SUBJECT: Regulating nursing homes

COMMITTEE: Human Services — committee substitute recommended

VOTE: 9 ayes — Hilderbran, Naishtat, Chavez, Christian, Davila, Krusee, Maxey, McReynolds, Wohlgemuth

0 nays

WITNESSES: For — Alison Dieter, Grey Panthers; Beth Ferris, Libby James, Lou O'Reilly, Glenda Smelser, Texas Advocates for Nursing Home Residents; Mark Gentle, Wilhelmina Gladden, Cathy Greene, Gay Nell Harper, Fairy Ladd, Sondra Laskay, Dick Massey, Myrhhine Schmitt, J.D. Payne, Mary K. Payne, Winnie J. Morgan, American Association of Retired Persons; Aaryce Hayes, Advocacy, Inc.; John Holtermann, Tom V. Perkins, Lewis Marshall, Texas Silver-Haired Legislature; Greg Hooser, Texas Dietetic Association; David Latimer, Texas Association of Homes and Services for the Aging; Marilyn Pattillo, Texas Nurses Association; Lisa McGiffert, Consumers Union; Bob Kafka, ADAPT; Peggy Gordon, Texas Retired Teachers Association; and 12 people representing themselves or others

Against — Tom Suehs, Dot Golding, Wanda Hendricks, Texas Health Care Association; Lindsay Thorpe, Chartwell Healthcare; and five people representing themselves

On — Donna Higginbotham; Tony Venza, Paul Leche, Department of Human Services (DHS); Marie Wisdom, Advocates for Nursing Home Reform; Chet Brooks; David A. Talbot, Jr., George Noelke, Office of the Attorney General; John Willis; Debra Green

BACKGROUND: Chapter 242 of the Texas Health and Safety Code governs the regulation of nursing homes and related institutions. Institutions are defined as establishments that furnish food and shelter, minor treatment under the direction of a physician, and other services to four or more persons unrelated to the proprietor or that provide residential foster care to fewer than five unrelated people.

Nursing homes must also comply with state and federally promulgated certification requirements to participate as providers in the Medicaid program, a health benefit program for low-income and disabled individuals. Medicaid pays for nursing home care for about 65,000 elderly Texans per month. State law pertaining to the Medicaid program is found in chapter 32 of the Human Resources Code.

The Department of Human Services is responsible for administering and enforcing state nursing home standards, Medicaid certification standards, and Medicaid reimbursement. The Attorney General's Office is authorized to prosecute nursing homes referred by DHS that threaten resident health and safety.

Last session the Legislature enacted HB 2644 by Hilderbran, which required state Medicaid requirements to be no different from federal Medicaid requirements; authorized the use of an arbitration process between nursing homes and the state for contested violations; prohibited the use of department findings that a nursing home has violated a Medicaid standard as evidence in civil actions; directed that institutions in compliance with Medicaid standards would be deemed in compliance with state licensing standards in areas in which both licensing and Medicaid standards apply; and prohibited a department from assessing a penalty for a violation arising out of the same act under both nursing home licensing laws and under Medicaid laws.

DIGEST:

CSHB 413 would amend nursing home regulation in chapter 242 of the Texas Health and Safety Code to establish acceptable levels of care, authorize the adoption of state standards more stringent than federal standards, require good compliance histories for license issuances, require specified services and medication procedures, and establish new resident rights and new response procedures to reported complaints.

CSHB 413 also would amend arbitration provisions and expand other enforcement and penalty procedures, including adding newly specified attorney general investigative authority, and would amend provisions prohibiting the admission of an institution's Medicaid violations as evidence in civil proceedings.

CSHB 413 also would establish chapter 242 as the minimum licensing standard for Medicaid contracted nursing home providers (institutions subject to section 222.0255 of the Health and Safety Code), and would make conforming and other amendments to Medicaid program requirements in the Human Resources Code (chapter 32).

CSHB 413 would take effect September 1, 1997. DHS would have to adopt necessary rules to implement the bill by January 1, 1998. Conduct occurring before January 1, 1998, would be governed by law in existence prior to September 1, 1997.

