct care staffing (Rider 38).

Under Rider 38, passed in the 76th Session, nursing homes can receive an enhanced rate in addition to the base rate, if the home achieves a certain staff-to-resident ratio and directs the enhanced funding solely to direct care spending. Due to the amount of money dedicated to the program, only about half of the homes that have elected to participate will be able to do so. The reimbursement enhancement system is a move in the right direction, but more funding must be directed through the methodology in order to truly improve the staffing in nursing homes. Again, the committee is not endorsing a specific appropriation.

3. Recommend that the Legislature direct HHSC and DHS to review the base reimbursement methodology for nursing home care to identify legitimate costs that may not be reflected in the rate.

Critics of the Medicaid rate have claimed for years that the methodology itself is inadequate. There may be legitimate costs of doing business that are justifiably reimbursable, but are not captured by the current methodology. A review of the allowable costs captured by the methodology is prudent and may identify some of the legitimate costs that are not captured. The review should also explore possible methods to identify and address sudden cost increases, such as liability insurance increases, that the state may want to account for sooner than the current process allows.

4. Recommend that the Legislature direct HHSC and DHS to evaluate the effectiveness of the new Medicaid nursing home rate methodology to provide incentives for increased direct care staffing (Rider 38), and consider the addition of incentives for increased dietary and other spending to improve quality of care and quality of life for residents.

The move to fund additional rate increases through a methodology that provides incentives for increased direct care spending is a positive policy shift. A periodic evaluation of the effectiveness of the methodology would identify beneficial changes that could further enhance the state's reimbursement system.

5. Recommend that the Legislature direct HHSC and DHS to conduct a new time study/recalculation of the Texas Index for Level of Effort (TILE) or other case-mix system to better account for varying resource needs of nursing home residents, especially those with dementia.

The current TILE reimbursement system was developed from a 15-year-old time study and does not accurately reflect the true resource needs of nursing home residents. For example, persons with Alzheimer's or related dementia demand extensive staff time, yet facilities generally receive the lowest reimbursement rate for such patients.

6. Recommend that the Legislature explore increasing nursing home reimbursement rates by enacting a "quality assurance fee" on the gross revenue of nursing homes to draw down matching federal Medicaid funds.

Oklahoma recently passed a measure intended to bring in nearly $100 million to increase nursing home rates. A six percent fee on the gross revenue of every nursing home operating in the state would be collected and then used to draw down federal Medicaid dollars at a federal-state match rate of approximately 60 to 40 percent. The collected funds, combined with the federal match, would be returned to the nursing homes in the reimbursement rate, resulting in a significant net increase. Preliminary projections show that this approach could bring $225 to $250 million to Texas to enhance the reimbursement rates.

7. Recommend that the Texas Department of Insurance (TDI) conduct a data call to collect more information about the nature of the liability insurance crisis.

As noted in this report, there are many unanswered questions regarding the liability insurance crisis. Because many of the companies that are currently writing coverage are from the surplus market, data that would answer those questions is not readily available. A recent data call by TDI may be adequate to answer several important questions. However, if that data call is inadequate, the data needed to answer many remaining questions and help policymakers better assess the situation should be pursued.

8. Recommend that the Legislature amend state law to allow for-profit nursing homes to purchase coverage through the Joint Underwriting Association (JUA).

Escalating liability insurance costs are making it difficult for nursing homes to find coverage. The number of underwriters for nursing home liability insurance has decreased over the past two years. Current law prohibits for-profit nursing homes from joining the JUA to purchase liability insurance. This change would ensure the availability of liability insurance.

9. Recommend that the Legislature require the JUA to utilize an "experience rating" process to determine a system of tiered rates for nursing homes.

In today's liability insurance market, homes with good operating histories are forced to pay high premiums despite their history. "Experience rating" is common in many lines of commercial liability insurance, allowing for varying premiums depending on the insured's conduct and history. Requiring the JUA to utilize an "experience rating" system could provide some cost relief for homes with good operating histories. Successful use of an "experience rating" system within the JUA could be a model to help bring the insurance industry as a whole back into the market. At the time this report went to print, TDI and the JUA leadership were discussing the possible use of such a system to develop tiered rates in the context of coverage for non-profit homes.

10. Recommend that DHS establish a temporary license for prospective nursing home operators going through the change of ownership process.

Currently, new operators who agree to take over a troubled facility face the challenge of addressing numerous deficiencies from the previous operator prior to resumption of Medicaid reimbursement payments. The proposed temporary license from DHS would restore the flow of Medicaid reimbursement while providing the new owner more time to fix prior deficiencies. Such a license would make it easier to find good owners to take over troubled homes, thus avoiding the need for the state to appoint trustees or close the homes.

11. Recommend that the Legislature increase funding for DHS audit staff to investigate the financial viability of nursing facilities.

As discussed in this report, the financial instability of nursing homes generates a significant amount of work for DHS to ensure the protection of residents. Current statutes provide sufficient authority for DHS to investigate and monitor the financial status of homes, but the large number of homes in financial crisis requires expanded audit capacity. The committee supports DHS' exceptional item in its Legislative Appropriations Request for the 2002-2003 biennium for this purpose.

12. Recommend that DHS increase the use of the "Amelioration of Violation" provision of Chapter 242 and provide DHS with new guidelines for appropriate use.

The "Amelioration of Violation" provision in Chapter 242 provides that, in lieu of ordering payment of an administrative penalty under Section 242.069, DHS may require a home to use, under the supervision of DHS, any portion of the penalty to ameliorate the violation or to improve services, other than administrative services, in the institution affected by the violation. To date, the provision has rarely been used. In light of the current financial crisis, the committee is sensitive to imposing undue financial burdens on nursing homes. While administrative penalties are an important component of the regulatory system, the committee believes there are instances when it is prudent to allow the penalties to be reinvested in resident care.

13. Recommend that the Legislature enact no reforms that would diminish any aspect of SB 190, 75th Session.

SB 190, 75th Session, provided a solid regulatory structure that protects residents of nursing homes. The rules implementing the major provisions of SB 190 represented a significant shift in the regulatory structure statewide and did not go into effect until March 1998. Enacting changes to the regulatory system set forth in SB 190, before the long-term results of the reforms can be realized and evaluated, would be premature and imprudent.

Discussion of "Insurance Reform" Recommendations

In addition to recommendations eight and nine above, the committee explored options a) requiring liability coverage for for-profit nursing homes to be rate-regulated by the Texas Department of Insurance, and b) requiring underwriters to use an "experience rating" system for nursing homes, tied to surcharges for "bad" homes and credits for "good" homes.

Liability insurance that the for-profit nursing home industry currently purchases is not rate-regulated by TDI and, therefore, TDI has limited information on this market. Consequently, it is difficult to know if the insurance industry is being fair and passing along justifiable premium increases. Requiring the product to be rate-regulated would allow the state to assess the rate increases experienced by the nursing home industry. Further, in the current liability insurance market, homes with good operating histories are forced to pay high premiums despite their history. "Experience rating" is common in many lines of commercial liability insurance, allowing for varying premiums depending on the insured's history. The use of such a system could begin to address affordability for a significant number of nursing homes.

The committee would like to see the benefits of these recommendations realized. Unfortunately, the nursing home industry is experiencing problems of availability as well as cost, and mandating such a change would likely drive the remaining few licensed insurance companies writing coverage out of Texas. The remaining underwriters are in the surplus market and the state has no real jurisdiction over their rates. It appears more prudent to model such an approach to rate setting in the Joint Underwriting Association to determine whether insurance companies can have success with a tiered rate system for nursing homes.

CHARGE 3: Assess the state's responsibilities and policies regarding supports for individuals with disabilities in community-based settings.

Introduction

Over the past two decades, Texas and the nation have seen an ideological shift towards serving people with disabilities in the community rather than in institutions. Persons with disabilities, disability advocacy groups and state officials have worked to increase the numbers of people with disabilities who are receiving services in the community. Texas witnessed a population decline within institutional settings as a result of this effort. While this decline resulted in an increase in persons receiving community-based services, the state, like many other states, has been unable to accommodate the growing demand for community-based services.

There are currently 62,200 individuals on waiting lists for community-based services in Texas. There are no waiting lists for institutional care.[65] Despite some progress, the state's responsibility to serve people with disabilities in the community remains a contentious issue due to the continued demand for care and the growing preference that care be delivered in the least-restrictive setting.

On June 22, 1999, the U.S. Supreme Court addressed the debate over appropriate care for people with disabilities. In *L.C. and E.W. v. Olmstead*, the court ruled that, in most cases, states must provide community-based services for people with disabilities if treatment professionals determine that this is appropriate and the individuals do not object to such placement.

> "Specifically, we confront the question whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions. The answer, we hold, is a qualified yes."
>
> - Justice Ginsburg announcing the judgment of the U.S. Supreme Court in the *Olmstead* case.

On September 28, 1999, in response to the ruling, Governor George W. Bush issued Executive Order GWB 99-2, affirming that "...the State of Texas is committed to providing community-based alternatives for people with disabilities and recognizes that such services advance the best interests of all Texans." The order directed the Texas Health and Human Services Commission (HHSC) to conduct "a comprehensive review of all services and support systems available to people with disabilities in Texas" and to "examine these issues in light of the recent United States Supreme Court decision in *Olmstead*."[66]

To facilitate legislative oversight of the state's activities relative to the *Olmstead* ruling, Speaker Laney charged the House Committee on Human Services to assess the state's responsibilities and policies regarding supports for individuals with disabilities in community-based settings.

Background on Long-Term Care Trends and Community-Based Services

In the early part of the twentieth century, people with disabilities were either cared for by their families with very little support from the state or they received services in large public institutions. In the 1960's, the alarming conditions and sub-standard care that residents received in these institutions were exposed. An increasingly vocal advocacy community and a series of class action lawsuits were primarily responsible for highlighting these egregious conditions, which fostered a nationwide debate about the government's responsibility to care for people with disabilities and the setting in which care is provided.

The debate that ensued represented a shift to the idea of de-institutionalization of people with disabilities who are able to live in the community. While the disability community fought for the development of a more flexible service delivery system, the lawsuits of the 1960's resulted in mandates that states improve the conditions in these institutions. Expanding community-based options was not addressed.

In 1974, a class action lawsuit, *Lelsz v. Kavanagh*, was filed against the Texas Department of Mental Health and Mental Retardation (MHMR) in federal district court. The petition sought relief, not in the form of monetary damages, but in instituting changes to correct chronic abuse and neglect, inadequate training, inappropriate institutionalization, and failure to expand community services.

In 1983, the parties signed a "resolution and settlement (R&S)," which obligated the state to reach minimally adequate goals in a wide range of areas pertaining to the care and treatment of mentally retarded persons in Texas. The R&S, approved by Judge William Wayne Justice, also required the state to provide each member of the plaintiff class with the least restrictive residential services appropriate. To that end, in June 1985, the judge ordered 279 persons from the named state schools to be moved to community residences by August 31, 1986. MHMR appealed this ruling and, in January 1987, the Fifth Circuit Court of Appeals vacated the order and ruled that there is no constitutional right to least restrictive placement.

