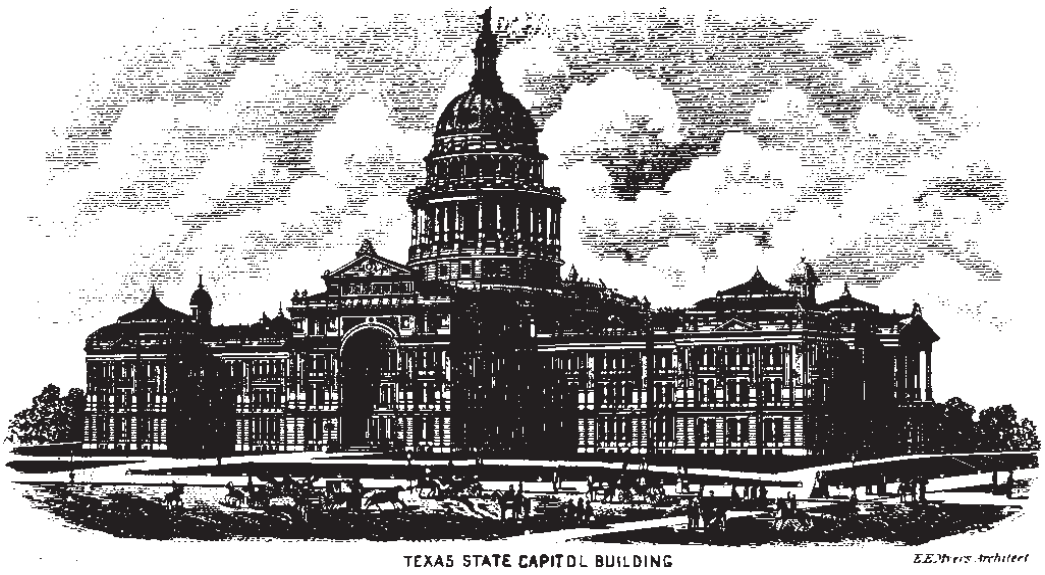
Sunset Advisory Commission



Department of Human Services

Staff Report

1998

SUNSET ADVISORY COMMISSION

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In 1977, the Texas Legislature created the Sunset Advisory Commission to identify and eliminate waste, duplication, and inefficiency in government agencies. The 10-member Commission is a legislative body that reviews the policies and programs of more than 150 government agencies every 12 years. The Commission questions the need for each agency, looks for potential duplication of other public services or programs, and considers new and innovative changes to improve each agency's operations and activities. The Commission seeks public input through hearings on every agency under Sunset review and recommends actions on each agency to the full Legislature. In most cases, agencies under Sunset review are automatically abolished unless legislation is enacted to continue them.

TEXAS DEPARTMENT OF HUMAN SERVICES

SUNSET STAFF REPORT

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EXECUTIVE SUMMARY

Executive Summary

The Department of Human Services (DHS) is primarily responsible for determining eligibility and certifying that clients are eligible to access long-term care and public assistance benefits. The agency administers more than 30 state and federally-funded programs designed to benefit low income families and children, people who are elderly or disabled, and victims of family violence. Services for families and children that help to support self-sufficiency are central to the State's efforts to comply with federal welfare reform and include Temporary Assistance to Needy Families (TANF), Food Stamps, and Medicaid eligibility. DHS is also responsible for providing long-term care services to needy persons who are blind, aged, or disabled through institutional and community care and Medicaid waiver programs. The family violence program educates the public about domestic violence and offers shelter and support services to victims and their children. In addition, DHS protects the health and safety of individuals in long-term care facilities through regulation of facilities such as nursing homes, institutional care facilities for the mentally retarded, adult day-care facilities, and personal care homes. DHS also licenses nursing facility administrators and credentials nurse and medication aides. To carry out its responsibilities, the Department had approximately 15,500 employees and a budget of $3.2 billion in fiscal year 1997. The Department is governed by the six-member Board of Human Services.

The Sunset review of DHS primarily focused on targeting the services for public assistance clients and improving the quality of long-term care services. Recommendations focus on improvements to contract management activities and the need for full implementation of outcome-based contracts in agency programs that purchase client services. The review also looked at improvements to regional management accountability, improving access to community care programs, and standardization and tracking of regulatory activities. The following material summarizes the results of the review.

1. Improve the Diversion of At-Risk Families Into Preventive Services to Help Break the Cycle of Welfare Dependency.

Families with the most complex, chronic problems have the most trouble in meeting Texas Works requirements and are most likely to lose all, or part, of their TANF benefits. Many TANF families will require expensive criminal and juvenile justice services, emergency medical and mental health care, and child protective services. The relationship between the TANF eligibility worker and an at-risk family provides an opportunity to direct clients into preventive services and away from high-cost, crisis-oriented interventions.

The Department should ensure that families at risk of losing or exhausting their TANF benefits have every chance to obtain the services they need to overcome their problems and participate successfully in employment programs. To achieve that end, DHS could actively identify family needs and problems and refer families to appropriate community health care services, drug and alcohol counseling, domestic violence programs, and other needed services. Services received as a result of such referrals make

family members more able to find and keep a job and help prevent later, high-cost intervention. In particular, DHS should ensure that children of at-risk families receive basic "safety-net" health and nutrition services that over time can help to break the cycle of welfare dependence.

***Recommendation**:* Require DHS to assess the service needs of families that are at-risk of being sanctioned or exhausting their benefits and require the Department to divert these families into preventive and support services offered by other agencies and organizations. Also, require DHS to prioritize the processing of sanctions.

2. Improve Access for the Aged and Disabled to Services in Community Care Programs.

Community care for aged and disabled clients has become an increasingly popular way for clients to have their daily living needs met while avoiding placement in institutional care. The State benefits from the use of these services, as they are typically less costly than institutional alternatives. Current program administration by DHS, however, can delay clients' access to these services. While waiting, clients can become sicker or not receive services that could delay or alleviate the need for placement in a nursing home. Prioritizing waiting list services, expediting eligibility determination, and using short-term care options will result in community care that is accessible to a greater number of people whose only choice previously would have been institutional care.

Recommendation: Require DHS to maintain need-based waiting lists for community care programs and authorize caseworkers to use presumptive eligibility procedures for clients seeking Community Based Alternatives or Primary Home Care services. Require DHS caseworkers to adjust a client's plan of care in response to a change in the client's condition, as determined by an official reassessment.

3. Improve the Quality of Community Care Services Through Better Contracting and Stronger Monitoring.

As use of community care programs continues to grow, the Department's ability to ensure that providers offer high quality services becomes increasingly important. Current contracting and monitoring practices limit the Department's ability to maximize resources and ensure quality services. DHS often enter into multiple contracts with one provider as well as contracts for providers that have no clients. As a result, the Department spends considerable resources to administer contracts rather than spending that time and money to provide direct care and client case management. The Department has not yet fully implemented performance contracting methods required by State law, and does not adequately monitor existing contracts. These practices increase financial risk and inhibit agency efforts to enhance service quality and protect the health and safety of clients.

Recommendation: Prohibit use of open enrollment contracting policies and require the use selective contracting procedures to minimize administrative costs. Require DHS to include the following provisions in all its contracts for community care services — clearly defined and measurable program performance standards based on client specific data; and clearly defined sanctions or penalties for nonperformance of any contractual obligations. Require DHS to use a risk assessment methodology to institute statewide monitoring of contract compliance of community care providers.

4. Strengthen DHS's Ability to Ensure that Quality Care is Delivered to Nursing Facility Clients.

As the largest purchaser of institutional care services, the Department must use all available tools to ensure that quality services are delivered to Texas' most vulnerable citizens. DHS has not taken full advantage

of the contracting process to address problems with consistently poor performing providers of institutional care. In addition, consumers do not have easy access to nursing facility performance and regulatory information. Easily understood and accessible information is critical to enable consumers to make fully informed decisions on where to place family members in need of nursing care.

Recommendation: Require DHS to develop rules setting minimum contract performance standards and include those minimum standards in all contracts for nursing facilities. Require the agency to assemble existing regulatory and service quality data in a format for use by the general public.

5. Strengthen Long-Term Care Regulation by Standardizing and Tracking Enforcement.

The agency has recently undertaken several major initiatives to overhaul its regulatory process in an attempt to improve the accountability of regulated facilities and to ensure quality care is provided to clients. The State must strive to ensure that quick and appropriate action is taken when problems are found in a long-term care facility. Current data on use of sanctions shows that opportunities exist to make more effective use of available sanctions. Also, data is not presently collected to track the timeliness of resolution of problems identified at nursing facilities. The lack of data limits the Department's ability to ensure timely resolution of faults or to effectively monitor the actions of regional staff.

Recommendation: Require the Department to continue to standardize enforcement policies and procedures across regions to achieve enforcement protocols that involve the full range of regulatory remedies, both state and federal. Require improved monitoring of regional regulatory offices for timely resolution of deficiencies and enforcement of sanctions. Require enhanced automated systems to track the history of each inspection and/or complaint investigation incident, including their resolution.

6. Increase Productivity by Establishing and Monitoring Regional Management Objectives.

DHS regional administrators are senior executives directly responsible for the effective delivery of critical human services. Regional administrators possess considerable decision-making autonomy in determining how services will be delivered. Autonomy allows for the flexible use of resources to meet unique local needs, but is not now coupled with a formal mechanism that holds regional administrators accountable for regional performance. At present, documentation of regional performance is based on budget management, compliance with federal requirements related to errors in benefit determination, and the diversion of clients away from TANF benefits. Regions have no performance or outcome based region-specific performance targets, strategies, or written objectives that gauge their performance and ensure Texas' citizens receive the best value for their tax dollars.

Recommendation: Require the DHS Commissioner to enter into a region-specific performance agreement with each Regional Administrator that sets performance objectives and includes key performance criteria related to legislative initiatives. Require the development of the regional performance agreement with the input of community health and human services providers, clients, and advocacy groups. Require the Department to consider regional objectives and performance in establishing regional budgets.

7. Improve the Administrative Hearings Process Through Transfer to the State Office of Administrative Hearings.

The Legislature has clearly expressed its intent to consolidate the hearings functions of state agencies if such a transfer would improve the independence, quality, or cost effectiveness of hearings. The review of the Department's APA hearings process indicated that SOAH has the ability to conduct the hearings

and that a transfer would provide more independence, would provide an equal level of quality, and could improve the cost effectiveness of the hearings process.

Recommendation: Transfer the Department's Administrative Procedure Act hearings to the State Office of Administrative Hearings

8. Decide on Continuation of the Texas Department of Human Services as a Separate Agency After Completion of Sunset Reviews of All Health and Human Service Agencies.

Most of the State's health and human service agencies are currently under Sunset review. While these agencies serve many unique purposes they also have many similarities that should be studied as areas for possible improvement through organizational change. This analysis should occur before decisions are made to continue the HHS agencies as separate entities, including the Department of Human Services.

Recommendation: Decide on continuation of the Texas Department of Human Services as a separate agency upon completion of Sunset reviews of all health and service agencies.

Fiscal Impact Summary

The recommendations of this report are intended to enable the Department of Human Services to better perform its functions within existing resources. Most recommendations will result in savings to the State but the savings cannot be estimated for this report. Those recommendations include improving the diversion of at-risk families, requiring the development contract performance standards for nursing facilities, improving access to community care programs, establishing and monitoring regional management objectives, and transferring the Department's administrative hearings to the State Office of Administrative Hearings. Other recommendations will result in minimal costs to the State or can be implemented with existing resources such as standardizing and tracking long-term care regulatory enforcement.

Approach and Results

Approach and Results

Approach

The Department of Human Services (DHS) is primarily responsible for administering financial assistance programs that provide social services for families and children, and for the aged and disabled. These programs are central to the State's efforts to support self-sufficiency and comply with federal welfare reform and include direct financial assistance, medical benefits, and food programs for income-eligible families. DHS is also responsible for institutional and community care and Medicaid waiver programs that provide long-term care services to needy persons who are blind, aged, or disabled. The agency also administers programs unrelated to a clients' income, including family violence services and disaster and refugee assistance. In addition, DHS fulfills the State's role to protect the health and safety of individuals in long-term care facilities through regulation of facilities such as nursing homes, institutional care facilities for the mentally retarded, adult day-care facilities, and personal care homes. DHS also licenses nursing facility administrators and credentials nurse and medication aides.

Beginning in 1983, the Legislature began dismantling much of DHS, transferring programs to other agencies.

DHS was created in 1939 as the State Department of Public Welfare to provide assistance to the poor, aged, and needy or abused children. The Legislature has modified the responsibilities of the agency numerous times since it was created. Over time, the history of DHS can be categorized by two major eras - a growth period from 1939 to about 1980 and a downsizing period beginning in 1983 through the present. The growth period was characterized by federal and state legislation that consistently broadened the agency's authority and responsibilities. Examples include the Medical Assistance program, Food Stamp program, Medicaid, Work Incentive program, and the Vendor Drug program.

Beginning in 1983, the Legislature began dismantling the agency and transferring programs to other state agencies amid performance concerns and assertions that the size of the agency and diversity of programs had become unwieldy. During this period, child support enforcement was transferred to the Office of the Attorney General, Medicaid-purchased health programs to the Department of Health, child and adult protective services and child care licensing to the newly formed Department of Protective and Regulatory Services, Medicaid administration to the Health and Human

Services Commission, and employment and child care services to the Workforce Commission.

The cumulative impact of the program transfers meant DHS was no longer in a direct service delivery role, but was left to determine eligibility for its two primary programs - public assistance and long-term care services. The agency also had a significant responsibility to provide administrative services to other health and human services agencies centered around the agency's position as the administrator of the core eligibility data system for the State.

Despite its downsizing, DHS is still at the center of the State's welfare reform.

The focus on program transfers does not diminish the importance of the programs still administered by DHS. The agency is at the center of the State's efforts to comply with the requirements of federal welfare reform to move clients off the welfare roles and into self-sufficiency. The need for long-term care services continues to increase as the population ages and new funding strategies have focused efforts on providing more alternatives for non-institutional care. Interrelated are the continued efforts to refine regulatory and contracting strategies to ensure quality care is delivered in long-term care facilities.

The Sunset staff looked for ways to improve the quality of client care and DHS program performance, and identified several areas for improvement. The recommendations in this report seek, in particular, to enhance and add value to the eligibility determination role that DHS plays. Sunset staff examined ways the agency could better target services for at-risk clients to help them achieve self-sufficiency. The review also focused on improving access to community care services, improving quality of care in nursing facilities through outcome-based contracting, and increasing the outcome-based accountability of regional administrators.

The Sunset review of DHS did not focus on areas addressed by other legislative committees.

The question of whether DHS should be continued as an agency is not addressed in this report. Because the programs of most health and human service agencies are currently under Sunset review, the Sunset Commission will complete its look across agency lines--at services provided, clients served, and funding sources, before making recommendations regarding DHS' organization and continuation. Staff recommendations regarding continuation of DHS will be included in the staff's work on HHS organization, to be completed in the Fall of 1998. This analysis will take into consideration the work of the interim committees currently studying DHS programs, the Senate Interim Committee on Home Health and Assisted Living Facilities and the Legislative Oversight Committee on Long Term Care Regulation.

Review Activities

In conducting the review of DHS, Sunset staff:

- Worked extensively with agency staff at DHS;
- Worked with staff of the Legislative Budget Board and State Auditor's Office;
- Researched agencies in other states with common functions;
- Researched agency information systems functions and applications;
- Reviewed legislative committee reports and attended hearings of the House Human Services and Economic Development committees, Senate Interim Committee on Home Health and Assisted Living, Senate Health and Human Services Committee, and Senate Finance and House Appropriations committees;
- Reviewed state statutes, past legislative reports and studies, and reports by the State Auditor's Office, State Comptroller's Texas Performance Review, and the Legislative Budget Board;
- Attended public meetings of the Board of Human Services and its Aged and Disabled, Client Self-Support Services, and Nursing Facility Administrators advisory committees;
- Met, upon request, with members of the Board of Human Services;
- Visited regional offices and discussed public assistance and aged and disabled client service delivery, regulatory, family violence services, and other agency activities with DHS staff in Arlington, Austin, El Paso, Houston, San Antonio, and Tyler;
- Visited DHS client service contractors, local health and human service departments, local Area Agencies on Aging, and regulated facilities in El Paso, Fort Worth, Houston, San Antonio, and Tyler;
- Met with various interest groups and trade associations, including ADAPT, American Association for Retired Persons, Disability Policy Consortium, Texas Health Care Association, Association for Home Health Care, Texas Medical Association, Center for Public Policy Priorities, Institute for Quality Improvement in Long Term Health Care, and the National Heritage Insurance Company;
- Attended meetings of the Long Term Care Regulatory Reengineering project working to implement the provisions of Senate Bill 190; and

- Worked with agency staff from the Department of Health, Health and Human Services Commission, Department of Protective and Regulatory Services, State Office of Administrative Hearings, Texas Workforce Commission, and the federal Health Care Financing Administration.

Results

The Sunset review of the Department started with an evaluation of whether the functions DHS performs continue to be needed. Public assistance services such as financial, nutritional, and medical assistance are critical for needy persons and their families who are seeking to become self-sufficient. As long as a growing percentage of the population ages, long-term care services will be needed to ensure those individual have the services necessary to maintain the activities of daily living. In addition, the State has a responsibility to ensure the health and safety of individuals receiving care in long-term care facilities. Notwithstanding the well-documented need for services provided by DHS, many of its services cross agency organizational lines, and an assessment of organizational alternatives needs to be performed before a decision can be made to continue the Department in its current form. After making this determination, the review focused on:

Aside from possible changes in organization, the Sunset review found several areas for improvement.

- improving the targeting of services for at-risk public assistance recipients;
- improving client access to community care programs;
- improving the quality of nursing facility and community care through outcome-based contracting and monitoring;
- improving the regulation of long-term care facilities; and
- establishing and monitoring regional management objectives.

Targeting services for at-risk clients — Under federal and state welfare reform, the main goal is to transition clients off public assistance and into self-sufficiency through work and personal responsibility by clients. Benefits are now time-limited, come with increased work requirements, and have sanctions for noncompliance. Welfare reform recognizes child support collection, domestic violence prevention, increased business involvement, family health and well being, and support services such as child care, as critical components of a comprehensive package to assist families in becoming self-sufficient. The impact of welfare reform is that states, under penalty of federal financial sanctions, must move operationally from mere eligibility determination under an entitlement system to active management of clients temporarily seeking benefits. Sunset staff examined the Department's efforts to implement the requirements of welfare reform and found opportunities for improvement. Although the Department is making

efforts to change its focus with the "Texas Works" initiative, most of the agency's resources are still directed at eligibility determination. **Issue 1** provides DHS with a way to focus on getting at-risk families into preventive services to assist them in their efforts to become self-sufficient.

Improving client access to community care programs — Community care for aged and disabled clients has become an increasingly popular way for clients to have their daily living needs met while avoiding placement in institutional care. The State benefits from the use of these services, as they are typically less costly than institutional alternatives. Over the last 10 years, the number of individuals being served in community care has increased over 60 percent. In response to the demand for these services, the Legislature authorized funds to fill an additional 4,000 slots in the Community Based Alternatives program. The agency, however, has had difficulty filling these slots on a timely basis despite having an extensive waiting list for the services. Sunset staff reviewed the program administration and identified several practices that can delay clients' access to these services. While waiting, clients can become sicker or not receive services that could delay or alleviate the need for placement in a nursing home. **Issue 2** provides strategies for the agency to improve access to its community care programs including prioritizing waiting list services, expediting eligibility determination, and using short-term care options.

DHS can improve clients' access to community care programs.

Improving the quality of long-term care through outcome-based contracting — The Legislature has repeatedly directed agencies that purchase client services to hold contractors accountable not only for the actual delivery of services but also for the quality of services delivered. The State is in a unique position of being able to require quality care from both the regulatory aspect through licensing and inspection and through the purchasing side as such a large buyer of long-term care services.

As use of community care programs continues to grow, the Department's ability to contract with high quality providers for high quality services becomes increasingly important. In fiscal year 1997, DHS spent approximately $600 million on community care services and managed approximately 1,900 contracts. Sunset staff identified current contracting and monitoring practices that limit the Department's ability to maximize resources and ensure quality services. For example, DHS policies result in entering into multiple contracts with one provider and many contracts for providers that have no clients. As a result, the Department spends considerable resources to administer contracts rather than spending that time and money to provide direct care and client case management. **Issue 3** directs the Department to fully implement performance contracting methods required by State law and to adequately monitor existing contracts.

Considerable public scrutiny has occurred over the last several years about the quality of care delivered in nursing facilities. Much of the reform effort has been initially focused in the regulatory area. As the largest purchaser of institutional care services, the Department has a strong financial tool to ensure quality services are delivered. In fiscal year 1997, DHS spent approximately $1.4 billion on institutional care. In addition, consumers can make better decisions on where to place family members in need of skilled nursing care if they have easy access to nursing facility performance and regulatory information. The Sunset staff review indicated DHS has not taken full advantage of the contracting process to address problems with consistently poor performing providers of institutional care. **Issue 4** seeks to strengthen the contracting process related to nursing facility care and directs the agency to make performance and regulatory data easily accessible to the public.

Contracting methods can be improved to strengthen monitoring and address problem providers.

Improving the regulation of long-term care facilities — As noted above, the 75th Legislature enacted Senate Bill 190 to correct a combination of identified weaknesses in state law in response to reports of ineffective regulation of substandard long-term care facilities. The agency has recently undertaken several major initiatives to overhaul its regulatory process in an attempt to improve the accountability of regulated facilities and to ensure quality care is provided to clients. Consistent with that effort, the Sunset staff reviewed data regarding the use of sanctions, which indicated that opportunities exist to make more effective use of available sanctions. Also, data is not presently collected to track the timeliness of resolution of problems identified at nursing facilities. The lack of data limits the Department's ability to ensure timely resolution of faults or to effectively monitor the actions of regional staff. **Issue 5** directs the agency to focus its reengineering effort on ensuring that DHS considers the full range of sanctions available to bring facilities into compliance. Efforts should also be made to ensure consistency of regulation in all regions of the State.

Regulation of long-term care should include consistent use of all available sanctions to ensure compliance.

Establishing and monitoring regional management objectives — Many of the problems identified above either result from or are exacerbated by the Department's regional management structure. Regional administrators possess considerable decision-making autonomy in determining how services will be delivered. Autonomy allows for the flexible use of resources to meet unique local needs, but can lead to inconsistent policy application if not managed. Sunset staff found that regions have no performance or outcome based region-specific performance targets, strategies, or written objectives that gauge their performance. The review found also, little public involvement in the agency's decisions regarding the regional allocations for administration and service delivery. This is becoming more important as the agency seeks to reallocate resources in the current environment of shrinking caseloads

due to welfare reform and the strength of the State's economy. **Issue 6** requires the DHS Commissioner to enter into a region-specific performance agreement with each Regional Administrator that sets performance objectives and requires the input of community health and human services providers, clients, and advocacy groups.

Oversight of regions needs strengthening to ensure policy is consistently followed.

Maximizing state resources — Sunset staff examined the administrative hearings function at DHS to assure that these hearings meet the State's goals of independence, cost effectiveness, and quality. **Issue 7** discusses the advantages of transferring the APA hearings to SOAH, including the historical cost savings resulting from previous transfers. The Department's fair hearings associated with federal benefit programs are not APA hearings, and thus would not be subject to the transfer.

Recommendations

1. Improve the diversion of at-risk families into preventive services to help break the cycle of welfare dependency.
2. Improve access for the aged and disabled to services in community care programs.
3. Improve the quality of community care services through better contracting and stronger monitoring.
4. Strengthen DHS's ability to ensure that quality care is delivered to nursing facility clients.
5. Strengthen long term care regulation by standardizing and tracking enforcement.
6. Increase productivity by establishing and monitoring regional management objectives.
7. Improve the administrative hearings process through transfer to the State Office of Administrative Hearings.
8. Decide on continuation of the Texas Department of Human Services as a separate agency after completion of Sunset reviews of all health and human service agencies.

Fiscal Impact

While significant future savings can be realized by diverting at-risk and sanctioned clients, and family members into alternative programs, the dollar figure on those savings is difficult to assess due to a lack of data from DHS. With the declines in client caseloads, DHS can adjust the duties of some

eligibility staff to assess at-risk families and divert them into existing preventive programs. The costs of assessing and diverting at-risk families can be met within the existing staff funding levels and the TANF block grant. DHS currently has unfilled eligibility staff positions and the federal government has indicated Texas has a TANF budget surplus when compared to previous Aid to Families with Dependent Children (AFDC) funding. By better using these TANF funds, DHS will be able to intervene in the cycle of welfare dependency, and help ensure that the future costs of social services are minimized. By prioritizing the processing of sanctions, DHS should realize savings over the current $1.6 million per month in sanctions through improved cash management.

The recommendation to improve access to community based services will have some initial costs to the agency that should be covered by savings over time. Maintaining risk-based waiting lists will involve additional DHS staff time in some cases but DHS staff already conduct the necessary needs assessments for other community care programs and much of the information will be available from the client's physician. Any additional cost should be offset by diverting individuals from entering higher cost nursing facility care. Presumptive eligibility carries a slight risk of providing services to clients who are later determined to be ineligible. In these cases, service costs may be covered through other federal funding sources, such as the Title III dollars available to serve individuals 60 years of age and older. Adjusting care plans to reflect a decreased need for services due to improvements in the client's condition should result in savings but the specific fiscal impact cannot be determined. All savings achieved through these recommendations would be reallocated within DHS for client services.

Requiring better contracting and stronger monitoring of community care services would result in a positive fiscal impact to the Department and the State. The savings would offset any costs associated with increased monitoring of provider compliance and performance since the Department would have fewer providers to monitor under a selective contracting system. Total savings from selective contracting cannot be determined as the number, value, and savings associated with contracts cannot be estimated.

The recommendation requiring DHS to develop contract performance standards for services to nursing facility clients would result in positive fiscal impacts to the Department and the State. Savings would accrue primarily through reduced payments to facilities providing substandard care. Total savings cannot be determined as the number, value, and savings associated with the contracts cannot be estimated. Requiring the agency to assemble existing regulatory and service quality data will require additional staffing

and other resources, but should be integrated into the current reengineering effort related to implementation of Senate Bill 190. The Department would achieve distribution of data to the public through the Department's existing toll-free phone numbers and Internet sites.

Improving the agency's long term care regulatory function by standardizing and tracking enforcement would have no additional fiscal impact to the State. Any costs associated with this effort should be included in the funds appropriated and budgeted for the current reengineering effort.

The recommendation requiring DHS to seek local input and set expectations for regional administrators to meet would be implemented with existing state office and regional staff. Considering regional objectives and performance in regional funding allocations should lead to a more efficient use of resources. Any savings generated could be used for additional client services.

ISSUES

Issue 1

Improve the Diversion of At-Risk Families into Preventive Services to Help Break the Cycle of Welfare Dependency.

Background

DHS conducts eligibility for public assistance benefits, helps clients find jobs, and provides referrals to other support services through its Texas Works program, formerly known as Client Self-Support. The focus of Texas Works is to help clients find employment and achieve independence from public assistance. For those clients who choose to use benefits, Texas Works performs eligibility determination for food stamps, Temporary Assistance to Needy Families (TANF), and Medicaid. The TANF program includes two components:

- cash grants to families substantially below the poverty level who lack financial support because one or both parents are absent or disabled; and
- grants to eligible two parent families when the principal wage earner is unemployed.

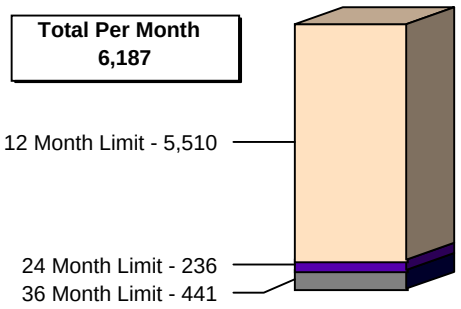
Over 6,000 Texans per month will lose benefits due to time-limits by 2001.