General rulemaking

CSHB 413 would state the goal of the Health and Safety Code, chapter 242 is to ensure that Texas institutions deliver the highest possible quality of care, and that rules and minimum standards would be created to protect a class of persons that include nursing home residents. Rules and standards could be more stringent than the standards imposed by federal law for participation in the state/federal Medicaid program. The rules and standards could not be less stringent than the Medicaid certification standards established under the federal Omnibus Budget Reconciliation Act of 1987 (OBRA '87).

The rules and standards would specifically apply to protecting consumers and establishing quality of care criteria as well as to state survey and enforcement actions. The board would be required instead of permitted to adopt rules relating to construction, sanitation, nutrition and other aspects of nursing home care and state regulation. Areas of care that are subject to the same standard under both the state licensing requirements and federal Medicaid or Medicare certification standards would be considered in compliance with state licensing requirements if in compliance with federal certification standards.

The bill would specify that chapter 242 is to be construed broadly to accomplish the purposes identified.

Licensing and background checks

The term “controlling person” would be newly established in chapter 242 and defined as a person who has the ability, acting alone or with others, to directly or indirectly influence or direct management, expenditures or policies of the institution or another person. A controlling person could include a management company or a controlling person of a management company; a landlord or entity that operates or contracts with others for the operation of an institution; or another person who is in a position of control or authority because of a personal or familial relationship with the owner, manager or provider of an institution.

For license issuance and renewal applications, provisions generally authorizing DHS to require evidence of compliance would be replaced by provisions requiring DHS to consider the background and qualifications of the license holder, partners, directors, or managing employees of the applicant or license holder or a controlling person.

License and license renewal procedures would require the furnishing of evidence establishing the applicant or license holder’s ability to comply with minimum standards of medical care, nursing care, financial condition, and any other applicable state or federal standard, and submission of a sworn affidavit of satisfactory compliance history in each state in which an institution was operated by the applicant or license holder or controlling person at any time during the past 10 years.

DHS could exclude a person from eligibility for a license if the person substantially failed to comply with state laws and rules. The exclusion could extend for at least two but not more than 10 years. DHS could establish a background examination fee to defray background examination administration costs. DHS also would not be required to issue a license if state requirements were met.

A license could be denied, suspended or revoked if a rule or standard was violated in a repeated or substantial manner, if false statements were made or other administrative infractions occurred, or if DHS has excluded from licensure the applicant, license holder, or related partners, officers, directors, managing employees or controlling persons.

Each institution would be required to have a licensed nursing facility administrator to work at least 40 hours a week to manage the institution and to be responsible for quality of care and policy implementation.

Required services

Institutions would be newly required by law to offer certain services, including at least one medical director responsible for a resident's plan of care, a pediatric consultative service, and nurses and doctors expert in the care of children for residents younger than 18 years of age and a director of nursing services who is a registered nurse.

An institution would have to provide the nursing care required to allow each resident to achieve and maintain the highest medically possible degree of function and independence. It also would have to maintain sufficient staff to provide nursing and related services in accordance with each resident's plan of care and to obtain and maintain the physical, mental and psychosocial functions of each resident at the highest practicable level. An institution also would have to care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life and dignity.

Institutions would be required to achieve these requirement by complying with DHS standards and by developing written policies to implement the standards. The policies and procedures would have to be made available to each physician, staff member, resident, resident next of kin, and the public.

Medication administration

An institution would have to establish medication administration procedures to ensure that medications were checked against doctor's orders; the resident was identified before the administration of the medication; each resident's clinical record included an individual medication record; medications and biologicals were prepared and administered by the same individual; and medication was not administered to the wrong resident.

An institution would have to employ or contract with a pharmacist; to store medications under appropriate conditions; to release medications of a

transferred resident; to dispose of discontinued, outdated medications or ones with illegible labels; and to maintain updated medication reference texts. Nursing staff would have to report medication errors and adverse reactions to the resident's physician in a timely manner and record the errors and reactions in the resident's clinical record.

Resident rights

Current law requiring the enforcement of resident rights as stated in Chapter 102 of the Human Resources Code would be repealed. DHS would have to adopt a statement of resident rights, which at a minimum would have to address the resident's constitutional, civil and legal rights and contain 21 other specified rights. An institution would have to develop and implement policies to protect resident rights and could not violate a right. A right of a resident could be restricted only to protect the right of another resident or to protect the resident from danger.

An institution also would have to explain the rights to residents and residents' next of kin and provide written copies. A copy signed by the resident or resident next of kin would have to be kept in the institution's records. Notices of DHS citations for violating a resident's right would have to be included in informational materials available for public inspection relating to an institution's compliance history.