In August 1987, Judge Barefoot Sanders found the state in contempt for failing to meet the provisions of the R&S and asked the parties to submit recommendations for remedies. Subsequently, in October 1987, all parties signed an "implementation agreement," which contains specific requirements that settled the contempt findings.

In March 1991, the state asked the court to issue a declaratory judgment to find the state in substantial compliance with the implementation agreement. After the court ordered the scheduling of a hearing on whether the state had failed to comply, the parties entered into a settlement agreement, which was approved by Judge Sanders on December 30, 1991.

According to the agreement, the lawsuit would be dismissed within seven days of the occurrence of two events: 1) the closure of a state school and 2) the placement of individuals in the community in a number equal to 300 placements a year from the date of the closure of the first state school. The agreement also mandated that Governor Ann Richards appoint a task force to make recommendations regarding the closure or consolidation of state schools for mentally retarded persons. After months of review, the task force submitted its recommendations, including the closure of the Fort Worth and Travis State Schools. On March 31, 1992, the governor accepted the recommendation and subsequent legislation directed MHMR to implement the closures. Since those two closures, which brought the number of state schools to 11 from 13, no further closure or consolidation has occurred.

The 1970's brought a new wave of legal challenges that sought not only to improve conditions within institutions, but to stop the institutionalization of people with disabilities who could be served in the community. In Texas, the landmark case, *Lelsz v. Kavanagh*, was brought in 1974 and spanned 18 years (see box on previous page [67]). While many health and human services experts believed that most people in institutions could be served in the community if given appropriate services, intense supervision and necessary medical care, many communities failed to adequately provide those supports.

Recently, states have worked to expand the variety of community-based options available to people with disabilities and, when appropriate, to further the goal of de-institutionalization. However, the level of commitment to de-institutionalization, the aggressive creation of community-based alternatives and the level of funding for community-based care varies from state to state. In 1991, New Hampshire and the District of Columbia (D.C.) became the first state and jurisdiction to close their only public institutions for people with disabilities and develop a delivery system based solely on community-based options. Since then, six states: Alaska, Maine, New Mexico, Rhode Island, Vermont and West Virginia have followed the example of New Hampshire and D.C.[68]

States/ Jurisdictions without Public Hospitals to Serve Persons with Developmental Disabilities *	**States that Rely on Public and Private Institutions to Serve Persons with Developmental Disabilities ***		
	Very Limited Reliance (< 20 %)	Moderate Reliance (20%-40%)	Extensive Reliance (> 40%)
Alaska D.C. Maine Hawaii New Hampshire New Mexico Rhode Island Vermont West Virginia	Arizona California Colorado Kansas Massachusetts Michigan Minnesota Montana Oregon South Dakota Wyoming	Connecticut Florida Idaho Indiana Iowa Louisiana Maryland Missouri Nebraska Nevada New York North Carolina North Dakota Pennsylvania South Carolina Washington Wisconsin	Alabama Arkansas Delaware Georgia Illinois Kentucky Mississippi New Jersey Ohio Oklahoma Tennessee **Texas** Utah Virginia

* Percentage of total out-of home placements that are in public or private institutions serving 16 or more people. *Source: January 2000 NCSL Publication*: *De-institutionalization of Persons with*

During the last 20 years, Texas has significantly increased the community-based options available to people with disabilities. There are approximately 29 programs in Texas providing various levels of services in community settings.[69] This shift in direction has resulted in a population decline within institutions. In 1986, the average daily census in state mental hospitals was 4,500 compared with 2,400 in 1999, representing a 46 percent reduction. Over the same period, state schools for mentally retarded persons saw a census

drop from 8,700 to 5,400, representing a 38 percent decrease. The number of nursing home residents has remained fairly constant.[70] Overall, this decline has resulted in a 211 percent increase in clients receiving community services through the Texas Department of Human Services (DHS) alone.

There is still much work to be done in Texas to fully realize the potential of community-based services and to meet the growing demand. Again, there are currently 62,200 individuals on waiting lists for community-based services in Texas. There are no waiting lists for institutional care.

The Texas Legislature appropriated for FY 2000 approximately $2.1 billion (all funds) for institutional care and $2.1 billion (all funds) for community-based care programs, although five times more individuals are served monthly through the community-based programs.[71] These programs are operated by four different agencies and lack coordinated administration, making them a challenge to access. Texas has also been less successful than other states in reducing reliance on services provided in public and private institutions (see chart on previous page[72]).

L.C. and E.W. v. Olmstead Supreme Court Ruling

In the Americans with Disabilities Act of 1990 (ADA), Congress described the isolation and segregation of individuals with disabilities as a serious and pervasive form of discrimination. Title II of the ADA, which proscribes discrimination in the provision of public services, specifies, *inter alia*, that no qualified individual with a disability shall, "by reason of such disability," be excluded from participation in, or be denied the benefits of, a public entity's services, programs, or activities.[73]

Congress instructed the U.S. Attorney General to issue regulations implementing Title II's discrimination proscription. One such regulation, known as the "integration regulation," requires a "public entity [to] administer … programs … in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Another section requires public entities to "make reasonable modifications" to avoid "discrimination on the basis of disability," but does not require measures that would "fundamentally alter" the nature of the entity's programs.

In the Americans with Disabilities Act of 1990, Congress described the isolation and segregation of individuals with disabilities as a serious and pervasive form of discrimination.

The *Olmstead* case was brought by two Georgia women, L. C. and E. W., whose disabilities include both mental retardation and mental illness. L. C. has been diagnosed with schizophrenia and E. W. with a personality disorder. Both women were voluntarily admitted to Georgia Regional Hospital (GRH) in Atlanta, where they were confined for treatment in a psychiatric unit. Although their treatment professionals concluded that each of the women could be cared for appropriately in a community-based program, the women were placed on a waiting list for community-based services and remained institutionalized at GRH.

"L.C. and E.W."
Lois Curtis and Elaine Wilson

"Olmstead"
Tommy Olmstead, Commissioner,
Georgia Dept. of Human Resources

Seeking placement in community care, L. C. filed suit against the State of Georgia. L.C. alleged that the state, in failing to place her in a community-based program once her treatment professionals determined this placement was appropriate, violated her right to live in the most integrated setting provided under Title II of the ADA. E. W. joined the suit, stating an identical claim. The district court granted partial summary judgment for the women, ordering their placement in an appropriate community-based treatment program. The court rejected the state's argument that inadequate funding, not discrimination against L. C. and E. W. "by reason of [their] disabilities],"accounted for their retention at GRH. Under the ADA, the court concluded, unnecessary institutional segregation constitutes discrimination per se, which cannot be justified by a lack of funding. The court also rejected the state's defense that requiring immediate transfers in such cases would "fundamentally alter" the state's programs.

The Eleventh Circuit affirmed the district court's judgment, but remanded the case for reassessment of the state's cost-based defense. The district court had left virtually no room for such a defense. The appellate court interpreted the statute and regulations to allow the defense, but only in limited circumstances. Accordingly, the Eleventh Circuit instructed the district court to consider, as a key factor, whether the additional cost for treatment of L. C. and E. W. in community-based care would be unreasonable given the demands of the state's mental health budget. Dissatisfied with the Eleventh Circuit's decision, the State of Georgia appealed the case to the U.S. Supreme Court.

On June 22, 1999, in a 6-3 decision, the U.S. Supreme Court issued its ruling in the *L.C. and E.W. v. Olmstead* case. Justice Ginsburg delivered the opinion of the court, concluding that, under Title II of the ADA, states are required to place persons with mental disabilities in community settings rather than in institutions when the state's treatment professionals have determined that community placement is appropriate; the transfer from institutional care to a less restrictive setting is not opposed by the individual; and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities.[74]

The Supreme Court, in interpreting Title II of the ADA and its implementing regulations, answered the fundamental question of whether it is discrimination to deny people with disabilities services in the most integrated setting appropriate. The court stated that, "Unjustified isolation . . . is properly regarded as discrimination based on disability." It further observed that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life" and "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

Source: Opinion of the Court: Olmstead, Commissioner, Georgia Department of Human Resources, et. al. v. L.C. Supreme Court of the United

Under the ADA, states are obligated to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity." Significantly, the Supreme Court provided specifics regarding the test as to whether a modification entails "fundamental alteration" of a program. The court indicated

that the test must take into account three factors: the cost of providing services to the individual in the most integrated setting appropriate, the resources available to the state, and how the provision of services affects the ability of the state to meet the needs of others with disabilities.

The ruling also requires that states demonstrate that they have a comprehensive, effective working plan, including timetables and progress reports, for placing qualified individuals in less restrictive settings. Further, states that maintain waiting lists must make a good faith effort to move people on the list to community-based programs, at a reasonable pace, not controlled by the need to keep its institutions fully populated.

The court cautioned, however, that nothing in the ADA condones termination of institutional settings for persons unable to successfully function in, or benefit from, community settings. Moreover, the state's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not unlimited.

Guidance from the Federal Government

Beginning with a "State Medicaid Director Letter" on January 14, 2000, the U.S. Health Care Financing Administration (HCFA) and the U.S. Department of Health and Human Services Office for Civil Rights (OCR) have issued extensive guidance to states regarding compliance with the *Olmstead* ruling. The January 14, 2000, letter states "the decision confirms what this administration already believes: that no one should have to live in an institution or a nursing home if they can live in the community with the right support."[75]

The HCFA/OCR guidance emphasizes that the Medicaid program can be an important resource to assist states in meeting the challenges laid out by the *Olmstead* ruling. HCFA/OCR points to the requirement, under Medicaid, that states periodically review the services of all residents in Medicaid-funded institutional settings as a possible key component to any *Olmstead* response. A later clarification issued by HCFA/OCR provides elaboration on the

Principles/Elements to Consider in Evaluating States' Plans

The plan ensures the transition of qualified individuals into community-based settings at a reasonable pace.

The plan ensures that individuals with disabilities benefit from assessments to determine how community living might be possible, without limiting consideration to what is currently available in the community.

The plan evaluates the adequacy with which the state is conducting thorough, objective and periodic reviews of all individuals with disabilities in institutional settings to determine the extent to which they can and should receive services in a more integrated setting.

The plan establishes procedures to avoid unjustifiable institutionalization in the first place.

The state has a reliable sense of how many individuals with disabilities are currently institutionalized and are eligible for services in community-based settings. The plan considers what information and data collection systems exist to enable the state to make this determination. Where appropriate, the state considers improvements to data collection systems to

role of the Medicaid program in states' efforts.

