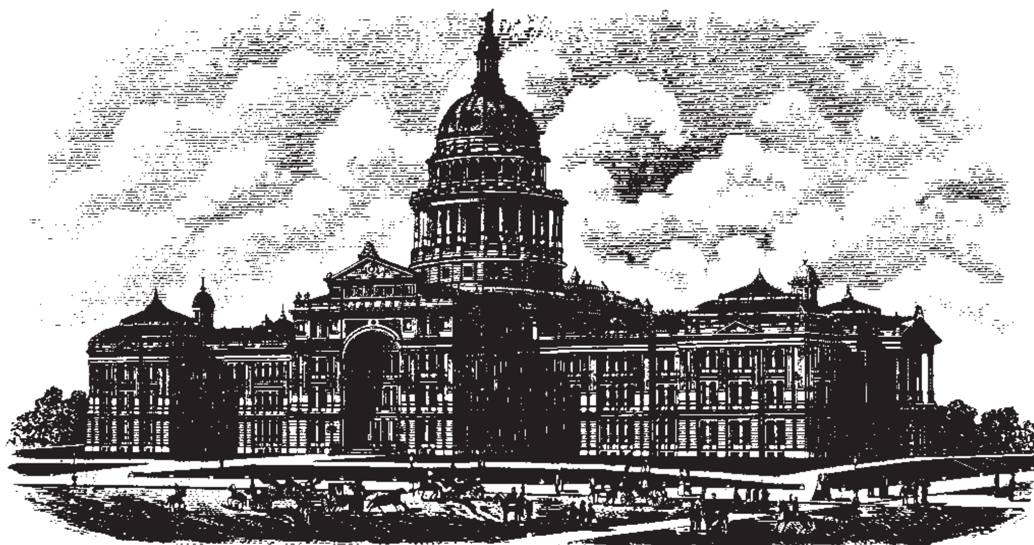
Sunset
Advisory Commission



Health and Human Services Commission

Organization and Delivery of Health and 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.

Health and Human Services Commission

Organization and Delivery of Health and Human Services

Sunset Staff Report

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REPORT SUMMARY

Report Summary

Health and human services programs in Texas represent the second largest function of state government, behind education, with appropriations for the 1998-99 biennium totaling more than $26 billion, or 30 percent of all state appropriations. A majority of these appropriations are associated with federal entitlement programs under Medicaid, Temporary Assistance to Needy Families, and Food Stamps. The total number of staff dedicated to administering the health and human services (HHS) function is approximately 55,000. Fourteen state agencies have a primary responsibility for delivering health and human services, with as many as 10 other agencies involved in delivering some type of health and human services to their clients. This complex network of state agencies must then work in partnership with local government, federal agencies, contractors, volunteers, and private advocate and consumer organizations to deliver services statewide.

Health and Human Services Programs in Texas represent the second largest function of state government.

Given that expenditures for these services represent such a significant portion of the State's budget, and that these services are often critical to the people who receive them, continual efforts have been made by the Legislature to evaluate and improve service delivery. Since the mid 1970's, significant efforts have been directed around better coordination of health and human services delivery in the State. These efforts all focused primarily on coordination and shared planning within the existing agency organizational structures. The most significant effort involved the Texas Health and Human Services Coordinating Council. The Council, composed of a mix of state agency board chairpersons and legislative leaders, was expected to cooperatively plan and coordinate health and human services across agency boundaries. However, the Council could not obtain meaningful coordination or reduce the fragmentation and duplication across agencies, and the Legislature abolished the Council in 1991.

Continual efforts have been made to evaluate and improve Health and Human Services delivery.

In 1991, in response to continuing increases in the cost of health and human services, the Texas Performance Review's (TPR) report, *Breaking the Mold*, proposed a complete reorganization of the entire health and human services system. The report proposed consolidation of multiple agencies into a single agency directed by one governing board to deliver health and human services in Texas. The proposed Board was to contain six public members and deliver services through an agency organized into six functional divisions. The report determined that a single unified system could improve health and

human services through achievement of several statewide service delivery goals:

- comprehensive statewide planning and development,
- a continuum of care for families and individuals,
- integration of services to improve client access,
- effective use of management information systems,
- incentives to maximize existing resources,
- systemwide accountability,
- an environment that promotes teamwork and creativity, and
- mechanisms that foster innovation at the agency and local levels.

House Bill 7 placed the existing HHS agencies under the authority of the newly-created Health and Human Services Commission.

The 1991 TPR report also recommended that the state be divided into geographic regions, with a planning board in each region responsible for local public input, community-based budget development, and strategic health and human services planning.

To accomplish the TPR recommendations, the 72nd Legislature enacted House Bill 7 which, rather than merging the existing independent agencies, maintained the existing agencies but placed them under the authority of a newly-created umbrella oversight agency, the Health and Human Services Commission (HHSC). The HHSC Commissioner was given broad oversight responsibilities for all the programs and activities of the State's health and human services agencies. HHSC was also charged with developing a six-year plan to achieve the objectives of House Bill 7 including:

- coordinated and consolidated strategic planning and budgeting;
- funds management and maximization;
- service integration;
- statewide needs assessment and forecasting; and
- local and regional planning and coordination.

Notwithstanding progress made since the creation of HHSC in 1991, questions remain about the State's progress toward fully realizing the goals of House Bill 7. When the Legislature created HHSC, it gave the agency significant authority to plan and direct the activities of health and human services agencies. HHSC's enabling legislation calls for the agency to redirect the activities of state agencies to "enforce the coordinated delivery of services." House Bill 7 empowered the HHSC Commissioner, on an ongoing

basis, to take the lead in reorganizing and streamlining health and human services agencies. The first and only plan submitted to the Legislature and the Governor in 1993 did not call for consolidation, reorganization, or streamlining of any state agency programs. Since 1993, no HHSC Commissioner has formally proposed a subsequent plan. Additionally, the only accomplishments HHSC has made in addressing duplication have been specifically mandated by the Legislature, not through any plan or proposal by the Commission.

The State's expectations for the increased effectiveness and efficiency of HHS programs are yet to be fully realized.

In 1997, the State Auditor concluded that the State's expectations for the increased effectiveness and efficiency of service delivery in health and human services programs and activities are yet to be fully realized. The Auditor questioned the performance of HHSC in several areas and concluded HHSC has not effectively carried out its health and human service oversight responsibilities.

The conclusions of the State Auditor are verified by the findings of recent Sunset reviews of health and human services agencies. Examples of problems identified include:

Recent Sunset reviews of all HHS agencies identified recurring problems.

- continued fragmentation of services,
- services delivered categorically developed around funding streams or eligibility requirements rather than actual client needs,
- limited administrative consolidation,
- information systems that are not integrated between agencies and running on disparate platforms,
- top-down decisionmaking emanating from Austin with no local input,
- continued problems related to purchasing client services,
- lack of a strategic vision for service delivery, and
- no service integration unless legislatively directed.

In addition, the State's delivery structure for health and human services contains several inherent barriers to change. No other large state relies on so many agencies to deliver services. Voluntary coordination between state agencies is difficult and has been infrequent because there are no incentives to do so and cooperative projects are outside any one agency's span of control. Agencies have little motivation to coordinate their administrative functions for fear of a loss of control.

Each agency has its own governing structure, however, the part-time boards have difficulty keeping up with the technical expertise needed to manage agencies today. Many operational activities may not even come to the attention of the policymaking body. Individual agency boards develop independent appropriations requests that compete for limited funding. Each agency participates individually in the appropriations process, with their separate constituencies advocating for services and funding to maintain the status quo.

Federal categorical funding and associated rules and reporting requirements also make service integration difficult and encourage services to be delivered in "silos." Many agency middle managers are near retirement which encourages a "wait it out" mentality when faced with change. In addition, the expertise of agency staff has not kept up with the shift from actual service delivery to managing services provided by independent contractors. All of these factors result in a fragmented and unnecessarily confusing system of service delivery.

The State's inability to improve the organization and management of HHS has risks.

The State's inability to fundamentally improve the organization and management of health and human service delivery has several risks. With the fragmented service delivery structures that exist, the State cannot deliver a complete continuum of services to key sectors of the population with rapidly growing needs, such as the aging. The lack of a strategic vision for service delivery creates fragmentation, which undermines safety-net services such as public and mental health and substance abuse services. Separation of program administration among many agencies limits the ability of the State to implement and take full advantage of changes in federal program administration, such as block grants, and limits the ability of the State to quickly modify service delivery structures to match private sector trends, such as managed care and real-time access to databases. Finally, inefficiencies in the health and human services delivery system limit the ability of the system, and the individual agencies, to effectively interface with complementary programs in other sectors of government, such as workforce development.

During this Sunset review period, the Sunset Commission has had most of the State's health and human services under review. This has provided an unprecedented opportunity to look at how each of these agencies operates individually and then how this area of government functions as a whole. The Sunset staff, once it completed its work on each individual agency, took that knowledge and assessed the possibilities for improving the overall HHS system. This included a scheduled review the Health and Human Services Commission, the lead state HHS agency. This effort focused on HHSC's

ability to fulfill its role to oversee and coordinate the delivery of health and human services in the state.

This report presents the conclusions of the 14 months of work by the Sunset staff. The recommendations are intended to provide the Sunset Commission, the Legislature, the HHS agencies, clients, advocacy groups, and the public with a proposal to change the organization and delivery of health and human services. The proposal includes numerous changes that are designed to be considered and implemented incrementally to allow the policy direction set by the Legislature in 1991, through House Bill 7, to be more fully and realistically accomplished.

In presenting this report, Sunset staff acknowledges that much public deliberation by the Sunset Commission and the Legislature is needed to refine and improve the recommendations proposed. Regardless of the final form, if a change process is adopted, Sunset staff believes that it will result in an improved HHS system that will benefit the citizens of this state.

Recommendations

Reshape the Health and Human Services Commission as the Authority over the HHS System

1. Continue the Health and Human Services Commission as the Agency Responsible for Overseeing the Operations of the State's Health and Human Services Agencies.

- The Legislature created the Health and Human Services Commission to enforce the coordinated delivery of the State's health and human services agencies. Since the creation of HHSC, the Legislature has consistently sought ways to improve and expand health and human services, and has added numerous responsibilities to HHSC's role.
- HHSC has not accomplished many of its goals set by the Legislature, as noted by State Auditor's reports and recent Sunset reviews. HHSC has not had a significant impact on the operations or decision making of the 11 health and human services agencies under its umbrella. In addition, each health and human services agency has its own governing structure, and agency coordination generally does not occur.
- The Sunset review concluded that, working within the current organizational and policymaking framework of health and human services, HHSC is unlikely to effectively fulfill its role as the leader of this area of government. However, transferring HHSC's functions to another agency would not provide an adequate solution.

Recommendation

- **Continue the Health and Human Services Commission only if it is given authority over the operations of the State's health and human services agencies.**

- **If continued, set the Commission's next Sunset review in 2007.**

2. Strengthen the Health and Human Services Commission's Operational Control Over Health and Human Services Programs.

- The authority to direct health and human services remains divided among multiple HHS boards, agency executive directors, and the Health and Human Services Commission. HHSC's focus is on improving the overall operation of the HHS system, while the strategic direction of HHS agencies comes from the policies of each agency's board and the management decisions and operational direction provided by agency executive management.

- HHSC lacks the authority to require HHS agencies to integrate their operations. The Commission is dependent on agency executive directors to achieve its legislative objectives. The 11 HHS agencies have not proved very willing to voluntarily change their operations to achieve cross-agency efficiencies.

- In addition, HHSC has not had the staff necessary to meet all of its responsibilities. Without access to resources necessary to plan and implement change, HHSC cannot be held accountable for achieving the legislative objectives outlined in its enabling statute.

Recommendation

- **Provide the HHSC Commissioner with clear authority to manage the operations of the State's health and human services agencies.**

- **Specify that the Commissioner has direct authority to hire the HHS agency executive directors.**

- **Clarify the respective authority of the HHSC Commissioner and the HHS policy boards.**

- **Direct the HHSC Commissioner to pursue improvements in specific operational areas as outlined in Issues 3-8 of this report.**

Direct HHSC to Improve Specific HHS Operational Areas

3. Strengthen the Health and Human Services Commission's Role in Managing Federal Funds.

- In 1991, House Bill 7 charged the Commission with establishing a federal health and human services funds management system and maximizing the availability of federal funds. In fiscal year 1998, 58.7 percent of the funds received by the health and human services agencies, or $7.4 billion, came from federal sources.
- The State must often make decisions about complex federal funding issues that involve multiple agencies and needs a single entity to ensure that the overall system makes the best use of federal funds. Individual agencies may be unaware of the effect on the overall health and human services system when making funding decisions, and changes in an agency's funding policies can impact other agencies' resources.
- The Commission has not effectively managed the use of federal funds across the health and human services system. HHSC has no overall strategy or objectives that shape the use of federal funds, and no guarantee that the State receives all of the federal funds to which it is entitled.
- All of Texas' 254 counties are eligible to receive federal funds for some of the health and human services the counties provide. However, many local entities are not aware of the opportunities to access federal funds or do not have the technical expertise to claim the funds.

Recommendation

- **Clearly designate HHSC as the state agency with authority over all federal funds received by health and human services agencies and responsible for ensuring the most effective use of those funds.**
- **Require HHSC to submit an annual report to the Legislature and the Governor on federal funding issues, ways to maximize the use of federal funds, and strategies to improve federal funds management.**
- **HHSC should build the expertise to respond to federal initiatives and maximize opportunities for the use of federal funds**.

4. Strengthen the Oversight of Purchasing and Contracting by Health and Human Services Agencies.

- Health and human services agencies spend approximately $10 billion each year to buy services for clients. Over the past few years, significant and widespread problems with the purchasing and contracting practices of HHS agencies have been identified.
- Despite the recent focus on contracting problems, HHS agencies continue to experience significant problems in procuring and administering contracts for services, including the lack of performance measures and the failure to use competitive or best value procurement practices. In addition, few of the recommendations made to improve contracting practices have been implemented.
- Without a single oversight agency authorized to require changes in purchasing and contracting practices across agencies, system-wide improvement is limited.

Recommendation

- **Require the Health and Human Services Commission, with the assistance of the HHS agencies, to improve HHS agency purchasing and contracting by consolidating contracting activities into a single, statewide system**.
- **Require HHSC to review and approve the procurement and rate-setting processes of all HHS agencies to ensure the rates are consistent and represent the best value for the State.**
- **Require HHSC to develop and implement a statewide plan to ensure that contractors and subcontractors are in compliance with the accessibility requirements of the Americans With Disabilities Act.**
- **Require HHSC to prepare a biennial report that assesses the performance of each HHS agency's compliance with purchasing and contracting requirements and identifies any material risk resulting from agencies' contracting practices.**

5. Improve Information Systems Planning and Management Across Health and Human Services Agencies.

- Health and human services agencies currently plan and manage information resources projects in a decentralized environment where each agency pursues projects that meet individual program needs. The lack of a single point of

accountability for system-wide information systems and technologies contributes to duplication of computer systems, data exchange problems, and systems that are not fully functional.

- The Texas Integrated Enrollment and Services (TIES) project development has experienced numerous problems, ranging from a lack of clear accountability for the success of the project, to unverified projected cost savings. Expectations that TIES will be a "silver-bullet" solution to the State's information resources needs has resulted in the development of computer systems that are under-used.
- The Legislature has expressed an interest in greater oversight of information systems projects, and HHS agencies need a system-wide approach to information systems with a single point of accountability.

Recommendation

- **Designate the Health and Human Services Commission as the authority responsible for strategic planning and oversight of information resources projects of all HHS agencies.**
- **Require HHSC to assume responsibility for the planning, development, and implementation of the Texas Integrated Enrollment and Services project.**

6. Strengthen HHSC's Operational Control Over Medicaid Managed Care and Require the Health Care Information Council to Assess the System's Performance.

- The Medicaid program in Texas serves nearly two million low-income residents. Since 1993, the State has provided Medicaid managed care in addition to the traditional fee-for-service method of health care delivery.
- The implementation of Medicaid managed care presents challenges for clients, providers, and state agencies. In addition, the State has created a complex system of operating agencies and contractors to administer the program. However, HHSC has not developed adequate information to assess the program's effectiveness in terms of quality of care and whether it meets legislative objectives.
- The Health Care Information Council, created by the Legislature in 1995, has collected and reported information about the performance of managed care programs. Expanding the Council's role to include the evaluation of Medicaid managed care would be consistent with the agency's current mandate, and would provide HHSC and the State with an independent, objective source of information regarding the overall performance of the Medicaid managed care system.

Recommendation

- **Strengthen HHSC's authority over the Medicaid activities of all HHS agencies, including related contracts.**
- **Require the Health Care Information Council, with the advice of HHSC, to examine the success of Medicaid managed care based on the criteria established by the Legislature.**
- **Require the Council to develop a plan to accomplish the recommended tasks in conjunction with HHSC, the presiding officer of each standing committee of the Senate and House of Representatives having primary jurisdiction over HHSC, and the Medicaid operating agencies.**
- **Require the Council to periodically report to HHSC and the Legislature on the continuing progress of the Medicaid managed care program.**
- **Transfer the responsibility for providing administrative support to the Council from the Texas Department of Health to HHSC.**

7. Improve the Regional Management of Health and Human Services Agencies.

- Most health and human services agencies have a central headquarters in Austin and a series of field offices throughout the state, often organized into regional systems. While the central offices generally perform administrative and oversight functions, the majority of service delivery takes place in the regions.
- Co-location of state agency offices is one mechanism to enhance the delivery of health and human services and to create management efficiencies. However, integrating agency operations through co-location has been only moderately successful. Agencies are able to avoid co-location through the use of emergency leases and no requirements exist for agencies to share space, equipment, or services once they are co-located.
- Additional opportunities exist for HHSC to improve regional management. Agencies have identified ways to improve and integrate regional support functions, but an entity is needed to plan and direct cooperative efforts. Regional business planning could organize and track agency initiatives to reduce the costs of HHS regional support functions.

Recommendation

- **Specify that HHSC has clear authority to require HHS agencies to co-locate and consolidate support services.**

- **Require HHSC to assess the potential benefits and costs of consolidating support services across HHS agencies in both regional offices and in Austin, and develop a plan and schedule for co-locating offices and consolidating support services where clear benefits have been identified.**

- **Charge HHSC with the development and implementation of an annual business services plan for each HHS region.**

- **HHSC, with the advice of the General Services Commission, should establish criteria for granting emergency leases and guidelines concerning shared space and facility management in co-located spaces.**

8. Improve Access to Information about Health and Human Services in Texas.

- Gaining access to information about community services is often difficult and confusing. Health and human services clients often rely on local telephone directories, which do not contain a systematic description of services or service providers.
- In 1997, the Legislature created two entities to improve consumer access to information and services — the Texas Information and Referral Network (I&R Network) at HHSC, and the Records Management Interagency Coordinating Council. These entities have not coordinated their efforts, resulting in inconsistent methods of defining and organizing health and human services, and increased consumer confusion.
- Although transportation is often a barrier to service delivery for health and human services clients, information regarding transportation services may not be available through the I&R Network.

Recommendation

- **Require the Texas Information and Referral Network and the Records Management Interagency Coordinating Council to establish a single, consistent method of defining and organizing information about health and human services for public access, including presenting the information in telephone directories.**

- **Require the Texas Information and Referral Network to include information regarding transportation services.**

Transfer Functions from HHSC that are Inconsistent With Its Mission.

9. Promote the Development of a Statewide Guardianship System by Integrating Guardianship Services and Strengthening the Role of the Guardianship Advisory Board.

- Guardianship is a protective service that attempts to ensure the well-being of individuals who are alone and cannot manage their personal or business affairs. Based on the growing need for guardianship services, the Legislature directed the Health and Human Services Commission, with the advice of the Guardianship Advisory Board, to adopt guardianship standards, develop and implement a statewide guardianship plan, and establish local volunteer guardianship programs. Because of limited resources, HHSC and the Guardianship Advisory Board are unable to fully develop a statewide guardianship system.
- The Department of Protective and Regulatory Services (PRS) is the primary state agency provider of guardianship services. Therefore, the Guardianship Advisory Board has little influence over the majority of guardianship services provided by the State. The Guardianship Advisory Board and PRS have not developed a joint effort to achieve a clear, statewide approach to guardianship.
- Allowing the Guardianship Advisory Board to advise PRS in the development and implementation of a statewide guardianship plan would provide a single, clear approach to guardianship in Texas. The Guardianship Advisory Board could also provide local expertise and input regarding guardianship services.

Recommendation

- **Transfer certain guardianship responsibilities from the Health and Human Services Commission to the Department of Protective and Regulatory Services.**
- **Expand the Guardianship Advisory Board by allowing the Department of Protective and Regulatory Services Board to appoint three consumer or advocate members and a representative of PRS.**
- **Strengthen the role of the Guardianship Advisory Board by adding responsibilities such as advising and assisting PRS in the development of a statewide guardianship program, reviewing and commenting on all State guardianship policies, and recommending an approach**

to a statewide guardianship system to the Governor and the Legislature.

10. Improve the State's Management of Empowerment Zone/ Enterprise Community Funds.

- Texas has received approximately $55 million in federal funds to administer the Empowerment Zone/Enterprise Community (EZ/EC) program. This program helps revitalize economically distressed communities through tax breaks, block grants, funding preferences, and waivers and exemptions from federal barriers.
- The administration of EZ/EC funds is outside the scope of HHSC's mission. HHSC focuses its limited resources on developing and administering the State's health and human services delivery system, and increasing its authority over the HHS agencies will further detract from its ability to devote time and effort to EZ/ EC administration.
- As the State's designated agency for community development, the Texas Department of Economic Development has the necessary resources and expertise to effectively manage the EZ/EC program. The Department operates a similar state program, and currently participates in the administration of the federal program.

Recommendation

- **Transfer the administration of the Empowerment Zones and Enterprise Communities program to the Department of Economic Development.**

Improve the Organization of HHS Through Service Integration and Program Consolidation

11. Improve the Delivery of Long-Term Care Services Through Creation of a Separate Agency.

- Five different state agencies are currently involved in delivering long-term care services to clients. As clients age, their service needs may change. Under the current system, these changing needs may require the individual to go through a new eligibility determination process to seek services from a different agency. The lack of a seamless continuum of care results in a discontinuation of services for some individuals while multiple administrative hurdles are crossed.
- Program fragmentation at the state level has led to a lack of clear accountability and limited strategic planning and has resulted in confusion and multiple intake and assessment processes for clients at the local level. Fragmentation often

results in more dollars spent on administration that otherwise might be available for direct services. Many agencies offer similar services such as assessment and casework for clients.

- Numerous reports have cited problems with the long-term care service delivery structure including a lack of accountability for effective service delivery, fragmentation of services, and consumer confusion about how to access services. Most have considered the creation of a single agency responsible for the delivery of long-term care services as a solution to the fragmentation.

Recommendation

- **Create a long-term care agency through a phased-in consolidation of related long-term care programs in the Department of Human Services, Texas Department of Aging, Texas Department of Health, Texas Rehabilitation Commission, and Texas Department of Mental Health and Mental Retardation.**

- **Study the feasibility of a subacute care pilot project.**

12. Improve the Delivery of Comprehensive Family Support Services to the State's Neediest Families.

- The State is under increasing pressure to meet welfare work participation rates and deal with the impact of families losing Temporary Assistance for Needy Families (TANF) benefits. Welfare reform coupled with a strong economy has contributed to a steady decline in the number of families on welfare. As most eligible TANF recipients with work participation requirements continue to seek work or job training, the remaining caseload will be exempted recipients that may not be job ready or clients losing their time-limited benefits. As a result, Texas will face increased difficulty in meeting federal work participation rates.

- Even with multiple screening and assessments, the State is failing to identify and address the basic needs of families facing difficulties in becoming independent. TANF recipients undergo three different "assessments," that do not identify many related family problems or conditions that inhibit becoming self-sufficient such as physical or mental illness, substance abuse, or domestic violence. Caseworkers must focus on obtaining information for program requirements, leaving little time to assess families for a broader range of support services.

Recommendation

- **Continue the Department of Human Services (DHS) with responsibility for family assistance programs for low-income families for eight years, until 2007.**

- **Require DHS to create a single comprehensive family assessment and case management function for all families eligible for DHS services, separate from the eligibility determination function.**

- **Require HHSC to evaluate whether other eligibility-based family assistance programs should be transferred to DHS.**

13. Improve the Delivery of Protective Services Through Consolidation of Protective Programs.

- In 1991, the Legislature created the Department of Protective and Regulatory Services (PRS) by transferring the State's protective services out of DHS to raise the visibility of these critical state services and address concerns that the State's protective services were overshadowed by the larger public assistance programs administered by DHS. When PRS was created, the Family Violence program was left at DHS to allow PRS to focus on improving the State's ability to deliver child and adult protective services. While family violence services are voluntary and the protective services delivered through PRS are not, the programs share one important characteristic. All seek to get individuals out of violent situations and ensure that they are able to remain in a safe environment.

- Now that PRS is fully operational, the State's protective services are fragmented with separate grants to local agencies, contractor selection, administration, and monitoring processes. Communities seeking to obtain funding for protective services programs must now make application to two separate agencies. Each grant program has different contracting and monitoring requirements.

- Referrals between local Family Violence programs and prevention programs are limited. At the local level, referrals from Family Violence shelters to PRS prevention programs are not common. Children who enter the Family Violence program have a wide range of needs and may be victims of abuse and neglect. In these cases, the Family Violence program will refer the case to Child Protective Services at PRS and the court system is responsible for resolving the situation.

Recommendation

- **Transfer the Family Violence Program to the Department of Protective and Regulatory Services.**

- **Allow funding of nonresidential family violence centers and require competitive bidding of contracts for training and technical assistance.**

- **Require all agencies conducting self-investigation of abuse and neglect complaints in residential or institutional facilities to develop common definitions and report to PRS and HHSC.**

14. Improve the Delivery of Mental Health and Substance Abuse Services Through Improved Planning, Service Integration, and Possible Consolidation.

- The State does not have a comprehensive approach for the delivery of mental health and substance abuse services. Planning for mental health and substance abuse services is fragmented. The Texas Department of Mental Health and Mental Retardation (TDMHMR) conducts planning and identifies local needs and priorities for mental health services, but only for a subset of the population with mental illness. The Texas Commission on Alcohol and Drug Abuse (TCADA) is federally required to determine the incidence of and assess the need for state alcohol and drug abuse services, but also focuses its efforts on those populations and geographic areas with the greatest need. Other agencies that provide mental health or substance abuse services conduct planning only for the services provided by their agency. Very little formalized or coordinated planning exists for mental health or substance abuse services.

- The current fragmentation in the delivery of mental health services leads to gaps in services and inconsistencies in the quality and types of services delivered. TDMHMR, despite its role as the State's mental health authority, does not have authority for setting standards and rules relating to the purchase, provision, and delivery of mental health services provided by other state agencies. TCADA has no authority role.

- Parallel and separate systems of care for the delivery of substance abuse and mental health services that can lead to gaps in services. No single system exists to treat the significant number of individuals who need treatment for both mental health and substance abuse disorders and consumers have to access two separate systems for treatment of interrelated problems.

- Several initiatives are currently underway to determine the best structure for overseeing the purchase of mental health and substance abuse services in Texas. TDMHMR currently has pilot sites exploring the role of the local mental health authority in the delivery of services. In addition, TCADA has proposed a new model of managing access to and delivery of substance abuse services by phasing-in service networks across the state incorporating tools of managed care and

bringing decision-making down to the local level. Both agencies are investing in the development of local administrative functions and the State needs to evaluate the best integrated service delivery structures.

Recommendation

- **Continue TDMHMR for eight years, until 2007.**
- **Require TDMHMR, TCADA, and any other state agency that provides mental health and substance abuse services to work with the Health and Human Services Commission to develop a comprehensive service delivery report.**
- **Strengthen the authority of TDMHMR and TCADA to set standards and expectations in mental health and substance abuse matters affecting other agencies.**
- **Integrate the service delivery structure for mental health and substance abuse services by combining administrative functions at the local level.**
- **Based on the success of service integration, create a single behavioral health care agency by consolidating TCADA and the mental health programs currently at TDMHMR.**

15. Improve Delivery of Rehabilitation Services to People with Disabilities Through Coordination, Integration, and Possible Consolidation.

- The Texas Rehabilitation Commission (TRC) and the Department of Mental Health and Mental Retardation provide employment services to overlapping client populations. Agreements defining each agency's roles and responsibilities for shared consumer populations have not been fully implemented. In addition, although TRC and TDMHMR have made some progress to reduce the number of TRC clients who are in TDMHMR's priority population, TRC still serves potential TDMHMR consumers while maintaining a waiting list for the program.
- Service and administrative duplication exists between the Texas Rehabilitation Commission and the Texas Commission for the Blind (TCB). TRC is the State's authority on the rehabilitation of persons with disabilities, except for persons with visual impairments who are served by TCB. Both agencies provide

vocational rehabilitation services with similar administrative structures for intake and service provision despite of both programs operating under the same federal law with the same guidelines.

- Currently, limited coordination exists between employment services for people with disabilities and a separate workforce development system, leading to duplication and fostering segregation of people with disabilities. TRC does not formally refer VR clients into the State's workforce development system and TWC does not track and report the number of people with disabilities that the agency serves. Many TRC clients could benefit from TWC's job training and job search services resulting in the availability of more services for VR clients.
- The Interagency Council on Early Childhood Intervention (ECI) could benefit from administratively integrating certain business functions with TRC. TRC currently provides many administrative functions such as for health and human service agencies co-located both in Austin and regionally. TRC has also developed an automated Rehabilitation Services System that integrates client case records management, client services purchasing, and financial systems. ECI providers could use TRC's client services system to authorize, track, and pay for client services.

Recommendation

- **Continue TRC, TCB, TCDHH, and ECI for eight years, until 2007.**
- **Require TRC and TDMHMR to reduce duplication and fragmentation of employment services by defining each agency's roles and responsibilities for shared client populations, and requiring TRC to target people who are not currently served by TDMHMR or another agency.**
- **Require TRC and TCB to develop a methodology, approved by the Legislative Budget Board and the State Auditor's Office, to split federal VR funds.**
- **Require TRC to refer appropriate VR clients to Local Workforce Centers, and require TWC to track and report services provided to people with disabilities.**
- **Require TCB and ECI to administratively integrate business functions with TRC, including purchasing of services, where appropriate.**

■ **Require HHSC to make recommendations on the appropriateness and feasibility of transferring the Vocational Rehabilitation program from TRC to the Texas Workforce Commission.**

■ **Depending on the success of coordination and integration, consolidate the Texas Rehabilitation Commission and the Texas Commission for the Blind into a single Rehabilitation Agency.**

16. Continue the Current System for Public Health Services.

- Most state-sponsored public health services are currently delivered through a single agency, the Texas Department of Health. Other state agencies have individual programs that closely relate to the public health programs administered by TDH, however, these programs are limited in scope and directly relate to the other operations of those agencies.
- Issue 11 of this report proposes transfer of non-public health related services from TDH to a long-term care agency. These services include the Medically Dependent Children's Program and Home and Community Support Service Agencies regulation.
- Significant problems identified in public health service delivery have been previously addressed in the Sunset staff report on TDH. The Sunset Commission recommended that the Board of Health develop and implement a comprehensive blueprint for services and that TDH integrate health care delivery programs, including Medicaid and non-Medicaid programs, to increase program coordination and eliminate administrative duplication.
- Concerns still exist over administration of TDH's regulatory programs. The Sunset Commission has recommended that TDH conduct a comprehensive evaluation of its regulatory functions with the assistance of the State Auditor's Office. In addition, since the regulatory programs at TDH are functionally distinct from other TDH public health programs, other organizational options may be viable.

Recommendation

■ **Continue the Department of Health as the State's public health agency for eight years, until 2007.**

■ **Require HHSC to consider consolidation and/or organizational alternatives for TDH's regulatory programs.**

■ **Require HHSC to monitor implementation of Sunset recommendations related to TDH.**

17. Provide a Framework for the Development of More Comprehensive, Community-Based Health and Human Services.

- Multiple federal funding streams and narrowly targeted categorical programs fail to give communities the ability to broadly address health and human service needs. These multiple funding streams generally contain strict eligibilty requirements with little flexibility. While block grants are often touted as the answer for greater flexibility, the vast majority of federal funds that Texas' health and human services agencies receive continue to have strict categorical requirements on how the money can be spent.
- The structure for the delivery of services varies considerably from one state agency to another. Some agencies deliver services through a regional structure. Others use systems that divide the state into smaller service areas or they contract directly with service providers. Agencies have also developed a number of mechanisms for local input, coordination, and/or support. While well-intentioned, the proliferation of these local initiatives, with no consideration from the state level of the combined impact on local community's resources, may simply become yet another barrier at the local level to a more comprehensive approach.
- Communities face a variety of barriers to improving the delivery of services at the local level including issues related to funding, resources, paperwork, and communication across different service delivery systems. Communities also need a single, more clearly identified state entity to go to for help in their efforts to improve services locally.
- Efforts to improve Texas' local service delivery have been implemented statewide in the past but address specific problems rather than the broader need for comprehensive local planning. In addition, pilots to develop more comprehensive local service delivery systems have shown success, but no plan exists to ensure cooperation across state agencies in support of implementing and sustaining changes on a broader, statewide basis.

Recommendation

- **Designate HHSC as the lead agency responsible for developing more comprehensive, community-based support systems for health and human services.**
- **Require health and human services agencies to work with HHSC in supporting the development of more comprehensive local services; and to submit any proposals for new community initiates to HHSC for review and approval to ensure consistency and guard against duplication.**

■ **Require HHSC to be a single point of contact for communities to work with to overcome institutional barriers to more comprehensive community support systems, particularly barriers tied to state agency policies and procedures.**

■ **Require HHSC to develop a system of blended funds from state health and human services agencies to allow local communities to customize services to fit the individual community's needs.**

Overseeing the Change Process

18. Implementing the Agenda Proposed in This Report to Change the Texas Health and Human Services System Will Require Transitional Legislative Oversight.

- The approaches for change proposed in this report represent significant departures from the status quo in the area of health and human services. These changes will require a transition process that needs legislative oversight. Direct legislative involvement allows for early detection and appropriate action to deal with emerging problems and changes before hardships occur.
- Because the proposed changes deal with multiple agencies and HHSC does not have a board, the Legislature is the appropriate entity to hear public concerns that can help shape change. In addition, most health and human services are provided locally, so public input from citizens, service providers, and advocacy groups is critical for legislators to obtain insight on local issues and service delivery aspects.
- In this proposal, the HHSC Commissioner will have considerably more authority over HHS agency directors. During the transition, legislative oversight is needed to promote, set the tone for, and facilitate these critical relationships.

Recommendation

■ **Create a Legislative Oversight Committee on Health and Human Services to monitor the integration and consolidation efforts of health and human services agency programs, recommend legislation, collect and report information about the HHS system, and ensure public input in the change process.**

■ **Specify the duties of the Health and Human Services Commission in support of the Legislative Oversight Committee.**

- **Specify the duties of the health and human services agencies in support of the Legislative Oversight Committee.**

- **Authorize the Legislative Oversight Committee for six years, with an expiration date of September 1, 2005.**

Agenda for Change

The table, *Agenda for Change*, outlines the timing of the various changes proposed throughout this report. Three phases of implementation are contemplated with each phase representing a 2-year period. This will allow the Legislative Oversight Committee to monitor changes in each phase and recommend any adjustments needed to be made in subsequent sessions of the Legislature. For example, if certain recommended service integrations occur, the need for the program consolidations in Phase III may no longer be deemed necessary and could be rescinded.

HHS Organization after Transition

The chart, *Organization of Health and Human Services After Transition*, shows what HHS would look like once the changes proposed by this report are completed. This chart assumes all potential integration and consolidations are accomplished. If adjustments are made in the phases outlined above, the HHS organization would also change.

Fiscal Impact Summary

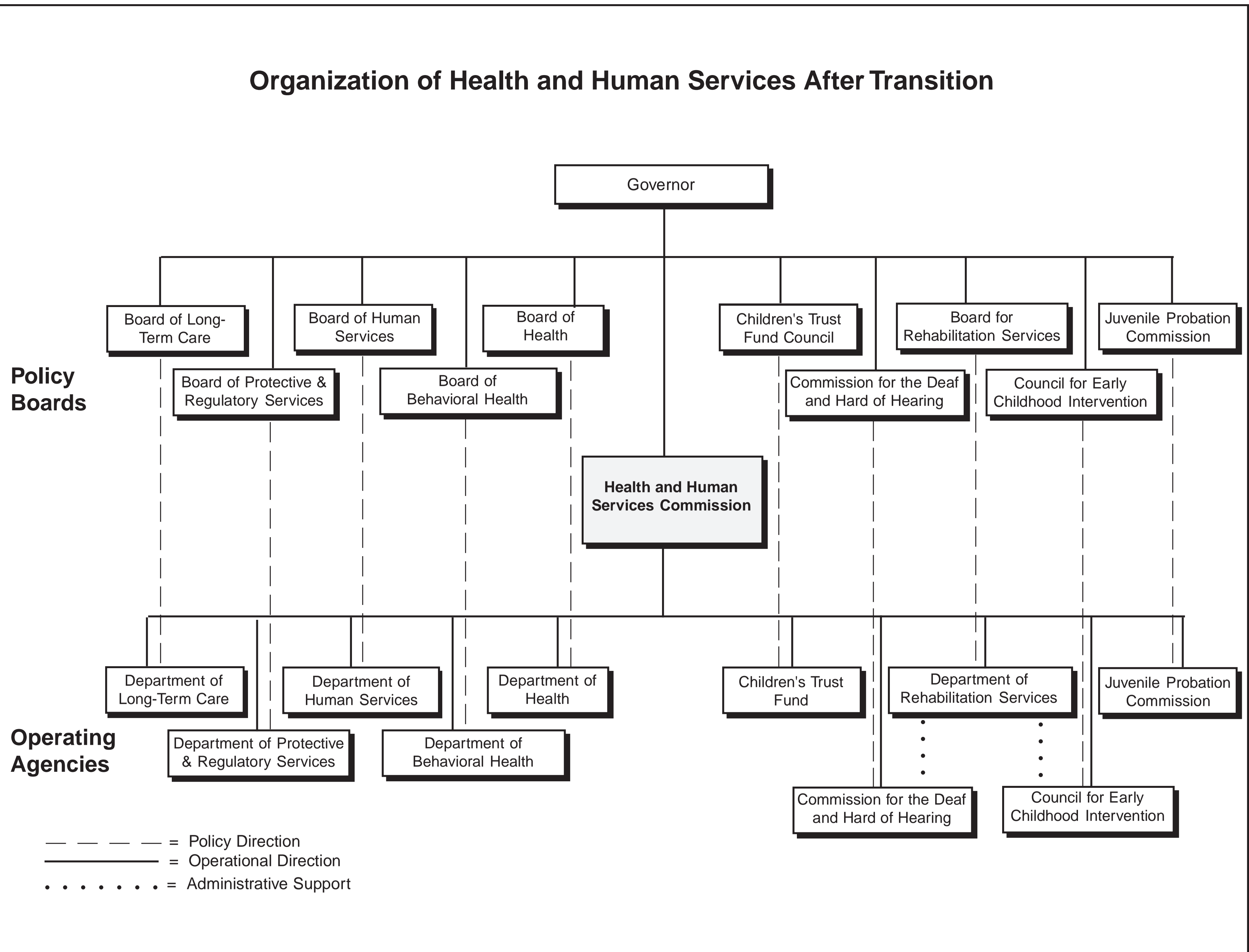
These recommendations, particularly those strengthening HHSC's operational control over HHS agencies, improving access to information about health and human services, promoting the development of a statewide guardianship program, and strengthening the role of the Guardianship Advisory Board, are intended to enable the HHSC and the HHS agencies to better serve their functions within existing resources. The recommendations to strengthen HHSC's operational control over Medicaid managed care, require the Health Care Information Council to assess the system's performance, and create a Legislative Oversight Committee may have a fiscal impact, but the exact amount cannot be estimated. Administering the EZ/EC program may result in a small fiscal impact to the Department of Economic Development, but the Department should be able to operate the program with existing resources. Finally, improving federal funds management, purchasing and contract administration, information systems planning and management, and regional management of HHS agencies should result in significant savings to the State. However, these potential savings cannot be estimated for this report. The fiscal impact of the organization and service delivery issues has not been estimated recognizing that additional information will need to be gathered during the transition oversight process.

Health and Human Services Agenda for Change

Subject	Issue #	Phase I	Issue #	Phase II	Issue #	Phase III
HHSC	1	Continue HHSC on the condition that it receives authority over HHS agency operations.				
	10	Transfer the administration of the Empowerment Zones and Enterprise Communities Program from HHSC to the Department of Economic Development.				
Long-Term Care	11	Create a long-term care agency through a phased-in consolidation of related programs at DHS, TDoA, TDH, and TRC.	11	Transfer TDH long-term care programs to long-term care agency.	11	Transfer mental retardation programs to long-term care agency.
	11	Require the long-term care agency to study the feasibility of designing and implementing a subacute care pilot project.				
Family Services	12	Continue DHS with responsibility for family assistance programs.	12	Require HHSC to evaluate whether other eligibility-based family assistance programs should be transferred to DHS.		
	12	Require DHS to create a single comprehensive family assessment and case management function for all families eligible for DHS services.				
Protective Services	9	Transfer certain guardianship responsibilities from HHSC to PRS.				
	13	Transfer the Family Violence program to PRS.				
	13	Expand the definition of family violence service providers to allow State funding of nonresidential family violence centers.				
	13	Require competitive bidding of contracts for family violence training and technical assistance services.				
	13	Require all agencies conducting self-investigations of abuse and neglect complaints in residential or institutional facilities to develop common definitions and report to PRS and HHSC.				

Health and Human Services
Agenda for Change

Subject	Issue #	Phase I	Issue #	Phase II	Issue #	Phase III
Mental Health/ Substance Abuse	14 14 14	Continue TDMHMR. Require TDMHMR, TCADA, and other agencies that provide mental health and substance abuse services to develop a comprehensive service delivery report. Strengthen the authority of TDMHMR and TCADA to set standards and expectations in mental health and substance abuse matters affecting other agencies.	14	Integrate the service delivery structure for mental health and substance abuse services by combining administrative structures at the local level.	14	Depending on the success of service integration, create a single behavioral health agency by consolidating TCADA and the mental health programs currently at TDMHMR.
Rehabilitation Services	15 15 15 15 15	Continue TRC, TCB, TCDHH, and ECI. Require TRC and TDMHMR to reduce duplication and fragmentation of employment services. Require TRC and TCB to develop a methodology to split federal Vocational Rehabilitation (VR) funds. Require TRC to refer appropriate VR clients to Local Workforce Centers and require TWC to track and report disability services provided. Require TCB and ECI to administratively integrate business functions with TRC.	15	Require HHSC to make recommendations on transferring the Vocational Rehabilitation program to TWC.	15	Depending on the success of coordination and integration efforts, consolidate TRC and TCB into a single vocational agency.
Public Health	16 16 16 6	Continue TDH. Require HHSC to monitor the implementation of TDH Sunset recommendations. Require HHSC to consider consolidation and/or organizational alternatives for TDH's regulatory program. Transfer the responsibility for providing administrative support to the Health Care Information Council from TDH to HHSC.				
LOC	18	Create a Legislative Oversight Committee on health and human services to oversee the change process.				


Organization of Health and Human Services After Transition
Governor
Board of Long-Term Care
Board of Human Services
Board of Health
Children's Trust Fund Council
Board for Rehabilitation Services
Juvenile Probation Commission
Policy Boards
Board of Protective & Regulatory Services
Board of Behavioral Health
Commission for the Deaf and Hard of Hearing
Council for Early Childhood Intervention
Health and Human Services Commission
Department of Long-Term Care
Department of Human Services
Department of Health
Children's Trust Fund
Department of Rehabilitation Services
Juvenile Probation Commission
Operating Agencies
Department of Protective & Regulatory Services
Department of Behavioral Health
Commission for the Deaf and Hard of Hearing
Council for Early Childhood Intervention
= Policy Direction
= Operational Direction
= Administrative Support

Issues

Health and Human Services Commission

Reshape the Health and Human Services Commission as the Authority over the Health and Human Services System.

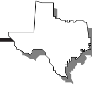
This section of the report addresses the functions performed by the Commission and the continuing importance of achieving the goals set in the Commission's statute. HHSC's impact on the operations of HHS agencies is assessed in relation to the roles of individual agency boards and the executive staff of the 11 HHS agencies. In addition, the Issues in this section discuss the resources available to the Commission to plan and implement change, and, given its limited resources, the steps that might be taken to achieve the legislative objectives outlined in HHSC's statute.

Issue 1. Continue the Health and Human Services Commission as the Agency Responsible for Overseeing the Operations of the State's Health and Human Services Agencies.

Issue 2. Strengthen The Health and Human Services Commission's Operational Control Over Health and Human Services Programs.

Issue 1

Continue the Health and Human Services Commission as the Agency Responsible for Overseeing the Operations of the State's Health and Human Services Agencies.



Background

Policymakers have spent considerable time over the last decade restructuring the health and human services system. The idea of a single agency responsible for health and human services was proposed in *Breaking the Mold,* a report issued by the Texas Performance Review (TPR) in July 1991. *Breaking the Mold* recommended the consolidation of multiple health and human services state agencies into one agency, directed by a single governing board and organized by function into six divisions. The TPR recommendation to eliminate the 14 appointed boards was intended to improve health and human services in two ways. First, requiring one board to adopt all programmatic rules was hoped to result in a rational service delivery system with a continuum of services and consistent eligibility requirements and benefits.

Second, placing one executive director over the operations of the 14 agencies (grouped into six divisions) was expected to result in a broad range of management benefits. Among the anticipated benefits were consolidated information systems, improved federal funds management, and a single system to deliver management services such as purchasing, leasing, warehousing, supply distribution, and printing.

The *Breaking the Mold* recommendation to create a single state health and human services agency did not become law. Rather than merge existing independent state agencies, the Legislature maintained the existing agencies but placed them under the authority of a newly-created oversight agency, the Health and Human Services Commission (HHSC). The HHSC Commissioner was charged with developing a six-year plan to achieve the ambitious legislative objectives established in House Bill 7, shown in the text box, *Goals of the Health and Human Services Commission.*

Goals of the Health and Human Services Commission

- Maximize federal funds through the efficient use of available state and local resources.
- Provide a system that delivers prompt, comprehensive, effective services to the people of Texas.
- Promote the health of the people of Texas.
- Foster the development of responsible, productive, and self-sufficient citizens.
- Provide needed resources and services to the people of Texas when they cannot provide or care for themselves.
- Protect the physical and emotional safety of all the people of Texas.
- Improve the coordination and delivery of human

Over time, the Legislature has assigned HHSC other, more specific, responsibilities for tasks that often require coordination among multiple health and human services agencies. HHSC is charged with developing a plan to implement the Texas Integrated Enrollment and Services (TIES) program, achieving a one-stop or service center method of service delivery by co-locating state agencies, assembling demographic and state agency caseload data, developing guardianship standards for local service providers, and integrating and expanding transportation services.

The Sunset review process requires that certain conditions must be met in order to continue an agency and its functions. 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 another 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 review of the Commission focused on whether the State continues to need an agency to oversee the delivery of health and human services, how well equipped the agency is to fulfill that role, and whether the agency accomplished the mission given to it by the Legislature. The evaluation of the need to continue the Commission and its functions led to the following findings.