TANF recipients can receive Medicaid benefits and other services such as child care, employment services, and family planning.

As a result of recent welfare reform initiatives, federal and state laws limit the amount of time an individual can receive cash assistance during his or her lifetime. Under Texas welfare reform, clients can receive TANF benefits for 12, 24, or 36 months, depending on their education level and employment history. The hardest to employ clients get more months of benefits.

DHS has estimated the impact of time limits on Texas Works clients under state time limits. Approximately 3,600 TANF adults with work requirements will lose benefits each month starting this fiscal year, increasing to approximately 6,200 per month by fiscal year 2001. The impact of having 6,200 clients per month losing TANF is that more than 70,000 clients, and their family members, may be at risk of using higher cost state services.[1] The chart, *Adults Exhausting TANF*, shows how many TANF clients in each time limit category could exhaust their benefits by fiscal year 2001.

Adults Exhausting TANF Time Limits
Fiscal Year 2001



As of April 1998, the TANF caseload was about 190,000, of which approximately 71,000 have work participation requirements, with the remaining 119,000 TANF cases exempt from work requirements. Clients can be exempt from work requirements if they meet one of the following criteria — care for a child four years old or less, live in a county without work programs, experience a hardship, or have a good cause exemption such as domestic violence. The chart, *TANF Caseload Characteristics*, details TANF work requirements.

TANF Caseload Characteristics
Fiscal Year 1997

Time Limit	Caseload Number	TANF Cases w/ Work Requirements
12 Months	76,000	20,000
24 Months	38,000	51,000
36 Months	76,000	
	TOTAL	71,000

Source: DHS Programs Budget and Statistics, April 30, 1998.

DHS refers non-exempted TANF and food stamp recipients, and those exempted who volunteer, to the Texas Workforce Commission (TWC) for employment, job counseling, child care, and transportation subsidy services. The 74th Legislature transferred DHS employment services (JOBS) and child care (CCMS) functions to the newly-formed Texas Workforce Commission (TWC) in June of 1996. The chart, *Transfer of Work and Child Care Programs to TWC*, shows the programs, formerly in DHS, that are now located at TWC.

Transfer of Work and Child Care Programs to TWC

The Job Opportunity and Basic Skills Training Program (JOBS) was mandated by the Family Support Act of 1988, and was implemented by DHS in 1990. The goal of JOBS is to provide TANF caretakers access to education, job training, employment and child care to increase their ability to attain self-sufficiency. Ultimately JOBS will be administered by Local Workforce Development Boards, and TWC will manage the contracts with these local entities.

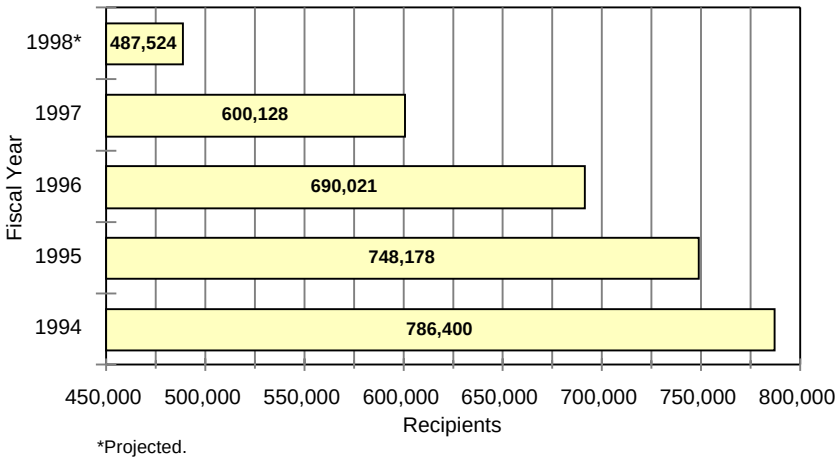
Child Care Management Services (CCMS) is the state system for providing subsidized child care as an employment support to TANF recipients, low income families, teen parents, and parents of disabled children. The CCMS system operates in partnership with TWC and 20 local human service agencies contracting to manage CCMS in 27 service delivery areas.

In fiscal year 1993, the economic recession pushed the number of Americans on food stamps and number of families on Aid to Families with Dependent Children (now TANF) to record highs. Between 1989 and 1994, assistance caseloads in Texas grew by 50 percent. Since 1994, caseloads have declined, including Medicaid cases. The following chart, *TANF Recipients Per Month*, shows the impact of declining caseloads as reflected in the decreasing average number of recipients per month getting benefits.

When potential clients apply for benefits, they are first screened through a DHS job placement resource room where the client completes a work assessment form, and DHS staff attempts to divert the client from starting their time-limited benefits. If the client chooses to go ahead with eligibility determination,

DHS assesses the client's education level, obtains financial eligibility information, and has the client sign the Personal Responsibility Agreement (PRA), which states what is expected of the client in exchange for benefits. DHS then refers the client to TWC for employment services, unless the client is exempt. TWC assesses the client for employability, and may revise the preliminary DHS assessment.[2] The chart, *TWC TANF Service Levels*, outlines the service levels assigned to a client by TWC. When TWC notifies DHS that the client has registered for employment services, DHS completes the eligibility determination process. Time limits on benefits start when the client receives notice from TWC of an opening in an employment services program.

TANF Recipients Per Month



*Projected.

Source: DHS Programs Budget and Statistics. April 17, 1998.

Adult TANF recipients and able-bodied 18- to 50 year-old food stamp recipients must actively seek work or, if they lack the education and background to compete for jobs, participate in job preparation activities. If a recipient fails to comply with work and other requirements, DHS can administer a sanction resulting in the denial of some cash benefits. The purpose of client sanctions are to increase compliance with program requirements, and motivate families to reach self-sufficiency.[3] DHS estimates that 25,000 TANF cases per month have one or more sanctions, with a monthly value of approximately $1.6 million in reduced benefits.[4] If a client moves off the assistance rolls before a penalty is imposed, the sanction can be pended if (or until) the client requests further assistance. The text box, *Client Sanctions*, details the sanctioning process and penalties.

TWC TANF Service Levels

Level I: Recent work experience, jobs skills training, or high school diploma, or equivalent.

Level II: Eighth grade or higher, no high school diploma, and some work experience.

Level III: Less than eighth grade, limited work experience, personal or family barriers.

The Sunset review focused on the Department's public assistance processes to determine whether clients receive needed services and DHS takes action when clients fail to meet their responsibilities. The review also examined if DHS has created unintended barriers for clients in the public assistance system.

25,000 TANF families per month have one or more sanctions.

Client Sanctions

If a non-exempt Texas Works client does not comply with employment services, child support, or the PRA, a financial penalty can be imposed. Clients are sanctioned for JOBS non-compliance at a minimum for one month (first violation), three months (second violation), and six months (third violation). The penalty will be waived if DHS determines the client has good cause, or has made a good faith effort to comply.

The penalties are:

- $78 for a single parent, or $125 for two parents, per month for violations of employment and child support requirements, and
- $25 per month, with a $75 cap, for PRA violations such drug abuse, lack of school attendance, and lack of child immunizations.

PRA penalties remain in effect until clients comply, except for drug and alcohol abuse which remains in effect until the next review.

Findings

▼ **Recipients who do not remove sanctions by meeting program requirements are at greater risk of using higher cost State services in the future.**

◗ Studies show that sanctioned families have higher rates of drug/alcohol abuse, mental/physical health problems, and involvement with child protective services.[5] Minnesota found that 40 percent of sanctioned families had at least two of these barriers to independence.[6] These barriers can make it difficult for clients to respond in a positive way to sanctions, therefore exposing the children and the elderly in these families to greater risks of using higher cost services on an emergency basis.

Sanctioned families need more preventive services to help them become independent.

Sanctioned families face multiple risk factors making them more likely to require services to help them become independent. These services include:

— criminal and juvenile justice intervention,

— at-risk children and youth programs,

— substance abuse programs,

— domestic violence services, and

— health care and nutrition programs.

- DHS acknowledges that at least 30 percent of the Temporary Assistance to Needy Families (TANF) caseload face, in addition to poverty, multiple barriers to self-sufficiency.[7] Many of these families have the potential of receiving reduced benefits through sanctions because of these barriers. The chart, *Barriers to Self-Sufficiency*, details factors increasing the difficulties Texas Works clients face in achieving independence.

Barriers to Self-Sufficiency

- Lack of work experience
- Lack of skills to obtain and keep employment
- Lack of financial child support
- Transportation problems
- Child care issues
- Housing instability
- Lack of appropriate role models
- Poor personal and social support systems
- Education - low basic skills and learning disabilities
- Physical disabilities
- Health or behavioral limitations
- Mental health problems
- Domestic violence problems
- Substance abuse problems

- Clients with extreme barriers to independence may not respond to sanctions at all and "drop out" of the TANF system, posing even greater risks to other family members by inadvertently penalizing their children by losing access to other benefits. In Texas, 41 percent of clients leaving TANF were on Medicaid one year later, showing a continuing need for medical services to needy families.[8]

- Targeting preventive services to children from TANF families, particularly families with other problems making them at-risk of incurring TANF sanctions, is critical to reducing the future costs of juvenile crime. Texas county juvenile probation departments show a 38 percent average TANF eligibility rate for children being placed out of the home by the courts.[9] These figures are consistent with the national average of 40 percent of juvenile crime being committed by children from TANF families.[10]

▼ Texas Works does not maximize the use of alternative resources by diverting sanctioned families into preventive services.

- Texas Works does not have procedures to divert the family members of sanctioned clients into preventive services that can assist families in breaking the cycle of welfare dependency. Texas Works eligibility practices continue to stem from the old AFDC program, which required fast processing of entitlement benefits under increasing case loads. Texas Works and participating families are now in a radically different environment under welfare reform, time limited benefits, and a declining caseload.

- While DHS identifies clients facing barriers to self-sufficiency, Sunset staff field visits showed that DHS does not have procedures in place to use sanctions to trigger diversion into preventive services. Sanctions specifically identify a target population in need of services. Penalties against clients can serve as "red flags," alerting DHS staff that a family may be in crisis and need preventive services. However, DHS takes no further action than to put the sanction in place.

▼ DHS caseworkers do not consistently access available services for sanctioned clients.

- As discussed previously, problems of domestic violence, drug abuse, high-needs children, and others can all lead to clients failing to meet requirements for TANF and achieve meaningful self-sufficiency. However, the State has services available to help address the barriers to independence facing families.

Violence and abuse in the home helps prevent families from breaking the cycle of welfare dependency.

- Family Violence programs provide shelter, legal assistance, counseling, and other non-residential services to victims of abuse. Victims of domestic violence have higher risks of being sanctioned for not meeting TANF program requirements. For example, abusive partners can actively prevent clients from meeting JOBS requirements. Studies show that nationally, approximately 25 percent of TANF recipients are currently victims of domestic violence, and approximately 60 percent have been abused in the past.[11] Sunset interviews with DHS eligibility workers showed that identifying, assessing, and referring families suffering from domestic violence to support services is not a priority.[12]

- As a result of H.B. 3428, 75th Legislature, DHS, TWC, and the Attorney General's Office, in consultation with providers, are examining how family violence programs can better meet the needs of TANF clients.

- Studies show that female children subjected to abuse/neglect in the home are 77 percent more likely than not to be arrested for drug and property crimes as adults.[13] The Texas Department of Protective and Regulatory Services (PRS) provides support services that could help TANF families reduce the risk of abuse/neglect in the home, and help reduce crime rates. PRS services that troubled families can access

include community-based Family Outreach centers that focus on strengthening family life, and the Services to At-Risk Youth (STARS) program. STARS uses community-based contractors to provide 24-hour availability of family crisis intervention, short-term residential care, and counseling to runaways, truants, and youth in at-risk situations.

- Drug and alcohol abuse is another major factor that can work to prevent families from achieving independence. Youth and families can receive services from the Texas Commission on Alcohol and Drug Abuse (TCADA). The goal of TCADA is to change attitudes and behaviors relating to the use of alcohol and drugs through prevention, education and treatment. TCADA provides services through contracts with local providers. These programs target prevention and intervention services to different populations including youth, pregnant women, infants, persons with health conditions, and those involved in the criminal justice system.

- While TANF clients exempted from work requirements may wish to volunteer for employment services, they can be prevented from doing so if they have children with special needs. Children less than three years of age, and at risk of developmental delay, can receive services from the Texas Interagency Council on Early Childhood Intervention (ECI). ECI administers a statewide system of early intervention services to ensure that eligible children receive medical services, and families receive case management services that can assist them in developing independency skills. These services are available at no cost to families. Sunset staff, during field visits found that Texas Works staff were mostly unaware of local ECI programs and rarely referred families to ECI programs.

Texas Works staff are often unaware of programs that could benefit DHS clients and their families.

- DHS provides clients with Texas Works program information and referrals to other services primarily using printed handouts and pamphlets for clients to take home. Sunset field visits found that the quality, readability, and comprehensiveness of these handouts varied widely between offices, at times were almost unreadable, and were not always provided in the clients' first language.

▼ **Other states are following through with welfare reform by targeting preventive services to at-risk, or sanctioned, clients.**

- As the numbers of families with multiple barriers to independence increase, other states, including Illinois, Minnesota, Nebraska, and Oregon, are diverting TANF clients into preventive services. Oregon identified problems faced by the "bottom third" of hardest to serve TANF clients, including mental health (75 percent), drug/alcohol abuse (50 percent), violence/sexual abuse (50 percent), criminal history (30 percent), and no high school education (42 percent).[14] Oregon diverts TANF clients into mental health and substance abuse programs, and estimates that diverting these high risk families into alternative programs results in savings of five dollars in future social services costs for every dollar invested.[15]

- Other states, including Wisconsin, Nevada, Utah, and Oregon also use sanctions as a means to identify at-risk families, and to encourage these families to participate in TANF work and personal responsibility requirements.

TANF sanctions are inconsistently assessed, applied and managed between DHS, TWC, and the OAG.

▼ **DHS does not consistently or rapidly apply TANF sanctions.**

- Sanctions can only be an effective tool if quickly and consistently applied. Sunset field visits found that DHS regions do not impose sanctions in a consistent manner. The sanction implementation processes between DHS, the Texas Workforce Commission (TWC), and the Office of the Attorney General (OAG) are an inconsistent mix of electronic, paper, and verbal notices, and use of manual verifications. In addition, DHS processing and data entry policies treat client sanctions the same as other changes, like a client's address, and do not prioritize the processing of sanctions.[16]

- DHS also has no management information to know whether sanctions are working, or even taking place. For example, DHS does not know the average time it takes to process a sanction, and does not track backlogs. As a result, DHS does not have management information to discover delays in sanctioning, and to address the impact of those delays.[17]

Delayed sanctions have negative impacts including:

— wasting state and federal funds by sending incorrect benefits to clients,

— eroding the effect of sanctions to motivate clients to participate in program requirements, and

— decreasing the ability of DHS to identify at-risk families for services.

- DHS processing of sanctions is made more difficult by the quality of information received from both TWC and OAG. DHS staff indicated during Sunset field visits that sanction processing can be delayed by TWC sending large batches of pending sanctions at one time that are time-consuming to process. DHS has also indicated that, since August 1997, OAG has not provided appropriate computer tapes to sanction clients for failure to meet child support requirements.[18]

DHS is presently unable to sanction clients for failure to meet child support requirements.

- Sunset staff found barriers in client "hand-offs" (transitioning) between DHS, TWC, and the OAG, when clients access these agencies. The successful use of sanctions as a compliance tool also depends on client transitioning between agencies to enable DHS to correctly apply sanctions, and to enter changes in the DHS database to reduce, or restore, benefits.

Sunset staff field visits identified several factors that affect client transitioning including:

— inadequate information materials about program requirements,

— co-located offices not being open the same hours,

— co-location not resulting in improved cross-agency referrals, and

— OAG on-site staff being removed from DHS offices.

Conclusion

While welfare reform has created methods to help clients break the cycle of reliance on public benefits, the process may prove costly in several respects. Families who have the greatest difficulty in breaking the cycle are likely to be sanctioned for not participating in program requirements, may fall out of the Texas Works system completely, or may fail to take the steps necessary

to obtain or continue to receive benefits. Others may use up their time-limited benefits. These high-risk families potentially enter the most expensive systems—those that are also the least effective from a prevention standpoint. For example, criminal and juvenile justice, emergency medical and mental health care, and child protective services are crises oriented, and costly.

Texas has a window of opportunity to help the children of TANF families to break the cycle of welfare dependency.

Prevention can have a significant impact on families. Children in families where drug abuse is prevalent are more likely to also abuse drugs. Children who live in abusive families may require protective services such as foster care. Studies show that juvenile crime is closely related to drug abuse, family violence, and high unemployment.

As high-risk families begin comprising a growing percentage of the declining DHS caseload, DHS, while attempting to break the cycle through job assistance, has not shifted its focus to ensure that the families most at risk of failing the TANF system receive alternative services to prevent high-cost intervention later. DHS, by becoming a facilitator of currently available services, can identify and assist families to receive essential services. Children in these at-risk families should be given the opportunity to break the cycle of welfare dependence by getting families into available services.

Recommendation

Change in Statute

- **Require DHS to assess the service needs of families that are at-risk of being sanctioned or exhausting their benefits.**
- **Require DHS to divert these families into preventive and support services offered by other agencies and organizations.**
- **Require DHS to prioritize the processing of sanctions.**

While DHS Texas Works has implemented new initiatives to help clients find employment, the core of the program still functions similar to the AFDC program, with a focus on eligibility determination. DHS can incorporate a social work function into agency services that can help reintegrate DHS, and it's clients, into the fabric of support systems to assist clients in reaching meaningful self-sufficiency, reduce the future costs of social services, and help reduce juvenile crime.

This recommendation will prepare the State of Texas for the fuller implications of state and federal welfare reform as time limits on benefits come into effect and an increasing percentage of the caseload is composed of families at a higher risk of imposing greater costs to the

State. DHS will need to adopt rules defining clients "at-risk" of being sanctioned, or of losing services that will impact the most vulnerable family members. DHS will be able to better ensure that benefits to eligible children are not interrupted by identifying at-risk families, assessing their needs, and diverting them into preventive services.

The chart, *Client Diversion Example*, shows a potential client diversion process for DHS. This example is an attempt by Sunset staff to illustrate how DHS might improve the diversion process. DHS would need to determine the best overall approach.

By prioritizing the processing of client sanctions, the State will realize the full cost reduction when a TANF benefit is lowered. In addition to preparing the State for the long-term impacts of welfare reform, the recommendation will strengthen and improve the agency's existing information, assessment, and referral process for all clients generally.

Management Action

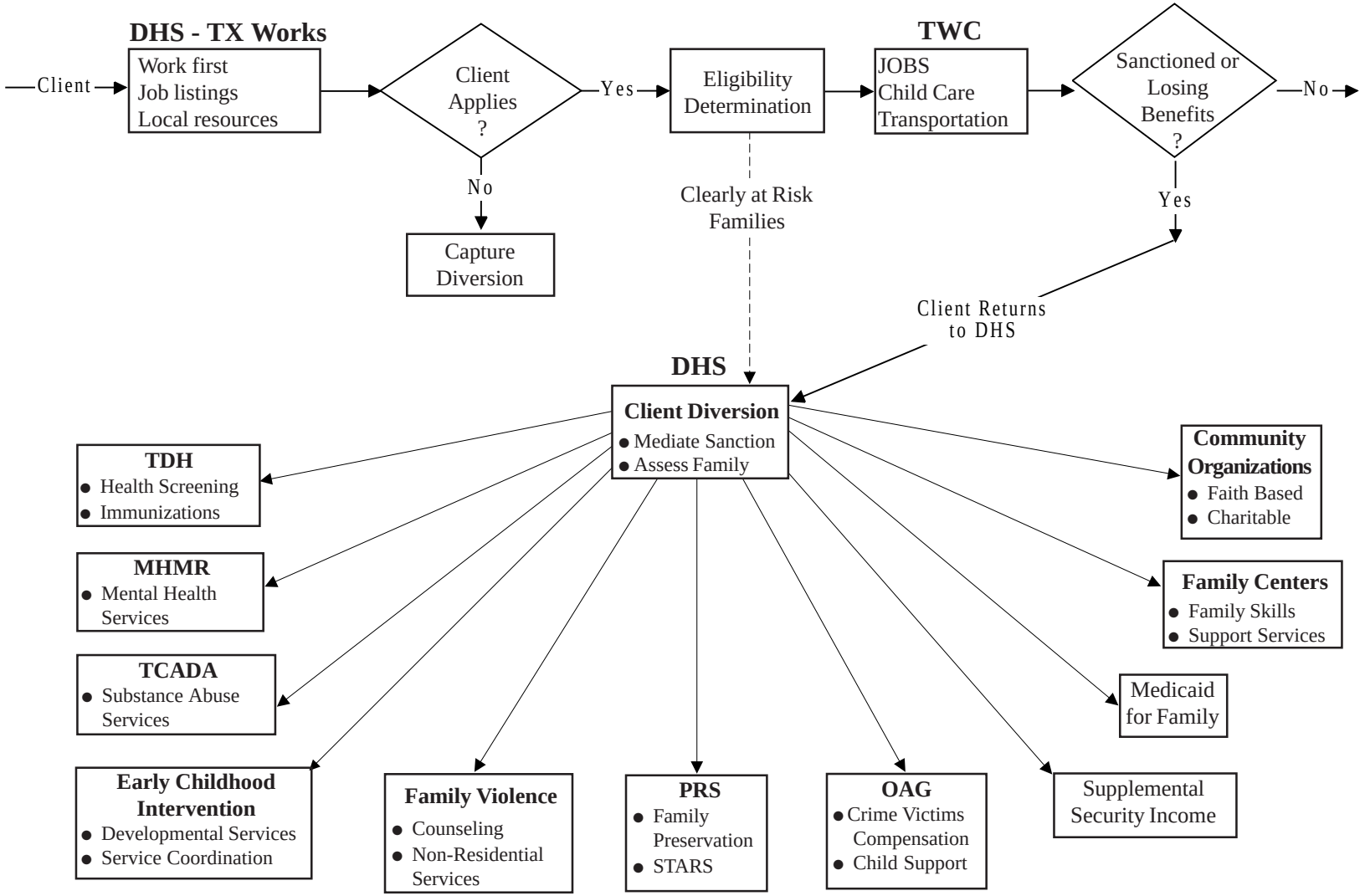
- **DHS should review current client service policies to:**
  - **improve, where possible, current client "hand-offs" to other state agencies during eligibility, sanctioning, and diversion processes; and**
  - **improve the quality of client handout materials.**

By reviewing current client "hand-offs" (transitions) to other state agencies, DHS can improve Texas Works service delivery, and help bring more clients into program compliance by removing barriers to services. DHS should manage the production of a basic packet of program information on participation requirements, benefit time-limits, and client rights/responsibilities for distribution to the regions. By producing better program information, DHS could better inform clients of changes in the welfare system to prepare them for independence.

Fiscal Impact

With the declines in client caseloads, DHS can adjust the duties of some eligibility staff to assess at-risk families and divert them into existing preventive programs. The costs of assessing and diverting at-risk families can be met within the existing staff funding levels and the TANF block grant. As of April 1998, the DHS Texas Works program had 1,038 eligibility staff positions unfilled statewide.[19] In addition, an analysis by the United States General Accounting Office shows that in 1997 Texas had a 32 percent (239.2 million dollars) TANF budget surplus when compared to a baseline of program costs derived from the previous AFDC funding based upon caseloads.[20] By better using these TANF funds, DHS will be able to intervene in the cycle of welfare dependency, and help ensure that the future costs of social services are minimized.

Client Diversion Example



States across the country are facing TANF budget surpluses as caseloads decline and current funding levels remain constant. Federal law requires that states maintain, and spend, 80 percent of their pre-TANF state contribution to the costs of welfare. States must maintain these spending levels or face a dollar-to-dollar penalty on the TANF grant. Because states are not increasing cash benefits, these surplus funds may be spent on increased services to clients.[21]

DHS estimates that approximately 25,000 TANF clients per month have at least one sanction, and these client sanctions have a monthly value of approximately $1.6 million to the State. As the number of clients facing multiple barriers to independence increases in the caseload, DHS anticipates that the number of sanctioned families will increase. By prioritizing the processing of sanctions DHS will realize savings over the current $1.6 million per month through improved cash management.

While significant future savings can be realized by diverting at-risk and sanctioned clients, and family members into alternative programs, the dollar figure on those savings is difficult to assess due to a lack of data from DHS. Diverting clients into support services could also better prepare Texas to qualify for new funds from federal high performance grants such as the Illegitimacy Bonus Fund, where five states will be awarded $100 million to each state over five years, starting in fiscal year 1999.

[1] Telephone interview with Lea Isgur, Director of DHS Programs Budget and Statistics, April 30, 1998.

[2] TWC is currently implementing statewide functional literacy assessments that will increase the amount of TANF clients in the harder to employ categories. Currently an average of 100 TANF client service levels are revised downwards per month, and DHS expects this number to rise.

[3] Pavetti, Olson, et al. *Designing Welfare-to-Work Programs for Families Facing Personal or Family Challenges: Lessons from the Field.* December 30, 1996. Page 15. Http:/www.urban.org/welfare/report2.htm, downloaded. April 2, 1998.

[4] *Management Information Focus Report*, DHS, March 1998. Page 27.

[5] Pavetti, Olson, et.al. *Welfare-to-Work Options for Families Facing Personal and Family Challenges*. The Urban Institute, 1998. Page. 10. Http://www.urban.org/welfare/pave1197.html. Downloaded February 2, 1998.

[6] *Survey of Sanctioned Families*, Minnesota Department of Human Services. March 6, 1996.

[7] "Welfare and Workforce Reform," comments by DHS Commissioner Eric Bost. January 27, 1998. Also: DHS Programs Budget and Statistics, April 17, 1998.

[8] *Medicaid Dynamics in Texas: Recidivism, Program Transfers, and Turnover.* Texas Health and Human Services Commission Fiscal Policy Division, Research Department. May 1998. Page 18.

[9] Juvenile screenings of children placed out of the home by courts, conducted by Bell, Bexar, Dallas, Denton, Tarrant, and Williamson counties for Title IV-E administrative claiming purposes. Texas Juvenile Probation Commission. April 17, 1998.

[10] Telephone interview with Vonzo Tolbert, Director of Research and Planning, Texas Juvenile Probation Commission, April 12, 1998.

[11] *Trapped by Poverty, Trapped by Abuse: New Evidence Documenting the Relationship Between Domestic Violence and Welfare.* Jody Raphael and Richard M. Tollman, Ph.D., School of Social Work, University of Michigan. April 1997. Page II.

[12] Sunset field visits to local DHS offices in Austin, Houston, Dallas/Ft. Worth from January-April, 1998.

[13] Cathy Wisdom. *The Cycle of Violence*. Research in Brief, National Institute of Justice, October 1992.

[14] *Newest Challenge for Welfare: Helping the Hard-Core Jobless*. The New York Times. November 20, 1997. Page A-1 and A-14.

[15] Ibid.

[16] DHS Eligibility Services. April 30, 1998.

[17] Ibid.

[18] Letter from Eric Bost to Dan Morales, June 12, 1998.

[19] *Regional Information and Performance Report.* DHS Regional Operations.

[20] *Welfare Reform: State are Restructuring Programs to Reduce Welfare Dependence.* United States General Accounting Office. June 1998. Page 79.

[21] *Welfare Spending: More for Less.* Jack Tweedie. State Legislatures, March 1998.