Abuse/neglect reporting and investigations

In addition to current requirements for reporting alleged incidences of abuse or neglect, the DHS board would be required to adopt rules requiring the reporting of conduct or conditions that result in exploitation, accidental injury, or hospitalization of the residents.

DHS would be newly required to investigate all reports within specified times and using specified procedures. Investigations would have to begin within 24 hours of receipt of a report of death or danger to resident health and safety, and before the end of the next working day for all other reports. The complainant, the resident and next of kin would have to receive periodic information regarding the investigation.

The investigator would be required to, instead of permitted to, make an unannounced visit to the institution and interview each available witness. The investigator's report would be available for public inspection with resident, complainant and interviewed individuals' names deleted.

Other complaints

The board would be required to adopt a system for prioritizing investigation of and action on complaints. A person could request an inspection of an institution by making a complaint to DHS of an alleged violation of law. DHS could not inform institutions about the complaint before an on-site inspection. The name of the complainant would be confidential. In most cases DHS would have to make an on-site inspection or otherwise respond to the complaint within a reasonable time period and to promptly notify the complainant about its course of action.

CSHB 413 also would provide a private cause of action in addition to others currently in law for complainants who are retaliated against by an institution for reporting abuse, neglect or other complaint or for cooperating in any investigation or governmental proceeding.

Enforcement

Injunctive relief. The department could petition a district court for a temporary restraining order for a threatened violation, in addition to a continuing violation, if the department believed the threatened violation created an immediate threat to resident health and safety. A suit for injunctive relief would be permitted, but no longer required, to be filed in Travis County.

Civil penalties. Violations of Medicaid participation requirements would be added to violations subject to civil penalties. The range of applicable penalties would be raised to $2,000 to $15,000 from the current range of $100 to $10,000. The trier of fact would have to consider various points when awarding a penalty, including: the history and seriousness of violations; efforts made to correct the violation; any misrepresentations; and fine amounts considered necessary to deter future violations.

Each resident who suffers directly due to the violation, in addition to each day of the violation, would constitute a separate ground for recovery.

Administrative penalties. Administrative, instead of civil, penalties would be assessed against a person who violated a chapter rule or standard; made false statements on license application forms; willfully interfered with enforcement actions or refused to allow record inspection when under investigation; or failed to pay penalties. An administrative penalty would range from $500 to $15,000 per pay for each violation. Administrative penalties could be assessed against a license applicant, license holder, partner, officer, director, managing employee, or controlling person.

Penalties could not exceed $1,000 per day for violations of resident rights, the posting requirement during suspension of admissions, and rules requiring reporting of resident exploitation or hospitalization.

Administrative penalties could not be assessed under certain conditions if the institution corrected the violation, and the violation was not one that resulted in or posed serious resident harm or another serious offense. The correction would have to be maintained for at least a year, or the institution would be subject to a penalty of not less than $500 or more than $30,000 for each day of violation. Institutions also could be ordered to apply any portion of a penalty to ameliorate the violation or to improve services. Procedures for authorizing and monitoring corrections in lieu of penalty payments would be specified.

The DHS commissioner also could order an institution that was found guilty of administrative violations to suspend admissions. CSHB 413 would require a posted notice of the suspension on all doors and would allow institutions the opportunity to appeal the order.

Monetary penalties. Sec. 32 of the Human Resources Code would be amended to require, instead of permit, DHS to provide for the assessment of monetary penalties as required by federal law. DHS rules regarding monetary penalties would have to include an informal dispute resolution process, but administrative appeals processes would be repealed. An assessment of monetary penalties could be subject to arbitration.

DHS would be required to terminate a nursing facility's provider agreement with Medicaid if the department imposed category II or III remedies on the facility three times within a 24-month period.

AG investigations. The attorney general would be authorized to conduct an investigation of a violation of law or rule if DHS requested the investigation and the AG had reason to believe that the investigation was warranted. The AG could require from a person written statements about the alleged unlawful act, examinations under oath, and reasonable on-site inspections.