Findings

▼ **Texas, like the nation, has a continuing need to protect the health and well-being of its citizens.**

◗ One of the primary functions of government is to protect the health and welfare of its citizens. All states provide publicly-funded services that enhance public health, protect those vulnerable to abuse and neglect, and provide a safety net for families and individuals who experience financial or physical hardship.

Public health and human services provide a safety net for Texans.

The federal government provides much of the funding for health and human services across the nation. In Texas, federal funds account for 58 percent of the dollars spent for health and human services. Most federal dollars are used to meet the basic health care and nutritional needs of the State's poorest citizens. To receive federal funds, states must meet complex federal programmatic and reporting requirements Each state is required to ensure, on a statewide basis, that an eligible individual has equitable access to all allowable services, and

states must maintain a statewide system of planning, fund allocation, and control. The federal requirements for ensuring equal statewide access to services and for statewide planning, control, and reporting generally prevent local entities from administering most federal programs. Instead, local organizations receive federal funds through contracts with the state agency designated as the lead agency in meeting the federal funding requirements.

The Texas health and human services system is a complex network of public and private agencies, organizations, and providers.

- To meet the need for health and human services, Texas uses a complex network of state agencies working in partnership with local government, federal agencies, contractors, volunteers, and private advocate and consumer organizations. Fourteen state agencies have a primary responsibility for delivering health and human services, and as many as 10 other agencies, including the Texas Education Agency, the Attorney General, and schools for the visually impaired and hearing impaired, are involved in delivering health and human services to their clients.

- Over the last 15 years, the Legislature has consistently sought ways to improve and expand the quality and availability of health and human services. A few examples of these many important legislative initiatives include efforts to increase childhood immunizations, enhance the state Medicaid program, promote community-based and in-home services, expand health insurance coverage, and better serve individuals who depend on the State for long-term and foster care.

The Legislature has, for the last 15 years, sought to improve the State's HHS system.

▼ **The Health and Human Services Commission has the authority to oversee the activities of the State's health and human services agencies.**

- Through House Bill 7, passed in 1991, the Legislature further emphasized the importance of health and human services by creating the Health and Human Services Commission as the state agency with centralized authority to plan for and protect the health and well-being of Texans. HHSC is responsible for developing a system which will increase the effectiveness and efficiency of service delivery in the State's health and human services programs and activities, as carried out by the various health and human services agencies.

HHSC is the State's latest attempt to enforce the coordinated delivery of HHS services.

- Before the creation of HHSC, legislative attempts to change the health and human services system relied on promoting coordination and shared planning among the health and human services agencies. HHSC's predecessor, the Texas Health and Human Services Coordinating Council, was composed of a mix of state agency board chairpersons and legislative leaders, but possessed no direct policymaking control over the independent health and human services agencies. Members of the Council were expected to cooperatively plan and coordinate health and human services programs across agency boundaries.

  The work of the Council did not result in joint planning or resolve fragmentation and duplication of state services. In 1991, through the Sunset process, the Legislature concluded that the Council had not served as a definitive and practical forum for the coordination of health and human services, and the Council was abolished.

- When the Legislature created HHSC in 1991, it gave the agency significant authority to plan and direct the ongoing activities of the State's health and human services agencies, as shown in the text box, *Authority of the Health and Human Services Commission*. HHSC's enabling legislation calls for the agency to redirect the activities of state agencies to "enforce the coordinated delivery of health and human services." House Bill 7 empowered the Health and Human Services Commissioner to take the lead in reorganizing and streamlining HHS agencies. The study and reorganization of health and human services was anticipated to be an ongoing process.

Authority of the Health and Human Services Commission

- Facilitate and enforce the coordinated planning and delivery of services.
- Require HHS agencies to assign staff to perform functions for HHSC.
- Review all proposed rules for HHS agencies and require agencies to withdraw or amend proposed rules.
- Approve HHS agency information resource plans. Review and comment on agency appropriations requests, operating budgets and fund transfers.
- Perform independent special outcome evaluations of HHS programs.
- Arbitrate and render final decisions on agency disputes.

Source: Tex. Govt. Code Ann. Ch. 531 (Vernon 1998).

- The Legislature has since designated the Health and Human Services Commission as the single state agency responsible for administering Medicaid, the largest single source of federal funds for Texas health and human services programs. Medicaid will contribute about $12 billion in federal dollars to the state budget for the 1998-99 biennium, and requires a match of $6.2 billion from state general revenue.

  Although HHSC has a large number of diverse responsibilities, the agency's role as the single state agency for the Medicaid program in Texas has become the agency's primary focus. HHSC is unique nationwide because it serves as the state

policymaking agency for Medicaid but does not deliver Medicaid services. Texas provides Medicaid services through seven independent operating agencies that perform the day-to-day service delivery functions. As the State administrator of the Medicaid program, HHSC is responsible for:

- developing and maintaining the Medicaid State Plan;
- managing the Medicaid waiver process;
- implementing Medicaid managed care systems;
- directing rate-setting processes that compensate fee-for-service Medicaid providers; and
- administering programs to detect waste, fraud, and abuse, and to ensure quality in the Medicaid system.

▼ **HHSC has not accomplished many of the goals set by the Legislature.**

◗ As required in law, the first HHSC Commissioner submitted a plan to the Legislature and the Governor in 1993 that proposed changes to the health and human services system beyond those made through House Bill 7. The changes proposed by the Commissioner were relatively modest and did not call for consolidation of state agency functions. Since 1993, no HHSC Commissioner has formally proposed the consolidation, reorganization, or streamlining of state agency programs that perform similar functions or serve the same clients.

◗ In September 1997, the State Auditor concluded that "the state's expectations for the increased effectiveness and efficiency of service delivery in health and human services programs and activities are yet to be realized. The Health and Human Services Commission has not effectively carried out its health and human services oversight responsibilities." The State Auditor's report questioned the performance of HHSC in several areas, as shown in the text box, *Findings of the State Auditor Regarding the Health and Human Services Commission.*

Findings of the State Auditor Regarding the Health and Human Services Commission

- The statewide strategic plan and consolidated budget prepared by HHSC are agency-focused and not useful in planning for statewide needs.
- HHSC has not involved local government in strategic planning as required by House Bill 869 of the 74th Legislature.
- HHSC has never formalized its powers to settle interagency disputes.
- HHSC does not review all health and human services agency rules.
- The agency has not developed a formula for distribution of funds across health and human services regions, so funding is not clearly based on need.
- Initiatives related to integrated eligibility determination have stalled.
- HHSC has not developed a process to streamline and simplify the delivery of services, as required by Senate Bill 1675, 74th Legislature.

Source: Office of the State Auditor, A Combined Report on the Health and Human Services Commission, September 1997.

HHSC has not had a significant impact on the structure and delivery of services.

The conclusions of the State Auditor are borne out by the findings of recent Sunset reviews of health and human services agencies, and by the findings of this review. HHSC has not had a significant impact on the operations or decision making of health and human services agencies, and has not played a role in streamlining or consolidating health and human services programs. Legislative mandates to maximize federal funds, improve service delivery, and create an integrated, more efficient state agency infrastructure have not been addressed.

▼ **Policymakers, advocates, and clients continue to be justifiably concerned about the cost and effectiveness of the State's health and human services system.**

◗ No state has the resources to meet all of the health and human services needs of its citizens, and Texas' funding for health and human services is conservative when compared to other states. Limited resources require that funds be used as efficiently as possible. Advocates, clients, and the public expect government to be accountable for the best use of tax dollars.

Change is the One Constant

"Perhaps the one constant in health and human services today is the notion of change. Increasing demands for services, shrinking resources bases and greater expectations for services all combine to form a dynamic environment significantly impacting health and human services in Texas."

Source: Texas Health and Human Services Coordinated Strategic Plan, October 1998.

As indicated in the text box, *Change is the One Constant*, the Texas health and human services system should be viewed as complex and dynamic. Accountability is spread across 14 independent policymaking boards and 150 separate strategies, or items of appropriation, that receive state and federal funding.

Although the number of contracts is not specifically tracked, state agencies contract with as many as 10,000 separate providers to deliver health and human services.

◗ Given the current structure of the HHS system, voluntary coordination of services between state agencies is difficult and has been infrequent. Health and human services agencies have little motivation to coordinate their administrative and service delivery functions. Each health and human services agency has its own governing structure. Members of an agency's governing board are appointed by the Governor and are responsible for directing the work of their respective state agency. Individual governing boards are not required to coordinate their rules and operating procedures with other agencies, so coordination generally does not occur.

In fact, potential opportunities for interagency coordination may not be brought to the attention of a governing board. Agency managers are accountable, first of all, to their executive director for meeting their agency's priorities. Cooperative interagency projects are outside any one agency manager's span of administrative control, often raising the basic question of who has the final authority to make a decision and who is finally accountable for a project's success.

In particular, activities that are not clearly visible to clients and advocates, such as contracting, information management, regional administration, and quality control may not come to the attention of the various HHS policymaking boards. Agency managers have little apparent reason to champion interagency initiatives in these areas, especially initiatives that require consistent practices among agencies and may consequently decrease an agency's flexibility.

▼ **The State has a continuing need for a single oversight agency to guide many of the functions of health and human services agencies.**

- The Texas approach to delivering human services is extremely complex, at least in part because services are delivered by 14 separate agencies. Each is governed by an autonomous policymaking board. No other large state relies on so many agencies to deliver services. The independent HHS agencies have created a complex tangle of services, rules, eligibility requirements, and local service providers. Legislators and the public often describe a fragmented and unnecessarily confusing system of service delivery. Clients may not know what services are available or where to go to obtain services.

> Legislators and the public often describe a fragmented and unnecessarily confusing system of service delivery.

- The 11 HHS agencies perform many of the same types of administrative and operational tasks, which have been recognized by the Legislature, oversight agencies, clients, advocates, and the public as potential examples of duplication. Current law directs HHSC to adopt contracting and purchasing rules for HHS agencies, maximize federal funds, and integrate methods of determining client eligibility. Laws also require HHSC to establish a federal funds management system and ensure that the distribution of funds address regional need.

Breaking The Mold

"A single unified system of health and human services could improve health and human services through:

- comprehensive statewide planning and development,
- a continuum of care for families and individuals,
- integration of services to improve client access,
- effective use of management information systems,
- incentives to maximize existing resources,
- system-wide accountability,
- an environment that promotes teamwork and creativity, and
- mechanisms that foster innovation at the agency and local levels."

Source: Texas Performance Review, July 1991

Little progress has been made in consolidating any of these administrative functions.

- The Sunset review concluded that, working within the current organizational and policymaking framework of health and human services, HHSC is unlikely to effectively fulfill its role as the leader of this area of government.

Nevertheless, the mandates contained in the agency's statute reflect extremely important priorities that the State should continue to pursue. Transfer of HHSC's functions to another agency would not solve the fundamental problem created by the overlapping authority of HHSC and the State's HHS agencies. The solution is to change the HHS system to give the Commission the ability to achieve the goals outlined in TPR's *Breaking the Mold*.

Conclusion

The State has consistently sought to protect the health and well-being of its citizens by providing a network of effective health and human services. The size and complexity of the State's service delivery system, as well as changing federal directives, block grants, and funding reductions create the need for effective oversight of health and human services programs. The need for an oversight function, and oversight's potential benefits, have been clearly and frequently described in state law.

Transfer of HHSC's functions to another agency would not solve the State's problems.

Although the Health and Human Services Commission has the authority to oversee, coordinate, and direct the activities of the 11 health and human services agencies, it has generally not achieved the goals and objectives set out in its enabling legislation. HHSC's accomplishments have been limited because HHSC and the independent health and human services agencies possess overlapping authority to function within the HHS system. Consequently, HHSC has sought, with little success, to encourage voluntary cooperative change and coordination on the part of state agencies. Because this approach has not worked, the Commission should be better positioned to accomplish its current statutory mission.

Recommendation

Change in Statute

- **Continue the Health and Human Services Commission only if it is given authority over the operations of the State's health and human services agencies.**
- **If continued, set the Commission's next Sunset review in 2007.**

This recommendation would continue the Commission but only if it has the authority contemplated in Issue 2 of this report. Recommendations contained in Issue 2 would modify the relationship of HHSC and the other HHS agencies and their boards. HHSC would clearly be given operational control of health and human services and accountability for improvements in the HHS system. Other recommendations in the report establish a mechanism for legislative oversight of HHSC's activities to ensure that the important priorities of the State are effectively and responsively addressed.

Sunset staff further recommends that, if the Commission is continued, its next Sunset review should be after eight years, rather than the usual 12. This would set a Sunset date for the Commission of September 1, 2007 and allow the Legislature to reevaluate the Commission after the six-year timetable for change recommended throughout this report. This report will also adjust the Sunset dates of all health and human services agencies to 2007. This includes health and human services agencies such as the Texas Juvenile Probation Commission that are not currently under Sunset review.

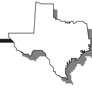
If the recommendations in Issue 2 are not adopted, the Sunset staff does not recommend the continuation of HHSC. The agency should be abolished and its functions transferred to other HHS agencies. The Legislature would need to decide where to relocate its functions, primarily its status as the State's Medicaid agency and current fraud and abuse responsibilities.

Fiscal Impact

The recommendation to continue the Health and Human Services Commission would result in the Commission receiving its current annual appropriation of approximately $32.5 million. Additional resources needed to carry out responsibilities recommended elsewhere in this report are discussed in those respective issues.

Issue 2

Strengthen The Health and Human Services Commission's Operational Control Over Health and Human Services Programs.



Background

State policies that guide the delivery of health and human services (HHS) are set by the Legislature, the Health and Human Services Commission, the boards of state HHS agencies, and by the executive directors of the respective agencies. State laws creating health and human services agencies and programs often provide detailed direction regarding what programs and services are to be provided and how the programs are to be operated.

Each of the 11 health and human services agencies operates as an independent organization. The Governor appoints the members of each agency's governing board. Board members serve on a part-time, voluntary basis, and generally meet quarterly to conduct the business of the respective board. State agency boards composed of private citizens help to ensure that the work of government is conducted openly and honestly, and all HHS boards are required to provide a means for citizens to address the board and comment on board rules and agency operations.

Although state laws vary somewhat from agency to agency, in practice state agency boards perform similar tasks and go about their work in a consistent manner. The statutory duties most common to HHS agency boards are shown in the text box, *Common Duties of Health and Human Services Agency Boards.*

Common Duties of Health and Human Services Agency Boards

- Adopt policies and rules for the government of the agency.
- Select an executive director, in some instances with the approval of the Governor.
- Supervise the executive director's administration of, and enforcement of, the laws that impose duties on the agency.
- Adopt policies that provide the public with a reasonable opportunity to appear before the board and to speak on any issue under the jurisdiction of the board.
- Appoint advisory committees to assist the board in performing its duties.

Board members have the primary responsibility for setting the direction and priorities of an agency. All HHS agency boards are required to review and approve the agency's legislative appropriations request, biennial strategic plan, and annual operating budget. Participation in the legislatively-driven budget and strategic planning process requires board members to assess the public need for agency services, identify reasonable levels of service, set related performance objectives, and to request the funding necessary to effectively deliver services.

State agency boards select an agency executive director, in some instances with the approval of the Governor, to manage and organize the operations of the agency. Although state agency boards may monitor important administrative projects, boards don't exercise direct management control over the projects. The distinction between the board members' policymaking role and the executive director's management responsibilities are often spelled out in statute.

The Sunset review examined the role of the Health and Human Services Commission in directing the operations of health and human services agencies. In particular, the review sought to identify the appropriate roles of HHSC, the HHS boards, and agency executive directors to allow the Commission to carry out its statutory mission. The staff also assessed the potential for effective strategic decisionmaking within the current organizational framework of health and human services.

Findings

▼ **The authority to direct health and human services remains divided among multiple HHS boards, agency executive directors, and the Health and Human Services Commission.**

Purposes of the Health and Human Services Commission

- Develop a comprehensive approach to planning services.
- Create a continuum of care for families and individuals.
- Integrate services to allow for efficient and timely delivery.
- Maximize existing resources.
- Ensure effective management information resources.
- Provide for system wide accountability.
- Promote teamwork, creativity and innovation at the state and local levels.

Source: Texas Health and Human Services Coordinated Strategic Plan, October 1998.

◗ The 72nd Legislature created the Health and Human Services Commission to redirect the operations of agency health and human services programs, as shown in the text box, *Purposes of the Health and Human Services Commission.* HHSC's mission is fundamentally different from the missions of other state HHS agencies. HHSC has no direct responsibility for delivering services to clients or for adopting programmatic rules or policies. Instead, HHSC's focus is on improving the overall operation of HHS by working across the 11 HHS agencies. HHSC is charged with improving the management of HHS programs by consolidating programs, directing the co-location of offices, coordinating planning and budgeting, increasing federal funds, and taking other actions that improve service delivery.

◗ The strategic direction of HHS agencies comes from the policies of each agency's board and the management decisions and operational direction provided by agency executive management. Within the current HHS structure, agency boards set programmatic rules (formulate policy), and agency

executive directors manage agency operations (implement policy). Each HHS agency has the authority to adopt rules to ensure that the agency complies with state and federal law. The Texas Administrative Procedure Act requires agency policy statements to be placed in rule when the policies have a broad or statewide impact, usually in the form of an impact on the benefits or procedural requirements of agency programs.

◗ Responsibility for managing a health and human services agency is assigned to an executive director, who controls and directs agency resources to achieve the goals and outcomes set by the agency's board. An agency's written statements concerning the internal management or organization of an agency do not have to be adopted by the agency's board as rules. Consequently, agency executive directors have the authority and flexibility to manage agency operations without prior board authorization. Although boards often take an interest in agency operations, boards seldom direct the management of an agency. For example, the board of the Department of Protective and Regulatory Services (PRS) is required to "supervise the executive director's administration of, and enforcement of, the laws of this state that impose duties on the department or the board."[1] The PRS board is further required in statute to "develop and implement policies that clearly separate the policy making responsibilities of the board and the management responsibilities of the executive director and the staff of the department."[2]

Agency executive directors manage the operations of HHS agencies.

The Sunset Commission has consistently recommended separating board and staff functions as an across-the-board approach. For example, through the Sunset process, the Legislature now requires the board of the Department of Human Services to "adopt policies that clearly define the respective responsibilities of the board and the staff of the department."

▼ **Although both HHSC and the executive directors of HHS agencies play important roles in managing health and human services, they have a different, often incompatible focus.**

◗ An agency executive director's role, managing the operations of an individual agency, and the responsibility of HHSC to

improve the overall operations of the HHS enterprise are not necessarily compatible. HHSC's enabling legislation reflected the Legislature's conclusion that parts of the HHS system such as information technology, funds management, and strategic planning, do not work very well. Consequently, HHSC was mandated to look across all HHS agencies to develop integrated methods of service delivery and improve specific system-wide operational functions.

HHSC and HHS agency executive directors play different, often incompatible roles.

In contrast, most agency directors, while acknowledging that system-wide performance could always be better, feel that their agency does a good, and sometimes excellent, job of delivering services within available resources. Their view is often supported by data comparing Texas with other states. Most importantly, executive directors balance the immediate needs of the agency's clients and the expectations of their agency's board members with the long-term need for system-wide coordination. In both public and private organizations, long-range planning usually takes a back seat to the immediate pressures of delivering services.

- Agency directors face extremely complex administrative problems involving management, funding, information technology, human resources, accounting, procurement, and contract management. Any strategic benefit of cooperating with other state agencies is often difficult to quantify and difficult to achieve. Even in situations where clear benefits could result from interagency cooperation, such as sharing resources through agency co-location, agencies must make difficult decisions about sharing costs and resources, adjusting work processes, phasing out equipment and communicating across different chains of command. Efforts to achieve a vague, long-term incremental benefit often require immediate, intense efforts that diminish the resources needed to meet daily performance objectives. Agency executive directors aren't rewarded for taking on complex interagency projects unless the projects are mandated by the Legislature.

- Very few state agencies have the staff or expertise to analyze the costs and benefits of consolidating functions across agencies, create a re-engineering plan, and carry it out. Should one agency have the resources to plan a cross-agency re-engineering process, partner HHS agencies may not have

similar resources or an interest in participating. Multiple agencies with different missions and cultures, and an investment in business as usual, are not likely to, and are not usually capable of, working together to voluntarily re-engineer their programs.

In the best of situations, where multiple agencies have both the motivation and resources to integrate their functions, agencies still must create a governance structure that manages shared functions across agency lines. When sharing resources and functions, agencies have to identify the decisions that require participation from all agencies, and the types of decisions that can be made by a lead agency. The result, often management of relatively unimportant activities by an interagency committee, can be frustrating and ineffective. Agencies are particularly reluctant to relinquish autonomous control over mission-critical functions such as information technology support, telecommunications equipment and access, and systems for accounting and expenditure control.

HHS agencies have been reluctant to integrate operations voluntarily, and HHSC lacks the authority to require integration.

- **HHSC does not possess the enforcement authority necessary to require HHS agencies to integrate their operations.**

  - As the State Auditor noted in 1993, "The implementation of House Bill 7, 72nd Legislature, has been impeded for a variety of reasons. The bill did not grant any enforcement authority to the Health and Human Services Commission. This has prevented the Commission from making decisions or issuing directives to the agencies under its umbrella of authority. Instead, the Commission has had to rely on a time-consuming process of negotiation and consensus building with each agency."

    The State Auditor's comments regarding the dependence on consensus building are exemplified by HHSC's *Coordinated Strategic Plan, 1999-2004,* published in October 1998. The Plan states that:

    "The Health and Human Services Coordinated Strategic Plan for Fiscal Years 1999-2004 was developed interactively by the health and human services agencies. This plan represents the consensus of the agency chief executive officers. It does not attempt to rank the importance of one agency, program or

HHS Agency Accomplishments in Addressing Duplication of Services

The Texas Workforce Commission and Department of Protective and Regulatory Services developed a Child Care Management System.

The Department of Mental Health and Mental Retardation and the Department of Protective and Regulatory Services improved abuse and neglect investigations in MHMR facilities.

The Texas Commission on Alcohol and Drug Abuse and the Department of Mental Health and Mental Retardation shared dual diagnosis staff.

Agencies co-located in the Brown/Heatly Building shared administrative service functions.

Child services agencies developed Child and Youth Community Resources Coordination Groups.

Two local agencies and a DHS regional office in East Texas jointly contracted for home delivered meals.

Source: Texas Health and Human Services Coordinated Strategic Plan, October 1998

strategy over another. Rather, it demonstrates a spirit of teamwork and cooperation addressing some of the most critical health and human service issues. Most importantly, this plan candidly discusses duplication of services and identifies where Texas can better serve Texans through prevention and targeted investments."

The Coordinated Strategic Plan contains a "candid discussion of duplication of services" that identifies seven recent cross-agency accomplishments, shown in the text box, *HHS Agency Accomplishments in Addressing Duplication of Services*. Ironically, although HHSC was created to direct change, each of the seven accomplishments addressing duplication was specifically mandated by the Legislature.

- HHSC has created a Health and Human Services Steering Committee to recommend cooperative improvements to administrative functions. Subcommittees of the Steering Committee have identified a number of opportunities for increased efficiencies among HHS agencies, including development of a statewide electronic purchasing system, coordination of internal audit processes and scheduling, creating two-way video conferencing facilities in key locations across the state, sharing contracted training services and purchased training materials, and developing long-range plans for the retention of electronic records. The potential success of these initiatives is limited because some of the larger HHS agencies have not participated in the Steering Committee's work. Even when the Steering Committee has developed a complete plan for achieving an efficiency, the question of what entity is finally accountable for the success of a project has not been resolved, and little progress has been made.

To create change, HHSC must get voluntary cooperation from the HHS agencies.

- To create system-wide change, HHSC must identify potential improvements to the HHS system, conduct a complex multi-agency cost/benefit analysis and feasibility study, develop a plan for change that all participating agencies can agree with, and then encourage the agencies to implement the plan. All of these activities are dependent on the voluntary participation and cooperation of the staff of HHS agencies.

- HHSC has the statutory responsibility to enforce coordinated planning and delivery of services[1]. While the HHSC Commissioner has the authority in law to redirect the activities

of a HHS agency, the Commissioner has no means of requiring an agency take a particular action, and no practical way of overriding the decisions made by an agency's board or executive director.

Because agency executive directors control the resources and information necessary to plan and implement changes to the HHS service delivery system, HHSC is dependent on the executive directors to achieve the objectives of HHSC's enabling legislation. More importantly, the control mechanisms often necessary to change agency processes and employee behavior rest with agency administrators. Currently, the HHSC Commissioner has no clear line of authority over an HHS agency executive director, so HHSC cannot direct the staff of HHS agencies to work to achieve cross-agency efficiencies. Without some authority to tap agency resources or direct activities, change can only occur on a voluntary basis.

HHSC is dependent on agency executive directors to achieve its legislative objectives.

Recognizing their limited authority, HHSC Commissioners have generally avoided conflict with agency boards and staff, and in doing so may have shied away from promoting change in HHS agencies.

▼ **HHSC's priorities and ability to meet legislative expectations have been shaped by the Commission's staffing level.**

◗ The Sunset review concluded that HHSC has not had the staff necessary to carry out all of its responsibilities under House Bill 7. Although HHSC has the authority to transfer staff from other HHS agencies to carry out its duties, it has no practical mechanism to allow the transfer to occur. Employees subject to transfer may not have the qualifications needed by HHSC and in most instances employees and agency administrators would resist the transfer. Because the number of state employees is capped in the state General Appropriations Bill, transfer of a significant number of employees would be likely to impact the performance of the transferring agency. In the few instances where employees have been transferred to HHSC, such as in Medicaid fraud prevention activities, the functional tasks performed by the employees were also transferred, so HHSC did not realize a net gain in agency resources.

HHSC does not have the staff to meet legislative priorities.

- To do its job, HHSC must have direct access to the information and employees of HHS agencies. At the same time, HHSC needs its own in-house staff to analyze agency operations and prepare realistic, creative recommendations. The HHS system is extremely complex, made up of as many as 60,000 employees who deliver hundreds of different services paid for by state and local funds as well as 120 separate federal sources. More than any other health and human services agency, HHSC's success in meeting its statutory objectives depends on the ability of its staff to understand the HHS system as a whole.

  HHSC has had limited staff to achieve the broad mandates for change outlined in House Bill 7. Of the agency's 169 positions, 110 are assigned to Medicaid. Only 29 staff occupy positions that would potentially allow them to analyze state agency operations, and all of those staff are assigned to carry out agency duties. The text box, *Number of HHSC Employees in Key Functional Areas,* shows the areas to which these staff are assigned.

Number of HHSC Employees in Key Functional Areas

Consolidated Budget, Forecasting and Demographics, and Strategic Planning (eight employees)

Responsible for analysis of HHS system financial and budget issues and for developing the HHS Coordinated Strategic Plan.

Information Resources (four employees)

Review and approve all HHS agency automation plans, and develop and maintain technical architecture standards.

Service Integration (16 employees)

Responsible for coordinating children's services, developing guardianship standards, client transportation planning, information and referral planning, community coordination of children's services, and several pilot projects.

Integrated Enrollment (one employee)

Responsible for developing systems for integrated enrollment of clients and implementation of House Bill 2777 related to the TIES project.

- The limited availability of staff requires the Commission to prioritize its many statutory tasks. HHSC is required by law to develop an Annual Workplan that prioritizes its responsibilities. The 1998 Annual Workplan identifies 139 separate substantive tasks to be performed, as well as another 39 administrative support tasks. Tasks are categorized as high, medium, or low priority. Many of the agency's low priority tasks are those specifically mandated by the Legislature to coordinate and improve HHS services.

  For example, low priorities of the agency include developing automation standards that allow agencies to use shared data, reviewing and commenting on state agency regional funding formulas, reporting on streamlined service delivery, coordinating with the Texas Workforce Commission, conducting targeted analysis of agency rules, and developing a plan for agency rules review to be submitted to the Governor and Legislature.

Conclusion

Initiatives to shape Texas' 11 independent health and human services agencies into a cohesive system of services that is accessible to clients, integrated, and efficient have not succeeded. A failed attempt in the 1980s to promote voluntarily coordination among state agencies led to a recommendation by the Texas Performance Review to establish one combined HHS agency. Instead, in 1991 the Legislature created an oversight agency, the Health and Human Services Commission, with the mandate to integrate the operations of the HHS system.

HHSC does not have the ability to direct HHS agencies to reshape the system.

Although the Commission is responsible for improving the operations of the HHS system, the executive directors of each HHS agency control the resources and information that are necessary to plan and implement system change. At present, HHSC does not have adequate ability to direct the activities of HHS agencies to reshape the organization of health and human services. The 11 HHS agencies, each with different missions and cultures, have not proved very willing to voluntarily re-engineer their operations to achieve cross-agency efficiencies. Voluntary, cooperative change has been minimal. Without access to the resources needed to plan and carry out change, HHSC cannot be held accountable for achieving the objectives that the Legislature outlined in its enabling statute.

Recommendation

Change in Statute

- **Provide the HHSC Commissioner with clear authority to manage the operations of the State's health and human services agencies.**
- **Adjust the term of the Commissioner's appointment to correspond with the term of the Governor, and require that the Commissioner be confirmed by the Senate.**
- **Specify that the Commissioner has direct authority to hire the HHS agency executive directors as follows:**
  - **existing agency directors would continue in their current positions, and**
  - **as vacancies occur, the Commissioner would select replacements with advice from the respective agency policy boards, subject to approval of the Governor.**

- **Clarify the respective authority of the HHSC Commissioner and the HHS agency policy boards by:**
  - **distinguishing the Commissioner's authority to manage and direct agency operations from the policymaking role of the HHS policy boards;**
  - **specifying the Commissioner's authority to adopt rules concerning agency operations;**
  - **maintaining the policy boards' authority to adopt rules guiding service delivery priorities and client issues but not in areas related to agency organization, operating procedures, or management; and**
  - **requiring the Commissioner and each HHS policy board to enter into agreements clearly delineating the respective authority outlined above.**
- **Direct the HHSC Commissioner to pursue improvements in specific operational areas as outlined in Issues 3 - 8 of this report.**

As stated in Issue 1 of this report, the Health and Human Services Commission should be continued only if the Commission is equipped so that it can reasonably be expected to achieve its statutory objectives. The intent of the recommendations is to 1) assign to HHSC the accountability for achieving legislative objectives, and 2) provide a means of achieving those objectives by creating a clear chain of command from the HHSC Commissioner to the executive directors of HHS agencies. These recommendations would provide HHSC with a means of meeting its statutory objectives while leaving the individual state agencies that deliver health and human services intact.

The Sunset review concluded that the Legislature's expectations for system-wide improvement could not be met within the current organizational structure. The recommendation to designate the HHSC Commissioner as the individual finally responsible for managing the operations of health and human services agencies may not be well-received by some HHS agency executive directors and board members. However, the Sunset review concluded that modifying the relationship between the HHSC Commissioner and the 11 HHS executive directors is the least disruptive and most direct way to establish accountability for achieving system-wide objectives. In fact, the broad authority granted to HHSC in House Bill 7 seems founded on the assumption that the HHSC Commissioner would direct some agency operations and should be held finally accountable for meeting legislative expectations.

This recommendation would vest tremendous authority with the HHSC Commissioner. The potential for the Commissioner, with increased authority over agency operations, to inappropriately intrude in the work of individual agencies should be controlled by several traditional mechanisms of government. First, and most importantly, the Governor exercises direct control over the HHSC Commissioner, HHS agency boards, and the executive directors

of HHS agencies. The Governor would appoint the Commissioner for a four-year term. Under this recommendation, the Governor would also approve the Commissioner's future appointments of HHS agency directors. The Governor has the direct authority to require a fair, productive balance between HHSC's role of delivering system-wide improvements and the impact of HHSC's efforts on an agency's ability to do its day-to-day work. This recommendation would require this balance to be formally adopted through agreements between the Commissioner and the HHS agency policy boards.

Clearly stated statutory direction and ongoing legislative oversight should focus the work of HHSC on system-wide priorities and control any potential micro-management of individual agency programs. The statutory objectives of HHSC are already focused on improvements in the key operational areas of information resources management, federal funds management, budget and strategic planning, and development of an integrated system of services. Several other issues in this report would provide the Commission with additional direction in these areas. The legislative oversight committee recommended in Issue 18 of this report would require that the HHSC Commissioner make an annual report to the legislative oversight committee describing the objectives of HHSC for the coming year and the accomplishments of the prior year. Each HHS agency board and the public would have the opportunity to provide the legislative oversight committee with their analysis of the impact of HHSC's annual strategic plan and the Commissioner's activities.

Fiscal Impact

This specific recommendation will not have a direct fiscal impact. The impact of expanding the Commission's role in reshaping health and human services is discussed elsewhere in this report.

[1] Tex. Hum. Res. Code Ann. ch. 40, sec. 40.028 (Vernon 1998).

[2] Ibid.

Health and Human Services Commission

Direct the Health and Human Services Commission to Improve Specific Health and Human Services Operational Areas.

This section of the report identifies the operational aspects of the health and human services system that would benefit from cross-agency analysis and direction. In general, each of these operational areas has been identified in prior legislation as a critical area of operation with potential for better management, but little progress has been made in achieving system-wide efficiencies.

Issue 3. Strengthen the Health and Human Services Commission's Role in Managing Federal Funds.

Issue 4. Strengthen the Oversight of Purchasing and Contracting by Health and Human Services Agencies.

Issue 5. Improve Information Systems Planning and Management Across Health and Human Services Agencies.

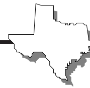
Issue 6. Strengthen HHSC's Operational Control Over Medicaid Managed Care and Require the Health Care Information Council to Assess the System's Performance.

Issue 7. Improve the Regional Management of Health and Human Services Agencies.

Issue 8. Improve Access to Information about Health and Human Services in Texas.

Issue 3

Strengthen the Commission's Role in Managing Federal Funds.



Background

In fiscal year 1998, the health and human services agencies had a combined total budget of $12.6 billion. Approximately 58.7 percent of those funds, or $7.4 billion, came from federal sources. The table, *Health and Human Services Agency Budgets,* shows the amount of federal funds received by each agency and the percentage those funds represent in each agency's total budget.

Combined, the health and human services agencies receive funds from over 120 different federal sources, or funding streams.[1] These multiple federal funding sources fall into four general categories. The text box, *Types of Federal Funds*, provides a brief explanation of each category. Although the State receives funds from so many funding streams, over 90 percent of federal funds come from just a handful of sources.[2]

Health and Human Services Agency Budgets Fiscal Year 1998

Agency	Total Funds (in millions)	Federal Funds (in millions)	Percent of Total Funds
TDoA	$57.9	$51.2	88.4%
TCADA	136.1	107.2	78.8
TRC	256.4	201.2	78.5
TCB	41.3	30.9	74.8
DHS	3,406.0	2,151.7	63.2
TDH	6,336.3	3,861.2	61.0
PRS	552.8	317.1	57.4
HHSC	9.8	5.4	55.1
ECI	69.0	32.7	47.4
TDMHMR	1,651.6	637.7	38.5
TCDHH	1.2	0	0
TJPC	90.6	0	0
TOTAL	$12,609.0	$7,396.0	58.7%

Source: 1998-99 Appropriations Act

Types of Federal Funds

***Entitlements* -** Entitlements guarantee a financial subsidy or service to individuals that meet a specific eligibility standard. Examples include Food Stamps and Medicaid.

Competitive Grants – Also called categorical grants, competitive grants have strictly defined purposes, eligibility requirements, and permissible uses. Examples include Residential Drug Prevention and Treatment Projects and Adoption Opportunities.

Formula Grants – Formula grants are also used for specific purposes, but the purposes are usually broader than with categorical grants. The amount awarded is determined by a prescribed formula, which might be based on factors such as population density or poverty ratio. Examples include the Nutrition Program for the Elderly and Vocational Rehabilitation Grants.

Block Grants – Block grants are a type of formula grant that have been created by merging several smaller competitive or formula grants together. Block grants offer much greater discretion in how they can be used. Examples include the Maternal and Child Health Services Block Grant and the Social Services Block Grant.

Source: Martin Orland et al., *Creating More Comprehensive, Community-Based Support System: The Critial Role of Finance* (Washington, DC: The Finance Project, November 1995) p. 5-8.

To administer federal funds, a state agency is often designated as the lead, or single state agency, for a particular funding stream. For example, the Health and Human Services Commission (HHSC) is the single state agency for Medicaid, the Department of Human Services (DHS) for Title XX (Social Services Block Grant), and the Department of Health (TDH) for Title V (Maternal and Child Health Block Grant). The single state agency is responsible for submitting a federally-required state plan that requests the funds from the federal agency and establishes how the funds will be administered, submitting any required reports, and serving as the central point of contact with the federal agency. Although one state agency is designated as the lead agency for a particular funding source, funds from that one source often go to multiple agencies. For example, DHS is the single state agency for Title XX, but Title XX funds also go to the Department of Protective and Regulatory Services (PRS), the Interagency Council on Early Childhood Intervention (ECI), TDH, and HHSC.

House Bill 7 required HHSC to establish a federal funds management system and to maximize the availability of federal funds.

In 1991, House Bill 7 required the Commission to establish a federal health and human services funds management system and to maximize the availability of federal funds. The Commission was given the statutory authority to:

- request budget execution for the transfer of funds from one agency to another;
- review and comment on each health and human services agency's legislative appropriation request, annual operating budget, and any transfer of funds between agency budget strategies; and
- review and comment on the state plan prepared by the designated single state agency for a particular federal funding source.

In addition, a rider to the Appropriations Act allows the Commission to transfer funds between the health and human services agencies up to five percent of the total appropriation of the agency from which funds are being transferred, subject to the approval of the Governor and the Legislative Budget Board.

The Commission also has responsibilities for overall planning and budgeting for the health and human services system. The Commission must prepare and submit to the Legislative Budget Board (LLB) and the Governor a consolidated health and human services budget recommendation. The budget recommendation is based on the priorities set in the coordinated strategic plan for health and human services, which the Commission is also required to develop.

The Sunset review looked at the Commission's activities in managing federal funds across the health and human services agencies and sought to determine the effectiveness of the Commission in responding to federal changes, maximizing federal funding, and identifying new opportunities to claim federal funds.

Findings

▼ **Health and human services agencies must effectively manage federal funds to pay for many of the services provided to Texas' clients.**

◗ In developing the *1999-2004 Coordinated Strategic Plan*, the Commission conducted a survey to identify issues of highest importance to stakeholders for consideration in its strategic planning efforts. The text box, *Issues Identified by Health and Human Services Stakeholders,* lists the top issues identified. Of the top 12, about half relate to the management of federal funds and the need to plan for their use and maximize their availability.[3]

Issues Identified by Health and Human Services Stakeholders

1. Needs of children, including child care and health care.
2. Lack of affordable health care for all Texans.
3. Insufficient funding for current HHS programs.
4. Long-term care options for elderly and disabled Texans.
5. Maximization of federal funds.
6. Elimination of fraud, abuse in HHS programs.
7. Miminizing adverse impacts of Medicaid and welfare reform.
8. Need for better HHS agency management and accountability.
9. Need for more prental care.
10. Need to plan for block grants.
11. Addressing organizational issues.
12. Co-location of HHS field offices.

◗ The State must often make decisions about complex federal funding issues that involve multiple agencies. These decisions may include responding to changes to existing federal programs or designing and implementing new initiatives. Development of a state strategy to allocate federal funds involves multiple agencies. No single agency is accountable for ensuring that the overall system makes the best use of federal funds.

◗ Individual agencies may be unaware of the effect on the overall health and human services system when making funding decisions, and changes in an agency's funding policies can impact other agencies' resources. For example, when a state agency spends more on Medicaid services, the general revenue dollars appropriated to TDH must be increased proportionally. However, TDH may not be notified of the expansion and general revenue appropriations to match Medicaid may be inadequate.

- Although the LBB has a federal funds analysis division, its focus is on the larger pictures of tracking the federal budget and the annual appropriations process. The LBB is interested in maximizing federal funds, but is not in a position to look at the more specific and on-going agency practices that must be considered.

▼ A federal funds management system could increase federal funding and improve the allocation and control of federal funds.

- Reviews of state agency operations often identify opportunities to attract additional federal dollars. In the 1996 report, *Disturbing the Peace*, the Texas Performance Review (TPR) noted that DHS pays for some social and day care services to the elderly and disabled with general revenue or the capped Social Services Block Grant that could be paid for with Medicaid dollars. TPR also noted that PRS may be able to claim Medicaid for some of the rehabilitative services the agency provides.[4] A recent Sunset review of ECI found that the agency pays for most of its services through Individuals with Disabilities Education Act (IDEA) early intervention funding. However, the report noted that ECI could tap additional funding sources, such as Medicaid or Title IV-E, to expand its funding base and extend services to more children.

Reviews of state agency operations often identify opportunities to attract additional federal dollars.

- The Social Services Block Grant (Title XX) is a broad grant that may be used for multiple purposes. Five state agencies receive Title XX funds, including DHS, PRS, TDH, ECI, and HHSC. In fiscal year 1998, the federal government cut the grant seven percent from the previous year, decreasing Texas' allocation from $176 million to $163 million. An additional cut of approximately 20 percent is proposed for fiscal year 1999.[5]

  Agencies receiving Title XX funds generally request what they received the previous year. Any funding cuts are then prorated across the five agencies. HHSC, or the agencies receiving the funds, do no analysis to ensure that the funding cuts are distributed in the most effective manner. The Legislature may make adjustments during the appropriations process, but no up-front process currently exists to ensure that the funds are distributed across the agencies in a manner that maximizes use of the funds and minimizes any cuts in services. In most

instances, agencies simply request general revenue to replace the lost Title XX funds.

- The Children's Health Insurance Program, or CHIP, was established by the Balanced Budget Act of 1997 to help states extend health insurance coverage to uninsured children. The complexity of the variables involved in CHIP requires extensive analysis to understand what the impact will be on the State and which model will be the most effective.[7] CHIP is being rolled out in two phases. In the first phase Texas, like many other states, accelerated implementation of new Medicaid requirements to expand coverage to children ages 14 to 18 who live in families earning up to 100 percent of the poverty level. In its first biennium of implementation, this phase is expected to cost a total of $80 million, with the State's funding share set at $21 million.[6]

  Phase two, which the State is currently designing, involves many more complex variables. The State must decide what type of coverage model it will use, either expand Medicaid, which is an entitlement, or a separate program that would not be an entitlement. The State must also decide up to what level of poverty will be covered, and if a program other than Medicaid is used, a benefits package must be developed. Depending on its final design, phase two is estimated to cost between $121 and $300 million in its first year of implementation. Regardless of the option, the State would pay roughly 26 percent of the costs and the federal government approximately 74 percent.

- In 1996, federal welfare reform legislation created the Temporary Assistance for Needy Families (TANF) block grant, consolidating several funding streams and providing states with greater spending flexibility. With this new financing mechanism, the State needed to reevaluate how welfare funds were distributed and for what services they could be used. Several new opportunities existed, including paying for services with TANF funds rather than general revenue.

  The Lieutenant Governor asked HHSC to take the lead on this analysis and develop a method for maximizing use of the TANF funds. The Commission, however, focused on programmatic and policy issues, and did not do a thorough financial analysis of how the TANF funds could best be used.

In the end, the Legislature had to turn to other entities to gather this information.

The need for financial analysis was not one time. With the $486.3 million grant distributed across nine agencies and the many services it can fund a system-wide perspective is needed to ensure the grant continues to be distributed in the most effective manner.

▼ **The Commission has not effectively managed the use of federal funds across the health and human services system.**

◗ Federal funds are the single most important component of the Texas health and human services system. For many years, the Legislature has emphasized effective management of federal funds by requiring that agencies maximize federal funds and control the expenditure of unanticipated federal funding. Recognizing the importance of federal funds, the Legislature has directed HHSC to develop a federal funds management system and has given HHSC a central, enterprise-wide role in budgeting, planning, and funds management.

HHSC has no overall strategy to guide the use of federal funds and cannot guarantee the State is receiving all the federal funds to which it is entitled.

In 1997, the State Auditor found that the Commission has no system in place to maximize federal funds for health and human services. The Commission does not maintain current information about federal funds or evaluate, guide, or monitor the use of federal funds across the health and human service agencies. Consequently, HHSC has no overall strategy or objectives to help shape the use of federal funds, and thus cannot guarantee that the State is receiving all of the federal funds to which it is entitled. Instead, HHSC's efforts to manage federal funds are informal and piecemeal. The Commission responds to funding problems when they arise or when directed by the Legislature. As a result, the Commission's actions are often reactionary rather than proactive and do not ensure that the State is maximizing its use of federal funds.

◗ The Commission has the authority to transfer funds between HHS agencies, but this tool is of little value without a solid picture of where funds are needed and how they are being used. HHSC has no process to systematically review and comment on agency operating budgets or transfers between

agency strategies.[8] Without knowing how HHS agencies use their federal funds and analyzing the use across the multiple health and human services agencies, the Commission cannot ensure that the State is effectively using its federal dollars. HHSC has no method to identify appropriations that might lapse, or amounts that could be available to meet critical needs in other agencies.

- In Texas, no central agency is responsible for liaison with the federal agencies that make funding policy. The Sunset review found that federal HHS regions may interpret federal regulations differently, and that Texas may not receive the same favorable interpretations that increase the flow of federal dollars to other states. For example, California receives significant federal reimbursements for providing services to clients who are potential Title IV-E "eligibles." Texas counties are not reimbursed for those same expenses. The Sunset review of the Texas Rehabilitation Commission (TRC) found that Texas appears to lose significant federal funds because residents are denied Social Security Disability benefits at a rate higher than most other states.

All of Texas' counties are eligible to receive federal funds for certain health and human services they provide.

▼ **Local units of government have little access to the information or technical support needed to claim federal funds.**

- HHSC is specifically charged with maximizing federal funds through the efficient use of local resources. All of Texas' 254 counties are eligible to receive federal funds for some of the health and human services the counties provide. Counties with large populations can often claim significant reimbursement from federal programs, freeing local dollars for other services. For example, Title IV-E reimbursements for Bexar County alone exceeded $1 million in 1998. Because counties do not have a state source of accurate, consistent information about federal funding sources and administrative requirements, they often must buy consulting services from private companies to get the advice they need to claim federal funds. Over the last two years, most large counties have employed private consultants to help claim federal Title IV-E funding and other federal funds.

- A survey of counties conducted by Sunset staff in 1996 found that counties are often not aware of federal funding sources that would pay for existing, county-delivered protective and regulatory services. In fact, only 23 of 185 eligible counties participated in one federally-funded program, the County Reimbursement Program available through PRS. Sunset recommended that PRS develop a county outreach initiative and inform counties of all available federal funding sources.

- Once counties identify potential federal funding sources, the administrative burden of working with state agencies to claim the federal funds can be complicated and frustrating. To claim federal funds, counties must enter into a contract with the state agency that pays the counties the federal money. The state agency payer must in turn enter into a contract with the single state agency for the funding source. Once the contracts are in place, counties must prepare a number of complex documents, usually including a proposed budget, estimate of services to be provided and a plan for allocating the costs of administrative overhead to the federal effort.

  Most state agencies do not have the staff to give counties the technical support they need to prepare the documents necessary to claim federal funds, although some agencies do have this expertise. Consequently, some agencies would be overwhelmed if even a third of Texas' 254 counties required technical assistance to claim federal funds.