HCFA/OCR also elaborated on the court's call for comprehensive, effective working plans to demonstrate compliance. Technical guidance that accompanied the initial State Medicaid Director Letter provided a significant amount of detail on the elements any plan should have and the principles states should adhere to in developing and implementing those plans. The letter also makes it clear that the principles and practices contained in the technical assistance are to serve as the foundation for the OCR to fulfill its responsibility for investigating discrimination complaints involving the most integrated setting issue. OCR also has authority to conduct compliance reviews of state programs.

The technical guidance is extensive (see box on previous page [76]). The following highlights its more notable and relevant aspects. First, the guidance stressed that comprehensive, effective working plans are best achieved with active involvement of individuals with disabilities and their representatives in design, development and implementation. HCFA/OCR advised that states should explore a structure to ensure constructive, on-going involvement and dialogue with all stakeholders.[77]

Significantly, HCFA/OCR also emphasized that the court's decision regarding integration into community settings applies to all individuals with disabilities protected from discrimination by the ADA. Although *Olmstead* involved two individuals with mental disabilities, the scope of the ADA is not limited to such individuals, nor is the

Principles/Elements, Continued

The state evaluates whether existing assessment procedures are adequate to identify institutionalized individuals with disabilities who could benefit from services in a more integrated setting.

The state evaluates whether existing assessment procedures are adequate to identify individuals in the community at risk of placement in an unnecessarily restrictive setting. The plan ensures that the state can act in a timely and effective manner in response to the findings of any assessment process.

The plan identifies what community-based services are available in the state. It assesses the extent to which these programs are able to serve people in the most integrated setting appropriate (as described in the ADA).

The plan evaluates whether the identified supports and services meet the needs of persons who are likely to require assistance in order to live in the community. It identifies what changes could be made to improve the availability, quality and adequacy of the supports and how the identified supports and services integrate the individual into the community.

The state reviews what funding sources are available to increase the availability of community-based services. Planners should assess the extent to which these funding sources can be organized into a coherent system of long-term care which affords people with reasonable, timely access to community-based services.

The plan examines the operation of waiting lists, if any. It examines what might be done to ensure that people are able to come off waiting lists and receive needed community services at a reasonable pace.

The plan ensures that individuals who may be eligible to receive services in more integrated community-based settings are given the opportunity to make informed choices regarding whether--and how--their needs can best be met. Planners address what information, education and referral systems would be useful to ensure that people with disabilities receive the information necessary to make informed choices.

The state also examines how it can best manage the overall system of health and long-term care so that placement in the most integrated setting appropriate becomes the norm. It considers what planning, contracting and management

scope of *Olmstead* limited to Medicaid beneficiaries.

In addition, HCFA/OCR advised that the requirement to provide services in the most integrated setting appropriate not only applies to persons already in institutions, but to those being assessed for possible institutionalization.

On July 25, 2000, HCFA/OCR sent two new letters regarding *Olmstead* to state Medicaid directors. The first letter was in response to numerous questions from states and the disability community that were generated from the initial letter of January 14, 2000. The second letter was a follow-up to HCFA/OCR's commitment to review federal Medicaid policies and regulations. HCFA/OCR identified areas in which policy clarification or modification would facilitate states' efforts to serve more individuals in the most integrated settings possible.

The first letter presented and answered several questions. Of particular interest was a discussion of DHHS' recognition of housing, in the context of the *Olmstead* ruling, as a critical need. DHHS is working with the U.S. Department of Housing and Urban Development (HUD) to improve affordable, accessible housing opportunities for persons with disabilities.[78] This is important because Texas is examining the issue of housing for this population as well, which will be discussed later in the report.

The question of the scope of *Olmstead* was again raised in the July 25th letter. One inquirer asked, since the decision in *Olmstead* involved two women with mental retardation and mental illness, is the decision limited to people with similar disabilities? HCFA/OCR answered with an unqualified "no." The decision applies to all persons with disabilities protected by the ADA. The full range of questions and answers can be found at HCFA's web site: www.hcfa.gov.

The second July 25, 2000, letter details policy changes and clarifications that HCFA is making to give states greater flexibility to serve more people with disabilities in different settings. While the entire document can also be found on the HCFA web site, there are a few policy changes that specifically address barriers identified by the House Committee on Human Services.

One such policy change involves the time it takes to determine eligibility for home and community-based waiver programs. Under current HCFA policy, states must meet several criteria before providing services through a waiver program in a home or community setting. The committee's research has shown that the time it takes to determine eligibility and provide community-based services is exponentially longer than the time needed for a nursing home placement. This extended time frame is often a barrier to a successful community placement. One of HCFA's requirements that extended eligibility determination time was the requirement that services be furnished according to an extensive, specific written plan of care. Under HCFA's policy change, a provisional plan of care which identifies the essential Medicaid services that will be provided in the first 60 days while an in-depth plan is being developed, will

HCFA is revising its policies to allow targeted case management during the last 180 consecutive days of a Medicaid recipient's institutional stay, if provided for the purpose of community transition.

now be accepted for eligibility determinations.[79]

Another identified barrier to successful transition into the community is the unmet need for "transition assistance" or case management to assist with the complicated planning involved. The second July 25th letter also provides clarification of the multiple ways case management may be furnished under the Medicaid program. HCFA also revised its policies to allow targeted case management during the last 180 consecutive days of a Medicaid recipient's institutional stay, if provided for the purpose of community transition.

Many more important policy clarifications and changes were delineated in the July 25th correspondences, including the circumstances under which Medicaid dollars can be used to assess the need for architectural modifications or actually make such modifications. As policymakers and program managers move forward to respond to *Olmstead*, DHHS' policy guidance, including any forthcoming correspondences, should be given due consideration.

Background on the Governor's Executive Order and the Promoting Independence Plan

On September 28, 1999, Governor George W. Bush issued Executive Order GWB 99-2, initiating Texas' efforts to respond to the *Olmstead* ruling. In the order, the governor affirmed that "the State of Texas is committed to providing community-based alternatives for people with disabilities and recognizes that such services advance the best interests of all Texans" and that "programs such as Community Based Alternatives and Home and Community Services provide the opportunity for people to live productive lives in their home communities."[80]

The executive order directed the Texas Health and Human Services Commission (HHSC), under the leadership of Commissioner Don Gilbert, to conduct "a comprehensive review of all services and support systems available to people with disabilities in Texas" and to "examine these issues in light of the recent United States Supreme Court decision in *Olmstead*."

The governor also directed HHSC to analyze the availability, application and efficacy of existing community-based alternatives for people with disabilities. The review is to focus on "identifying affected populations, improving the flow of information about supports in the community, and removing barriers that impede opportunities for community placement." HHSC intends to submit a report, as directed by the governor, to the governor, lieutenant governor, speaker of the house, and appropriate committees of the 77th Legislature no later than January 9, 2001. The report will include specific recommendations on how Texas can improve its programs for people with disabilities by legislative or administrative action. All affected agencies and public entities were directed by the governor to cooperate fully with HHSC's research, analysis and production of the report.

Through the executive order, the governor also stressed that HHSC should ensure the involvement of

consumers, advocates, providers, and relevant agency representatives in this review. HHSC's plan is entitled the Promoting Independence Plan. Meeting the governor's call for inclusion, an advisory board of advocates, parents, agency board members, and long-term care industry representatives was formed to work with HHSC in developing the plan.

The Promoting Independence Advisory Board has been meeting at least monthly since February. This group of volunteers has held seven public hearings and several more work sessions. The group has been working diligently to meet Commissioner Gilbert's charge to the advisory board to "provide guidance to the HHSC in the evaluation of the system of services and supports for people with disabilities in order to assure that Texans with disabilities have access to alternatives to institutional care when community care is preferable."[81]

Overview of Initial Promoting Independence Plan Findings and Proposed Agency Efforts

The advisory board has identified four areas of focus: 1) the current process for identifying people in institutions who may want to consider community-based services and the assessment process after that identification takes place, the accessibility of information used in evaluating community services, and how it is determined what community services are appropriate and adequate; 2) the delivery system's current capacity to serve identified individuals and those at imminent risk in the community; 3) barriers to implementation; and 4) funding.[82] While the advisory board has made progress in reviewing service delivery capacity issues and barriers to implementation, it has taken longer than expected to review agencies' processes for identifying clients in institutions who may desire transfer to the community.

Historically, no coordinated effort has been made to quantify the need for community services for institutionalized clients who have been recommended for, and expressed an interest in, community placement. As a starting point, HHSC and the relevant agencies developed initial estimates of those individuals who are currently known to the state in various settings, and plans are being developed for their transition. Further, relevant agencies have worked with the Promoting Independence Advisory Board to develop procedures for identification that are both timely and routine.

State Schools: As of September 1, 1999, HHSC had identified 409 individuals in the 11 state schools and the El Paso and Rio Grande State Centers, who have been recommended for, and expressed an

Institutionalization in Texas

As of September 1, 1999, there were approximately 98,000 people living in institutional settings in Texas, including:

66,500 in nursing homes,

3,100 in large Intermediate Care Facilities for the Mentally Retarded (ICF-MRs),

5,400 in state schools for people with mental retardation, and

2,400 receiving inpatient services in state hospitals for people with mentally illness.

Source: Texas Health and Human Services Commission. Draft Promoting Independence Implementation Plan. July 18, 2000.

interest in, community placement. The Texas Department of Mental Health and Mental Retardation (MHMR) is committed to making community options available to these 409 individuals by August 31, 2001.[83] For clients identified for community transfer under *Olmstead* criteria in the future, MHMR is committed to providing community options within 180 days of the recommendation and request for placement.

Large ICF-MRs: The state initially identified 216 persons in ICF-MRs of more than 14 beds who are on the waiting list for the Home and Community Services (HCS) waiver program, i.e., the waiver program for ICF-MR residents. Beginning December 2000, these individuals will be assessed for appropriateness for the HCS waiver program. Under the Promoting Independence Plan, community options will be offered to those who qualify no later than August 31, 2002, unless it is determined that the provision of these services would require a "fundamental alteration" in the state's programs. Under the plan, for those who are identified as appropriate in the future, community opportunities will be offered within 12 months.

MHMR has conducted further identification efforts to project the number of adults in nine-bed or more ICF-MRs and children in ICF-MRs of any size on the HCS waiting list. MHMR concluded that there are 402 individuals as of July 9, 2000.[84] MHMR also identified 269 total children in the entire ICF-MR program who are not currently on the waiting list. MHMR assumes all of the 269 children would be eligible for and would choose a community-based alternative. Based on these figures and estimates of ICF-MR residents not on the HCS waiting lists, MHMR projected that 1,278 individuals would be eligible for and would choose alternative services if made available.

Medicaid Waiver Programs

Many community-based programs are referred to as "waiver programs" because the federal government allows states to "waive" certain Medicaid requirements, thus permitting Medicaid dollars to be spent in the community. Examples include:

Community-Based Alternatives (CBA)
A "waiver" off the nursing home program for people over 21 who qualify for nursing home care.

Home and Community Services (HCS)
A "waiver" off the ICF-MR program for persons with mental retardation.