Issue 2

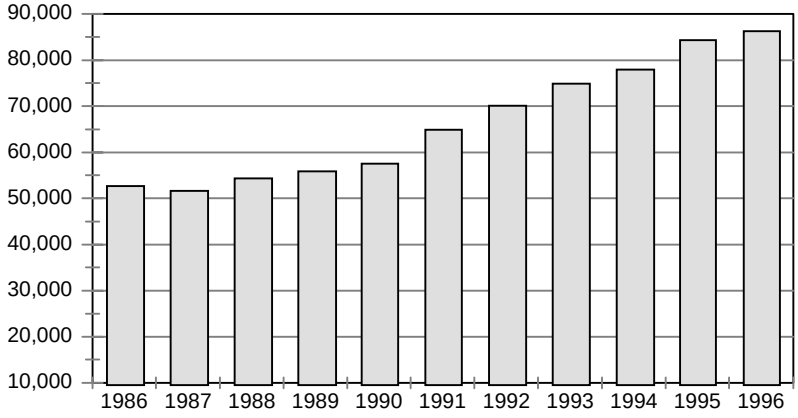
Improve Access for the Aged and Disabled to Services in Community Care Programs.

Background

Community care has been an increasingly popular option for individuals seeking assistance with tasks of daily living.

Community care has been an increasingly popular option for individuals seeking assistance with tasks of daily living. Traditionally, the only option available to an individual who did not possess the resources to pay for care in their home was entrance into a skilled nursing facility. Beginning in the mid-1970s, the federal government made funds available to the states to provide care outside of traditional nursing home settings, thus allowing individuals to maintain their independence in the familiar surroundings of their home and/or community. As the chart *Community Care, 10-Year Trend* illustrates, in 1986, 52,651 individuals were served in the community compared to 54,145 who received services in a traditional nursing facility. By 1996, the number of individuals receiving community care services grew to 86,262 (an increase of 64 percent) while nursing home care experienced much smaller growth with 65,234 individuals (an increase of 20 percent) receiving care. In addition, the overall cost of providing care in the community in 1996 was only slightly higher than the amount of dollars spent to care for individuals in a nursing home in 1986. [1]

Community Care
10-Year Trend



In addition, individuals with increasingly complex needs are now being served in the community through programs such as the Community Based Alternatives (CBA) waiver program, that provides services such as personal assistance, physical therapy, and nursing services. Federal waivers allow states to operate programs that involve exceptions to Medicaid's basic principles, such as the requirement that a program be available statewide. (See *Texas Medicaid Waiver Programs* textbox) To qualify for CBA services,

the individual must meet the same financial and medical criteria as an individual seeking services in a traditional nursing facility. The chart, *CBA Client Profile*, provides basic information on who receives CBA services. The average age of a CBA client is 71 and costs have averaged 78.8 percent of what would have been spent to care for these individuals in a nursing facility. [2] The demand for CBA services has been high, as reflected in the program's waiting list of 10,428 individuals in February 1998.

Texas Medicaid Waiver Programs

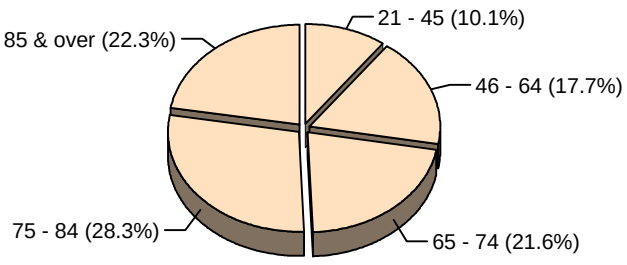
Medicaid Waiver Services

Community Based Alternatives (CBA): A 1915(c) waiver that provides long-term care services outside of institutional settings to people over 21 who qualify for nursing care and people with disabilities.

Community Living Assistance and Support Services (CLASS): A 1915(c) waiver that allows Texas to provide community-based services to people with developmental disabilities other than mental retardation as an alternative to ICF-MR VIII institutional care.

DHS also provides a wide variety of services to the disabled community across Texas. In December of 1997, people with disabilities made up approximately 28 percent of the individuals receiving services through DHS community care programs.[3] In addition, the Community Living Assistance and Support Services (CLASS) waiver program is designed specifically to meet the needs of physically disabled individuals. DHS delivers all community care services on a first come, first served basis and many of these programs have long waiting lists. In the meantime, some of these individuals may end up entering skilled nursing facilities because their physical and financial conditions make them unable to wait for services delivered in the community. This is particularly true for individuals seeking services through the Community Based Alternatives (CBA) waiver program.

CBA Client Profile
(Age Distribution)



The Sunset review examined the intake process for community care services to determine whether current DHS practices enable clients to maintain their independence and prevent institutionalization. In addition, the Sunset staff considered whether the agency's approach to service delivery allowed for the use of all available service options.

WAITING LISTS FOR COMMUNITY CARE

Findings

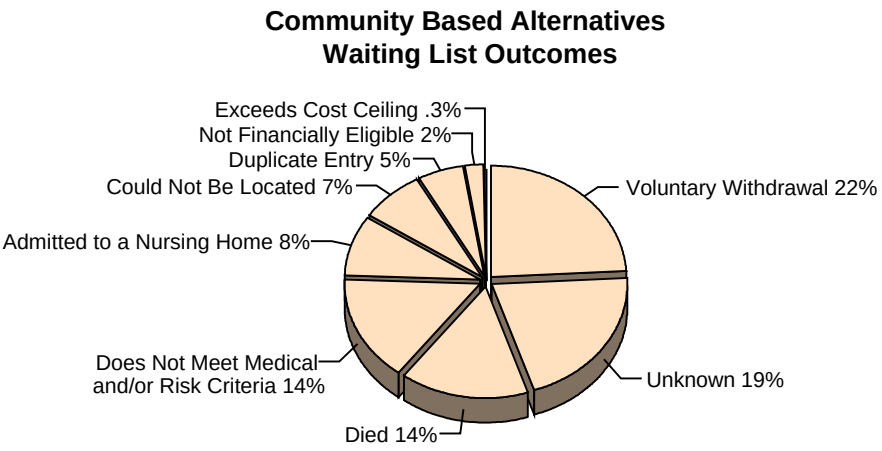
▼ **DHS's waiting list policy does not address the risk of institutional placement for those individuals most in need of services.**

◗ As of February 1998, all DHS community care programs, except Primary Home Care and Frail Elderly had waiting lists. By maintaining waiting lists on a first come, first served basis, DHS has been unable to meet the demand for services provided in the community for the most needy clients. No distinction is made for individuals in need of only a few services versus those individuals whose situations are more complex and have a need for comprehensive services. As a result, these medically complex individuals at high risk for institutional placement may never receive services in the community before their condition forces them into a nursing home. Such individuals ultimately end up costing the State more, since the cost of providing care in a facility such as a skilled nursing center is greater than the cost of caring for that individual in the community.[4]

By maintaining waiting lists on a first come, first served basis, DHS has been unable to meet the demand for services provided in the community for the most needy clients.

◗ The Community Based Alternatives program provides a good example of the costs to both the client and the State of not including risk assessments to determine waiting list status. Since the CBA program was designed to serve individuals who functionally qualify for nursing home level of care, these individuals are at the greatest risk as they wait to receive care. Although DHS was authorized funds during the 1997 Legislative Session to fill an additional 4,000 slots in the CBA program, many of these slots remained unfilled as late as February 1998.

The Department's first step in filling the additional slots was to work through the "interest list" the agency had maintained. Caseworkers discovered that many of the individuals had gone into institutions, died, or were otherwise unreachable. Of the 10,428 individuals deleted from the waiting lists, about 8 percent entered nursing facilities, costing the state an additional $3,307,560.[5] The *Community Based Alternatives Waiting List Outcomes* chart shows preliminary regional data on 4,546



individuals who were deleted from waiting lists across all the DHS regions.

- For individuals seeking services, a lack of information regarding clients on the waiting list created lengthy delays in filling new CBA slots. DHS policy initially required individuals seeking services to wait until the entire waiting list had been contacted before consideration for placement in CBA. Six months after the additional CBA slots became available, the Department began accepting new clients at the same time that caseworkers finished contacting individuals on the waiting list.

- As noted earlier, the CBA waiting list is the largest, but other community care programs also maintain waiting lists (See *Community Care Waiting Lists* table). As of February 1998, all of the Department's community care programs, except Primary Home Care and Frail Elderly, had a waiting list. The Community Living Assistance and Support Services (CLASS) waiting list is another example of the length of time individuals can wait for services. The CLASS waiver was designed to meet the needs of individuals with physical disabilities who were not eligible for admittance into an Intermediate Care Facility for the mentally retarded or the Home and Community Support Services waiver at MHMR. Unlike most of DHS's community care program clients, a large portion of CLASS clients are children who require services for a lengthy period of time. The client population, combined with the fact that CLASS services are not available statewide, means that individuals on the waiting list, may wait for as many as five years to receive services.

Community Care Waiting Lists Outcomes

Community Care Program	Waiting List February 1998
Community Based Alternatives (CBA)	10,428
In-Home and Family Support	8,069
Community Living Assistance & Support Services	4,105
Emergency Response Systems	2,106
Home Delivered Meals	2,046
Family Care (Primary Home Care Title XX)	1,585
Residential Care	341
Client Managed Attendant Services	330
Day Activity and Health Services	288
Respite Care	178
Adult Foster Care	29
Special Services to Persons with Disabilities	5

Conclusion

Community care for aged and disabled clients has become an increasingly popular way for clients to have their daily living needs met while avoiding placement in institutional care. The State benefits from the use of these services, as they are typically less costly than institutional alternatives. Current program administration by DHS, however, can delay clients' access to these services. While waiting, clients can become sicker or not receive services that could delay or alleviate the need for placement in a nursing home. Prioritizing waiting list services will result in community care that is accessible to a greater number of people whose only choice previously would have been institutional care.

Recommendation

Change in Statute

- **Require DHS to maintain need-based waiting lists for community care programs.**

This recommendation would require DHS to assess clients seeking community based services to determine the level of risk of placement in a nursing home. When DHS must place clients on a waiting list, DHS would assign clients a priority level based on this assessment to ensure those most at risk of institutionalization would receive the next available program slot. This system would be similar to a hospital emergency room where those most in need receive services first.

This change would have the greatest impact on the CBA and CLASS waiver programs. These programs, both with extensive waiting lists, would first provide services, when available, to the most frail clients. Conversely, due to limited funding, some eligible clients would wait longer for services than under the current first come, first served system. However, assigning priority to the most needy individuals meets the Department's mandate to use community care services to prevent the future need for more expensive levels of services. In addition, if community care dollars can be maximized, thereby decreasing the dollars spent for institutional care, the opportunity exists to expand the Department's community care programs.

In many cases, individuals seeking services from a program with a waiting list have already been assessed by a DHS caseworker to determine if another DHS program might meet some of their needs. The information from these assessments could be used to place individuals on the waiting lists of other programs if additional services were needed. For individuals who are not assessed in any way by DHS, the individual's physician may be able to provide enough information for DHS to determine the individual's risk of needing

nursing home care if community care services are not provided quickly. Since obtaining doctors orders can be a lengthy process, DHS should simply consider physicians as a resource and not as a required part of the eligibility determination process. DHS should also develop a simplified assessment process solely for determining waiting list placement.

Presumptive Eligibility Determination

Findings

▼ **A lengthy eligibility determination process delays services to those in need of immediate services.**

◗ The eligibility determination process, as set by federal statute, can take as long as 90 days to complete for individuals under the age of 65 and up to 45 days for individuals 65 years of age and over. To qualify for DHS programs, an individual must meet both functional and Medicaid financial criteria. During this waiting period, the condition of some individuals deteriorates to the point where they are forced to enter an institutional care setting. This is particularly true for individuals seeking CBA or Primary Home Care services funded through Frail Elderly funding. In many cases, these individuals have put off seeking assistance until their condition requires immediate action. For individuals who are in a crisis situation and seeking CBA or Frail Elderly services, a few weeks delay can have a devastating impact.

For individuals who are in a crisis situation and seeking CBA or Frail Elderly services, a few weeks delay can have a devastating impact.

◗ According to DHS eligibility determination staff, determining financial eligibility is the most time-consuming part of the eligibility determination process. DHS caseworkers must complete functional assessments within 1 to 14 days, depending upon the priority assigned to the client. The functional assessment also requires a physician's signature, which can delay the process for a few days.

Financial assessments, however, can be delayed for a week or more as the Medicaid eligibility worker waits for official documentation from sources such as banks and legal firms. According to regional eligibility staff, completion of financial eligibility determination in less than 30 days is unusual.[6] Sixty percent of the cases completed statewide during a two-week period in January/February 1998 required more than 30 days to certify the client's eligibility; almost six percent of those

cases required more than 90 days to complete.[7] Agency staff also stated that the DHS Medicaid eligibility worker is usually able, based on an initial review, to make a relatively accurate judgement that the client is highly likely to financially qualify for services, but must wait for third-party confirmation.

- Presumptive eligibility allows an individual to begin receiving Medicaid services before the individual is officially documented to be Medicaid eligible. Nursing homes have traditionally been willing to assume the financial risk of accepting a resident before Medicaid eligibility determination has been completed. The result is that an individual seeking care in a nursing home can be admitted in a very short time period whereas that same individual who wishes to remain in the community may have to wait up to three months before receiving services. Allowing the use of presumptive eligibility for individuals seeking CBA services would give DHS caseworkers the same option that already exists for nursing facilities.

Allowing the use of presumptive eligibility for individuals seeking CBA services would give DHS caseworkers the same option that already exists for nursing facilities.

- DHS has already begun to explore this option on a limited basis and is scheduled in summer 1998 to begin a streamlined application process for Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) clients to allow them to self-declare their financial eligibility for Medicaid. Based upon this information, the client is determined to be eligible and services may begin while the Department verifies the information through a third party. For QMB clients, DHS pays the individual's Medicare premiums, deductibles, and coinsurance fees for Medicare-covered services. For SLMB clients, the Department only pays Part B Medicare premiums. Neither of these programs involve the direct delivery of services; however, these concepts could be used to expand the concept into the CBA and Frail Elderly Primary Home Care service areas.

- Little risk arises from determining a client is eligible for Medicaid before receiving third party confirmation of financial status. A small percentage of individuals may ultimately be determined ineligible for Medicaid services. The risk, however, is slight, as demonstrated by the percentage of individuals who were removed from the CBA waiting list due to financial ineligibility. Out of a pool of over 10,000 individuals who had expressed interest in receiving CBA

services, DHS determined only two percent were financially ineligible.[8] The DHS eligibility determination process would further reduce this percentage. The development of DHS policies guiding the use of presumptive eligibility, such as time limits for receiving services under presumptive eligibility, would also reduce the risk to the State.

- If ineligible individuals do receive services, the majority of those individuals would be eligible to receive services funded by Title III dollars currently managed by the Texas Department on Aging. Title III funding does not require financial eligibility, but simply that the individual be over the age of 60. DHS Aged and Disabled staff indicated that approximately 75 percent of community care clients are age 65 and over[9]; therefore, the majority of individuals determined eligible through presumptive eligibility would qualify to receive Title III funds to cover costs of providing care. Difficulties in accessing these funds are addressed in the Sunset staff report on the Texas Department on Aging.

Conclusion

The goal of most elderly and disabled individuals is to remain independent and in their own homes for as long as possible. For this reason, many individuals wait until their condition has deteriorated significantly before seeking assistance from DHS. The fragile nature of these potential DHS clients requires the quick delivery of community care services to prevent these individuals from requiring nursing home care. The length of time required to gather functional and financial information to determination program eligibility is a barrier to the quick delivery of services. DHS caseworkers generally have easy access to enough information to presume the individual does qualify for services, allowing the client's condition to stabilize before more expensive nursing home care is needed.

Recommendation

Change in Statute

■ **Authorize DHS case workers to use presumptive eligibility procedures for clients seeking CBA or Primary Home Care services through Frail Elderly funding.**

Presumptive eligibility would enable some individuals to obtain services more quickly and prevent a further deterioration of their condition requiring more comprehensive and more expensive care in an institutional setting. The majority of clients would benefit from presumptive eligibility since 60 percent of these cases currently require 30 days or more to determine Medicaid eligibility. For individuals who meet the functional criteria to qualify for CBA services or for Frail Elderly funding, the waiting period could be decreased by a week or more.[10] Procedures for using presumptive eligibility, such as the development of client profiles to determine who would benefit most and present the lowest risk to DHS from the use of presumptive eligibility, would further decrease the number of individuals subsequently determined to be ineligible.

Adjusting Levels of Care

Findings

▼ **DHS caseworkers are not adjusting levels of care to match the needs of clients.**

◗ When an elderly or disabled individual first enters into the DHS Community Care system, a care plan is created that outlines the amount and types of services the client needs. Two reviews are conducted by DHS caseworkers to assess the client's needs. At six months, the caseworker is required to reassess the client to determine if the current care plan is appropriate. If the client requires additional services, those services are immediately added to the care plan. For some clients, however, the need for services has diminished since their entry into the DHS system, particularly individuals recently released from the hospital. At the annual assessment, the plan is again reviewed and changes are made to reflect changes in the client's needs.

Regional staff believe they do not have the authority to decrease services if warranted by a change in the client's condition until the annual reassessment. However, according

Regional staff believe they do not have the authority to decrease services, if warranted by a change in the client's condition, until the annual reassessment.

to staff at the state office, caseworkers are able to change services in response to any change in the client's condition. This confusion may lead to the provision of unnecessary services and wasted tax dollars.

- Clients have full access to an appeals process if they disagree with any DHS action. In any instance in which the client disagrees with a service change, DHS policy requires the agency to continue to provide services at the level prescribed in the original care plan until the annual review of the plan takes place. Federal Medicaid policy also requires that the client receive advance notice of an adverse action, including a reduction of services. The client then has the opportunity to appeal any changes. This process ensures that service level decisions are made based on the client's condition and not as an attempt to stretch agency resources.

DHS has traditionally thought of community care services in terms of long-term service delivery.

- Delivering care at a level to meet the client's condition may result in the availability of more resources for individuals with more complex and chronic needs, as well as potentially serving a greater number of individuals. DHS has traditionally thought of community care services in terms of long-term service delivery.[11] For the majority of DHS clients, their need for services may indeed exist for long periods of time. However, some individuals within the aging and disabled population have service needs that are short term.

  The Legislature has recognized the need for short-term services by funding Texas Department on Aging's Options for Independent Living program, which provides services for approximately three months. The caseworkers' inability to consider a range of appropriate care options in response to a client's changing needs hinders the agency's ability to use the short-term services model used by TDoA.

Conclusion

A number of individuals seek community care assistance from DHS to address short-term needs, such as those needs resulting from a hospitalization. Immediately upon release, these individuals may require a high level of care. That level of need, however, may change rapidly as the individual recovers. Unclear direction from the State office has resulted in confusion among regional caseworkers over the authority of the Department to adjust levels

of care downward in response to changes noted during assessments of the client's condition. Full use of short-term care options will result in more appropriate care for clients while also enabling the Department to maximize limited resources and serve additional clients through community care programs.

Recommendation

Change in Statute

- **Require DHS caseworkers to adjust a client's plan of care in response to a change in the client's condition, as determined by an official reassessment.**

Although DHS policy does require caseworkers to adjust care to appropriately meet the client's needs, the policy is not consistently implemented. For many DHS clients, care needs are only likely to increase as the client ages. For some individuals, however, once their condition has stabilized they no longer need the same level of care. Allowing the caseworker to appropriately adjust services received in those situations simply reinforces the notion that care should not be provided beyond what the client needs and is consistent with federal regulations. DHS needs direction that its caseworkers can and should make changes in care levels as appropriate. Current appeals and protections will remain in place, ensuring client input into determinations of the level of care they receive.

Fiscal Impact

The recommendation to maintain risk-based waiting lists will involve additional DHS staff time in some cases. However, for some clients, DHS staff already conduct the necessary needs assessments for other community care programs, such as Home Delivered Meals; the client's physician may also have the necessary information. DHS staff will assess the client's condition when alternative sources of information are not available. The intent of risk-based waiting lists is to prevent individuals from entering higher cost nursing homes. The resulting savings are expected to more than offset any additional costs to DHS.

In carrying out presumptive eligibility, a slight risk exists of providing service to those later determined to be ineligible. In these cases, service costs may be covered through other federal funding sources such as the Title III dollars available to serve individuals 60 years of age and older. In any case, savings would result from early provision of less-costly community services to those who would otherwise enter nursing homes.

The recommendation to adjust care plans to reflect a decreased need for services due to improvements in the client's condition may also result in savings; however, the specific fiscal impact of these recommendations cannot be determined. All savings achieved through these recommendations would be reallocated within DHS for client services.

[1] DHS, “Overview of Long Term Care Services,” July 1997.

[2] DHS, “Fact Sheet, Community Based Alternative Program”, March 1, 1998.

[3] DHS, “FY 98 Grant Benefit Budgets by PAC”, March 26, 1998.

[4] DHS, “Fact Sheet, Community Based Alternative Program”, March 1, 1998.

[5] DHS, “Fact Sheet, Community Based Alternative Program March 1, 1998” and “Community Based Alternatives Mapper System Data Base Statistics Statewide” March 1, 1998.

[6] Telephone conversation with Martha Strickland, DHS Medicaid Eligibility Supervisor, Central Texas Region 7, February 11, 1998.

[7] DHS, “Timeliness of Application Disposition, Mid-month report” February 7, 1998.

[8] DHS, “Community Based Alternatives, Mapper System Data Base Statistics Statewide” March 1, 1998.

[9] Telephone conversation with Jackie Johnson, Acting Deputy Commissioner, DHS, February 11, 1998.

[10] Conversation with Anita Anderson, DHS staff, April 14, 1998.

[11] Meeting with Jackie Johnson, DHS Deputy Commissioner, February 23, 1998.

Issue 3

Improve the Quality of Community Care Services Through Better Contracting and Stronger Monitoring.

Background

DHS contracts for a variety of services to provide long-term care assistance to elderly and disabled people. The Department provides care primarily through two programs — institutional care services and community care programs. DHS contracts with nursing facilities to provide institutional care to Medicaid recipients who have a documented medical condition requiring the skills of a licensed nurse regularly.

In fiscal year 1997, DHS spent nearly $600 million on community care services and managed 1,900 contracts.

Community care services are designed to prevent or delay institutionalization. DHS contracts with home health agencies to provide assistance with activities of daily living, such as bathing and dressing, in the clients' homes. In addition, the Department has used waivers from federal Medicaid rules that allow the agency to use funds designated for institutional care to contract for services in the community. These waiver programs include the Community Based Alternatives waiver (CBA) and the Community Living Assistance Support Services (CLASS) waiver. These contracts provide comprehensive care services, such as skilled nursing, that are not available through regular DHS community care programs.

DHS reimburses community care providers, typically home health agencies, monthly based on the actual hours of service authorized by DHS and delivered to the client by the provider. In fiscal year 1997, DHS spent approximately $600 million on community care services and managed approximately 1,900 contracts.

Typical services provided through DHS community care contracts:

- Adult Foster Care
- Home Delivered Meals
- Emergency Response Service
- Personal Assistance Services such as:
  - bathing
  - dressing
  - meal preparation
  - housekeeping
- Respite Care
- Minor Home Modifications
- Assisted Living/Residential Care

Providers of community care who wish to receive clients from DHS become eligible through the agency's open enrollment process. In an open enrollment procurement system, any licensed provider that meets contracting standards is eligible to provide services and receive clients. Contract requirements ensure that providers are licensed, have a minimum of two months operating funds to provide services, and have adequate staff to provide services. While any

provider with the capacity to provide the array of services can become a DHS provider, DHS does not guarantee the provider any clients.

Regional staff perform all monitoring of the Department's contracts with community care providers, with the exception of the CLASS waiver program which is monitored by State office staff. Current monitoring efforts focus on ensuring the financial compliance of providers. DHS requires no additional monitoring; however, several regions have begun compliance monitoring for some of their community care programs.

The focus of DHS monitoring visits is on billing and other paperwork errors, not on a provider's compliance with clients' plans of care, and the quality of services.

The Sunset review focused on current contracting practices at DHS to procure community care services; and whether changes to those practices could strengthen the Department's ability to ensure the delivery of quality services.

Findings

▼ **DHS does not consistently monitor community care providers throughout the state.**

- Currently, DHS does not have a statewide system of compliance monitoring of the Department's community care providers. Monitoring is left to the discretion of the regions to design, schedule, and implement. Interviews with regional staff indicated that the level of compliance monitoring of community care providers varied greatly. Not all regions that do compliance monitoring evaluate the same programs. For example, some regions do compliance monitoring for all of their programs while others only do fiscal monitoring. The result is a patchwork of varying levels of monitoring across the state.[1]

- In most regions, compliance issues are dealt with only when discovered as a part of the fiscal monitoring process. Compliance issues may also be addressed in response to consumer complaints; or changes in the physical condition of the resident that are either self-reported, reported by family or a home health agency, or noted by a DHS caseworker.

▼ **DHS does not focus on holding community care providers accountable for client outcomes.**

- The focus of fiscal monitoring visits is on billing and other paperwork errors, not on a provider's compliance with clients'

plans of care, and the quality of services that are subsequently delivered. As a result, DHS does not maintain reliable information on which providers are meeting client's needs and which ones are performing poorly.

- DHS contracts do not include performance or outcome measures and providers are not required to report such measures. DHS is in the process of updating a contractor handbook to be used by DHS contract management staff that does include some outcome measures, but DHS staff do not monitor providers on items not currently included in the contract.

- Sanctions are not widely used as an accountability tool against substandard providers. Standard sanction tools include corrective action plans, client hold (the contractor cannot take new clients), and vendor hold (the Department withholds payment). However, few regions use the sanction options available to address providers' noncompliance issues. DHS was unable to provide comprehensive, detailed information on the use of sanctions by each region.

  For example, providers in some regions were reluctant to accept new CBA clients when the Legislature funded new slots. DHS regional staff have the authority to sanction providers for failure to provide services according to contract requirements, however, regional staff are not consistently using the sanctions available and have expressed some confusion over DHS policy on how to apply sanctions.[2]

DHS contracts do not include performance or outcome measures and providers are not required to report such measures.

▼ The DHS contracting process does not enhance quality of care and is inefficient.

- DHS' open enrollment policy allows any licensed provider to contract with the agency to provide services, regardless of whether additional providers are needed. As a result, many providers who contract with the agency do not have any clients. For example, a third of the more than 300 contracts in the Houston area do not have any clients. Those contracts, however, still require administrative and technical support and oversight from DHS staff. Providers without clients also drive up the rates DHS pays for care since provider overhead costs are included in the cost reports used to set reimbursement rates for all providers.

- The open enrollment process is not an incentive to provide quality care, especially for providers of community care. Providers do not have to worry about whether they will lose the DHS contract to another local provider who may provide better services. DHS also does not have any way to evaluate providers to distinguish those that provide quality services. Since DHS is not able to differentiate the higher quality providers, a large amount of DHS caseworkers' time is subsequently taken up providing technical assistance to poorer performing providers to improve quality of care.

- Many providers have multiple contracts with DHS even though the services purchased by the Department are similar. DHS has several programs that provide essentially the same services for clients. While DHS has recently consolidated contracts for many regular community care programs, separate contracts are still required to provide services through the Department's waiver programs. Most of the contracting duplication occurs between the Primary Home Care (PHC) program and the Community Based Alternatives (CBA) waiver program.

  For example, contractors seeking to provide emergency response services to individuals in the PHC program and the CBA waiver program must sign two separate contracts even though the service being provided is the same. A contract manager in one region estimated that combining the contracts for waiver and non-waiver programs would cut the number of contracts administered in each region in half.[3]

  Managing multiple contracts also makes the development of a risk-based monitoring system more difficult since providers are monitored separately for each contract. Currently, information on a contractor with a problem providing services to PHC clients may not be considered when the provider is monitored for delivering the same services to a CBA client. Each contract requires separate legal, administrative, monitoring, and enforcement efforts.

The open enrollment process is not an incentive to provide quality care, especially for providers of community care.

▼ DHS lacks consistent enforcement of contract management policies.