Local agencies sometimes operate under perceived rather than actual requirements or limitations.

- The requirements governing most federal funds leave some room for flexibility and creativity. Local agencies and grantees often have little direct understanding of the flexibility associated with a funding source, and sometimes operate under perceived rather than actual requirements or limitations. HHSC, through a "blended funding" pilot project, has discovered that many local agencies do not know how to develop integrated funding initiatives that best address local needs.

Conclusion

The Health and Human Services Commission has not fulfilled its charge to develop a federal funds management system. As a result, the State cannot ensure that it is achieving the best use of its resources and maximizing the amount of federal funds that can be brought to the State. As changes to

federal programs and funding arise, the State needs a central entity to guide implementation of these changes and ensure that the overall needs and priorities of the State are addressed. Because many federal funding sources are distributed across agencies, the State also needs a central entity to ensure that this distribution is done in the most appropriate way to optimize the system-wide use of federal funds. In addition, the State's efforts to maximize federal funds should not stop with state agencies. The State should work with local entities to identify and access opportunities to receive federal funding.

Recommendation

Change in Statute

- **Clearly designate that HHSC is the state agency with authority over all federal funds received by health and human services agencies and should:**
  - **develop and implement a strategic plan that sets priorities across agencies for the use of federal funds in coordination with the coordinated strategic plan and strategic budget;**
  - **review and approve state federal funding plans;**
  - **estimate and track potential unspent funds, estimates of federal funds, and earned federal funds;**
  - **ensure the State meets federal match and maintenance of effort requirements;**
  - **coordinate and monitor the use of federal fund to ensure that funds are spent across agencies in the most cost-effective manner;**
  - **transfer appropriated amounts, within limits set by the Legislature, to enhance receipt of federal funds and respond to client needs; and**
  - **ensure that local units of government have access to complete and timely information about all sources of federal funds for health and human services programs, and that technical assistance is readily available to obtain federal funding.**
- **Require HHS to submit an annual report to the Legislature and the Governor on federal funding issues. The report should identify ways to maximize the use of federal funds and detail strategies to improve federal funds management. In addition, the results of past activities to better manage federal funds should be reported.**

This recommendation builds on the Commission's existing statutory requirement to develop a federal funds management system. It directs HHSC to build a comprehensive picture of the use of federal funds across the health and human services system. This picture should be based on needs and opportunities recognized through the Commission's coordinated strategic planning and budgeting process. Having a system-wide plan for the use of federal funds will ensure that dollars are tied to identified priorities and are spent in the most cost-effective manner across the health and human services agencies.

To build this comprehensive picture, the Commission can use its existing authority to review agencies' legislative appropriation requests and operating budgets. The Commission should evaluate these items with a system-wide perspective. If opportunities are identified to better use funds across the health and human service system, the Commission should work with the agencies to redirect their funds or efforts. If opportunities are identified after the appropriations process, the Commission can use its authority to transfer funds from one agency to another. In addition, this recommendation requires the Commission to review the federally-required plans prepared by the designated single state agencies, rather than just allowing it the opportunity. HHSC should ensure these plans maximize opportunities for use of the particular funding streams.

By being more involved up-front, the Commission can play a more active role in the management of federal funds rather than reacting to problems as they arise. With a comprehensive, system-wide perspective, the Commission can better plan for and direct the use of federal funds to ensure they are used in the most efficient and effective manner.

The Commission can serve as a point of support and guidance to the Legislature and the Governor on federal funding issues. During the regular appropriations process or in response to specific federal initiatives, HHSC can assist in understanding and making decisions on complex federal issues. The recommendation directs the Commission to prepare an annual report that recommends strategies to maximize the use of federal funds, including tools needed to manage the use of federal funds. The report should also comment on the results of the Commission's efforts to better manage federal funds.

In addition to guiding state agencies' use of federal funds, the recommendation also directs the Commission to ensure that all potential opportunities for local entities to access federal funds are pursued. Local entities are often unaware of opportunities to draw down federal funds or do not have the expertise to complete the often complex requirements. Through the various health and human service agencies, the Commission should ensure that local entities are aware of potential sources of federal funds for their programs. It should also ensure the local entities have access to technical assistance to assist the agencies in meeting all the requirements and completing all necessary paperwork and documentation.

Management Action

- **Require HHSC to build its expertise to respond to federal initiatives and maximize opportunities for the use of federal funds by:**
  - **using existing staff expertise in the health and human services agencies;**
  - **coordinating with the Legislative Budget Board;**
  - **coordinating with the Office of State-Federal Relations (OSFR), including placing a staff person in OSFR's Washington, D.C. office;**
  - **understanding the full requirements, limitations, and potential uses of new and existing funding sources; and**
  - **tracking creative and innovative uses of federal funds by other states or entities.**

To support its ability to effectively manage federal funds, the Commission must build its capacity as an expert on federal funds requirements and opportunities. The Commission should consolidate and organize the staff expertise that currently exists in the health and human service agencies and should also work with the federal funds analysis division of the Legislative Budget Board. Likewise, HHSC should develop a working relationship with the OSFR, including having a staff person work out of OSFR's Washington office. Several agencies, including the LBB, use this approach to work directly on issues at the federal level. The Commission should use its expertise to ensure agencies are maximizing all potential uses of a funding stream and not operating under perceived requirements or limitations. The Commission should also track how other states and entities are being innovative and creative in their use of federal funds. Through such steps, the Commission can help ensure that the State is most effectively using its federal dollars.

Texas receives about $7.4 billion in federal funds each year. Even a slight improvement in federal funds management can have significant positive impact on the resources available to the State. Although the exact benefit cannot be estimated, this recommendation is anticipated to have a positive fiscal impact to both the state and local units of government. Equally as important, HHSC can play an objective role in identifying any excess funds within the HHS system and responding to service delivery changes that disrupt the planned use of federal funds. While this recommendation anticipates that HHSC would require some additional staff to develop expertise in managing federal funds, at least half of the cost of the staff could be paid with federal funds and the increase in federal dollars would greatly exceed the additional State dollars needed.

Fiscal Impact

During the last few years, the Legislature has authorized state agencies to employ consultants to capture additional federal funds by preparing Medicaid waivers and redesigning state strategies to better claim indirect costs associated with federal programs. The costs of consultants far exceeds the costs of creating a federal funds analysis capability at HHSC, and even a small staff of HHSC employees engaged in system-wide planning could potentially recover its cost many times over. Finally, the recommended requirement that HHSC submit "an annual report to the Legislature and the Governor on federal funding issues and ways to maximize the use of federal funds and detailing strategies to improve federal funds management" provides an accountability mechanism to ensure that HHSC's management of federal funds has a significant net benefit to the State.

[1] Health and Human Services Commission, *Texas Health and Human Services Consolidated Budget, 2000-2001* (Austin, Tex., October 1998), p. 49.

[2] Ibid.

[3] Health and Human Services Commission, *Texas Health and Human Services Coordinated Strategic Plan, 1999-2004* (Austin, Tex., October 1998), p. 42.

[4] Texas Performance Review, *Disturbing the Peace: The Challenge of Change in Texas Government* (Austin, Tex., December 1996), p. 254.

[5] Legislative Budget Board, *Federal Funds Watch*, vol. IV, no. 5 (August 11, 1998).

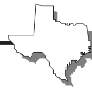
[6] Texas Department of Health, "Children's Health Insurance Plan (CHIP) - Phase II," http://www.tdh.state.tx.us/child/chip2.htm, October 19, 1998.

[7] Ibid.

[8] Office of the State Auditor, *A Combined Report on the Health and Human Services Commission*, report no. 98-001 (Austin, Tex., September 1997), p. 14.

Issue 4

Strengthen the Oversight of Purchasing and Contracting by Health and Human Services Agencies.



Background

Most health and human services (HHS) agencies purchase goods and services for their clients from private organizations. HHS agencies spend approximately $10 billion each year to buy services for clients, including medical care, mental health and mental retardation services, residential care for children, substance abuse counseling, and nursing facility care. Over the past few years, the State Auditor, Joint General Investigating Committee, and Comptroller's Texas Performance Review have identified significant and widespread problems with the purchasing and contracting practices of HHS agencies. Every study of the contracting practices of the state's health and human services agencies has called for extensive and fundamental improvements. Recommendations for improvement are summarized in the text box, *Conclusions About the Contracting Practices of HHS Agencies, 1995-1998*.

Concerns about state agency contracting practices fall into two general areas. First, ineffective contract administration creates loopholes that allow contractors to exploit the state financially. Audits have found that some contractors have been paid for services that don't benefit clients, and have been paid at unreasonably high rates. A second area of concern relates to the quality of the services provided to clients. Clients that receive health and human services depend on contractors to meet their basic living needs. Poor or neglectful performance by a contractor may directly jeopardize the health and safety of a client or a family. The Sunset staff, in its reviews of HHS agencies, further confirmed these findings and has made several recommendations in recent reports.

Conclusions About the Contracting Practices of HHS Agencies, 1995-1998

Texas State Auditor's Office – Agency oversight of contractor performance does not provide sufficient information to determine if taxpayer's funds are allocated to contractors who consistently provide the best services. Contract administration practices do not ensure that public funds are used prudently.

Joint General Investigating Committee on State Contracting – Contractor reimbursement rates are based on inaccurate data, contractor selection may be subjective, procedures for constructing contracts need improvement, contracts are not effectively monitored, and a lack of formal policies and procedures has weakened almost all state contracts.

Comptroller of Public Accounts, Texas Performance Review – State agencies must follow fragmented purchasing guidelines, developed by state and federal agencies, contained in numerous laws and rules. Each state agency establishes its own purchasing and contracting procedures and interprets laws with little or no oversight. State agencies do not share information, and coordination of contract monitoring is rare.

Health and Human Services Commission, Contract Administration Workgroup – To ensure that state funds are being expended in the most efficient and effective manner possible, much more consistency and standardization across agencies is needed.

> "Overall, there is a lack of central guidance or oversight of contract administration efforts, resulting in duplication of effort and a piecemeal approach on a statewide basis. Although multiple state agencies use the same contractor, agency regulations are inconsistent and there is no coordination or communication among agencies regarding the contractors' performance."

Source: Office of the State Auditor, Contract Administration at Selected Health and Human Services Agencies, February, 1996

The Legislature has attempted to improve agency contracting practices through riders contained in the General Appropriations Act. Beginning in September, 1996 each HHS agency's contracts were required to:

- include clearly defined goals, outputs, and measurable outcomes which directly relate to program objectives;
- contain clearly defined sanctions or penalties for noncompliance with contract terms and conditions; and
- specify the accounting, reporting, and auditing requirements applicable to funds received under the contract.

In addition, each HHS agency is required to implement a formal program using risk assessment methodology to monitor compliance with financial and performance requirements under the contract. The methodology should include a determination of whether performance objectives have been achieved, and contain a mechanism to evaluate program cost information to ensure that all costs, including administrative costs, are reasonable and necessary to achieving program objectives.

In the 1996 report, *Disturbing the Peace*, the Comptroller's Texas Performance Review recommended that all agencies with health and human services related programs adopt "best value" purchasing practices, and that HHSC oversee this process. Based on this report, the 75th Legislature, in 1997, adopted SB 1066, which outlines provisions regarding the purchasing of goods and services by health and human services agencies, other agencies with health related programs, and by public and private local providers, to maximize savings of state funds through procurement reform.

Factors to be Considered When Making Best Value Purchases

- Installation costs
- Delivery terms
- Quality and reliability of vendor's goods or services
- Extent to which goods or services meet agencies' needs
- Indicators of probable vendor performance under the contract, such as past vendor performance; performance responsibility
- Impact on the ability of the agency to comply with HUB requirements
- Total long-term cost
- Training costs
- Agency productivity
- Acquisition price

SB 1066 requires HHSC and the other agencies to document their consideration of all relevant factors in determining best value, including those listed in the text box, *Factors to be Considered When Making Best Value Purchases*. To oversee this process, the legislation requires HHSC to adopt rules and procedures for the acquisition of goods and services for all health and human services agencies that allow purchasing through a group purchasing program; coordinate the procurement practices of all health and human services agencies; and encourage those agencies to use efficient procurement practices. HHSC is authorized to transfer the procurement functions of an agency to another appropriate state agency if the transfer is determined to be advantageous to the State.

Although the Legislature's intent to improve agency purchasing through SB 1066 is clear, HHSC's authority under SB 1066 is limited

to coordinating HHS agencies' procurement practices and encouraging those agencies to use efficient procurement methods. HHSC has no direct enforcement authority over agency purchasing practices.

Another bill related to purchasing was passed by the Legislature in 1997, but vetoed by the Governor because it gave HHSC authority to set standards for the purchase of client services by agencies outside the HHSC umbrella such as the Texas Department of Criminal Justice and Texas Department of Housing and Community Affairs. SB 1240 would have required HHSC to coordinate and adopt rules to:

- describe various contracting arrangements and assist agencies in determining which arrangements are appropriate;
- clearly define contracting terms;
- list minimum contracting requirements and standard language for contracts;
- prescribe performance and outcome measures for contracts; and
- prescribe procedures for efficiently coordinating audits of contractors.

The bill also would have directed the Comptroller to assist HHSC in compiling information on purchases across HHS agencies by using data available on the Comptroller's uniform statewide accounting system.

The Sunset review focused on the authority of HHSC to improve agency purchasing and contracting practices and the changing role of the Commission resulting from recent legislation. Based on the findings of prior reviews and its own work, Sunset staff took as a given that improvements are needed.

> "The State Auditor's office has identified millions of dollars of questionable expenditures at the contractor level. While these questionable expenditures represented a small percentage of all audited costs, perhaps even within acceptable tolerance levels, they point to serious deficiencies in state contract administration practices. Such ineffective contract administration practices offer an opportunity to exploit the system at the expense of the state."

Source: Report of the Joint General Investigating Committee on State Contracting, October, 1996

Findings

▼ **HHS agencies continue to experience significant problems in procuring and administering contracts for client services.**

◗ Despite the attention focused on contracting problems at state agencies, the Sunset review found that most large HHS agencies continue to have problems with contract administration and monitoring. Many contracts do not contain outcome and output measures, even though the requirement that contracts contain such measures has been in law for three years. Some agencies do not use competitive or best value

> Most large HHS agencies have serious contracting problems.

procurement practices when buying services for clients, and other agencies fail to document how purchasing decisions are made. In large agencies such as the Texas Department of Health (TDH) and the Department of Human Services (DHS), contracting duties are fragmented among multiple divisions and regional offices.

- The Department of Human Services-Sunset staff found that DHS had not fully implemented performance contracting methods required by the Legislature and does not adequately monitor existing contracts with community care providers. As a result, DHS spent considerable resources to administer contracts rather than spending that time and money to provide direct care and client case management.

- Department of Health-Sunset found that the agency does not consistently use resources available for contract administration, such as HHSC, in developing Medicaid and non-Medicaid contracts, nor does TDH consistently use past contractor performance information in making procurement decisions. Staff noted that these oversights in contract development and contractor selection leave TDH at risk for contractor abuses and contribute to financial inaccuracies.

  In particular, poorly written contracts and delays in signing contracts have threatened the TDH's ability to obtain information about the quality of services delivered through the Medicaid managed care pilot programs. The Department of Health contracts with the Texas Health Care Quality Alliance (the Alliance) to assess the quality of Medicaid managed care services. Because contracts with the Alliance were not signed by TDH on a timely basis, scheduled surveys of client satisfaction could not be completed.

- Interagency Council on Early Childhood Intervention (ECI)- Sunset staff found that ECI's method of procuring services through grants does not comply with best value purchasing, does not create incentives for the effective delivery of services, and does not provide basic and essential control over contract expenditures. Although contractors were paid on a per child basis, ECI's method of setting its rates was undocumented. In addition, ECI's contracts do not contain client outcomes, as required in state law.

- Texas Rehabilitation Commission-Sunset staff found that TRC does not comply with statutory requirements related to best value procurement for services and did not effectively promote competition in its procurement process, as required in TRC's statute. Sunset staff also found that TRC does has not established a documented rate-setting methodology that ensures that amounts paid for medical services for its clients are rationally based, equitable, and clearly tied to the cost of providing services. As a result, the agency is not able to document that best value is a consideration in TRC's rate setting, as required by law.

◗ Another important area of contract compliance results from the requirements of the Americans with Disabilities Act (ADA). During the Sunset review, clients and client advocates emphasized that the facilities of contractors are sometimes inaccessible to people with disabilities. Although compliance with the ADA has been a contractual requirement for providers since at least 1994, inspection of contractor facilities, to the extent inspection occurs, does not appear to have resulted in ADA compliance. Sunset staff found that agency employees may not be fully aware of the details of the accessibility requirements of the ADA and may not be willing to impose sanctions on contractors, and create related operating costs, in a geographic area with limited service providers.

▼ **Few of the recommendations made to improve contracting practices have been implemented.**

◗ For the most part, the many good recommendations for system-wide contracting improvements developed in response to the findings of the State Auditor have not been implemented. Some HHS agencies, such as the Texas Commission on Alcohol and Drug Abuse, have been recognized by the State Auditor as making progress toward better contracting practices, but most agencies have not made significant contracting changes. In September, 1996, HHSC's Contract Administration Workgroup recommended an extensive list of almost 100 improvements that should be made to contracting practices. The Sunset review found that after two years, most of these recommendations have not been implemented. At present, no central entity other than the State Auditor monitors whether the recommendations made by oversight agencies and the

HHSC Contract Administration Workgroup have been implemented by the individual HHS agencies.

- The Sunset review found that HHS agencies pay different amounts to contractors, and often the same contractor, for the same services. Most contractors who provide services to the State accept Medicaid as a source of payment. Medicaid rates are significantly lower than the customary rates charged by providers to private pay clients. Several agencies, including the Interagency Council on Early Childhood Intervention, Texas Rehabilitation Commission, and the Department of Protective and Regulatory Services, pay contractors more than the Medicaid rate. While exceeding the Medicaid rate may be justified in some instances, no documentation of the need to pay more than Medicaid has been developed by these agencies.

▼ **The absence of consistent oversight systemwide improvement and contributes to duplication of effort.**

- The report of the Contract Administration Workgroup acknowledges that some of the Workgroup's recommendations, such as interagency coordination of contract monitoring and consolidated risk analysis, must be coordinated or directed by an overall lead agency. Because no lead agency has been designated, and no single agency has the authority to require changes in contracting practices across agencies, progress on these important recommendations has stalled. Consequently, multiple state agencies continue to waste resources monitoring the same contractors.

Conclusion

Serious problems with agency purchasing and contracting, beginning with problems at the Texas Commission on Alcohol and Drug Abuse but later found in almost all state HHS agencies, have caused the Legislature to seek improvements to agency contracting practices. The process that agencies follow to buy and monitor services for clients has been studied intensively. These studies have yielded over a hundred specific recommendations that would significantly improve the quality of services and the fiscal controls of state agencies. Very few of these recommendations have been implemented, primarily because no single agency possesses the authority to require HHS agencies to change their contracting practices or to consolidate contracting activities to create a more efficient statewide system of contract management.

Recommendation

Change in Statute

- **Require the Health and Human Services Commission, with the assistance of the state HHS agencies, to improve HHS agency purchasing and contracting by:**
  - **Establishing statewide contracting and procurement standards;**
  - **Developing uniform language and formats for common contract provisions to be used by all HHS agencies;**
  - **Developing a single contract management handbook that establishes consistent contracting policies and best practices to be followed by HHS agencies;**
  - **Developing a single statewide risk analysis of HHS contracts to prioritize contract monitoring activities, and coordinate contract monitoring efforts among HHS agencies; and**
  - **Developing a single contract management database, in cooperation with the Comptroller of Public Accounts, that identifies all HHS agency contracts.**
- **Require HHSC to review and approve the procurement and rate-setting processes of all HHS agencies to ensure that the amounts paid to contractors are consistent and represent best value for the State.**
- **Require HHSC to develop and implement a statewide plan to ensure that contractors and subcontractors are in compliance with the accessibility requirements of the Americans with Disabilities Act.**
- **Require HHSC to prepare, with the assistance of the State Auditor, a biennial report to the Legislature and the Governor that thoroughly and objectively assesses the performance of each HHS agency in complying with purchasing and contracting requirements established by the Commission and identifies any material risk to the State or to clients resulting from the agencies' contracting practices.**

These recommendations would establish HHSC as the single agency with responsibility for improving the contracting practices of HHS agencies and provide the Commission with the operational authority to correct ongoing agency practices that may be ineffective. To a large degree, the recommendations correspond to recommendations made by other oversight agencies, including the Joint General Investigating Committee on State Contracting. Because of the scope of agency contacting practices, implementation of systemwide contracting reforms could take considerable time, and HHSC should develop a plan to prioritize improvements.

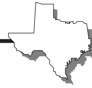
Fiscal Impact

These recommendations would require HHSC to develope contracting expertise. At present, the same contracting and purchasing tasks are performed by a large number of employees spread cross all HHS agencies. Potential consolidation of some purchasing and contracting tasks such as contract monitoring, legal support, record keeping and audit, in one agency could lead a reduction of staff or reassignment of staff to perform any new tasks required through these recommendations.

Improving purchasing and contract administration, including rate-setting, at HHS agencies should result in significant savings to the State and better services for clients. Even a small improvement in the $10 billion contracting system could yield significant savings, however, these savings cannot be estimated. HHSC should implement these changes with existing resources and assistance from the staff of the 11 health and human services agencies. Because the contracting system is, for the most part, invisible to clients, well planned administrative changes should not disrupt a client's services.

Issue 5

Improve Information Systems Planning and Management Across Health and Human Services Agencies.



Background

Currently, 11 state agencies provide most of the State's health and human services under the Health and Human Services Commission (HHSC) umbrella. To support service delivery, these agencies rely extensively on information systems to determine eligibility, calculate benefits, pay providers, generate reporting information, and share data between state, federal, and private entities. These information systems cost about $249 million per year to administer and maintain. The chart, *HHS Information Systems Expenditures*, shows information systems expenditures, employees, computer-related contracting, and year 2000 compliance costs for Texas health and human services agencies.

Texas will spend about $249 million on HHS information resources for fiscal year 1998.

All state agencies, including health and human services agencies, must submit plans for major information systems projects to the Department of Information Resources (DIR) for review to ensure these plans coincide with the State's overall strategic direction. This information resources strategic planning process helps agencies plan for long-term improvements in information systems, set performance priorities, and measure progress in achieving agency goals. Agencies must also prepare Biennial Operating Plans (BOPs) that detail information resources budgets. DIR and the Quality Assurance Team (QAT) use BOPs to evaluate projects and provide guidance to agencies. The text box, *State Technology Planning and Quality Assurance*, explains these plans and the QAT. While state agencies are responsible for quality assurance in their information resources projects, QAT provides oversight for high-profile projects that could be at-risk of failure. QAT oversight attempts to ensure that major information resources projects are completed on-time, on-budget, and with the promised functionality. To ensure the State is kept informed on the status of at-risk projects, QAT submits annual reports to the Legislature.

State Technology Planning and Quality Assurance

Information Resource Strategic Plan - State agencies develop a strategic plan for direction and development of information resources.

Biennial Operating Plan (BOP) - The BOP details how agencies plan to implement items in the information resources strategic plan. The plan must contain information on how information resources projects:

- impact the agency's ability to meet goals,
- change service delivery, and
- are determined cost-effective and appropriate.

Quality Assurance Team (QAT) - QAT consists of DIR and the State Auditor's Office, and is responsible for identifying and monitoring significant information resources projects in the State.

HHS Information Systems Expenditures Fiscal Year 1998						
Agency	MIS FTEs	MIS Salaries	MIS* Contracts	MIS* Contract Costs	Total MIS Costs FY 98 (Rounded)	Total Y2K Costs 1996 - 2001
Cancer Council	0	$0	1	$1,100	$19,000	$1,560
Children's Trust Fund of Texas	0	$0	1	$57,000	$149,000	$0
Commission on Alcohol and Drug Abuse	12	$455,905	5	$1,098,600	$2,322,000	$95,548
Commission for the Blind	21	$559,173	1	$264,780	$2,830,000	$120,648
Commission for the Deaf and Hard of Hearing	0	$0	0	$0	$154,000	$0
Department on Aging	3	$171,068	4	$12,985	$265,000	$70,627
Department of Health	362.3	$12,151,945	31	$37,331,138	$36,845,000	$11,202,000
Department of Human Services	515	$18,991,238	16	$31,748,111	$119,710,000	$91,215,373
Department of Mental Health and Mental Retardation	187.5	$6,927,500	20	$7,284,005	$26,395,000	$2,317,700
Department of Protective and Regulatory Services	109	$4,119,960	4	$8,249,113	$28,454,000	$314,731
Health Care Information Council	2.4	$119,000	6	$694,530	$922,000	$35,200
Health and Human Services Commission	14.5	$598,935	17	$5,338,550	$7,500,000	$206,437
Juvenile Probation Commission	3	$130,490	0	$0	$182,000	$90,384
Interagency Council on Early Childhood Intervention	2	$73,118	1	$18,000	$194,000	$8,300
Texas Rehabilitation Commission	76	$3,340,759	48	$3,522,933	$22,893,000	$85,000
TOTAL	**909**	**$47.6 M**	**155**	**$95.6 M**	**$248. 9 M**	**$105.7 M**

* These figures include both information technology consultant and service contracts.

Source: Texas Department of Information Resources, November 1998.

Central to the administration of some aspect of virtually every Texas HHS program is the Management Information Systems (MIS) division at the Department of Human Services. DHS has an executive level Information Resources Manager (IRM) who is responsible for MIS division operations, as is the case with other HHS agencies. This division supports critical functions for Temporary Assistance to Needy Families, Food Stamps, Medicaid, long-term care programs, and maintains the System for Application, Verification, Eligibility, Referral and Reporting (SAVERR). SAVERR contains data on six million Texans, processes $20 million in benefits and payments each day, and is the largest mainframe computer in the Southwest. SAVERR interacts and shares data with 58 other state, federal, and private organizations. DHS also shares responsibility with HHSC for

the development of the Texas Integrated Enrollment and Services project (TIES), which is to eventually replace 80 percent of SAVERR's functions.

In its review of health and human services agencies, Sunset staff focused on the ability of the state to improve planning, development, and management of information resources across agencies. Sunset looked at how agencies can increase purchasing power, standardize software needs, create uniform technical standards, share best practices, and help develop the skills of information systems staff. In addition, the review examined Texas Integrated Enrollment and Services project planning.

Findings

▼ **Information systems projects are at great risk of failing or exceeding their budgets.**

◗ Large information systems projects have a high probability of failure. In 1996, Standish Group International estimated that public and private technology projects of more than $10 million have success rates of zero, meaning they are delayed and over budget. Overall, 30 percent of government technology projects are total failures, and 52 percent exceed budgets, are delayed, and do not have the promised functionality.[1] The text box, *Problems Contributing to the Failure of Computer Systems*, provides more information on specific risk factors for information systems development.

Problems Contributing to the Failure of Computer Systems

Risk factors that can contribute to the failure of information systems include:

- inadequate development of systems specifications and functions;
- failure to fully anticipate project costs and complexity;
- expansion of scope that contributes to development problems;
- system size, particularly large undefined projects;
- lack of consistent leadership, or a project champion;
- lack of adequate skilled staff for project management, systems planning, and contract monitoring of information technology vendors; and
- lack of sufficient internal quality assurance procedures, such as risk assessment and project benchmarking.

▼ **Health and human services agencies have planned information resources development to meet the needs of each independent agency.**

◗ Generally, each health and human services agency plans for information resources independently. To support its goals and objectives, each individual agency has developed an information resource infrastructure tailored to best fulfill that agency's business needs. This silo effect has created multiple independent and sometimes duplicative automation initiatives that increase costs to the State. For example, all health and human services agencies need an integrated statewide administrative system to effectively manage the agency's human resources, payroll, budgeting, purchasing, and

Administrative Systems Interfaces

- Uniform Statewide Accounting System (USAS)
- Uniform Statewide Personnel System (USPS)
- General Services Commission (GSC)
- Surplus Property Asset System (SPA)
- Human Resources Management Information System (HRMIS)
- Financial Management Information System (FMIS)

The Year 2000 Problem (Y2K)

The year 2000 problem prevents computers from accurately calculating dates with years before 1900 and beyond 1999.

Because older computer chips had limited memory, dates have been recorded using only the last two digits of the year, such as "98" for 1998. Thus, when the year 2000 comes, the date will show "00."

Computers linking information to the date may pass incorrect dates to programs. Computers may fail, data will be lost, and many functions dependent on embedded chips, such as security systems, 911 communications, traffic lights, and elevators could be disabled. Y2K will affect all public and private computer systems that have not been reprogrammed.

Many state agencies use old computers with millions of lines of computer code that must be reprogrammed and tested. This process is expensive and time consuming. For example, DHS estimates it will spend $91.2 million to solve the agency's Y2K problem. For all the state health and human services agencies, Y2K costs could exceed $106 million.

accounting functions. HHS agencies have also duplicated efforts to interface with many administrative systems including those shown in the chart, *Administrative Systems Interfaces.*

◗ The Legislature appropriates funds for information resources projects on an individual agency basis. Agencies develop information systems projects to meet their own needs as they compete for funding. These circumstances contribute to a lack of consistency and cooperation among agencies even when planning information resources projects that affect statewide service delivery.

◗ Agencies are often hard pressed to implement new technologies that are outside the scope of their individual priorities due to staffing limitations and the need to implement program-specific mandates. Also, state agencies have limited ability to recruit and retain information technology staff who possess the skills to plan and develop information systems. For example, 50 percent of DHS's MIS staff have less than one year of experience. In addition, DHS has devoted 54 percent of staff work hours to just two initiatives, Year 2000 remediation and welfare reform requirements.[2] The problems posed by Year 2000 remediation are explained in the text box, *The Year 2000 Problem.*

▼ **The narrow focus of information systems development has resulted in projects that are under-used or not fully functional.**

◗ The lack of a single point of accountability for information systems planning over the entire health and human services enterprise contributes to development of information systems that are under-used by agencies. For example, several computer systems have been developed by state agencies, but not fully implemented due to expectations that TIES would include the functions of these systems.

Some systems are not fully used by agencies because HHSC does not have authority to mandate participation. Failure to implement systems that are already developed results in wasted resources and lost benefits for both agencies and their clients. Specific examples of computer systems that have not been fully implemented are shown in the chart, *Under-Used HHS Information Systems.*

- The lack of a single point of accountability for systems development has resulted in data exchange problems between agencies and difficulty in keeping pace with system updates. Data relating to the administration of large programs such as Medicaid, Temporary Assistance to Needy Families (TANF), and child support enforcement flow between several agencies, making systems compatibility and functionality critical to all agencies. For examples of HHS computer systems with data exchange problems, see the text box, *HHS Information Systems Problems Affecting Program Administration.*

The State lacks a single point of accountability for the planning and development of HHS information resources.

▼ **The largest public sector information systems project ever undertaken, Texas Integrated Enrollment and Services, is experiencing project development difficulties.**

	Under-Used HHS Information Systems
Texas Eligibility Screening System (TESS)	TESS was mandated by the Legislature as an attempt at one-stop shopping for HHS service delivery, and was planned to be available statewide in 3,600 sites, including 600 DHS offices, 500 TDH offices, and 400 other sites in 1994. TESS is a software system that screens clients for potential eligibility for a wide range of health and human services programs provided by 11 agencies. DHS estimated the five year total cost for 3,600 users of TESS to be about $2.8 million. Currently, 280 TDH providers use TESS for screening patients for medical related services. TESS is written at an eleventh grade level, requires minimal computer skills, can run on older computers and takes 10-15 minutes to screen a client. TESS has a 90 percent accuracy rate and saves clients effort in accessing services. DHS never fully implemented TESS statewide and it is currently not in use by DHS offices.[8] Currently only a few community providers are using TESS. As a result, an inexpensive and effective tool for client information and referral has not been in place for over four years. The State Auditor noted significant resources were expended on TESS, yet the system was not fully implemented due to development of TIES.[9]
Integrated Data Base Network (IDBN)	IDBN was mandated by the Legislature (House Bill 7) and developed by a contractor for HHSC. IDBN indexes data bases on health and human services clients. About 80 percent of the State's human services client population is indexed on the system, which provides a clients participation status in different programs. The project suffered from inadequate contract management, which resulted in DHS inheriting administration of the system and expending additional funds to populate the data base.[10] DHS manages the system at an annual cost of $185,000, and is the largest user of IDBN, searching for TDH immunization records on clients. TDMHMR, TDH, and TRC have access to IDBN, but do not use the system often. The State Auditor noted significant resources were expended on IDBN, yet the system was not fully implemented due to development of TIES.[11]
The Health and Human Services Consolidated Network (HHSCN)	HHSCN is administered by DHS. HHSCN is a telecommunications cooperative between state agencies and private enterprise that manages the statewide network for the HHS enterprise. Governed by a board of its constituents, HHSCN reduces operating costs and provides easier access to services by sharing wide and local area network resources and services. The network also has several private sector customers that generate additional revenue. While HHSCN has been generally successful, nothing requires state agencies to participate in the network to further lower costs to the State. HHSCN could improve the level of savings to the State by requiring state agencies to use the network and securing more private sector customers. Overall network cost avoidance for the state of Texas in the next five years of HHSCN operations may be more than $24 million.

	HHS Information Systems Problems Affecting Program Administration
The Medicaid ID Card	Currently, uniform access to accurate electronic Medicaid eligibility data is not available statewide to providers.[12] The current Medicaid ID card is costly, prone to loss, and does not meet the needs of the State, recipients, or providers. Information on the cards can be inaccurate, creating difficulties for clients to access Medicaid services and for providers to determine eligibility for services. Texas spends $7.4 million per year to issue the Medicaid ID card to recipients, of which $ 5.3 million is spent on postage and 30,000 cards per month are returned.[13] Efforts to use Electronic Benefits Transfer (EBT) technology to provide access to Medicaid benefits have been postponed due to the thought that TIES will address Medicaid ID card issues.
TANF Sanctions	DHS does not have management information from the SAVERR system to discover delays in TANF sanctioning and to address the impact of those delays.[14] DHS regions do not impose TANF sanctions in a consistent manner, and implementation processes between DHS, Texas Workforce Commission (TWC), and Office of the Attorney General (OAG) are an inconsistent mix of electronic, paper, and verbal notices and use of manual verifications.[15] In addition, DHS has the responsibility to administer sanctions, yet has no management information to know whether sanctions are working or being consistently applied. DHS processing of sanctions is made more difficult by the quality of information received from both TWC and OAG. Sanction processing can be delayed by TWC sending large batches of pending sanctions at one time that are time consuming to process.[16] While TWC has implemented a new computer system that can request DHS sanctions, the system is still new. DHS has also indicated that since August 1997, OAG had not provided appropriate computer tapes to sanction clients for failure to pay child support.[17] While the problem with OAG computer tapes has been corrected, it illustrates the State's vulnerability in administering programs when critical data must be shared across agencies.

- Since its inception, TIES has lacked stable leadership, has suffered planning setbacks, and still has no single point of accountability at DHS or HHSC. When TIES was proposed in 1995, DHS and the Texas Workforce Commission (TWC) were preparing to bid separately for the project, each with a private sector partner. As the scope of TIES changed, DHS and TWC abandoned these efforts, and were expected to cooperate as the key agencies involved in development and implementation. TIES was further disrupted by changes in executive level management at HHSC, prompting the Governor to request that DHS assume leadership for the project. Currently, HHSC has statutory authority for TIES and DHS has development responsibilities.

TIES will cost more than all other HHS agency information resources combined for fiscal year 1998.

- TIES will cost more than all other information resources expenditures for health and human services agencies combined for fiscal year 1998, but may not result in promised savings. The TIES cost-benefit analysis bases projected savings to the State primarily on reductions in DHS full-time staff. However, current DHS staffing levels used in the analysis are not adequate to support the projected savings of TIES. Current DHS staffing for TANF, Food Stamps, and Medicaid programs

is about 8,700.[3] TIES savings are based upon a DHS baseline staffing of 12,412 for these programs and a reduction of 3,466 FTEs.[4] Using these figures, TIES would actually require an increase of 246 FTEs over current DHS staffing if the projections are accurate. While information submitted to Sunset staff by DIR shows that TIES savings have been revised downwards, as of mid-November 1998, HHSC was not able to provide Sunset staff with a final cost-benefit analysis that was to be completed with the TIES Advanced Planning Document.

◗ The number of employees needed to support TIES is calculated on the basis of the amount of time it takes an employee to perform a specific task, such as processing a client application or taking a telephone inquiry. Sunset staff was unable to verify that the method used to calculate projected TIES staff was accurate. HHSC could not provide documentation showing how the estimated time to perform a task was determined. Although TIES has a statutory requirement to result in savings to the State, without verifiable methods for calculating work loads and staffing, the cost-benefit analysis of TIES may not be reliable.

Texas Integrated Enrollment and Services Project

Costs and Time Line

TIES is projected to cost about $277 million, with annual ongoing operational costs of about $56 million.* TIES will be phased in over five years, from 1999 to 2004. In each phase, more programs will be added and pilot projects will lead to statewide rollout.

Project Goals

Goal 1 – To improve client access and quality of services by:
- re-engineering the eligibility and service delivery business process,
- integrating services, and
- supporting client transition to the new process.

Goal 2 – To produce long-term savings by investing in the health, well being, and self-sufficiency of people to minimize or prevent future dependence on government and to achieve immediate cost savings by:
- streamlining services,
- implementing the appropriate technology to support the re-engineered business process,
- eliminating duplication of services, and
- streamlining the organizations.

Goal 3 – To promote personal responsibility and move clients from welfare to work by:
- improving education and work readiness through better access to preventive health, job placement, job search, and job training services; and
- coordinating child support, child care, employment services, and cash assistance eligibility determination.

Goal 4 – To continuously improve performance relative to defined standards for eligibility determination and service delivery.

* Department of Information Resources, November 1998.

◗ DHS could not provide Sunset staff with information regarding the implementation of short-term initiatives that could immediately benefit HHS agency operations and their clients while waiting for TIES roll-out. These 37 initiatives required through H.B. 2777, were identified in 1997 and include the expansion of call centers to receive information from clients, increased use of existing automated support, and reducing the production of Medicaid cards.[5] Also, DHS has lost the benefits of not implementing TESS since its development in 1994 due to expectations that TIES would provide this functionality.

The Legislature has consistently attempted to achieve greater oversight of information resources and development.

▼ The Legislature has expressed interest in greater oversight for all health and human services information systems projects.

- Over the last fifteen years, the State has passed legislation emphasizing the importance of greater planning and management oversight of the State's HHS information systems infrastructure. In 1991 the Legislature passed House Bill 7, which called for improvements in cross-agency communication and service delivery, including automated support for data sharing and data integration to minimize redundancy and duplication in information management.

- In 1995, the Legislature passed House Bill 1863, requiring HHSC to develop, with DIR, automation standards for computer systems to enable HHS agencies to share pertinent data. These efforts resulted in HHSC establishing information systems architecture to provide a framework for effective planning and integration of new products, technologies, and standards by the agencies under its jurisdiction.

- The Legislature has also directed HHSC to review and approve the eleven HHS agencies' automation plans before submittal to DIR. HHSC reviews and approves the automation plans based on compliance with:
  - health and human services architectural standards,
  - use of the Health and Human Services Consolidated Network,
  - sharing of information across agencies, and
  - opportunities for coordination and collaboration.

▼ A system-wide approach is needed to improve HHS information resources planning and management.

- Because HHSC has limited statutory authority over health and human services agencies, the State must rely on voluntary collaboration and coordination to improve information resources results between agencies. While Information Resource Managers from the health and human services agencies meet on a monthly basis to foster interagency coordination, improve data exchange, and share best practices,

these meetings alone can not be fully effective in overcoming barriers between agencies.

- Additional opportunities exist to increase productivity, reduce costs, and achieve other improvements through collaborative efforts. For example, HHS agencies have 155 information resources contracts costing $95.6 million for fiscal year 1998.[6] Outsourcing for information resources is increasing and agency staff must be prepared to meet the demands of outsourcing, which can involve complex statewide systems. Agencies should develop and share information resources outsourcing skills such as technical needs assessments, developing requests for proposals, improving negotiating skills, and contract monitoring.[7]

Increased outsource of information resources projects will place greater demands on agency contracting skills.

- The text box, *Benefits of Increased Information Resources Collaboration*, shows a wide range of improvements that can be realized by greater cross-agency collaboration and pooling of resources. HHSC has defined and established an information systems architecture framework to provide a strategy for effective planning and integration of new products, technologies, and standards by the HHS agencies. While the agencies support the concept of enterprise architecture, agencies have not implemented these standards.

Conclusion

Health and human services agencies currently plan and manage information resources projects in a decentralized environment where individual agencies pursue projects that meet individual program needs. Computer systems have high rates of failure and often come in late and over budget. Oversight of information resources projects is heavily dependent on internal agency quality assurance practices. Agencies do cooperate voluntarily for some purposes such as creating technical standards and sharing best practices, but increased opportunities for cooperation exist. The lack of a single point of accountability for enterprise-wide information systems and technologies contributes to a silo effect where computer systems are duplicated and experience data exchange problems.

Benefits of Increased Information Resources Collaboration

- Cooperative leasing of equipment
- Purchases of standardized software
- Standardized electronic mail
- Standardized financial software
- Leveraging funds for purchases
- Standard language for contracts
- Improved contract negotiations
- Improved contract monitoring
- Data center consolidation
- Data warehousing
- Shared I.R. staff training
- Improved I.R. staff skill sets
- Recruitment and retention of staff
- Joint development projects
- Improved risk analysis and mitigation
- Improved co-location capacities

Texas is undertaking the largest public information systems project ever developed, TIES, without clear accountability for the success of the project. Also, Sunset staff was unable to verify the cost savings

purportedly generated by TIES. Expectations that TIES will be a "silver-bullet" solution to the State's information resources needs has resulted in missed opportunities to make immediate improvements in HHS service delivery. While the Legislature has expressed an interest in greater oversight of information systems projects, health and human services agencies need a system-wide approach to information systems and a single point of accountability.

Recommendation

Change in Statute

- **Designate the Health and Human Services Commission as the authority responsible for strategic planning and oversight of information resources projects of all HHS agencies.**
- **The Commission should be responsible for establishing the strategic direction for information resources across all health and human services agencies. To support improved development of information resources, responsibilities of HHSC should include:**
  - **developing a coordinated HHS information resources strategic plan;**
  - **setting information resources priorities;**
  - **establishing and ensuring compliance with policies, procedures, and technical standards; and**
  - **reviewing and approving the Information Resources and Biennial Operating Plans of agencies under the authority of HHSC.**

The recommended HHS strategic information resources plan should address the following objectives:

- information resources management for the next five years,
- defining goals and objectives for information resources management,
- prioritization of information resources projects and technologies,
- integration of HHS program and strategic planning,
- establishing information resources standards for interoperability and security, and
- leveraging state information resources purchasing.

HHSC should establish an advisory committee composed of state agency and private sector information resources managers and HHS agency Executive Directors to advise HHSC in the following areas:

- establishing overall enterprise goals and objectives;
- coordination of agency information systems plans;
- developing strategies for implementing standards;
- developing migration strategies for architecture integration;
- developing strategies for staff training, skill set development, and recruitment and retention policies;
- developing information resources outsourcing standards and skill sets;
- maximizing the use of installed technologies;
- developing cost recovery mechanisms and performance levels;
- assessment of agencies' information resources management; and
- assessment of current and future information resources management technologies and practices and potential applications to state government.

The advisory committee should also advise HHSC with regard to information technology functions to increase productivity, reduce costs, and achieve other improvements through collaborative efforts. The focus should be on information technology functions that are not tied to support a specific agency function, including, but not limited to:

- cooperative leasing of equipment,
- data center consolidation,
- network operations,
- technical support functions (help desk, call centers),
- data warehouses,
- administrative applications (human resources, accounting, purchasing),
- purchases of standard software,
- joint training efforts,
- recruitment and retention of staff, and
- video conferencing.

The role of the Department of Information Resources and the QAT would not change. This recommendation would improve HHS information resources project development, and the ability of agencies to effectively comply with DIR planning requirements such as the BOP. In addition, improved information resources planning would help reduce risk factors that necessitate bringing these projects under QAT oversight.

- **Require HHSC to assume responsibility for the planning, development, and implementation of the Texas Integrated Enrollment and Services project.**

This recommendation would ensure that the TIES project has a single point of accountability and oversight for management of the project. Clarifying this accountability, in conjunction with the other recommendations in this issue, will help ensure TIES planning, development, and implementation are successful. Critical tasks relating to TIES planning and development include:

- streamlining program rules;
- project management and development quality assurance;
- developing compatible technical standards;
- outsourcing project tasks; and
- close communication between agencies, vendors, and the Legislature

Fiscal Impact

The recommendations would result in savings to the State from improved coordination of information systems development, pooling purchasing power, and implementing currently available technologies. The Commission would be able to implement the recommendation within the agency's existing resources. Because the recommendation is broad, and impacts many agencies, exact savings could not be estimated.

[1] Ellen Perlman, "Technotrouble," *Governing*, September 1998, p. 22.

[2] Department of Human Services, *Automation Overview*, February 1998, p. 28.

[3] Department of Human Services, *Client Self-Support Staffing*, August 1998.

[4] Health and Human Services Commission, *TIES Volumetric Model Workbook* (Metrics.xls), August 1998, p. 21.

[5] Health and Human Services Commission, *TIES Immediate Improvements Report*, December 1997, p. I-3.

[6] Department of Information Resources, Information provided to Sunset Advisory Commission, November 10, 1998.

[7] Outsourcing in Government Options for Strategic Success, Conference held November 10, 1998.

[8] Department of Health, *Current TESS Users*, Data Sheet. January 1998.

[9] Office of the State Auditor, *A Combined Report on the Health and Human Services Commission*, September, 1997, p. 17.

[10] Interviews with DHS Management Information Systems staff, Austin, Texas. November, 10, 1997.

[11] Office of the State Auditor, *A Combined Report on the Health and Human Services Commission*, September, 1997, p. 17.

[12] Department of Health, *Medical Identification Card Needs Assessment,* January 1998, p. 5.

[13] Department of Health, *White Paper on Future State Medicaid ID for Medicaid*, Undated.

[14] Ibid.

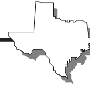
[15] Sunset staff visits to DHS offices, January-April, 1998.

[16] Ibid.

[17] Letter from Eric Bost executive director of DHS, to Dan Morales Texas Attorney General, June 12, 1998.

Issue 6

Strengthen HHSC's Operational Control Over the Medicaid Managed Care System and Require the Health Care Information Council to Assess the System's Performance.