Community Living Assistance and Support Services (CLASS)
A "waiver" program off the ICF-MR program for people with developmental disabilities other than mental retardation.

State Hospitals: The majority of in-patient care in state hospitals is relatively brief, lasting no more than a few weeks.[85] However, some treatment needs require longer stays. As of October 1, 1999, 54 individuals being treated in state hospitals for longer than 12 months were identified for discharge into the community.[86] The Promoting Independence Plan does not include time lines for addressing the needs of those recommended for discharge at this time.

Nursing Homes: The Promoting Independence Advisory Board and the committee found that the lack of information about the need for community services for residents who have been recommended for, and have expressed an interest in, community placement is especially profound in nursing homes. For state schools, large ICF-MRs and state hospitals, there is a process in place to

identity individuals for whom community transfer is appropriate and desired. There is no such process in nursing homes and no estimates of possible transfer candidates exist.

On October 29, 1999, a new DHS rule became effective. The new rule grants an exception to the first-come, first-served rule in the Community-Based Alternative (CBA) program, the waiver program for nursing home residents. The exception is granted to individuals who have resided in a nursing home within the last six months and will now automatically move to the top of the waiting list for CBA eligibility determination. However, it is clear that without ensuring that all individuals with disabilities in nursing homes are aware of available community options and this rule change, the success of the state's efforts to respond to *Olmstead* in nursing homes will be limited. A routine process for making residents aware of their options and identifying and assessing those residents for appropriateness to be served in the community should be established.

Agencies' Proposed Identification and Assessment Efforts

MHMR and DHS are the agencies involved in developing processes to better identify people in institutions who may be interested in and appropriate for community placement. Much of the Promoting Independence Advisory Board and the committee's interim work has focused on the agencies' proposals.

MHMR: For the state school population, MHMR has developed a process that the agency believes serves as an adequate identification and assessment tool under the Promoting Independence Plan. Use of the Person Directed Planning process and the Community Living Options instrument to discuss options with residents has been required since February 2000.[87] This process occurs during the annual scheduled "staffing" for each resident. However, if there is a change in the resident's condition or an interest is expressed before the scheduled staffing, the process is initiated at once. While MHMR believes this process is sufficient, there was discussion of a need for more qualified staff to adequately perform the identification and assessment duties.

Person Directed Planning process and the Community Living Options instrument

The Person Directed Planning process identifies, explores and emphasizes the goals, desires and dreams of the person with a disability. The professionals participating in the planning process assist the individual in overcoming barriers to achieving his or her personal goals.

The Community Living Options instrument is a worksheet used in conjunction with the section of the Person Directed Planning process that focuses on living arrangements for the person with a disability.

MHMR has proposed a process, starting September 2000, in which ICF-MR providers will be asked to use the Person Directed Planning process and the Community Living Options instrument to annually discuss options with residents on the HCS waiting list. A rule change scheduled for the fall of 2000 will make the process mandatory. The process will occur at least annually, but if there is a change in the person's condition or an interest is expressed, the process will be initiated immediately. If the resident expresses an interest in community options, the local Mental Retardation Authority (MR) will be contacted, provided

with a profile of the resident and directed to establish contact to explore the resident's desire for community placement. If transfer to the community is desired, the MR will conduct a more extensive assessment. Also, beginning September 2000, the MR will be responsible for reviewing the entire HCS waiting list to confirm the preferences of those on the list. MHMR stressed that utilizing this type of process would be a paradigm shift within ICF-MRs.

Regarding persons with mental illness in state hospitals, MHMR maintains that the paradigm shift toward keeping stays as temporary as possible has already occurred. Approximately 65 percent of those receiving inpatient treatment are discharged within 30 days. It was also pointed out that the court controls about 90 percent of admissions. In light of these dynamics, no new identification and assessment process has been proposed for state hospitals

DHS: On July 20, 2000, DHS presented a detailed proposal for a sequential, multi-phase identification process in nursing homes. Phase One, which could be implemented with existing resources by September 2000, consists of written notification to the authorized representatives of nursing home residents, new applicants and SSI recipients, explaining the CBA option. Persons identified as interested would be referred for CBA eligibility determination. DHS also proposed that various community awareness activities could begin in Phase One.[88]

If additional resources can be allocated to DHS for Fiscal Year 2001, the agency proposes more intense relocation and community awareness activities. Twenty new staff would conduct outreach and identification activities in five urban areas. Contracts with local Areas on Aging, Independent Living Centers and/or other community organizations would be entered into to perform relocation activities. Permanency planning activities for children in nursing homes would also be intensified with the allocation of additional funds.

Source: Texas Department of Human Services (DHS). DHS Plan to Address Promoting Independence in Nursing Facilities. July 19, 2000.

DHS proposed that Phase Two would involve the building of an infrastructure similar to the MHMR local system, and include funding for "relocation specialists" to transition residents from nursing homes. Contingent on an appropriation from the 77th Legislature, Phase Two would be implemented over a two-year period beginning September 1, 2001. As proposed, year one would begin with the hiring and training of relocation specialists and other related personnel, development of an identification and assessment process, and a pilot of the process in five urban counties. Year two of Phase Two would be full statewide implementation.

DHS' Phase Three contemplates a preventative approach to focus on diversion from institutionalization in the first place. This phase would go beyond the activities of phases one and two and include placement of additional staff in hospitals to assist with pre-admission and admission screening activities. Phase Three would not occur until the 2004-2005 biennium.

While it has dominated much of its time, the Promoting Independence Advisory Board's work has not been limited to overseeing the aforementioned agency proposals. The board has heard extensive public testimony on a variety of related issues, including several presentations on the structure of different service

delivery systems in Texas, the capacity of the provider community, the role of hospital discharge planners, the possible role of community-based organizations, and the multitude of barriers that face individuals who desire transfer to the community.

Identified Issues and Barriers to Reducing Inappropriate Institutionalization

Through public hearings, workgroups and extensive research, both the House Committee on Human Services and the Promoting Independence Advisory Board have identified multiple issues and barriers that should be addressed if the state is to effectively respond to *Olmstead*.

Lack of awareness of available state-provided, community-based options is a key barrier to community placement. Too often, doctors, hospital discharge planners, family members, and individuals with disabilities are not fully aware of the range of community-based options that may be available. When a patient is leaving the hospital, nursing home placement may be the only widely-known option. Further, there is not an adequate process to outreach, identify and assess individuals who may be interested in a community-based alternative.

Barriers to Community Placement

- Individual's lack of awareness of options;
- Inadequate outreach and identification process;
- Hospital discharge planners and doctors lack of awareness of options;
- Community-based programs' eligibility procedures;
- Legitimate fear and anxiety;
- Lack of support in dealing with fear, anxiety and basic transition issues;
- Lack of affordable, accessible and integrated housing;
- Extensive waiting lists;
- Individual cost-caps for community-based programs.

Eligibility procedures for community services are another barrier to reducing inappropriate institutionalization. Especially when compared to the time it takes to place an individual in a nursing home, eligibility procedures for community-based alternatives take far too long. The use of presumptive eligibility makes nursing home placement occur timely. Determining eligibility and getting CBA services to an individual can take an average of 90 to 120 days.[89] The same process can take between 60 and 90 days for the Frail and Elderly Program, another community-based program at DHS. The lack of presumptive eligibility and several other requirements, many of them federal, that must be met before CBA services can be provided are to blame for the length of the process. For example, a detailed official plan of care must be completed before CBA services can be initiated. A home health provider must also be identified to outreach the individual and perform the required medical assessment. Further, nursing homes have the ability to bill for services three months retroactively for most residents and often require a deposit from the individual in case eligibility is denied. CBA providers do not have the luxury of billing three months retroactively.[90]

Once an individual and his or her family have made the difficult decision to enter an institution and the individual has become accustomed to living there, there is often legitimate fear and anxiety about moving

into the community. Fear and anxiety are barriers to community transition. There are also a number of basic transition issues and tasks associated with relocation to a community-based alternative. In addition to overcoming the anxiety brought on by these issues, there is often a need for assistance with many related tasks. For example, an individual who has lived in an institution for many years could need assistance with basic paperwork for securing an apartment, setting-up utilities and scheduling attendant care in the home. Many individuals do not have the time-limited transition assistance that is necessary for a successful transition.

Affordable, accessible and integrated housing for persons with disabilities is limited.[91] In most communities, there are few housing units available to people who live on disability income . While progress has been made through passage of the Fair Housing Act and the ADA, there is limited availability of accessible units for people who require modifications to their living environment.

Too often, housing that is made available to persons with disabilities is not integrated, but takes the form of group homes and residential treatment settings. It is not uncommon for an individual to request community placement, be deemed appropriate, but be unable to receive services in the most integrated setting because no housing is available.

Waiting lists for community-based services are another significant barrier to reducing inappropriate institutionalization. There are currently 62,200 individuals on waiting lists for community-based services in Texas. Often, because of waiting lists, individuals enter institutions when they could have been better served in the community. In some cases, while waiting on a list, an individual's condition degenerates to the point that institutional care is the only available option. Many community-based programs have average waiting list times of between three and seven years.[92]

The inadequacy of some community-based alternatives in meeting the needs of persons with disabilities and individual cost-caps on community services are also barriers to reducing inappropriate institutionalization. For example, while the Frail and Elderly Program at DHS does not provide prescription drug coverage, the nursing home program does.[93] Many Frail and Elderly Program participants must enter nursing homes solely to receive the drug coverage they cannot afford. Further, individuals who are functioning well in the CBA program can be forced into nursing homes because the cost of services they are receiving increases slightly, resulting in the surpassing of arbitrary individual cost-caps. In community-based programs, the lack of delegation of some tasks by nurses to less costly attendant care can also drive up costs unnecessarily.

Closing Comments

While the *L.C. and E.W. v. Olmstead* Supreme Court ruling was the impetus behind the governor's executive order, the Promoting Independence process and the House Committee on Human Services' related charge, the resulting changes to the service delivery system for persons with disabilities should be seen in a broader context than the court's decision. The scope and breadth of the ruling, and the responsibilities it places on states, can be argued. However, as Governor Bush emphasized in his executive

order, Texas' response should not just be about basic compliance with the ruling, but rather about "undertaking] a broader review of our programs for people with disabilities and enduring] services offered are in the most appropriate setting."

Taking a broader approach and ensuring that services are provided in the most appropriate setting for all persons with disabilities will take significant changes, both cultural and procedural, to the service delivery system. Throughout the interim, the relevant agencies have worked to develop proposals to change their policies, the procedures of the provider base and the culture of the entire system. Similarly, the Promoting Independence Advisory Board and the Committee on Human Services have received input from consumers and advocacy groups proposing innovative ideas and highlighting barriers that must be addressed.