- Contracting for community care programs has traditionally been left to the regions to manage. Without clear direction

from the State office, regions have developed differing management practices that have led to confusion among regional staff about the State office policies and procedures. The lack of clear direction for regional contract management staff has resulted in contract staff that do not use all of the existing tools to address problems that arise with providers.

As an example, regional directors recently expressed confusion over a region's authority to sanction providers. As the regions attempted to enroll new clients in the CBA program, the program staff discovered that some providers were reluctant to accept new clients, a clear violation of DHS contract standards. The confusion over how and when providers can be sanctioned for noncompliance with their contract resulted in DHS not sanctioning any providers for their unwillingness to accept new clients.[4]

Regional autonomy has led to confusion and differences in contract monitoring across the state.

- Regional autonomy has also led to regional differences in contract monitoring. Based on interviews with contract managers across the state, some regions have aggressively pursued both fiscal and compliance monitoring of all their community care providers while other regions have waited for instruction from the State office. Variations in regional policy also impact providers, such as home health agencies, that must comply with differing monitoring requirements across the State. Several large home health agencies operate across regions in Texas and must prepare for different types of monitoring, often for the same services, depending upon the region's monitoring policies.

▼ **Despite recent efforts by DHS, problems identified by the Department's Internal Auditor continue to exist and directives from the State Auditor and the Legislature continue to be inconsistently applied.**

- A 1997 DHS internal audit report noted the lack of performance measures in community care contracts and inconsistent monitoring of providers. In response to this report, the DHS board adopted outcome measures for future contracts for CBA services and the Department created a committee to revise the contracting handbook. However, the vast majority of aged and disabled clients are receiving services under contracts that have no performance measures. Although progress has been

made in CBA contracts, the Department must actively work to develop outcome measures for non-waiver programs as well.

- The agency has not fully developed other contract administration system components as required by state statute and has not implemented recommendations from the Department's Internal Auditor, including:

  — development of outcome measures to be included in all community care programs;

  — development of risk assessment criteria for use in a statewide fiscal and compliance monitoring system; and

  — criteria to select providers who allow the Department to meet "best value" contracting requirements, the purchase of quality services at the lowest possible price.

The Legislature has directed all health and human service agencies to consider contractor performance, financial resources, ability to perform, experience, and responsibility into contractor selection.

- The State Auditor's Office (SAO) has released a series of reports focused on contract management at four health and human Service agencies, including the Department of Human Services. SAO has noted the importance of including outcome measures in all provider contracts and using a risk management system to structure provider monitoring.

- Legislation from the 74th Legislative session required the Department to include performance measures in all contracts. In addition, the Legislature has directed all health and human service agencies to consider contractor performance, financial resources, ability to perform, and experience and responsibility into contractor selection.[5]

Conclusion

As use of community care programs continues to grow, the Department's ability to contract with high quality providers for high quality services becomes increasingly important. Current contracting and monitoring practices limit DHS's ability to maximize resources and ensure quality services. DHS policies result in entering into multiple contracts with one provider and many contracts for providers that have no clients. As a result, the Department spends considerable resources to administer contracts rather than spending that time and money to provide direct care and client case management.

DHS has not yet fully implemented required performance contracting methods, and does not adequately monitor existing contracts. These practices increase financial risk and inhibit agency efforts to enhance service quality and protect the health and safety of clients.

Recommendation

Change in Statute

- **Prohibit use of open enrollment contracting policies and use selective contracting procedures to minimize administrative costs.**
- **Require DHS to include the following provisions in all of its contracts for community care services:**
  - **clearly defined and measurable program performance standards based on client specific data, and**
  - **clearly defined sanctions or penalties for nonperformance of any contractual obligations.**
- **Require DHS to use a risk assessment methodology to institute statewide monitoring of contract compliance of community care providers.**

Medicaid law allows selective contracting if consumers have a choice among providers. Using selective contracting would allow the Department to focus limited staff time and resources on providing higher quality services to more clients. The implementation of selective contracting procedures should include steps to ensure that more than one provider is available in a specific geographic area. Including outcome measures in community care contracts will refocus the State's attention on ensuring quality service delivery, rather than simply focusing on meeting minimum federal and state requirements. In addition, discontinuing the use of open enrollment policies and using selective contracting procedures, as well as the inclusion of outcome measures in contracts, will bring DHS into compliance with the best value contracting principles required by the Legislature of all health and human service agencies.

Finally, selective contracting and the inclusion of outcome measures will not impact the quality of care delivered unless appropriate monitoring of providers takes place. Since continual monitoring of all community care providers is not an effective use of limited resources, the Department should design a risk-based monitoring system that focuses on poor performing providers to ensure that quality services are being delivered to clients.

Management Action

- **DHS should develop statewide contracting policies and procedures to guide areas such as contract procurement, monitoring, and sanctioning to be used in all DHS regions.**

Regional autonomy has left regional directors and their staff unclear about their responsibilities when contracting for community care services. Clearer direction from the State office would address areas of confusion that exist relating to current agency policy. With greater understanding of contracting policies and procedures, regional directors will be better able to manage provider contracts and use sanctions where appropriate to maintain high quality care among providers. Regions should maintain a certain level of autonomy and authority to allow regional staff to respond to regional concerns.

- **DHS should explore requiring all providers to use one contract for waiver and non-waiver program services.**

Multiple contracts with one provider create an unnecessary administrative and monitoring burden for the Department and the providers. Combining the waiver and non-waiver program contracts would give the Department a complete picture of each provider's service delivery system that could be used to determine the risk posed by each provider. In addition, a single contract across program areas will allow the Department to streamline monitoring of similar services provided through different programs, decrease the number of administrative errors, and reduce the time and money required to administer multiple contracts.

Fiscal Impact

This recommendation to use selective contracting procedures would result in a positive fiscal impact to the Department and the State. The savings would offset any costs associated with increased monitoring of provider compliance and performance since the Department would have fewer providers to monitor under a selective contracting system. Total savings from selective contracting cannot be determined as the number, value, and savings associated with contracts cannot be estimated. Any savings achieved through implementation of this recommendation should be reallocated within the Department for client services.

[1] Interviews with DHS regional staff in El Paso, Austin, and Houston areas. January through May 1998.

[2] Telephone interview with DHS State Office Contract Management staff, April 30, 1998.

[3] Sunset staff interview with DHS Regional staff, Region 7, May 1998.

[4] Sunset staff interview with DHS State Office Contract Management and Internal Audit staff, May 1998.

[5] Tex. Gov. Code Ann. ch. 2155, sec. 2155.144 (Vernon 1997).

Issue 4

Strengthen DHS's Ability to Ensure that Quality Care is Delivered to Nursing Facility Clients.

Background

DHS has two primary roles with respect to Long Term Care — purchaser and regulator. DHS contracts for a variety of services to provide long term care assistance to elderly and disabled people. Care is provided primarily through two programs - institutional care services and community care programs. DHS contracts with nursing facilities to provide institutional care to Medicaid recipients who have a documented medical condition requiring the skills of a licensed nurse. The State reimburses facilities at a daily rate for client care based on the level of care provided each resident. In fiscal year 1997, the approximately $1.4 billion DHS spent on institutional care accounted for 70 percent of the dollars spent on long-term care.

In fiscal year 1997, DHS spent $1.4 billion on long-term care.

Clients must be determined medically and financially eligible to receive nursing facility services through DHS. To be admitted into a nursing home, an individual must require nursing care on a daily basis. Nursing facilities complete the medical assessment for individuals seeking nursing facility care. Providers of institutional care who wish to serve DHS clients become eligible through the agency's open enrollment process. In an open enrollment procurement system, any licensed provider that meets contracting standards is eligible to provide services and receive clients. While any provider with the capacity to provide the array of services can become a DHS provider, DHS does not guarantee the provider will receive any Medicaid clients. A 1986 moratorium on nursing home contracts prevents the open enrollment of new providers. However, the existing facilities were contracted with on an open enrollment basis rather than based on selective contracting practices of choosing the best provider at the lowest cost.

DHS contracts with the National Heritage Insurance Company to receive information from nursing facilities to determine whether an individual's medical condition requires the skilled nursing care provided by a nursing facility. Residents are assigned a Texas Index for Level of Effort (TILE) rate that determines the amount the nursing facility will be reimbursed for providing care. TILE rates are broken into four categories — heavy care, rehabilitation, clinically complex, and clinically stable. Nursing homes

1998 Rates for Texas Index for Level of Effort Categories		
Care Needs	**Payment Code**	**Daily Cost of Care**
Heavy Care	201	$123.82
	203	$105.13
Rehabilitation	202	$110.89
Clinically Complex	204	$88.53
	206	$83.38
	208	$73.64
Clinically Stable	205	$82.49
	207	$76.10
	209	$68.96
Clinically Stable with Mental/Behavioral Condition	210	$60.58
	211	$58.53

receive the highest reimbursement rate for individuals classified as heavy care (see table *1998 Rates for Texas Index for Level of Effort Categories*). Payment levels can be adjusted every six months in response to a change in the resident's condition. The nursing facility submits information to DHS to make payment level changes.

Utilization review staff at the Health and Human Services Commission (HHSC) conduct reviews of the information nursing homes submit regarding changes in residents' conditions. The focus of the utilization reviews is to determine the validity of the data submitted by the nursing facilities for reimbursement. Nurses from HHSC visit each nursing facility in Texas approximately every seven months. Twenty-five to thirty percent of the forms submitted by each facility to DHS are compared with the residents to determine if the resident's condition matches the information sent to the Department for reimbursement. If problems are discovered, the nursing facility must carry out a corrective action plan and undergo a second review by the utilization review staff. Fraud discovered during the review is referred to the HHSC Medicaid Fraud staff. Incidents of abuse are referred to the Long Term Care Regulatory staff at DHS. The UR process recoups about $10-$12 million per year in incorrect Medicaid payments.

Sample of Survey Components

- Assessment of the delivery of services such as medication dispensation and nutrition.
- Appropriateness of the physical structure in accommodating the residents' needs.
- Fire safety components such as building structure, fire alarm systems, and building exits.
- Licensure requirements such as structural requirements, the type of clients that can be served, the kind of services to be provided, how long those services will be provided and by whom.

Nursing homes must comply with state and federal certification requirements to participate as providers in the Medicaid program. To be certified, a nursing facility must meet all federal Health Care Financing Administration (HCFA) standards along with life safety code requirements and licensure standards. DHS conducts annual survey visits to monitor a facility's compliance with HCFA rules and regulations. HCFA rules cover a broad array of requirements for administering and delivering services in a nursing facility. Fire safety components and licensure requirements are also monitored during the survey visit. The overall purpose of these sets of rules and regulations is to promote and provide for the safety and well-being of the residents.

In 1997, the Legislature passed S.B. 190 to address problems with nursing facilities that do not meet these licensing and certification requirements. S.B. 190 is focused on improving the quality of care delivered in nursing facilities through the development of a minimum acceptable level of care for use in survey visits, imposing penalties for noncompliance, and developing a quality index to provide the public with information concerning the quality of care delivered by nursing facilities.

The Sunset review focused on current contracting practices at DHS to procure institutional care services and whether changes to those practices could strengthen the role of contracting in ensuring the delivery of quality services. The review also looked at the information currently being collected on nursing facilities and how that information is used both within the agency and by the general public.

Findings

▼ **DHS does not make best use of the contracting process to address service delivery problems in nursing facilities**.

◗ The State has an obligation as the largest purchaser of nursing facility services, and as the representative of some of Texas' most vulnerable citizens, to contract for quality services. Contracting is the instrument through which the State carries out this dual role of consumer and caretaker. The role of contractor differs from the State's regulatory function whose mission is to monitor minimum licensing standards. Although contracts generally provide methods to sanction providers determined to be out of compliance, contract monitoring has never resulted in a canceled contract with a nursing facility.

Contract monitoring has never resulted in a canceled contract with a nursing facility.

DHS has not established minimum contracting standards for nursing facilities. Currently, as long as the facility meets licensure and certification requirements, their contract with the Department is renewed automatically. Without contracting standards, nursing facilities are only subject to regulatory standards set by HCFA and state licensure and certification requirements.

In DHS' community care programs, contract staff use a variety of sanction tools, including contract cancellation, to deal with providers who have violated contract provisions. In community care, providers are subject to separate licensure and contracting requirements. A community care provider may meet Home and Community Support Services Agency licensure standards and still be sanctioned by DHS due to contract violations. In one region, in fiscal year 1997, the Department terminated 12 community care contracts for contract violations.[1]

Sources of Nursing Facility Information

Regulatory Information - DHS collects a wide variety of information through on-site survey visits including the physical condition of the facility; nutrition services, including the dietary needs of the residents; and the condition of a sample of residents.

Cost Reports - Cost reports are submitted by the facility for reimbursement and reviewed by DHS Internal Audit for accuracy.

Utilization Reviews - Nurses from the Health and Human Services Commission review resident assessment information to determine whether the level of care assigned to a resident is appropriate.

Minimum Data Set - The MDS is an assessment of the residents' general condition. It includes items such as medical condition, mental status, and rehabilitation potential. This assessment is done upon admission, quarterly, and annually, or if significant changes occur in the resident's condition. Medicaid nursing facilities are required to submit their MDS to DHS.

- DHS does not use available information to judge contractor performance. However, DHS collects data about the performance of nursing facilities that can be used to determine best value (see *Sources of Nursing Facility Information* textbox). Regulatory data contains information such as the record of facility compliance with state and federal standards, sanctions for violations, and the outcomes of any corrective action plans. The Department also receives cost report data and utilization review data. Cost report information indicates the dollars spent on staff to provide direct care to residents. The amount of staff per resident can be one indicator of the quality of service delivered in the facility. The utilization review data provides information on the quality of the medical judgements being made by the facility.

Additional information is contained in the self-reported data nursing facilities must complete to meet HCFA requirements. The Minimum Data Set (MDS) is used by the nursing facilities to develop a plan of care for each resident and requires a comprehensive collection of information about the resident ranging from basic demographic information to mood and behavior patterns. While DHS does collect MDS data, the information is not currently used by the Department to determine Medicaid reimbursement rates. The data is used to verify the information submitted by the nursing facility on the assessment form currently being used by the Department to determine reimbursement rates. The federal government is also accessing the MDS data collected by the Department to determine Medicare reimbursement rates.

Regulatory information is not easily accessible or understandable to the general public.

▼ **The State and consumers are not fully informed on the quality of care being delivered in nursing facilities.**

- Regulatory information is not easily accessible or understandable to the general public. The Department collects regulatory information to meet the needs of the survey staff and not the needs of the general public. The focus of the information, therefore, is on facility compliance with health and safety requirements, HCFA rules and regulations, and complaint investigations. The data is not gathered with the intent of providing information to the public on the quality of care delivered in specific facilities. The result is data that is

not user-friendly. An individual must know what to ask for to get the information needed to select a facility. In addition, even if the individual does receive survey data, the information is likely to be in a format that is not easily understood and not related to the quality of care provided in the facility.

- DHS is no longer receiving nursing home information it had previously used to make important policy changes. Utilization Review nurses at the Health and Human Services Commission review the data nursing homes submit to change the amount DHS reimburses the facility for providing care. The utilization review function was previously a part of DHS, however, the program was transferred to HHSC during the 75th Legislative session as a part of the State's efforts to address the problem of Medicaid fraud.

  Since moving to the Commission, Utilization Review reports have not been shared with the Department. Interviews with staff at DHS and the Health and Human Services Commission indicate that the reports were not purposely discontinued; rather, no provision was made to continue reporting the data to DHS after the program was transferred. DHS used to receive monthly Utilization Review reports that contained information on the number of TILES reviewed, the number of errors detected, and the amount of money recouped from the nursing facilities. The information identified problem areas and was used to make necessary policy changes or training changes to address the problems.

Conclusion

As the largest purchaser of institutional care services, the Department must use all available tools to ensure that quality services are delivered to Texas' most vulnerable citizens. DHS has not taken advantage of the contracting process to address problems with consistently poor-performing providers of institutional care. In addition, consumers do not have easy access to nursing facility information. Easily understood and accessible information is critical to enable consumers to make fully informed decisions on where to place a loved one in need of skilled nursing care.

DHS should use its contracting process to deal with consistently poor-performing providers.

Recommendation

Change in Statute

- **Require DHS to develop rules setting minimum contract performance standards and include those minimum standards in all contracts for nursing facility care.**

DHS should build on, but not duplicate Medicaid standards for nursing homes, to better ensure outcome-based contracting decisions that incorporate quality of care analyses. To date, the focus of efforts to ensure quality care in institutional settings has been on the Department's regulatory functions. While regulatory tools are an important part of creating an environment where quality service delivery is the norm, DHS is still missing some key tools to ensure quality — outcome-based contracting. Contracting methods give DHS another way to ensure that the State purchases quality care in institutional settings. Including minimum service delivery requirements in DHS's contracts with nursing facilities strengthens the Department's ability to deal with facilities that consistently provide substandard care. This would also fulfill the Legislature's requirement that the State only pay for quality services.

The Department should use information gathered through the regulatory process, cost reports, and utilization reviews, to develop minimum performance standards each facility must meet to maintain its contract with the Department. DHS should also explore ways to include MDS data in the development and monitoring of these minimum contracting standards. Failure to meet minimum requirements in these areas would result in the prompt use of existing sanction options to bring the facility into compliance. The sanction options should include, as a first step, a DHS-directed corrective action plan detailing the action the facility must take to comply with the minimum standards included in the contract.

Including minimum standards in contracts would enable the Department to cancel contracts with facilities that consistently fail to meet the requirements of the contract. The facility would also have a clear understanding of the State's expectations for the quality of care to be delivered to DHS clients.

- **Require the agency to assemble existing regulatory and service quality data in a format for use by the general public.**

Ensuring easy access to information enables the general public to make fully informed choices and use consumer choice to encourage quality care in nursing facilities. The data made available to the general public should contain existing regulatory information such as the number of complaints, final outcomes of complaint investigations, and final sanction information. Available quality data such as facility staff turnover, staff to resident ratios,

and dollars spent on direct patient care, should also be included in the information made available to the public. All of this information is currently public information but is not easily accessed.

The Department should not be expected to use this data to rank facilities or make judgments on the quality of the care provided in specific facilities. Instead, the Department should make this information easily accessible and understandable and allow the public to make its own decisions about the quality of care provided. This data will provide individuals with an immediate source for information, an interim step while the agency continues the process of developing the quality index mandated by SB 190. For greatest accessibility, the information should be made available via the Internet, toll-free phone numbers, and also through traditional paper copies.

Management Action

- **DHS should receive information gathered by the Utilization Review staff at the Health and Human Services Commission. DHS should use the HHSC information to make necessary policy changes and to identify high risk facilities requiring additional monitoring.**

Information on the accuracy of facility data on resident conditions, as well as the general state of residents within a facility reflected in the rate change information, should be shared with DHS Long Term Care Regulatory staff and Program staff. The information can be used to assist the Department in deciding whether to continue contracting with a facility. In addition, Utilization Review data can provide information on recurring problems in resident outcomes at each facility. Survey staff could use the information to plan survey visits to ensure that potential problems are addressed during the survey visit.

Fiscal Impact

The recommendations requiring DHS to develop contract performance standards would result in positive fiscal impacts to the Department and the State. Savings would accrue primarily through reduced payments to facilities providing substandard care. Total savings cannot be determined as the number, value, and savings associated with the contracts cannot be estimated. Requiring the agency to assemble existing regulatory and service quality data will require existing contract management staff to undertake these efforts and also should include regulatory staff from the current reengineering effort related to implementation of Senate Bill 190. The Department should distribute data to the public through the Department's existing toll-free phone numbers and Internet sites. Any savings achieved through implementation of these recommendations would be reallocated within the Department for client services.

[1] Staff interview with Cathy Smith, Contract Manager for Region 7, March, 1998.

Issue 5

Strengthen Long-Term Care Regulation by Standardizing and Tracking Enforcement.

Background

DHS is responsible for the regulation of long-term care facilities, primarily nursing homes, and certain persons employed in these facilities. Long-term care facilities regulated by DHS include nursing homes, intermediate care facilities for mental retardation or related conditions, personal care homes, and adult day health care centers. The division of Long Term Care Regulatory (LTCR) administers facility regulatory laws, rules, and regulations. The Office of Program Integrity (OPI) credentialling section regulates long term care occupations, including nursing home administrators, medication aides, and nurse aides. Regulatory activities for LTCR are primarily carried out by regional regulatory staff within each of the eleven health and human services regions. Regulatory activities of OPI are centralized at the state office in Austin; however, activities related to complaint investigations and follow-ups are coordinated with LTCR regional staff.

DHS is responsible for the regulation of long-term care facilities, nursing home administrators, and nurse and medication aides.

The regulation of facilities is derived from a combination of state and federal law. State law governs the criteria used to determine the competence, character, financial condition and level of compliance with standards of care needed to obtain and retain a license to operate a nursing facility. Federal law governs the criteria used to be "certified" or eligible to receive funds through federal programs such as Medicaid. Nursing facilities must meet all state licensing requirements, otherwise they are not eligible to participate in the federally-funded programs. In this regard, state law is the primary vehicle to assure meaningful protection of current and future residents of nursing facilities.

In response to reports of ineffective regulation of substandard facilities, the 75th Legislature enacted Senate Bill 190 to correct a combination of identified weaknesses in state law. Among other provisions, the legislation intended to establish effective state licensure authority over nursing facilities in Texas by providing DHS authority to exercise discretion to issue and renew licenses for only those facilities that meet the new, more stringent licensing requirements and by establishing a variety of state enforcement measures.

The agency is currently undertaking a reengineering effort to implement the provisions of the legislation.

The Sunset review focused on assessing what changes need to be made to improve the effectiveness of the agency's long term care regulatory effort. Given the timing of the implementation of recent legislative initiatives, the review did not focus on evaluating those efforts. Instead, the review looked at additional areas of performance. Specifically, the review assessed whether the agency's inspection, complaint investigation, and sanction processes or protocols needed to be strengthened and whether the agency had and used the full range of regulatory tools.

Findings

The Department has not fully used the regulatory tools available to sanction poor performing long term care providers.

- A wide range of regulatory remedies are available under federal and state law but the Department has primarily focused on the imposition of federal remedies related to Medicaid certification. The wide range of remedies are intended to give the Department the broadest flexibility possible to deal with quality of care issues at regulated facilities. As detailed in the chart, *State and Federal Sanctions*, during fiscal year 1997, approximately 10 percent of the sanctions recommended involved state licensure remedies. However, DHS staff indicate that fiscal year 1998 sanctions through July 1 have increased after implementation of Senate Bill 190. As an example, administrative penalties imposed have increased 57 percent.

Only 10% of the sanctions recommended in fiscal year 1997 involved state licensure remedies.

State and Federal Sanctions
Nursing Facilities - FY 1997

Sanction	Final Actions	
State		
Denial/Revocation of License	246	10 %
Administrative Penalties	200	9 %
State Total	**446**	**19 %**
Federal		
Denial/Termination of Medicaid Certification	683	29 %
Civil Monetary Penalties	216	52 %
Federal Total	**1,899**	**81 %**
TOTAL	**2,345**	

- The Department's annual inspection process has historically focused on meeting federal requirements for Medicaid certification. Both state and federal regulatory requirements are clear that the inspection and monitoring process should enhance residents' quality of life and quality of care. However, DHS survey staff indicated, during Sunset field visits, they were hesitant to cite facilities for deficiencies not directly related to federal Medicaid certification requirements. Staff felt that general quality of care issues did not fit easily in the certification inspection categories of the inspection process.

Inspections have focused on meeting Medicaid certification, not general quality of care issues.

- Administrative penalties have been used on a limited basis, even though such penalties often provide quicker remedies. In fiscal year 1997, only 200 administrative penalties were recommended compared to 1,216 civil monetary penalties. Administrative penalties are monetary fines for violations of state licensing law or rules administered by the Department. Civil monetary penalties may be imposed by the Health Care Financing Administration (HCFA) for noncompliance with Medicaid/Medicare participation requirements. Both sanctions can be used for violations that create a threat to the health and safety of facility residents as well as those that do not.

  When violations create a threat to the health and safety of a facility's residents, the Department may request that the Attorney General file a suit for civil penalties. The Department has typically used State civil penalties instead of administrative penalties for health-related matters even though the definitions of criteria and health-related conditions for the assessment of administrative penalties show little variance from the intent for civil penalties in the Texas Administrative Code. DHS has historically used administrative penalties on a limited basis for technical and organizational matters rather than health-related matters.[1] Administrative penalties provide the Department with an additional regulatory tool that can be used more expediently than civil monetary penalties that require the participation of HCFA or civil penalties that must be imposed by the Attorney General's Office. Other state agencies also use administrative penalties to sanction facilities or professionals on an interim basis for less serious or repeat violations.

DHS has historically used administrative penalties for non health-related violations.

Recommended and Final Actions Nursing Facilities - FY 1997		
Sanction	**Rec.**	**Final**
Denial/Revocation of License	246	4
Denial/Termination of Medicaid Certification	683	26
Denial of Payment	1,006	284
Civil Monetary Penalties	1,216	63
TOTAL	**3,151**	**377**

▼ The Department does not have a standardized system to track the implementation or effectiveness of corrective action plans.

◗ When sanctions are recommended, the agency predominantly relies on informal processes and corrective action plans, to bring facilities into compliance. As shown in the chart, *Recommended and Final Actions,* facilities correct the majority of problems and no final action is taken. In fact, only 11 percent of recommended enforcement actions result in final actions. In addition, facilities may implement corrective action plans before a sanction is even recommended.

Only 11% of recommended enforcement actions resulted in final actions in fiscal year 1997.

◗ While corrective action plans may be an appropriate way to bring facilities into compliance, the agency is unable to uniformly track the history of events related to an inspection or a complaint investigation, including resolution of identified problems. A key element of enforcement monitoring is to ensure compliance is achieved in a reasonable time frame. DHS was unable to provide information on the timeliness of corrective action plans. No information is available to determine how quickly DHS ensures that nursing facilities achieve compliance with problems found during inspections. In addition, the agency cannot monitor regional regulatory offices to assess whether the offices effectively comply with time lines for follow-up inspections, completion of corrective action plans, and for enforcement of sanctions.

◗ The predominant use of corrective action plans focuses formal sanctions on the poorest performing providers while sanctions may still be warranted in other facilities. The Department's reengineering efforts have focused on ensuring the regulatory process identifies and sanctions chronically bad facilities. While this is important, preliminary data gathered as a part of the reengineering effort shows that 15 percent of the facilities with the highest rate of deficiencies cited only account for 42 percent of the total deficiencies identified.[2] The remaining facilities with cited problems should be subject to the full range of regulatory remedies as appropriate.

▼ **The agency has made progress in nursing home regulation as a part of the reengineering effort to implement recently enacted legislation.**

◗ As a result of Senate Bill 190 that was enacted to establish effective state licensure authority over nursing facilities, the Department is currently reengineering its regulatory process to make improvements in the following areas:

- customer service related to reports and resolution status of complaints and incidents;
- single, integrated facility enrollment process;
- standardized licensing protocols and variable timing for compliance reviews;
- consistency in use of full range of enforcement options;
- automated tracking system for on-line access to enforcement history;
- standardized and improved training for regulatory staff; and
- quality assurance for the regulatory program.[3]

◗ The Department expects full implementation of the reengineering effort by December 31, 1998.

The agency is currently working to improve regulatory performance through the implementation of Senate Bill 190.

Conclusion

The agency has recently undertaken several major initiatives to overhaul its regulatory process in an attempt to improve the accountability of regulated facilities and to ensure quality care is provided to clients. The State must strive to ensure that quick and appropriate action is taken when problems are found in a nursing facility. Current data on use of sanctions shows that opportunities exist to make more effective use of available sanctions. Also, data is not presently collected to track the timeliness of resolution of problems identified at nursing facilities. The lack of data limits DHS' ability to ensure timely resolution of faults or to effectively monitor the actions of regional staff.

