From: Sunset Advisory Commission
To: Dawn Roberson
Subject: FW: Form submission from: Public Input Form for Agencies Under Review (Public/After Publication)
Date: Sunday, June 08, 2014 12:38:24 PM

-----Original Message-----
From: sundrupal@capitol.local [mailto:sundrupal@capitol.local]
Sent: Friday, June 06, 2014 5:29 PM
To: Sunset Advisory Commission
Subject: Form submission from: Public Input Form for Agencies Under Review (Public/After Publication)

Submitted on Friday, June 6, 2014 - 17:29

Agency: DEPARTMENT AGING AND DISABILITY SERVICES DADS

First Name: Marina

Last Name: Hench

Title: Director of Public Policy

Organization you are affiliated with: Texas Association for Home Care and Hospice

Email: marina@tahch.org

City: Austin

State: Texas

Your Comments About the Staff Report, Including Recommendations Supported or Opposed:

Thank you for the opportunity to comment on the Sunset Commission report for the Department of Aging and Disability Services. Texas Association for Home Care & Hospice (TAHC&H) represents over 1,400 licensed home and community supports services agencies (HCSSAs) that provide therapy, nursing and personal attendant services to Texans of all ages.

We will comment on two sections of the DADS report: Issue 4 "Few Long-Term Care Providers Face Enforcement Action for Violations"; and Issue 5 "DADS Lacks a Comprehensive, Effective Approach to Contract Management, Which Increases Financial Risks to the State".

Issue 4

We appreciate the hard work that Sunset staff put into developing this report and recommendations. Unfortunately this section of the report has many inaccuracies about the regulatory process and enforcement of HCSSAs. The report therefore reaches conclusions that misrepresent the industry and makes recommendations that would not achieve the desired result and could result in uncessary harm to the home care instustry.

Our Association is committed to ensuring that high-quality home care and hospice services are delivered to Medicaid beneficiaries with an unfailing dedication to the health, safety and well-being of our patients and clients.

In order to achieve this goal – that is clearly shared by the Sunset Commission – we will correct the mistakes made in this Sunset report and provide alternate recommendations that are based on the actualities of DADS regulation and enforcement of HCSSAs.

1) While the Sunset report attempts to avoid the use of acronyms in order to be easily understood, it is inaccurate to refer to licensed home and community services supports agencies as "home health". HCSSA is the acronym and should be used because this is the accurate term. It encompasses all types of home care services to include home health, private duty, and hospice services delivered by licensed providers.

2) P. 44 states that "home health agencies contract directly with DADS to provide Medicaid entitlement and waiver

services". This is inaccurate.

Only some agencies contract with DADS and the rest contract with managed care organizations (MCOs), or are directly enrolled as a Medicaid provider through the state contractor (TMHP) to provide Medicaid entitlement services. Home care agencies can contract with other governmental agencies such as the Veterans' Administration, private insurance, or directly with consumers to provide a vast array of home care services. The majority of former Community Based Alternatives (CBA) and Primary Home Care (PHC) program providers now contract with MCOs. By September 1, 2014 CBA and PHC will no longer exist, with the exception of a few PHC-eligible populations and their providers remaining in fee-for-service. In short, few HCSSAs contract with DADS to provide home and community based supports services.

3) The Sunset report, in a variety of places, includes statements that indicate the author/s do not understand how HCSSAs are regulated for health and safety by DADS and how penalties are imposed. Furthermore, the way in which DADS conducts enforcement has likely skewed the data and how Sunset interprets the data.

On p. 44 the report states, "While one enforcement action may cover multiple violations, the agency could not account for the number of violations tied to these 225 enforcement actions". This does not make sense because each penalty is tied to a particular violation for HCSSAs. It appears that this may be an interpretation of other provider's violations to enforcement ratio. Perhaps DADS is not keeping adequate records or Sunset has not been able to access them.