Background

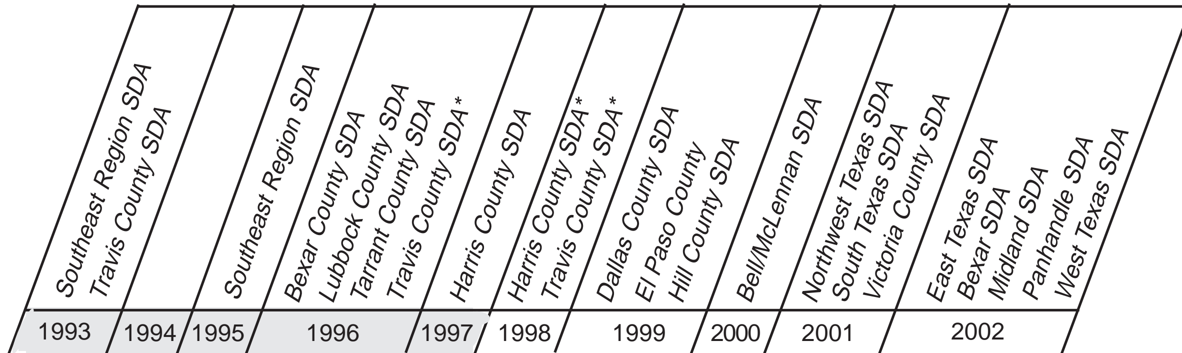
The Medicaid program in Texas serves nearly two million low-income residents, primarily women and children. From 1967 to 1993, Texas operated only a fee-for-service Medicaid system for clients and providers. Beginning in 1991, the Legislature directed the Health and Human Services Commission (HHSC) to develop a managed care program for Texas' Medicaid population. In doing so, the Legislature instructed HHSC to achieve the goals shown in the text box, *Medicaid Managed Care Goals: Senate Bill 10*.[1]

Medicaid Managed Care Goals: Senate Bill 10

- Emphasize preventive health care,
- Promote continuity of care,
- Ensure high quality care,
- Provide a medical home for Medicaid clients,
- Achieve a cost savings for the State, and
- Expand Medicaid eligibility with the savings.

Senate Bill 10 directed HHSC to establish Medicaid pilot projects to test the cost-effectiveness of a managed care system of health care delivery. As a result, in 1993 the STAR project (State of Texas Access Reform), the State's first Medicaid managed care pilot, was implemented in Travis County, and included 38,000 Medicaid clients. A second pilot program was implemented later that year in the Gulf Coast area and included an additional 40,000 members. Then, in 1995, the Legislature made further changes to the Medicaid health care delivery system and directed HHSC to expand the existing managed care sites across the state. The *Managed Care Conversion Schedule* shows the timing of the conversion to managed care throughout the state.

Medicaid Managed Care Conversion Schedule by Service Delivery Area (SDA)



- Shaded portion of time line indicates SDA where Medicaid managed care has been implemented
- SDAs include multiple contiguous counties

* Expansion to surrounding counties

Medicaid managed care pilots have expanded to include seven service delivery areas, which include some cities and some whole counties, and approximately 430,000 clients, or approximately 26 percent of Texas' Medicaid population. Service delivery areas include the Southeast region (the Gulf coast area of Jefferson, Chambers, and Galveston counties), and Travis, Bexar, Lubbock, Tarrant, Travis, and Harris Counties. The next regions to be served by Medicaid managed care are the Dallas County and the El Paso service delivery areas, increasing the total number of enrollees to approximately 578,000. The Dallas and El Paso pilots are expected to begin in 1999.

In addition to the STAR project, which primarily serves acute care clients, such as pregnant women and children, the State also has two specialty managed care pilots. In March of 1998, HHSC, together with the Texas Department of Health (TDH) and the Department of Human Services (DHS), initiated the STAR+Plus pilot project in Harris County. This project serves approximately 52,000 clients, referred to as dually eligible, who are eligible for Medicaid and Medicare, and who need long-term care services, such as nursing home care or community based care. The other specialty pilot project, NorthSTAR, is scheduled to be included in the Dallas service delivery area and is a collaborative effort between HHSC, the Texas Department of Mental Health and Mental Retardation (TDMHMR), and the Texas Commission on Alcohol and Drug Abuse (TCADA) to serve the behavioral health care needs of Medicaid clients.

Medicaid Managed Care Models

HMO Model: Texas contracts with privately and publicly formed HMOs to provide health care for clients. The State negotiates with the HMOs to provide a package of services for a set monthly rate, called a capitated rate, per client. Capitated rates are based on fee-for-service claim costs, discounted by the anticipated savings from managed care.

PCCM Model: Primary care providers contract with the State for a fee-for-service reimbursement plus a $3 per client per month fee for case management. Primary care providers, such as family practice physicians or obstetricians, coordinate the care of clients by caring for all basic health care needs and making referrals for specialty care.

Texas uses two managed care models to deliver services to the State's Medicaid clients, the Health Maintenance Organization (HMO) and Primary Care Case Management (PCCM) models, described in the text box, *Medicaid Managed Care Models*. The State contracts with 11 HMOs and self-administers the PCCM model to deliver managed care services.

In addition to standard requirements set by the Texas Department of Insurance, HMOs serving the State's Medicaid population must meet requirements designed specifically for the needs of the Medicaid population. For example, HMOs contracting to care for Medicaid clients must subcontract with community health care providers who demonstrate a tradition of serving Medicaid clients. In addition, HMOs must arrange for the delivery of services from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program and develop education and needs assessment programs that meet the specific needs of Medicaid clients.

The State's contracts with HMOs contain requirements that attempt to ensure that Medicaid managed care clients receive quality services. Medicaid managed care HMOs are required to develop an internal quality improvement program to evaluate the care of clients according to specific disease categories and special risk status. HMOs must ensure that network providers meet certain clinical care standards or practice guidelines, such as those established by national professional medical associations for the care of children or pregnant women. Plans are also required to conduct focus studies that evaluate health care outcomes for certain categories of clients who need prenatal care, behavioral health care, or routine children's checkups.

Because Texas is still in the development phase of the Medicaid managed care system and the Legislature has expressed interest in the success of this new system, Sunset staff focused on ways HHSC could determine whether managed care is meeting the Legislature's original goals.

Findings

▼ **State-implemented managed care presents new challenges for clients, providers, and state agencies.**

Challenges for Clients

◗ While managed care offers benefits previously unavailable to low-income Texans under a fee-for-service model, such as routine checkups and other preventive care, managed care also creates change that may be difficult for some clients. For example, some Medicaid clients are accustomed to using the emergency room for routine health care. In the managed care system, clients are required to choose a primary care physician (PCP) who will coordinate all of the client's care.

Medicaid clients do not understand how the system operates.

A study conducted by the Texas A&M, Public Policy Research Institute, in June 1998, found that Medicaid managed care clients "lack [an] awareness about how the [managed care] enrollment process operates. Many Medicaid recipients fail to realize that they must select both a plan and a PCP." Further, when clients are recertified for Medicaid, and then must re-enroll in Medicaid managed care, "many [clients] still fail to properly respond." As a result, "the system often default assigns Medicaid recipients to new plans and PCPs."[2]

The habits and experiences of Medicaid clients, combined with the added complexity of managed care, create difficulties in evaluating the performance of managed care providers, especially when performance is judged by client satisfaction. In a 1997 client satisfaction survey, clients reported that they found the Medicaid managed care system more confusing than traditional Medicaid.[3]

Challenges for Providers

- One of the basic tenets of managed care is that of prevention. Medicaid managed care clients are offered annual visits to a PCP who provides preventive care in addition to coordinating all of the clients' care. The success of preventive care is dependent on education and periodic checkups aimed at either preventing disease from occurring or keeping a condition under control once it has occurred.

Medicaid clients are only eligible for services for approximately 5.6 months at a time.

Short-term participation in Medicaid limits the opportunity for prevention. The income of Medicaid clients frequently fluctuates, causing clients to "cycle" in and out of Medicaid. As a result, the average Medicaid client is only eligible for Medicaid for 5.6 months at a time.[4] Clients who are not continuously eligible to receive Medicaid services do not receive the continuity of care needed to deliver effective preventive care, and HMOs and the State do not receive the savings resulting from prevention.

- Further, as a group, Medicaid clients have different, often more complex health care needs and conditions than those found among traditional private-pay managed care clients. Because of factors including family history and poor diet, Medicaid clients are often at greater risk of developing diseases such as diabetes and high blood pressure. The special health care needs of Medicaid clients must be taken into account when HMOs select health care providers for their networks, educate their providers, and develop educational and preventive programs for the clients.

- Medicaid managed care presents further challenges for health care providers because the State is examining the quality of health care for its clients in a way never considered under the fee-for-service system. Providers are expected to include more preventive services and education for clients, and their

decisions about health care are scrutinized more than ever as the State seeks to hold HMOs accountable for client health outcomes that reflect the effectiveness of preventive care.

Managed care also presents administrative challenges for providers. For example, TDH is having difficulty ensuring that accurate information about client eligibility and plan enrollment is available. Documents, such as clients' plan enrollment cards and Medicaid cards, and primary care provider enrollment lists, often do not contain accurate eligibility information leading providers to furnish care for clients not enrolled in that provider's practice. This results in delayed payments to providers, and sometimes reduced payment for serving out of network clients.[5,6,7]

Accurate data about client eligibility is not always available for providers.

Challenges for State Agencies

- Managed care requires state agencies to develop new administrative skills. Working with HMOs requires more expertise in negotiating contracts and contractor oversight than a fee-for-service system in which the State works directly with providers.

  Perhaps most important, managed care brings about the need to monitor quality of care. In the fee-for-service system of payment for health care, health care providers are paid for each service provided. As a result, providers are inclined to deliver more care because of the payment structure. However, in the managed care system, since payment rates are capitated, an incentive exists to provide less care to save money. Because of this difference in fee-for-service and managed care, purchasers of managed care services feel compelled to increase the monitoring of the quality of health care.

Managed care requires the State to develop contract negotiation and oversight skills.

- The federal government requires states that use Medicaid managed care to attempt to ensure the quality of services. Federal regulations require states to conduct an annual review of the quality of services furnished by each HMO.[8] Texas contracts with a quality monitor, Texas Health Quality Alliance (THQA), to examine the quality of managed care services.

  While managed care organizations have gained some experience in recent years in examining health outcomes, no

Texas is charting new territory in developing performance benchmarks for Medicaid health outcomes.

standard structure or processes exist to assess and monitor the quality of care for Medicaid clients. Organizations, such as the National Committee for Quality Assurance and the Joint Commission for the Accreditation of Healthcare Organizations, are working to develop measures that adequately reflect Medicaid patient outcomes, and are publishing guidelines for states to use in evaluating managed care quality based on the same criteria used in private sector managed care. However, states implementing managed care for their Medicaid clients are charting new territory in establishing performance benchmarks for Medicaid health outcomes.

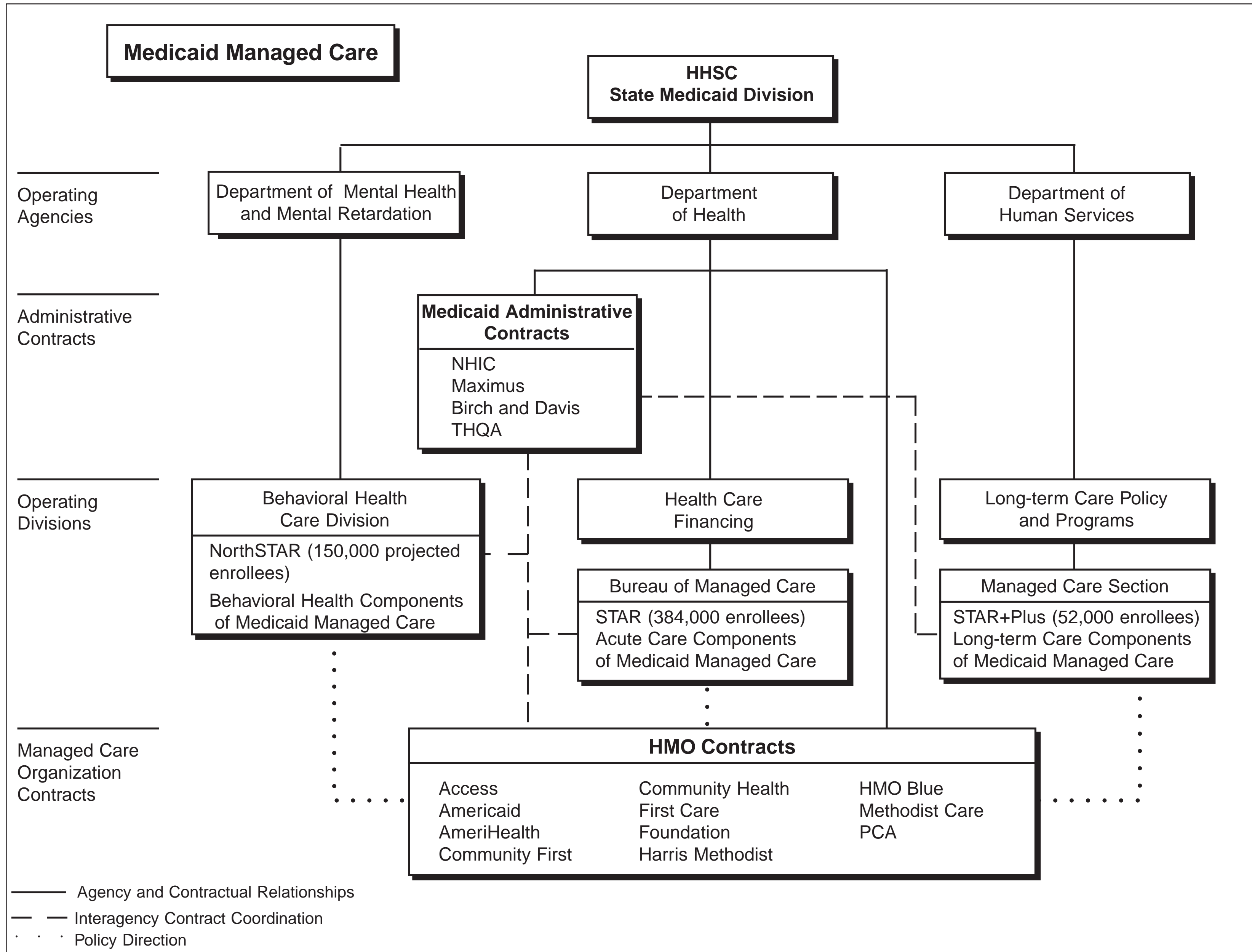
▼ **The State has created a complex system of operating agencies and contractors to administer the Medicaid managed care program.**

- In 1995, the Legislature directed HHSC to "develop a health care delivery system that restructures the delivery of health care services provided under the state Medicaid program."[9] In establishing this directive, the Legislature has held HHSC accountable for the overall development and oversight of the design and implementation of the Medicaid managed care system. However, because of the magnitude of this initiative, HHSC has relied heavily on the Medicaid operating agencies to assist in the design and implementation of Medicaid managed care.

- The system of delivering Medicaid managed care is extremely complex, as shown in the chart, *Medicaid Managed Care,* on the following page. The Medicaid managed care system is made up of four state agencies and more than 15 contractors. While HHSC is ultimately accountable for the Medicaid program, it is removed from the day-to-day operations of the program. Instead, operations of the Medicaid managed care program occur primarily at three health and human services agencies, TDH, TDMHMR, and DHS.

The Medicaid managed care system uses four state agencies and more than 15 contractors.

TDH administers the acute care portion of Medicaid managed care, called the STAR program. In addition, TDH develops, procures, administers, and oversees the contracts with the HMOs as well as the four administrative contracts. DHS develops policy for the long-term care portions of the managed care program, which includes clients in the STAR program


Medicaid Managed Care
HHSC
State Medicaid Division
Operating Agencies
Department of Mental Health and Mental Retardation
Department of Health
Department of Human Services
Administrative Contracts
Medicaid Administrative Contracts
NHIC
Maximus
Birch and Davis
THQA
Operating Divisions
Behavioral Health Care Division
NorthSTAR (150,000 projected enrollees)
Behavioral Health Components of Medicaid Managed Care
Health Care Financing
Bureau of Managed Care
STAR (384,000 enrollees)
Acute Care Components of Medicaid Managed Care
Long-term Care Policy and Programs
Managed Care Section
STAR+Plus (52,000 enrollees)
Long-term Care Components of Medicaid Managed Care
Managed Care Organization Contracts
HMO Contracts
Access
Americaid
AmeriHealth
Community First
Community Health
First Care
Foundation
Harris Methodist
HMO Blue
Methodist Care
PCA
Agency and Contractual Relationships
Interagency Contract Coordination
Policy Direction

and the STAR+Plus pilot in Harris County. The long-term care components of Medicaid managed care include care for children with special health care needs and clients who are eligible for Medicaid and Medicare. Care for such clients can include nursing home care and community-based care, in addition to medical treatment and prescriptions. TDMHMR develops policy for the behavioral health aspects of the program, which include clients enrolled in the STAR program who need behavioral health care, and the upcoming NorthSTAR pilot.

Medicaid Administrative Contracts

Contractor	Function	FY 97 Contract Payments
National Heritage Insurance Company	provider outreach, provider enrollment, claims processing, managed care assistance	$80 million
Maximus	enrolls client in PCCM or the HMO of choice	$13.5 million
Birch & Davis	PCCM provider network development	$10 million
Texas Quality Health Alliance (TQHA)	ensures that HMOs provide quality care to Medicaid clients by auditing client records	$6.5 million
	Total	$110 million

The Medicaid managed care system depends on numerous contractors for the administration of the Medicaid managed care program. As shown in the chart, *Medicaid Administrative Contracts,* the State spends approximately $110 million for various administrative duties associated with Medicaid managed care. TDH also has contracts with 12 HMOs that form networks of health care providers to deliver health care services to the Medicaid managed care clients. The HMOs provide a variety of services, including behavioral health and long-term care services.

▼ **The State has had difficulty implementing Medicaid managed care and developing adequate information to assess its effectiveness.**

TDH develops, procures, and oversees all Medicaid managed care contracts.

◗ Medicaid operating agencies have experienced a number of problems in implementing Medicaid managed care. Because the implementation of managed care requires skills not fully developed by the health and human services agencies, problems with contract administration have resulted. One such problem arises from the fact that TDH develops, procures, and oversees the contracts for services. This arrangement causes problems because the contracts direct long-term care and behavioral health service expectations of the contractors, and the expertise of the Department of Health lies with acute care services.

Advocacy groups and other stakeholders told Sunset staff that weaknesses exist in the areas of behavioral health and long-term care in terms of contractor performance. For example, clients who are dually eligible for STAR and STAR+Plus services cannot ask any one agency questions about their benefits. Clients may need multiple services that are paid for by both the STAR and STAR+Plus program. However, clients cannot always determine through which program they should receive the services, or which operating agency could best address their needs.

Medicaid clients cannot always determine which agency can best meet their needs.

- One of the most significant barriers to the analysis of the effectiveness of managed care for the Medicaid population relates to data collection and reporting. Accurate data collection and analysis is necessary for the State to assess whether the contractors, managed care organizations, and health care providers, are delivering the best possible services to clients, and to examine changes in the needs of the population Medicaid serves. To date, the State has been unable to obtain much useful information from existing Medicaid managed care data.

Numerous complex and technical reasons cause difficulties in collecting valid managed care client encounter data. Problems relate to the State's design of the data collection and analysis system, and the direction given to the contractor. Private HMOs that contract with the State have developed systems for collecting and reporting that are not always compatible with state-developed systems for data collection. This results in long delays in translating reported data into useful information. TDH, the agency charged with collecting and analyzing encounter data, is working to correct these problems, but has had difficulty reporting on the changes in client outcomes associated with managed care.

The State has not seen much useful information from Medicaid managed care data.

In part, problems in reporting information about the effectiveness of Medicaid managed care relate to the State's decision to collect data every time a Medicaid recipient encounters the Medicaid managed care system. The magnitude of this task has led to incomplete data sets and variations in reporting by managed care organizations. Like many states that are implementing managed care, Texas is having difficulty collecting and analyzing, and thus reporting, useful information about client health outcomes from the encounter data.

The State's business partnership with contractors inhibits the independent assessment of Medicaid managed care.

- HHSC, the Medicaid operating agencies, HMOs, and the administrative contractors act as business partners in the State's Medicaid managed care system. Through this partnership, each entity is inextricably interdependent, thus preventing the independent assessment of any entity by the other. The nature of the interdependence between the quality monitor contractor and the Medicaid operating agencies has inhibited the independent assessment of Medicaid managed care success.

▼ **HHSC has been unable to oversee implementation of Medicaid managed care and evaluate whether it is meeting the objectives established by the Legislature.**

- The statutory objectives of Medicaid managed care are to:
  - emphasize preventive health care,
  - promote continuity of care,
  - ensure high quality care,
  - provide a medical home for Medicaid clients,
  - achieve a cost savings for the State, and
  - expand Medicaid eligibility with the savings.

  In addition, the Legislature directed HHSC to develop a Medicaid managed care system that includes methods for ensuring accountability. These methods include financial reporting; quality assurance; utilization review; and a single point of accountability for collection of uniform data, assessment of client health outcomes, cost efficiency, and analysis of alternative health care delivery systems.[10]

HHSC has not taken a leadership role in Medicaid managed care quality assessment or contract administration.

- As the state agency responsible for the Medicaid program in Texas, HHSC is specifically charged with redesigning the State's Medicaid service delivery system. HHSC has the authority to require an agency that delivers Medicaid services (an operating agency) to adopt rules related to the Medicaid program, and may delegate the authority to perform Medicaid functions to an operating agency. However, as discussed previously in this report, the Commissioner does not have direct control over the health and human service agencies' operations and is limited in effecting change. This has contributed to HHSC not taking a leadership role in resolving data collection and reporting requirements, or in developing and helping to manage the contracts between the state operating agencies, the HMOs, and the quality monitor, THQA.

- After five years, the Commission is still not able to report to the Legislature on the effectiveness of managed care in meeting the requirements established by the Legislature. Both quality and cost are essential to determining the overall value of managed care for Texas' Medicaid population. To date, HHSC has not reported on a comparison of the cost of the managed care delivery system to the fee-for-service system, or improvements in the quality of care for clients. Until HHSC assesses the quality of services purchased by the State, and especially the effectiveness of prevention, the Legislature will not be able to determine the long-term cost-effectiveness of the pilots.

HHSC must assess Medicaid managed care quality to determine its long-term cost-effectiveness.

- Several factors have prevented HHSC from being able to evaluate the quality of managed care, including a significant delay in TDH's procuring and signing the quality monitor contract with THQA. Because the contract was not procured until December 1997, the analysis of quality of care is just now beginning, even though the State began implementing managed care in different cities across the state in 1993. Further, before the quality monitor contractor could begin concurrent quality assessment, TDH requested that a retrospective study be conducted to evaluate the performance of the HMOs to date. This study has taken THQA the better part of its first year of operation to complete, releasing its results in October 1998.

- At present, little evidence exists that the State can effectively improve the quality of Medicaid managed care, particularly when faced with the challenge of meeting the complex health care needs of Medicaid clients. Efforts to measure and improve the quality of care are founded on assumptions that reliable, valid data can be collected to assess the quality of care, that analysis will show how quality can be improved, and that the work of physicians can be directed to achieve higher quality care. The chart, *Texas' Experience in Assessing the Quality of Managed Care*, on the following page, describes the ways the State assesses the quality of care delivered by its HMOs and the outcomes of those assessments. These efforts have not provided information on which to base changes in implementing the managed care system.

Assessing the quality of Medicaid managed care is a difficult task.

Texas' Experience in Assessing the Quality of Managed Care		
Assesment Tool	**Assessment Tasks**	**Texas' Experience**
Focus Studies	Analysis of clients with similar social or health care needs aimed toward improving health care outcomes for the specific population.	Texas found that HMOs have not yet conducted studies that would allow HHSC to examine factors related to the quality of care for target populations.
Client Satisfaction	Surveys of Medicaid managed care clients.	Texas has conducted two surveys in five years, using different methodologies, and concluded that clients were happier and viewed their plans very positively.
Encounter Data Analysis/ Validation	Analysis of client encounters with health care providers based on standard criteria such as Health Plan Employer Data and Information Set (HEDIS) created by the National Committee for Quality Assurance.	Texas' first attempt to analyze Texas' Medicaid managed care encounter data was unsuccessful because of problems with data collection definitions and assumptions. To date, an analysis of the data has not been completed.
Managed Care Organization (MCO) On-site Surveys	Each MCO assesses the structure and process used to guide health service delivery.	On-site surveys are conducted for all plans. Surveys determine if the components of managed care are in place, but do not assess effectiveness.

▼ **The State currently has no independent, objective source of information regarding the overall performance of the Medicaid managed care system.**

- In reviewing the Medicaid managed care system, Sunset staff found it difficult to identify the cause of a system problem and determine what organization should solve the problem. The interconnected business relationships among the many organizations that make up the Medicaid managed care system are complex, and both problems and solutions often cut across the entire system. For example, problems with inaccurate encounter data may begin in a doctor's office, but directly impact record keeping and the accuracy of reports, the ability to assess the quality of care, the payment history of a provider, and the provider training requirements contained in the contract between the state agency and the HMO.

The Department of Health, Department of Human Services, and Department of Mental Health and Mental Retardation are all involved in contracting for services, quality monitoring, and interacting with HMOs. Objective information is essential for HHSC to be able to make policy decisions that would change the way Medicaid managed care services are delivered, but the interdependence of agencies in the system leads to finger-pointing and a lack of accountability for addressing complex problems. Consequently, the Legislature is not likely to see objective information on the effectiveness of Medicaid managed care.

The Legislature needs objective information about Medicaid managed care to make policy decisions.

◗ In considering ways to provide objective assessment of the Medicaid managed care system, Sunset staff looked for other health and human services agency statutes that focus on data collection and analysis, experience with quality of care reporting, and recommendations for improvements to health care systems.

In 1995, the Legislature created the Health Care Information Council (HCIC) to provide a wide range of health care information gathering, assessment, and reporting. The text box, *Role of the Health Care Information Council*, details the Council's charges.

Role of the Health Care Information Council

The Council is charged with developing;

"A statewide health care data collection system to collect health care charges, utilization data, provider quality data, and outcome data to facilitate the promotion and accessibility of cost-effective, good quality health care."

The Legislature directed the Council to:

- direct the collection, dissemination, and analysis of data;
- contract with the Texas Department of Health to collect data from health care providers;
- avoid duplication of other data collection;
- review public health data collection programs and recommend consolidation;
- determine a format for health care providers to submit data;
- develop and implement a methodology to collect and disseminate data reflecting provider quality;
- assure that data collected is made available and accessible; and
- educate the public regarding the interpretation and understanding of:
  - information that is made available,
  - charges and rates of change in charges for health care services,
  - recommendations concerning required legislation,
  - quality and effectiveness of health care, and
  - access to health care for all Texans.

Source: Chapter 108 of the Texas Health and Safety Code

Members of the Health Care Information Council

The Council is composed of 19 members, made up of 15 gubernatorial appointees and four voting, ex officio members.

Governor's Appointees Represent:

- the business community (3)
- labor (2)
- consumers (2)
- hospitals (2)
- health maintenance organizations (1)
- practicing physicians (3)
- health care research and planning (2)

Ex Officio Members:

- Commissioner of Health
- Commissioner of Health and Human Services
- Commissioner of Insurance
- Public Insurance Counsel

Advisory Committees to the Council

- Quality Methods and Consumer Education Peer Review
- Medical Education and Research Costs
- Health Maintenance Organizations
- Health Information Systems

- As shown in the text box, *Members of the Health Care Information Council*, the HCIC board has broad representation from the business community, hospitals, physicians, consumers, and state officials involved in managed care service delivery and regulation. HCIC board members are involved in the analysis of managed care systems and are familiar with the kinds of information necessary to assess Medicaid managed care as well as the processes and industry standards that guide health care information management.

- The Sunset review concluded that HCIC has effectively collected and reported information about the performance of managed care programs. HCIC collects a broad range of data on health care benefits, fees, quality of care, and patient satisfaction, and it uses the data to create publications that describe HMO performance. Each HCIC report covers HMOs that operate in a specific region in Texas. For example, the HCIC Booklet on South Texas compares the performance of HMOs in a 47-county region. Performance measures shown in the text box, *HCIC Performance Measures for HMOs*, compare how a particular HMO stacks up against others in the region.

HCIC Performance Measures for HMOS

- Provider Turnover
- Accreditation Status
- Percentage of Board Certified Physicians
- Percentage of Breast Cancer Screenings
- Percentage of Cervical Cancer Screenings
- Prenatal Care in the First Trimester
- Well Child Check-ups in the First Fifteen Months
- Eye Exams for People With Diabetes

Source: HCIC Quality Check-up

HCIC has experience in reporting on managed care quality.

- Because of the current role of the Council, expansion of the scope of HCIC to include the evaluation of Medicaid managed care would be consistent with the agency's current mandate. This would provide HHSC with an objective source of information about the Medicaid managed care system in Texas, including the performance of state agencies, contractors, and HMOs.

Conclusion

Implementation of Medicaid managed care requires a change in the way state agencies, physicians, clients, and HMOs operate within the Medicaid system. Quality of care is difficult to measure, and Medicaid clients offer more challenges than private-pay clients. The current climate of complex partnerships between HHSC, the state agencies that administer Medicaid, the entities that provide services, and the contracted quality monitor decrease the likelihood that the Legislature will see objective information on the effectiveness of Medicaid managed care. HHSC, although designated as the state Medicaid agency, is not equipped with tools to effectively lead the State's efforts in this critical area of health and human services.

Recommendation

Change in Statute

- **Strengthen HHSC's authority over Medicaid by providing it clear authority over the Medicaid activities of all HHS agencies, including related contracts.**

This recommendation would increase HHSC's direct involvement in the operations of the Medicaid program. As the agency responsible for Medicaid managed care, HHSC should be held accountable for all components of the service delivery system. To be accountable, HHSC should be given clear authority to plan and direct the operations of the Medicaid program in each state agency. This authority is consistent with the expanded operational authority over all health and human service agencies recommended in Issue 2 of this report. In particular, HHSC should be responsible for the development, procurement, management, and oversight of all Medicaid managed care contracts to ensure that contract provisions are consistent with the needs of the various populations who receive Medicaid services.

- **Require the Health Care Information Council, with the advice of HHSC, to examine the success of Medicaid managed care based on the criteria established by the Legislature, including:**
  - **conducting an in-depth analysis of the success of the Medicaid managed care system;**
  - **determining the long-range needs for Medicaid managed care;**
  - **identifying critical problems in the Medicaid managed care system and recommending strategies to solve those problems;**

- **assessing the cost-effectiveness of the Medicaid managed care system compared to the fee-for-service system, taking improvements to quality of care into consideration in the comparison; and**
- **advising and assisting the Legislature in developing plans, programs, and proposed legislation for improving effectiveness of the Medicaid managed care system.**

■ **Require the Council to develop a plan to accomplish these tasks in conjunction with HHSC, the presiding officer of each standing committee of the Senate and House of Representatives having primary jurisdiction over HHSC, and the Medicaid operating agencies.**

■ **Require the Council to periodically report to HHSC and the Legislature on the continuing progress of the Medicaid managed care program.**

■ **Transfer the responsibility for providing administrative support to the Council from TDH to HHSC.**

This recommendation would require transferring the Health Care Information Council from TDH to HHSC to provide the Council some independence from the operating agencies. This change in structure would place HMO quality oversight in the agency charged by the Legislature with the accountability for Texas health and human services, including Medicaid.

The Council should report to HHSC and the Legislature biennially detailing the performance of the Medicaid managed care system, including the operating agencies' actions needed to improve the quality of services delivered to Medicaid managed care clients. HHSC would then use information reported by HCIC to reevaluate policy goals for Medicaid managed care. Once the objectives and policies have been refined, HHSC would be able to strengthen contracts with HMOs to encourage them to deliver improved quality services for clients.

Further, the Council's scope could be expanded to include evaluation of other areas of health and human services to fulfill a role in which the Legislature has expressed interest. During the 74th Legislative Session, the Legislature considered a bill that would have formed a Health and Human Services Policy Council. This bill was created out of the desire by the Legislature to obtain objective and valid information about the success of health and human services in Texas. While Medicaid is only a part of the whole health and human services enterprise, it represents almost half of the State's expenditures for these services.

Fiscal Impact

This recommendation will have a fiscal impact on the State. The Council will need additional staff and resources to accomplish its expanded mission. HHSC, with added responsibility to support the Council, should provide the funding required. Using current budget transfer authority, HHSC should require each Medicaid operating agency to share supporting the Council's funding needs on a pro rata basis.

[1] Tex. Govt. Code ch. 532, sec. 532.102 (Vernon 1997).

[2] Texas A&M Public Policy Research Institute and University of Texas Center for Social Work Research, "Texas' Medicaid Managed Care Waiver Study: A Final Analytical Report," College Station, Texas, June 1998, p. 7-2.

[3] ESI, *STAR Health Plan Client Satisfaction Survey Report*, Austin, Texas, April 1997, Revised May 6, 1997.

[4] Interview by Sunset staff with Josie Williams, M.D., Medical Director, THQA, Austin, Texas, October 22, 1998.

[5] Interview by Sunset staff with Bureau of Managed Care staff, Texas Department of Health, Austin, Texas, November 1998.

[6] Interview by Sunset staff with Texas Medical Association staff, Austin, Texas, November 1998.

[7] Interview by Sunset staff with Agape Clinic staff, Dallas, Texas, March 1998.

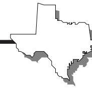
[8] Health Care Financing Administration, *A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States*, (July 1994), Ch. 4.

[9] Tex. Govt. Code ch. 532, sec. 532.101 (Vernon 1997).

[10] Tex. Govt. Code ch. 532, sec. 532.102 (Vernon 1997).

Issue 7

Improve the Regional Management of Health and Human Services Agencies.



Background

Texas health and human services (HHS) agencies operate from almost 1,300 different sites across the state. Agencies generally have a headquarters office in Austin and a series of field offices located throughout the state. HHS agencies' field offices are often organized into geographic regions. To standardize the regional activities of HHS agencies, the Health and Human Services Commission (HHSC) has established 11 standard geographic regions. For example, the Department of Human Services (DHS) uses the 11 standardized regions, and assigns a regional office to coordinate and oversee the activities of all the field offices in that region.

The chart, *HHS Regional Structure*, describes each agency's regional structure and shows the number of field offices and the number of employees located in the central office and the regions. While the central offices generally perform administrative and oversight functions, most agency activities take place in the regions. Regional services often involve eligibility determination, inspection of facilities, direct service delivery such as counseling with clients, investigating allegations of abuse or neglect, and the planning and management of purchased services.

Texas health and human services agencies operate from almost 1,300 sites across the state.

Maintaining regional offices requires a complex array of support services, including telecommunications services, information technology planning and support, record retention systems, facility leasing and management, purchase and distribution of capital equipment and supplies, warehousing, document and forms production, and mail services.

Although most regional offices need the same support services, state agencies have developed their administrative services systems independently. In 1997, a Health and Human Services Steering Committee was formed to identify opportunities for HHS agencies to coordinate and cooperate more effectively in the delivery of administrative services. The Committee is comprised of representatives from each of the HHS agencies and meets periodically to review activities in the areas of automation support, co-location, human resources, internal audit, video conferencing, and records management.

Health and Human Services Regional Structure		
Agency	**Regional Structure**	**Employees**
DHS	593 Regional and Field Offices	Central Office - 2,732 Regional and Field Offices - 13,723
PRS	268 Regional and Field Offices	Central Office - 513 Regional and Field Offices - 6,077
TRC	1 Disability Determination Services Office 142 Regional and Field Offices	Central Office - 375 Disability Determination Services - 847 Regional and Field Offices - 1,508
TCB	39 Regional and Field Offices	Central Office - 256 Regional and Field Offices - 342
TDMHMR	*38 Community Centers** 10 State Operated Community Services 22 State Facilities	Central Office - 738 State Operated Community Services - 5,279 State Facilities - 21,654
TDH	8 Regional Offices *66 Local Health Departments**	Central Office - 2,886 Regional Offices - 2,246
TJPC	*168 Local Probation Departments**	Central Office - 49
TDoA	*38 Area Agencies on Aging**	Central Office - 33
TCDHH	23 *Councils**	Central Office - 9
TCADA	8 Field Offices	Central Office - 205 Field Office - 27
ECI	71 *Local Contractors**	Central Office - 66

* locally-operated entities, not state employees

Sunset staff examined the regional structure of the HHS agencies and efforts to consolidate both service delivery and operational functions across agencies. In particular, staff looked at the Health and Human Services Commission's efforts to fulfill the House Bill 7 requirement to facilitate and enforce coordinated planning and delivery of health and human services, including the co-location of services. Finally, staff looked for other opportunities to integrate and streamline agency operations.

Findings

▼ **Co-location of state agency offices can enhance the delivery of health and human services and create management efficiencies.**

◗ House Bill 7 charged the Commission with facilitating and enforcing the coordinated planning and delivery of health and human services, including co-location of services, integrated intake, and coordinated referral and case management. Co-location can serve dual purposes of improving access to

services and reducing agency costs. First, locating agencies together, or creating a point of one-stop shopping, can minimize the time and effort clients must spend looking for and getting to services. Second, co-location can reduce administrative costs by allowing agencies to consolidate operational support. Agencies can share common spaces such as break rooms and conference rooms, share services such as janitorial and copy machine repair, and coordinate equipment and supply purchases.

The Brown-Heatly Building in Austin provides a good example of the benefits of co-location. Ten agencies are located in the building and the Texas Rehabilitation Commission (TRC) provides support services, such as security, janitorial, and parking services, to all the agencies. TRC also provides human resource and purchasing services to HHSC. In addition, the agencies share common spaces such as conference and meeting rooms.

HHSC is charged with improving access to services through co-location.

▼ **HHSC has made little progress in co-locating agencies.**

◗ In 1991, HHSC was charged with improving local access to services and with enforcing the coordinated delivery of services through the co-location of services. In 1995, the Legislature required that as leases expire on office space, the Commission should determine the needs for space and the location of health and human services agencies to achieve a cost-effective, one-stop or service center method of service delivery. At present, about one-half of the HHS sites are co-located in the same building with another HHS agency. A significant number of co-located sites involve DHS and the Department of Protective and Regulatory Services, which were once together as a single agency. The chart, *Health and Human Services Agency Location*, shows the total number of agency sites and the number of sites that are co-located.

Health and Human Services Agency Location

Agency	Total Sites	Co-Located Sites*	Percent Co-Located
DHS	591	227	38%
TDMHMR**	93	20	22%
PRS	263	192	73%
TCADA	4	1	25%
TCB	33	20	61%
TDH	153	104	68%
TRC	159	121	76%
TOTAL	**1,296**	**685**	**53%**

Source: HHSC Location Database
* Only includes sites co-located with other HHS agencies
** Only includes State Operated Community Services.

Many HHS agency leases are processed as an emergency, thus bypassing HHSC's review.

- To facilitate co-location, the Commission reviews and approves lease requests for all health and human services agencies. When an agency needs a new lease, it must submit to the Commission a co-location worksheet that assesses both its spatial and programmatic needs. Based on the information submitted, the Commission approves or denies the lease request. The Commission must approve the request before the General Services Commission (GSC) can proceed in securing the lease.

  However, GSC can process emergency leases without the approval of the Commission. An emergency lease is needed when GSC does not have enough time to go through a full bid process to find the best lease option. Although GSC notifies agencies 18 months in advance that their lease is expiring to allow time to go through a complete bid process for a new lease, some agencies do not seek new space in time. The percentage of HHS leases processed as emergency leases varies from month to month, but can be as much as 50 percent.[1] Because emergency leases exempt agencies from having to comply with co-location efforts, HHSC does not have full control over co-location efforts.

- The Commission's location database only tracks whether agencies are physically located together. The Commission does not monitor whether the agencies share space, services, or equipment. Consequently, HHSC cannot assess whether co-location efforts have increased administrative efficiencies.

- The Health and Human Services Steering Committee established a workgroup to address co-location issues. The workgroup drafted a set of facility management guidelines to be considered when preparing for co-location. The guidelines address areas such as shared equipment, supplies, resources, and space. The text box, *Potential Shared Equipment and Services in Co-Located Facilities*, gives examples of items that agencies can cooperate and consolidate around. The guidelines, however, only suggest that such activities should be discussed, they are not requirements. No designated authority monitors whether agencies are going beyond simply locating in the same building. Sharing services depends on the willingness of individual agencies.

Potential Shared Equipment and Services in Co-Located Facilities

- Copy machines and faxes
- Telephone services and maintenance
- Security systems and services
- Common area furniture and furnishings
- Utilities
- Janitorial services
- Building environmental systems
- Recycling services
- Additional parking
- Mail services
- Building receptionist
- Switchboard operator
- Lease/facility management services
- Automation support services

▼ Opportunities to improve client access to contracted services are limited.

◗ The potential to consolidate services in one location to improve client access is frequently outside the control of the State. Most health and human services delivered to the public, with the exception of determining eligibility for services, are delivered by local agencies that contract with the State. In almost all cases, providers who contract with the State have a long history of serving a community. State payments may be a small part of the contractor's income, so state agencies may have no financial leverage to direct where a contractor locates an office. Although the location of a provider's office should be considered in the provider selection process, requiring the provider to move to a new, co-located site will create costs that will most likely be passed on to the State.

No mechanism exists to plan and direct cooperative efforts to reduce costs and improve operations.

▼ Additional opportunities exist for HHSC to improve regional management.

◗ Even though the HHS agencies have voluntarily studied ways to improve some regional support functions, no mechanism exists to plan and direct cooperative efforts to reduce costs and improve operations. For example, the Purchasing Workgroup of the Health and Human Services Steering Committee recommended adopting a standard, automated purchasing system, but concluded that implementing a purchasing system required a central authority to analyze systems, plan the implementation, direct agencies to comply, make consolidated appropriations requests, and serve as a single point of accountability. Similarly, the Training Workgroup of the Steering Committee, identified the potential to improve cross-agency training and evaluation through means such as video conferencing and automation, but pointed to the need for a central authority to guide the implementation of shared training.

◗ All agencies are required to retain vital state records. The Texas State Library and Archives Commission (TSLAC) stores records for state agency offices located in Austin. Regional offices, however, are "on their own" when it comes to maintaining records and must come up with their own storage system. Members of a cross-agency workgroup identified the

lack of a unified central system for "hard-copy" records, similar to the system provided by TSLAC in Austin, to allow coordination of records retention in the regions.

- The 75th Legislature recognized the importance of developing a policy to manage state records in digital, electronic format, and charged the Department of Information Resources (DIR) with recommending policies to retain electronic records. DIR has stated that an operational electronic directory of government information and services should be established. State agencies are to be responsible for maintaining the information content.

Storing and Retrieving Electronic Records

In the early 1940s, the proliferation of paper created a need for more and more file cabinets. Texas government is in the same situation now with electronic records. More and larger storage units are purchased to handle data that may or may not have any business value. The implementation of sound electronic records management practices can result in a number of benefits for government: reduced costs for storage of obsolete records, reduced resources for the retrieval of records required for business activity, greater accountability of the expenditure of government funds, and better access to public information.

Source: Texas Department of Information Resources, Biennial Report

Although the local offices of all HHS agencies generate electronic records, no consolidated, cross-agency planning is underway to develop consistent and efficient records management practices. The increasing need for record retention strategies is pointed out in the text box, *Storing and Retrieving Electronic Records.* Opportunities to address electronic record retention needs of multiple HHS agencies in a geographic region, or even statewide, by purchasing services from a private vendor have not been explored. Consequently, each agency must create its own plan for maintaining electronic records and develop "migration" strategies that ensure that critical records are accessible when hardware and software change. As with hard-copy records, agency local offices are usually "on their own" when storing electronic records, and may not be aware of the types of data that must be retained as a record and the most cost effective way to do so.

HHSC provides no plan for cross-agency assessment and consolidation of specific business and support services.

- The need to store supplies, forms, and equipment can create a significant cost for HHS agencies. As with other administrative functions, HHSC has not assessed the opportunity to consolidate warehouse functions among state agencies. The Department of Protective and Regulatory Services (PRS) has developed an efficient method of purchasing and delivering supplies that reduces warehousing costs. PRS has a contract for the purchase and delivery of supplies with OfficeMax. Each month, PRS field offices send their supply order to the central PRS office, which places one order with OfficeMax. OfficeMax then delivers the supplies to each field location. This arrangement reduces both the administrative burden on field office and headquarters staff

and the cost of warehousing supplies. Other state HHS agencies could join PRS in the same or a similar consolidated contract and potentially reduce both the need for warehouse space and the time required to process multiple purchase orders.

- **Regional business planning could organize and track agency initiatives to reduce the costs of HHS services.**

  - Opportunities to consolidate support functions vary considerably across the 11 HHS regions and depend, to some degree, on population density and the long-term lease commitment already made by agencies. HHSC's biennial coordinated strategic plan addresses, generally, some business functions, but provides no plan for a cross-agency assessment and consolidation of specific business and support services.

    Most large state agencies have begun the practice of developing an annual business plan that describes agency needs, sets priorities and key tasks, and establishes deadlines and performance objectives for the agency as a whole and for agency managers. Development of a regional business plan that identifies cost saving improvements across HHS agencies would complement HHSC's statewide planning efforts, as well as the statewide plans of HHS agencies. A regional HHS business plan would provide a tool for ensuring accountability and measuring agency participation and success in improving its business practices at the level where most of an agency's activities take place.

A regional business plan that identified cost saving improvements across HHS agencies would complement HHSC's statewide efforts.

Conclusion

Co-location as a tool to improve the access to health and human services is limited because most services are delivered by contractors who may not choose to co-locate. Despite this fact, HHS agencies still have a number of ways they could achieve efficiencies at the local level. More agencies are physically located together than in the past. However, many agencies still insist on maintaining separate operations, so cost savings through the sharing of space, services, or equipment are not being achieved. The Sunset review and state agency staff have identified a number of significant opportunities to increase regional management efficiencies, but no central authority exists to plan and prioritize these efforts, compel participation in cross-agency consolidation, guide implementation, and track agency initiatives in this area.

Recommendation

Change in Statute

- **Specify that HHSC has clear authority to require HHS agencies to co-locate and consolidate support services.**
- **Require HHSC to assess the potential benefits and costs of consolidating support services across HHS agencies in both regional offices and in Austin, and develop a plan and schedule for co-locating offices and consolidating support services where clear benefits have been identified.**
- **HHSC should report the results of its assessment and its proposed plan of action to the Legislature, the Governor, and appropriate oversight agencies by September 1, 2000.**
- **Charge HHSC with the development and implementation of a annual business services plan for each HHS region that establishes business performance objectives across HHS agencies and measures agency efficiency and success in achieving those objectives.**

This recommendation would establish HHSC as the central authority for ensuring that regional management practices are streamlined and cost efficient. The Commission should assess current management practices to identify potential opportunities for improvement. The work already done by the Health and Human Services Steering Committee can serve as a starting point for this assessment. The Committee has identified functional areas where standard practices or systems can be adopted. However, a central authority is needed to guide development and implementation. The Commission should serve as this authority and develop a schedule for co-locating offices and standardizing and consolidating regional management operations.

Management Action

- **HHSC, with the advice of the General Services Commission, should:**
  - **establish criteria for granting emergency leases that ensure that the emergency was outside of the control of the agency and reasonably unforeseen, and**
  - **establish and enforce guidelines concerning shared space and facility management in co-located spaces.**

The Commission should work with the General Services Commission (GSC) to establish criteria to minimize the necessity for emergency leases. Limiting the ease with which an agency can get an emergency lease should prompt agencies to begin planning well in advance to fully explore opportunities for co-location and allow GSC adequate time to go through

the bid process. The Commission should plan for future lease expiration by establishing a standard leasing schedule for all agencies, and explore all opportunities for co-location when agencies are looking for new space or acquiring a new lease. In addition, the Commission should work with GSC to establish and enforce guidelines concerning shared space and facility management functions in co-located spaces. These rules should ensure agencies are minimizing duplicative activities.