Recommendation

Management Action

- **The Department should continue to standardize enforcement policies and procedures across regions to achieve the following objectives:**
  - **standardized enforcement protocols that involve the full range of regulatory remedies, both state and federal;**
  - **improved monitoring of regional regulatory offices for timely resolution of deficiencies and enforcement of sanctions; and**
  - **enhanced automated regulatory systems to track the history of each inspection and/or complaint investigation incident including their resolution.**

This recommendation will require the Department to use the full range of regulatory tools available under state law and the federal Medicaid/Medicare rules. By using the full range of regulatory remedies, the Department can tailor its regulation based on the seriousness of the violation and the history of the provider. Standardizing the enforcement protocol across the agency will provide regional consistency and eliminate variances in provider treatment across the state. Improved monitoring of the resolution of deficiencies across all regions will ensure timely corrections of problems.

Monitoring should also include an evaluation of the adequacy and effectiveness of corrective action plans. Each of these improvements should be monitored with an improved automated system that tracks regulatory activity at both the facility and regional levels. Users of this information should be able to quickly discern when each independent incident was initiated, what actions have taken place during the follow-up process, and what is the current status or final resolution of the incident.

Fiscal Impact

The Department has begun to address many of these elements through its reengineering process related to the implementation of Senate bill 190. The Department should ensure that these efforts adequately address the recommendations contained in this issue.

The recommendations to improve the agency's long-term care regulatory function by standardizing and tracking enforcement would have no additional fiscal impact to the State. Any costs associated with this effort should be included in the funds appropriated and budgeted for the current reengineering effort.

[1] State Auditors Office, *An Audit Report on the Long-term Care Regulatory Program at the Department of Human Services*, June 1997, page 13.

[2] Department of Human Services, LTC Quality Information System, Presentation, June 23, 1998.

[3] Department of Human Services, *Texas CARES Project, Handout*, April 16, 1998.

Issue 6

Increase Productivity by Establishing and Monitoring Regional Management Objectives.

Background

DHS delivers its services through 10 regional offices. A regional administrator who reports to the Deputy Commissioner for Regional Operations in Austin, supervises each DHS region. Each regional administrator employs program directors to oversee the Texas Works (formerly Client Self Support) and Community Care for the Aged and Disabled (CCAD) programs of the region. DHS Long Term Care (LTC) - Regulatory staff are housed in regional offices and supervised by a regional Long Term Care Administrator who reports to the Associate Commissioner for Long Term Care-Regulatory in Austin. DHS regions operate under program-specific and administrative policies established by the state office.

DHS delivers services through 10 regional offices with a total budget of $455 million and 12,800 staff.

For fiscal year 1998, the total budget for DHS regional operations was $455.8 million, funding 12,800 staff. A single DHS region may cover more area and serve more clients than most other states. The three largest DHS regions, Dallas, Houston and the Rio Grande Valley, each have budgets of approximately $75 million. Funds are allocated to DHS regions primarily on the basis of historic caseload. Agency executive staff from the Program, Finance and Regional Management areas all participate in the allocation process. The chart, *DHS Regional Allocation*, gives more detail on each region's resources.

DHS Regional Allocation

Region	Funding ($)	FTEs
1 - Lubbock	22,797,043	1,036
2/9 - Abilene	36,268,102	460
3 - Arlington	75,143,570	2,129
4 - Tyler	28,827,704	754
5 - Beaumont	23,307,482	632
6 - Houston	75,758,146	2,257
7 - Austin	41,255,056	1,116
8 - San Antonio	54,427,416	1,443
10 - El Paso	25,416,475	765
11 - Edinburg	72,574,446	2,225
TOTALS	$455,775,440	12,817

DHS regional administrators manage their regions with considerable autonomy. A regional administrator may independently set staffing levels and contract for purchased client services, as long as the administrator stays within the

regional budget. The autonomy granted to Regional Administrators allows service delivery strategies to be adapted to meet local needs and objectives.

The review focused on the systems and processes in place to promote the accountability and effectiveness of DHS regions. The Sunset review focused on the DHS regional service delivery structure and how regional administrators manage regional operations. Specifically, the review focused on regional management objectives and the system in place to hold regional administrators accountable for their performance.

Findings

▼ DHS regions have not effectively met some legislative objectives.

Many DHS regions have not been fully successful in implementing important initiatives established by the Legislature. DHS executive management has not developed regional objectives and related data collection mechanisms to assess regional performance in meeting legislative mandates. Several problems, identified in previous issues of this report, highlight the need for improved management information and performance.

DHS has not required its regions to prioritize processing of TANF sanctions.

◗ DHS has no information regarding a region's performance in processing TANF sanctions.

HB 1863 of the 74th Legislature required each adult recipient of Temporary Aid to Needy Families (TANF) to enter into a "Responsibility Agreement" with the State. The agreement requires the adult recipient of TANF to obtain health screening and immunizations for his or her children, engage in activities that promote financial self-sufficiency, ensure their child's school attendance, and refrain from using controlled substances. TANF recipients must also actively seek work or participate in job preparation activities if they lack the education and background to compete for jobs. If a recipient fails to comply with work and other requirements, DHS can administer a sanction resulting in the denial of some cash benefits. DHS has adopted rules that set sanctions and penalties for TANF recipients who violate the Responsibility Agreement and/or the work requirements.

DHS has not required regions to prioritize the administrative processing of TANF sanctions and DHS has no organized, useable information regarding a region's performance in processing sanctions. DHS maintains sanction information, which may not be current, on an employee level at local offices. Information is not consolidated into a regional management report. In interviews with Sunset staff, Texas Workforce Commission employees indicate that sanctions are not processed on a timely basis. Through a review of DHS automated records, Sunset staff found that as long as three months may elapse before imposition of a one-month sanction. DHS management has no methods to monitor the extent or cause of delays and address processing backlogs in DHS regions. As a result, sanctions may not be effective in changing client behavior, and payments to clients may continue past the sanction date and result in overpayments to clients who do not come into compliance with program requirements.

- **DHS regions have no accurate record of the need for Community Based Alternative services.**

DHS has no accurate record of clients who need community services.

The 75th Legislature addressed the increasing need for additional Community Based Alternative (CBA) services by authorizing an additional 4,000 slots for clients. Because regions have not maintained current, updated regional client waiting lists for CBA, DHS had no accurate record of clients who need CBA services. Agency management has stated that inaccurate client lists have hindered the Department's ability to use increased FY 1998 funding for clients needing in-home services.[1]

Policies for the Community Care for the Aged and Disabled (CCAD) do not address critical issues related to client care such as how a region should manage program waiting lists to ensure that those most at-risk of institutional placement receive services. DHS regions provide CCAD services on a first come-first served basis, but have no policies describing the regional staff's responsibility for serving clients who experience an acute crisis and can't wait for services. In FY 1996, projected overspending for Community-Based Services that provide an alternative to care in a nursing facility resulted in those services being closed to new clients for the month of August, 1996.

- **DHS regions have not complied with performance measurement components of state contracting laws.**

  The agency's Internal Auditor has found that CCAD contracts do not contain contractor outputs and outcomes, even though these specific contracting requirements have been in the General Appropriations Act for over three years.[2] DHS regional staff have not received training recommended by the auditor on how to write appropriate contracts, and contracts have not been revised to address the auditor's findings.

Standardizing regional inconsistencies has been a primary focus of long-term care regulatory reengineering.

- **Effectiveness of long-term care regulatory activities has been hindered by regional diversity.**

  The Legislature enacted Senate Bill 190 during the 75th Session, which has led DHS to reengineer its long-term care regulatory process to emphasize the delivery of quality nursing home care. According to the DHS "Texas Cares Project" presentation of April 16, 1998, significant reengineering efforts have been focused on problems caused by each region's use of different processes for carrying out its regulatory responsibilities. While regional flexibility can help meet local needs, DHS should strive for equity and consistency in performing basic regulatory functions. Although the current "Texas Cares" project is intended to improve the performance of Long Term Care - Regulatory programs, at present, regulatory performance data is not centrally available for use by management. Situations exist where the agency lacks adequate regional performance standards, including:

  — no documented, consistent enforcement procedures used across regions; and

  — the potential for use of unenforceable, inconsistent criteria for licensure denial, revocation, and suspension.

- **DHS regions have not established management objectives related to service quality, funding allocations, or key administrative tasks.**

  - In interviews with Sunset staff, DHS regional administrators were unable to identify any regional strategies, objectives, or performance targets that direct their activities related to client services or administrative tasks. Written region-specific

management objectives and priorities are not in place, so the performance of a region is left to subjective judgment and "management by exception" with no assurance that critical client needs have been appropriately addressed. State office staff indicate that they become aware of regional management problems when they hear complaints about the region.

- The agency's Internal Auditor reported that the process currently used by the agency to allocate amounts to DHS regions for Community Care for the Aged and Disabled ($41 million in FY 1997) and Medicaid Determination ($26 million) does not provide reasonable assurance that available funds are allocated to the regions in an appropriate and equitable manner.[3] The report stated that weaknesses in the allocation process include the use of outdated workload data, the absence of case load forecasting methods and inaccurate regional reports. Although agency management agreed with almost all of the auditor's findings, no corrective action plan has been developed or implemented to improve the allocation process. Consequently, current funding levels for regional CCAD and Medicaid Determination services are not reliably tied to regional need.

- In the past, the agency's Contract Administration Handbook policies required each DHS region to develop a regional service delivery plan that, at a minimum, identified contractors and described services available in a region. At present, DHS regional administrators state that they are not required to develop a written service delivery strategy that documents what services are needed within the region, how those services will be made available to clients and the objectives that the services should achieve. Regional administrators are held accountable for performance outcomes detailed in internal performance evaluations.

Regional funding has not reflected the downturn in caseloads due to welfare reform and the strong economy.

▼ **As caseloads have declined, DHS regions have not reallocated resources to strengthen performance or meet other regional needs.**

- DHS funding for regional operations increased from $419 million in FY 1997 to $455 in FY 1998. Although employee pay raises and increases in client service budgets contribute to the increase, regional funding has not reflected the downturn

in caseload attributed to welfare reform and the continuing strength of the Texas economy. TANF caseloads decreased by 19.7 percent from January 1997 to January 1998, and Food Stamp caseloads decreased by 21.5 percent during the same period. Statewide, reports show that only 64 percent of the agency's TANF advisor positions were filled in April 1998. Despite significant workload reductions and unfilled positions, DHS has not required regional administrators to develop regional service delivery objectives, other than agency-wide initiatives such as Texas Works, that make use of newly available resources and adjust for decreased workload. DHS regional staff indicate that they have no plan at present to use projected unspent salary dollars.

Conclusion

Regions do not have written objectives or outcome-based performance targets for the public to measure their performance.

DHS regional administrators are senior executives directly responsible for the effective delivery of critical human services. Regional administrators possess considerable decision-making autonomy in determining how services will be delivered. Autonomy allows for the flexible use of resources to meet unique local needs, but is not coupled with a formal mechanism that holds regional administrators accountable for regional performance. At present, documentation of regional performance is based on budget management, compliance with federal requirements related to errors in benefit determination and the diversion of clients away from TANF benefits. Regions have no performance or outcome based region-specific performance targets, strategies, or written objectives that gauge their performance and ensure Texas' citizens receive the best value for their tax dollars.

Recommendation

Change in Statute

- **Require the DHS Commissioner to:**
  - **enter into a region-specific performance agreement with each DHS Regional Administrator that sets performance objectives and includes key performance criteria related to legislative initiatives;**
  - **develop the regional performance agreement with the input of community health and human services providers, clients, and advocacy groups;**
  - **disseminate the performance agreement to the public and other health and human services agencies in the community;**

- **assess the performance of each region in meeting its objectives and annually report the results of the assessment to the Legislature; and**
- **consider regional objectives and performance in establishing regional budgets.**

State laws consistently emphasize the importance of accountability in the use of public resources. Organizations that contract with the State are expected to achieve specific measurable outcomes and outputs and to be accountable for proving best value for the state's dollar. Executive managers responsible for delivering services within a DHS region should, at a minimum, be held accountable to similar measurable performance standards. The responsibilities of a regional administrator should extend well beyond the requirement of staying within a regional budget and meeting federal TANF and Food Stamp processing standards. Regional administrators should be expected to use State resources in innovative and effective ways that are communicated to and understood by the public, extend quality services, and allow for across-region comparisons.

Regional Performance Agreement

Sunset staff offers the following as a guide to the content and focus of the agreement required of the DHS Commissioner and each Regional Administrator. The agreement should:

- *set ambitious, measurable objectives related to the volume of services delivered, program outcomes and quality of services, and allow for an assessment of the regions performance in meeting its objectives;*
- *be developed with the input of community human service agencies, advocacy groups, and clients;*
- *encourage creativity and local service coordination;*
- *result in a public, region-specific document that fosters local coordination and accountability by identifying regional resources, priorities and objectives; and*
- *provide a means of evaluating regional funding allocations based on documented program successes and opportunities.*

Legislative committees and the Comptroller's Texas Performance Review have emphasized the importance of local participation in planning and delivering human services, but DHS has no public method or formal process for collaborating with local client advocates and community-based programs. Regional administrators should be required to identify and prioritize client needs and participate in coordinating state and local resources. Absent a public performance contract, the local responsibilities and objectives of DHS are not clearly defined to the public.

Fiscal Impact

The recommendation requiring DHS to seek local input and set expectations for regional administrators to meet would be implemented with existing state office and regional staff. Considering regional objectives and performance in regional funding allocations should lead to a more efficient use of resources. Any savings generated could be used for additional client services.

[1] DHS Legislative Briefing, date.

[2] General Appropriations Act, Seventy-fifth Legislature, Regular Session, Special Provisions Relating to all Health and Human Services Agencies, Sec. 13.

[3] Internal Audit Report, Department of Human Services, July 1997.

Issue 7

Improve the Administrative Hearings Process Through Transfer to the State Office of Administrative Hearings.

Background

The Texas Department of Human Services set hearing dates for 245 hearings governed by the Administrative Procedure Act (APA) in fiscal year 1997, as shown in the chart, *Types of APA Hearings Set - Fiscal Year 1997.*

Types of APA Hearings Set
Fiscal Year 1997

Adult Foster Care	1
Community-Based Alternatives	4
CLASS	4
Day Activity Health Services	6
Electronic Benefits Transfer	4
Food Stamp Program	65
ICF-MR	1
Medicaid Provider	1
Medication Aid	12
Miscellaneous	2
Nurse Aide	6
Nursing Home	137
Primary Home Care	2
Total APA Hearings	245

One hundred and thirty-seven APA hearings in fiscal year 1997 were brought by nursing home providers primarily involving DHS sanctions, audit exceptions, level of care payments, loss of training programs, and licensing issues. Sixty-five APA hearings were brought involving the food stamp program regarding client sanctions, audit exceptions, claim payment, and loss of commodity food items. The remaining 43 APA hearings involved nursing facility administrators (licensing and sanctions), nurse and medication aides (sanctions and denial of applications), and community care programs (sanctions and client benefits recovery).

The primary DHS staff participants in APA hearings are attorneys from the Office of General Counsel or the regions, the Administrative Law Judges (ALJs) from state office, and those program staff necessary for presentation of the Department's case. Program staff may be from the regional office, state office, or both.

DHS also conducts fair hearings for clients and recipients of federal benefit programs, including Temporary Assistance for Needy Families (TANF), food stamps, and Medicaid to resolve disputes regarding federal benefit programs. The fair hearings are less formal and are not governed by the APA. Recipients of benefits under these federal programs are entitled to fair hearings when services are denied, suspended, reduced, or terminated. DHS conducted 31,650 fair hearings in fiscal year 1997. These fair hearings are heard by regional hearings officers. Of these fair hearings, 25,516 were client benefit appeals, 6,005 were client fraud administrative disqualifications, and 129 were Nurse Aide Registry appeals. Nurse Aide Registry appeals involve

determinations of whether a nurse has abused, neglected, or misappropriated the property of a nursing facility resident.

Due to recent legislation (S.B. 190, 75th Legislature) that gave DHS more enforcement options related to nursing homes and professions, DHS anticipates that requests for APA hearings will increase. The new types of cases include nursing facility administrator sanctions, facility sanctions based on poor performance, and an increased level of facility licensing sanctions. Additionally, all nurse aide registry cases will be heard by ALJs in APA proceedings, rather than fair hearings.

In 1991, the Legislature created the State Office of Administrative Hearings (SOAH) to conduct administrative hearings for state agencies. The Sunset Commission has routinely reviewed administrative hearings conducted by agencies to determine whether this service could be better performed by SOAH. The review focused on whether transferring the Department's APA hearings to SOAH would increase the independence, quality, and cost effectiveness of the hearings. The agency functions relating to fair hearings are not part of the Sunset review, and are not subject to transfer.

Findings

▼ **DHS's administrative hearings process would be more independent if located at SOAH.**

The Department's APA hearings would be clearly independent if conducted by SOAH.

- The majority of the participants in DHS hearings including the ALJs, the Department's attorneys, and the staff that investigates and brings the charge of a regulatory violation, are all employed by DHS. This relationship provides the opportunity for ex parte communication and creates the perception that the hearings process and the ALJs decisions are not independent or fair.

- The lack of perceived independence, would not exist if APA hearings were conducted by an ALJ employed by SOAH. The ALJs assigned to perform hearings for DHS would be housed with SOAH. Transferring administrative hearings would separate the Department's role from its responsibility to conduct the hearing.

▼ **SOAH has the experience and ability to hold quality administrative hearings.**

- SOAH serves as the central administrative hearings office for the State and hires qualified ALJs. SOAH currently employs 54 ALJs who receive, on average, more than 73 hours each of continuing education and in-house training on hearings and law-related topics every year.[1] In addition, new legislation from the 75th Legislative session requires that SOAH provide 30 hours of continuing legal education and judicial training within the first year of employment to any new ALJ with less than three years of presiding experience.

- SOAH conducted 18,515 hearings in fiscal year 1997 for about 50 agencies, including a number of health and human service agencies such as the Department of Mental Health and Mental Retardation and the Texas Commission on Alcohol and Drug Abuse.[2] In addition, SOAH has shown its ability to conduct complex hearings through its work for the Public Utility Commission, and its hearings on environmental regulations for the Texas Natural Resource Conservation Commission.

Transferring hearings to SOAH has resulted in a 38.9 percent reduction in the cost of hearings.

▼ **SOAH would provide better access to regional hearings than DHS.**

- By hearing cases regionally, SOAH would give affected persons convenient access to the hearings process and would reduce costs by eliminating travel time of an ALJ sent from DHS in Austin. In 1997, SOAH employed 21 ALJs at nine regional offices in Corpus Christi, Dallas, El Paso, fort Worth, Houston, Lubbock, San Antonio, Tyler, and Waco.[3] The ALJs travel to locations within their regional areas to hold hearings.

- Department ALJs traveled to several different regions in Texas in fiscal year 1997 to hold administrative hearings on 11 cases, with a total travel cost of $2,145, or approximately $195 per hearing. The remaining 234 cases and hearings governed by the APA were held in Austin.

▼ **SOAH has reduced overall hearing costs for state agencies that have transferred their hearing functions to SOAH.**

- SOAH has consistently been able to reduce the overall hearing costs to the State. SOAH estimates that it saved more than $727,000 in hearings costs that would have been incurred by 50 state agencies had the hearings been conducted in-house. This savings represents approximately a 39 percent reduction in the cost of hearings.[4]

In keeping with the intent of the Legislature, the Department's APA hearings should be transferred to SOAH.

- DHS spent approximately $192,318, to docket 245 hearings in fiscal year 1997, resulting in an average cost of $785 per hearing. DHS anticipates that the 1998 fiscal year average cost per hearing will decrease to $425, as the amount of hearings rises due to new state laws giving DHS more regulatory authority. The chart, *Costs of DHS APA Hearings*, shows the costs associated with hearings in fiscal year 1997.

▼ **SOAH has provided state agencies and citizens with a fair and efficient administrative hearings process.**

- Results from a survey conducted by the Senate State Affairs Committee in 1996 indicated that 43 out of 46 agencies for which SOAH held hearings believed that SOAH was fulfilling its mission as the State's hearing office.[5]

- Eighty-five percent of the participants surveyed by the Legislative Budget Board for fiscal year 1997 were satisfied with the overall process of SOAH.[6]

Conclusion

The Legislature has clearly expressed its intent to consolidate the hearings functions of state agencies if such a transfer would improve the independence, quality, or cost effectiveness of hearings. The review of the Department's APA hearings process indicated that SOAH has the ability to conduct the hearings and that a transfer would provide more independence, would provide an equal level of quality, and could improve the cost effectiveness of the hearings process.

Recommendation

Change in Statute

■ Transfer the Department's Administrative Procedure Act hearings to the State Office of Administrative Hearings.

This recommendation would transfer the Department's APA hearing function to the State Office of Administrative Hearings. DHS set 245 APA hearings in fiscal year 1997. These hearings, as well as a likely increase in the number of APA hearings resulting from enhanced long-term care licensing and enforcement efforts would be transferred to SOAH. Fair hearings would continue to be conducted by DHS regional staff. DHS employs three Administrative Law Judges, one of whom also serves as Director of the Hearings Department. DHS may no longer need all ALJs once SOAH begins holding DHS hearings. DHS support staff must remain with DHS because SOAH does not perform various tasks relating to docketing cases, transferring hearing requests to SOAH, providing notices to parties, arranging for court reporters, and providing support during the pendency of a case.

In conducting hearings, SOAH would consider DHS's applicable substantive rules or policies. In this way, the Department would still determine how broader policy matters or recurring issues would be treated by administrative law judges. As with the current DHS hearings process, DHS would have the option of letting SOAH issue proposals for decision to the Commissioner of Human Services or final decision-making authority could be delegated to each ALJ who hears an appeal. If the Commissioner chose to make the final decision, they could alter the ALJs proposal only if (1) the ALJ did not properly apply or interpret applicable law, agency rules, written policies, or prior administrative decisions, (2) the ALJ relied on a prior administrative decision that is incorrect or should be changed, or (3) a technical error in a finding of fact should be changed. The agency must state in writing the specific reason and legal basis for a change.

In 1997, the Legislature, for the first time, appropriated a lump sum to SOAH from the General Revenue Fund, to conduct hearings. In addition, some agencies choose to pay SOAH a lump sum based on an estimated case load for the agency. Traditionally though, agencies have paid SOAH an hourly rate to conduct its hearings. If the Legislature transferred the hearings, any of these options could be considered.

Fiscal Impact

Historical data indicates that costs related to administrative hearings transferred to SOAH have been reduced by approximately 39 percent. However, the fiscal impact of this transfer of duties cannot be determined because the specific costs for DHS related to the hearings will depend on the payment structure determined by the Legislature and whether DHS is able to reduce its number of ALJs. Any savings would be reallocated within DHS.

[1] Information provided by Sheila Bailey Taylor, Chief Administrative Law Judge, the State Office of Administrative Hearings, March 12, 1998.

[2] Ibid.

[3] Ibid.

[4] Memorandum from Sheila Bailey Taylor, Chief Administrative Law Judge, the State Office of Administrative Hearings, April 10, 1998.

[5] Data derived from Senate State Affairs survey of state agencies regarding SOAH performance, February 28, 1996.

[6] Summary Assessment of Agency Performance, Fiscal Year 1997, Legislative Budget Board, Page VIII-6.

Issue 8

Decide on Continuation of the Texas Department of Human Services as a Separate Agency After Completion of Sunset Reviews of all Health and Human Service Agencies.

Background

The Legislature scheduled most of the State's health and human service agencies for Sunset review in 1999. Health and human services (HHS) is the second largest function of State government. With a combined appropriation of $26.1 billion for the 1998-99 biennium, these agencies account for almost 30 percent of State government's budget.

With most HHS agencies under review together, the Sunset Commission has an unprecedented opportunity to study how the State has organized this area of government. Currently, 13 separate agencies have primary responsibility to carry out the numerous state and federal programs, services, assistance, and regulations designed to maintain and improve the health and welfare of the citizens of Texas. Reviewing these agencies together will enable a look across agency lines — at types of services provided, types of clients served, and funding sources used. Assuming any organization changes are needed, this information will prove valuable in the analysis of how best to make those changes.

DHS is one of 13 health and human services agencies currently under Sunset review.

Central to the Sunset review of any agency is determining the continuing need for the functions it performs and whether the current agency structure is the most appropriate to carry out those functions. Continuation of an agency and its functions depends on certain conditions being met, as required by the Sunset Act. First, a current and continuing need should exist for the State to provide the functions or services. In addition, the functions should not duplicate those currently provided by any other agency. Finally, the potential benefits of maintaining a separate agency must outweigh any advantages of transferring the agency's functions or services to another agency.

The Sunset staff evaluated the continuing need for the Texas Department of Human Services (DHS) and its functions in light of the conditions described above. This approach led to the following findings.

Findings

▼ **Texas has a continuing need for the services provided by the Texas Department of Human Services.**

◗ The Department's main functions, determining eligibility and certifying that clients are eligible to access long-term care and public assistance benefits, are critical to the State's goal of providing financial, health, and human services that promote the greatest possible independence and personal responsibility for all citizens. The agency accomplishes this through administration of more than 30 state and federally-funded human service programs designed to benefit low income families and children, victims of family violence, and people who are elderly or disabled. One of the agency's primary functions is to determine eligibility and certify that clients are eligible to access benefits.

The Department's main functions — determining eligibility for and providing long-term care and public assistance should be continued.

◗ Services for families and children that help to support self-sufficiency are central to the State's efforts to comply with federal welfare reform. Primary programs for families and children administered by DHS include Temporary Assistance to Needy Families (TANF), Food Stamps, and Medicaid eligibility. In addition, DHS refers TANF and Food Stamp clients to employment services administered by the Texas Workforce Commission.

The Temporary Assistance to Needy Families program provides temporary financial and medical assistance to families with needy children who lack adequate parental support. During fiscal year 1997, over 200,000 families and 600,000 individuals received TANF benefits in an average month. DHS also determines eligibility for Medicaid programs for TANF recipients and for low-income children and pregnant women who are ineligible for TANF.

The Food Stamp program permits low-income households to buy nutritionally adequate food to supplement the diets of families, elderly people, and single adults. In fiscal year 1997, an average of approximately 2.1 million clients were served each month at an annual cost of $1.8 billion.

Other DHS programs providing services to children and families include nutrition programs such as the child and adult nutrition program and the refugee and disaster assistance programs.

- DHS is responsible for providing long-term care services to needy persons who are blind, aged, or disabled. DHS uses three types of programs to provide services including institutional care, community care, and medicaid waiver programs. Clients of these DHS programs often have chronic health problems that limit their abilities to care for themselves and need some assistance to help maintain independence and improve quality of life. Most services are funded by Medicaid.

  Institutional care includes nursing facility care and hospice services. Nursing facility services include skilled nursing care and related services including room and board, social care, special supplemental diets, medicine, medical equipment and supplies, and rehabilitative therapies. During fiscal year 1997, an average of over 68,000 people per day received care in nursing facilities at an annual cost of more than $1.3 billion.

  DHS has a critical mission to regulate long-term care facilities to ensure the health and safety of residents.

  Community care offers a range of services that enable elderly individuals and people with disabilities to live in their homes or community settings and are designed to prevent or delay institutionalization. Services include adult foster care, attendant services, home-delivered meals, and residential care. Waiver programs allow the State to use Medicaid funds for home-based care of clients who otherwise would be cared for in Medicaid-paid nursing home. During fiscal year 1997, an average of 96,000 individuals per month received community care services at an annual cost of over $600 million.

- The State regulates long-term care facilities to ensure the health and safety of residents and to certify compliance with federal Medicaid/Medicare program participation requirements. DHS is responsible for regulating long-term care facilities such as nursing homes, institutional care facilities for the mentally retarded, adult day-care facilities, and personal care homes. In this capacity, the agency licenses and inspects facilities and investigates allegations of abuse and neglect in facilities. In addition, DHS licenses nursing facility administrators. In fiscal year 1997, DHS conducted over 4,500 inspections and received over 12,000 complaints.