On p. 44 and continuing throughout the chapter, Sunset compares and sometimes combines the data of violations and penalties amongst long term care providers. This is very confusing and misrepresentative because different long term care providers are governed by different rules and regulations.

For example, the quoted statement above is wrong because, for HCSSAs, each enforcement action is tied to a single violation. The statement may - or may not be - true for other provider types, but it is not true of HCSSA rules and should not be represented as true of all long term care providers. Likewise the chart on p. 44 is confusing because it compares data resulting from dissimilar rules and regulations.

4) On p. 45 the report states, "The effective and fair use of penalties plays a key role in deterring violations and increasing compliance with regulations intended to protect the health and safety of the public". It states that serious threats to health and safety warrant more aggressive action (paraphrased). On p. 46 the text goes on: "Without ratcheting up penalties tied to repeat offenses, provider lack incentive to come into long-term compliance by addressing more numerous and frequently occurring minor violations".

While our Association agrees that "the effective and fair use of penalties plays a key role in deterring violations and increasing compliance with regulations" we refute the assumption that the current regulations and penalties are inadequate and also the assumption that increasing penalties alone would somehow result in better compliance and quality of care. The report author/s has not presented any evidence to indicate that the current regulatory and enforcement climate is tied to a poor level of health, safety or quality in the Medicaid program. (We will present information as to why citations are an inaccurate measure of health and safety for HCSSAs.) Furthermore the author/s has not cited any evidence – peer reviewed studies or articles – that would indicate that increasing penalties would actually result in higher rates of compliance. (We will present alternate recommendations that will actually improve compliance.) On p. 46 the report states, "Home health agencies also commit a significant number of serious violations. In fiscal year 2013, DADS ranked 63 percent of the 6,530 home health violations and serious, resulting in threats to health and safety, serious harm, or potentially death". This is misleading and an inaccurate analysis because Sunset does not understand the way that HCSSA rules are written and applied by DADS.

- When the Sunset report author/s uses the term "serious" violation, we assume this means Severity Level B violations in accordance to our health and safety code. Use of the term "serious" is somewhat misleading because of everything that constitutes a Severity Level B violation and the arbitrary discretion used by DADS surveyors to categorize an error as Severity Level B.

- For HCSSAs, not all Severity Level B violations/citations actually result in "threats to health and safety, serious harm, or potentially death".

Many of Severity Level B violations are administrative failures that did not result in any actual harm. Our Association maintains the position that Title 40, Part 1, Chapter 97, Subchapter F, Rule 97.602 governing Administrative Penalties need to be restructured so that the violations and citations are reflective of the true severity of the error.

- For example: §97.256 relating to keeping a written emergency plan on file is administrative in nature. We agree that this requirement is critically important to health and safety but it is not (as the report assumes) a medical error that resulted in immediate harm or death.
- Another example is §97.260 relating to documentation requirements for continuing education of an administrator and alternate administrator. Again, while critically important, forgetting to

have a copy of paperwork demonstrating continuing education does not mean that an individual was harmed.

- Each of these violations can be cited as a severity level B violation

regardless of whether there was actual or potential harm to the client and therefore classified as serious and mistakenly leading one to the conclusion that the majority of violations committed by HCSSAs are serious.

- We recommend that this section of our rules should be broken-out into

three categories: A, B, C. A (administrative, minor violations); B (those things that could substantially limit the ability to provide care); C (imminent threat of harm to health and safety or care that resulted in harm or death). Overlaps between the existing categories should be sorted out and eliminated in order to give a better picture of the actual status of the industry.

In summary, we cannot conclude that the "serious" violations referenced by the report actually resulted in harm to patients and clients. The rules should be changed in order to report this information accurately and, most importantly, to assess appropriate enforcement action.