A person also could be required to produce documentary material for inspection and copying under the order of a civil investigative demand. CSHB 413 would include specific provisions governing the content, processing, enforcement and deadlines of the demand, and would limit disclosure of material to that which is considered discoverable under either Chapter 242 of the Health and Safety Code or the Texas Rules of Civil Procedure. The contents of the material obtained by an investigative demand could not be disclosed to anyone outside of the AG office, DHS or a court without written consent of the person who produced the material.

An institution that refused to comply with a demand would be liable for a civil penalty of $10,000 for each day of refusal, and a person could be liable for contempt of court if the AG petitioned the district court in Travis County to enforce a demand.

Use of fees and penalties. DHS would be prohibited from including an administrative or civil penalty as a reimbursable item to a nursing facility.

Fees or penalties collected by or on behalf of DHS would be deposited to the general revenue fund and could be appropriated only to DHS to administer the chapter. CSHB 413 would raise the floor for the nursing and convalescent home trust fund to $500,000 from $100,000, and would direct funds in excess of $500,000 to be transferred to the general revenue fund at the end of each fiscal year for appropriation only to DHS for administration and enforcement of this chapter.

The attorney general could recover reasonable expenses and costs if the office brought an action against an entity that resulted in an injunction being granted or a finding of liability for a civil or administrative penalty. The costs would be deposited to the general revenue fund and could be appropriated only to DHS and the AG.

Arbitration

The party that elects arbitration would have to pay for the cost of arbitration. CSHB 413 would remove provisions that require the department to pay for arbitrations it elects and that split the cost of institution-elected arbitrations.

The arbitrator's order could be vacated on application of either the department or the institution. Arbitration could not be elected if the subject matter of the dispute was part of the basis for suspension of a license, issuance of a closing order, or suspension of admissions.

Evidence

CSHB 413 would amend current law to replace the term "department finding" with "a department survey, complaint investigation, incident investigation or survey report" documenting a Medicaid violation to be inadmissable as evidence in attempts to prove that the institution had committed a civil violation.

CSHB 413 also would specifically not prohibit or limit the testimony of a department investigator, or bar admission of written findings and reports that were offered to establish warning or notice to an institution of a relevant finding or under any rule or evidentiary predicate of the Texas Rules of Civil Evidence.

Public information requirements

Each institution would be required to post notices that DHS can provide summary reports relating to the institution and that the Board of Nursing Facility Administrators can provide administrator information, inform of an imposed suspension of admissions if applicable, and state where compliance history information is available for inspection at the institution. The

compliance history information would have to be updated at least monthly and would have to cover the period of a year preceding the last updated information.

SUPPORTERS SAY:

CSHB 413 would substantially improve nursing home oversight and enforcement of state and federal standards, establish enforceable resident rights protections, and improve the quality of life and care for thousands of vulnerable Texas nursing home residents.

General rulemaking. CSHB 413 would allow federal regulations to serve as broad guidelines under which Texas could impose more stringent standards as needed, and reverse provisions enacted last session that had removed the state's ability to tailor it own regulations by requiring state standards to be "no different from" federal standards. Specific state requirements also are easier to enforce and offer better public protection than the broadly worded, ambiguous federal regulatory standards.

CSHB 413 would continue to allow state licensing and Medicaid certification rules to be combined when possible. Any potential confusion among state and federal nursing home requirements would be minimized by CSHB 413 provisions deeming mutual compliance in areas in which state and federal standards are similar, coordinating the development of licensing standards with federal rules, and making other conforming provisions between the Health and Safety Code and the Medicaid provisions in the Human Resources Code.

Licensing amendments. CSHB 413 would address the problem of identifying and holding accountable persons responsible for nursing home operations and would provide DHS with much needed management and background history to prohibit chronic violators from operating nursing home businesses. It would also clarify DHS authority for suspending, denying or revoking licenses.

CSHB 413 would place in statute rules requiring nursing homes to be operated by licensed nursing home administrators, which would give the force of law to legislative intent that nursing homes should be operated by qualified individuals. It also would maintain licensing requirements as another means of ensuring quality care, monitoring management

performance, and removing from the nursing home industry, if necessary, poorly qualified or negligent administrators.

CSHB 413 also would help the state identify and monitor individuals other than nursing home administrators who make financial and other decisions that cause many nursing home problems. State records do not always reveal who actually operates a nursing home. Nursing home entities that are licensed by DHS, though ultimately responsible for the care given in the home, are sometimes not the same entity that manages daily operations.