- The family violence program educates the public about domestic violence and offers shelter and support services to victims and their children. In fiscal year 1997, over 11,000 women and 14,000 children sought shelter in 65 state-contracted family violence shelters, and an additional 20,000 women received nonresidential services. DHS funded $10.5 million to contracted shelters.

▼ While the agency's current functions should continue, organizational alternatives exist that should be explored.

- DHS is one of 13 separate agencies that perform the State's health and human service functions. These agencies' responsibilities are generally unique, but the types of services offered, clients served, and funding sources used are sometimes very similar. For example, many of the same clients that are eligible to receive Medicaid services under Temporary Assistance for Needy Families from DHS are also eligible for acute medical services provided by the Texas Department of Health. In addition, clients who are receiving time-limited benefits must comply with work training requirements administered by the Texas Workforce Commission. Receipt of child support payments through the Office of the Attorney General is a key component of TANF and welfare reform.

- Because of these similarities, many options to the current system have been and should continue to be considered. For example, the interim work of the Legislature during the past four years has yielded more than 550 recommendations for change in HHS policies and operations. Many of these recommendations have not been implemented and should be considered in the Sunset process.

- Continuation of an agency through the Sunset process hinges on answering basic questions about whether duplication of functions exists between agencies and whether benefits would result from consolidation or transfer of those functions. The Sunset staff has identified several instances where organizational change may be warranted. Examples include consolidation of core administrative functions, collocation of field offices, collapsing of contracting functions, better alignment of similar services to similar clients, and a close look at how planning and budgeting could be improved. These

changes should be looked at before the Sunset Commission makes decisions to continue an HHS agency under review.

▼ **Continuation of DHS as a separate agency should be decided after completion of all HHS agency Sunset reviews.**

- The Sunset reviews of the HHS agencies are scheduled for completion at various times before the end of 1998. The Sunset staff will use the results of this work in its review of the Health and Human Services Commission, the umbrella agency for HHS. The staff will also study the overall organizational structure of this area of government. Finally, the staff will evaluate issues that cut across agency lines, such as the need for a single agency for long-term care, consolidation of services to persons with disabilities, the need for a single agency to administer Medicaid services, and streamlining regulatory functions.

- The Commission's schedule sets the review of the Health and Human Services Commission and HHS organizational and cross issues for the Fall of this year (1998). Delaying decisions on continuation of all HHS agencies, including DHS, until that time allows the Sunset staff to finish its work on all the agencies and base its recommendations on the most complete information.

The Sunset Commission should decide on continuation of DHS once all HHS agency reviews are completed.

Conclusion

Most of the State's health and human service agencies are currently under Sunset review. While these agencies serve many unique purposes they also have many similarities that should be studied as areas for possible improvement through organizational change. This analysis should occur before decisions are made to continue the HHS agencies as separate entities, including the Department of Human Services.

Recommendation

Change in Statute

■ **Decide on continuation of the Texas Department of Human Services as a separate agency upon completion of Sunset reviews of all health and service agencies.**

Sunset review of several other HHS agencies are ongoing. Sunset staff recommends that the Sunset Commission delay its decision on continuation of DHS as a separate agency until those reviews are completed. The results of each agency review should be used to determine whether changes are needed in the overall organization of health and human services.

The staff will issue a report to the Commission in the Fall of this year (1998) that will include recommendations for each HHS agency — to continue, abolish and transfer functions, or consolidate specific programs between agencies. This report will also include, for possible action, three agencies under the HHS umbrella not scheduled for specific review this cycle, the Department of Protective and Regulatory Services, the Texas Commission on Alcohol and Drug Abuse, and the Texas Juvenile Probation Commission. These agencies were reviewed by the Sunset Commission in 1996 and continued by the Legislature last year. Possible reorganization of health and human services may affect the continuation of these agencies as independent entities.

ACROSS-THE-BOARD RECOMMENDATIONS

Texas Department of Human Services	
Recommendations	**Across-the-Board Provisions**
	A. GENERAL
Update	1. Require at least one-third public membership on state agency policymaking bodies.
Already in Statute	2. Require specific provisions relating to conflicts of interest.
Already in Statute	3. Require that appointment to the policymaking body be made without regard to the appointee's race, color, disability, sex, religion, age, or national origin.
Update	4. Provide for the Governor to designate the presiding officer of a state agency's policymaking body.
Already in Statute	5. Specify grounds for removal of a member of the policymaking body.
Already in Statute	6. Require that information on standards of conduct be provided to members of policymaking bodies and agency employees.
Apply	7. Require training for members of policymaking bodies.
Already in Statute	8. Require the agency's policymaking body to develop and implement policies that clearly separate the functions of the policymaking body and the agency staff.
Already in Statute	9. Provide for public testimony at meetings of the policymaking body.
Already in Statute	10. Require information to be maintained on complaints.
Already in Statute	11. Require development of an equal employment opportunity policy.

Texas Department of Human Services (Nursing Facility Administrators)	
Recommendations	**Across-the-Board Provisions**
	B. LICENSING
Update	1. Require standard time frames for licensees who are delinquent in renewal of licenses..
Already in Statute	2. Provide for notice to a person taking an examination of the results of the examination within a reasonable time of the testing date.
Do Not Apply	3. Authorize agencies to establish a procedure for licensing applicants who hold a license issues by another state.
Update	4. Authorize agencies to issue provisional licenses to license applicants who hold a current license in another state.
Already in Statute	5. Authorize the staggered renewal of licenses.
Already in Statute	6. Authorize agencies to use a full range of penalties.
Not Applicable	7. Revise restrictive rules or statutes to allow advertising and competitive bidding practices that are not deceptive or misleading.
Already in Statute	8. Require the policymaking body to adopt a system of continuing education.

BACKGROUND

Background

AGENCY HISTORY

The Department of Human Services (DHS) is responsible, under the Human Resources Code, for administering financial assistance programs that provide social services for families and children, and for the aged and disabled. These programs include nursing home and community-based care for the aged and disabled; and direct financial assistance, medical benefits, and food programs for income-eligible families. The agency also administers programs unrelated to a client's income including family violence services, disaster assistance, refugee assistance, and the regulation of long term care facilities. The Department funds these programs with both state and federal funds.

Mission: The mission of the Texas Department of Human Services is to provide financial, health and human services that promote the greatest possible independence and personal responsibility for all clients.

Key Focus: The Department's key responsibilities to the citizens of Texas include fostering of individual choice, dignity and independence for the aged and disabled; sustaining individuals and families in time of need while encouraging self sufficiency; and using public funds in an effective and efficient manner.

Source: DHS Strategic Plan 1997-2001

DHS was created by the Legislature in 1939 as the State Department of Public Welfare (DPW) to "provide necessary and prompt assistance to citizens, especially the poor, aged, and the needy or abused children." The agency assumed the duties of three divisions previously under the direction of the State Board of Control — the Old Age Assistance Commission, the Texas Relief Commission, and the Child Welfare Division. Under the law, DPW was responsible for old age assistance, child welfare, and state administration of federal assistance programs established by the Social Security Act of 1935.

The Legislature has modified the responsibilities of the agency numerous times since it was created. Federal legislation also has consistently broadened the agency's authority and responsibilities. In 1958, a constitutional amendment authorized the Medical Assistance Program and the Legislature created the program in 1961. Federal legislation created the food stamp program in 1964 and DPW began pilot food stamp programs in 1967 with statewide implementation by 1973. In 1967, federal legislation created the Medicaid program and established the Work Incentive Program. Funds were appropriated to set up the Vendor Drug program in 1971 and the agency assumed responsibility for child support enforcement in 1974.

Beginning in 1983, the Legislature began dismantling and transferring the agency's programs to other state agencies, starting with the transfer of child

support enforcement to the Attorney General's Office. In 1991, legislation significantly reorganizing health and human service delivery (House Bill 7) transferred Medicaid purchased health programs from DHS to the Department of Health; and child and adult protective services, and child care licensing to the newly formed Department of Protective and Regulatory Services. The legislation also designated the newly-created Health and Human Services Commission as the state's Medicaid administrative agency. Additionally, state welfare reform legislation (House Bill 1863), enacted in 1995, transferred employment and child care services from DHS to the newly-formed Texas Workforce Commission (formerly the Texas Employment Commission).

Recent reorganization of health and human services, and welfare reform, significantly changed the role and scope of DHS.

POLICYMAKING BODY

A six-member Board governs the Department of Human Services. The Governor appoints the Board, with the advice and consent of the Senate, which must represent all geographic regions of the state. To qualify for appointment, a person must have shown an interest in and knowledge of human services. Members are appointed to serve six-year staggered terms, with terms of two members expiring on January 20 of each odd-numbered year. After the biennial appointment of new members, the Board elects the chair and vice-chair. The chart, *Board of Human Services Members*, identifies the current Board members.

Department of Human Services Board Members

David Herndon, Austin (Chair)
Carlela Vogel, Fort Worth
Bill Jones, Houston
Anchi Ku, Dallas
Elizabeth Seale, San Antonio
Carole Woodard, Houston

The Human Resources Code sets out the duties and responsibilities of the Board. The Chair presides over meetings and, with the other Board members, adopts policies and rules governing the Department, approves its budget, and requests appropriation of funds from the Legislature. The Board also selects the Commissioner of Human Services, subject to the Governor's approval of the nominee.

Until recently, the Chair appointed Board subcommittees to address specific items. In April 1997, the Chair appointed standing subcommittees for audit, contracts, long-term care, and family and children's assistance. Subcommittees work directly with staff on major issues related to programs, funding contracts, and internal audits. The Audit Subcommittee also oversees the duties and activities of the internal auditor. The Board met 11 times in fiscal year 1996 and 13 times in fiscal year 1997. The Board is assisted by seven advisory committees relating to specific subject areas. The chart,

DHS Committees, details the current advisory committees and Board subcommittees.

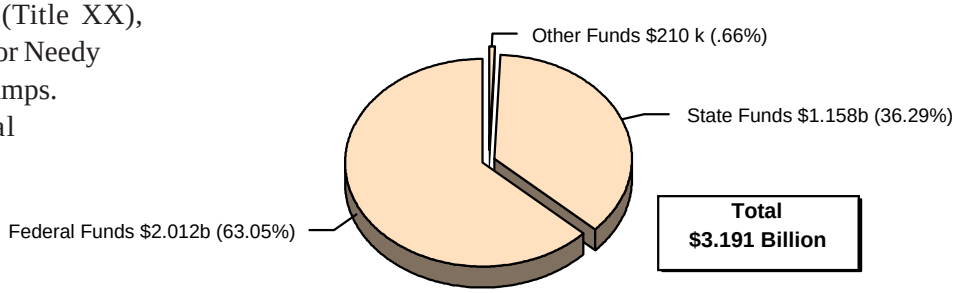
Department of Human Services Committees	
Board Subcommittees	**Current Advisory Committees**
Audit	Personal Care Facilities
Contracts	Sanctions and Penalties
Long-term care	Aged and Disabled
Family and Children's Assistance	Child and Adult Care Food Program
	Client Self-Support Services
	Nursing Facility Administrators
	Alzheimer's

FUNDING

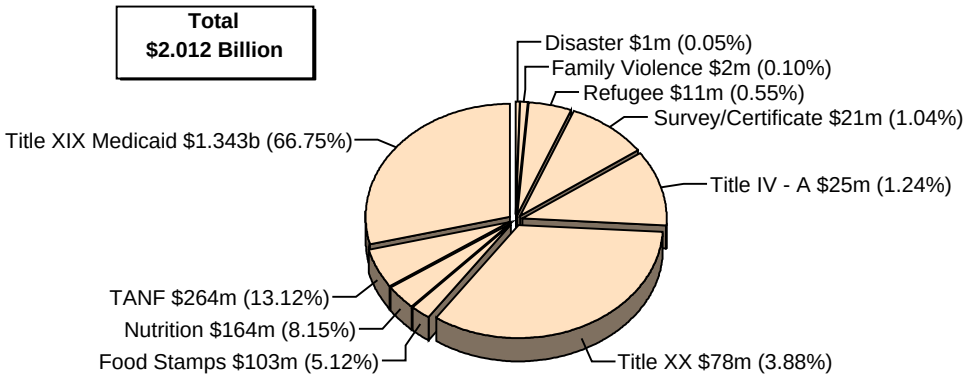
Revenues

In fiscal year 1997, the Department of Human Services received about $3.2 billion in revenue.[1] DHS receives funding primarily through federal grants or as matching funds for specific state expenditures. These federal funds comprise 63 percent of the agency's revenue. DHS receives most of its federal funds through Medicaid (Title XIX), the Social Services Block Grant (Title XX), Temporary Assistance for Needy Families, and Food Stamps. In addition to federal funds, DHS receives state general revenue, most of which is used as the required match for Medicaid funds and the TANF block grant. DHS also receives appropriated receipts from its licensing activities and interagency revenues primarily derived from information services provided to other agencies. The charts, *Sources of Revenue - Fiscal Year 1997*, shows total and detailed revenue by source. DHS appropriations increased by $686.6 million over the previous biennium primarily to fund Medicaid-eligible long-term care services. Approximately $238.5 million of the increase is from General Revenue funds.

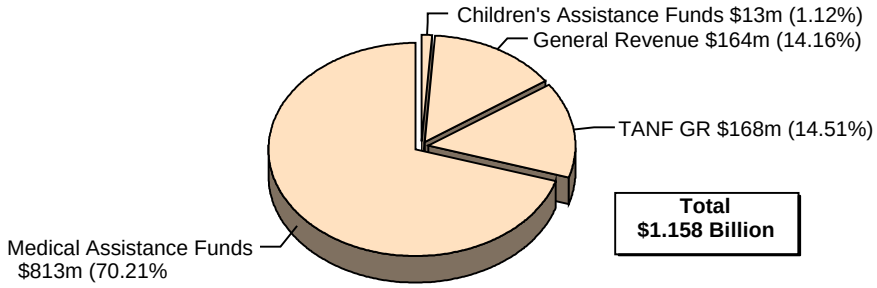
Sources of Revenue
Fiscal Year 1997



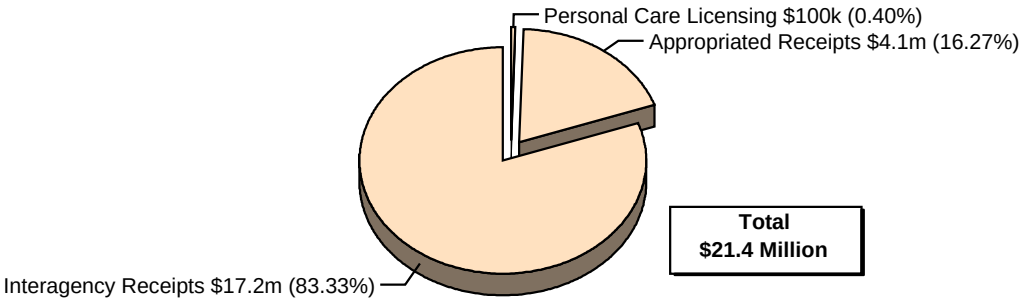
Sources of Revenue
Federal Funds



Sources of Revenue
State Funds



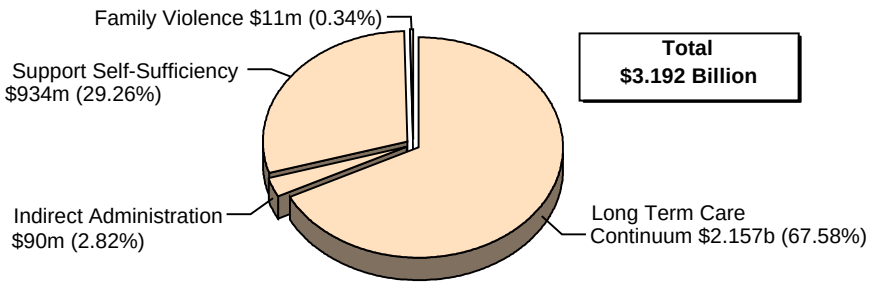
Sources of Revenue
Other Funds



Expenditures

In fiscal year 1997, DHS allocated its revenue among three primary program strategies — long-term care continuum for elderly and disabled individuals, support self sufficiency, and family violence. The long term-care continuum strategy includes activities related to eligibility determination, payments for community care services and nursing home care, and facility and professional licensing. The support self sufficiency strategy includes eligibility determination; public assistance grants; and nutrition, immigration/refugee, and disaster assistance programs. The family violence strategy funds grants for community-based shelter and assistance services. The remaining revenue is used to fund agency indirect administration. The chart, *Expenditures by Strategy - Fiscal Year 1997*, details the agency's expenditures.

Expenditures by Strategy
Fiscal Year 1997



DHS allocates funds to regional offices in the 11 uniform health and human service regions for the long-term care continuum and support self sufficiency strategies based generally on historical caseloads. Need and historical funding levels are used to a lesser extent. The chart, *Funding and Staffing by Region - Fiscal Year 1998*, shows the actual regional allocations. DHS awards contracts across the State to provide family violence services directly from the state office.

Funding and Staffing by Region
Fiscal Year 1998

Region		Total Funding	FTEs
Region 1	Lubbock	$ 22,647,572	622
Region 2	Abilene	$ 19,687,762	450
Region 3	Arlington	$ 74,660259	2,129
Region 4	Tyler	$ 28,303,909	754
Region 5	Beaumont	$ 22,926,063	632
Region 6	Houston	$ 75,230,574	2,257
Region 7	Austin	$ 40,833,198	1,116
Region 8	San Antonio	$ 53,898,608	1,443
Region 9	Abilene	$ 16,075,838	412
Region 10	El Paso	$ 25,258,030	765
Region 11	Edinburg	$ 72,165,508	2,225
TOTAL		$ 451,687,321	12,805

HUB Expenditures

The Legislature has encouraged agencies to make purchases with Historically Underutilized Businesses (HUBs). The Legislature also requires the Sunset Commission to consider agencies' compliance with laws and rules regarding HUB use in its reviews. In 1997, DHS purchased 14.1 percent of goods and services from HUBs. The chart, *Purchases from HUBs - Fiscal Year 1997*, provides detail on HUB spending by type of contract and compares these purchases with the statewide goal for each spending category. The

Purchases from HUBs Fiscal Year 1997				
Category	Total $ Spent	Total HUB $ Spent	Percent	Statewide Goal
Heavy Construction	N/A	N/A	N/A	11.9%
Building Construction	N/A	N/A	N/A	26.1%
Special Trade	$745,453	$54,826	7.35%	57.2%
Professional Services	$3,554	$3,135	88.20%	20%
Other Services	$53,848,716	$7,401,951	13.70%	33%
Commodities	$21,164,077	$3,197,255	15.10%	12.6%
TOTAL	$75,761,800	$10,657,167	14.07%	

chart shows that DHS exceeded state HUB purchasing goals in two categories, professional services and commodities, while falling short of state goals in the purchase of special trade and other services.

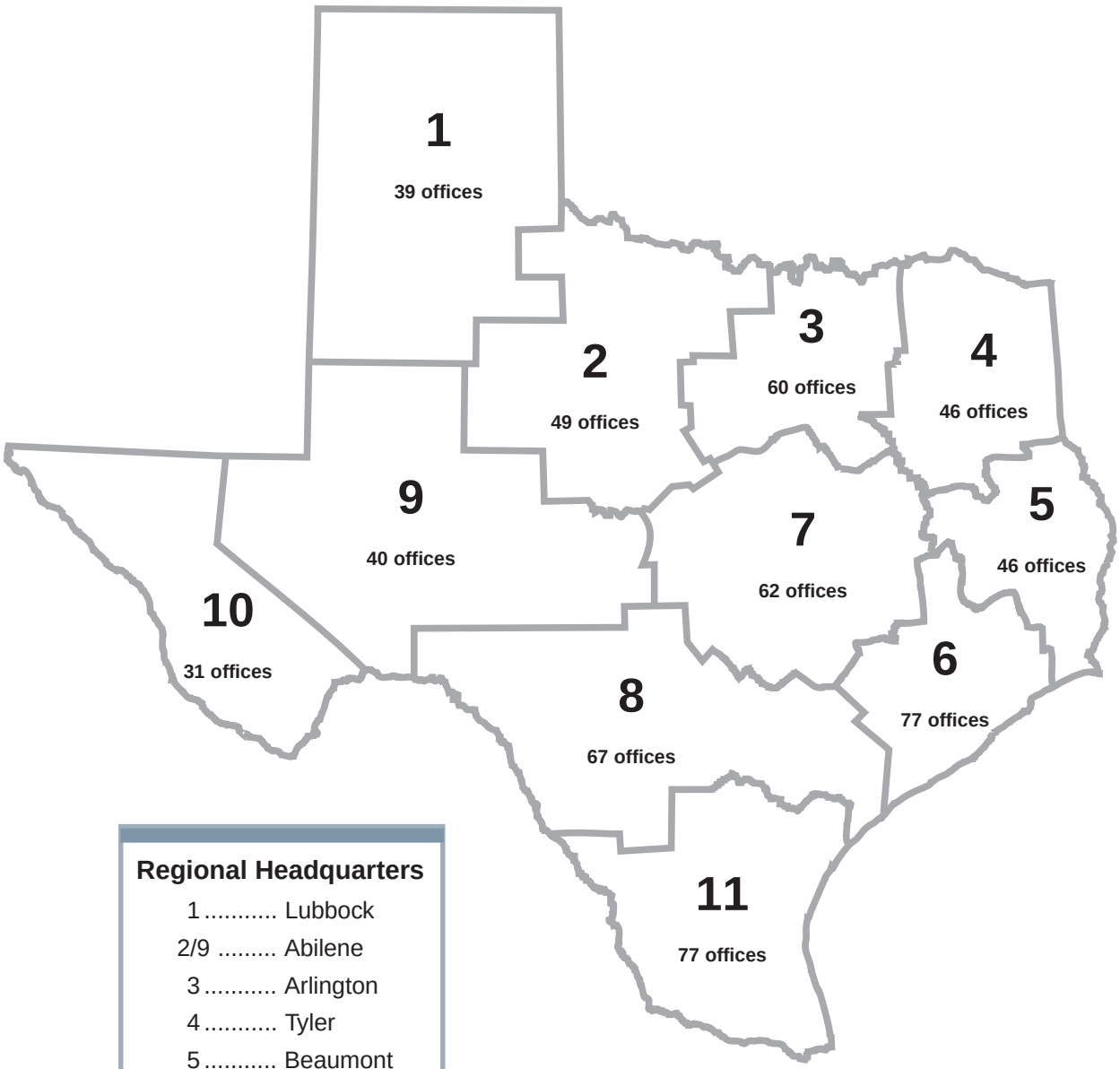
ORGANIZATION

DHS is budgeted for 15,523.5 staff, including General Appropriations Act riders. Staff are housed at the agency's headquarters in Austin, seven additional locations in Austin, and at 585 field offices across the state in each of the 11 uniform health and human service regions. Austin also serves as the regional headquarters for Region 7. Regions 2 and 9 are combined administratively which gives the agency 10 regional administrators who are responsible for programs in each region. Regional administrators and offices are in Lubbock, Abilene, Arlington, Tyler, Beaumont, Houston, Austin, San Antonio, El Paso, and Edinburg. The chart, Regional *Boundaries, and Office Locations*, details DHS regional information.

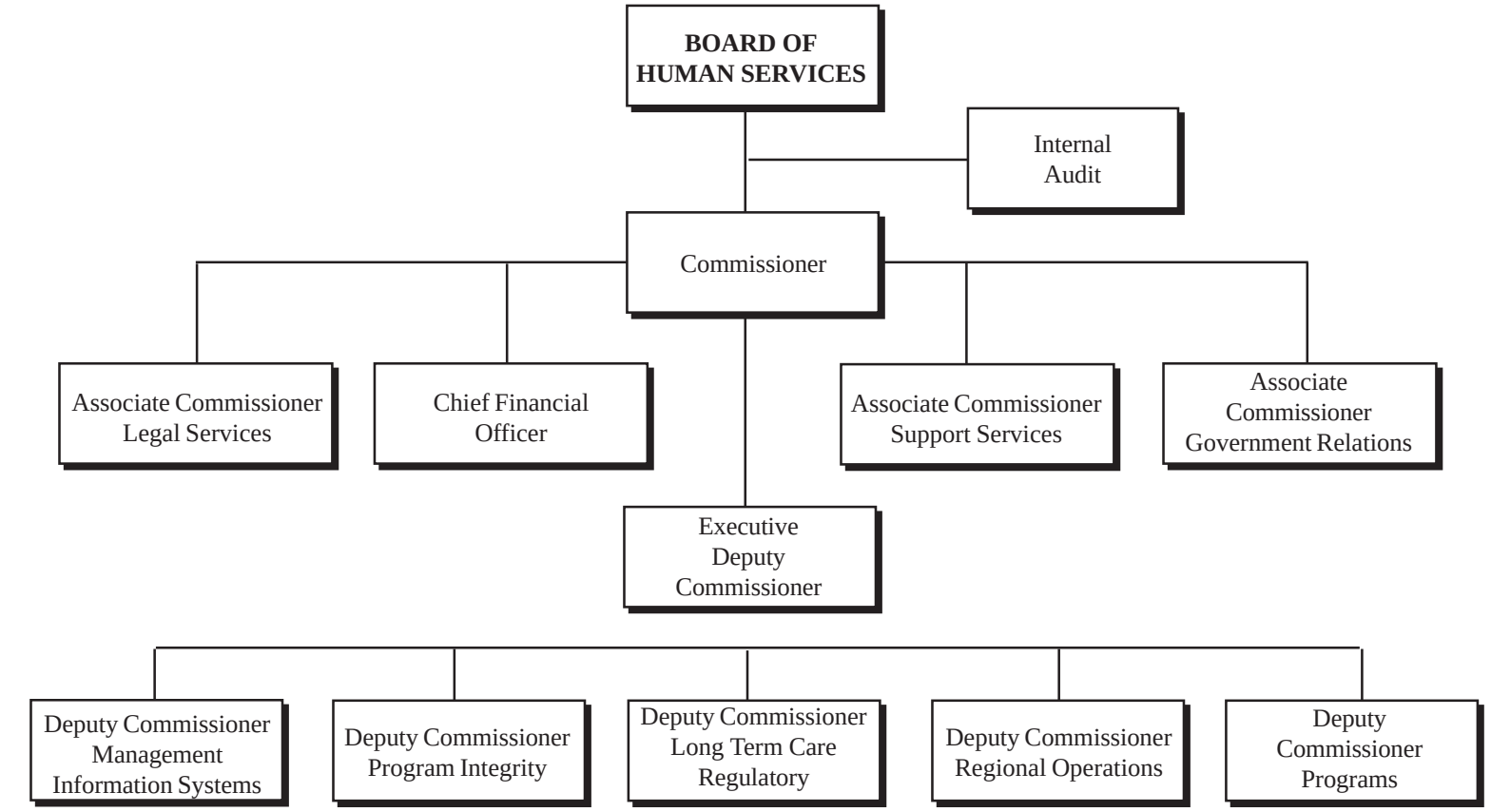
The Commissioner of Human Services administratively leads DHS. Ten executive staff lead programmatic and support functions who, along with the Commissioner, make up the agency's executive staff. Five deputy commissioners are charged with responsibility for management of information systems, program integrity, support services, regional operations, and programs. Three associate commissioners oversee legal services, government relations, and long-term care regulation. The remainder of the executive staff include the internal auditor and chief financial officer. The organizational structure of DHS is illustrated in the chart *Department of Human Services Organizational Structure*.

Regional Boundaries and Office Locations

Department of Human Services



Texas Department of Human Services
Organizational Chart



DHS is subject to the General Appropriations Act, including provisions that set employment goals for minorities and women by specific job category. These goals are a useful measure of diversity and an agency's commitment to developing a diverse workforce. The chart, *Equal Employment Opportunity Statistics, Fiscal Year 1997*, shows the composition of the Department's workforce compared to the State's workforce. DHS exceeds most civilian labor force percentages for employment of women and minorities.