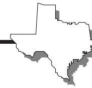
Fiscal Impact

Most of the 55,000 state employees who work for health and human services agencies are located in offices outside of Austin. Texas spends hundreds of millions of dollars each year to provide support services to those employees. This recommendation is anticipated to reduce the cost of supporting field office employees by consolidating multiple, fragmented support services into one business system. Because business services are fragmented among HHS agencies, no information is available to estimate the costs of providing support services. Models of consolidated support services are common in the private sector and should provide an objective basis for assessing the financial benefit of consolidation, once the costs of the current system are established. Sunset staff estimate that savings of consolidated business functions could be very significant, although no estimate could be made, and should more than pay for all costs associated with this recommendation and all the other recommendations contained in this report.

[1] Office of the State Auditor, *A Combined Report on the Health and Human Services Commission*, report no. 98-001 (Austin, Tex., September 1997), p. 34.

Issue 8

Improve Access to Information About Health and Human Services in Texas.



Background

State and local governments provide a wide variety of health and human services through contracts with public and private agencies. Gaining access to information about the services available in a community is often difficult and confusing. As the mother of a medically fragile child wrote in a letter to the Sunset Commission, clients "don't know where to go for services and don't know what the rules are." Recognizing this difficulty, policymakers have emphasized the importance of creating a "single door" to integrated services.

Gaining access to information about community services is often difficult and confusing.

Recent efforts to integrate service delivery began in 1991, when HHSC was assigned the responsibility of co-locating state agency offices. Although co-location has yielded some success in consolidating information, the Sunset review found that obtaining information about the full range of community services is very difficult. Many health and human services are provided by contractors whose name may not reveal the actual services provided. Even health and human services professionals are often not aware of the range of services available in their own communities. Sunset staff found that some state agency employees did not know of the existence of other state agencies in their community that serve the same clients. In addition, some local service providers in Dallas were unaware that the Department of Human Services has not provided Child Protective Services since 1992.

In 1997, to address the need for information about local services, the Legislature formally established the Texas Information and Referral Network (I&R Network) at HHSC. The I&R Network is charged with developing, coordinating, and implementing a statewide health and human services information and referral network that integrates existing community-based information structures with state and local agencies. The I&R Network is a public-private partnership that intends to provide the infrastructure necessary to connect I&R providers, service providers, and consumers. An I&R task force was also established to implement the statewide information and referral system and to coordinate the development of state and local I&R databases.

The task force consists of representatives from the State's health and human services agencies, the Texas Alliance of Information and Referral Services, the United Way, and public and private community-based organizations involved in providing information and referral for health and human services.

The I&R Network provides information through Community Information Centers (CICs). CICs are selected by the local community to serve as the single organization to coordinate information and referral services in that area. CICs are operated by a variety of public and private entities including local state agency offices and community-based nonprofit organizations. CICs maintain health and human resource information in their area and are involved in local networking and collaborative efforts among service providers.

Staff and volunteers at CICs provide information about services for food, clothing, housing, child and youth services, job placement assistance, education, recreation, and support groups. The I&R Network has designated CICs in 140 counties, serving over 90 percent of the state's population. Statewide, CICs receive over one million calls per year.

The I&R Network is Responsible for:	The RMICC is Responsible for:
• providing access to information on health and human services based on service descriptions, • developing a comprehensive classification of health and human service descriptions, • providing information about services, including food, clothing, and housing, through local Community Information Centers, • producing a directory of information and referral providers in Texas, and • producing a reference guide on available state health and human services programs.	• developing a classification of all state agency programs and telephone numbers by subject matter and agency, • cooperating with the General Services Commission to ensure that the subject matter listings of programs and telephone numbers in the telephone directories are consistent with the categorization, • reviewing the activities of each member agency that affect the State's management of records, • studying other records management issues, and • reporting its findings and recommended legislation to the Governor and the Legislature.

The I&R Network produces *Finding Help in Texas: A Directory of Information and Referral Providers*. The most recent edition includes 535 profiles of organizations that provide information and referral services in Texas. This directory is the only comprehensive directory of information and referral providers in Texas. The I&R Network also produces a reference guide on available state health and human services programs. Additionally, the I&R Network is charged with providing access to information based on service descriptions. HHSC, with the assistance of an advisory committee, has developed a common classification of service definitions and descriptions to be used in organizing information about health and human services.

In 1997, the Legislature also established the Records Management Interagency Coordinating Council (RMICC). RMICC is composed of the Secretary of State, the State Auditor, the Comptroller, the Attorney General, the Director and Librarian of the State Library and Archives

Commission, the Executive Director of the General Services Commission, and the Executive Director of the Department of Information Resources.

RMICC is responsible for reviewing state records management activities, coordinating the State's record management activities and making other improvements in the State's management of records. RMICC is required to categorize all state agency programs and telephone numbers by subject matter as well as by agency. State agencies provide the council with the necessary information. The General Services Commission is required to ensure that the subject matter listings of programs and telephone numbers in the telephone directories are consistent with the categorization developed by RMICC.

The Sunset review examined the roles of the I&R Network and RMICC, and sought to identify ways for HHSC to improve consumer access to health and human services information.

Findings

Health and human services are not defined or categorized consistently.

▼ **Texas has no single entity responsible for defining and categorizing its health and human services.**

- The I&R Network at HHSC is required to provide access to information about health and human services in Texas based on service descriptions. HHSC staff, with the assistance of an advisory committee, has developed a comprehensive classification of health and human service descriptions to be used in organizing information about services.

- RMICC is required to develop a statewide subject-matter index for organizing state information, including all state agency programs and state public services. RMICC is required to categorize state agencies and their programs by subject matter in coordination with the affected state agencies.

- Currently, the work of the I&R Network and RMICC are not coordinated to ensure that the health and human services descriptions and the subject matter listings are consistent. Failing to coordinate will result in the I&R Network and RMICC developing different definitions or subject matter listings for the same health and human services, creating confusion for consumers.

▼ Information on where to go to receive health and human services is not consistently organized and is generally not contained in local telephone directories.

Most people rely on the telephone directory for information on where to purchase goods and services.

- As "customers" of state programs, health and human services clients should have easy access to information about these services. Most people rely on the telephone directory for information about where to purchase goods and services. Many local telephone directories do not contain a systematic description of the health and human services available in the community or the names of the providers of the services.

- Recent legislation requires RMICC to create a standard way of classifying and organizing information to show the public where to go to get information about all state agency programs and services, including health and human services. A description of the subject matter of state agency programs must be shown in telephone directories by state agency name. However, because many state services are provided by independent contracted service providers, information about state agency programs and services may not help clients find a local service provider.

The I&R Network has no plan to include its HHS classification system in telephone directories.

- At present, the I&R Network is working to categorize local information about health and human services and coordinate access to that information. The I&R network is creating a health and human services classification system that would organize information about state and local health and human services. However, the I&R Network has no plan to have telephone directories use the classification system to list, by type of service, the providers of local and state health and human services. This system should be reflected in the way the State lists such services in telephone directories to improve customer access.

- The I&R Network has developed an Internet site to provide information to the public regarding the health and human services provided by public or private entities throughout the state. Information is geographically indexed to inform consumers about the health and human services provided in the area where they live. Although electronic access to information and referral services is important, most consumers do not have access to the Internet.

▼ Information on transportation services is difficult to obtain in Texas and may not be available through the I&R Network.

Transportation is essential to access health and human services.

- Transportation is among the most frequently cited barriers to service delivery for health and human services clients in Texas. Without transportation, clients are unable to access services for which they are eligible. Transportation is a problem primarily for those who do not own a personal automobile, or are unable to drive for other reasons, and thus considered "transportation disadvantaged." This can include people with a mental or physical disability, the elderly, and low-income individuals. In 1997, approximately 6 million adult Texans, or 31 percent of the population, qualified as transportation disadvantaged. This figure is expected to grow to 9.5 million by 2020.

- The Office of Community Transportation Services (OCTS) at HHSC is statutorily responsible for data collection, statewide planning and evaluation, and coordination regarding transportation services. OCTS works to address community transportation issues such as coordinating state agency transportation resources, developing a coordinated response to transportation needs, and maximizing available transportation funding.

- Both OCTS's 1994 Report to the Commissioner of Health and Human Services and a 1995 report by John Doolittle and Associates, et al. for the Texas Department of Transportation identified the lack of information about available client transportation services as a major barrier to accessing needed transportation.

Client transportation information is not a required part of the I&R Network.

- The majority of OCTS's efforts have focused on planning, data collection, and providing information about access to transportation services to consumers. However, OCTS and the I&R Network have not engaged in formal coordinated planning efforts. Although OCTS and the I&R Network have informal discussions and exchange some information, client transportation information is not a required part of the I&R Network.

Conclusion

Access to necessary state services, especially health and human services, has been a concern of the State for many years. Separate initiatives to improve consumer access to information and services may not adequately and practically help clients find the service providers in their communities. The State needs to ensure that information about important health and human services is effectively organized and available throughout the state, that information about all necessary services, including transportation services and other contracted services, are included, and that this information is easily accessible through the local telephone directory.

Recommendation

Change in Statute

- **Require the Texas Information and Referral Network and the Records Management Interagency Coordinating Council to:**
  - **establish a single, consistent method of defining and organizing information about health and human services for public access; and**
  - **ensure that information about health and human services is consistently organized and clearly presented in telephone directories across the state.**

The I&R Network and RMICC have each been working to improve access to information. Although these efforts have resulted in many improvements, these entities need to work together to develop a single, consistent method of defining and organizing health and human services information. Instead of having different definitions and descriptions for services, service definitions should be consistent throughout the state, to reduce confusion for consumers as well as providers. This information should be clearly presented in telephone directories throughout the state by December 2000 to ease customer access.

- **Require the Texas Information and Referral Network to include information regarding transportation services in the I&R Network.**

Transportation services are an integral part of the health and human services system in Texas. Without transportation services, consumers are often unable to access necessary health and human services. The I&R Network is designed to improve access to health and human services by improving consumer access to information throughout the state, which should include transportation services. The I&R Network should coordinate with OCTS to develop the transportation access information to be included.

Fiscal Impact

These recommendations will not result in a fiscal impact to the State. The entities involved can accomplish these initiatives with existing resources.

Health and Human Services Commission

Transfer Functions from the Health and Human Services Commission that are Inconsistent With Its Mission.

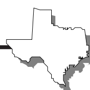
This section of the report contains material that recommends the transfer of some functions currently performed by the Health and Human Services Commission to other agencies. Implementation of these recommendations would group like functions in organizational settings that will facilitate central policy direction and enhance the program operations.

Issue 9. Promote the Development of a Statewide Guardianship System by Integrating Guardianship Services and Strengthening the Role of the Guardianship Advisory Board.

Issue 10. Improve the State's Management of Empowerment Zone/Enterprise Community Funds.

Issue 9

Promote a Statewide Guardianship System by Integrating Services and Strengthening the Role of the Guardianship Advisory Board.



Background

Guardianship is a protective service that attempts to ensure the well-being of individuals who are alone and cannot manage their personal or business affairs. Guardians are court-appointed surrogate decision makers who protect incapacitated persons from neglect and exploitation. People in need of guardians include the elderly, persons with mental illness or mental retardation, and persons impaired by accidents or illness. Both statutory probate judges and county court-at-law judges are responsible for appointing guardians. Because courts consider the mental or physical limitations of an individual when appointing a guardian, guardians may be appointed with full authority or the court may limit the guardian's role to only those areas necessary to protect and assist the individual. A limited guardianship allows the incapacitated person to make personal and financial decisions commensurate with the person's ability.

Guardianship services are provided through state and local programs.

The Texas court system currently monitors approximately 47,200 guardianships. Family members or other interested persons usually assume the role of guardian. In 1997, 5,147 guardianships were filed in Texas and, in 4,255 of the cases, a family member or other interested person served as the guardian. When a family member or interested person is not willing or able to act as a guardian, judges may appoint a guardian from a local guardianship program or may appoint a state agency as guardian. Guardianship services are provided through state and local programs. Of the 254 counties in Texas, 28 have local guardianship or money management programs serving a total of approximately 2,500 clients.[1] Individuals who serve as guardians often do so on a voluntary basis.

Types of Guardianships

Guardian of the person	A guardian that makes personal decisions only, such as housing and medical care.
Guardian of the estate	A guardian that makes financial decisions only.
Guardian of the person	A guardian that makes both personal and the estate and financial decisions.

The Department of Protective and Regulatory Services (PRS) is the state agency that provides the most guardianship services. When no other individual or entity is available to serve as guardian, specialized Adult

Protective Services (APS) staff at PRS are required to provide guardianships for elderly persons, adults with disabilities, and children aging out of Child Protective Services conservatorship that appear to be incapacitated and who are in a state of abuse, neglect, or exploitation. The following table shows the types of guardianship programs available in Texas and the number of clients served at the end of fiscal year 1998.

Type of Guardianship Program	Number of Programs	Counties Served	Clients Served	Number of Paid Staff	Number of Volunteers
PRS - APS Legal Protection Specialist Program*	1	254**	317	24	0
Local Guardianship and Money Management Programs	16	28	2,459	82	578
1. Federally Managed	1	1	11	1	24
2. County Managed	3	2	1,285	38	0
3. Private Nonprofit	11	22	1,154	41	554
4. Private For-Profit	1	3	9	2	0

* APS also contracts with six of the local guardianship programs to serve approximately 234 clients in 18 counties.
** APS Legal protection specialists are available to provide guardianship services in every county of the state; they currently manage PRS guardianships in 82 counties.

In 1997, the Legislature required HHSC, with the advice of a Guardianship Advisory Board, to adopt minimum standards for guardianship, develop and implement a statewide guardianship plan, and establish local volunteer guardianship programs. The 11 members of the Guardianship Advisory Board are appointed by probate and county judges statewide to represent the 11 health and human services regions.

The Sunset review focused on the potential for creating a statewide system of guardianship that would expand the availability of guardianship services statewide, and create a single point of accountability for guardianship services in Texas.

Findings

The Legislature has recognized the need for a statewide guardianship system since 1991.

▼ **Guardianship services are needed, but unavailable in most areas of the state.**

◗ The Legislature has recognized the need for a statewide system of guardianship since 1991. The text box, *Recommendations to Establish a Statewide Guardianship Program in Texas*, describes some of the efforts made to enhance guardianship services.

◗ At least 2,300 incapacitated persons in Texas are currently without guardians and the need for guardians is projected to increase. Only 28 counties have a local guardianship or money management program. Judges in more than 40 counties have expressed the need for a guardianship program.[2]

Recommendations to Establish a Statewide Guardianship Program in Texas

1991	The Senate Interim Committee on Health and Human Services recommended establishing an Office of Public Guardian to develop a statewide system of county and regional guardianship programs.
1995	SB103 created a Guardianship Resource Board as a state agency. This agency was authorized to create a nonprofit corporation in order to develop a state guardianship plan and program, provide technical assistance and training for guardians, as well as information and referral services. However, this bill was vetoed by the Governor.
1996	The House Committee on Human Services recommended developing and implementing a statewide guardianship plan, including establishing minimum standards for guardianship.
1997	SB586 required HHSC, with the advice of the Guardianship Advisory Board, to adopt minimum standards for guardianship, develop and implement a statewide guardianship plan, and establish local volunteer guardianship programs.

▼ **HHSC does not have the resources to develop and implement a statewide guardianship plan.**

◗ In 1997, the Legislature directed HHSC, with the advice of the Guardianship Advisory Board, to develop guardianship standards and to develop and implement a statewide guardianship plan to address the need for guardianship services in Texas. However, HHSC has only one staff person and $118,169 to carry out these challenging directives.

◗ Because of limited resources, HHSC and the Guardianship Advisory Board are unable to achieve all of the objectives of the Legislature in developing a statewide system of local guardianship programs.

▼ **The Guardianship Advisory Board has little influence over the guardianship services provided by the State.**

◗ Guardianship services in Texas are provided by a variety of state and local entities that develop and implement their own standards, rules, and regulations. The Legislature has made HHSC responsible for the development of guardianship standards to be followed by all providers of guardianship services. PRS, the primary state agency provider of guardianship services, has also developed guardianship policies and

Functions Necessary for Development of Statewide Guardianship Services

1. Provide technical assistance to local guardianship programs.
2. Create minimum standards for guardianship programs.
3. Disburse grants to local guardianship programs.
4. Coordinate guardianship services with other agencies.
5. Continue public education efforts.

Source: Guardianship Advisory Board

procedures, statewide standards and outcome measures for its local guardianship contracts. Consequently, the State does not have one clear, statewide set of standards for guardianship programs.

The Guardianship Advisory Board and PRS have not developed a joint effort to promote delivery of guardianship services.

- The priority of the Legislature and the Guardianship Advisory Board is the development of local volunteer guardianship programs. The Guardianship Advisory Board provides grants to five local guardianship programs, while PRS staff serve as guardians for 317 clients and contracts with local guardianship programs to provide guardians for 234 additional clients. The Guardianship Advisory Board and PRS have not developed a joint effort to promote delivery of guardianship services through local programs rather than through PRS employees. Most of the state money spent for guardians is used to employ staff at PRS.

▼ Integrating the functions of the Guardianship Advisory Board and PRS would offer several advantages.

PRS operates the closest system the State has to a statewide guardianship program.

- PRS operates the closest system the State has to a statewide guardianship program. PRS has the administrative structure and legal staff necessary to develop and implement a statewide guardianship system, and employs 24 specialized staff, Legal Protection Specialists, available to provide guardianship services statewide. PRS staff could provide support and technical expertise when the issues are too complex for a local guardianship program or a volunteer to handle.[3]

- The Guardianship Advisory Board is made up of 11 persons appointed by the judges of the regional statutory probate courts. The Board's close local ties could provide PRS with the advice of judges and local programs in regards to guardianship services. Without such an advisory board, local advice and input into the development and implementation of guardianship services is limited at PRS.

- By integrating the functions, the legislative priority of developing a statewide system of local guardianship programs could be fostered. This system could ensure that state employees would be appointed as guardians only when local guardianships are not available. Integrating the functions would also allow for the development of a single set of

statewide standards for guardianship programs and maximize the State's guardianship resources.

Conclusion

As the need for guardianship services increases, the development of a statewide guardianship system is necessary to ensure that guardianship services are available statewide. The Legislature recognized this need and directed the Health and Human Services Commission, with the advice of the Guardianship Advisory Board, to develop and implement a plan to ensure that guardianship services are available statewide. HHSC and the Guardianship Advisory Board were also directed to foster the development of local volunteer guardianship programs to meet this need.

The State needs a single, statewide approach to guardianship.

Although the Legislature placed the responsibility for statewide guardianship services with HHSC, the Commission's role in guardianship is limited. The Department of Protective and Regulatory Services is the primary state agency provider of guardianship services and the majority of state dollars spent for guardianship services is used to employ staff at PRS. Allowing the Guardianship Advisory Board to advise PRS in the development and implementation of a statewide guardianship plan would better serve the State. The Guardianship Advisory Board could provide necessary local expertise and input regarding guardianship services, and the Board would have more influence over guardianship services provided by the State.

Recommendation

Change in Statute

- **Transfer the following guardianship responsibilities from the Health and Human Services Commission to the Department of Protective and Regulatory Services:**
  - **develop and adopt minimum guardianship standards,**
  - **develop and implement a statewide guardianship plan,**
  - **foster the establishment and growth of local volunteer guardianship programs, and**
  - **responsibility for administrative support of the Guardianship Advisory Board.**

As Texas continues to address the increasing need for guardianship services, the State should centrally plan for the most effective means to provide these services statewide. The State should encourage the development of a statewide guardianship system and have a single entity responsible for the development of such a system. This entity would provide a central point of information and accountability for all guardianship services in Texas. Currently, PRS is responsible for the majority of protective services in the state, including guardianship. PRS has the necessary infrastructure and legal expertise as well as capable contract monitoring staff to help implement a well-developed and well-managed guardianship system. Finally, having a single entity responsible for all guardianship services would centralize guardianship funding and resources.

Currently, the Guardianship Advisory Board is administratively attached to the Health and Human Services Commission. Prior to the creation of this Board, HHSC had a limited role in guardianship services. In fact, the primary state agency provider of guardianship services is the Department of Protective and Regulatory Services. The Guardianship Advisory Board has extensive guardianship expertise, especially regarding local guardianship programs. This expertise should be better used in developing a statewide guardianship system that maximizes state and local resources to serve more individuals. By placing the Guardianship Advisory Board at PRS, the opportunity and ability for the Board to develop statewide guardianship policy would increase. Additionally, PRS and the Guardianship Advisory Board would be required to prioritize the development of local volunteer guardianship programs in order to maximize available guardianship resources. Local guardianship programs have been shown to cost less than guardianship services provided by state employees. Having local guardianship programs available prevents the state from being appointed guardian and saves money that could be used to provide additional services rather than maintain costly state guardianships.

- **Expand the Guardianship Advisory Board by adding three consumer or advocate members and a representative of the Department of Protective and Regulatory Services.**
- **Specify that the consumer or advocate members should be persons that advocate on behalf of or in the interest of the elderly or persons with mental illness or mental retardation.**
- **Specify that the PRS Board shall appoint the four additional members.**

Currently, having experience working with a person or an organization that advocates on behalf of or in the interest of elderly individuals or individuals with mental illness or mental retardation is considered when making appointments to the Guardianship Advisory Board, but this experience is not a requirement for appointment. Requiring the appointment of three consumer or advocate members would ensure the representation of these individuals. Elderly individuals or individuals with mental illness or mental retardation should have

permanent representation on the Board due to their special needs which may put them at a higher risk of needing guardians.

Expanding the membership of the Guardianship Advisory Board to include a representative from PRS would provide the Board with the expertise regarding guardianship services provided by this agency. Since the guardianship program operated by PRS is the closest system the State has to a statewide guardianship system, it is imperative that this system and the services it provides are considered when developing a statewide guardianship system.

- **Strengthen the role of the Guardianship Advisory Board by adding the responsibilities to:**
  - **advise and assist PRS in the development of a statewide guardianship program;**
  - **review and comment on all state policies, procedures, and rules related to guardianship;**
  - **review and comment on guardianship services provided by local entities;**
  - **conduct an annual review of guardianship services provided throughout the state; and**
  - **recommend an approach to a statewide guardianship system to the Governor and the Legislature.**

The Guardianship Advisory Board should advise and assist PRS in the development of a statewide guardianship system. Using the Board's expertise and experience would provide a necessary component to the development of such a system. To aid in the development of a statewide system, the Board should also be required to review and comment on all state guardianship policies, procedures, and rules as well as guardianship services provided by local entities to ensure consistency and prevent duplication. Additionally, the Board should conduct an annual review of guardianship services provided throughout the state. This information should be used to direct the expansion of guardianship services to those areas of the state where there is the greatest need. The Board should also use this information to recommend an approach to developing an implementing a statewide guardianship system. This approach should be reported directly to the Governor and the Legislature.

Fiscal Impact

The recommendation will not result in a significant fiscal impact to the State. Instead, the recommendation is intended to promote the development of a statewide guardianship program and to strengthen the role of the Guardianship Advisory Board.

The dollars and staff currently needed to administer the Guardianship Advisory Board would be appropriated by the Legislature to PRS. While prioritizing the development and use of local guardianship programs may result in some savings, staff cannot estimate the amount at this time. Any savings achieved could be used to expand local guardianship programs to additional areas of the state.

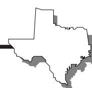
[1] HHSC Guardianship Advisory Board

[2] HHSC Guardianship Advisory Board, judges survey

[3] Correspondence from Bettye Mitchell, Director, Adult Protective Services, October 1,1998.

Issue 10

Improve the State's Management of Empowerment Zone/ Enterprise Community Funds.



Background

In 1993, Congress created the Empowerment Zone/Enterprise Community (EZ/EC) program, a federal government initiative to revitalize distressed communities through tax breaks, block grants, funding preferences, and waivers and exemptions from federal barriers. Under this program, the United States Department of Health and Human Services grants funds to states for programs that focus on business development, education and training, medical service facilities, housing, children's services, health care, and infrastructure. Projects are developed locally and are based on priorities established through citizen input. To receive funds, local entities must apply to the United States Department of Agriculture (USDA) and Department of Housing and Urban Development (HUD). USDA and HUD evaluate and designate the EZs and ECs.

The Empowerment Zone/Enterprise Community program helps revitalize distressed communities.

In Texas, EZ/EC funds are received by the Health and Human Services Commission (HHSC) and passed through to the local entities under Memorandums of Agreement and other federal regulations. HHSC also provides technical assistance to recipients of EZ/EC grants, including processing their requests to "draw down" federal funding.

The Texas Department of Economic Development also plays a role in the federal EZ/EC program. The Governor's Office designated the Department as the state nominating entity for the federal program, and it is charged with coordinating the State's efforts in helping Texas communities apply for federal empowerment zone designation. The Department's certification responsibilities include determining the eligibility of a governmental entity to nominate an area as an empowerment zone; verifying that the nominated area meets minimum eligibility requirements, such as size and poverty level; and determining that the State appropriately uses programs, services, and funding. Once the Department certifies and nominates community applications, it forwards the applications to USDA or HUD.

The Sunset review focused on HHSC's responsibility and expertise in administering the Empowerment Zone/Enterprise Community program in Texas.

Findings

▼ **EZ/EC funds have benefitted economically distressed areas in Texas.**

- The EZ/EC program is designed to offer communities opportunities for growth and revitalization. The program empowers communities by supporting local plans that coordinate economic growth with sustainable community and human development. Through the EZ/EC initiative, an urban or rural economically distressed area develops a comprehensive strategy to promote economic opportunity and community revitalization.

- As a result of this program, Texas was awarded approximately $55 million to administer the EZ/EC initiative over a 10-year period. This grant has provided $40 million to the Rio Grande Valley and 10-year grants of almost $3 million each to Dallas, Houston, San Antonio, Waco, and El Paso.

- To continue receiving the benefits of the EZ/EC program, the State must have an agency to administer the funds. Originally, EZ/EC funds were administered by the Texas Department of Human Services. However, the responsibility for the administration of the EZ/EC grant was transferred to HHSC at the request of the Governor in 1995.

The administration of EZ/EC funds is inconsistent with HHSC's mission.

▼ **HHSC's statutory mission does not include administering funds allocated for community development initiatives.**

- HHSC focuses its limited resources on its mission of developing and administering the State's health and human services delivery system, and does not provide a full-time employee for EZ/EC administration. Instead, this responsibility is shared among six employees from divisions ranging from accounting to legal counsel. These employees are responsible for various aspects of the program in addition to their many other duties.

- Issue 2 of this report redefines the future mission of HHSC as one of increased authority over the State's health and human services agencies. Administration of the EZ/EC program is inconsistent with this new role. Focusing on the new role will further diminish HHSC's ability to devote time and effort to the EZ/EC program.

▼ **The Legislature has assigned the responsibility for community development in Texas to the Department of Economic Development.**

The Texas Department of Economic Development is responsible for community development in the State.

- In contrast to the mission of the Health and Human Services Commission, the Texas Department of Economic Development (TDED) helps Texas communities create relationships and complete transactions that increase wealth. In carrying out this mission, TDED has developed the expertise necessary to effectively manage the federal EZ/EC program.

- In addition to participating in the federal program, TDED operates a similar state program, the Texas Enterprise Zone Program. The purpose of this program is to create and retain jobs and induce investment in areas of economic distress by providing economic benefits and removing certain governmental regulations for businesses located in these areas.

- As the State's economic development agency, TDED has the necessary resources to effectively manage the federal program. Three full-time equivalent staff members, including two program specialists and one senior program specialist, currently work on the Texas Enterprise Zone Program and on the federal program.

Conclusion

To receive federal funds for Empowerment Zones and Enterprise Communities, a state agency must be delegated to manage the funds. Currently, HHSC is that designated agency.

As the State's designated agency for community development, the Department of Economic Development is charged with helping Texas communities create relationships and complete transactions that increase wealth. TDED has the expertise to manage the federal EZ/EC program, and already plays a significant role in reviewing community applications and

nominating applicants to receive program funding. The administration of economic development funds is generally not within the scope of HHSC, which does not have experience and resources to easily administer the EZ/EC program.

Recommendation

Change in Statute

- **Transfer the administration of the Empowerment Zones and Enterprise Communities program to the Texas Department of Economic Development.**

Placing the administration of EZ/EC funds at the Department of Economic Development would increase the State's ability to effectively manage the federal funds and distribute them to communities. This recommendation would eliminate fragmentation of the program among multiple state agencies. TDED would serve as a single point of accountability and provide expertise on community development. The recommendation would also more clearly focus the role of HHSC on the operational functions of the health and human service agencies, as recommended elsewhere in this report.

Fiscal Impact

Administering the EZ/EC program may result in a small fiscal impact to the Department of Economic Development, but the Department should be able to operate the program with existing resources. In addition, the federal government allows the designated state agency to use EZ/EC funds for administrative expenses, as provided in Memorandums of Agreement with local entities.

ORGANIZATION AND DELIVERY OF HEALTH AND HUMAN SERVICES

Improve the Organization of Health and Human Services Through Service Integration and Program Consolidation Issues 11-17

Fourteen state agencies have a primary responsibility for delivering health and human services, with as many as 10 other agencies involved in delivering some type of health and human services to their clients. No other large state relies on so many agencies to deliver services.

In 1991, the Texas Performance Review's (TPR) report, *Breaking the Mold*, proposed a complete reorganization of the entire health and human services system by consolidating multiple agencies into a single agency directed by one governing board and delivering services through six functional divisions. The report determined that a single unified system could improve health and human services through achievement of several statewide service delivery goals:

- comprehensive, statewide planning and policy development,
- a continuum of care for clients,
- integration of services to improve client access,
- improved use of management information systems, and
- mechanisms that foster innovation and decision making at the local level.

These goals became the basic tenets outlined in House Bill 7 passed by the Legislature in 1991. Recent Sunset reviews of all health and human services agencies, however, indicate many of the these statewide service delivery goals have not been fully achieved. Examples of problems identified during each of these reviews include continued fragmentation of services, limited administrative consolidation, and lack of a strategic vision for service delivery. In addition, the only accomplishments made in addressing service duplication have been specifically mandated by the Legislature, not through any plan, proposal, or action by the Health and Human Services Commission or the agencies.

In each of the issues presented in this section, staff reviewed the services each agency provides, the populations eligible for services, and the commonalities between each agency's services and target populations as compared with other agencies. As a result, opportunities for improved service delivery and reorganization were identified. In each case, the evaluation focused on improved services for clients with the goal of restructuring services to better meet the broader goals of the Legislature, as established in House Bill 7.

Issues are organized into the functional categories of Long-Term Care, Family Services, Protective Services, Mental Health/Substance Abuse, Rehabilitation, and Public Health. The recommendations relate both to opportunities for improved service and administrative integration and coordination, as well as recommendations for program and agency consolidation. In some cases, consolidation is recommended immediately since the areas of review have been under considerable study in the past and few issues remained to be worked out. Issues that contain consolidation recommendations where more study is needed, phase in the consolidation over time. In other cases, the recommendations focus on service integration and/or administrative consolidation, with consolidation recommended contingent on the success of those efforts.

The fiscal impact of most of these issues has not been estimated for the purpose of this report. Recognizing that each of the recommendations will require additional information to be gathered during the transition oversight process, fiscal considerations would have to be addressed at that time, relying on the expertise of HHSC, the LOC, and the Legislative Budget Board.

Implementation

Other issues in this report address expanding the operational authority of the Health and Human Services Commission (HHSC) and creating a Legislative Oversight Committee (LOC) to provide direction to the Commission and to oversee services integration and reorganization of health and human services. HHSC, under the guidance of the LOC, would be required to manage the service integration and functional agency consolidations recommended in these issues.

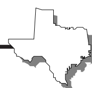
The HHSC Commissioner would be responsible for implementation of each of the approved service integration and consolidation recommendations. Each state agency affected by service integration efforts or the transfer of program jurisdictions would be required to cooperate with the Commissioner in formulating and implementing a transition plan including the development of interim operating budgets and the temporary assignment of staff necessary to ensure an orderly transition. Programs unaffected by service integration or consolidation efforts would remain administratively distinct.

In formulating the transition approach, the Commissioner would need to consider issues such as the impact on federal funding and program requirements, potential legal issues, and appropriateness of existing administrative rules. The approach should also be developed with adequate public input and comment. When appropriate, the Commissioner should request the State Auditor's Office to evaluate the adequacy of management and fiscal control systems.

The HHSC Commissioner would be required to present transition plans to the Legislative Oversight Committee. The LOC could seek additional public input and comment, as needed. In addition, the LOC would have available an independent research and data gathering capability. After review by the LOC, the Commissioner would be required to implement service integration and functional consolidation consistent with the agenda for change.

Issue 11

Improve the Delivery of Long-Term Care Services Through Creation of a Separate Agency.



Background

Long-term care programs encompass a wide variety of services and serve a diverse client population. Each year the State spends billions of dollars to provide long-term care to people of all ages and functional levels. *For the purposes of this review, long-term care was defined as any service that a client requires on a long-term basis to maintain a high quality of life and function well in society.* The two main client groups who receive long-term care services are the elderly and individuals of all ages with a disability (including both developmental disabilities and mental retardation) that prevents them from becoming or remaining independent. A definition of developmental disabilities is provided in the textbox, *Definitions of Developmental Disabilities*.

> **Definitions of Developmental Disabilities**
>
> ***Developmental disabilities, when applied to individuals 5 years of age or older, are a severe, chronic disability that:***
> - is attributable to a mental or physical impairment or combination of mental and physical impairments;
> - is manifested before the individual attains age 22;
> - is likely to continue indefinitely; and
> - results in substantial functional limitations in three or more life activities, including self-care, receptive and expressive language, learning, mobility, self-direction, capacity of independent living, and economic self-sufficiency.
>
> ***When applied to children from birth to age five, developmental disabilities include those with:***
> - a substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

Five state agencies currently provide long-term care services to the elderly and/or individuals with disabilities: the Department of Human Services, the Department of Health, the Department of Mental Health and Mental Retardation, the Texas Rehabilitation Commission, and the Department on Aging. Long-term care services are typically delivered in one of three settings: the community, other residential settings, and nursing homes.

Community care is typically delivered through in-home or community day services and can include services such as home- delivered meals; assistance with tasks such as bathing and dressing; and furnishing medication, wheelchairs, and other items needed to function independently. Community care services are designed to prevent people from requiring institutional care.

Residential services are delivered in settings such as supported apartments, community based residential facilities, or adult family homes, and includes many of the same services offered in the community. Nursing home options

include intermediate and skilled nursing facilities, including Intermediate Care Facilities-Mental Retardation (ICF-MR); and provide services such as 24-hour nursing care, social services, and medications.

Most of the long-term care services in the state are regulated by the Department of Human Services (DHS). DHS long-term care regulatory responsibilities include both facilities and certain persons employed by these facilities. Long-term care service providers include nursing homes, intermediate care facilities for mental retardation or related conditions, personal care homes, adult day health care centers, nursing facility administrators, nurse aides, and medication aides. The Texas Department of Health (TDH) is currently responsible for licensing and regulating Home and Community Support Services Agencies (HCSSAs).

Numerous reports have cited problems with the health and human services structure and presented solutions to some of the problems identified. For example, in 1993, the Texas Health and Human Services Commission convened a Task Force on Long-term Care and concluded that the system of long-term care services was fragmented and difficult to navigate for consumers. In response, the group considered the creation of a single agency responsible for the delivery of long-term care services as a solution to the fragmentation. The report included policy changes that resulted in a more consumer focused system that emphasized the importance of community care services to keep people out of institutional settings. However, even though a single point of entry for long-term care services was recommended, the necessary changes did not occur.

Individuals with developmental disabilities, in particular, have had difficulty accessing services under the current organizational structure. These individuals often have to go to multiple agencies to receive services since one agency does not have primary responsibility for providing the array of services needed by this population. In 1996, the Texas House Human Services Committee Interim Report to the 75th Legislature determined that persons with disabilities could best be served through a system based on functional need and individualized personal assistance services rather than based on medical diagnosis.

Despite numerous previous attempts to improve the delivery of long-term care services, problems continue to exist.

Despite numerous previous attempts to improve the delivery of long-term care services, problems continue to exist, as evidenced by the recent Senate Interim Committee on Home Health and Assisted Living Facilities review of long-term care services in Texas. The committee noted that many individuals continue to describe the current system as fragmented and difficult for consumers to navigate. The report concluded that a long-term care agency

would provide a more streamlined delivery of services and a more focused long-term care policy and planning process.[1] This report and other studies carried out in recent years provided the groundwork for the Sunset review of long-term care services.

The following provides a description of the long-term care services provided by each of the health and human services agencies studied.

Department of Human Services (DHS)

The Department of Human Services provides long-term care services to low-income elderly and individuals with disabilities who meet functional criteria. The largest percentage of the agency's client population is over the age of 60. DHS contracts with community care providers, residential facilities, and nursing homes across the state to deliver a variety of services. Community providers deliver services such as home delivered meals, assistance with daily tasks such as bathing and dressing, and rehabilitative services such as physical therapy. Residential facilities and nursing homes provide room and board as well as services such as skilled nursing care and social services.

Department on Aging (TDoA)

All of TDoA's programs and services are available to individuals who are 60 years of age or older; however, federal law mandates that priority be given to those with the greatest social and economic need. Services are provided through contracts with local Area Aging Agencies (AAAs). These entities contract with local providers to deliver services such as home delivered meals, personal assistance, residential repair, respite care, and transportation. Services such as information and assistance and case management are provided by AAA staff. All services are provided in the community.

Rehabilitation Commission (TRC)

TRC's primary emphasis is on vocational rehabilitation and helping persons with mental or physical disabilities prepare for, find, and maintain employment. In addition, TRC operates smaller programs that assist persons with disabilities who need more intensive support to obtain or maintain employment, as well as programs that increase the ability of persons with severe disabilities to live more independently in their home or community. Three of these smaller programs are the Personal Attendant Services program (PAS), the Comprehensive Rehabilitation Services program (CRS), and the Deaf-Blind with Multiple Disabilities program (DBMD), a Medicaid waiver program. PAS provides services in the client's home or workplace that assist and enable the client to remain employed. Clients must have one or more severe disabilities that cause a need for personal attendant services to maintain

employment. The goal of the program is to maximize independence, communication, orientation, and mobility. The CRS program is designed to assist individuals with brain and spinal cord injuries sustained in an accident. The program helps these individuals regain basic life skills such as eating and dressing as well as new skills such as transferring to and from a wheelchair. Most of these individuals will require on-going assistance, such as personal attendant care, after leaving the CRS program. DBMD provides residential support in apartments, group homes, or with a parent or guardian. DBMD clients must be Medicaid-eligible in addition to being deaf and legally blind with one other disability resulting in substantial impairment to independent functioning. PAS and DBMD services are delivered in the community.

Department of Mental Health and Mental Retardation (TDMHMR)

TDMHMR provides services to individuals with mental retardation, regardless of age and income, and includes vocational training, rehabilitative services such as physical therapy, and adaptive aids. Services are provided in the client's home, residential facilities, or in institutional settings such as state schools and state centers. Institutional services provide 24-hour residential services for people with mental retardation, especially those who are medically fragile, severely physically impaired or have severe behavior problems and cannot be served in the community or who chose to continue to receive campus-based services.

Department of Health (TDH)

TDH delivers long-term care services to children through three programs. The Medically Dependent Children's Program (MDCP) provides a broad array of services, such as nursing, home modifications, adaptive aids, respite, and support enabling children to participate in child care. The goal of the program is to keep these medically fragile children out of nursing homes. The Chronically Ill and Disabled Children (CIDC) program delivers services to children with specific medical diagnoses such as cystic fibrosis and provides services such as screening and medical treatment specific to diagnosis, medications and nutrition prescribed by a physician, and case management. The Children with Special Health Care Needs Case Management provides case management services to children with specific diagnoses. All services are provided in the community.

The chart, *Agencies Providing Long-Term Care*, presents a summary of the services delivered by the state agencies currently involved in the delivery of long-term care services.

In this issue, Sunset staff used the knowledge and understanding gained by the Sunset review of the health and human service agencies. Staff identified the services each agency provides, the populations eligible for services, and the commonalities between services and target populations across agencies. In doing so, staff identified a number of programs that overlap in the services they provide and the people they serve. The evaluation of those overlapping programs was undertaken with the goal of restructuring services to better meet the broad goals of the Legislature, as established in House Bill 7; and the specific goals contained in HHSC's report on Texas' long-term care system, which are as follows:

Sunset staff identified a number of programs that overlap in the services they provide and the people they serve.

- better coordination of long-term care service delivery and administration;
- increasing access to services through a variety of strategies, including single point of entry, mobile outreach, coordinated transportation, co-location, and integrated information and referral;
- expanding the available array of services to include more community-based options;
- providing quality individualized, culturally competent services that maximize independence and autonomy of the individual; and
- maximizing resources through developing funding strategies that support consumer choice.

Findings

Service Delivery

▼ **Currently, five different agencies are involved in delivering services in the long-term care continuum.**

◗ Each of the agencies outlined in the chart, *Agencies Providing Long-Term Care*, deliver an array of long-term care services ranging from community care services such as personal attendant care, case management, and assistive devices, such as wheelchairs, to more intensive care in nursing facilities. All of the individuals served through these programs have needs that will continue for the rest of the client's life. The majority of the clients are over the age of 18 with most of those over the age of 60. The result is the overlap and duplication of administrative functions, contract for services, and populations served.

Five separate agencies deliver an array of long-term care services ranging from community care to more intensive care in nursing facilities.

Agencies Providing Long-Term Care					
Agency*	**DHS**	**TDOA**	**TRC**	**TDMHMR**	**TDH**
FY 1997 Expenditures	Federal: $1.3 billion State: $745 million	Federal: $50 million State: $4 million	Federal: $1.9 million State: $11.2 million	Federal: $529 million State: $491 million	Federal: $17 million State: $35 million
Eligibility	Individuals who meet functional and financial criteria	All 60+ (target those with greatest economic and social needs)	Severe disabilities that cause need for services to maintain employment or to live as independently as possible.	Must be diagnosed with mental retardation. No age or financial requirements.	0 to 21 years of age; meets functional and financial criteria
FY 1997 # of clients served	183,000	300,000	717	28,756	51,711
Population Served	0-21 1,970 21-64 14,722 65-74 35,644 75-84 52,303 85+ 48,589	60+ 300,000	0-21 5 21-44 626 45-65 43 65+ 1	0-18 7,542 18-64 20,370 65+ 844	0-21 51,711
Administrative Services					
Assessment	✔	✔	✔	✔	✔
Case Management	✔	✔	✔	✔	✔
Information and Assistance	✔	✔	✔	✔	✔
Services					
Institutional Care	✔			✔	
Residential Care	✔		✔	✔	
Care Giver Education/Training	✔	✔	✔	✔	✔
Respite	✔	✔	✔	✔	✔
Assistive Devices & Medication	✔	✔	✔	✔	✔
Personal Attendant Services	✔	✔	✔		✔
Residential Repair/ Modifications	✔	✔	✔	✔	
Habilitation/ Rehabilitation	✔		✔	✔	✔
Nutrition Counseling		✔	✔		✔
Transportation	✔	✔			✔
Life Skills Training			✔	✔	✔
Adult Day Care	✔	✔			
Home Delivered Meals	✔	✔			
Hospice	✔	✔			
Emergency Response	✔	✔			

* For a detailed description of the specific programs being considered for consolidation in a long-term care agency, please see the descriptions of each agency presented in the background section of this issue.

- As clients age, their services needs may change. Under the current system, these changing needs may require the individual to go through a new eligibility determination process to seek services from a different agency. For example, as children receiving services from TDH age out of the TDH system they may need to transition into services from DHS. This transition is often difficult as the individual runs into different financial requirements and long waiting lists for services. The lack of a seamless continuum of care may result in a discontinuation of services for some individuals while multiple administrative hurdles are crossed.

▼ **Fragmentation at the state level has led to a lack of clear accountability and limited strategic planning.**

- The overall goal of long-term care services is to improve the quality of life for clients. Holding a single state agency responsible for achieving that improvement for each client is difficult, if not impossible, if services are being delivered by multiple state agencies. Achieving outcomes is more difficult if each agency can say that it should not be held responsible for achieving a particular outcome since it is only responsible for meeting a portion of the client's needs. In addition, comprehensive planning to address the client's long-term needs is also complicated by the fact that the client is likely to need services from more than one agency as they age and their needs change.

Achieving results is difficult to measure when clients are being served by multiple agencies.

- The development of a single state plan and a focused state long-term care policy for the delivery of services is difficult to achieve under the current organizational structure. Programs are scattered across numerous agencies, each with an independent board and separate policy development and rulemaking procedures. These multiple policymaking functions make modifying programs to bring them more into line with service delivery procedures at other agencies difficult.

▼ **Fragmentation has resulted in confusion and multiple intake and assessment processes for clients at the local level.**

- Multiple service delivery structures have been developed over the years to meet the needs of specific populations. Programs

Individuals with disabilities, in particular, must go to multiple agencies to receive services.

have traditionally been built around funding streams or waivers to serve populations meeting specific eligibility criteria, resulting in a patchwork of programs developed to meet narrowly defined needs. This is particularly true for individuals with developmental disabilities who are not mentally retarded. For these individuals, no one agency provides the majority of their services. For example, the Home and Community Support (HCS) Waiver at TDMHMR and the Community Living Assistance and Support Services (CLASS) wavier at DHS provide a similar array of services. However, the HCS program includes a requirement that the client be diagnosed with mental retardation. At the same time, DHS and advocates for the developmentally disabled developed the CLASS program to provide services to individuals who were not mentally retarded but shared many of the same needs to remain out of institutional settings.

Over time, the CLASS program at DHS and the Home and Community Support program administered by TDMHMR began to look more alike both in the services provided and the population served. The result is that the same individuals must navigate two separate agencies' eligibility assessments and waiting lists as they seek to receive the same services.

- Each of the agencies has a different intake and assessment process to determine whether an individual is eligible to receive services. The fact that individuals may be eligible for services from multiple agencies means that they must go through separate intake and assessment procedures at each agency. This is not only time consuming but also means that if an individual is determined not to be eligible at one agency, they must go through the eligibility determination process again for another agency. For example, an elderly person may seek services through DHS only to discover that they do not meet the financial eligibility criteria. This same individual must then contact TDoA and go through a second assessment to receive services.

▼ **Multiple agencies providing long-term care services have prevented the State from maximizing funding and ensuring consistent contracting policies.**

- Multiple contracts with the same provider is problematic for the State. In many cases, the State is paying the same provider different rates for the same services. For example, DHS pays an average of $3.24 for a home-delivered meal. TDoA pays as much as $5.29 for the same meal, in most cases, from the same provider. In another example, TRC pays $9 an hour for personal attendant services while DHS pays rates that range from $7.05 to $9.83 per hour for the same service through its Client Managed Attendant Care program. While regional differences provide some basis for differing rates, rates should be uniform among agencies in the same geographic location.

- Fragmentation often results in more dollars spent on administration that otherwise might be available for direct services. Some of these agencies offer services that are similar, if not identical, types of service. For example, all of the agencies considered to be part of the long-term care service delivery system provide assessment and casework for clients. Consolidation of long-term care programs should result in savings on the administrative costs of service delivery.