As the state moves forward on this issue, the committee believes it is important to have a coordinated approach regarding all the proposals. While the process being conducted by HHSC is not yet complete, the committee is concerned that there is a lack of coordination between the processes being planned at DHS and MHMR. Furthermore, there seems to be a need for a more coordinated approach to incorporation of some of the innovative ideas presented to the Promoting Independence Advisory Board by the agencies.

Both plaintiffs in the *Olmstead* case had mental illnesses. Many of the supports that are lacking in the community for persons with physical disabilities are also lacking for persons with mental illness. Unfortunately, the issues of persons with mental illness have received little attention during both the Promoting Independence process and the House Committee on Human Services' hearings. In presenting a Promoting Independence Plan for individuals with mental illness in state hospitals, MHMR maintained that the paradigm shift toward keeping stays as temporary as possible has already occurred. MHMR also pointed out that the court controls about 90 percent of admissions. No new identification and assessment processes have been proposed for state hospitals.

There is just as much need for the state to address the issues surrounding mental illness as there is for other disabilities. While each stay at a mental hospital may be temporary, individuals often cycle in and out of these institutions. For those individuals with mental illness, the lack of adequate supports in the community may not manifest itself in long-term institutionalization, but rather in a cycle of short-term commitments that is not healthy for the individual or the community. Similar to what is being planned with other populations, the strengthening of appropriate community supports for persons with mental illness could reduce repeated and unnecessary institutionalizations. More routine mental health services in the community, increased stable housing options for people with mental illness, and access to assistance with routine daily living activities when needed, should all be considered. More attention should be focused on addressing the issues of persons with mental illness in the Promoting Independence process.

The institutionalization of children is a tragedy which warrants the state's full attention. Both the Promoting Independence Advisory Board and the Committee on Human Services heard testimony on this issue and conducted further research on strategies to eliminate the institutionalization of children. This report makes recommendations that speak specifically to this problem. However, the committee believes that this issue

deserves more consideration. As directed by Senate Bill 374, 76th Session, HHSC formed the Children's Long-Term Care Policy Council. The policy council's volunteer members and HHSC support staff have devoted considerable time to researching and developing recommendations that would help the state reduce and prevent the institutionalization of children. The policy council's report, "Moving to a System of Supports for Children and Families," should be given serious consideration by policymakers if the state is to adequately address the problem of children growing up in institutions.

Finally, the committee also believes that, in working to ensure compliance with the *Olmstead* ruling, the state should consider placing a higher degree of emphasis on reforms that minimize unnecessary institutionalizations before they occur. The *Olmstead* ruling and much of the deliberations in Texas this interim were focused on identifying and transferring individuals who are currently in institutions. While addressing the needs of individuals already in institutions is central to *Olmstead*, it is counterproductive not to focus on unnecessary institutionalizations before they occur. The task of transitioning someone already in an institution is an extremely difficult and often lengthy process. That process never ends if there continues to be an influx of inappropriately institutionalized individuals. The committee is concerned that some of the agencies' proposals and the work of the Promoting Independence Advisory Board have placed a chronological priority on intense efforts to identify clients already in institutions. Strong consideration should be given to minimizing inappropriate institutional placements.

Recommendations

1. Recommend that the Legislature authorize and fund a comprehensive pilot and sequential "roll-out" that encompasses concepts presented to the committee and the Promoting Independence Advisory Board.

To effectively model the proposed system-wide changes contemplated by this committee and the Promoting Independence Advisory Board, several innovative concepts should be piloted together. One comprehensive pilot program, modeled in multiple sites with a pre-determined plan for "roll-out," would best aid state policymakers in redesigning the long-term care service delivery system. There are several approaches and concepts that a pilot project could include:

- A comprehensive approach to testing new policies and procedures to ensure that individuals with disabilities are not inappropriately placed in institutional settings in the first place. Pre-admission screening processes could be reformed, physician and hospital discharge planners could participate, and the effectiveness and resultant savings could be evaluated.

- A program to work with, train and educate hospital discharge staff and physicians to reduce unnecessary placement in nursing homes and other institutions and increase knowledge and utilization of community-based alternatives. Under this pilot, the Legislature could require doctors and discharge planners to inform patients of the full spectrum of long-term care options prior to making long-term care placement decisions. Further, the Legislature should explore requiring doctors and discharge planners to contact a "permanency planning specialist" prior to making a long-term care placement decision.

- A housing program to provide housing assistance to persons with disabilities in the community and to increase the number of accessible and affordable housing units in existing stock and through new construction. The program could provide rental subsidies in the form of vouchers for individuals identified for *Olmstead* transition. Another aspect of the program could be a project-based rental subsidy to encourage developers to build more accessible units, which could be earmarked for *Olmstead* transition.

- A program of "transition case managers" to assist individuals identified for transition in moving out of institutions and integrating into the community. There are many basic transition issues for which

individuals could use assistance. The transition period is crucial for a successful community outcome, and the intensity of this type of case management would not have to be sustained beyond a transition period.

- The funding of grants to community-based organizations to conduct third-party outreach and identification initiatives in institutional settings. Various community-based organizations have the capacity and experience to conduct effective outreach and identification efforts. By entering into partnerships with community-based organizations, the state could maximize its resources.

- Authorization of the use of "presumptive eligibility" for community-based programs. Nursing homes have the advantage of presumptive eligibility to facilitate prompt placement. Title III, Title XX and Options for Independent Living funds could be used to provide services to clients who are later found financially ineligible.

- A provision that if third parties are involved in state-supported outreach efforts in state schools, qualifications will be established for all those who have contact with residents; legal guardians will be required to be present during any visits; and the state will prohibit all third-party participants from being alone with a resident.

The Legislature should direct HHSC to evaluate all promoting independence related pilot programs to establish official statewide policies and procedures. Establishment of any related pilot programs should include the explicit expectation that improved statewide policies and procedures will be adopted from lessons learned in the various sites.

2. Recommend that the Legislature fund additional slots to significantly reduce the waiting lists for community-based waiver programs.

Any effort to reduce inappropriate institutional placements is hindered by the existence of significant waiting lists. Until the community-based program waiting lists are reduced or eliminated, unnecessary institutional placements will continue due to lack of access to community options.

3. Recommend that the Legislature explore strengthening the mechanisms and adopting budgeting approaches that allow funds to "follow" the individual who leaves the institution for community-based programs.

In many cases, agencies already have the ability, with varying approval requirements, to transfer funds from an institutional line-item to a community line-item. However, budgeting approaches that dedicate funds and performance measures to each program without explicit direction regarding the transfer of those funds are a barrier to the "funds following the person" when a transfer occurs. The state should explore ways to budget for projected transfers out of institutions and into community-based programs. New budgeting concepts could be tested regionally in the context of a pilot.

4. Recommend that the Legislature direct DHS to incrementally raise the individual expenditure cap in the Community-Based Alternatives (CBA) program annually and assess each increase's effect on waiver cost-effectiveness.

The individual expenditure cap for the CBA program is set at 100 percent of the individual's costs under the nursing facility program. Medicaid waiver programs at MHMR have individual expenditure caps at 125 percent of non-waiver program costs. Because many consumers' expenditures are below 100 percent of non-waiver program costs, aggregate cost-neutrality for the waivers is maintained. Lower individual annual cost-caps penalize people with the most significant support needs. Small changes in a person's care plan can cause him or her to "cost out" of the community and be forced into a nursing home. Incrementally increasing the individual caps could

prevent unnecessary institutionalizations, while guarding against violating the federal government's cost-neutrality requirements.

5. Recommend that the Legislature authorize prescription drug coverage for clients in the Frail and Elderly Program at DHS.

A major barrier to people with disabilities remaining in the community is the ability to pay for prescriptions. The Frail and Elderly Program at DHS only provides attendant services. A participant's high prescription drug costs can force him or her to access more costly, full Medicaid coverage through the nursing facility program or the Community-Based Alternatives Waiver. A DHS exceptional item in its Legislative Appropriations Request for 2002-2003 would provide three prescriptions per month to 25,000 clients and would divert clients from more expensive programs.

6. Recommend that the Legislature require the development of a notification system for DHS when a child's admission to a long-term care institution is approved.

DHS often does not know about a placement until the "bill" for admission is received. There may be a way to have DHS's automation system generate a list whenever a child is admitted. This could trigger a permanency planning team to intervene to ensure that full choice was explored and the placement is appropriate.

7. Recommend that the Legislature clarify the requirement that permanency planning occurs for every child in an institution.

Inappropriate institutionalization is especially troubling in the case of children. Every effort should be made to keep children from having to grow up in an institution. While statutes require permanency planning, there is concern that this does not consistently occur.

8. Recommend that the Legislature authorize children in the state's custody with severe long-term care needs to bypass the waiting lists for community-based waiver programs and fund

dedicated waiver slots.

Children in the state's custody are sometimes placed in institutions because waiting lists block access to waiver programs. Statewide, the number of children who would benefit from such a bypass would be relatively small. The state could request permission from the federal government to allow these children to bypass the waiting lists. Further, the state would need to create and fund a "pool" of community-based waiver program slots that could be disbursed statewide as needed.

9. Recommend that the Legislature establish safeguards to ensure the safety of individuals who are transferred to community-based programs.

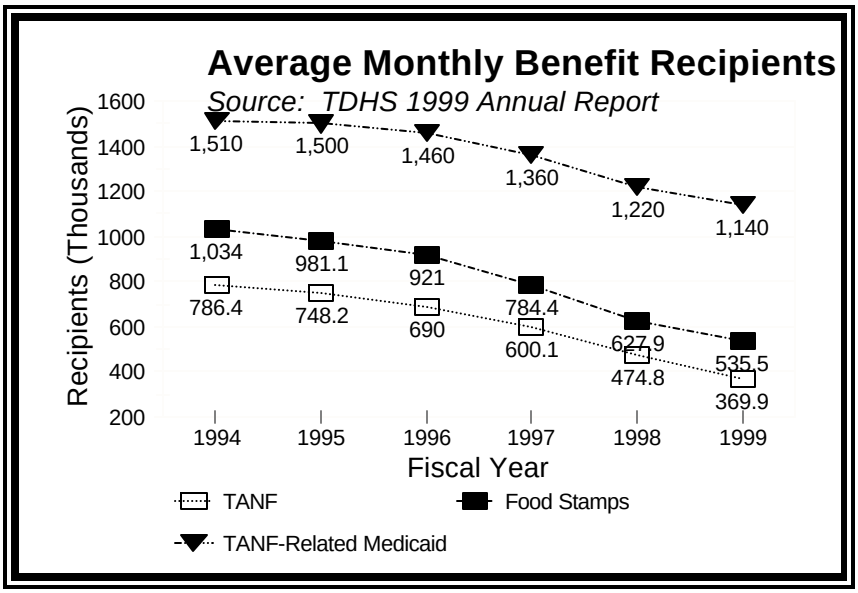
While the least restrictive environment is preferred, without proper support, an individual may end up in more danger and remain isolated in the community. The Legislature needs to ensure that DPRS has adequate resources to address possible increased investigations in the community.