Current law does not provide DHS clear authority to prohibit or curtail the business of nursing home "bad actors" — owners and operators with histories of irresponsible care-giving — or to define criteria by which to judge violation histories as a basis for issuing, suspending or revoking licensure. Shutting down a bad nursing home does little to protect the public if the owner or other business entity is free to again operate another nursing home.

CSHB 413 also would preserve licensing as a state privilege, instead of making it an applicant's right, by giving DHS necessary discretion to issue licenses only to applicants deemed capable and willing of upholding care standards and other requirements.

Required services and care standards. CSHB 413 would place in statute many regulations regarding nursing home services and care, and thereby establish clear legislative intent about a nursing home's essential activities and subject violations of those standards to legal actions.

CSHB 413 would enact strong quality of care standards, yet also allow nursing homes sufficient flexibility in staffing to meet those standards as they pertain to their particular resident mix of medical and other conditions. Specific nurse aide-to-resident staffing ratios, as advocated by some, would not be useful because they would most likely result in an expensive and empty paperwork requirement that focuses on "body counts" instead of care. Often one well-trained, compassionate nurse aide can do better work than two unmotivated aides.

Resident rights. CSHB 413 would enact into law resident rights that are specific to nursing home conditions. It would enhance nursing home compliance by requiring the resident's next of kin to be informed of those rights, by specifically prohibiting a nursing home or its staff from violating a right, by making resident rights violations subject to administrative penalties, and by clearly establishing nursing home residents as a protected class.

Current resident rights laws do not specify penalty or other enforcement provisions, and in some court cases nursing homes have argued that because they contract with DHS for Medicaid participation, they were only responsible for complying with contractual obligations, under which residents have no inherent legal rights. The provisions would*not* increase liability for class action lawsuits, but would hold nursing homes accountable for complying with residents' rights and would strengthen resident recourse when violations occur.

Complaint amendments. CSHB 413 would improve the early or timely identification of hazardous nursing home conditions by requiring individuals to report conditions that result in exploitation, accidental injury, or hospitalization in addition to current reporting requirements relating to abuse and neglect. DHS handling of complaints would be improved by requirements specifying investigation procedures and rapid response.

CSHB 413 also would encourage the reporting by employees and other individuals of a nursing home's hazardous conditions or conduct by specifically by ensuring confidentiality and protecting complainants from retaliation by the nursing home. Residents' family members and nursing home employees are often inhibited from reporting suspicious conditions or problems because they fear the nursing home will demand the resident's transfer or fire the complaining employee.

Enforcement. CSHB 413 would fill in loopholes and ambiguities caused by the current mix of state and Medicaid laws and standards by requiring the standard of care requirements that would be established in chapter 242 to be broadly construed and by clearly establishing enforcement action under state licensing laws. It would also reenact the authority for nursing homes to be penalized under both state and federal standards, an authority that would

retain the requirements of both levels of government that was removed by legislation enacted last session.

CSHB 413 would update penalty amounts so that penalties provide a sufficient deterrent and are not simply viewed as a "cost of doing business." It also would help minimize the number of unnecessary court or administrative appeals by requiring interest to accrue on penalty payments that are deferred by the appeals process.

Allowing nursing homes to use fines to ameliorate violations instead of paying the state would help residents by providing a faster, more appropriate approach to getting a nursing home's problems fixed. Shutting down a nursing home, or assessing huge fines, can unnecessarily penalize a nursing home and its residents, especially in a rural area where facilities are limited. Mandated amounts in the nursing home trust fund were raised to guarantee sufficient funds in cases of trusteeship.

Attorney general authority. CSHB 413 would improve nursing home oversight by giving the attorney general more investigative authority to remedy some of the enforcement problems and delays associated with lack of information. Investigative demand is an authority granted to the AG in several other statutes and allows the AG to fully investigate a case prior to taking action. It would not cause duplication of effort because the AG's Office, as experts in civil litigation, would only investigate situations or ask for information that is necessary for legal proceedings but may have not been fully covered in a DHS investigation.

Arbitration amendments. CSHB 413 would balance arbitration provisions newly enacted last session by allowing both the state and a nursing home to appeal an arbitrator's order under certain conditions. Current law allows only the nursing home to appeal an arbitrator's civil order, which is an exceptional right — no other licensed profession has a similar one — and which could delay state enforcement and nursing home compliance because nursing homes will appeal every order not in their favor. CSHB 413 also would remove provisions that required the state to pay for all or a portion of the cost of every arbitration, even if elected by the nursing home.