Fragmentation results in dollars being spent on administration that could be used for direct services.

- In addition, most federal dollars require a match of state funds to draw down the maximum amount of state dollars. In some instances, agencies may be prevented from receiving the maximum amount of federal dollars due to a lack of state dollars. Opportunities may exist through consolidation to pool funds for use in matching federal dollars.

▼ **Multiple reporting requirements and monitoring visits results in confusion and increased administrative burdens for local providers.**

- Because of an overlap of services, state agencies often end up contracting with the same providers for the same services, in some cases to the same client population. The result is that some of these local providers receive funding from as many as three different state agencies in addition to other local or private support. All of the state agencies have separate reporting requirements, conduct separate monitoring visits, and deliver separate technical assistance. Given that many of these local agencies have small staff, the result is that the agencies do not have the staff to easily administer the grants, leading to less staff time spent on delivering services.

▼ **Other states have undertaken efforts to integrate or consolidate long-term care services.**

- Several states have chosen to consolidate all of the components of long-term care programs for the elderly into a single administrative structure at the state level and a highly integrated delivery system at the local level. In Oregon, a single state agency manages all of the state's community and institutional long-term care programs for the elderly. This agency handles Medicaid, community care programs, and the Older Americans Act. The Division also licenses and certifies nursing homes, reimburses them for the care of Medicaid clients, and develops long-term care policy for the state.

- Other states use a human services umbrella agency to oversee the delivery of long-term care services at the state level. In Wisconsin, the Department of Health and Social Services is the umbrella over the Division of Community Services and the Division of Care and Treatment Facilities. The Division of Community Services serves all populations needing long-term care, including the elderly, physically disabled, developmentally disabled, chronically mentally ill, and chemically dependent through services delivered in the community. Care in nursing and other institutional facilities is available through the Division of Care and Treatment.

- A third model retains independent, cabinet-level agencies for managing various long-term care programs, but establishes an interagency long-term care committee to keep agencies informed of each other's activities and to coordinate the development of interagency long-term care policies. In Maryland, responsibility for long-term care programs for the elderly is divided among three state agencies. The directors of these three agencies constitute the Interagency Committee on Aging Services, created by the Legislature to improve state level coordination.

Regulatory

▼ **Clients served by home health care agencies increasingly fall under the State's long-term care continuum.**

- Home health care broadly refers to a wide array of services provided to individuals in their own homes or in community

settings which address medical, nursing, social, or therapeutic treatment and/or assistance with essential activities of daily living. These services may be acute or long-term in nature. Most of these services are paid with federal Medicare dollars, with the State and private insurance paying the remainder. Home health care agencies can provide these services if they continually meet both the federal Medicare requirements - Conditions of Participation - and the State's licensure requirements.

- Home health care is becoming increasingly focused on the delivery of long-term care. The overwhelming majority of Texans receiving home health care through the state have long-term, chronic health care needs, requiring both medical services and assistance with activities of daily living. According to a 1997 Kaiser Family Foundation report, 66% of Medicare home health beneficiaries nationally are long-term care home health users, half of whom have medically complex conditions.[2]

Problems have been identified with the current regulatory framework.

- Separating a key regulatory component of the long term care continuum from other similar program functions impedes service delivery. With the exception of regulation of home health care services, most of the other components of long-term care services area reside under DHS. Separating regulation of home health agencies was appropriate when most of the home health services provided to individuals were of an acute nature - short term and medically intensive. However, the present regulatory structure is no longer feasible or practical given the significant, on-going shift in individuals' needs to services delivered under a long-term care model.

The present regulatory structure is no longer feasible given the changing nature of home health services.

- Various programmatic and administrative concerns have been noted. The Senate Interim Committee on Home Health and Assisted Living Facilities recently reported that multiple state-administered community care programs have a large home health component. Several different agencies offer these programs, and each program has its own particular set of rules, rates, and contracts governing home health care agencies participation.

The Interim Committee further noted that tension is inherent in the current regulatory system. Medicare home health has historically been based on the delivery of acute care services through a highly medical model of care. Emerging community care programs being developed by the State, on the other hand, overwhelmingly offer long-term care services based on either a social model or a combination of a social and medical models. Even the nature of the typical Medicare home health clients in Texas is changing to one that has more long-term medically complex needs.[3] The Senate Interim Committee in its review noted that serious concerns also exist about how DHS and TDH agencies categorize, resolve, and provide access to complaints against home health agencies.[4]

- In addition, the State Auditor's Office raised administrative concerns regarding the current regulatory structure. The State Auditor reported that DHS and TDH are, at present, unable to effectively share regulatory information about health care providers and, as such, are not able to hold these providers accountable for performance.[5]

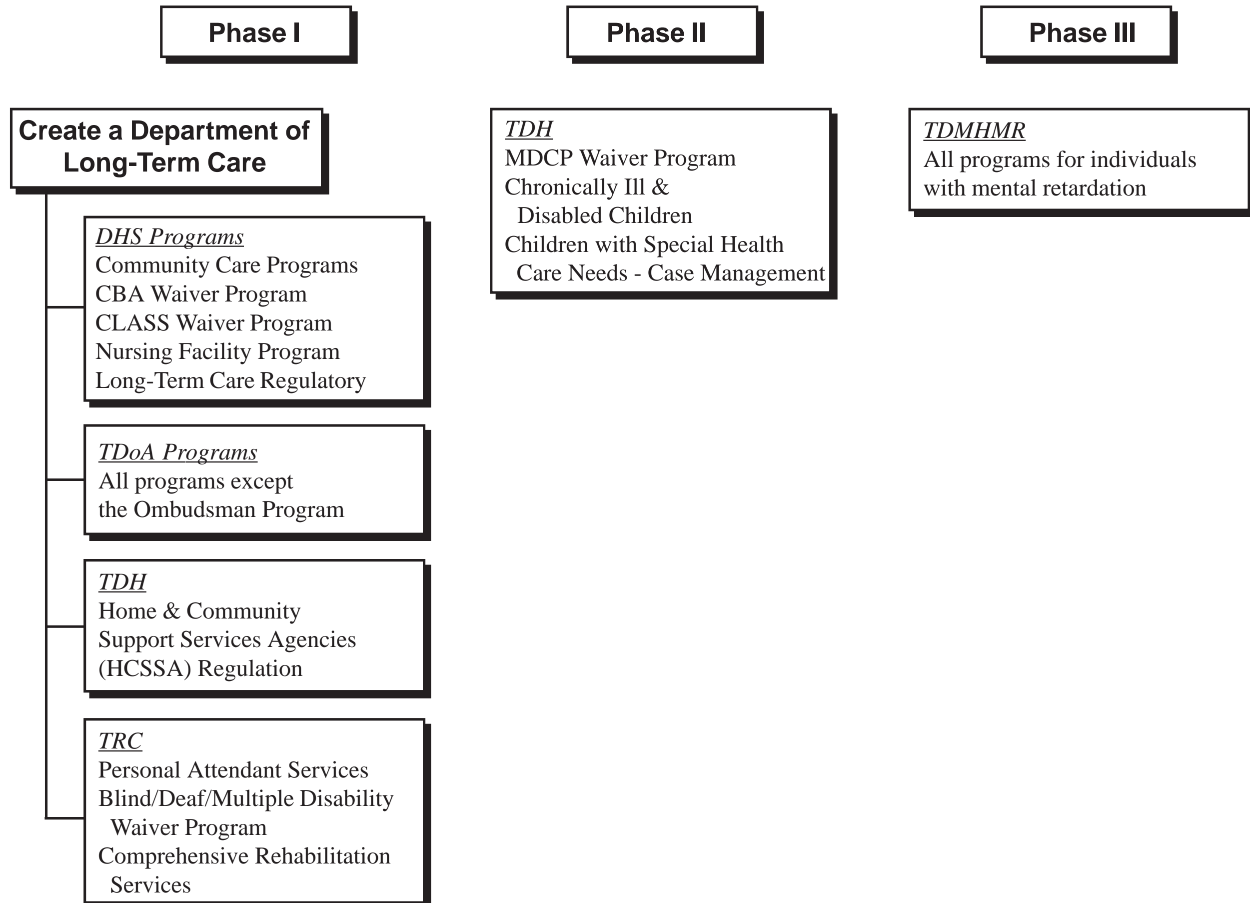
Conclusion

Multiple long-term care studies in Texas and other states have consistently identified the same problems- a lack of accountability for effective service delivery, fragmentation of services, and consumer confusion about how to access services. Consolidation of long-term care services into a single agency creates a variety of benefits. For the State, consolidation could result in centralized planning to meet the growing demand for long-term care services and create a single point of accountability for the quality of those services. A single long-term care agency would reduce confusion for clients and simplify the intake process so that clients would have easy access to an array of services designed to meet their changing needs. Providers would benefit from a simplified contracting and monitoring process that would reduce administrative costs and could result in more resources for direct services. Finally, consolidation increases opportunities for blended funding and other methods to maximize federal, state, and local dollars to serve more clients.

Recommendation

Change in Statute

■ **Create a long-term care agency through a phased-in consolidation of related programs of the State's health and human services agencies.**



Consolidation Process

Phase I

For the consolidation of long-term care programs to be successful, the consolidation would need to be done gradually, phasing in certain elements over a specific period of time. The order for the recommended consolidation of agencies and programs was determined based on the similarity of the services each agency delivers and the population they serve. Accordingly, the first phase in the creation of a single long-term care agency is the consolidation of DHS and TDoA programs in a new Department of Long-Term Care. This new agency would have a Sunset date of 2007, consistent with the other agencies discussed in this report. The programs at DHS and TDoA were selected for consolidation during the

first phase since the programs deliver many of the same services and the majority of the clients served are over the age of 65. Administrative support services, including Medicaid eligibility determination and benefit disbursement, for the new agency should be provided under interagency contract with existing agencies. TDoA's Ombudsman Program would be transferred to the Adult Protective Services (APS) Division of the Department of Protective and Regulatory Services. This is necessary to comply with federal law that prohibits the placement of the Ombudsman Program in the same agency as the nursing facility regulatory function. APS is currently involved in investigating individual claims of abuse, neglect, or exploitation of individuals in nursing facilities and has the appropriate experience to operate the Ombudsman program.

Once the major components of services to the elderly have been combined, Sunset staff recommends the transfer of TRC's Personal Attendant Services program, Comprehensive Rehabilitation Services program, and the Blind/Deaf with Multiple Disabilities waiver program. In addition, the Health and Human Services Commission is currently developing a common functional assessment tool across populations. This common assessment would need to be in place before adding programs from TRC, TDMHMR, and TDH to the long-term care agency. These programs are included as the next step because the client population most resembles the clients receiving services from DHS and/or TDoA and the services delivered by each program are similar to services currently being delivered by these two agencies.

The current Home and Community Support Services Agencies Regulatory function currently at TDH should be combined with the Long-Term Care Regulatory function at DHS and placed in the long-term care agency. Moving home health care regulatory program from TDH to DHS will resolve any coordination problems that between the two agencies, will improve overall long-term care policy by making home health a part of the overall long-term care continuum, and will focus regulatory efforts away from an acute care model to social/medical model.

Phase II

The programs at TDH being recommended for consolidation provide the majority of long-term care services to children. Children have a variety of factors that make providing services different than serving adults. For example, the developmental needs of a child change much more quickly than those of adults requiring more frequent adjustments of the child's care plan. In addition, the needs of the family are an important factor when determining how best to serve the child. Given the medically fragile nature of many of the children served by these programs, the long-term care agency must have a working intake, assessment, and case management system in place to ensure that the needs of these children and families can be met before these programs are transferred. For this reason, the creation of a special intake, assessment, and case management system is the next step recommended before increasing the number of children receiving services from the long-term care agency.

A different functional assessment tool for children may also be needed in addition to the common assessment tool currently being developed by the Health and Human Services Commission. Current efforts at creating a common functional assessment tool have had difficulty creating a tool that works for both children and adults. Finally, the role of the Texas Education Agency in delivering services to children should be considered as a part of the long-term care plan the agency develops for each child.

Phase III

The final step recommended in the creation of a long-term care agency is the consolidation of TDMHMR's programs for individuals with mental retardation. This timeline allows the long-term care agency to plan and receive public input on how to best integrate these two significant and large service delivery systems. Consolidating the MR programs presents additional challenges due to the issues surrounding state schools, state centers, and local community mental health centers that are involved in delivering services to this population. Leaving consolidation of mental retardation services as the final piece also allows the long-term care agency to develop administrative services that could handle this part of the merger.

When all of the recommended programs have been consolidated into the long-term care agency, HHSC, in conjunction with the Legislature, should evaluate other state agency programs to determine whether consolidation into the long-term care agency would improve service delivery. For example, programs such as the TDH Health Steps Comprehensive Care Program could be considered for consolidation.

Agency Organization

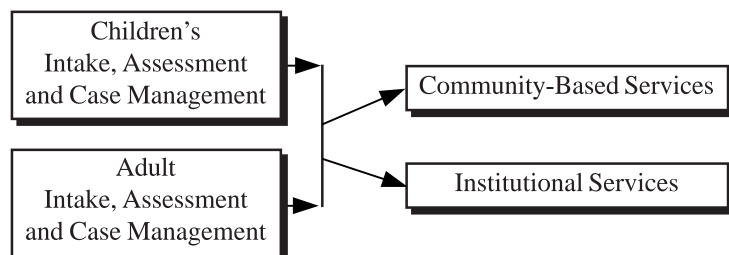
Board

During Phase I of program consolidation, the Governor would appoint a new six-member board to govern the new long-term care agency. The Board would be composed on public members with a demonstrated interest in long-term care issues. The Board will have the authority to appoint advisory committees, as needed, in areas such as aging services, mental retardation services, and children's issues.

Structure

To accommodate the needs of the wide variety of individuals receiving long-term care services, the new agency will have a separate intake and assessment process for children and adults. Services would logically

Client Intake Flow Chart



be provided through a Community Care program and an Institutional Care program. For an example of the client intake system at the new agency, please see the flow chart entitled, *Client Intake Flow Chart*. Contracting and monitoring of providers, including quality outcomes as discussed in the Sunset Staff Report on the Department of Human Services, would be carried out by staff in both the community care program and the institutional care program. Regulatory functions for all of the providers delivering long-term care services would be placed in a separate division of the new agency.

Administration

The agency will decide the best method for delivering services with the goal of integrating service delivery at the local level. This would include the appropriate regional administrative structure and the appropriate service delivery network, such as Area Agencies on Aging and other community-based providers. All of the administrative resources currently used to deliver long-term care services at the Department of Human Services would be available to support the long-term care agency. Appropriate administrative support will also be transferred with each program being consolidated or contracted for with the agency that previously administered the program.

Consolidation Oversight

Other issues in this report address expanding the authority of the Health and Human Services Commission (HHSC) and creating a Legislative Oversight Committee (LOC) to oversee the reorganization of health and human services. HHSC, under the guidance of the LOC, would be required to manage the consolidation recommended in this issue. In so doing, HHSC would need to address:

- eligibility requirements so that individuals currently receiving services would continue to receive services based on current eligibility criteria,
- compliance with all federal laws and funding requirements, and
- local effort so that funding is not compromised.

State Impact

Combining programs providing similar services should allow the State to achieve most of the benefits outlined in HHSC's report on long-term care services. For example, services should be easier to access if the client only has one agency to apply to for services, regardless of why they need long-term care services. Better coordination of funding and decreased administrative costs could also result in greater ability to expand waiver programs to increase client choice. Sunset staff recognizes that all the services delivered to clients on a long-term basis are not the same. The phased-in approach recommended here allows for modifications of the details that will guide the consolidation of these programs to ensure that these differences are addressed appropriately as the State seeks to develop a single

long-term care service delivery system at both the state and the local level.

Goals of HB 7	
Objective	**Applies**
Facilitates Comprehensive, Statewide Planning and Policy Development	✔
Enhances Continuum of Care for Clients	✔
Achieves Integration of Services to Improve Client Access	✔
Maximizes ExistingResources	✔
Improves Use of Management Information Systems	✔
Foster Innovation and Decision Making at the Local Level	✔

Combining the administration of long-term care services into a single agency will not alter program eligibility requirements established by federal law. For example, as required by the federal Older Americans Act, the over-60 clients will continue to receive services as mandated by the Act. The consolidation of all long-term care services will make it easier to ensure accountability for client outcomes since one agency will be providing all aspects of the client's long-term care. Common outcome measures should be developed to determine the overall effectiveness of the State's long-term care services. The table, *Goals of HB 7*, shows which of the goals contained in HB 7 are met through the implementation of this recommendation.

Local Impact

At the local level, this recommendation should improve the delivery of long-term care services by decreasing the administrative burden through a single contracting and monitoring process for all long-term care services. Streamlined contracting should allow these providers to spend a greater portion of their resources delivering services rather than filling out paperwork. In addition, the goal of this recommendation at the local level is to:

- encourage DHS, TDH, and TDMHMR and their providers to work together to address client needs that cross agency lines as the long-term care agency is created;
- encourage local providers, boards, councils, and other interest groups to work together to identify local long-term care needs;
- encourage local providers to work together to blend funds at the local level and coordinate local service delivery through the release of RFPs requiring joint applications;
- reduce the administrative burden on local providers;
- maximize federal, state, and local funds to meet local needs; and
- develop consistent rates and contracting practices to ensure the State receives the best value for services.

Alternative to Program Consolidation

In the event that consolidation of long-term care programs across agency lines is not approved, to better integrate services between the agencies providing long-term care, the Sunset staff recommends that the following at a minimum, should occur.

Recommendation

Change in Statute

- **Require DHS, TDoA, TRC, TDMHMR, and TDH to better coordinate service delivery through:**

  - developing a single functional assessment tool for adults and a single assessment tool for children;
  - streamlining contracting and monitoring procedures across agencies, including
  - agreement on a common set of contracting standards, reporting requirements, and monitoring schedules within common program areas;
  - creating a single access point to services at the community level; and
  - coordinating computer systems to enable sharing of client information for individuals receiving services from multiple agencies.

Achieving better integration of services and coordination between agencies will move the State closer to providing clients with a seamless service delivery system throughout their lives. Many of the coordinating activities listed above are already occurring between some of the long-term care service delivery agencies and these efforts need to continue and expand. However, the need still exists for planning how these agencies will continue to coordinate and the timeframe for achieving certain concrete goals. The drawbacks to requiring only greater coordination rather than consolidation include difficulty in holding a single agency accountable for developing a client-friendly system and achieving positive client outcomes. In addition, strategic planning for all long-term care services would be more difficult if programs are left in their respective agencies.

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[1] Senate Interim Committee on Home Health and Assisted Living Facilities, Report to Seventy-sixth Legislature, October 1998, p 15.

[2] Senate Interim Committee on Home Health and Assisted Living Facilities's report to the seventy-sixth Legislature, October 1998. pp. 73-74, 114.

[3] Ibid, pp.75

[4] Senate Interim Committee on Home Health and Assisted Living Facilities's report to the seventy-sixth Legislature, October 1998. pp. 2

[5] State Auditor's Office, Home and Community-Based Services at TDH and DHS. October 1998. Report # 99-005.

Study the feasibility of a Subacute Care pilot project

Subacute care was another aspect of long-term care examined by Sunset staff in this report.

Background

Medicaid acute care, which consists primarily of physician and hospital care, is administered by the Department of Health (TDH). Acute care consists of preventive and primary care services, such as prenatal care, child birth, and pediatric services. Acute care also includes diagnosis and treatment of various acute illnesses, which usually occur suddenly and can be cured relatively quickly, such as influenza and broken limbs. Medicaid long-term care programs, which include both nursing facility care and home and community-based care, are administered by the Department of Human Services (DHS). Long-term care consists of a broad range of health care, personal care, and related social services delivered over a sustained period to individuals who lack some capacity for self-care because of a chronic illness or condition. Unlike acute illnesses, chronic conditions, such as heart disease, arthritis, and Alzheimer's, last for an extended period of time and are not typically curable. The purpose of long-term care is to help people live as meaningfully and productively as possible given their disabilities.

A relatively new treatment option being explored by other states and private providers is subacute care, which is not technically acute care or long-term care, but it incorporates elements of both. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) defines subacute care as "goal oriented treatment rendered immediately after, or instead of, acute hospitalization . . . [which] requires the coordinated services of an interdisciplinary team." Subacute care is, therefore, generally more intensive than traditional nursing facility care but less intensive than hospital care. Therefore, the subacute care population consists basically of medically complex patients who are, in general, stable enough for hospital discharge but who are too sick to go home. Subacute care is designed to enhance the available continuum of care in institutional settings. Providers of either acute care or long-term care can, and do, provide subacute care.

Subacute care is a new treatment option being explored by other states and private providers.

Government and private payors are constantly looking for ways to increase cost-effectiveness or even reduce costs of health care, without reducing the quality of care. Some advocates believe that subacute care is one promising way to contribute to both objectives. The likely effect of a Medicaid subacute care program would be to reduce the number of acute hospital days and substitute them either for temporary short-stay nursing home care or less

intensive and less expensive hospital care. While subacute care is increasingly being recognized as a distinct level of care in the private sector and in some state Medicaid programs, it is not currently explicitly recognized by the Texas Medicaid program. The Sunset review examined the structure of subacute care reimbursement, the potential benefits of implementing a subacute care strategy, and the feasibility of implementing the system in Texas.

Findings

▼ **Subacute care could be used as intermediary between traditional hospital and nursing home care.**

- A subacute care option could provide acute care hospitals an incentive to improve their overall performance by moving patients from their own facilities to lower, less expensive levels of subacute care. This is true because under the prospective payment system the hospital gets to keep the difference between what they are paid and what the alternative care costs them.

- Reimbursing for subacute care could enable some nursing homes to fill empty beds and establish a higher reimbursement rate. Nursing homes have traditionally had much lower fixed operating costs than hospitals, which accounts for a large part of the difference in reimbursement rates between the two types of facilities. Hospitals have much higher staffing ratios and a much greater need for expensive high-tech equipment. Many freestanding nursing facility subacute care programs are clinically and therapeutically comparable to the medical, surgical, or rehabilitation units of an acute care hospital. Yet the cost of the care in these subacute centers is significantly less than comparable care in a hospital acute care setting. Treatment in a subacute setting potentially offers significant cost advantages over acute care and rehabilitation hospitals.

Treatment in a subacute setting potentially offers significant cost advantages over acute care and rehabilitation hospitals.

▼ **Treatment in a subacute setting potentially offers significant cost advantages over acute care and rehabilitation hospitals.**

- Implementing a Medicaid subacute care program has the potential both to increase flexibility for facilities and to reduce reimbursement costs. Subacute care can be provided in appropriately equipped wings or units of hospitals and nursing

facilities, or in specialized stand-alone facilities. A growing elderly population, technological change, and various cost containment efforts, are leading to an increasing number of patients for whom post-hospital placement is difficult. Also, an increased number of medically intensive chronically ill patients offer more opportunities to care for patients outside the hospital setting.

- Subacute care has the potential to save considerable amounts of money based on a comparison of per diem rates, which frequently run over $1,000 per day in acute care settings and $800 to $900 in an acute rehabilitation hospital. Subacute care rates, in contrast, range from $200 to about $600 per day in a long-term care setting.[1] A report on subacute care prepared by Lewin/VHI estimates the current annual national volume of subacute care at between 1.2 million and 8.1 million patient days.

- Several studies detail the potential cost savings of subacute care. The American Association for Respiratory Care reported that on any given day, over 11,500 chronic ventilator patients are receiving care in U.S. hospitals at a cost of about $789 per patient day totaling over $9 million a day. Once a patient is pronounced medically stable and able to be discharged, it takes an average of 35 days to place him or her in an alternative setting translating to an excess of $27,000 per patient in unnecessary hospital costs.[2]

  A study performed by Abt Associates for the California Association of Health Facilities identified 69 diagnostic related groups (DRGs) that could be treated in freestanding nursing facilities offering subacute care. Estimated savings of up to $964 million in 1992 (averages of approximately $386 per patient day for 2.5 million days). The Medi-Cal portion of savings estimated at $232 million, or 24 percent of the total. Although the state has reduced their savings estimates now that they have begun implementation, significant savings are still anticipated.

▼ **Other states Medicaid programs and the private sector have begun to investigate and implement subacute care programs**

- The California Medicaid program (Medi-Cal) has had a subacute care program since 1986, specifically intended for ventilator dependent patients requiring long-term care. This care is provided by both hospitals and nursing facilities. A much newer program, termed "transitional care," in order to avoid confusion with the already existing "subacute care" program, is intended to provide relatively short-term care following a hospital stay. This newer program actually more closely resembles what is now generally termed "subacute care." This type of care was originally going to be provided only by nursing facilities.

- The Lewin/VHI report suggests that private managed care organizations have achieved significant cost savings through the use of subacute programs for patients with short-term medical and rehabilitation needs. If providers, like hospitals, are paid prospectively, they can retain any savings, and they have a strong financial incentive to transfer patients to lower cost settings. Under managed care, the potential exists for payers to capture this savings by negotiating lower capitation rates.

▼ **In Texas, current Medicaid policy presents barriers to the provision of subacute care.**

At the present time, considerable obstacles would impede the implementation of an effective subacute care system in the Texas Medicaid program.

Current state Medicaid policy presents barriers to using subacute care.

Current reimbursement methodologies

- Under the current reimbursement system, any savings resulting from providing care in lower cost settings would be captured by the hospitals and not by the State's Medicaid program. Texas Medicaid reimburses most hospitals according to a prospective payment system (PPS), which pays most hospitals a fixed rate according to the patient's diagnosis, regardless of length of stay. For hospitals reimbursed under PPS, if a person is discharged from the hospital and then admitted to a subacute care facility, Medicare or Medicaid incurs an additional charge, rather than saves money. If hospitals get to keep the difference, they have an incentive to find a lower cost setting for their patients. But, for payers to benefit from the lower cost setting, the DRG rates would need to be adjusted.

Differences in licensing requirements between hospitals and nursing facilities

- Hospitals are licensed by the Department of Health and must meet one set of quality standards. Nursing facilities are licensed by the Department of Human Services and have different standards. Since subacute care occupies a middle ground between acute and long-term care, both hospitals and nursing facilities could provide subacute care. Both types of organizations would want a level playing field and similar, if not identical regulations governing subacute care for the various providers of that level of care.

Hospitals and nursing facilities would want a level playing field if subacute care is considered.

Difficulty in estimating potential savings from a subacute care program

- The amount of potential savings in Medicaid cannot currently be reliably estimated without knowing the amount of hospital care devoted to patients for whom subacute care is appropriate, what type of hospital provided that care, and whether or not it was reimbursed under PPS or on a cost basis. Aggregate data shows the total number of hospital admissions and the total number of patient days associated with those admissions for each diagnostic-related group (DRG). From this data, an average length of stay can be calculated but the variation around this average cannot be calculated. Without this information, the number of days of acute care that could be substituted for subacute care cannot be calculated.

- Medicaid cannot save money on patients who reside in hospitals that are reimbursed on a PPS basis. Medicaid also cannot save money by reducing Medicare costs, because Medicare is a federal program. Since most hospital costs for the dually eligible (those eligible for both Medicare and Medicaid) are paid for by Medicare, the potential savings to Medicaid for this population are minimal. Most of the potential savings in Medicaid hospital costs from a subacute care program lie with the under 65 population.

Conclusion

Reimbursement for subacute care potentially offers significant cost advantages over acute care. Subacute care could be used as an intermediary between traditional hospital and nursing home care allowing those facilities

to lower costs and convert unused beds for care. Subacute care may also increase the effectiveness of community care by helping to stabilize patients and enabling them to return to community more quickly. Several other states are in the process of considering the implementation of a subacute care program. In spite of the potential benefits, some obstacles stand in the way of implementing a subacute care program in the Texas Medicaid program. As a result, the pros and cons of subacute care should be carefully studied and, if feasible, a pilot project should be implemented.

Recommendation

Change in Statute

- **Require the Long-Term Care agency to study, with the assistance of HHSC where appropriate, the feasibility of designing and implementing a subacute care pilot project.**

The issue of subacute care and its relationship to acute and long-term care in the continuum of care for Medicaid clients is complex. Additionally, more data needs to be gathered from which to develop reliable estimates of either potential cost savings or potential impact on the quality of care. Other states are beginning to implement subacute care programs in their state Medicaid programs. In addition to California, Virginia has developed a rate setting methodology for what is termed "specialized care." Minnesota and Illinois have also begun to explore Medicaid subacute care programs. Staff at HHSC and the HHS operating agencies should stay in contact with these other states, monitor the development of their subacute programs, carefully review any evaluation findings, and attempt to learn from those states' experiences.

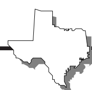
The study would allow the State to test whether subacute care could actually save money (and if so, how much) without compromising the quality of care. A study would allow the State to determine how quickly and effectively nursing facilities could develop the necessary capacity to provide subacute care. The Long-Term Care agency would need to work closely with the TDH and HHSC to evaluate the impact of subacute care on Medicaid acute care.

[1] Banta, Mark G. and Todd B. Richter, "The Future of the Nursing Home Field," *Dean Witter— Facility-Based Long-Term Care Industry*, April 2, 1993.

[2] U.S. Congress, House Committee on Ways and Means Subcommittee on Health, Testimony of Sam P. Giordano, American Association for Respiratory Care, 103rd Congress, 1st Session, November 2, 1993, page 4.

Issue 12

Improve the Delivery of Comprehensive Family Support Services to the State's Neediest Families.



Background

Several Texas state agencies including the Department of Human Services (DHS), the Texas Workforce Commission (TWC), the Office of the Attorney General Child Support Division (OAG), and the Department of Health (TDH) deliver family support services to low income families and children. These services help families meet basic needs for income support, nutrition, shelter, and health. The ultimate goal of providing these services is to ensure that a safety net of basic life needs is available, and to help families reach meaningful self-sufficiency from public assistance.

DHS, TWC, TDH, and the OAG share responsibility for delivering family support services in Texas.

DHS is the primary agency responsible for meeting the needs of low income families in Texas, primarily through the Temporary Assistance to Needy Families (TANF) program, food stamp program, and by determining eligibility for Medicaid programs. TWC provides the employment services component of family support services by registering TANF and food stamp clients with work requirements for job related services such as Choices (formerly JOBS), and Food Stamp Employment and Training programs. TWC contracts with Local Workforce Development Boards (LWDBs) in most areas of the state. LWDBs in turn set policy for local employment needs and outsource service delivery to local workforce centers. The OAG administers the States' child support enforcement program to obtain financial support for families. The OAG provides services to both TANF and non-TANF families. TDH administers many Medicaid related programs such as Texas Health Steps, a health screening program for children, and non-Medicaid programs such as the Special Supplemental Nutrition Program for Women Infants and Children (WIC).

Cross-agency interaction involves both clients that must access these different agencies to meet program requirements, and aspects of program administration such as sanctioning TANF benefits for failure to meet work or child support requirements. The chart, *Support Services for Low-Income Families in Texas - FY 1997,* shows the state agencies responsible for service delivery to low income families, and how these agencies interact.

Support Services for Low-Income Families in Texas - Fiscal Year 1997			
Agency	**Program**	**Agency Services and Functions**	**Clients Served**
Department of Human Services	Temporary Assistance to Needy Families	✔ provides basic income support ✔ eligibility determination (agency employees) ✔ calculates and delivers benefits ✔ assess clients based upon achieved grade ✔ administers sanctions (benefit reduction) ✔ refers clients with work requirements to TWC ✔ refers clients with child support needs to OAG ✔ determines exemptions from work or child support requirements	Recipients per month: 6000,00
	Food Stamps	✔ provides basic nutritional needs ✔ eligibility determination (agency employees) ✔ service delivery (via "Lone Star Card") ✔ refers clients with work requirements to TWC	Recipients per month: 2,100,000
	Medicaid	✔ provides basic health needs ✔ eligibility determination (agency employees)	Recipients per month: 2,000,000
Department of Health	WIC	✔ supports family nutrition and health	684,000 per year
Texas Workforce Commission	Choices (formerly JOBS)	✔ provides employment services ✔ service delivery (local contracts) ✔ registers clients for services who must participate as a condition of TANF ✔ functional assessment of client's work ability ✔ requests benefits sanctions from DHS	TANF clients eligible for JOBS: Approximately 50,000
	JTPA Title II-A	✔ provides employment services ✔ service delivery (local contracts) ✔ receives client referrals from DHS	Total served FY 97 20,600
	Child Care Services	✔ provides child care ✔ service delivery (local contracts)	70,000 per day 30,000 waiting list
Office of the Attorney General	Child Support Enforcement Provides same services to TANF and Non-TANF clients	✔ provides income support ✔ service delivery (agency employees) ✔ receives client referral from DHS ✔ sanction request to DHS for TANF clients that do not cooperate ✔ collection of support for foster care - PRS ✔ collection of support for medical care - TDH ✔ unemployment insurance intercept - TWC	Case load: 275,000 TANF 781,000 non-TANF

The structure of family support services has been undergoing change since 1983. Most of the State's family support and preservation programs were located at DHS prior to 1983, when the Legislature transferred child support enforcement from DHS to the Attorney General's Office. In 1991, legislation significantly reorganized health and human service delivery (House Bill 7), including the transfer of Medicaid purchased health programs from DHS to TDH. Family preservation services, including child and adult protective services, and child care licensing were transferred to the newly formed Department of Protective and Regulatory Services. Additionally, state welfare reform legislation (House Bill 1863), enacted in 1995, transferred employment and child care services from DHS to the newly-formed TWC (formerly the Texas Employment Commission). With the passage of HB 1863, and the consolidation of employment programs at the local level, the Legislature made a fundamental decision to separate welfare-related work programs from the social services function of DHS.

In 1995, the Legislature made a fundamental decision to separate employment services from social services.

The result of moving programs from DHS has left the agency with two core functions: eligibility determination for means tested programs such as TANF, Medicaid and food stamps, and the administration of long-term care programs. In addition, DHS maintains the States' primary health and human services computer system responsible for eligibility, calculating benefits, and paying providers; known as the System for Application, Verification, Eligibility, Referral and Reporting (SAVERR).

In addition to changes in the State's social services delivery system, state and federal welfare policies have changed. The State enacted welfare reform legislation in 1995 followed by large-scale changes in the federal welfare programs in 1996 with the passage of the Personal Responsibility and Work Opportunity Act of 1996. Changes enacted by these bills require that welfare benefits no longer last for an indefinite period. Welfare benefits are now time-limited, and come with increased work requirements and sanctions for noncompliance. In addition, more transitional benefits, such as Medicaid, child care, and transportation subsidies, were added to help families make the move to self-sufficiency.

In conducting this review, Sunset staff identified the support services each agency provides and the problems associated with the delivery of those services, including client access and gaps in services. Sunset staff also identified challenges the State faces in coordinating family support services across several agencies and meeting welfare work participation rates.

If the State removes exemptions from work requirements, the importance of assessing the needs of families will increase.

Findings

▼ **The State is under increasing pressure to meet welfare work participation rates, as well as deal with the impact of families losing TANF benefits.**

◗ Since 1995, welfare reform, combined with a strong economy, contributed to a 40 percent decline in TANF case loads, with 300,000 fewer recipients and over 100,000 fewer families on welfare. Currently about 117,000 parents are remaining on the rolls, and 50 percent of these parents (58,000) are exempted from work participation requirements, due to having a child under the age of four, hardship, or other reasons.[1] While TANF and food stamp caseloads have declined, Medicaid demand has increased slightly, and child support case loads have gone up sharply.

◗ TWC has registered most recipients with work participation requirements in local TWC programs, leaving many exempted recipients that may not be job ready on the TANF rolls. In addition, by 2001, over 6,000 clients per month will be losing TANF benefits, and may be at-risk of failing the TANF system. The result is that Texas will face increasing difficulty in meeting federal work participation rates. How local workforce centers will respond to the lack of eligible clients for work programs is not clear. For example, local providers may, or may not, contact exempted clients who can volunteer for work related services, to assist in meeting work participation rates.

◗ State agencies have proposed several solutions to assist the State in meeting work participation rates including:

- changing the work requirement exemption for having a child under four years of age to having a child under one year old, or
- eliminating work requirement exemptions for two-parent families, hardship, and lack of local jobs.

The importance of assessing and managing the service needs of these families to assist them in entering the work place will increase as the State adopts policies to limit the grounds for exemption from work participation requirements.

▼ Even with multiple screenings and assessments, the State is failing to identify and address the basic needs of families facing difficulties in becoming independent.

- TANF recipients undergo three different "assessments," one at DHS intake, another at DHS eligibility determination, and a third one at TWC. These fragmented screenings do not identify many related family problems or conditions such as physical or mental illness, or domestic abuse. In addition, the lack of a comprehensive assessment contributes to the inability of DHS to provide the best information possible to the OAG when referring families for child support services.

- During the review of DHS, Sunset staff found that eligibility workers do not have the resources or training to fully assess the needs of families. While the agency has implemented a job oriented screening at first intake, DHS is still operating from the older Aid to Families with Dependent Children (AFDC) structure that emphasizes eligibility and benefits processing. While observing eligibility sessions, Sunset staff saw that caseworkers must spend the majority of their time gathering information for program requirements, leaving little time to assess families for a broader range of support services.[2]

- DHS acknowledges that at least 30 percent of the TANF caseload face, in addition to poverty, multiple barriers to self-sufficiency.[3] The chart, *Barriers to Self-Sufficiency*, details problems that increase the difficulties families face in achieving independence, and shows the range of potential issues family assessments can help identify.

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

- Getting child support to families is increasingly critical under welfare reform. A General Accounting Office (GAO) report shows that in several states where TANF time limits are coming into effect, 70 to 80 percent of families did not have any child support collected for them in the 12 months before benefits

Gathering quality information from parents during the first interview is critical in helping to collect child support.

ended. More than half of the child support cases without collections even lacked court orders obligating noncustodial parents to pay child support at the time assistance ended. The report emphasized collecting better information from custodial parents at the first interview for services to help collect child support.[4] Improving information collected by DHS workers about missing parents would help OAG find these parents and obtain child support.

- Finally, getting families suffering from domestic violence into programs that can help break the cycle of abuse demonstrates the need for comprehensive family assessments. Victims of domestic violence have higher risks of failing the health and human services system. 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.[5] Sunset interviews with DHS eligibility workers showed that identifying, assessing, and referring families suffering from domestic violence to support services is not a priority.

▼ Other states have adopted more intensive case management models to help families with multiple barriers become independent from public assistance.

- Oregon has developed a family-centered case management model addressing the need for assessment, service coordination, and case management over time, as shown in the chart, *Focal Points of Case Management - Oregon Model.* Oregon also has guidelines and decision criteria assisting case managers in assessing families depending on particular circumstances, which could involve domestic violence, pregnancy in the home, child care needs and other issues. While Texas provides the work-oriented assessment at TWC, the chart shows the range of potential issues that can be addressed in a family assessment.

- Other states, including Illinois, Minnesota, Nebraska, and Oregon, are providing more intensive services to families that are at-risk of failing the TANF system. Oregon identified problems faced by the "bottom third" of the 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).[6] 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.[7]

Focal Points of Case Management - Oregon Model

Work Status			Family Issues					Teens
Working	**Ready to Work**	**Almost Ready toWork**	**Youth & Child**	**Pregnancy & Infants**	**Substance Abuse & Health**	**Domestic Violence**	**Child Support**	**Teen Parent**
getting a better job skills training	job search child care transportation	work experience life skills GED and training	education juvenile justice abuse and neglect counseling or therapy	nutrition prenatal care immunizations childhood development early intervention	obtain evaluations identify substance abuse identify health concerns arrange treatments	identify violence safety planning counseling medical treatment	cooperate with child support paternity establishment paying support visitation issues legal rights	safe living high school completion family planning parenting issues

Conclusion

Welfare reform efforts are placing greater emphasis on employment and training designed to assist families achieve independence. As these changes occur, identifying the services the family needs to achieve independence and connecting the family with those services becomes increasingly important. As the agency that determines eligibility for welfare programs, DHS is the State's central point of contact with families. However, DHS' traditional approach of taking applications and determining eligibility is no longer sufficient to meet families needs in the welfare reform environment. Instead, DHS must assess those needs, identify and obtain services, and follow-up with families to assist in the independence effort.

As DHS moves toward a case management approach, case managers will identify a wide range of State-supported services to assist families. For services other than TANF, Food Stamps, and Medicaid that carry income eligibility requirements, DHS will have to refer clients to another agency. Families would be better served by identifying agencies with eligibility-based programs and moving the application and determination of eligibility for those programs to the DHS family assessment model.

Recommendation

Change in Statute

Phase I

- **Continue the Department of Human Services with responsibility for family assistance programs for eight years.**

DHS would retain current eligibility determination functions for TANF, Food Stamps, and Medicaid. The agency would also retain responsibility for the Refugee Cash Assistance, Medical Assistance, and Social Services programs, as well as the Disaster Assistance program. The programs related to long-term care, currently the responsibility of DHS, would be transferred to a new long-term care agency, as discussed in Issue 11 of this report. The Department would continue to be responsible for operation of SAVERR system and would need to coordinate with HHSC as the Texas Integrated Enrollment and Services (TIES) project is phased in, and the old SAVERR computer system is replaced. The Department would be continued until September 1, 2007.

DHS Core Functions

Family Assessment
- ✓ Family Issues
- ✓ Education
- ✓ Child Support
- ✓ Domestic Violence
- ✓ Health/Safety Needs

Case Management
- ✓ Service Coordination
- ✓ Referral to Preventive and Support Services
- ✓ Referral to Employment Services
- ✓ Referral to Child Support Enforcement
- ✓ Post Assistance Follow Up

Program Administration
- ✓ TANF Eligibility
- ✓ Food Stamps Eligibility
- ✓ Medicaid Eligibility
- ✓ Benefits Sanctions
- ✓ Reporting Requirements

- **Require DHS to create a single comprehensive family assessment and case management function for all families eligible for DHS services, separate from the eligibility determination function.**

The recommendation complements and builds on the previous recommendations of the Sunset Commission related to DHS by expanding assessment and case management services for all families, not just at-risk families. The new case management function of DHS would improve client access, and referral to family support services including employment, child support services, family violence services and other preventive services. Specifically the recommendation requires that DHS:

- develop a single comprehensive assessment tool for all families eligible for DHS services,
- create a case management and referral function, and
- develop job descriptions, policy guidelines, and training for case managers who assess families.

DHS would provide this assessment as a case management service to all families eligible for programs under the agency's administration. When a family no longer requires, or is no longer eligible for services, DHS should provide follow up services to determine how successful the family was in achieving independence. Client assessments relating to employment skills will be performed by TWC providers. In fiscal year 2003, the Texas Workforce Commission will be under Sunset review, allowing an opportunity to assess this aspect of the service delivery system and consider further changes.

Phase II

- **Require HHSC to evaluate whether other eligibility-based family assistance programs should be transferred to DHS.**

The State provides several benefit programs for low-income families that are not currently administered by DHS. The most significant example is the Special Supplemental Nutrition Program for Women Infants and Children (WIC) administered by the Department of Health. WIC provides vouchers for supplemental foods for low-income families that are nutritionally at-risk. Eligibility is determined by local WIC providers.

The addition of other eligibility-based family support programs to DHS should be considered as efforts to assess the effectiveness of changes in local service delivery are completed and as the State seeks to centralize and streamline eligibility processes with the implementation of TIES. Moving these programs to DHS would allow the Department to become the single-door entry point for the State's eligibility-based programs. Given other recommendations in this report regarding the expanded oversight role of the Health and Human Services Commission, it would be best positioned to make these evaluations and recommend action to the Legislature.

State Impact

The new DHS assessment function would improve the delivery of family support services to the State's most needy families. The agency would be able to focus on meeting the needs of families to help eliminate the risk of these families failing the TANF system, and focus on achieving closer client/agency cooperation. The case management function would increase the State's ability to meet federal work participation rates, by increasing positive outcomes for families, such as meaningful independence from public assistance. In addition, the State would have the opportunity to impress on clients the importance of cooperation with child support requirements, and secure better quality information to assist with child support collection efforts.

The State would also be better able to administer aspects of the TANF program, such as mediating sanctions for noncooperation, and hopefully reduce the need to sanction clients by achieving a higher rate of compliance with program requirements. More effective

processing of sanctions would create savings for the State, and increase client participation rates. The table, *Goals of HB 7*, shows the goals contained in HB 7 that are met through the implementation of this recommendation.

Goals of HB 7	
Objective	**Applies**
Facilitates Comprehensive, Statewide Planning and Policy Development	
Enhances Continuum of Care for Clients	✔
Achieves Integration of Services to Improve Client Access	✔
Maximizes Existing Resources	
Improves use of Management Information Systems	✔
Foster Innovation and Decision Making at the Local Level	✔

Local Impact

At the local level, this recommendation should improve the delivery of family support services, and coordination of local support services, by having case management staff familiar with the situations of individual families serving as a point of access for local entities such as workforce centers, family centers, community organizations, and faith-based organizations. Improved access to agency staff will increase local involvement and input in to the processes of helping families become independent.

[1] DHS, TWC, HHSC, TCWEC, the Governor's Office, *Legislative Issues Welfare-to-Work,. Submitted to the Texas State Legislature*, Draft, September 1998.

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

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

[4] United States General Accounting Office. *Welfare Reform - Child Support an Uncertain Income Supplement for Families Leaving Welfare.* GAO/HEHS-98-168. August, 1998. Page 2.

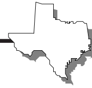
[5] Jody Raphael and Richard M. Tollman, Ph.D., *Trapped by Poverty, Trapped by Abuse: New Evidence Documenting the Relationship Between Domestic Violence and Welfare*, School of Social Work, University of Michigan, April 1997, Page II.

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

[7] Ibid.

Issue 13

Improve the Delivery of Protective Services through Consolidation of Protective Programs.



Background

Protective services provided by the State include child protective services, adult protective services, family violence services, and regulation of child care facilities. The State's system of delivering services to protect children and families from abuse, neglect, and violence has undergone tremendous change over the last five years. Historically, all services were provided by the Department of Human Services (DHS). Some individuals voiced the concern that the State's protective services were overshadowed by the larger public assistance programs administered by DHS. In response, in 1991, the Legislature created the Department of Protective and Regulatory Services (PRS) as a part of House Bill 7. The child protective services, adult protective services, and child care licensing functions formerly carried out by DHS were transferred to the new protective services agency to raise the visibility of these critical state services. When PRS was created, the Family Violence program was left at DHS. This reorganization strategy allowed PRS to focus on improving service delivery of its largest protective services functions.

The State's system of delivering services to protect children and families has undergone tremendous change in the last five years.

The Department of Protective and Regulatory Services provides protective and preventive services to children, individuals with disabilities, and the elderly who have been victims of abuse, neglect, and/or exploitation through four programs: Child Protective Services, Adult Protective Services, Child Care Licensing, and the Community Initiatives Division. The mission of Child Protective Services (CPS) is to ensure that children and youth live in safe, nurturing, permanent homes, free from abuse or neglect. CPS investigates child abuse and neglect by parents or others responsible for the child and provides services when caregivers cannot act in their protective role. CPS services include intake/investigations, family preservation, foster care, and adoption.