CHARGE 4: Study the current public assistance eligibility, application and review processes, and other Department of Human Services' client communications to ensure that clients are getting the supports necessary to make a successful transition to self-sufficiency.

Introduction

Public assistance programs such as Temporary Assistance to Needy Families (TANF), the Food Stamp Program and Medicaid provide vital supports for low-income Texans. There have been major changes in enrollment processes since 1994, which have increased the difficulty in accessing benefits. All programs have seen major caseload declines since 1994, yet the level of poverty has not decreased significantly during this period.[94]

State and federal legislation reforming the cash assistance program, or welfare, was implemented beginning in 1996. A review of research and testimony presented to the House Committee on Human Services indicates that efforts by the state to reduce the TANF caseload contributed to the decline in Food Stamp and Medicaid participation, leaving hundreds of thousands of eligible Texans without vital services.



Food Stamp participation declined by nearly 50 percent between 1994 and 1999. Approximately 12 percent of this reduction can be attributed to legislation barring certain legal immigrants from receiving benefits.[95] However, almost two-thirds of recipients who left the Food Stamp Program after finding employment remained eligible based on their income.

There were also significant declines in the number of Medicaid recipients, despite the fact that applications for Medicaid from low-income families actually increased between 1994 and 1999.[96] As with Food Stamp participants, many leaving Medicaid remained eligible based on income.[97] Children accounted for a large portion leaving Medicaid. By 1999, some 193,400 fewer children were enrolled in Medicaid, a 14.2 percent decline.[98]

The committee was charged with studying the process by which low-income Texans access these benefits. This report highlights issues related to public assistance enrollment that have contributed to steep declines.

Throughout the interim, the committee studied the needs of those still living in poverty as well as the impact public assistance programs can have on the poor and working poor in this state. Following the section on enrollment issues, the report discusses the challenge of using public assistance to improve the well-being of children, working families and immigrants.

Issues Related to Public Assistance Enrollment and Re-Certification

Many of the changes affecting public assistance enrollment and re-certification are relatively new. Since 1996, the state has been altering programs dramatically to emphasize the importance of employment versus dependence on cash assistance. The Department of Human Services (DHS), the agency responsible for enrollment in each program, was given the challenge of implementing these reforms. Changes such as client diversion and TANF caseload reduction have had an impact on Food Stamp and Medicaid enrollment. Clients today encounter greater difficulty in both receiving and maintaining benefits. DHS was also responsible for improving the quality of fraud control and error reduction for these programs during the period since 1996. These changes impact the process of obtaining benefits as well. During this same period, the Texas Legislature cut the number of eligibility workers, thereby increasing the workload. Turnover among these workers nearly doubled. Finally, recent guidance by the Immigration and Naturalization Service pertaining to benefits legal immigrants can access, without endangering their ability to change their status in this country, have not been adequately communicated by DHS. This has slowed the reinstatement of benefits to Legal Permanent Residents.

Client Diversion

It is important to note that, while caseload declines in all programs have occurred, the number of applications for benefits has remained about the same. A diminishing Food Stamp and Medicaid caseload cannot be entirely attributed to declines in TANF recipients. Other policy changes related to TANF may also contribute to steep declines.

For instance, DHS instituted changes in TANF program administration in order to emphasize the importance of work at the time of certification. Part of this approach calls for workers at local offices to attempt to divert cash assistance applicants from applying at all. Workers are directed to explain

Messages for Potential Clients

Communicate these messages at the pre-application phase as well as during the eligibility interview. Choose the appropriate message for every contact you make.

- "There's a lifetime limit on how long you can receive cash assistance. The economy is good at this time and you may want to look for a job now and save your benefits in case you have to use them later."
- "Work comes first; welfare should be a last resort."
- "Providing for your family is your responsibility. You are expected to use your strengths, talents, and abilities to support yourself and your family."
- "We want you to find and keep a job. Or, if you have a job, we want you to get a better job that will provide long-term benefits for you and your family."
- "You work to become self sufficient and independent. Your children learn good work habits that they can take into the job market with them. Remember, work is good for you and your children."
- "When you work, you are a positive role model for your children."

the time-limited nature of TANF and to encourage applicants to search for work before seeking benefits. The box on the previous page is an excerpt from the DHS Texas Works Advisor Training Manual, which illustrates common statements applicants hear when applying for TANF.

Testimony to the committee suggests that client diversion may have a chilling effect on Medicaid and Food Stamp enrollment. Applicants who enter a DHS office may not be entirely clear about the help they need. A caseworker may not distinguish between a client's need for food or health coverage and the need for cash benefits. If an applicant wants to apply for all three benefits, the diversion message is delivered. The Legislature may need to direct DHS to clarify these messages so that employees are able to distinguish between TANF, Food Stamp, and Medicaid Program guidelines.

The Link Between TANF Cash Assistance, Medicaid and Food Stamps

Traditionally, there has been a link between cash assistance and the Food Stamp and Medicaid Programs. Applicants typically access all of these benefits at the same location. Enrollment for all of these programs is administered within the same division of DHS. Therefore, policy and administrative changes to one program may have an effect on the others.

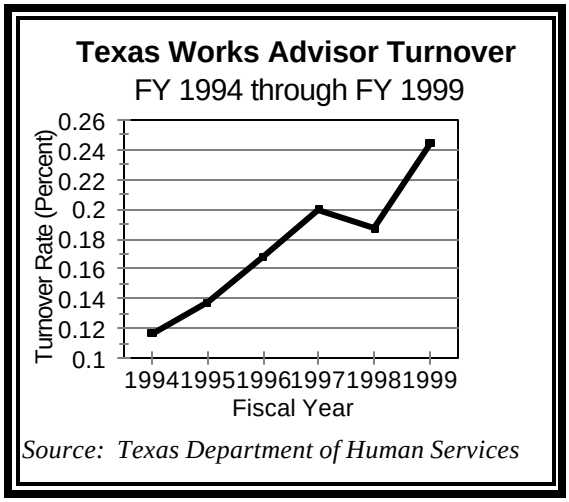
The link between TANF, Medicaid and Food Stamps is most apparent when looking at caseload declines in TANF relative to declines in the other programs. A study conducted by Texas A&M University indicated that only 65 percent of individuals leaving TANF (or AFDC) continued to receive Food Stamps and Medicaid.[99] As large declines occur in TANF each month, an increasingly smaller number of people take advantage of Food Stamps and Medicaid. Further, the percentage of former TANF recipients who left the rolls without Medicaid, Food Stamps, or both, increased by ten percent between 1995 and 1999.

> "States must determine whether individuals and families lost Medicaid coverage when their TANF case was closed, or when their TA coverage period ended without a proper notice or without a proper Medicaid redetermination, including an ex parte review consistent with previous guidance."
>
> -HCFA Letter to State Medicaid Directors, April 7, 2000

The Personal Responsibility and Work Opportunity Reconciliation Act, the federal welfare reform legislation passed by Congress in 1996, contains language related to de-linking Medicaid from TANF. House Bill 820, 76th Session, was an attempt to bring Texas into compliance with federal regulations by requiring DHS to notify individuals leaving the TANF Program that they or their children might still be eligible for Medicaid. The Health Care Financing Administration also sent letters to all State Medicaid Directors providing guidance regarding each state's responsibility to ensure that those who leave the cash assistance rolls retain Medicaid benefits when eligible. Similar guidance was sent to commissioners of human services from the U. S. Department of Agriculture related to the Food Stamp Program. DHS began implementation of HB 820 in January 2000, and the agency conducted a review of its operations to ensure that it was in compliance with federal guidelines. These actions are a good start, but more needs to be done to eliminate the impact of TANF reforms on both Medicaid and Food Stamp enrollment.

Staff Turnover and Workload Increases at DHS Local Offices

Texas Works Advisors, the eligibility workers for Texas' public assistance programs, face increasing challenges during the era of welfare reform. As policy changes increase the emphasis on error reduction and fraud control, the duration of interviews increases as well. Despite the fact that the number of applications remained constant or increased, the number of full-time DHS employees was cut by the Legislature.[100] Possibly as a result of these burdens, the turnover rate among Texas Works Advisors more than doubled between 1994 and 1999.



Source: Texas Department of Human Services

Much of the turnover occurred among seasoned employees leaving DHS for better paying jobs. This has serious consequences for the quality of client services and communications. With fewer experienced staff members, new hires lose the benefit of their mentoring. New workers must put a significant portion of their effort into quality control, and less time is spent interacting with clients who may need guidance in negotiating a complicated system.

Turnover also places an increased burden on local DHS offices because managers must scramble to keep their offices adequately staffed. Further, regional staff at DHS have had to double their recruitment and training efforts. Texas Works Advisor Training is four weeks in duration, a lengthy and costly endeavor. Unfortunately, low unemployment, relatively low wages at DHS and the complicated nature of the Texas Works Advisors' job ensure that the problem with turnover will not end soon.

Fraud and Error Control

In response to a poor rating in 1994 by the U. S. Department of Agriculture, the federal agency responsible for the Food Stamp Program, DHS implemented several strategies to reduce errors. For instance, to decrease fraud, all recipients and household members are required to be fingerprinted before they can receive Food Stamps. The agency also created specialized case workers to conduct pre-certification investigations. These workers actually visit client homes, their neighbors and their workplace in order to verify applicant information. Many recipients are now required to visit a DHS office every one to three months in order to maintain their benefits. Although these measures assist DHS in preventing errors, they also create additional requirements for

Fraud Prevention Measures

* Shortened certification periods;
* Pre-certification investigations;
* Computerized verification; and
* Finger Imaging

clients, which may result in barriers to the program, particularly for working adults.

While eliminating fraud and lowering error rates are essential responsibilities of DHS, quality control efforts must be balanced with efforts to ensure access to benefits. More frequent case reviews in the Food Stamp Program force clients to take more time off work. They must also locate child care and transportation, which may not be readily available in some areas of the state. Furthermore, the criteria for determining which households must re-certify more frequently vary according to DHS regions. In every region families with uncertain or fluctuating incomes are required to re-certify more frequently than those households on fixed incomes or no potential for earned income (as is often the case for elderly clients or clients with disabilities). Many DHS offices even require monthly re-certification for employed clients. In effect, the agency is inadvertently mandating a much more onerous process for those who work.

The finger imaging system may also present a barrier to obtaining Food Stamps for some families. DHS requires not just the adult recipient of Food Stamps, but all members of that individual's household to be finger printed. This creates an added burden because a household may be composed of school age children or other working adults who have difficulty taking the time to go to a DHS office.

> "Given the stigma already associated with receipt of Food Stamps, the value placed on privacy, and the distaste for excessive government interference in one's personal life, it is likely that many people, even those desperately in need of assistance, do not pursue their application for Food Stamps when they learn about the finger imaging requirement."
>
> *Source: Center for Public Policy Priorities, Testimony to the Legislative Budget Board, September 7, 2000*

Not all fraud control has a negative impact on enrollment. The agency installed computerized data systems in all offices to simplify verification responsibilities. Texas Works Advisors can now verify vehicle registration, residence, credit information, employment, and criminal convictions simply by utilizing a computerized database. In many cases, clients no longer have to provide secondary verification for several items on their applications.