Arbitration offers both the state and nursing homes a tool frequently used by private businesses to settle disputes in an impartial manner. It is needed to remove biases caused by the dual roles the state plays as both "policeman" and "judge." Arbitration will reduce frivolous lawsuits against nursing homes by creating a setting in which decisions rest on a case's factual base, not on heightened, negatively emotional issues often raised before juries.

Arbitration will not burden state enforcement costs because it will probably not be used very much. To date no nursing homes have elected arbitration, and the number of nursing homes that may be eligible for arbitration is relatively small due to a 1995 federal ruling regarding nursing homes that are dually certified for the Medicaid and Medicare program, which constitute most nursing homes in Texas.

Use of evidence. CSHB 413 would clarify evidentiary questions surrounding provisions enacted last session relating to the use of compliance histories in civil lawsuits. The term "DHS finding" in current law is ambiguous, and was interpreted by some to refer to verbal testimony.

CSHB 413 would not prohibit the introduction of relevant evidence or testimony that validly demonstrates a nursing home's "track record" in providing quality long-term care, but it would protect against the misuse of inspection reports by plaintiff lawyers who try to demonstrate a pattern of nursing home negligence. Most nursing homes are cited with some sort of deficiency during nursing home inspections, and findings represent only a "snapshot" of a nursing home's operation at a particular time; they do not convey the context of the problematical situation.

Inspection reports present a legitimate, relevant "track record" of how a nursing home has operated and as public documents should be available as evidence in court. Identified incidences of neglect or abuse to some residents are pertinent to lawsuits involving other residents because they indicate a pattern or tendency on the part of the nursing home staff and administration.

OPPONENTS SAY:

CSHB 413 would provide DHS with unnecessary and overly punitive enforcement authority. Many of the nursing home enforcement problems are due to DHS bureaucracy and improper use of current authority, not to a shortage of laws, rules or penalties. Combined with a lack of funding and a lack of appropriate planning for consumer needs, this bill could actually hinder the nursing home industry's ability to offer quality care.

Enacting punitive measures alone will not guarantee that quality care will be provided or that residents will be satisfied with their treatment. The state should require objective measurements of quality and resident satisfaction, so that the state regulators and the public can be better informed about what is going well with Texas nursing homes and future deficiencies can be prevented. So far three states — Ohio, Mississippi and South Dakota — have received or requested permission from the federal government to conduct quality focused surveys as part of their regulatory process.

Licensing. CSHB 413 would give DHS too much discretion in issuing licenses, by permitting instead of requiring DHS to issue a license to applicants who meet state requirements. Not issuing a license to a qualified applicant would represent an unjustifiable restraint of trade, and the bill would provide no protections or recourse for applicants who may suffer from the abuse of this authority.

DHS also would be given open-ended authority to suspend or revoke a license by eliminating the threshold requirement that the license holder *substantially* failed to comply with Health and Safety Code requirements. Revoking or suspending a license is a serious step and should only be taken when substantial or repeated violations occur.

Enforcement. CSHB 413 may penalize nursing homes twice for one violation using both Medicaid and state licensing penalties and cause an unfair "double jeopardy" situation that would violate the Texas and U.S. Constitutions. DHS has on hand a wide range of penalties and other remedies to address nursing home problems and standards violations and should be charged with selecting just one approach that is appropriately punitive or corrective.

CSHB 413 would unreasonably lower the threshold for the ordering of an injunction by allowing DHS to petition a district court for violations that were not only actual but *threatened* and on the basis that DHS *reasonably believed* health and safety would be jeopardized rather than an actual DHS finding. Temporary restraining orders and injunctions should only be used in the more severe cases, and given the range of DHS enforcement authorities to address threatening or undocumented situations, current law offers sufficient and appropriate resident protection and state enforcement response.

By allowing civil penalties for a violation to be multiplied by the number of residents harmed, CSHB 413 would be throwing the civil penalty system out of balance with the rest of the enforcement penalties. High penalty assessments can be overly punitive and detract from a nursing home's ability to mend the problems. Penalties work best as an "attention grabber" for recalcitrant homes, but if a nursing home's violations actually cause widespread harm, the nursing home should be shut down.