5) P. 47 states "the agency revoked the licenses of 43 home health agencies. While this does represent a larger number of revocations, this is still less than 1 percent of the 6,296 agencies in Texas." Our Association seriously questions the inherent assumption that there is an "ideal"

number of license revocations – especially given that the current structure of regulation and enforcement is so flawed (see #4). Given the current structure of regulation and enforcement, one cannot accurately determine what percentage of HCSSAs should have their license revoked. Certainly this should not be a measure of success in the Medicaid program.

6) P. 47 states, "The right to correct substantially hinders the agency's ability to implement its own enforcement guidelines…Allowing providers to repeatedly commit the same violations, by later coming into compliance, weakens the integrity of the regulatory process." We refute this statement.

First, for HCSSAs, Severity Level B violations can and do result in "no right to correct" anyway. The only violations that HCSSAs are allowed to correct are for Severity Level A violations that have no imminent threat to harm a beneficiary and are classified as minor. Even if the agency comes into compliance with the Severity level B violation, DADS can choose to assess an administrative penalty, regardless of whether or not the agency corrected the violation. DADS can also take enforcement action against a HCSSA, including revoking their license without the need for a follow up visit.

Second, maintaining the ability to correct a mistake is important to maintaining an adequate provider network and ensure quality services for beneficiaries. But it requires DADS to actually follow-up to see if the issues are corrected. Our members tell us that they very rarely do. The State should A) dedicate adequate funding for survey and enforcement; and B) the enforcement arm of DADS should do follow-through.

Third, restructuring the Severity Level violations and penalties would result in more effective prioritization of enforcement. As stated above, Severity Level B contains so many administrative-type errors that this is what makes it hard for DADS' enforcement department to target actual serious and immediate threats to patients and clients. They have not segregated out what is real harm versus overall capacity to give good care.

In summary, there is not a lot of clarity in the application of Severity Level A and B violations; DADS lacks the manpower or willpower to follow-through and ensure that errors were corrected; the current structure of the rules may make it hard for DADS to prioritize serious situations; and the assertion that "right to correct" means providers are committing the same violations repeatedly is a fallacy and only true in the sense that DADS does not ensure the corrections were actually made.

7) The chart on page 47 is misleading and confusing. This is likely because it is unclear whether the violations were Severity Level A or B (resulting in different penalty amounts). Fewer violations could result in larger penalties because of the severity level assigned to each violation.

8) On p. 48 the report states, "For home health agencies and assisted living facilities, the upper limit of $1,000 fails to provide an adequate deterrent to potentially serious violations that can threaten the health and safety of elderly individuals and persons with disabilities". Again, this statement represents the author/s lack of understanding of HCSSA regulations.

First, there is no cap or limit on the total financial amount of penalties that can be assessed to a HCSSA. While nursing homes may have a total cap per inspection, the $1,000 cited in the report for HCSSAs is per violation.

For example, an agency could have triggered five Severity Level A violations assessed at $100 per violation, two Severity Level A violations assessed at $200, and one Severity Level B violation assessed at $1,000 for a total of $1,900 in total penalties.

Second, (again) given the inherent flaws in the current regulatory structure we cannot accurately determine what percentage of violations actually threatens the health and safety of beneficiaries. We also know that DADS staff assess penalties and assign severity levels at their discretion.

Third, (again) the Sunset staff has presented no evidence to support their assertion that increasing penalties will result in overall improved health and safety in the program.

Lastly, a large percentage of home care services delivered through the Medicaid program are not part of a medical model therefore it is erroneous to compare these violations to medical professional penalties.

9) On page 49 the report states, "Low penalties can become a cost of doing business instead of deterrence against committing violations." Perhaps.

But (again) the author/s offers no evidence or studies to correlate increased penalties with increased compliance. Furthermore, $8000 in penalties for an agency with patient census of 10,000 does not have the same impact as $8,000 penalty for an agency with 50 patients.