To re-emphasize, fraud control is an essential activity and DHS does it quite well. However, in light of the fact that more and more potential benefits recipients are working but poor, the agency needs to look closely at fraud control measures. There may be ways to accomplish fraud control without discouraging potential recipients.

Confusion Related to Legal Immigrant Policies

Federal welfare reform in 1996 drastically limited legal immigrants' access to public benefits. Although some of these benefits have since been restored, the majority of legal immigrants are still ineligible for Food Stamps, and most legal immigrants who arrive or arrived in the country after August 22, 1996 face a lock-out period before they can receive Food Stamps, Medicaid, CHIP and TANF. In addition to these cuts in

eligibility, fear has increased within the immigrant community regarding the use of public benefits and its potentially negative impact on a person's immigration status. Testimony to the committee suggests that many legal immigrants avoid applying for benefits for themselves or their children due to fear, misinformation, or confusion over eligibility requirements.

A May 1999 guidance from the Immigration and Naturalization Service (INS) indicated which benefits would not result in a "public charge" determination. When an immigrant is deemed a public charge, it means that he or she is likely to be dependent on the government for care. Such a determination could prevent an immigrant from being granted permanent residency, the first step toward becoming a citizen. The guidance clarified that immigrants can access most services, including Food Stamps and Medicaid, without jeopardizing their immigration status. Testimony to the committee indicated that the INS guidance information is not communicated effectively by DHS. The agency began providing training to incoming Texas Works Advisors regarding public charge in the spring of 2000, but has not instituted any outreach efforts on the subject.

INS Guidance on Public Charge

Benefits that will NOT affect an immigrant's ability to get a green card or become a citizen:

- *Health Care Services* - Medicaid, CHIP, Emergency Medicaid, immunizations, prenatal care, city and county health programs, Community Health Centers, Texas Healthy Kids Corporation, mental health services, substance abuse services, and all other public health programs (see exception below);
- *Nutritional Services* - Food Stamps, WIC, school meals, senior nutritional programs, or federal commodity assistance;
- *Other non-cash benefits* - public housing, disaster relief, family violence services, child care and Head Start, energy assistance, job training, or transportation assistance.

Benefits that MAY cause problems for some immigrants if they have relied on the following benefits in the past AND are likely to continue to rely on them:

- *Cash Assistance* - TANF and SSI;
- *Nursing Home or other Long-Term Institutional Care* paid for by Medicaid or other government funds.

Furthermore, few outreach efforts focus specifically on communities where immigrants or families composed of individuals of mixed-immigration status reside. For example, although 12 percent of the decline in public assistance recipients can be attributed to changes in eligibility policies for legal immigrants, these policy changes resulted in a 55 to 90 percent decline along the Texas/Mexico border. The federal government reinstated Food Stamps and Medicaid for over 29,000 legal immigrants in Texas in 1998, but the state did little to notify immigrant families of the new law. Consequently, there was no noticeable increase in Legal Permanent Residents' Food Stamp enrollment. More outreach could result in larger numbers of eligible legal immigrants receiving the benefits necessary to support their families.

Administrative Burdens

In a study of individuals leaving the Food Stamp rolls, researchers identified common reasons for voluntary

termination of benefits.[101] The most common reason was clients' increased earnings; however, about two-thirds of these former recipients of Food Stamps were still eligible based on income. The next most common reason was administrative hassles or problems. Public assistance recipients have always been responsible for ensuring that they continue to receive the benefits for which they are eligible. Researchers, however, assert that Texas Works Advisors in recent years are less likely to make a special effort to prevent a client from losing benefits compared with employees during the years prior to welfare reform.[102] This may be due to increased turnover, reduced staffing and an emphasis on decreasing the level of dependence on public assistance in general.

The process of obtaining and re-certifying for benefits can be difficult and time consuming. A typical face-to-face interview lasts more than one and a half hours, not accounting for waiting time and return visits, which can add several hours in total to the visit.[103] Clients must complete additional paperwork, supply multiple forms of verification and, oftentimes, have neighbors or employers account for statements made on an application. Testimony provided to the committee indicated that these burdens have the effect of discouraging many low-income families from completing the application process.

Suggestions about the Process of Obtaining Benefits

As more and more cash assistance clients enter the workforce, the ranks of low-income Texans are increasingly composed of the working poor. These are families that, despite their own best efforts, continue to live in poverty. Food Stamps and Medicaid represent vital supports that fill the gap between living expenses and income from employment. The process of obtaining these benefits should be tailored to the needs of working families.

As more and more cash assistance clients enter the workforce, the ranks of low-income Texans are increasingly composed of the working poor. These are families that, despite their own best efforts, continue to live in poverty.

The state can simplify the administrative requirements by minimizing the face-to-face interview requirements. Eligibility workers at DHS could conduct interviews over the phone when necessary. Also, if verification of information is required, forms could be sent through the mail. These changes would reduce the need for applicants to take off work or locate child care in order to access benefits.

Already, DHS has taken steps to minimize verification requirements, as well as to simplify the public assistance application. The Medicaid Application Workgroup, composed of DHS employees, advocates and legislative staff, scrutinized the application and verification requirements. The recommendations of this group would reduce the amount of verification, and the application would be revised so that applicants would have an easier time supplying necessary information. The agency is currently considering these recommendations. This is a good start, and future efforts along these lines should be strongly encouraged by the 77th Legislature.

Currently, DHS does not measure the performance of local offices based on efforts to make the enrollment process more effective and responsive to the needs of working applicants. The agency does measure performance based on the number of people diverted, as well as the success of fraud and error reduction. It is likely that diversion and fraud control activities add to the burdensome aspects of the enrollment process. Therefore, it is important for DHS to expand its performance measures to ensure that client diversion and error control do not supersede goals such as:

- The percentage of eligible people who leave TANF but retain Food Stamps and Medicaid.
- The percentage of eligible families who receive Food Stamps and Medicaid.
- The number of applicants who complete the application process after requesting services.

Uninsured Children

Medicaid is a vital support for many Texas children. Unfortunately, not all low-income children benefit from the program. This is a dilemma that deserves special attention, particularly in light of the fact that nearly 600,000 Texas children qualify for Medicaid but remain unenrolled. The consequences of failure to provide adequate healthcare for children are costly, both in human and financial terms. Many of the enrollment barriers imposed to limit errors in the Medicaid program are unnecessary for children. Texas has a good deal of flexibility to simplify the application process for this program.

In April 2000, Texas began taking applications for the Children's Health Insurance Program (CHIP). CHIP expands government sponsored health coverage for children living in families with incomes below 200 percent of the national poverty level. The state implemented an aggressive CHIP outreach strategy that has resulted in enrollment of 111,317 children in less than half a year. During this same period, however, 37,782 referrals from CHIP were made to DHS because the income on the CHIP application was within Medicaid income guidelines. Of these referrals, 19,382 are still going through the intensive Medicaid enrollment process, 11,209 abandoned the process entirely and were denied, and only 4,767 were actually enrolled in Medicaid. These figures illustrate the difficulty many parents have with the enrollment procedures for Medicaid as opposed to CHIP.

The CHIP application process is strikingly different from that of Medicaid. Parents need not go to a state office to apply for CHIP, since application materials are sent through the mail. When a parent has questions or when more information is necessary, contacts can be made over the telephone. Also, parents do not have to verify assets for CHIP as they do for Medicaid. Self disclosures on the CHIP application are sufficient and only income is verified. Once a child is enrolled in CHIP, the enrollment period lasts for one year. With Medicaid, the parent must re-certify for benefits at least every six months. Furthermore, changes in income must be reported within ten days, and this may result in the termination of benefits. Testimony from a broad-based coalition of stakeholders called for reform of the Medicaid enrollment process for children, including elimination of the face-to-face interview, discontinuation of the assets test,

and the implementation of 12 months of continuous eligibility.

Eliminate Face-to-Face Interviews	Discontinue the Assets Test	Implement 12-Month Continuous Eligibility
Currently, 38 states have done this for their children's Medicaid programs. This will ensure that a CHIP applicant who is determined to be income eligible for Medicaid will be able to complete the enrollment process over the phone or through the mail.	The assets test is not required by federal law, and 40 states have done away with it for children's Medicaid. Studies indicate that a minute percentage of families who earn income that makes them eligible for Medicaid have assets greater than $2000.	The Social Security Act allows states to do this for children under age 19. Fifteen states have implemented continuous eligibility for children's Medicaid. Parents would not be required to re-certify for benefits every six months, nor would they have to report changes in income.

There are good reasons to consider these recommendations. First, the CHIP Program will cover children in families with incomes higher than Medicaid income guidelines, or up to 200 percent of poverty. Because a family with a child who is determined to be ineligible for Medicaid based on income or assets can now apply for CHIP, there is no advantage or incentive for parents to provide false information on their applications. This reduces the need for a time consuming face-to-face interview conducted at DHS. Second, while the income guidelines for Medicaid and CHIP differ only slightly, they may be different depending on the age of a child. It is possible for parents to have one child eligible for CHIP and another eligible for Medicaid. Unless the eligibility processes for both programs are similar, many parents are likely to encounter difficulty navigating between the programs. Third, most states have taken actions to streamline Medicaid enrollment for children so that the process parallels the CHIP enrollment process.

Legal Immigrants' Eligibility for Public Assistance

In 1996, the federal government substantially limited immigrants' eligibility for public assistance benefits. Texas has a large population of immigrants, and 12 percent of the state's decline in public assistance caseloads occurred because of the 1996 policy change. Some communities were hit particularly hard, especially those along the Texas/Mexico border, where 55 to 90 percent of the Food Stamp participation decline occurred. As a sobering footnote, health and nutrition problems are on the rise in these communities. Policies impacting immigrants' access to public assistance deserve special attention in this state.

The right to Food Stamps and Medicaid was reinstated by Congress in 1998 for legal immigrant children. The law also reinstated these benefits for elderly and disabled immigrants who were lawfully present in the U.S. before August 26, 1996. Legal immigrants who enter or entered the U.S. after this date can only access Medicaid five years after they become Legal Permanent Residents and must accrue 10 years of work experience before they are eligible for Food Stamps. A similar policy exists for TANF, but states have the option whether or not to implement it. Thus far, Texas has not elected to give access to TANF for legal immigrants after their five year bar. There is no prohibition in federal law, however, that prevents states from providing public assistance to legal immigrants using state dollars. Addressing the issue of public assistance for legal immigrants should be a focus of the 77th Legislature, particularly for vulnerable populations,

including pregnant women and victims of domestic violence.