Adult Protective Services (APS) are similar to CPS services and are aimed at protecting persons 65 years and older and individuals with disabilities from abuse, neglect, and exploitation. Major APS activities include community investigations, mental health and mental retardation facility and

community center investigations. The services provided through CPS and APS are not voluntary. PRS contracts with local providers to deliver services such as residential care and therapy. PRS is also responsible for licensing and regulating child residential and day care facilities to ensure that licensees meet minimum standards and provide a caring, safe, and healthy environment for children.

The Community Initiatives Division is responsible for managing community-based programs to prevent child abuse, neglect, and delinquency. The Community Initiatives Division contracts with local community agencies to provide prevention programs.

The Children's Trust Fund (CTF) is also involved in child abuse and neglect prevention efforts. This agency is the subject of a separate Sunset staff report issued during this Sunset review period.

The Family Violence Program has been located in DHS since the program was established in 1981 and is currently administered by the Intergovernmental Affairs Division of DHS. The program provides funding for shelters across the state to house women and children on a short-term basis who are fleeing a violent situation. The services provided through the Family Violence Program are voluntary. The Legislature appropriates funds for the program, and DHS contracts with local family violence centers to provide services. Each local center is an independent, non-profit agency with a board composed of representatives from the local community. Funding through DHS represents, on average, approximately 29 percent of local family violence centers' budgets. DHS currently contracts with the Texas Council on Family Violence for administration of the family violence program which includes providing technical assistance to shelters, training, public education, and policy development. DHS also provides funding to local providers for nonresidential services such as legal and therapeutic services through federal grant money. DHS currently contracts with 75 non-profit organizations, including 66 shelters, to provide direct services to victims of family violence.

A negative perception of PRS' early performance, particularly in the delivery of child protective services, has resulted in a continued strained relationship between PRS and other state agencies. In some instances, this negative perception has prevented agencies that deliver protection or prevention services from working together and coordinating service delivery at the local level, resulting in limited access to services in some communities. Communities are forced to coordinate these services among multiple agency service delivery systems and providers are subject to multiple contracting requirements for similar services. The end result is that children and families are not receiving the quantity and quality of protection and prevention services

they need. Through the Sunset process, staff has identified a number of ways that the efforts of these agencies can be combined to more effectively meet the varied needs of this population.

Findings

▼ **The State's protective services are fragmented with separate grants to local agencies, contractor selection, administration, and monitoring processes.**

- The Legislature created PRS in 1991 to focus more attention on the protection of the State's most vulnerable citizens by consolidating most protection programs in a single agency. In 1997, PRS spent $436 million on protective services for children, adults and their families.

- During the creation of PRS and the reorganization of protective services, the Family Violence Program was retained at DHS to allow PRS to focus on improving the State's ability to deliver child and adult protective services. While family violence services are voluntary and the services delivered through CPS and APS are not, the programs share one important characteristic. All seek to get individuals out of violent situations and ensure that they are able to remain in a safe environment.

Both PRS and the Family Violence Program seek to get individuals out of violent situations.

- Communities seeking to obtain funding for protective services programs must now make application to two separate agencies. As the chart, *Grant Programs at PRS and DHS*, shows, both agencies fund local providers to deliver services.

- Each grant program has different contracting and monitoring requirements. Currently, the number of providers who deliver prevention services and family violence services is limited. However, as nonresidential services are expanded, this administrative overlap is likely to increase since some current providers of prevention services have the capacity to provide all of the required family violence services as well, except residential services. These providers could begin to receive funding from the Family Violence Program in addition to funding already being received from PRS and CTF. More information on nonresidential services is provided later in the issue.

Grant Programs at PRS and DHS

Agency	Programs	Eligible Population (Direct Services)	Number of Contracts for Direct Services FY 97	Number of Participants in Agency-Funded Programs FY 97	Funding
PRS	STAR Community Youth Development Family Outreach Texas Families Together and Safe	Children and their families who seek services or who have been identified as at-risk of future trouble.	101	55,210	$33.2 million in FY 1997
DHS Family Violence	Family Violence Shelters Nonresidential Services	Client population is mostly women, often accompanied by children.	68	52,909	$25.2 million in FY 1998-99 biennium

▼ **Coordinated policy development and planning is needed to address situations where clients are involved in multiple systems.**

- The separation of the Family Violence Program from other protective services creates some problems in the coordination of each agency's functions. For example, CPS occasionally receives a report of child abuse for a child residing in a family violence shelter. In many instances the alleged batterer is the same individual the woman is trying to escape by going to the family violence shelter. However, many family violence shelters do not want to provide any information to CPS about whether the woman or the child is in the shelter for fear that the batterer will find out where the woman is located. While the concerns of the shelter are valid, CPS is required by law to pursue reports of child abuse. The refusal of the shelter to cooperate with CPS greatly delays investigation of the case and may place the child at greater risk for future abuse.

- The separation of prevention services grant programs among different agencies makes strategic planning across programs difficult. Identifying local needs and developing a plan for how the State can meet those needs is essential to take advantage of the State's limited resources and create coordinated service delivery. Consolidation of prevention programs and family violence efforts would enable the State to ensure coordination where appropriate between family violence shelters and providers of prevention services.

▼ **Referrals between local family violence programs and prevention programs are limited.**

- At the local level, referrals from family violence shelters to PRS prevention programs are not common. Children who enter family violence shelters have a wide range of needs. Some of these children may be victims of abuse and neglect. In these cases, the family violence shelter will refer the case to Child Protective Services at PRS and the court system is responsible for resolving the situation. In some instances, however, the child may have been living in a violent home but may not have been abused. For these children, the types of prevention programs offered through both PRS and CTF are critical to teach these children skills to keep themselves safe in the future and learn more productive ways to relate to others. For the parents in the family violence system who were victims of abuse, these programs may also provide useful information on different ways to parent to better meet the needs of their children.

- Fragmentation of prevention programs between PRS and the Children's Trust Fund also makes coordination between family violence programs and prevention programs difficult and may prevent clients from accessing all the services available in the community. Individuals may only be aware of the services provided through the family violence shelter or the local prevention program instead of being provided information about all services in the community.

Fragmentation of prevention programs between PRS and CTF makes coordination between family violence programs and prevention programs difficult.

Before the creation of PRS, the Legislature severed CTF's administrative relationship with DHS and designated it as an independent state agency. CTF provides funding to local agencies for a variety of child abuse and neglect prevention programs. Since its inception, PRS has evolved into an agency that provides an array of prevention services in addition to the protective services for children and adults. In 1997, PRS spent approximately $33 million to fund a variety of local prevention programs. However, consolidation of the State's prevention programs is not included in the recommendations that follow.

Conclusion

Clients do not have easy access to the full array of state services for individuals in at-risk situations.

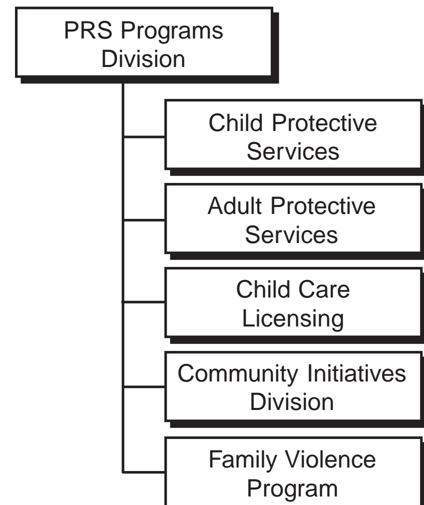
Both PRS and the Family Violence Program seek to protect individuals from violent situations. The Legislature has designated PRS as the agency responsible for protecting vulnerable children and adults from abuse and neglect. In addition, a number of the individuals receiving family violence services may also be in need of services provided by PRS. The current relationship between family violence shelters and PRS' prevention programs, as well as CTF, results in clients not having easy access to the full array of state services for individuals in at-risk situations. This means that children and families who could benefit greatly from a variety of prevention programs may not have knowledge of or access to these programs, thus perpetuating the cycle of violence.

In addition, while the services provided in family violence shelters are different from the prevention programs managed by PRS, all of these programs are administered through grants to local providers. Maintaining separate administrative systems at the state level to carry out the same function prevents the development of a comprehensive strategic plan and makes accountability for delivering effective services difficult. Separation of the programs also contributes to the number of agencies with which communities have to interact as they seek to obtain funding to develop a coordinated system of protective services. Streamlining administration of services should result in more dollars available to fund direct services.

Recommendation

Change in Statute

- **Transfer the Family Violence Program to the Department of Protective and Regulatory Services.**



The Family Violence functions currently located at DHS should be transferred to PRS and placed as a distinct program under the Programs Division, as shown to the right. The funding for family violence shelter and nonresidential services would continue to be available to local providers who meet the State's qualifications. Since PRS currently administers significant grant activities through its child abuse prevention programs, the Family Violence program should work with the Community Initiatives Division to develop common contracting and monitoring processes where appropriate. While PRS is not

currently under Sunset review, its Sunset review date should be moved to 2007 to coincide with the review of HHS agencies.

State Impact

This transfer would streamline administration of grants and allow the State to strategically plan for the most effective way to deliver these services. Consolidation would also create a single point of accountability for the protection of Texas' children and families and decrease confusion at the local level regarding sources of funding and technical support to deliver these services. Consolidation of all child abuse prevention programs at PRS would facilitate the successful collaboration of family violence services and prevention services. Again, while this consolidation could include the functions of the Children's Trust Fund, this is not included in this staff recommendation. The table, *Goals of HB 7*, shows which of the goals contained in HB 7 are met through the implementation of these recommendations.

Goals of HB 7

Objective	Applies
Facilitates Comprehensive, Statewide Planning and Policy Development	✔
Enhances Continuum of Care for Clients	✔
Achieves Integration of Services to Improve Client Access	✔
Maximizes Existing Resources	
Improves use of Management Information Systems	
Foster Innovation and Decision Making at the Local Level	✔

Local Impact

At the local level, this recommendation seeks to:

- create consolidated planning and policy development for all programs relating to children and families in dangerous situations;
- ensure connection of family violence victims with prevention programs at the local level;
- streamline the grantmaking process and local provider contract administration;
- require providers of PRS prevention services and DHS family violence services to work with other local organizations involved in abuse prevention to develop procedures for referral across programs; and
- encourage local advocacy groups and policy development boards such as the Family PRIDE Councils, Child Welfare Boards, and Local Councils on Family Violence to coordinate their efforts.

Alternative to Program Consolidation

In the event that administrative consolidation of Family Violence is not deemed feasible at this time, Sunset staff offers the following alternative to better integrate services between the agencies to achieve important service delivery improvements.

Recommendation

Change in Statute

- **Require the DHS Family Violence Program and PRS to develop policies and procedures to coordinate their activities at the state and local level.**

Coordination between PRS and DHS' Family Violence Program would include:

- requiring a joint plan on how the State will deliver services to children and families in at-risk situations;
- developing streamlined contracting and reporting requirements;
- coordinating the development of community-directed service delivery systems;
- developing policies to guide the referral of clients between local providers; and
- developing policies to resolve issues surrounding individuals receiving services from both agencies.

State Impact

Better coordination between PRS and the Family Violence Program should resolve some long-standing conflicts between the agencies regarding clients involved with both agencies. The development of guidelines for referring clients between PRS prevention programs and family violence shelters should increase access to services at the local level.

Local Impact

At the local level, this recommendation seeks to:

- increase referrals between family violence programs and PRS prevention programs; and
- enable better identification of community needs, planning for how to meet those needs, and the consolidation or coordination of resources to see that it happens.

Improve Administration of and Expand Family Violence Services

Regardless of the action taken on the previous recommendations in this issue, Sunset staff offers the following improvements to how family violence funds are used.

Background

Current law limits state funding of family violence services to facilities that provide residential services to victims of domestic violence. As a result, funds appropriated by the Legislature for the DHS Family Violence Program can only be used to fund shelter services. State funds cannot be used to fund comprehensive nonresidential family violence centers, even if such centers meet all the criteria except for providing residential shelter for victims of family violence. Federal family violence funds can be spent on nonresidential family violence programs, and federal law requires that a portion of federal family violence funds go for nonresidential services. In the current biennium, DHS has funded nonresidential family violence programs using federal funds it receives separate from funds appropriated by the Legislature for family violence shelter centers. In fiscal year 1998, DHS funded four nonresidential service providers through the federal Family Violence Prevention Act at a total annual amount of $1.7 million.

State funds cannot be used to fund comprehensive nonresidential family violence centers, even if such centers meet all the criteria except for providing residential shelter for victims of family violence.

Current law also requires DHS to contract for the delivery of a portion of the Department's family violence services for technical assistance and training for family violence shelters. The Department can also choose to contract out additional services such as public education and research. DHS meets this requirement through two contracts with the Texas Council on Family Violence. One contract is for training, technical assistance, and public education and the other is for administration including policy development and implementation, education and information to other professions, and assistance in developing reports to comply with state and federal laws.

Findings

▼ **Many individuals seeking to escape a violent situation do not need residential services.**

- While some victims of family violence need to move into a shelter for a short time to escape the batterer, others do not need or want to go into a shelter. Their needs can be met through comprehensive nonresidential services such as safety planning, legal assistance, counseling, nonresidential support

groups, job planning and placement, and assistance in finding housing, transportation, and child care. Even for clients who move into a shelter, nonresidential services can become a very important source of support once they leave the shelter.

- The federal government has recognized the benefit of providing nonresidential services. In fiscal year 1998, DHS received $3.3 million in Family Violence Prevention Act dollars. The federal government requires that 25 percent of those funds be spent to support nonresidential services.

▼ **The statutory requirement to fund only residential services prevents the State from meeting the need for broader family violence services.**

Allowing state funding for comprehensive nonresidential family violence centers would expand the availability of services to more communities.

- Many urban and rural areas of the state do not have sufficient family violence services to meet the needs of their communities. Allowing state funding for comprehensive nonresidential family violence centers would expand the availability of services to more communities. A wide array of providers exist who are already involved in providing services in the community to children and families. The requirement to provide residential care prohibits many of these local agencies from serving this population. In addition, some individuals may not want to receive shelter services and therefore do not have access to any family violence services.

▼ **DHS has not competitively bid the contract for family violence technical assistance and training services since 1982.**

- DHS currently contracts with the Texas Council on Family Violence for administration of the Family Violence Program, which includes providing technical assistance to shelters, training, public education, resources, and program and policy development. In 1985, the family violence contract was for approximately $91,000. By 1997, the contract had risen to $975,000. When the Family Violence program began, individuals and organizations with expertise in family violence issues were less common. The only organization with enough knowledge of the issues to assist DHS was the Texas Council on Family Violence. In recent years, however, a wide variety of organizations have developed expertise in specific issues

surrounding the problem of family violence. Expanding contracting options to a variety of organizations could ensure that the State is receiving the highest quality services for all its Family Violence Program needs.

Recommendation

Change in Statute

- **Expand the definition of family violence service providers to allow state funding of nonresidential family violence centers.**

This recommendation would remove the arbitrary limitation on the types of family violence services funded and allow the State to fund a mix of residential and nonresidential services as appropriate. Nonresidential family violence centers should meet all the requirements that family violence shelters must meet, with the exception of having a residential shelter within their program. To assure that the nonresidential centers are well-established and supported by the community, they should be required to be in operation and providing comprehensive family violence services for at least three years before becoming eligible for funding. Before granting funding to a nonresidential center, DHS, or its successor, should be required to determine that the center would address an unmet need in the community.

- **Require contracts for family violence training and technical assistance services to be competitively bid.**

Competitive procurement would ensure that the providers of family violence support services consistently deliver high quality services in an attempt to remain the State's contractor. The Department should also explore the benefits of breaking the contract up rather than bidding the contract as a single package. Providers may have expertise in one area, such as training or technical assistance, that is a better value for the Department, or its successor, than if all services were received from one provider.

Standardization of Client Abuse and Neglect Complaint Functions

Regardless of the action taken on the previous recommendations in this issue, Sunset staff offers the following improvements for agencies that self-investigate allegations of abuse and neglect.

Background

A number of state agencies conduct investigations of abuse and neglect within their own facilities. For example, the Texas School for the Deaf conducts all investigations into abuse and neglect at the School for the Deaf. The text box, *Agencies Conducting Abuse and Neglect Self-Investigations,* presents a list of the agencies that self-investigate claims of abuse and neglect. Nursing homes are not included in this list because they are governed by a separate statute.

Agencies Conducting Abuse and Neglect Self-Investigations

- Department of Protective and Regulatory Services
- Texas School for the Deaf
- Texas School for the Blind
- Texas Juvenile Probation Commission, Pre- and Post Adjudication Facilities
- Local Law Enforcement for County Juvenile Detention Centers
- Texas Youth Commission facilities
- Texas Commission on Alcohol and Drug Abuse
- Texas Rehabilitation Commission
- The University of Texas System-psychiatric hospitals
- Texas Department of Health- private

In 1995, the Legislature passed a law requiring all agencies that investigate their own facilities to develop rules for the investigation, issue a written report, notify law enforcement of any reports received, and maintain statistics on incidence of child abuse and neglect in the facility. At the present time, the degree with which these agencies have complied with the above requirements is unknown.

A variety of definitions of abuse and neglect are used by these agencies to determine whether a claim of abuse or neglect warrants investigation. Some agencies use the definition contained in the Family Code, which was designed to protect individuals living in their own home with other family members. Others follow the definition set out in the Human Resources Code, which focuses on the abuse and neglect of the elderly. Still others use the definition contained in the Administrative Code of the Department of Mental Health and Mental Retardation, which contains a broad definition covering individuals of all ages and addresses the needs of individuals who reside in out-of-home placements. The Legislature began to address the issue of common definitions in 1997 with the passage of Senate Concurrent Resolution 28, stating that the psychiatric hospitals in the University of Texas System

should use the definitions of abuse and neglect found in the Human Resources Code and report all investigative activities to the Governor, Lieutenant Governor, and the Legislature.

Findings

▼ **The agencies conducting self-investigations continue to use different definitions of abuse and neglect, resulting in the potential for conflicting policies on conducting investigations.**

- All of the agencies listed in the text box, *Agencies Conducting Abuse and Neglect Self-Investigations*, have a definition of abuse and neglect that is used to determine whether an investigation of a claim is needed. In addition, each of the agencies is required by law to develop policies and procedures governing their investigations of abuse and neglect. No central reporting has been done to determine what definitions are being used or whether the agencies have developed appropriate policies and procedures to guide abuse and neglect investigations.

No central reporting has been done to determine what definitions are being used to guide abuse and neglect investigations.

▼ **The different definitions result in conflicting methods of counting and classifying incidents of abuse, making investigation performance across agencies difficult to assess.**

- Many of the agencies keep data on items such as the number of investigations and the percentage of confirmed cases of abuse and neglect. However, the different definitions and conflicting methods of counting and classifying incidents results in information that is not consistent and cannot be easily compared. Measuring whether an agency is appropriately and effectively carrying out investigations is difficult if the State cannot compare the activities of all the agencies conducting self-investigations.

- Differing data collection methods also prevent the State from having a clear understanding of the prevalence of abuse and neglect in out-of-home placements. This information is essential to evaluate the best methods for investigating abuse and neglect in a variety of institutional settings.

Recommendation

Change in Statute

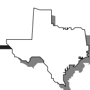
- **Require all agencies conducting self-investigations of abuse and neglect complaints in residential or institutional facilities to develop, and adopt as formal rules, common definitions of abuse and neglect no later than September 1, 2000.**
- **Require PRS to report these common definitions to the Health and Human Services Commission by October 1, 2000.**
- **Require each agency to submit a report to the Department of Protective and Regulatory Services detailing the agency's efforts to develop rules governing the agency's investigative functions by January 1, 2000.**
- **Require that each agency submit a quarterly report and annual report of all investigative activities beginning January 1, 2000, to the Department of Protective and Regulatory Services that includes, at a minimum:**
  - **the number of investigations conducted at each facility;**
  - **the number of serious physical injuries sustained by patients at each facility;**
  - **the average number of days required to complete an investigation at each facility;**
  - **the number of investigations referred by each facility to law enforcement agencies; and**
  - **the number of confirmed cases at each facility.**
- **Require PRS to submit a consolidated annual report to the Health and Human Services Commission and to the Governor, Lieutenant Governor, and Speaker of the House no later than December 1st of each year beginning December 1, 2000.**

Consistency across agencies regarding the definitions used to conduct investigations of abuse and neglect will ensure that all individuals residing in out-of-home placements are equally protected under the law. Requiring the common definitions to be placed in each agency's rules will ensure public comment in the development of the definitions. Based on PRS' report on the definitions, HHSC may then make recommendations to the Legislature if further legislative action is needed.

In addition, common data collection methods will allow the State to have a better understanding of the pervasiveness of abuse and neglect in out-of-home settings. This information can be used to make decisions on the best method for conducting these investigations and evaluate the value in transferring responsibility for all investigations to one agency, such as PRS.

Issue 14

Improve the Delivery of Mental Health and Substance Abuse Services Through Improved Planning, Service Integration, and Possible Consolidation



Background

In Texas, mental health services and substance abuse services are the responsibility of two separate agencies. Mental health services are primarily provided by the Texas Department of Mental Health and Mental Retardation (TDMHMR) and substance abuse services are the primary responsibility of the Texas Commission on Alcohol and Drug Abuse (TCADA). TDMHMR is the State's mental health authority with responsibility for planning, policy development, resource development, and allocation for and oversight of mental health services in the state. TDMHMR provides campus-based mental health services though the eight state hospitals it operates and community-based mental health services through its system of 38 locally-operated, state-funded, community mental health centers (centers). In addition, TDMHMR operates 10 state-operated community services which provide community-based mental health services in largely rural areas.

In Texas, mental health services and substance abuse services are the responsibility of two separate agencies.

TDMHMR focuses its services on those individuals most in need of services, and provides mental health services to over 100,000 persons a year in its state hospitals and community mental health centers. The community centers are governed by a locally-appointed board of directors. Each center receives funds from the Department through a performance contract that specifies the types and quantities of services each center is to provide, and the population which is eligible for services. TDMHMR's mental health program provides mental health assessments and coordinates treatment, training, and supports for individuals with severe and persistent mental illness. Centers provide many services and contract with private providers for others.

TCADA coordinates alcohol and drug abuse services and funds community-based prevention, intervention, and treatment services. TCADA works to change attitudes and behaviors relating to the use of alcohol and drugs through prevention, education, and treatment. Prevention services are intended to reduce a person's risk of abusing alcohol or a controlled substance or

becoming chemically dependent. To meet these goals, TCADA conducts needs assessments, studies and distributes information on the problems of chemical dependency, educates the public on the prevention and treatment of chemical dependency, and trains professionals about substance abuse services. In addition, TCADA licenses all chemical dependency treatment facilities and chemical dependency counselors in the state, and certifies driving while intoxicated education and repeat offender programs.[1]

TCADA does not directly provide services to clients but contracts with private providers to provide a continuum of prevention, intervention, and treatment services. TCADA provides technical support to service providers, evaluates service providers' performance, and monitors compliance of substance abuse programs, facilities, and professionals. TCADA also funds 49 Councils on Alcoholism and Drug Abuse (Councils) to provide screening, assessment, and referral activities for each of the 254 counties. Outside of providing essential community services, Councils distribute information, work on social policy issues, and follow-up on clients once they are placed for services.

TPR recommended that the Legislature consider the pros and cons of combining TCADA and TDMHMR.

Although TDMHMR is the State's primary provider of mental health services, and TCADA is the State's primary provider of substance abuse services, other agencies provide or purchase mental health and substance abuse services. These agencies include the Texas Rehabilitation Commission, Texas Youth Commission, Texas Juvenile Probation Commission, Texas Department of Protective and Regulatory Services, the Texas Education Agency, the Texas Department of Health, Texas Department of Criminal Justice, and the Texas Council on Offenders with Mental Impairments. A general description of each agency's services is on the following page.

Reevaluation of the State's service delivery system for mental health and substance abuse services has historically centered around two issues—the appropriate roles of the state and local mental health authorities and whether the State should maintain separate agencies for mental health and substance abuse services. In 1997, TDMHMR was required by H.B. 1734 to form an advisory committee to direct the development of an appropriate structure for the management and delivery of mental health services in Texas. The committee found that the State's role in the delivery of mental health services is fragmented and uncoordinated due to the overlap or intersection of responsibilities of different state agencies, both in terms of funding for services and in terms of their policymaking and regulatory authority.[2]

In *New Models of Care*, a report on TDMHMR published in 1996, the Comptroller's Texas Performance Review (TPR) recommended that the Legislature consider the pros and cons of combining functions of TCADA with those of TDMHMR. TPR's review identified potential opportunities

Agency	Mental Health	Substance Abuse
Texas Rehabilitation Commission	TRC provides vocational rehabilitation services to persons with mental illness and purchases mental health services for clients as part of its vocational rehabilitation program.	TRC provides vocational rehabilitation services to persons with a history of alcoholism or drug abuse and purchases substance abuse services to help clients transition to employment.
Texas Youth Commission	TYC operates an impatient facility for clients with mental impairments. It also provides medications, counseling, and other treatments to youth in its other facilities and youth on parole.	TCADA funds treatment services to juvenile offenders at TYC.
Texas Juvenile Probation Commission	TJPC provides limited funding to local probation departments for the purchase of mental health care. TJPC also funds inpatient facilities that treat youth with mental impairments.	TCADA transfers funds for prevention and treatment services to TJPC each year for the purpose of funding substance abuse grants to local juvenile probation departments.
Texas Department of Protective and Regulatory Services	Children in the custody of PRS and some who are not in custody but who have been abused or neglected may receive mental health treatment (inpatient and outpatient) through the Medicaid fee-for-service program.	TCADA funds prevention and treatment services to children in foster care at PRS.
Texas Education Agency	Local school districts determine if students are in need of mental health services, which may be provided with local and federal funds. TEA also has a small amount of funds for mental health services to children.	Local school districts determine if students are in need of substance abuse services, which may be provided through the State Compensatory Education Project. Federal funds are also used for prevention and education efforts in the schools.
Texas Department of Health	TDH, through the state Medicaid program, funds inpatient, outpatient, and medication for mental illness to children and adults on Medicaid.	TDH, through the state Medicaid program, funds a limited amount of substance abuse treatment to children and adults on Medicaid.
Texas Department of Criminal Justice	TDCJ provides mental health services to inmates in the prison and parole system.	TDCJ Provides substance abuse treatment services to inmates in Substance Abuse Felony Punishment Facilities (SAFPF). TCADA also transfers funding directly to TDCJ for the provision of substance abuse treatment programs for probationers.
The Texas Council on Offenders with Mental Impairments	TCOMI contracts for mental health services mandated by parole boards or courts as a condition of release from custody. Currently, TCOMI purchases case management, medication, and other support services from nine community MHMR centers.	TCOMI funds Good Chemistry groups for offenders with substance abuse and mental disorders. TCOMI also funds local substance abuse prevention and education efforts.

for improved consumer services, savings, and the elimination of redundant management systems. Included in TPR's discussion are many factors for consideration, including the agencies' separate but complementary missions, the two agencies' shared client population, the future of managed care, and administrative and functional duplication.

In this issue, Sunset staff identified the services each agency provides, the populations eligible for services, and the commonalities between each agency's services and target populations. In doing so, staff identified fragmentation in the planning and delivery of mental health and substance abuse services. The evaluation of these fragmented programs was undertaken with the goal of restructuring services to better meet the broader goals of the Legislature, as established in House Bill 7.

Findings

▼ **The State does not have a comprehensive approach for the delivery of mental health and substance abuse services.**

- Planning for mental health and substance abuse services is fragmented. TDMHMR conducts planning and identifies local needs and priorities for mental health services, but only for a subset of the population with mental illness. TCADA is federally required to determine the incidence of and assess the need for state alcohol and drug abuse services, but also focuses its efforts on those populations and geographic areas with the greatest need. Other agencies that provide mental health or substance abuse services conduct planning only for the services provided by their agency. Very little formalized or coordinated planning exists for mental health or substance abuse services.

- The H.B. 1734 Committee recognized that fragmented planning for mental health services exists and stated that to ensure coordination, consistency, and efficiency in services, a critical planning role must include mental health services that do not come under the direct administrative responsibility of the State.[3] The committee recommended that planning for mental health services at the state and local levels address the integration of all mental health services provided by the State, and mental health services with other service systems. The committee also recommended that the state mental health

authority define standards, rules, and performance expectations for all publicly and privately funded mental health programs.

- Data for a statewide needs assessment is lacking. Neither TDMHMR nor TCADA have data detailing the types and quantities of mental health and substance abuse services provided by other agencies or how much the State spends on mental health and substance abuse services. This information could be used by each agency to create efficiencies from better management and coordination of mental health and substance abuse services.

TDMHMR, although the State's mental health authority, does not have the ability to fulfill that role.

The current fragmentation in the delivery of mental health services leads to inconsistencies in the quality and types of services delivered.

- TDMHMR, despite its role as the State's mental health authority, does not have authority for setting standards and rules relating to the purchase, provision, and delivery of mental health services provided by other state agencies. Most agencies that provide mental health services define their own standards and expectations for performance, quality, outcomes, and rights protection. As a result, consumers of mental health services provided by the State receive different levels of care, without coordinated or consistent approaches to treatment.

- TDMHMR only serves a fraction of the persons with mental illness needing services. TDMHMR's statute requires that funds appropriated by the Legislature for mental health services may only be used to provide services to the Department's priority population (see text box, *Priority Population for Mental Health Services*). The priority population includes only 17.5 percent of persons in Texas identified as having a mental illness and, of these, TDMHMR serves about 25 percent. Persons with mental illness not served by TDMHMR, or not in its priority population, are served by other agencies, private systems, or do not receive services at all.

Priority Population for Mental Health Services

TDMHMR estimates that 2.9 million Texans have a mental illness. Statute directs TDMHMR to define a priority population to target limited resources on those who have the most severe mental illness and therefore are most in need. The priority population for mental health services includes:

- children and adolescents under the age of 18 who have a diagnosis of mental illness who exhibit severe emotional or social disabilities which are life-threatening or require prolonged intervention; and
- adults who have severe and persistent mental illnesses such as schizophrenia, major depression, manic depressive disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.

- Many agencies provide mental health and substance abuse services to clients, resulting in varied approaches to treatment. The mental health services provided by other agencies are typically secondary to the primary services an agency provides. As an example, in 1997, 21 percent of all clients served by TRC were diagnosed with a mental illness. TRC provided substantial mental health services to these clients to support their vocational rehabilitation. PRS provides mental health services to individuals in need of protective services. TDMHMR does not have the authority to ensure the quality or the standards of these State-provided mental health services. The lack of consistent standards may result in some agencies providing mental health services deemed ineffective by another agency.

No single system exists to treat the significant number of people who need both mental health and substance abuse services.

Parallel and separate systems of care for the delivery of substance abuse and mental health services leads to gaps in services.

- TDMHMR and TCADA share responsibility for the dually diagnosed, a large, high-risk, high-cost population (see text box, *Dual Diagnosis*). According to the Statistics Sourcebook of the Substance Abuse and Mental Health Services Administration, of the 35 percent of the population, age 15 to 54, who have had a mental disorder in their lifetime, 39 percent also had substance abuse and/or dependence. Of the 27 percent of the population, age 15 to 54, who have had substance abuse and/or dependence in their lifetime, almost half also had a mental disorder.[4] The prison population has a high incidence of co-occurring mental illness and substance abuse. The homeless are also characterized by a high prevalence of mental illness and substance abuse.

- No single system exists to treat the significant number of individuals who need treatment for both mental health and substance abuse disorders. For example, consumers who seek substance abuse services and have aggravated mental illness are often told to first get treated for their mental illness. Similarly, consumers who seek mental health services and are abusing substances are told to first undergo substance abuse treatment. This approach puts the burden on the consumer to access two separate systems for treatment of interrelated problems.

Dual Diagnosis

Individuals living with a co-occurring substance abuse and mental health disorder are commonly referred to as the dually diagnosed. Persons with schizophrenia and bipolar disorder, two psychiatric disorders most often associated with severe mental illness, are among those most likely to be dually diagnosed. Services to this population have focused on those patients with severe mental illness who also have alcoholism and/or drug addiction, and who need treatment for both disorders. Also in need of services are those individuals with a mental illness that is complicated by substance abuse, whether or not the patient views substances as a problem, and those individuals with alcoholism or drug addiction who have psychiatric complications, though not necessarily major mental illnesses.[5]

- In 1995, the Senate passed a resolution (SCR 88) to improve the delivery of services by integrating the current parallel, separate systems of care. SCR 88 resulted in what is now 12 pilot sites, funded by TCADA and TDMHMR, that have attempted to integrate mental health and substance abuse services. For most of the state, however, the dually diagnosed are required to access different agencies or programs for each of their disorders.

▼ **Several initiatives are currently underway to determine the best structure for overseeing the purchase of mental health and substance abuse services in Texas.**

- The Medicaid managed care pilots have attempted to integrate the provision of mental health and substance abuse services. In 1995, for example, the Senate passed a resolution (SCR 55) that directed the Medicaid division of the Health and Human Services Commission to develop and pilot a program which would integrate mental health and substance abuse services into Medicaid managed care on a pilot basis. In another pilot, NorthSTAR, the State plans to create a single, seamless system of public behavioral health care in which both chemical dependency and mental health services will be provided using Medicaid, state general revenue, and federal block grant funds.

- TDMHMR currently has five pilot sites exploring the role of the local mental health authority in the delivery of services as required by H.B. 2377 in 1995. Responsibilities of the local authority, as defined by H.B. 2377, include ensuring the provision of services by developing and managing a coordinated system of services in its area. As such, local authorities are moving from providing services to purchasing services through a network of service providers.

- H.B. 1734 further examines the role and responsibilities of the local mental health authority. H.B. 1734 repealed the preferential status given to community MHMR centers in their designation as local authorities and required TDMHMR to appoint a committee to determine, among other things, the responsibilities to be delegated by the state authority to the local authority. The committee's final report defines the responsibilities of both the state and local authority in the areas

of planning, policy development, resource development, resource allocation, oversight, network development, and consumer empowerment.

- TCADA has proposed a new model of managing access to and delivery of substance abuse services. In its Statewide Service Delivery Plan, TCADA states its intention to phase-in service networks across the state. This new model incorporates tools of managed care and brings decision-making down to the local level. The network system is intended to strengthen the continuum of care by integrating substance abuse services across prevention, intervention, and treatment. Provider networks will also serve to reduce the fragmentation and duplication of services that result from individual contracts with multiple providers.

  TCADA has piloted this model in two areas, Amarillo and El Paso, to test the feasibility of organizing a coordinated network of independent, community-based, non-profit service providers. The projects are performing prevention, central assessment, and case management services for member organizations. The central assessment and case management function in Amarillo has proven successful at bringing the mental health and substance abuse systems closer together and improving continuity of care.

Overlap between TCADA and TDMHMR will increase as TCADA builds a local infrastructure.

▼ Both agencies are investing in the development of local administrative functions.

- Administrative overlap between TDMHMR and TCADA is likely to increase as TCADA builds a local infrastructure to support the development of service networks. For example, at the state level, TCADA is in the process of developing appropriate monitoring methods and processes and a quality improvement system. The local infrastructure for the delivery of substance abuse services will be responsible for the financial and programmatic aspects of the network and will act as a gatekeeper that screens, assesses, and refers individuals and supervises case management within the service array.[6]

  TDMHMR has invested much time and resources in developing a local infrastructure capable of the planning, policy development, resource development and allocation, oversight, and network development functions. Many local

authorities have undertaken local planning and needs assessments. H.B. 2377 and H.B. 1734 greatly expanded the responsibilities of the local authority to include quality improvement processes, and monitoring and oversight of providers.

- In some areas, TCADA is using the TDMHMR administrative structure to oversee its programs. For example, in a pilot located in Amarillo, TCADA is contracting with the local mental health authority to serve as the network manager for substance abuse services. However, as TCADA establishes service networks across the state, it may contract with an entity other than a local MHMR authority to perform monitoring and oversight of substance abuse providers. Contracting with an entity other than a local MHMR authority would result in duplicative administrative structures at the local level performing essentially the same oversight functions, an inefficient use of limited resources. It would also prevent the two agencies from more closely aligning substance abuse and mental health services and achieving substantial benefits for clients.

▼ **Mental health and substance abuse services are consolidated in other models at the state and federal level, resulting in administrative efficiencies and client benefits.**

Approximately 20 states deliver mental health and substance abuse services through one agency.

- The federal Department of Health and Human Services oversees mental health and substance abuse services under one division, the Substance Abuse Mental Health Services Administration. Approximately 20 states deliver both mental health and substance abuse and alcohol services through one authority, or through an umbrella agency.[7] Several states, in addition to Texas, are pursuing innovative treatment models, including California, Maine, North Carolina, Oregon, Massachusetts, Ohio, and Arkansas.

- The management and administration of mental health and substance abuse services are often combined in both the public and private sectors. Private managed health care systems combine mental health and substance abuse services in a single benefit package. Several states have achieved significant savings and improved service access, choice, and coordination by combining substance abuse and mental health care functions into one contract.[8]

- As TPR found in its review of TDMHMR in 1996, both TDMHMR and TCADA are adopting some of the features of modern managed health care to improve public accountability and adapt to trends in health care delivery and financing.[9] Local monitoring and oversight of providers of mental health and substance abuse services is one step toward increasing accountability and ensuring that quality services are delivered efficiently. The two agencies will be better equipped to compete in the managed care environment if they continue to work in a more coordinated fashion to develop standards and tools to ensure the efficient delivery of behavioral health care.

Conclusion

Although TDMHMR is the State's primary provider of mental health services, and TCADA is the State's primary provider of substance abuse services, other agencies provide or purchase mental health and substance abuse services. The two agencies' authority to plan for the needs of all persons with mental illness and substance abuse is unclear. In this void, the State does not have a complete picture of the needs and potential efficiencies that could be gained with increased coordination. In addition, neither TDMHMR nor TCADA has authority to set standards, expectations, or use its expertise in mental health or substance abuse matters affecting other agencies. As a result, the quality of care differs from agency to agency due to fragmentation and a lack of consistency in standards and performance expectations.

The State has not yet determined how to best oversee the provision of mental health and substance abuse services.

Given the widely divergent nature of the many initiatives that are playing out in pilots and studies, the State has not yet determined how to best oversee the provision of mental health and substance abuse services. However, the testing and evaluation of these models must not happen independently of each other. Each model that is piloted results in a costly investment in local infrastructures, dollars which are no longer available for client services. The benefits found in these current pilots and studies, to be determined at their completion, should be the basis of any decision for reorganization. The best model will demonstrate the blending of funds and the integration of systems to achieve benefits both in terms of administrative efficiencies and consumer outcomes.

Recommendation

Change in Statute

Phase I

- **Continue the Texas Department of Mental Health and Mental Retardation for eight years.**
- **Require TDMHMR, TCADA, and any other state agency that provides mental health and substance abuse services, to work with the Health and Human Services Commission to develop a comprehensive service delivery report. This report should include:**
  - **a complete listing of all mental health and substance abuse services provided or purchased by, but not limited to, TRC, TYC, TJPC, DPRS, TDH, TEA, TDCJ, and TCOMI**;
  - **the populations to whom services are provided;**
  - **an account of all State resources expended on mental health and substance abuse services;**
  - **a detailed description of interagency coordination and collaborative initiatives related to mental health and substance abuse services; and**
  - **an assessment of the overlap of persons served across agencies.**
- **Strengthen the authority of TDMHMR and TCADA to set standards and expectations in mental health and substance abuse matters affecting other agencies.**

This recommendation would continue TDMHMR until September 1, 2007. To effectively carry out the development of a comprehensive report on mental health and substance abuse services, representatives from other agencies would be required to participate in local mental health planning advisory committees and TCADA's Regional Advisory Consortiums on an ex-officio basis. By coordinating service delivery and planning for all mental health and substance abuse needs among state agencies, with the oversight of the Health and Human Services Commission, efficiencies can be gained. A result of this planning should be improved coordination between state agencies and the local mental health authorities that oversee service delivery.

In addition, because TDMHMR is the primary provider of mental health care, and TCADA is the primary provider of substance abuse services, other agencies and systems should draw on the expertise of these two agencies when appropriate. This recommendation strengthens the ability of each agency to participate in the development of standards and

expectations for mental health and substance abuse services provided by other agencies or systems. This recommendation does not include a transfer of funding streams, consolidation of programs, or giving TDMHMR or TCADA the authority to approve the purchase of mental health and substance abuse services by other agencies.

Phase II

- **Integrate the service delivery structures for mental health and substance abuse services by combining administrative functions at the local level. This will include the creation of:**
  - **local behavioral health authorities responsible for planning for and overseeing the delivery of mental health and substance abuse services;**
  - **shared training, information management, and administrative support functions;**
  - **a shared approach to managing the quality of client care and access to services;**
  - **a single point of entry for mental health and substance abuse services with centralized screening, intake, scheduling, and assessment; and**
  - **integrated case management to coordinate the delivery of substance abuse and mental health services.**

To strengthen the continuum of care and reduce fragmentation and administrative duplication between substance abuse and mental health services, each agency's local administrative and service delivery functions should be integrated into a local behavioral health authority. The creation of local behavioral health authorities should follow the implementation and evaluation of the local behavioral health authority and NorthSTAR pilots, and allow for significant input from SCR 55 pilot results. Before determining the best model to use in the development of local behavioral health authorities, the recommendations adopted by the H.B. 1734 Committee, which will substantially impact TDMHMR's local authority structure, should be fully implemented and evaluated.

The local behavioral health authority will have both mental health and substance abuse advisory councils or other mechanisms to assure input from clients, their families, advocates and professionals and related organizations into planning, coordinating, and prioritizing the allocation of services and resources. The existence of advisory councils for each service delivery area will maintain expertise on mental health and substance abuse separately. The local behavioral health authority will conduct needs assessments in coordination with advisory committees to determine service needs in the community. Other responsibilities of the local behavioral health authority will include developing a network of service providers and managing the quality of and access to services. The use of tools such as utilization, quality,

and information management will not only allow providers to better manage a clients's care, it will also eventually allow state planners to quantify the number of people served and define best practices for behavioral health care.

Integrating mental health and substance abuse service delivery will provide for a single point of entry, which creates a "no wrong door" approach for consumers to access services. At the single point of entry, persons with mental illness and/or substance abuse are screened and assessed for need for and appropriateness of admission to services and provided case management to coordinate the delivery of services. Coordinated assessments and coordinated treatment planning are two ways to improve integration of services at the local level. Case management is another tool which can be utilized to ensure service integration. Case managers direct and coordinate the necessary and available services, including ensuring multiple agencies work together to meet the needs of specific clients.

Phase III

- **Depending on the success of service integration, create a single behavioral health care agency by consolidating TCADA and the mental health programs currently at TDMHMR.**

Consolidation of TCADA and the mental health programs currently at TDMHMR would achieve the elimination of redundant Central Office administrative structures and staffing and infrastructure costs, and prevent costly investments in the development of duplicative clinical and management systems. Savings from the elimination of administrative inefficiencies should be reinvested in essential community services.[10] In addition, the current studies and pilots occurring between the two agencies, including SCR 55, SCR 88, NorthSTAR, and the behavioral health pilots, will have been completed and will guide the process of consolidating the agencies' programs and administrative structures. No further studies or pilots should be undertaken until existing pilots have been fully implemented and evaluated.

The two agencies should undertake a significant education effort to identify commonalities between agencies and learn to accommodate differences. This might include adapting current organizational structures, such as co-locating programs and cross-training staff, to facilitate sharing and coordination. TCADA's focus on prevention and intervention, particularly as it relates to youth, should be maintained and safeguarded as the reorganization occurs. If consolidation does not occur, TCADA's next Sunset review date should be changed to 2007. This would place the agency under reveiw at the same time as the other HHS agencies.

Agency Organization

Board

During Phase III of program consolidation, the Governor would be required to appoint a new nine member board to serve staggered, six-year terms. The Board would be composed of three members with a demonstrated interest in mental health issues, three members with interest in substance abuse issues, and three public members. The Board will have the authority to appoint advisory committees, as needed.

Structure

To accommodate the different aspects of planning and policy development for mental health and substance abuse, the new agency will have separate divisions for mental health and substance abuse services. This would allow prevention activities for substance abuse to continue and TCADA's present emphasis on services to youth to be maintained. Separate divisions would also allow each agency to maintain different treatment approaches and distinct models of care. Administrative functions such as contract management, financial services, information management, and the development of managed care tools should be combined.

Administration

The model as presented in the H.B. 1734 report should be used to determine the division of responsibilities between the state and local levels. A local behavioral health authority will be responsible for overseeing mental health and substance abuse services, including contracting and monitoring of providers, with the goal of integrating service delivery at the local level. Local behavioral health authorities will have a single point of entry for mental health and substance abuse services.

Consolidation Oversight

Other issues in this report address expanding the operational authority of the Health and Human Services Commission (HHSC) and creating a Legislative Oversight Committee (LOC) to provide direction to the Commission and to oversee services integration and reorganization of health and human services. HHSC, under the guidance of the LOC, would be required to manage the service integration and functional agency consolidations recommended in this issue.

In managing the transition, HHSC would need to specifically address:

- the amount and type of mental health and substance abuse services provided by other state agencies to children and adults,

- the need for coordination and evaluation of existing efforts to define the most appropriate service delivery structure for the provision of mental health and substance abuse services, and
- compliance with federal and state requirements regarding the administration of mental health and substance abuse services.

State Impact

Statewide planning and policy development for mental health and substance abuse helps to ensure that similar standards, rules, performance expectations, quality, outcomes, and rights protection are available to Texans regardless of the agency through which they receive services. Clarifying agency roles and limiting the number of agencies involved in purchasing services, setting standards, and regulating programs can also result in administrative efficiencies.[11]

In addition, using the resources of TDMHMR and TCADA in a fully integrated and coordinated fashion will result in administrative efficiencies and client benefits. Local monitoring and oversight of providers of mental health and substance abuse services will increase accountability for funds spent and ensure that quality services are delivered in an efficient manner. The two agencies would work as one to develop standards and tools for managing provider networks and ensuring that quality services are provided in the most efficient manner possible.

The table, *Goals of HB 7*, shows which of the goals contained in HB 7 are met through the implementation of these recommendations.

Goals of HB 7

Objective	Applies
Facilitates Comprehensive, Statewide Planning and Policy Development	✔
Enhances Continuum of Care for Clients	✔
Achieves Integration of Services to Improve Client Access	✔
Maximizes Existing Resources	✔
Improves use of Management Information Systems	✔
Provides Mechanisms that Foster Innovation and Decision making at the Local Level	✔

Local Impact

Planning across state agency lines will require a shift in the orientation of existing planning efforts at the local level. Planning responsibilities of the local mental health authorities will be expanded from the priority population to all persons in need of mental health services. Local mental health authorities will work with the local entities that provide mental health services for other health and human service agencies to collect this information and attempt to coordinate service provision.

At the local level, this recommendation should improve the delivery of mental health and substance abuse services. Creating a single point of entry for consumers of mental health

and substance abuse services will significantly reduce the amount of information provided by applicants for services by centralizing eligibility determination for multiple programs. Integrated case management ensures that mental health and substance abuse services are coordinated and clients do not slip through the cracks created by the current fragmentation of services.

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[1] Texas Sunset Advisory Commission, Staff Report on the Texas Commission on Alcohol and Drug Abuse, 1996.

[2] House Bill 1734, Report to Senate Health and Human Services Committee and House Public Health Committee, September 1998, p. 14.

[3] Ibid, p. 29.

[4] Substance Abuse and Mental Health Services Administration, Substance Abuse and Mental Health Statistics Sourcebook, October 1995, pp. 39-40.