Issue #4 Recommendations

4.1 – We partially agree with this recommendation in the sense that the violations and penalties need to be restructured and tiered to appropriately capture the severity of the violation and enforce as needed. However HCSSAs through our licensure already have progressive sanctions for serious or repeated violations and DADS already has revocation authority to target severe cases of repeated noncompliance. While they already have this authority they are not using it effectively. We would appreciate the opportunity to participate in a stakeholder process to restructure violations, penalties, and enforcement action to more accurately reflect the nature of the violation and therefore result in more consistent and accurate enforcement.

4.2 – The provisions surrounding "right to correct" are sufficient insofar as DADS commits to follow-through with enforcement actions. Our licensure rules already dictate the types of violations that qualify for "right to correct" and those that do not. DADS already has significant discretion on what qualifies for right to correct. This Sunset recommendation is unnecessary for HCSSAs.

4.3 – This was partially addressed in our earlier comments. As previously stated, a large percentage of home health services delivered through the Medicaid program are not part of a medical model therefore it is erroneous to compare these violations to medical professional penalties. In addition, the Sunset staff has presented no evidence to support their assertion that increasing penalties will result in overall improved health and safety in the program. This recommendation should be tabled until there is better data on the nature of HCSSA violations (administrative versus imminent harm) and a restructuring of the Severity levels to more accurately identify the nature of the violation.

Further recommendations from TAHC&H

The State should dedicate monies from the penalties back to the survey and certification activities of licensed HCSSAs so that DADS (or whoever) has the resources to enforce regulations, rather than this money going in the General Fund.

Issue 5

We agree that it is a problem that DADS contracts are "isolated" from HHSC.

As DADS programs move into managed care, there is no risk-evaluation and no ability for HHSC to properly set up managed care contracts if they have little understanding of what the beneficiaries have been receiving from a programmatic standpoint, and what providers have been expected to provide.

This is why, in our experience, moving programs from DADS to the more needs-based delivery model of managed care has been so problematic.

Another way to improve contracting at DADS that would also be a preparation for more waiver program moving to managed care is the following:

Currently providers of Home and Community Based Services (HCBS) may have different contract requirements, based on the waiver that they are operating under and whether they operate under a HCSSA license. Some providers of HCBS do not have a license and are held accountable to health and safety standards purely through their contract with DADS.

The State should:

1. Identify and define same services across programs.
2. Standardize names and definitions for these services.
3. Standardize minimum provider qualifications for each given service: for

HCBS this should be licensure thus eliminating contracting standards that are duplicative of licensure.

This would simplify contracting requirements for HCBS and potentially create some cost-savings to the state. It will also support the transition of waiver programs to managed care. Once all HCBS is delivered through managed care, the state will need to rely exclusively on licensure to enforce basic health and safety regulations, while the health plans will assume the role of contract monitoring and enforcement.

P. 57 discusses "Inconsistent use of centralized sanction review committee". We contend that there are many problems with the Sanction and Review Committee (SARC):

- It is unclear what the minimum experience or qualifications are required

to be on SARC. How do they choose the members? Do they have experience with long term services and supports?

- In our experience, SARC simply reviews what has already been decided by DADS. What process exists to make sure they are making an appropriate decision? Provider are not allowed provide additional information or context and DADS doesn't provide additional information.
- Our view is that SARC is a compilation of people who do not appear to understand the program or contract and make their decision based on a recommendation from DADS.

To improve SARC we recommend that A) there should be better qualified individuals conducting the review; and B) a process by which the provider has the opportunity to refute the case. SARC could become a meaningful first level of appeal, like IDR or IROD. The advantage of making SARC a first-level appeal process is that the state would free the State Office of Administrative Hearings (SOAH) to hear more meaningful cases, while SOAH might attempt come to reach amenable decisions in order not to be taken any further. C) SARC should be housed within HHSC or an agency independent from DADS and LTSS.

Any Alternative or New Recommendations on This Agency: Included in main text.

My Comment Will Be Made Public: I agree