Department of Human Services
Equal Employment Opportunity Statistics
Fiscal Year 1997

Job Category	Total Positions	Minority Workforce Percentages					
		Black		Hispanic		Female	
		Agency	Civilian Labor Force	Agency	Civilian Labor Force	Agency	Civilian Labor Force
Officials/Administration	62	10%	5%	11%	8%	27%	26%
Professional	8,866	19%	7%	31%	7%	72%	44%
Technical	311	15%	13%	32%	14%	49%	41%
Para-Professionals	632	20%	25%	43%	30%	80%	55%
Administrative Support	2,752	20%	16%	44%	17%	93%	84%
Service/Maintenance	1,358	36%	19%	32%	32%	0%	27%

AGENCY OPERATIONS

DHS is responsible under state law for administering human service programs designed to benefit three major client groups — low-income families and children, people who are elderly or disabled, and victims of family violence. In addition, the federal government has designated DHS as the single state agency for administration of Temporary Assistance to Needy Families (TANF), Food Stamps, Benefits, and Refugee Assistance federal funds. This designation requires DHS to develop the policy for the delivery of services in each of these areas. In addition, DHS is responsible for cross-agency coordination of all programs funded by Title XX - the Social Services Block Grant.

DHS has three major client groups: low income families and children, people who are elderly or disabled, and victims of family violence.

The Department carries out these mandates under three primary goals — Client Self-Support; Long Term Care Continuum which includes Aged and Disabled programs and Long Term Care Regulatory; and Family Violence Services. Strategies or activities under Client Self-Support include eligibility determination for TANF, Food Stamps, and Medicaid and the Immigration/ Refugee and Disaster Assistance programs. Activities under the Long Term Care Continuum goal include eligibility determination and referrals for community and institutional care as well as the regulation of long term care facilities. DHS contracts for local residential and non-residential Family Violence Services under the third goal.

Client Self-Support

Overview

Client Self-Support, also known as Texas Works, provides most of the agency's services to families and children. The goal of Texas Works is to determine eligibility for and provide comprehensive services to low-income families. Texas Works services help families meet basic needs, provide referrals to support services, and encourage families to reach self sufficiency and long term independence. Clients can access the following assistance programs through Texas Works:

Texas Works provides most of the agency's services to families and children.

- Temporary Assistance to Needy Families (TANF),
- Food Stamps,
- Medicaid for Children and Families (TANF related),
- Medicaid for Needy Families (non-TANF),
- Immigrant/Refugee Assistance,
- Disaster Assistance, and
- Special Nutrition.

Potential clients can access Texas Works programs in approximately 580 locations around the State, including selected co-located sites housing the Texas Workforce Commission (TWC), and/or the Texas Office of the Attorney General (OAG). On average, more than two million Texans per month receive Texas Works benefits. The following chart, *DHS Texas Works Recipients Per Month*, summarizes the average recipient use of the major Texas Works programs. The chart also reflects the caseload declines in these programs since fiscal year 1994.

DHS Texas Works Recipients Per Month

Fiscal Year	TANF (AFDC)	Food Stamps (all recipients)	F.S. 18-50 Year Olds	F.S. Legal Immigrants	Medicaid Families and Children (Includes TANF)	Medicaid per Month (Children, pregnant Women, Medically Needy)
1994	786,313	2,795,111	N/A	N/A	1,505,204	586,531
1995	746,343	2,637,195	N/A	N/A	1,497,158	629,093
1996	650,291	2,443,988	N/A	N/A	1,4;57,300	666,091
1997	600,199	2,117,429	65,343	144,189	1,362,955	664,278
1998*	487,524	1,711,617	29,250	56,897	1,244,462	649,079

*estimated

The Deputy Commissioner for Regional Operations directs most Texas Works programs, with the Deputy Commissioner for Programs responsible for policy, and the Associate Commissioner for Government Relations administers policy for the refugee programs. The Deputy Commissioner for Support Services manages Electronic Benefits Transfer (the Lone Star Card), and the finger imaging fraud detection project.

Federal welfare reform replaced entitlement with time-limited benefits based on personal responsibility.

Federal and State Welfare Reform

Title IV-A of the federal Social Security Act of 1935 first mandated federal welfare assistance which began in Texas in 1943 with a case load of 11,257 families receiving services.[2] In 1962, the name was changed to Aid to Families with Dependent Children (AFDC). The federal Omnibus Reconciliation Act of 1981 caused major changes in AFDC by tightening eligibility requirements, strengthening administration, and implemented the Community Work Experience Program to help clients find work. Passage of the federal Personal Responsibility and Work Opportunity Act (PRWORA) in 1996 abolished AFDC and replaced it with Temporary Assistance to Needy Families (TANF). The law reflected a changing philosophy from entitlement benefits to time-limited benefits based on personal responsibility. For more information on the history of public assistance, see *Evolution of Public Assistance in the United States*, see Appendix B.

Under PRWORA, the federal government allocates block grant funds in fixed amounts directly to states, ending the previous funding method where federal funds were calculated based on contributions of states. With the TANF block grant, states receive a fixed grant from 1997 to 2002. Texas received a base grant of $486.3 million, and qualified for supplemental funding that will increase the block grant to $536.0 million in fiscal year 2001. The first block grant to Texas in fiscal year 1996 created a $393 million surplus of which $152 million replaced existing state spending. The remaining amounts include $189 million used to fill budget gaps and expand services, $25.3 million set aside in a contingency fund, and $30.9 million used to meet emergency appropriations to DHS, TWC and the Texas Department of Protective and Regulatory Services (PRS).[3] The federal government has not yet indicated how TANF block grant funding levels will be calculated after 2002, but DHS anticipates the grant level may reflect declines in the caseloads. Medicaid and Food Stamp funds are not contained in TANF block-grants.

Under federal reform, the main goal is to transition clients off welfare and into self sufficiency through work.

Under PRWORA, the main goal is to transition clients off welfare and into self-sufficiency through work and personal responsibility by clients. Welfare benefits are no longer an entitlement lasting an indefinite period. Now welfare benefits are time-limited, come with increased work requirements, sanctions

Comparison of Federal and Texas Time Limits on Benefits	
Federal Welfare Reform	**Texas Welfare Reform (HB 1863)**
Sixty-month time limits for the family.	Time limits vary from 12, 24, to 36 months, based on education and work experience and apply only to adults in the family.
Lifetime caps, after which no reapplication is allowed.	Five-year "freeze-out" period, after which clients may reapply.
Twenty percent of cases can be granted hardship exemptions.	No limit on hardship exemptions.
Time limit starts with first receipt of benefits.	Time limit starts with notice from TWC to client of an opening in a JOBS program.

for noncompliance, and more transitional benefits, such as Medicaid, child care, and transportation subsidies. Federal welfare reform views child support collection, domestic violence prevention, increased business involvement, family health and well being, and support services such as child care, as critical components of a comprehensive package that can assist families in becoming self-sufficient. Federal reforms also place tighter limits on benefits to immigrant populations.

Texas passed its own welfare reform in 1995 (HB 1863), and received a federal waiver to operate the Texas version of welfare reform instead of meeting federal program requirements. The waiver expires in 2002. The chart, *Comparison of Federal and Texas Time Limits on Benefits*, summarizes the key differences between federal and state welfare reform time limits. For information on the directions other states' policies on welfare reform are heading, see *Trends in States' Current Public Assistance Reforms*, in Appendix C. For more information on DHS' implementation of welfare reform, see *DHS Texas Works Initiative*, in Appendix D.

The Client Eligibility Determination Process

Under Texas Works, DHS provides job finding advice for potential clients and attempts to divert clients from applying for time-limited benefits. If a client chooses to apply, the eligibility determination begins with a Texas Works advisor (eligibility staff), who gathers pertinent client and family information. TANF, food stamp, and Medicaid information are gathered on one application form, and the Texas Works advisor helps the client determine what programs the client, and family members, may qualify for. If the client is not exempt from work requirements, or volunteers to participate in a work programs, DHS pends the application while the client is referred to TWC to register for job placement, training, transportation, and child care services. Clients applying for Medical Assistance Only (MAO) services, or emergency food stamps, are not referred to TWC.

DHS continues the eligibility process after the client returns to the DHS office with a completed TWC referral form, or TWC gives DHS electronic, or verbal, confirmation of registration. If a client refuses to participate with TWC after certification of benefits, DHS sanctions the client by assessing a financial penalty on benefits. DHS can also administer sanctions for not complying with child support after notification from the Office of the Attorney

General (OAG), and for violation of the Personal Responsibility Agreement, after a determination by a DHS case worker. In many cases, the Texas Works advisor spends extra time outside of the eligibility interview to verify information, and may have other investigative staff look into information that appears to conflict with the client's situation or application. DHS must complete the eligibility determination within 30 days (non-expedited food stamps) or 45 days (TANF/Medicaid) from receipt of the client's application.

Program Descriptions

Temporary Assistance for Needy Families (TANF)

TANF is a cash assistance program providing temporary support for families who do not have enough income for basic needs, including shelter, clothing, health, and safety. The program is funded by the TANF block grant with state funds expended to meet maintenance of effort requirements. Texas sets the eligibility requirements for TANF and the cash benefit levels. When TANF benefits expire, clients can receive transitional Medicaid and child care.

TANF is cash assistance, temporary support for families without income for basic life needs.

One-Time TANF Benefits (OT-TANF)

The goal of OT-TANF is to alleviate a family's financial crisis and divert it from longer-term assistance by providing a one-time TANF payment of $1000. (HB 1863, 75th session)

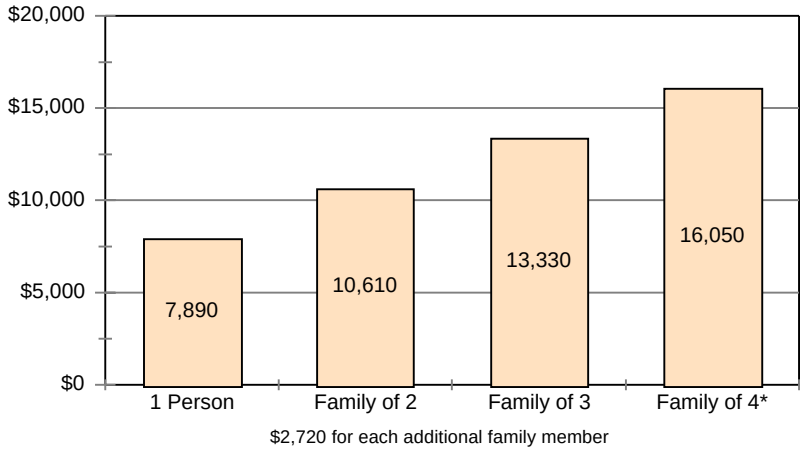
- For a family to be eligible, it must be in crisis, as defined by DHS rule. For example, a caretaker may be underemployed and at risk of losing the family's housing.
- DHS will offer a one-time lump sum payment of $1,000, regardless of family size, instead of regular TANF.
- Clients must agree to a "freeze out" from regular TANF and the automatic Medicaid benefits that come with TANF.
- Clients still have the option of applying for the Medicaid program separate, to ensure that eligible family members are covered.
- OT-TANF recipients are exempt from typical TANF requirements for work registration, child support, transitional Medicaid, third party resources, and the Personal Responsibility Act.
- OT-TANF does not impact federal or state time limits.
- OT-TANF will be implemented in Hidalgo and Cameron counties first, with state wide roll out in anticipated by late 1998.

The TANF-Unemployed Parent (TANF-UP) program covers children in two-parent households whose parents meet the income and resource guidelines for the program, and in which the principle wage earner is unemployed or under-employed. The One-Time TANF program being piloted in parts of the state is targeted to families in crisis. The chart, *One-Time TANF Benefits*, explains how the one-time cash grant works.

To qualify for TANF, a family or caretaker, must have children and meet TANF income limits, as a percentage of the Federal Poverty Level, in the case of TANF, 17 percent for a family of three. The chart, *1997 Federal*

Poverty Income Guidelines, shows the definition of income poverty for different size families. The caretaker in the home and children can receive monthly benefits if one or both of the biological parents are absent from the home, disabled, deceased, or unemployed/underemployed. TANF recipients are automatically eligible for Medicaid. A typical TANF family of three must make less than $402 per month, after deductions. The family must have less than $2,000 in assets, or $3,000 if a family member is disabled (excluding a home), and may have a car valued under $4,650. A family of three can qualify for a maximum of $188 in TANF, and $313 in food stamps, per month. With TANF, food stamps and Medicaid combined, the typical family has benefits of $795 per month, equal to 74 percent of the federal poverty level, (or $1,111 per month). Clients use the Lone Star Card, a plastic debit card, to electronically access their TANF and Food Stamp benefits at retail outlets across the State. Clients also receive a monthly Medical Care Identification form (or "card") that shows Medicaid eligibility and lists any restrictions.

Federal Poverty Income Guidelines
(100 Percent FPL - 1997)



The Food Stamp Program

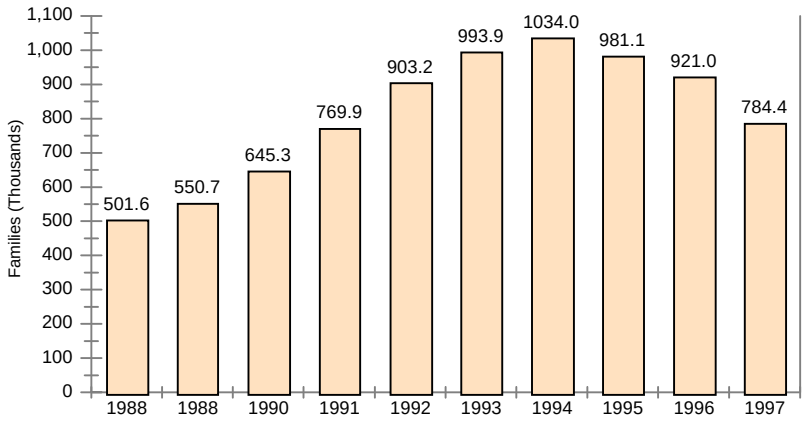
The Food Stamp program helps low income households meet basic dietary needs. The program permits eligible households to buy nutritionally adequate food to supplement the diets of families, elderly people, and single adults. The federal government provides 50 percent of the State's administrative and fraud prevention costs, and pays the total cost of benefits.

USDA establishes all eligibility standards for the food stamp program.

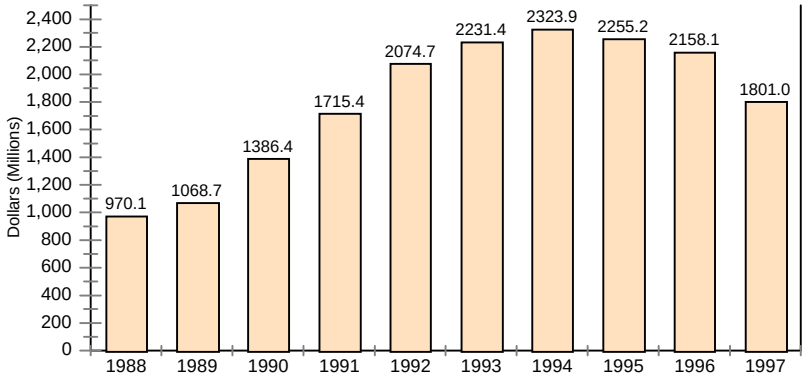
The U.S. Department of Agriculture establishes all eligibility and certification policy for the food stamp program. The effects of federal reforms are contributing to declines in food stamp case loads, particularly among able-bodied adults aged 18 to 50, and immigrants. Benefits are limited to three months in a 36-month period for able-bodied persons aged 18 to 50, unless working 20 hours a week, or participating in job training, or exempted due to hardship. In fiscal year 1997, 65,343 able-bodied 18- to 50 year-olds received food stamps, and DHS projects 29,250 will do so in fiscal year 1998. In fiscal year 1997, 144,189 legal immigrants are receiving food stamps, and DHS projects 56,897 will do so in fiscal year 1998. The chart

Average Monthly Food Stamp Caseload, shows the decline in overall food stamp caseloads, and the chart, *Value of Food Stamp Benefits Distributed*, shows the decline in the dollar value of food stamps distributed.

Average Monthly Food Stamp Caseload
Fiscal Years 1988 - 1997



Value of Food Stamp Benefits Distributed
Fiscal Years 1988 - 1997



Eligibility must be determined within 30 days for regular food stamps, and in one day for emergency food stamps. Eligibility redetermination is done at varying times, from every month by telephone, to every six months by clients visiting DHS, or once a year for SSI recipients. In Texas, the average food stamp amount per person, per month was $71 in fiscal year 1997. Benefits are electronically deposited in a recipient's account each month and debited for food purchases with the Lone Star Card.

Medicaid

Medicaid provides basic health care to families in need. DHS is the agency federally designated to receive Medicaid funding and determine eligibility while the Texas Health and Human Services Commission sets policy for the State's overall Medicaid program. The Texas Department of Health (TDH) administers the Medicaid for Needy Families programs. TDH has administered acute care Medicaid services programs that offer a comprehensive set of services, primarily for women and children, since taking over the programs from DHS in 1993. The comprehensive set of services includes primary and specialty care, early diagnosis and screening for children through the Texas Health Steps program, medical transportation, and prescription drug benefits. Medicaid payments are made directly to doctors, hospitals, pharmacies, and other contract providers. As payor of last resort, Medicaid pays only when Medicare or other insurance benefits are not available.

Medicaid, as payor of last resort, pays only when Medicare or other insurance is not available.

DHS's primary role in Medicaid is to determine eligibility. Generally, those who qualify for TANF or Supplemental Security Income (SSI) qualify for Medicaid. Clients and family members not qualifying for, or choosing not to use TANF benefits, can apply for Medicaid separately. Like TANF, Texas determines its own eligibility guidelines for Medicaid. Medical assistance to families does not run out when time limits for TANF benefits are surpassed, or when the family no longer qualifies for TANF due to receiving child support or increased earnings. Persons who lose TANF eligibility are given 4 to 18 months of transitional Medicaid coverage based on the reason for loss of eligibility.

Texas provides Medicaid coverage for children up to age six at 133 percent of the Federal Poverty Level (FPL), children up to age fourteen at 100 percent of the FPL, and pregnant women and infants under age one up to 185 percent of the FPL. Coverage of pregnant women ends two months after delivery. Medicaid pays for about half of all births in the state.[4] Non-U.S. citizens cannot receive Medicaid unless they are documented aliens. Undocumented aliens can receive Medicaid only for medical emergencies.

During fiscal year 1997, an average of 1,362,955 recipients per month in the Medicaid for Families and Children program (includes TANF) were eligible for services, and in fiscal year 1997 an average of 664,123 recipients per month in the Medically Needy Families program were eligible for services. Clients whose income rises slightly above the Medicaid limit are eligible for similar basic health care services funded through programs administered by the Texas Department of Health, such as the County Indigent Health Program, Primary Health Care Program, and the Maternal and Child Health block grant.

Immigration and Refugee Assistance

Immigration and Refugee Assistance services provides temporary cash, medical, and social services to eligible refugees, and helps refugees become self-sufficient as quickly as possible after arrival in the United States. DHS operates three programs for refugees:

- The Refugee Cash Assistance,
- Refugee Medical Assistance, and
- Refugee Social Services.

The Refugee Cash Assistance and Refugee Medical Assistance programs are available for low-income or unemployed refugees who have lived in the United States for eight months or less. DHS staff in local offices determine eligibility.

Refugee Social Services consists of employment services, such as job placement, support services such as English as a Second Language classes, transportation, and child care. Services are available for refugees living in the United States for five years or less. Providers contracting with DHS must verify and document client eligibility. DHS also provides emergency services to United States citizens living abroad who have developed serious health problems and need to return to the U.S. During fiscal year 1996, an average of 2,315 refugees received direct assistance via state warrants and 11,344 refugees received services through contracts with local nonprofit providers. The refugee programs are 100 percent federally funded.

DHS handles grants for federal disaster declarations, which Texas receives an average of 1.5 times per year.

Disaster Assistance Program

The program determines eligibility and provides grants to victims of disasters in Texas, and coordinates the provision and delivery of food, water, and ice to disaster victims identified by the Governor. Program staff also represent DHS on the State Emergency Management Council.

The grant eligibility for clients is determined using Federal Emergency Management Agency criteria set out in the DHS Individual and Family Grant Program Handbook. Over the last 23 years, Texas has averaged 1.5 presidential disaster declarations per year. The average disaster results in about 3,000 applications and 1,900 grants for an average of about $5 million. Grant funding is 75 percent federal and 25 percent state funded, with all administrative costs paid by federal funds.

Long Term Care Continuum

As mentioned earlier, this strategy has two main programs — Aged and Disabled and Long Term Care Regulatory. These are discussed below.

Aged and Disabled

DHS is responsible for providing services to needy persons who are blind, aged, or disabled. DHS uses three types of programs to provide services to blind, aged, or disabled clients — Institutional Care Services, Community Care Programs and, Medicaid Waiver Programs.

In Long Term Care, DHS provides services to needy persons who are blind, aged, or disabled.

Clients of DHS Aged and Disabled programs often have chronic health problems that limit their abilities to care for themselves and need some assistance to help maintain independence and improve quality of life. In 1936, DHS began distributing funds directly to elderly individuals as Old Age Assistance. With the creation of the Medicaid program in 1967, Old Age Assistance was replaced and the State began to provide skilled nursing

care in facilities. Throughout the 1970s, nursing home care was the only Medicaid program available to meet long-term care needs. During the late 1970s and early 1980s, the Legislature began scrutinizing the high cost associated with traditional forms of long-term care. With the arrival of federal funding programs such as Supplemental Security Income (SSI) and the Social Services Block Grant (Title XX), the Legislature directed DHS to develop alternatives to institutional care. These community care alternatives, along with the traditional institutional care options, make up DHS's Aged and Disabled program.

DHS determines eligibility and contracts with nursing homes and community providers for services.

Texans who benefit from DHS' Aged and Disabled programs include the elderly, people of all ages with developmental disabilities (such as mental retardation), and people with physical disabilities. Persons with difficulty carrying out activities of daily living, such as dressing and cooking meals, whose income does not exceed program income limits, are entitled to receive long-term care Medicaid services. Usually, the individual must also be over the age of 18 to receive services from DHS. With a few exceptions, children are served by Medicaid through other state agency programs. DHS's primary responsibility is to determine eligibility for services. Once eligibility has been determined, services are provided through contracts with nursing homes and community care providers. Regional staff determine client eligibility for community care programs and manage provider contracts. Program policy development resides at the State office. A description of the three DHS Aged and Disabled programs follows. The chart, *DHS Long Term Care Programs*, indicates the number of clients served across the State in each long-term care program and the amount expended to provide the care in fiscal year 1997.

Institutional Care Services

Institutional care services have historically been at the center of long-term care services for the aged and disabled. Even with the shift to the development of long-term care options within the community, institutional care remains an important component of the continuum of care. The chart, *DHS Institutional Care Services*, summarizes the program's services. Nursing facility services include skilled nursing care and related services including room and board, social care, special supplemental diets, medicine (except insulin), medical equipment and supplies, and rehabilitative therapies.

Program Eligibility and Intake — Individuals seeking institutional care must have a medical necessity and prove financial eligibility. DHS caseworkers initially determine eligibility. Once the client is admitted to a nursing home, the facility can request Medicaid reimbursement based on the level of nursing involvement. DHS contracts with the National Heritage Insurance

DHS Long-Term Care Programs Fiscal Year 1997		
Programs	**Average # of Clients Per Month**	**Annual Expense (FY 97)**
Adult Foster Care	364	$1,680,527
Client Managed Attendant Care	485	$4,892,280
Home Delivered Meals*	11,259	$7,981,727
Day Activity and Health Services	9,818	$45,697,685
Emergency Response*	10,687	$2,647,531
In-Home and Family Support	3,567	$6,500,000
Primary Home Care/Family Care	65,116	$345,831,376
Residential Care	813	$6,112,492
Respite Care	593	$1,194,748
Special Services to Persons with Disabilities and 24-hr Attendant Care	135	$966,770
Community Based Alternatives	15,593	$162,095,742
Community Living Assistance and Support Services	835	$24,195,044
Program of All-Inclusive Care for the Elderly	274	$6,490,916
TOTAL for CCAD	**96,548**	**$616,286,838**
Nursing Facility Care	68,738	$1,371,437,203
Rehabilitative Services	176	$409,225
Specialized Services	73	$152,563
Hospice Program	1,818	$37,936,369
Emergency Dental Services	2	$3,023
ICF-MR Program & ICF-MR for Persons with Related Conditions	7,690	$346,932,127
TOTAL for Institutional Services	**78,497**	**$1,756,870,510**
* Includes multiple service units to individual client		

Corporation (NHIC) for review of Medicaid claims to determine whether or not the individual meets the medical criteria requiring a nursing facility level of care. Once the final determination of medical necessity has been made, NHIC authorizes Medicaid payment for the nursing facility care. After the initial determination of medical necessity is completed by NHIC, nursing facilities are required to submit an assessment form for all of the facility's residents to DHS every six months reporting changes in resident conditions.

DHS contracts with NHIC to review Medicaid claims for medical necessity and authorizes payments for nursing facility care.

DHS Institutional Care Services

Nursing Facility Care: Institutional nursing care to Medicaid recipients who demonstrate a medical condition requiring the skills of a licensed nurse on a regular basis.

Preadmission Screening and Resident Review: Screens all persons seeking entry into a nursing facility to identify individuals who have mental illness, mental retardation, or a related condition to determine whether or not a different setting would more appropriately meet the individual's needs.

Nurse Aide Training: Provides a training and competency evaluation program for nurse aides.

Swing Bed Program: Permits participating rural hospitals to use their beds for both acute hospital care and long term nursing facility care when no long term care beds are available in the geographic area.

Rehabilitative Services: Physical, occupational, or speech therapy to Medicaid recipients residing in Medicaid nursing facilities.

Specialized Services: Physical, occupational and speech therapy and restorative nursing to Medicaid recipients who have been identified in the Pre-Admission & Screening & Annual Resident Review process.

Hospice Program: Palliative care consisting of medical, social, and support services to terminally ill patients.

Emergency Dental Services: Provides emergency dental services to Medicaid recipients in Medicaid nursing facilities.

ICF-MR Program: Residential care and services for individuals with developmental disabilities based on their functional needs.

ICF-MR Level of Care for Persons with Related Conditions: Institutional care and treatment for persons with severe, chronic disabilities related to mental retardation that result in significant, lifelong impairment.

If the individual is mentally ill or mentally retarded, DHS conducts a Preadmission Screening Review to determine whether the nursing facility is the most appropriate place for the individual to receive care. If not, the only prerequisite for placement in a nursing facility is whether or not the individual's medical needs require placement in a nursing facility.

Nursing Facility Resident Classification and Facility Payments — Nursing home residents are classified according to the Texas Index for Level of Effort (TILE) classification system, based on the amount of time and effort required by staff to care for them. Thus, nursing facility payment rates vary according to the individual resident's level of need. Eleven TILE rates are used to determine the daily amount of reimbursement paid to the facility. TILE rates are grouped into four clinical categories. For example, clients who are comatose or quadriplegic are classified as heavy care while a client with Alzheimer's but without other medical needs is classified as Clinically Stable/Behavioral Condition. The chart, *TILE Rates*, shows how these clinical categories correspond to the daily rates paid to nursing facilities.

Nursing facility rates are required by statute to be reviewed annually. Rates can be adjusted more frequently to respond to actions such as the addition of a new service for clients. All rate changes must be approved by the Health and Human Services Commission.

Community Care Programs

The Community Care program offers a range of services funded by state general revenues, Medicaid, and federal grants that enable elderly individuals and people with disabilities to live in their homes. Community care includes services designed to prevent or delay institutionalization of the elderly and/or persons with disabilities by helping them achieve or maintain independence within their own homes or other community settings.