References to protecting nursing home residents as a class are confusing and should be eliminated or clarified. The provision could be interpreted as increasing state and nursing home liability against class action lawsuits, which would be unnecessary due to other provisions in the bill that would help target penalties and licensing sanctions against both individual and corporate owners and operators who are substandard.

Attorney general authority. By expanding the AG's investigative authority, CSHB 413 could cause duplication and confusion in state investigations and complicate nursing home efforts to respond. Facilities could be subject to two independent investigations of the same violation by two separate state agencies. Attorney general investigators do not have the training and knowledge of nursing home operations that DHS regulators have, which could cause unnecessary or irrelevant inquiries and demands for information. AG investigations should be more closely coordinated to DHS investigations and should be limited to only the most immediate and severe cases.

Arbitration. Arbitration provisions enacted last session should be eliminated entirely. The arbitration alternative will reduce nursing home compliance with regulations by removing the threat of lawsuit and public scrutiny. Arbitration also will raise the overall cost of enforcement by creating an expense in addition to the processes at hand. Its use will probably result in lower assessments because allegedly life-threatening cases will be heard in a relatively obscure forum conducted by a bureaucratic official instead of in a public forum that allows photographs of resident conditions and mistreatment allegations to be viewed by a jury.

OTHER OPPONENTS SAY:

Staffing and standard of care requirements in CSHB 413 are too broadly written to enforce and therefore fail to provide a sufficient minimum standard; identifying a staffing problem usually first requires the occurrence of resident neglect or abuse. Texas should enact nurse aide-to-resident staffing requirements as do other states because nurse aides perform the majority of direct nursing home resident care. Staffing ratios could be made flexible by being tied to resident conditions and the availability of other health related staff, such as medication aides, since resident conditions drive service demands.

CSHB 413 may provide DHS with too much flexibility in making state standards more stringent than Medicaid standards and could cause confusion through a proliferation of rules or dual standards. A December 1993 report by the state auditor, *A Review of Nursing Home Regulation in Texas*, noted confusion among regulators and nursing home staff caused by the complexity of federal, state and local laws. Federal standards were revised in 1987 under the guidance of a prominent national committee made up of consumers and provider representatives, and federal standards alone offer sufficient resident protection in most cases. Federal regulation also provides nursing homes with flexibility to meet specified objectives, unlike state standards that are often process-oriented and impose requirements that may not directly result in good resident care.

CSHB 413 should give the attorney general *concurrent* authority to investigate nursing home problems. An independent civil litigator is needed to respond quickly and appropriately to complaints received from the public, and to reduce time lags caused by the requirement for DHS referral.

CSHB 413 would increase regulatory and consumer expectations on nursing home services without providing nursing homes assurances that they will be adequately compensated for increased levels of care. The Texas reimbursement level for Medicaid recipients in nursing facilities is 44th in the nation, and nursing homes recently had to file a suit against DHS to ensure updated reimbursement levels took into consideration the full extent of cost increases caused by the federal minimum wage increase. The state should only increase regulatory requirements above federal Medicaid requirements if it increases Medicaid program funding.

NOTES:

Major additions made by the committee substitute to the original version of the bill include provisions that would make violation of a minimum acceptable level of care legally forbidden; establish standards to protect a class of persons to which residents of institutions belong; direct the recovery of fees by the attorney general and the deposit and use of all fees and penalties; require licensing applicants to file financial condition information; raise licensing fees; direct the board to adopt a system of prioritizing actions on complaints; require nursing homes to make available compliance history information to the public; authorize DHS to exclude certain persons from licensing; make changes to temporary restraining order provisions; direct the determination of civil penalty amounts; and expand attorney general investigation authorities.

Other changes made by the committee substitute to the original version include adding complaint reporting procedures and minimum standards for quality care and removing references to the use of restraints, provisions that would have allowed the complainant to accompany the DHS investigator; a directive to DHS to adopt separate standards for licensing and for Medicaid certification, and a directive to DHS to provide nursing home reimbursement for the fair rental value of the facility’s investment in the property.

The companion bill, SB 190 by Zaffirini, Moncrief, et al., passed the Senate on April 3 and was reported favorably, as substituted by the House Human Services Committee on April 17, making it eligible to be considered in lieu of HB 413.