Conclusion

Testimony provided to the committee indicated that many eligible families will avoid obtaining Food Stamps or Medicaid rather than endure the bureaucratic hurdles or perceived invasions of privacy encountered at DHS offices. Instead, many families utilize emergency rooms for minor conditions, frequent local food pantries for regular meals, or go without necessary food or medical attention entirely. There are expensive consequences. Emergency room care is far more costly than routine care from a family physician, and local governments are forced to pay the bill. By discouraging Medicaid applicants, Texas is shifting, not reducing, healthcare costs, increasing the local tax burden and encouraging inefficiency. This is unsound fiscal and social policy.

The same is true in relation to Food Stamp applicants. Food Stamps are funded entirely with federal dollars, with the exception of administrative costs. These benefits allow recipients to purchase food from local vendors which, in turn, contributes to the economy. Discouraged applicants instead seek out charitable food pantries, which do not have the resources or infrastructure to keep up with the increase in need resulting from the unwarranted drop in Food Stamp enrollment. The state should prioritize improvements in the public assistance enrollment and re-certification process to encourage eligible families to apply for the Food Stamp Program and Medicaid.

By discouraging Medicaid applicants, Texas is shifting, not reducing, healthcare costs, increasing the local tax burden and encouraging inefficiency. This is unsound fiscal and social policy.

Recommendations

1. Recommend that the Legislature direct DHS to eliminate the face-to-face interview requirement for children's Medicaid applications.

Currently, 38 states and Washington, D.C., have done this for children's Medicaid. This will minimize the burden on families who have a child eligible for CHIP and another child eligible for Medicaid, and facilitate enrollment in Medicaid generally.

2. Recommend that the Legislature direct DHS to discontinue the assets test for children's Medicaid applications.

Assets tests are not required by federal law. Forty states and Washington, D.C. have done this for children's Medicaid. A common argument against dropping the assets test is that it will result in children who were eligible for CHIP becoming eligible for Medicaid. Given that the state's matching rate for CHIP is better than it is for Medicaid, the state could end up spending more than it would have if the assets test remained. It is important to note, however, that a very small percentage of families who meet Medicaid income guidelines have assets greater than $2000.

3. Recommend that the Legislature direct DHS to implement 12-month continuous eligibility for children's Medicaid.

Twelve-month continuous eligibility for children's Medicaid is allowed for all children age 19 and younger under Section 1902(e)(12) of the Social Security Act. Fifteen states have implemented this for children's Medicaid. Without this option, parents must report changes in income within ten days, and they must re-certify for benefits at least every six months. This places an undue burden on working families.

4. Direct DHS to adopt documentation requirements for children's Medicaid applications that are similar to CHIP application and verification requirements, and direct DHS to simplify documentation requirements for all public assistance applicants.

Currently, CHIP requires all families to verify income and some families to verify citizenship. Medicaid, on the other hand, requires extensive verification and documentation. One family may have a child eligible for Medicaid and another eligible for CHIP. Inconsistency in documentation requirements may result in a parent completing the process for one child but not another. Studies indicate that families eligible for the Food Stamp Program or Medicaid do not seek the benefits they need because of burdensome application and verification requirements. Much of the information on applications can be verified through secondary data sources.

5. Direct DHS to minimize face-to-face requirements for Food Stamp and adult Medicaid applicants who are working.

Studies show that one of the major reasons that so many people who are eligible for the Food Stamp Program or Medicaid in Texas do not access these benefits is the lengthy face-to-face interview. Local DHS offices usually schedule these mandatory meetings during normal business hours, forcing working parents to take time off work. Even when the interview is scheduled after hours, a working parent may have difficulty locating child care or transportation. The agency has the option of applying for a waiver to discontinue or curtail face-to-face interviews.

6. Recommend that the Legislature revise resource requirements for the Food Stamp Program to ensure that families with children can own a reliable vehicle.

Under current federal law, families applying for the Food Stamp Program cannot have more than $2,000 in countable resources ($3,000 if the household includes an elderly member age 60 or above), and the value of a car greater than $4,650 is counted toward this limit. This regulation prevents many low-income families from getting Food Stamps. States may raise the resource limit through revised asset determination policies, which is allowed by the federal government.

7. Direct DHS to conduct an extended hours survey and implement extended office hours at all appropriate locations across the state.

DHS already extends office hours in selected areas of the state. These are test sites; the results will help the agency determine the optimal hours of operation. This recommendation directs the agency to develop a more sophisticated study of extended office hours wherein all DHS units participate.

8. Recommend that the Legislature fund increased staffing at DHS to handle an increase in children's Medicaid applications as a result of Children's Health Insurance Program(CHIP) outreach efforts.

During the 76th Session, the fiscal note attached to SB 445, the enabling legislation for CHIP in Texas, included recommended funding for increased FTEs at DHS to process increased children's Medicaid applications spilling over from CHIP. The money for these FTEs was never appropriated. The agency has seen a significant reduction in FTEs despite the fact that applications for public assistance have remained constant and are expected to increase as a result of CHIP. The lack of adequate staff at DHS can slow Medicaid enrollment for all children, including those referred by CHIP.

9. Recommend that the Legislature fund and direct DHS to develop customer satisfaction performance measures and provide incentives for meeting or exceeding these standards.

This recommendation would reward improved outcomes on the following performance measures:

- The percentage of eligible people who leave TANF but retain Food Stamps and Medicaid.
- The percentage of eligible families who receive Food Stamps and Medicaid.
- The number of applicants who complete the application process after requesting services.

In Texas, more value is placed on payment accuracy than quality service delivery to clients. Consequently, workers spend much more time verifying information on the application rather than focusing on helping applicants to complete the process. Also, Texas makes budget projections based on caseload declines in all three programs: TANF, Food Stamp and Medicaid. It is unlikely that an emphasis on improved customer service can occur unless financial incentives are added to balance the influence of other budgetary concerns.

10. Direct DHS to establish an "Office Standards Working Group."

In order to implement customer satisfaction performance measures, standards for the public assistance application and re-certification process would need to be better defined. This could be accomplished in a workgroup setting similar to the Medicaid Application/Verification Workgroup. The charge of this workgroup would include establishing uniform standards for all regions regarding:

1) minimum wait times;
2) acceptable parameters for setting shortened certification periods;
3) procedures for conducting pre-certification investigations;
4) duration of certification interviews; and
5) the number of documents that must be provided to receive Food Stamps.

11. Direct DHS to review and revise all levels of client communications in a workgroup process.

Advocates, legislative staff and DHS employees worked diligently to develop a new application and verification process in the Medicaid Application/Verification Workgroup. Many of these participants expressed a desire to continue this workgroup to help improve other facets of the public assistance process. The issues that would be addressed by such a workgroup include alleviating the impact of the TANF client diversion message on potential Food Stamp and Medicaid applicants and reviewing all relevant notices, forms, applications and videos. The workgroup would also look at Texas Works Advisor training to ensure that workers are able to distinguish between TANF, Food Stamp and Medicaid requirements.

12. Recommend that the Legislature fund outreach programs that target harder to reach populations for access to the Food Stamp Program and Medicaid.

Studies indicate that communities where working poor, mixed families, i.e., those composed of citizens and non-citizens, and urban families reside could benefit from outreach efforts. Such efforts help to promote trusting relationships between outreach staff and clients, thereby increasing the likelihood that a client will complete the application process. Also, such efforts are reported to increase word-of-mouth communication between clients and potential applicants.

13. Recommend that the Legislature fund and direct DHS to develop a web-based screening tool for community-based organizations to use to determine if their clients are eligible for the Food Stamp Program.

Second Harvest, a national group that provides hunger relief, is currently developing such a tool. Because potential Food Stamp applicants access multiple services outside of DHS, a web-based screening tool would allow community case managers to help determine whether clients are eligible before sending them to a DHS office.

14. Recommend that the Legislature mandate that a certain percentage of any enhanced federal funding Texas receives for Food Stamp error rate reduction be invested in efforts to increase participation in the Food Stamp Program.

Some reports suggest that the actions the state takes to reduce errors in Food Stamp eligibility and benefit determinations e.g., shortened certification periods and increased verification responsibilities, may result in clients avoiding the process altogether. Therefore, a certain amount of enhanced funds dedicated to increased participation may help to offset declines among those who remain eligible for the Food Stamp Program.

15. Recommend that the Legislature fund food, medical and cash assistance as well as work supports such as child care for immigrant victims of domestic violence.

Currently, immigrants who come to the U.S. as the spouse of a citizen can self-petition (not list a sponsor) for permanent status if they leave the relationship due to domestic violence. However, as with everyone who became a Legal Permanent Resident after August 22, 1996, these individuals are locked out of Medicaid for five years and the Food Stamp Program until they accrue 10 years of work experience. This proposal would allow this specific population to access these benefits before five years have lapsed, and help to prevent victims of abuse from returning to an abusive partner. These benefits would be funded through General Revenue. The number of legal immigrants who self-petition as a result of domestic violence is very small, so the fiscal impact would be minimal.

16. Recommend that the Legislature provide TANF to Legal Permanent Residents after their five-year lock out has elapsed.

According to Federal Regulations, a state has the right to decide whether or not to provide TANF to LPS after their five-year lock out period has expired. Texas currently does not allow this population to seek cash assistance. This prevents these individuals from receiving TANF work supports such as child care and increases the likelihood that they will remain near or below the poverty line and struggle to reach self-sufficiency.

17. Recommend that the Legislature direct HHSC and TDH to promote access to prenatal and maternity care services for legal immigrant women subject to the five-year lock-out from full Medicaid benefits.

Legal immigrant women can access prenatal care services funded by the federal Maternal and Child Health Block Grant. Also, if their income is at or below 185 percent of poverty, they can have their delivery covered by Emergency Medicaid, a program originally created to pay healthcare providers for emergency care, including labor and delivery, provided to undocumented persons. Texas could improve access to prenatal care for legal immigrant women who have not completed their five-year lock-out by requiring Texas Title V contractors to perform targeted outreach to this population. Contractors could then coordinate the provision of prenatal care with initiation of paperwork needed to file for Emergency Medicaid coverage of the mother's labor and delivery costs.

18. Recommend that the Legislature direct HHSC to exercise the option to extend full Medicaid pregnancy benefits to certain legal immigrant women, if Congress creates such an option.

Current pending federal legislation would give states the option of providing full Medicaid pregnancy benefits to legal immigrant women who have not completed their five-year lock-out. If such legislation passes, Texas could exercise this option, instead of promoting the Title V-based approach described in Recommendation 17 above.

19. Recommend that the Legislature amend current law to include state recognition of nonresidential family violence centers and to authorize their funding with state appropriations to DHS for the Family Violence Program.

This recommendation would allow DHS to use allotted funds for the Family Violence Program to cover services beyond domestic violence shelters and include other family violence services. This would allow the agency to support resources for victims of domestic violence beyond the current small number of shelters. This recommendation was included last session in the DHS Sunset bill.

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