Nursing facility rates are set by DHS and required to be reviewed annually.

TILE Rates

Clinical Categories	Daily Rate
Heavy Care	$99.95 to $117.73
Clinically Unstable	$70.00 to $84.16
Clinically Stable	$55.62 to $78.42
Rehabilitation	$105.43

Community care options have steadily increased as federal funding has become available; targeted to reduce inappropriate institutional care, and because of legislative directives to reduce the high cost of providing long-term care in institutional settings. In addition, the trend toward providing services in the community is customer driven as the community-care alternative expands client choice. The 11 community care programs provide services ranging from home delivered meals to 24-hour supervision in a group setting, as shown in the chart, *Community Care Programs*.

Program Eligibility — DHS uses income eligibility and functional assessments to determine whether the individual is eligible to receive services. In addition, age requirements, and the onset of the disability, limit who is eligible to receive services from some programs.

The Legislature has placed a cap on the money that can be spent to provide care in a community setting, not to exceed the amount that would have been spent on institutional care. By 1997, the number of Medicaid recipients who receive community care had grown to an average of over 96,000 per month, an increase of 87 percent over 1987, while the Medicaid population in nursing homes increased only 24 percent.

Medicaid Waiver Programs

Waiver programs allow the State to use Medicaid funds for home-based care of clients who otherwise would be cared for in Medicaid-paid institution. Under federal law, states may apply to the Health Care Financing Administration for permission to operate programs that involve exceptions to Medicaid principles such as the required array of benefits, or the mandated eligibility and income groups. These waivers use the same rules that apply to institutional care to determine if someone is financially qualified for Medicaid. The chart, *Medicaid Waiver Services*, summarizes the services provided under each program.

Community Care Programs

Adult Foster Care: Residential services and care in a family home or a small group home.

Client Managed Attendant Services: Personal care program in which the attendant is supervised by the individual receiving the service.

Home Delivered Meals: Provides a nutritious meal taken to the client's home.

Day Activity and Health Services: Medical, personal care and socialization for up to 10 hours per day, five days a week in a licensed facility.

Emergency Response: An electronic signaling device for use in emergencies.

In-Home and Family Support Program: Provides direct grant benefits to individuals with physical disabilities or his family for purchasing services that enable the individual to live in the community.

Primary Home Care: Assistance with personal care and housekeeping tasks, for persons with medically related personal care needs.

Residential Care: 24-hour care in a licensed group setting for emergency care or supervised living.

Respite Care: Short-term services for elderly and disabled adults who require care and supervision while giving temporary relief to care givers.

Special Services to Persons with Disabilities: A variety of in-home care and advocacy services for persons with disabilities.

Special Services to Persons with Disabilities 24-Hour Attendant Care: Provides 24-hour attendant care to one apartment setting in Houston.

Medicaid Waiver Services

Community Based Alternatives (CBA): Provides long-term care services outside of institutional settings to people over 21 who qualify for nursing facility care.

Community Living Assistance and Support Services (CLASS): Allows Texas to provide community-based services to people with developmental disabilities other than mental retardation as an alternative to ICF-MR VIII institutional care.

Program of All-Inclusive Care for the Elderly (PACE) Waiver Project: Allows Texas to provide comprehensive community and medical services on a capitated basis, to frail elderly people (55 and older) who qualify for nursing facility care. The waiver is part of a national demonstration project. There is one site in Texas (in El Paso).

The Community Based Alternatives (CBA) and Community Living Assistance and Support Services (CLASS) waivers enable the State to provide community-based services to people who would otherwise require care in an institution. Clients can remain in their communities and the State uses Medicaid to pay for their care. Individuals in the CBA and CLASS waiver programs must meet income eligibility requirements and be medically needy.

Community Based Alternatives (CBA) — CBA services include skilled nursing, attendant care, therapy services, respite, emergency response services, adaptive aids and medical supplies, and minor home modifications. Services can be provided in the individual's home, in adult foster care settings, or in licensed personal care facilities. The cost of providing care may not exceed the average Medicaid nursing facility rate. DHS started the CBA program in select counties in March 1994 and expanded statewide by September 1995. The CBA program currently serves approximately 16,000 participants and, due to increases in funding, is expected to serve 22,000 participants by the end of the 1998 - 99 biennium.

Federal waiver programs allow clients to stay in their community and use Medicaid to pay for care.

Community Living Assistance and Support Services (CLASS) — CLASS provides services to people with related conditions as an alternative to institutional placement. People with related conditions are people who have a disability, other than mental retardation, which originated before age 22, that affects their ability to function in daily life. The CLASS service model focuses on client independence and integration of the client into everyday community life. CLASS services include minor home modifications, physical therapy, nursing services, case management, habilitation, respite care, psychological services, occupational therapy, speech pathology and adaptive aids, and medical supplies. CLASS currently serves approximately 835 individuals in 60 counties and is projected to serve 1,052 clients in 1998.

Program of All-Inclusive Care for the Elderly (PACE) — PACE is a research and demonstration waiver project which is part of a national replication of the managed care model developed by On Lok in San Francisco, California. The PACE program integrates both Medicare and Medicaid funding to provide any and all health-related services needed including in-patient and out-patient medical care, specialty services like dentistry and podiatry, social services, in-home care, meals, transportation, day activity and housing assistance. A monthly capitated fee is paid by both Medicare and Medicaid for providing all necessary services. The Medicaid rate is 95 percent of the comparable cost of nursing facility care. The pilot program is available only in El Paso. Clients must be over age 55, qualify for a nursing facility level of care, qualify for Medicaid in a nursing facility and choose PACE services. The PACE program provided services to approximately 274 clients in 1997.

For more information on the types of Medicaid waivers available, and the guidelines states must follow to receive Medicaid funds under these waivers, see Appendix A.

Long Term Care Regulatory

Regulation of Facilities

DHS is responsible for the regulation of long-term care facilities, primarily nursing homes, and certain persons employed in these facilities. These functions are housed within the Division of Long Term Care Regulation (LTCR) and the Office of Program Integrity (OPI).

Long-term care facilities regulated by DHS include nursing homes (NH), intermediate care facilities for mental retardation or related conditions (ICF-MR/RC), personal care homes (PCH), and adult day health care centers (ADHC). The Office of the Associate Commissioner for Long Term Care Regulatory administers facility regulatory laws, rules, and regulations. The Credentialing Department of the Office of the Deputy Commissioner for Program Integrity regulates long-term care occupations, including nursing home administrators, medication aides, and nurse aides.

Continuing concern about abuse and neglect have prompted ever increasing regulation of long-term care facilities, especially nursing homes.

Texas began regulating long-term care facilities in the 1960s, and state regulation has continued to grow. The expansion of long-term care regulation has been driven by several factors including an increasing population of elderly Texans, increasing need for services and residences, and the corresponding growth in facilities providing these services. In addition, numerous well-publicized incidents of abuse, neglect, and exploitations of residents in these facilities in the 1980s and 1990s has prompted both the federal and state government to further strengthen their regulation or oversight of these institutions, especially nursing homes.

The primary mission of the agency in regulating facilities is to ensure facilities comply with state licensure standards and to certify facilities for compliance with conditions of participation in federal Medicaid/Medicare programs as part of a state-federal contract to receive federal dollars from these programs. In addition, DHS enforces laws that protect and promote the health and safety of persons residing in these facilities As of August 1997, 3,332 regulated facilities were operating in the State, with the capacity to serve over 180,000 residents in Texas. In addition, DHS estimates about 4,000 personal care homes are operating illegally—i.e., without a license. The chart, *Facilities Regulated by DHS*, details the types, numbers, and capacities of regulated facilities.

Facilities Regulated by DHS Fiscal Year 1997		
Type of Facility	**Number of Facilities**	**Facility Capacity**
Nursing Homes	1,379	131,817
ICF-MR/RC	894	14,484
Personal Care Homes	818	22,365
Adult Day Health care Centers	241	16,977
TOTAL	3,332	185,643

DHS LTCR/OPI Staffing Fiscal Year 1997	
Program Activity Description	**Staff Ceiling/FTEs**
Geriatric (NHs, ADHCs and PCHs)	463
Facilities Licensing	15
ICF-MR/RC	107
Medication Aides Permitting	2
Nurse Aide Certification	11
Administrative/Generic	161
Operation Restore Trust - (Federal Medicaid fraud project)	2
TOTAL	**761**

Source: DHS LTCR/OPI

The chart, *DHS LTCR/OPI Staffing*, details the activities and staff allocated to each DHS long term care regulatory program for fiscal year 1997.

Funding

DHS funds the facility licensing and certification program primarily with state general revenue and federal funds. All licensed facilities are required to pay fees which are established in statute. The chart, *Facility Licensing Fees*, shows the fee structure for different facilities. Program revenues generated by fees are deposited in the General Revenue account.

Regulatory Activities

Nursing Homes and ICF-MR/RCs — DHS licenses all nursing and ICF-MR/RC facilities in the state and certifies facilities that choose to participate in the Medicaid/Medicare programs. Licensure and certification is accomplished through an annual inspection process. DHS inspects most nursing homes on a 12-month cycle, but the frequency can vary from between 9 to 15 months. Inspections are conducted by regulatory staff assigned to each of the 11 health and human services regions. In fiscal year 1997, DHS conducted 2,570 inspections. In addition, the staff investigate complaints filed against facilities. In fiscal year 1997, the agency investigated 9,788 complaints. To deal with non-compliance or other issues that adversely impact the residents' health and safety, the regional inspection staff recommend and assist with the enforcement of sanctions. Sanctions can range from putting the facility on a fast-track (23 days) medicaid contract termination to imposing administrative and/or civil penalties on the facility. The chart, *DHS LTCR Enforcement*, details regulatory actions recommended and taken by the agency.

Facility Licensing Fees	
Description	**Current Fee**
Nursing Facility and ICF-MR Licenses	$150 plus $5/bed
Personal Care - Type A &B Licenses	$100 plus $3/bed
Adult Day Health Care Licenses	$25

Personal Care Homes and Adult Day Health Care Centers — Regional regulatory staff license facilities annually for compliance with health and

life safety code standards. In fiscal year 1997, DHS conducted 1,946 inspections. Complaints filed against these facilities are also investigated and applicable state licensure remedies are enforced by the licensing staff. In fiscal year 1997, DHS investigated 1,180 complaints on licensed and unlicensed facilities. Actions recommended and taken are included in the chart, *DHS LTCR Enforcement*.

In addition to facility regulation, the staff also enrolls providers to participate in the Medicaid and Medicare programs. Applications filed by facilities for participation in the federal Medicaid/Medicare program are first processed at the State office and then regional inspection staff evaluate the prospective provider and submit their recommendations to the State office. Facilities or providers that meet federal participation requirements are issued a Medicaid contract.

DHS LTCR Enforcement
Recommended and Final Punitive Actions from July 1, 1995 through August 31, 1997

	Number Recommended					Number Final				
	Facility Type					Facility Type				
Type of Action	Nurs. Fac.	ICF/ MR	Adult Day	Pers. Care	Unlic.	Nurs. Fac.	ICF/ MR	Adult Day	Pers. Care	Unlic.
Administrative Penalties	200	113				200	113			
Vendor Hold	-	137					125			
23-day Termination	1	10				0	10			
90-day Termination	4	113				0	103			
Initial Certification	24	0				2	0			
Denial of License	211	3	8	22	4	1	0	0	3	2
License Revoked	35	7	1	15		3	0	0	3	0
Invoke ACC	-	52					46	-		
Terminations/Denial of										
Recertification	654	19				24	17	0		
Trustee	13	0	0	1	1	13	0	0	1	1
Denial of Payment for New Admissions	1,001	-			-	284				-
Denial of Payment for all Individuals	5	-			-	0				
Civil Monetary Penalties ($50 - $3,000)	1,148 $13.7m	-			-	57 $1.1m				-
Civil Monetary Penalties ($3,000-$10,000)	68 $3.1m	-			-	6 $270k				-

REGULATION OF OCCUPATIONS

Concurrent with the regulation of nursing homes in the early 1960s, the State also started regulating Nursing Home Administrators (NHAs). In the early 1980s, the State expanded its oversight role by requiring that all nursing home staff administering medication be licensed or specifically trained to provide medication under the direction of a licensed nurse. In addition, the regulation of nurse aides came under states' oversight authority as a result of the federal Omnibus Re-conciliation Act of 1987, as part of federal Medicare/Medicaid requirements. Actual enforcement of nurse aide regulations by the State was delayed until 1989 while the federal Health Care Financing Administration (HCFA) developed rules.

The oversight of NHAs underwent major revision in 1997 after concerns were raised by the public and the Legislature regarding the impartiality and independence of the Board of Nursing Home Administrators. The 75th Legislature changed the composition of Board, moved oversight to DHS from the Texas Department of Health, and created an advisory committee at DHS.

The agency's mission for regulating key staff of nursing homes and related institutions is to protect the public's health and safety and assure quality service delivery. Regulators — through licensure, certification, and permitting — ensure that these institutional staff meet minimum practice standards in carrying out their responsibilities. The chart, *Occupation Regulatory Data*, outlines the types of professions regulated by DHS and the total licenses, or certifications, issued in fiscal year 1997.

Occupation Regulatory Data

Type of Occupation	FY 1997 Totals
Nursing Home Administrators (NHAS)	2,572 licensed
Medication Aides (MA) MA Training Programs	6,945 permits issued 75 programs approved
Nurse Aides (NA) NA Training Programs	24,000 certified 760 programs approved
NA Registry Data Active NA in Registry All NA in Registry	 92,000 182,000

Funding

DHS funds the occupational regulatory program through fees, state, and federal funds. State statute sets the amount of the regulatory fees for occupations. All fee revenue is deposited in the General Revenue account.

The chart, *Licensure, Certification, and Permitting Fees*, provides more details on the types of fees contributing to defraying the cost of regulation.

Licensure, Certification, and Permitting Fees	
Nursing Home Administrator	
Application Fee	$100
Examination Fee Texas State Standards Natl. Assoc. of Boards of Examiners of NHAS, Inc.	 $150 $125
Licensure Fee (initial)	$250
Renewal fee (biennially)	$250
Formal Inactive Status Fee	$250
Medication Aides	
Medication Aides	
Permit Application and Examination Fee	$25
Renewal Fee	$15
Permit Replacement Fee	$5

Regulatory Activities

Nursing Home Administrator's Licensing — DHS tests and annually licenses facility administrators. OPI staff, with the help of LTCR, also investigates complaints filed against the administrators and present their findings to the nursing facility Administrator Advisory Committee. The advisory committee, in turn, makes recommendations to DHS staff regarding sanctions. Sanctions, ranging from additional training to suspension of license, are then enforced.

Medication Aides Permitting — Medication aides serve as an extension of nursing services in nursing homes, personal care homes, institutions in the criminal justice system, and mental retardation group homes. DHS permits or certifies qualified individuals to assist with the administration of medication under the supervision of a licensed nurse. Permits are issued by DHS to individuals who pay a fee and meet requirements related to training from a state approved training program, clinical experience, and testing. The agency also ensures that approved schools comply with the requirements of the training program. Complaints filed against medication aides are referred to LTCR staff for investigation. If validated, the aide's permits can be denied, suspended, or revoked. In fiscal year 1997, DHS received five complaints resulting in three permit revocations.

Nurse Aides Certification — Nurse aides provide direct care services in nursing facilities. DHS certifies qualified individuals to provide nursing or nursing related service under the supervision of a licensed nurse. Individuals are certified if they meet requirements related to training, clinical experience, and testing. As with medication aide training programs, the agency approves and reviews programs and their curriculum for compliance with applicable laws. DHS also maintains a nurse aide registry. If the agency finds an aide abused or neglected a nursing facility resident or misappropriated resident property, the finding is placed on the registry and state law prohibits the aide from future employment in a nursing facility. Complaints against nurse aides are handled in the same manner as for medication aides. In fiscal year 1997, 164 nurse aide certificates were revoked.

In addition to credentialing occupations, OPI staff also conduct criminal history checks. The Health and Safety Code requires that individuals who have direct contact with residents and are not licensed professionals be checked for criminal history as a condition of permanent employment. DHS collects requests for checks and sends them to the Texas Department of Public Safety, then returns the results to the requesting facility. In fiscal year 1997, DHS received 172,030 requests from facilities for this service at a cost to the Department of $173,176.

Family Violence Services

The Family Violence program provides services to any person who is a victim of domestic abuse in Texas. Services include emergency placement of families in shelters to escape immediate violence and non-residential services including emergency medical care, counseling, transportation, legal assistance, employment information, community education, referrals to community services, and volunteer recruitment.

DHS contracts with the Texas Council on Family Violence to assist with family violence matters.

The federal Wellstone/Murray Family Violence Amendment, a part of welfare reform, allows states to exempt TANF recipients that are victims of domestic violence from work requirements when necessary. As a result of House Bill 3428, 75th Legislature, DHS, TWC, and the OAG, in cooperation with the Texas Council on Family Violence, are examining how to best identify, assess, and exempt domestic violence survivors for up to one year.

The administration of the Family Violence program is under the Government Relations division of DHS, and expended $10,243,807 for fiscal year 1997. Funding is from the Federal Family Violence Prevention and Services Act, state appropriations, and federal Title XX funds. DHS was appropriated an additional $1.8 million for fiscal years 1998 and 1999 from Crime Victims Compensation funds to provide non-residential services.

DHS contracts with the Texas Council on Family Violence (TCFV) to assist DHS in administrative support, service delivery, and policy development relating to family violence shelters and non-residential services. The fiscal year 1998 contract with TCFV is for $990,557. DHS contracts with 75 non-profit organizations, of which 66 are shelters, to provide direct services to victims of family violence. Contractors provided shelter for 11,178 women and 14,618 children, and 18,805 women received non-residential services. In 1997, approximately 52,909 clients received residential and non-residential services from family violence providers.

[1] Does not include the value of food stamps distributed ($1.8 billion) or commodities distributed ($68 million) by the agency.

[2] Sunset Advisory Commission, *DHS Sunset Report*, 1986.

[3] *Welfare Reform*, The Center for Public Policy Priorities. September 1, 1997. Page 11.

[4] Texas Health and Human Services Commission, *Texas Medicaid in Perspective*, Second Edition, January, 1997. Page 11.

[5] *A Partnership for Independence*, Texas Comptroller of Public Accounts. January 1995. Page 6.

[6] Ibid.

APPENDICES

Appendix A

Medicaid Waivers

States must follow the basic principles of the Medicaid program listed below to continue to receive federal Medicaid funds.

- ***Statewideness***

All Medicaid services must be available on a statewide basis and may not be restricted to residents of particular localities.

- ***Amount, Duration, and Scope***

The amount of services, the length that services are covered and the settings in which a service is covered must be "reasonably sufficient." States may impose limits on services only for Medicaid clients who are over age 21; but services must not be arbitrarily limited for any specific illness or condition.

- ***Comparability***

Except where federal Medicaid law specifically creates an exception, the same level of services has to be available to all clients.

- ***Freedom of Choice***

Clients must be allowed to use any Medicaid health care provider meeting program standards.

To develop creative ways to provide higher quality services at a reasonable cost, many states have undertaken pilot projects in Medicaid that do not meet the above criteria by requesting Medicaid waivers from the Health Care Financing Administration. These "waivers" allow states to depart from Medicaid's usual rules.

States have three different waivers to choose from.

— *Freedom of Choice* waivers allow states to limit clients' choice of Medicaid providers thus allowing the State to test alternatives such as managed care organizations as the service delivery mechanism. Freedom of choice waivers are referred to as 1915(b) waivers from the section of the federal Social Security Act that establishes them. The current STAR and STAR PLUS Medicaid Managed Care initiatives underway in Harris county are examples of a 1915(b) waiver program.

— *Research and Demonstration* waivers enable the State to test new ideas for meeting the goals of the Medicaid program. These waivers are referred to as 1115(a) waivers. An example of an 1115(a) waiver is the Program of All-Inclusive Care for the Elderly (PACE) in El Paso.

— *Home and Community-based Services* waivers enable the State to provide care in community settings for individuals who would otherwise require care in an institution. Home and community-based waivers are referred to as 1915(c) waivers. The CLASS and CBA programs at DHS are examples of 1915(c) waiver programs.

Appendix B

The Evolution of Public Assistance in the United States

1600's ***The Elizabethan Poor Laws***

The main principles of the Elizabethan Poor Laws were that local communities provided for the poor, people supported their own poor relatives, and towns were responsible for their residents. Parishes in England divided the poor into those unable to work - "the lame, impotent, old, blind", and the able-bodied. The poor who could work were provided public service employment, an Elizabethan version of workfare.

1700's ***Poor Laws adapted to the United States.***

In the U.S., Benjamin Franklin noted that the Poor Laws "...offered a premium for the encouragement of idleness...", a consistent theme in the history of public assistance. In the Northern states able-bodied recipients were sent to poor farms and public workhouses, while the Southern states tended to provide aid to the poor who lived with relatives.

1800's ***Counties establish the public responsibility for poor relief.***

Local governments and communities carried out state imposed poor relief by contracting with wealthy families for care, placing the needy in work houses, providing assistance in the home, and in some cases auctioning off the poor.

1850's ***Social work and the "child saving" movement.***

Modern social work began with Scientific Charity reformers working to enhance families and rehabilitate them from poverty. Reformers started the "child saving" movement by arguing in the courts that children had less rights and protections, in public life, than privately-owned animals. The poor and at risk children were "saved" by being taken from their homes and placed in institutions or work farms.

1900's ***The care and retention of children in their homes.***

By 1912, 40 states enacted Mothers' Pension laws, that offered income support to mothers made destitute primarily by the death of a husband. The new laws imposed obligations on women to be good care takers of their children. Social workers focused on homes that were "deserving" of aid, and the social worker closely monitored the behavior of the mother.
Strategy: Child well-being.

1935 ***Social insurance versus public assistance.***

The Social Security Act of 1935 started the Aid to Dependent Children (ADC) program after debates between advocates of universal, contributory social insurance, and non-contributory means-tested assistance to the poor. ADC caseloads sharply increased as the population grew after WWII, and African Americans began migrating to the North from the Southern states.
Strategy: Child well-being.

Appendix B

The Evolution of Public Assistance in the United States

1962 ***President Kennedy's Social Security Amendments.***
Kennedy's 1962 amendments added "Families" to ADC, and created Aid to Families and Dependent Children (AFDC), that provided unlimited matching federal funding (75%) to states' contributions (25%). States began more social casework strategies that failed under rapidly increasing caseloads, and cash grant entitlements to families increased under policies that favored meeting clients economic needs. The Community Work and Training program began, which helped to develop client work skills.
Strategy: Income needs and human capital development.

1975 ***Child Support Enforcement.***
The federal government established the Office of Child Support Enforcement as Part IV-D of the Social Security Act, with the goal of reducing AFDC payments to parents by insuring that both legal parents contributed to raising their children. Teen births and the number of single parents on AFDC continued to climb. States' policies changed to make cooperation with child support enforcement a requirement for AFDC.
Strategy: Family formation.

1988 ***The Family Support Act (FSA).***
The Jobs Opportunity and Basic Skills Training program (JOBS) in the FSA made self sufficiency, not income support, the main principle of public assistance. Federal funding for JOBS was partial, and only 20 percent of states initially participated in the program. AFDC caseloads continued to climb, and debates on the well-being of children increased, including proposals to place needy children in orphanages.
Strategy: Labor market participation and family formation.

1996 ***The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA).***
PRWORA replaced AFDC with Temporary Assistance to Needy Families (TANF), and merged AFDC, JOBS, and Emergency Assistance dollars into fixed block grants to states until 2002. Benefits are limited to five years, eligibility is restricted, and clients must work, or attend job training. States can operate their own programs under federally approved waivers, with varying benefits and time limits.
Strategy: Social contract and child well-being.

Source: Thomas Kaplan, *Welfare Policy and Caseloads in the United States: Historical Background*. The Institute for Research on Poverty, University of Wisconsin, Madison. March 1997. Http://www.ssc.wisc.edu/irp.

Appendix C

Trends in States' Public Assistance Reforms	
Programs focus on client behavior, not just granting assistance.	Programs are moving away from only determining eligibility and giving cash assistance, and moving towards focusing on changing clients' attitudes and behaviors. Programs are giving consistent work first messages, emphasizing personal responsibility, and using sanctions to bring clients into compliance with program requirements.
Benefits vary and policy changes quickly.	Programs are increasingly complex, with many levels of benefits and eligibility criteria for TANF, Medicaid and Food Stamps. Program policy changes quickly, placing more importance on training caseworkers, getting information to clients, and having flexible computer systems that can keep up with changes.
Systems are dynamic, not static.	Programs are oriented towards change with the most important unit being the family. Programs actively work to remove barriers to independence facing families, and work to get families involved with their plans for self sufficiency.
Clients in a process leading to independence.	Programs focus on the status of clients relative to their time limited benefits. Clients move up a "ladder" in a process that leads to meaningful self sufficiency, including job getting, continuing education, life skills training, and referrals to support services. Programs survey families that have left the rolls to determine job retention and true independence from all forms of public assistance.
Agencies target many groups.	Programs have many groups targeted for support services caretakers, children, families, and absent parents. Human Service agencies are changing their internal cultures. Programs focus on outreach to groups outside of state agencies including child care providers, employers, community organizations, charitable groups, and faith-based organizations.
Service delivery focuses on the family.	States are reorganizing Health and Human Service agencies into Departments for Children and Families, which include health, mental retardation, disabilities, early childhood intervention, public assistance, child support, child care, transportation, work training, education, and family support services.
Case workers take initiative and use discretion.	Program employees are more professional, empowered, and allowed discretion in crafting family service plans. Clients are not treated alike, and an array of family support services aiding self sufficiency are targeted to specific family needs. Case workers grant appropriate exemptions from work requirements for domestic violence, hardship, and low employment rates.
Targeted case management.	Programs assess the needs of families, refer them to programs, and track the use of benefits. As time limits move clients off of assistance and the most employable find jobs, a larger percentage of the caseload are the most needy, least skilled, and hardest to employ. To ensure the well being of families, caseworkers actively monitor the progress of at-risk families towards independence.

Source: Tom Corbett, *Informing the Welfare Debate: Introduction and Overview*. The Institute for Research and Poverty, University of Wisconsin, Madison. March 1997. Http://www.ssc.edu.irp.

Appendix D

The Department of Human Services Texas Works Initiative

The *Texas Works* initiative is a three-phase plan by DHS with the overall mission of helping needy Texans get "Work Instead of Welfare."

Phase One: The DHS Culture Change Initiative (February 1997).

- Agency-wide teleconference with welfare-to-work expert Greg Newton, with 3,000 DHS staff participating, production of a video tape, and management follow up sessions.
- Newton's goals are to transform agency "welfare" culture, have caseworkers act as "consultants, coaches, and cops" for clients, send consistent jobs messages, and train staff on responding to clients concerns about assistance reforms.

Phase Two: Expansion of Texas Works to DHS Offices (November 1997).

- Establishment of jobs resource rooms staffed with a Texas Works Advisor. With new intake processes, potential clients are referred to the resource room and provided pre-application employment counseling. Any person can come and access TWC job listings, employer information, and community resources information from a Texas Works resource room.
- Development of the Texas Works logo, renaming case workers as Texas Works Advisors, posting consistent work messages in all offices, and producing a Texas Works video.
- Expansion of mentoring and volunteer programs.

Phase Three: Follow Through of Texas Works (current).

- Continuing Quality Control to reduce fraudulent claims and benefit payment errors.
- Collaborating with other agencies to enhance support services such as child care and transportation.
- Collaborating with community colleges on work training, and getting faith-based organizations and businesses involved in job finding efforts for clients.
- Capturing diversion data on clients that have chosen not to use benefits. As of June, 1998, DHS has redirected a total of 15,689 potential food stamp and TANF clients from the assistance rolls, who would have been eligible, for a savings of $3.5 million.
- Implementation of simplified benefits policy.

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