[5] Mental Health Issues Today, *Providing Coherent Treatment to Those with Co-Occurring Addictive and Mental Disorders Requires New Vision*, Volume 1, Number 2 (Winter 1997), p. 2.

[6] Texas Commission on Alcohol and Drug Abuse, Statewide Service Delivery Plan, Austin, Texas, February 1998, p. 13.

[7] Mental Health Issues Today, *Providing Coherent Treatment to Those with Co-Occurring Addictive and Mental Disorders Requires New Vision*, Volume 1, Number 2 (Winter 1997), p. 3.

[8] Texas Comptroller of Public Accounts, Texas Performance Review, Special Delivery; New Models of Care, Austin, Texas, February 1996, p.94

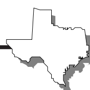
[9] Ibid, pp. 93-94.

[10.] Ibid, p. 95.

[11.] House Bill 1734, Report to Senate Health and Human Services Committee and House Public Health Committee, September 1998, p. 15.

Issue 15

Improve Delivery of Rehabilitation Services to People with Disabilities Through Coordination, Integration, and Possible Consolidation.



Background

Rehabilitation services are designed to help people with physical or mental disabilities live independently and become integrated into their communities. Each year, the State spends close to $500 million administering programs that provide physical, mental, and vocational rehabilitation to a wide range of clients with various functional limitations and needs. In this issue, the term *rehabilitation services* means physical, mental, and employment services designed to assist and empower individuals with disabilities to reach their full potential. Rehabilitation services span a wide array of people with varying abilities and needs. Examples include physical restoration, physical therapy, medical services, assistive devices, and nutrition services. Services geared toward mental rehabilitation include counseling, special instruction, speech-language therapy, psychological services, and skill building. Five state agencies deliver rehabilitation services, including the Texas Rehabilitation Commission, the Texas Commission for the Blind, the Texas Commission for the Deaf and Hard of Hearing, the Texas Department of Mental Health and Mental Retardation, and the Interagency Council for Early Childhood Intervention.

Currently, five state agencies deliver rehabilitation services.

Currently, most of the State's rehabilitation dollars are spent on employment services to help people with disabilities gain or maintain competitive jobs in their communities. Three agencies, the Texas Rehabilitation Commission, the Texas Commission for the Blind, and the Department of Mental Health and Mental Retardation, provide these services. The types of employment services a person needs depends on the individual's functional capacity. Whereas one person may simply need counseling and guidance, another may require vocational or technical training. Further, individuals with the most significant disabilities may need ongoing job supports to work in a competitive integrated setting.

Outside the health and human services umbrella, the workforce development system, comprised of the Texas Workforce Commission and a network of local boards, provides comprehensive employment services to the general

population. The Texas Workforce Commission oversees the development of local workforce development boards, and continues to provide services in areas without a certified local board.

The following provides a summary of the rehabilitation services offered by health and human service agencies.

Texas Rehabilitation Commission (TRC)

The Texas Rehabilitation Commission is the State's primary authority for rehabilitation of people with disabilities, except for individuals with vision impairments who are served by the Texas Commission for the Blind and Visually Impaired. TRC's largest program, Vocational Rehabilitation (VR), provides services to help people with disabilities gain or maintain employment. In fiscal year 1997, approximately 99,000 clients received more than $140 million worth of VR services such as surgeries, diagnostic evaluations, assistive devices, and job training and job placement. With the Vocational Rehabilitation program as the centerpiece, the agency also offers an array of additional services including extended rehabilitation, comprehensive rehabilitation, independent living, and personal attendant services. The Extended Rehabilitation Services (ERS) program provides ongoing job support to people with severe disabilities who would most likely be determined ineligible for Vocational Rehabilitation services. ERS provided community-integrated employment for 812 clients and sheltered employment for 468 clients in fiscal year 1997.

Both TRC and TCB administer the federal-state VR program.

Texas Commission for the Blind (TCB)

The Texas Commission for the Blind is the agency responsible for providing all services to visually disabled persons except welfare services and services provided by educational agencies. TCB services help clients enter careers and develop independent living skills by providing adaptive technologies, sight restoration and preservation, vision aids, skills training, counseling, information/referral, and case management services. All TCB clients receive intake, assessment, and eligibility determination. Like TRC, the agency administers the federal-state Vocational Rehabilitation program, providing services to over 11,000 Texans who are blind or visually impaired. In addition, TCB's Business Enterprise Program provides training and certification, contract negotiation, start-up costs, and management support for blind persons in food services and vending facilities throughout Texas.

Texas Commission for the Deaf and Hard of Hearing (TCDHH)

The Texas Commission for the Deaf and Hard of Hearing is primarily responsible for advocacy, information and referral, and communication access services for persons who are deaf or hard of hearing. The General Appropriations Act requires the agency to contract with the Texas Commission for the Blind for administrative support functions, such as contract administration and accounting. TCDHH delivers services to clients through contracts with 23 private and public agencies, called Councils. The 23 Councils include local service providers such as nonprofit agencies and local government health and human service agencies that provide an array of services to consumers who are deaf or hard of hearing. The agency's largest program is Communication Access Services, which provides sign language, oral interpreting, and Computer Assisted Realtime Translation services to persons who are deaf or hard of hearing for access to essential life activities and community participation. TCDHH's Senior Citizens Program provides coping skills training, independent living services, case management, and recreational activities to persons 60 or older.

Interagency Council on Early Childhood Intervention (ECI)

The Interagency Council on Early Childhood Intervention was established in 1981 to plan and implement early childhood intervention services for children who have, or are at risk of having, developmental delays. ECI is responsible for the administration, supervision, and monitoring of a statewide comprehensive system to ensure that all children in this State, who are below the age of three and have developmental needs, receive services. These services are provided in partnership with their families and in their local community. In 1997, the 75th Legislature enacted legislation that changed the composition of the ECI Board from a coordinating entity made up of state agency employees to one composed of family members of children with developmental delays and a representative of the Texas Education Agency. ECI purchases services through grants to contractors who provide comprehensive early intervention services, or who participate in ECI child find programs that seek to identify low birth weight babies at risk of developmental delay. The most common services that ECI clients need are special instruction, speech-language therapy, family counseling, occupational therapy, physical therapy, social work services, and assistive technology.

Texas Department of Mental Health and Mental Retardation (TDMHMR)

The Texas Department of Mental Health and Mental Retardation funds services for individuals who meet the agency's definition of "priority population." The Department provides services by operating campus-based facilities, such as state hospitals, state schools, and state centers, and community-based services such as State-Operated Community Services, or by contracting for mental health and mental retardation services with locally operated community mental health and mental retardation centers. In fiscal year 1997, TDMHMR served 18,754 persons in campus-based institutions and 168,091 in community-based settings. TDMHMR services include employment services. In fiscal year 1997, 4,161 persons with mental illness received supported employment services, and more than 10,000 persons with mental retardation received vocational training, supported employment, and/or job placement assistance.

The chart, *Rehabilitation Services Across Agencies*, presents additional information about the services delivered by the five health and human service agencies currently involved in delivery of rehabilitation services.

Sunset staff reviewed rehabilitation services currently provided by the state agencies, and identified the populations eligible for services and the commonalities between programs and target populations. In doing so, staff identified programs that overlap in the services provided and the people served. Sunset staff reviewed these services to determine if opportunities exist to better integrate rehabilitation services for people with disabilities to meet the key objectives outlined in House Bill 7.

Findings

Vocational Rehabilitation Services

▼ **The Texas Rehabilitation Commission and the Department of Mental Health and Mental Retardation provide employment services to overlapping client populations.**

- Agreements defining each agency's roles and responsibilities for shared consumer populations have not been fully implemented. Individuals with a primary diagnosis of mental illness or mental retardation may receive services from TRC, TDMHMR, or both. In 1997, 21 percent of TRC's 99,000 Vocational Rehabilitation clients had a mental illness, and four

Rehabilitation Services Across Agencies

	TRC	TCB	TCDHH	MHMR	ECI
FY 1997 Expenditures	$159.2 million	$38.4 million	$1 million	$207 Million	$59.3 million
FY 1997 # of clients served	106,344	22,391	7,263	20,623	21,872
Eligibility	Varies according to program. Generally, disability causing impediment to employment; smaller programs require presence of severe disability.	Visual impairment that is a substantial impediment to employment or independence.	Deaf or hard of hearing.	Must be in *priority population*, which focuses on individuals with severe conditions and the need for ongoing support.	Children under age three with developmental delay; no income criteria.
Population Served	Individuals with physical or mental disabilities, except vision impairments.	Individuals who are blind or visually impaired.	Individuals who are deaf or hard of hearing.	Approximately 500,000 children and adults with mental illness and approximately 80,000 children and adults with mental retardation/ developmental disorders.	Families with children under age three with developmental delay or at risk of developmental delay.
Assessment	✔	✔	✔	✔	✔
Case Management	✔	✔	✔	✔	✔
Information and Referral	✔	✔	✔	✔	✔
Counseling and Guidance	✔	✔	✔	✔	✔
Assistive Devices and Medical Services	✔	✔	✔	✔	✔
Personal Assistance Services	✔			✔	
Residential Repair/ Modifications	✔	✔		✔	
Independent Living Services	✔	✔	✔	✔	
Education/Skill Development	✔	✔	✔	✔	✔
Transportation	✔	✔	✔	✔	✔
Supported Employment	✔	✔		✔	
Job Readiness Training	✔	✔		✔	
Transition Planning	✔	✔		✔	

percent had mental retardation. TRC's VR services are not designed to offer long-term support, but simply to rehabilitate and stabilize a client through up-front assistance. When applicants for TRC services are assessed as needing long-term employment supports, they will likely be determined ineligible for TRC's VR services. Therefore, a separate employment system has evolved at TDMHMR which operates as a safety net for consumers deemed ineligible for VR services because they need long-term employment supports.[1]

- TRC and TDMHMR have made some progress to reduce the number of TRC clients who are in TDMHMR's priority population. TRC's Extended Rehabilitation Services program provides long-term employment supports to people with severe disabilities. This program has an annual budget of $3.6 million and serves over 1,300 individuals but still maintains a waiting list for services. In the past, TRC has been criticized for serving too many TDMHMR consumers in the program. In 1996, Extended Rehabilitation Services provided services to 400 TDMHMR consumers while at the same time maintaining a waiting list of 500 persons.[2] Currently, the program serves 192 potential TDMHMR consumers and has a waiting list of approximately 400 persons.[3]

Although the agencies have improved coordination, duplication still exists between TRC and TDMHMR.

Service and administrative duplication exists between the Texas Rehabilitation Commission and the Texas Commission for the Blind.

- TRC is the State's authority on the rehabilitation of persons with disabilities, except for persons with visual impairments who are served by TCB. Both agencies provide services to help people to actively and independently participate in society. Both TRC and TCB provide a variety of services, including counseling and guidance, independent living skills, vocational training, physical restoration and assistive technology devices, and transition planning for students graduating from high school.

  The agencies' counselors work one-on-one with clients to assess their needs and abilities, develop goals, and devise a plan of services to achieve a successful outcome. While clients' needs, eligibility requirements, and availability of services may vary from program to program, the basic steps

leading up to service delivery do not. These steps include intake, assessment, eligibility, and procurement of services. In some cases, agency staff directly provide the needed service, but many services are purchased from providers who serve clients at the local level.

- In the case of TRC's and TCB's Vocational Rehabilitation programs, the entire administrative structure, from intake to provision of services, is duplicative. Both VR programs, which account for almost 80 percent of each agency's budget, are driven by the same federal law and operate under the same guidelines.

- Having both TRC and TCB administer VR programs is not only administratively duplicative, but may also lead to inequity in access to services. In fiscal year 1997, Texas drew down approximately $140 million in federal VR funds, with TRC receiving approximately 80 percent and TCB receiving approximately 20 percent of these funds. Sunset staff found no rationale for this traditional 80/20 split between the two agencies. The chart, *Federal Vocational Rehabilitation Funds*, shows the breakdown of federal dollars and the number of clients each agency served in 1997. The chart shows that individuals with vision impairments who are served by TCB have more federal VR funds available to them than people with mental and physical disabilities, including individuals with hearing impairments, who receive services through TRC.

Federal Vocational Rehabilitation Funds
Fiscal Year 1997

	Federal Funds	% of Federal Fund	Clients Served	% of Clients Served	Federal VR Dollars Available per Client
TRC	$114 million	80	99,214	89.5	$1,149
TCB	$26 million	20	11,595	10.5	$2,224
TOTAL	$140 million	100	110,809	100	$1,263

Employment Programs

▼ **Currently, limited coordination exists between employment services for people with disabilities and a separate workforce development system, leading to duplication and fostering segregation of people with disabilities.**

- Currently, two distinct systems deliver employment services in the State. The rehabilitation system provides services to people with physical or mental disabilities to help them enter or return to the workforce. The workforce development system, comprised of the Texas Workforce Commission (TWC) and a network of local workforce development boards, provides comprehensive employment services to the general population. Employment and training services are delivered through local one-stop Workforce Centers. TWC's mission is to place Texans in jobs and equip workers with job skills. The agency also offers a variety of services to employers such as providing tax incentives to hire targeted workers and disseminating labor market information.

The federal government is moving toward consolidating VR into the workforce system.

- The federal government is moving toward combining the VR system with the workforce development system to promote inclusion and integration of people with disabilities into the mainstream workforce. In July 1998, Congress reauthorized the federal Vocational Rehabilitation Act and combined it with the Workforce Investment Act. The new Act states that "increased employment of individuals with disabilities can be achieved through statewide workforce investment systems."[4] Although Congress combined the laws, the continuation of a separate VR funding stream ensures that people with disabilities have continued access to specialized services tailored to their individual needs.

- Currently, TWC does not track and report the number of people with disabilities that the agency serves. The Texas Legislature has recognized the need for close alignment between the workforce development system and the rehabilitation system. The Workforce and Economic Competitiveness Act requires rehabilitation agency representation on the local workforce

development boards. Although the law gives local boards wide latitude in choosing its rehabilitation representative (the member can be from a state agency or a private provider such as a local rehabilitation hospital), TRC is represented on 22 of the 26 local workforce development boards. The purpose of rehabilitation agency representation is to promote employment opportunities for people with disabilities within their communities.

TWC provides services that could benefit people with disabilities who want to work.

- TRC does not formally refer VR clients into the State's workforce development system. Closer alignment between the workforce development system and the rehabilitation system, particularly with regard to Vocational Rehabilitation services, would benefit the State and the people who need services. For example, many TWC providers offer free job search seminars on job hunting skills, and in fiscal year 1997, 27,000 Texans participated in TWC job search seminars.[5] Many TRC Vocational Rehabilitation clients could benefit from TWC's job training and job search services, resulting in the availability of more services for VR clients. In addition, by aligning VR and the workforce development system, Texas would move closer to integrating people with disabilities into the general population.

Early Childhood Intervention Services

▼ **ECI could benefit from administratively integrating certain business functions with TRC.**

- ECI's method of purchasing services is most like a grant-making process where contractors are paid monthly to provide services to children based on the funded program capacity. Providers are reimbursed on a per capita basis rather than for units of service actually delivered. Most other agencies that contract for rehabilitation services purchase them on a unit cost basis.

  The Sunset staff report on ECI identified that ECI's current method of purchasing services does not ensure the State receives the best value for its dollars. As a result, the Sunset Commission recommended requiring ECI to promote competition whenever possible and to reimburse providers on the basis of services actually provided to clients.

ECI could benefit from using TRC's case management and client services purchasing system.

- ECI could benefit from using TRC's case management and client services purchasing system. TRC counselors, like ECI providers, are responsible for conducting client assessments and developing a service plan. Once services are authorized in a plan of care, payment is electronically authorized once services are delivered. ECI providers could access TRC's system through regional and local offices and use the system to document service delivery plans and pay providers for services delivered. In some cases, both agencies may use many of the same providers.

- TRC currently provides many business services to other HHS agencies both in Austin and regionally. TRC provides some support services to ECI at the Brown-Heatly Building in Austin.

Conclusion

Currently, five separate state agencies deliver rehabilitation services to people with disabilities. TRC and TDMHMR serve overlapping client populations, while TRC and TCB provide many of the same services through the state-federal Vocational Rehabilitation program and several smaller programs with similar administrative and service delivery structures. Also, employment services for people with disabilities are generally provided separately from the State's emerging workforce development system that can provide many comparable services and benefits for people with disabilities while integrating them into the general community and workforce. While some of the agencies have made progress in recent years to coordinate services and reduce duplication, many individuals with disabilities are still faced with a confusing web of agencies and programs. Duplication and fragmentation could be reduced through continued coordination and planning, integration of administrative functions, and ultimately consolidation.

Recommendation

Change in Statute

Phase I

- **Continue the Texas Rehabilitation Commission, the Texas Commission for the Blind, the Texas Commission for the Deaf and Hard of Hearing, and the Interagency Council on Early Childhood Intervention for eight years.**

- **Require TRC and TDMHMR to reduce duplication and fragmentation of employment services by:**
  - **defining each agency's roles and responsibilities for shared client populations, and**
  - **requiring TRC's Extended Rehabilitation Services to target people with developmental disabilities who are not currently served by TDMHMR or another agency.**

This recommendation would continue the agencies until September 1, 2007. TRC and TDMHMR would be required to continue their efforts to coordinate services for overlapping client populations, and to work to fill the gaps for those individuals who currently do not receive services. In 1996, the Texas Performance Review's *New Models of Care* recommended these and other specific proposals, many of which have not been implemented. TRC and TDMHMR should continue working to meet the goals laid out in *New Models of Care*. Specifically, the agencies should set a realistic deadline to reach an interagency agreement defining their roles and responsibilities for shared populations and outlining ways to avoid duplication. In addition, TRC's Extended Rehabilitation Services should continue working to target persons with disabilities who do not receive services from TDMHMR, or who do not have another designated agency. Although implementation of this recommendation ultimately rests on these two agencies, the Health and Human Services Commission would play a key oversight role in its expanded capacity as discussed in other issues in this report.

- **Require TRC and TCB to develop a methodology, approved by the Legislative Budget Board and the State Auditor's Office, to split federal VR funds.**

This recommendation addresses the lack of justification for the way TRC and TCB divide federal Vocational Rehabilitation dollars. The split of federal VR dollars between TRC and TCB should reflect changing needs rather than the status quo. Therefore, TRC and TCB should develop a methodology to periodically review and, when necessary, modify their legislative appropriations requests for VR funds. This recommendation does not dictate how federal VR dollars should be split between the two agencies, but simply requires the agencies to develop a way to justify their appropriations requests. The State Auditor and the Legislative Budget Board have the expertise and authority to help the agencies implement this recommendation.

- **Require TRC to refer appropriate VR clients to Local Workforce Centers, and require TWC to track and report services provided to people with disabilities.**

This recommendation would more closely align the rehabilitation system with the workforce development system. The recommendation would make TRC responsible for referring

Vocational Rehabilitation clients to TWC for comparable services and benefits, and requires TWC to track and report the number of clients with disabilities the agency serves. While certain individuals who need ongoing job supports, like TRC's Extended Rehabilitation Services clients and TDMHMR's current priority population, would not be good candidates for workforce programs, many VR clients could benefit from the workforce system's job training and job search services. This recommendation would result in cost savings to the VR program, allowing more people to be served. Further, this recommendation would position Texas for potential changes at the federal level if the current trend to consolidate workforce and VR programs continues.

- **Require TCB and ECI to administratively integrate business functions with TRC, including purchasing of services, where appropriate.**

This recommendation requires TCB and ECI to integrate administrative functions with TRC. TCDHH would be included in this process since the agency is administratively tied to TCB. TRC currently provides many administrative functions for health and human services agencies co-located in Austin and regionally. TRC has also developed an automated Rehabilitation Services System that integrates client case records management, client services purchasing, and financial systems. Both TCB and ECI could use TRC's client services system to authorize, track, and pay for client services. In addition, use of TRC's client services system would help ECI implement the Sunset Commission recommendations related to the purchase of client services. The State would realize administrative efficiencies by integrating these functions. Each agency and its providers would continue to perform intake, assessment, eligibility determination, and case management services for their particular programs and client populations.

Phase II

- **Require HHSC to make recommendations on the appropriateness and feasibility of transferring the Vocational Rehabilitation program to the Texas Workforce Commission.**

This recommendation would require the Health and Human Services Commission and the Legislative Oversight Committee to consider whether the state-federal Vocational Rehabilitation program should be transferred to the Texas Workforce Commission. By consolidating VR into the workforce system, the State could move a step closer to an inclusive service delivery environment, where people who want to work can access the employment services they need, without regard to disability.

Phase III

- **Depending on the success of coordination and integration, consolidate the Texas Rehabilitation Commission and the Texas Commission for the Blind into a single rehabilitation agency.**

This recommendation would consolidate similar rehabilitation services into a single agency. The goal of a single rehabilitation agency would be to allow individuals with disabilities to access the services they need based on their functional needs rather than their primary diagnosis. The rehabilitation agency would provide physical, mental, and certain employment services currently administered by TRC and TCB.

Agency Organization

Throughout the coordination and integration stages, the agencies would retain their current governing and administrative structures. To ensure that services are not disrupted, the agencies would continue to have separate intake and assessment processes. However, procurement of goods and services would begin to be integrated as TCB and TRC combine administrative functions.

After consolidation, all rehabilitation services would be provided by a single agency governed by a six-member Board appointed by the Governor with at least two members representing persons with visual impairments. The Board would have the authority to appoint advisory committees in the areas of physical, mental, and vocational rehabilitation as needed.

Consolidation Oversight

Other issues in this report address expanding the operational authority of the Health and Human Services Commission (HHSC) and creating a Legislative Oversight Committee (LOC) to provide direction to the Commission and to oversee service integration and reorganization of health and human services. HHSC, under the guidance of the LOC, would be required to manage the service integration and functional agency consolidations recommended in this issue. In developing the transition plan, HHSC would need to specifically address:

- eligibility requirements so that individuals currently receiving services would continue to receive services based on current eligibility criteria;
- compliance with all federal laws and funding requirements; and
- local effort, so that funding is not compromised.

State Impact

Combining programs providing similar services should allow the State to achieve most of the benefits outlined in House Bill 7. For example, services should be easier to access if clients have one agency to apply to for services, regardless of why they need rehabilitation services. The Sunset staff realizes that all rehabilitation services are not the same. The recommendations allow for modifications as the State seeks to develop a single rehabilitation service delivery system at both the state and the local level.

Combining the administration of rehabilitation services into a single agency will not alter program eligibility requirements established by federal law. Consolidation will make it easier to ensure accountability for client outcomes since one agency will be providing all rehabilitation services. Common outcome measures should be developed to determine the overall effectiveness of the State's rehabilitation services. The table, *Goals of HB 7*, shows which of the goals contained in HB 7 are met through the implementation of this recommendation.

Goals of HB 7	
Objective	**Applies**
Facilitates Comprehensive, Statewide Planning and Policy Development	✔
Enhances Continuum of Care for Clients	✔
Achieves Integration of Services to Improve Client Access	✔
Maximizes Existing Resources	✔
Improves use of Management Information Systems	✔

Local Impact

At the local level, these recommendations should improve the delivery of rehabilitation services by decreasing the administrative burden through a single contracting and monitoring process for all rehabilitation services at TRC and TCB. Streamlined administration should allow these providers to spend a greater portion of their resources delivering services rather than filling out paperwork. In addition, the goals of these recommendations are to:

- encourage TRC, TCB, TCDHH, TDMHMR, and ECI, and their providers to work together to address clients' needs that cross agency lines as the rehabilitation agency is created;
- encourage local providers, boards, councils, and other interest groups to work together to identify local rehabilitation needs;
- encourage local providers to work together to blend funds at the local level and coordinate local service delivery through the release of RFPs requiring joint applications;
- reduce the administrative burden on local providers;
- maximize federal, state, and local funds to meet local needs; and
- develop consistent rates and contracting practices to ensure the State receives the best value for services.

Among the benefits of more closely aligning the VR program with the workforce system is the ability to "piggyback" service delivery onto the already functioning Local Workforce Centers. In addition, the local boards should play an integral role in assessing local community needs and available resources. Most of the State's 26 functioning boards already

have TRC representation, while the others have a TRC liaison. From the local providers' perspective, this recommendation would have no impact, since vocational rehabilitation counselors currently work at the local level procuring goods and services directly from local providers. However, the recommendation would have a significant positive impact for clients, who would gain access to workforce development services and benefits in their local communities.

[1] Texas Comptroller of Public Accounts, Texas Performance Review, *Special Delivery: New Models of Care*, Austin, Texas, February 7, 1996, p. 42.

[2] Ibid.

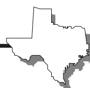
[3] TRC reports that 17 ERS clients with a primary diagnosis of mental retardation are actual TDMHMR consumers. TRC reports that 175 ERS clients with a primary diagnosis of mental illness are *potentially* TDMHMR consumers.

[4] Workforce Investment Act of 1998, *Findings; Purpose; Policy*, Sec. 2(a)(4).

[5] Texas Workforce Commission, *1997 Annual Report*, Austin, Texas, p.18.

Issue 16

Continue the Current System for Delivery of Public Health Services.



Background

The State of Texas administers numerous federal and state programs that seek to assess health needs and address those health needs through direct health care services, regulation, prevention, and education. Primary programs include direct health care services, Medicaid acute care, and regulatory programs for health professions, facilities and industries impacting public health. The Texas Department of Health (TDH) is the primary agency assigned the responsibility of protecting and promoting the health of Texas residents through administration of over 100 public health programs. These programs use two methods to deliver public health services: direct provision and service contracting.

TDH administers 22 health care delivery programs, including non-medicaid programs, such as the Chronically Ill and Disabled Children (CIDC) and the Maternal and Child Health Block Grant (Title V) Programs; and four Medicaid programs, such as the Texas Health Steps Program and the Medical Transportation Program. Additional health care delivery programs, such as the HIV/STD programs and the immunization program, focus on disease control and prevention. For these programs, the agency contracts with health care providers, including local health departments, for the provision of about $1 billion in services.

TDH is the primary agency dedicated to protecting and promoting the health of Texans.

Operation of the medicaid acute care programs includes Medicaid Managed Care and the Vendor Drug Program. To administer the Medicaid programs, TDH contracts with an indemnity insurance company (National Heritage Insurance Company), health maintenance organizations, quality assurance contractors, and others to provide over $5 billion in medical services to Medicaid-eligible clients.

TDH also operates a laboratory that performs analyses relating to a variety of diseases, genetic defects, and food and waterborne pathogens. These analyses provide information to individuals regarding their health, but also provide TDH with important information relating to health trends within the state.

Over the years, numerous recommendations have been made to improve the delivery of public health services in the state. Most of the recommendations made in the past relate to improving program performance, health care policy development, and the management of state health purchasing. The State Auditor's Office (SAO) has also made several recommendations relating to improving the regulation of health-related professions and facilities in the state.

In this issue, Sunset staff used the knowledge and understanding gained by the Sunset review of the health and human service agencies to identify the services each agency provides, the populations eligible for services, and the commonalities between services and target populations across agencies. The evaluation of those overlapping programs was undertaken with the goal of restructuring services to better meet the broad goals of the Legislature, as established in House Bill 7. In the area of public health services, the review focused on whether the Department of Health should remain the state agency responsible for this effort.

Findings

▼ **Most state-sponsored public health services are currently delivered through a single agency, the Texas Department of Health.**

TDH delivers, funds, or contracts for the majority of public health services in the state.

- TDH delivers, funds, or contracts for the majority of public health services in the state. TDH has over 100 public health programs employing over 5,700 employees and a budget exceeding $6.6 billion in fiscal year 1997. No other state agency employs as many workers or expends anywhere near a similar amount of funds devoted to preventing the spread of disease and enhancing the health of Texas residents.

- Other state agencies have individual programs that closely relate to the public health programs administered by TDH, however, these programs are limited in scope and directly relate to the other operations of those agencies. For example, TDH administers a Human Immunodeficiency Virus/Sexually Transmitted Disease (HIV/STD) Prevention Program dedicated to stemming the spread of sexually transmitted diseases in Texas. However, the Texas Commission on Alcohol and Drug Abuse (TCADA) also delivers a HIV public health program aimed at specifically addressing the spread of HIV through intravenous drug use.

▼ **Issue 11 of this report proposes non-public health related services be transferred from TDH's responsibility.**

- Multiple long-term care studies in Texas have consistently identified the same problems with long-term care services including a lack of accountability for effective service delivery, fragmentation of services, and consumer confusion about how to access services. Consolidation of long-term care services into a single agency would create a single point of accountability for the quality of services, reduce confusion for clients, and simplify the intake process so that clients would have easy access to an array of services designed to meet their changing needs. In addition, providers would benefit from a simplified contracting and monitoring process that would reduce administrative costs and could result in more resources for direct services. As a result, the following two non-public health related programs at TDH are proposed for transfer to a new long-term care agency.

- The Medically Dependent Children's Program (MDCP) provides respite care for families with medically-involved children under the age of 21, as an alternative to providing for their care in nursing facilities. Respite services provided through the MDCP include home modifications and adaptive aids and TDH staff provide care planning and resource coordination for program participants. Since this program is an option to long-term care in nursing facilities, Sunset staff recommends transferring this program from TDH to the new long-term care agency recommended in Issue 11 of this report.

Two non-public health related programs at TDH are proposed for transfer to a new long-term care agency.

- Home and Community Support Service Agencies (HCSSAs) broadly refers to organizations that provide a wide-range of services to individuals in their home or in community settings. These services include: medical treatment, nursing, social or therapeutic treatments, and/or assistance with the essential activities of daily living. While services by HCSSAs can be for acute episodes or long-term care, more and more agencies are moving toward providing long-term services. TDH regulates HCSSAs while most other long-term health care agencies are regulated by the Department of Human Services (DHS). While it is appropriate to separate regulation of home health agencies when most of the home health services provided to individuals were of an acute nature - short term

and medically intensive, the present regulatory structure is no longer feasible or practical given the significant, on-going shift in individuals' needs to services delivered under a long-term care model. As a result, Sunset staff recommends transferring regulation of HCSSAs from TDH to the new long-term care agency recommended in Issue 11 of this report.

▼ **Problems identified in public health service delivery have been previously addressed in the Sunset staff report on TDH.**

The Sunset Commission recommended a comprehensive blueprint for improved public health delivery.

- Despite over 50 mandated individual planning documents, TDH has no coordinated and integrated approach to improve the health of Texas citizens. The lack of cohesive health planning results in program and service overlap, and a system that is difficult to navigate for both service providers and recipients. In addition, TDH does not provide enough up-to-date, usable data that is critical to effective planning efforts by both the Department and local health departments. Further, TDH does not have well-developed methods for regional and community-based interaction, thereby hindering opportunities to develop a more coordinated state health system. Recognizing the need for strong statewide plans and goals, other state agencies have developed blueprints for enhancing the delivery of services. Designing program integration has proven helpful in efficiently carrying out those agencies' programs and could similarly help TDH. The Sunset Commission has recommended that the Board of Health develop and implement a comprehensive blueprint for services to address these issues.

- The Texas Department of Health is responsible for delivering health care services to low-income Texans, primarily pregnant women and children. These services are not well coordinated, causing administrative duplication across programs. TDH often sends separate staff to monitor and audit contracts with a provider who participates in more than one program. Claims for similar services are handled differently depending on which TDH program is paying for the service. Providers must separately apply to several programs to perform similar services. Clients are not always made aware of needed and available services. As a result, TDH clients have little management of their care and sometimes miss out on services

that would improve health outcomes, thus increasing health care costs to the State. The Sunset Commission has recommended that TDH integrate health care delivery programs, including Medicaid and non-Medicaid programs, to the maximum extent possible to increase program coordination and eliminate administrative duplication.

- Improvements in management of the State's Medicaid program are included in other issues in this report.

- Implementation of Medicaid managed care requires a change in the way the State, physicians, clients and managed care organizations (MCOs) operate within the Medicaid system. Quality of care is difficult to measure, and Medicaid clients offer more challenges than private pay clients. Complex partnerships between HHSC, state agencies that administer Medicaid, the quality monitoring contractor, and MCOs decrease the likelihood that the Legislature will see objective information on the effectiveness of Medicaid managed care. Issue 6 puts HHSC clearly in charge of the State's Medicaid programs, and requires the Health Care Information Council (HCIC) to examine the success of Medicaid managed care based on the criteria established by the Legislature. In addition, transferring the HCIC to the Health and Human Services Commission will help to ensure the objectivity of that assessment.

Improvements in management of the State's Medicaid program are included in other issues in this report.

▼ **Concerns still exist over administration of TDH's regulatory programs.**

- TDH administers 55 regulatory programs covering everything from general hospital licensing to optician registration. Together these 55 programs regulated more than 129,000 facilities and 118,000 professionals in fiscal year 1997. Although these programs inspect large numbers of facilities, performance statistics show unexpectedly few violations found and enforcement actions taken. Other regulatory programs receive high numbers of complaints, yet few violations lead to enforcement actions. The problems leading to this lack of results are not clear and bear more in-depth examination. The Sunset Commission has recommended that TDH conduct a comprehensive evaluation of it's regulatory functions with the assistance of the State Auditor's Office.

Organizational options regarding the regulatory programs at TDH may be viable.

- The regulatory programs at TDH are functionally distinct from other TDH public health programs. As a result, organizational options regarding the regulatory programs at TDH may be viable. For example, improved regulatory performance may be achieved by developing a health regulation agency structured similarly to the Texas Department of Licensing and Regulation, or expanding the responsibilities of the Health Professions Council to include a portion of the TDH regulatory programs. These options would best be considered after TDH has performed its regulatory program evaluation as recommended by the Sunset Commission.

Conclusion

The number of public health programs in the state requires a large and complex organization to administer well over 100 programs designed to prevent the spread of disease and ensure the public health. Most of the State's public health services are currently delivered by TDH, although a small number of agencies administer public health programs related to their core missions. Some TDH programs that do not directly relate to public health services are being proposed for transfer from TDH. Transferring such programs would further define TDH as the public health agency for the state. Although TDH will be evaluating the performance of its regulatory programs, opportunities may exist for more cost-effective administration of the programs. HHSC would be well-positioned to evaluate and address the restructuring of the State's health-related regulatory programs.

Recommendation

Change in Statute

- **Continue the Texas Department of Health with responsibility for the State's public health services for eight years.**

This recommendation would continue the agency until September 1, 2007. TDH would retain responsibility for all of the State's public health programs including Medicaid acute care and public health facility and professional regulatory activities. TDH's current responsibilities related to long-term care would be transferred to the new long-term care agency as proposed in another issue in this report.

■ **Require HHSC to monitor implementation of Sunset recommendations related to TDH.**

This recommendation would require HHSC to oversee the execution of the Sunset Commission recommendations for TDH. Requiring HHSC to play such a role will ensure that it is aware of the improvements and actions taken by TDH stemming from the TDH Sunset review. As a result, HHSC would be in a better position to modify its own actions and those of other HHS agencies, if necessary, to ensure changes are well-coordinated, efficiencies run across agency lines, and policy is set in a consistent manner.

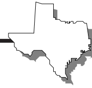
■ **Require HHSC to consider consolidation and/or organizational alternatives for TDH's regulatory programs.**

This recommendation would ensure that the entity charged with overseeing health and human services in the state, the Health and Human Services Commission, examines the structure of health-related regulatory programs to determine the most effective organizational structure. Specific options HHSC should consider include:

- establishing a new agency for all health-related regulatory programs structured in a similar manner to the Texas Department of Licensing and Regulation;
- expanding the responsibilities of the Health Professions Council to include some or all of the TDH regulatory programs;
- establishing a new agency to regulate all health-related professions and/or a new agency to regulate all health-related facilities; and
- maintaining all health-related regulatory programs at TDH.

Issue 17

Provide a Framework for the Development of More Comprehensive, Community-Based Health and Human Services.



Background

One of HHSC's key statutory directives is ensuring an effective service delivery system. The current structure of 11 state agencies, all under separate policymaking boards, is fragmented. Lines of authority run down vertically within each agency, but rarely cross over horizontally to other state agencies. Most often, the planning and decision making occurs in Austin, even though the delivery of services takes place in local communities throughout the state.

The planning for health and human services often occurs in Austin, even though the delivery of services takes place in local communities.

While state employees deliver some services, more often, services are contracted out to local private sector entities, including both for-profit and nonprofit businesses. Most of these services are funded based on federal and state requirements. Access to programs and the money that pays for them is tied to specific eligibility criteria. This rigidity keeps many people from getting services, and limits the flexibility providers need to attend to people and their families as a whole. Often services are not available until the problems become severe.

Since its creation in 1991, HHSC has been directed to explore ways to improve the service delivery system by fostering innovation at the local level. Recent changes in HHSC's enabling law further emphasize the Legislature's intent to support increased local health and human services planning and priority setting. For example, in 1997 the Legislature directed HHSC to identify local governmental entities that coordinate health and human services, and upon request, to help them in implementing a coordinated plan, tailored to meeting the special needs and priorities of that area.

At the center of these strategies is a shift towards greater local involvement in planning and decision making about the design and delivery of services in a community. Nationally, concerns about the ineffectiveness of a highly centralized, categorical system of human services has lead many states to shift toward greater local control. Federal changes, most notably the welfare reform legislation, have also accelerated the shift in decision-making authority

to lower levels of government. Many policymakers believe that local communities, using a blend of traditional public services in conjunction with more informal community supports, may be more effective than the federal or state government in meeting people's human service needs.

Sunset staff evaluated HHSC's efforts to promote more meaningful local involvement and decision making around health and human services. Many of the strategies to integrate services — such as a single information and referral system, co-location of services, integrated eligibility, and improved case management — are important to actual improvements in service at the local level, but are addressed in other sections of this report. Sunset staff found that while HHSC has set up numerous initiatives to support a more comprehensive local service delivery system, these initiatives have generally not moved beyond the pilot phase. In many cases, the policies of individual health and human services agencies, as well as strict federal funding streams, continue to pose barriers to a community's efforts to develop more integrated services on the local level.

Findings

▼ **A multitude of federal funding streams and narrowly targeted categorical programs fail to give communities the ability to broadly address health and human service needs.**

- Combined, the health and human services agencies in Texas anticipate receiving more than $7.3 billion in federal funds in fiscal years 1998 and 1999. These funds come from over 120 different federal funding streams.

Federal funds come to Texas in over 120 separate streams, each with its own set of strict eligibility requirements and little flexibility for innovation.

- These multiple funding streams generally contain strict requirements regarding who is eligible for the services paid for by these funds, with little flexibility. To be eligible for certain entitlements, such as Medicaid and food stamps, one must have no income or a low enough income to qualify. Services cease the moment a person's income goes above the limit, even though they may still be in need of assistance. Grant funds are also available, but are tied to specific problems, such as substance abuse or teenage pregnancy. Often these funds are aimed at addressing the most severe problems, so funds cannot be expended for earlier intervention or prevention of the problem.

Block grants are intended to address some of these concerns for greater flexibility. Several grants are merged into one with fewer restrictions and greater discretion for states and locals to decide how best to spend the money to meet the overall purposes of the grant. While block grants are often discussed, the vast majority of federal funds that Texas' health and human services agencies receive is not in the form of block grants. Most federal funds continue to have strict categorical requirements on how the money can be spent.

▼ **With 11 state agencies, a multitude of different regional structures, and a growing number of local initiatives, communities have difficulty working with the state to improve the delivery of services in their area.**

◗ At the state level, health and human services dollars, both federal and state, are appropriated to 11 different agencies by the Legislature. These agencies, in turn, either directly provide or purchase a wide variety of services. The structure for the delivery of services varies considerably from one state agency to another.

Only four of the 11 health and human services agencies use the uniform regional structure set up by the Health and Human Services Commission.

Most health and human services have historically been delivered through a regional structure. The Health and Human Services Commission has designated 11 uniform health and human services regions, but only four of the 11 agencies actually use this structure - the Department of Health, Department of Human Services, Department of Protective and Regulatory Services, and Department of Alcohol and Drug Abuse. The Commission for the Blind and the Rehabilitation Commission also use a regional approach, with 12 and five regions, respectively.

The other five agencies use systems that divide the state into smaller service areas or they contract directly with service providers. The Department of Mental Health and Mental Retardation delivers services through 38 Community MHMR Centers and 10 state-run centers; and the Department on Aging uses the 28 Area Agencies on Aging. The Juvenile Probation Commission does not provide services, but oversees the 160 local juvenile probation departments statewide. The Commission for the Deaf and Hard of Hearing contracts with 23 local Councils to provide services statewide; while the

Interagency Council on Early Childhood Intervention simply contracts directly with a variety of local service providers.

- Several agencies have also developed a number of mechanisms for local input, coordination and/or support. While well-intentioned, the proliferation of these local initiatives, with no consideration from the state level of the combined impact on local community resources, may simply become yet another barrier at the local level to a more comprehensive approach. For a listing of several of these initiatives, see the chart, *State Service Delivery Structures and Selected Mechanisms for Local Level Input/Coordination*.

Barriers to Local Collaboration

Funding

- Strict categories for who is eligible for services
- No flexibility to use funds to meet special needs
- Limited funds for initial planning, start-up efforts
- Limited help finding funds to sustain programs beyond pilots

Resources

- No technical assistance on how to collaborate, inventory existing resources, involve right local people to ensure success, prioritize competing needs
- No consistent data on key local indicators, statistics

Paperwork

- Different applications for every funding stream
- Different reporting requirements and performance measures for every project
- All the forms and red tape required by both federal and state requirements

Communication

- No consistent way for community planning to feed into the state planning process
- Differing expectations from state agencies
- No communication on why so much information is needed and how it will be used

Communities face a variety of barriers to improving the delivery of services at the local level.

- Many local communities have organized to improve the delivery of services locally. Examples of such local collaborative efforts include the: McLennan County Youth Collaboration in Waco; Gateway Community Prevention Project in Lufkin; Community Neighborhood Conference Committee in Austin; Project Unity in Bryan/College Station; Houston Collaboration for Children; Georgetown Project; and Fighting Back in San Antonio.

- As part of the HHSC review, Sunset staff attended a meeting of local community organizations and state agency representatives aimed at fostering communication between the two groups. Key challenges to implementing more comprehensive services on the local level were identified around funding, resources, paperwork, and communication across different systems. For more details, see the text box, *Barriers to Local Collaboration.*

- One example of the problems faced at the local level from the complicated funding and state organizational structure is illustrated by the city of Tyler's experience in 1997. At that time, the local community identified family violence and sexual abuse as a major priority and decided to explore potential funding sources for such services. According to the local United Way representative, at least six different state agency programs offered potential funding for these services.[1] The six programs included the:

State Service Delivery Structures and Selected Mechanisms for Local Input/Coordination		
Agency	**Regional/Local Structure**	**Selected Mechanisms for Local Input/Coordination**
Department of Health	11 HHS regions 8 regional offices 66 local health department	Commissioner's Council on Local Public Health; 22 Regional Trauma Advisory Councils; 26 HIV Care Consortia; Regional Family Planning Coordinating Committees; Managed Care Advisory Committees; Teen Action Planners for Adolescent Health; Hospital Oversight Committees; Medicaid Managed Care Regional Advisory Committees; Take Time for Kids grant sites; 2 CIDC On the Right Track grants (Houston, Temple)
Department of Human Services	11 HHS regions 10 regional offices 583 field offices	Councils on Family Violence; 28 Local Workforce Development Boards
Department of Protective and Regulatory Services	11 HHS regions 11 regional offices 257 field offices	Community Youth Development Boards; Child Welfare Boards; Community Partners Boards; Family Outreach Center Boards
Commission on Alcohol and Drug Abuse	11 HHS regions 3 field offices 5 technical support offices	Regional Advisory Consortium
Commission for the Blind	12 regional offices 137 field offices	None
Rehabilitation Commission	5 regional offices 137 field offices	None
Department of Mental Health and Mental Retardation	30 community mental health centers; 10 state operated community centers; State hospitals; State Schools	Each community center has a board that gets input from citizen advisory committees; Children's Mental Health Teams
Department on Aging	28 Area Agencies on Aging	28 Citizens Advisory Councils
Juvenile Probation Commission	160 Juvenile Probation Departments	Community Youth Development Boards
Commission for the Deaf and Hard of Hearing	23 local Councils (contracts)	None
Interagency Council on Early Childhood Intervention	Contract directly with providers from state level	None

- Department of Human Services' Family Violence program;
- Department of Protective and Regulatory Services' child abuse prevention programs;
- Department of Health's Rape Crisis program;
- Victim's Assistance program in the Governor's Office; and
- Funding for batterers from the Department of Criminal Justice and the Texas Commission on Alcohol and Drug Abuse.

Each of the potential state funding sources involves separate and detailed criteria and processes for applying for funds. And, if funding is granted, a different reporting and monitoring process is required by each state agency. Often, this means that everyone who works in a program receiving these funds must closely track and allocate their time, depending on what type of client they are dealing with and which funding source can cover it.

Communities need a single, clearly identified state entity to go to for help in their efforts to improve services locally.

- Communities also need a single, more clearly identified state entity to go to for help in their efforts to improve services locally. The Georgetown Project is a non-profit organization set up in 1997 by a partnership including business, government, education, health, and religious communities. Community leaders, seeing the success of a local effort to bring people together around economic development, decided to use the same model for addressing concerns about its children and youth. Previous interagency councils, where different health and human service providers shared information on what they were doing, never had any common direction or focus, and little change was made. This new initiative, rather than focusing on a single issue or problem, gathered basic statistics and indicators for the community as a whole, inventoried the community assets, and developed an action plan to fill in the gaps in service.[2]

However, one of the key difficulties the Georgetown Project faced was simply getting reliable baseline data on where they stood so that they could make good, informed decisions in setting priorities and identifying gaps. They contacted numerous state agencies to gather various statistics and discovered no established mechanism at the state level to provide this type of assistance on any ongoing basis.[3] See the

text box, *The Georgetown Project, Selected Community Indicators,* for a sample of the many basic statistics that had to be compiled at the community level to get this project started.

The Georgetown Project Selected Community Indicators

Basic demographics
Population
Annual growth rate
Level of poverty
Unemployment rates

Safety
Violent juvenile offenses
Gang-related referrals
Runaway reports
Domestic violence calls
Child abuse and neglect reports
Investigations

Health and Welfare
Trauma cases in emergency rooms
Suicide rates
Substance abuse use
Teenage pregnancy rates
Families on welfare, food stamps

Education
Expenditures per student
TAAS scores
SAT and ACT test scores
Disciplinary problems in schools

Early Childhood
Immunizations
Waiting list for Head Start

▼ **Two efforts to improve Texas' local service delivery through public-private partnerships have been implemented statewide, but address specific problems rather than the broader need for comprehensive local planning.**

◗ The Texas I&R Network, a public-private partnership, under the direction of HHSC, was formed in 1992 to integrate the numerous information and referral services into a single hotline to call in each local area. The Texas I&R Network is unique in two ways. First, it is facilitated and supported by the state, but it is not state-run; and second, information is available about private-sector services in a community, as well as public or governmental services. Similar systems in most other states involve only public services. The Network currently receives over 1 million calls per year through its 100 Community Information Centers statewide, covering 140 counties and more than 90 percent of the state's population. And, in 1997, the Texas Legislature formally established the I&R Network in state law as the recognized system for information and referral services in Texas.

◗ Community Resource Coordination Groups (CRCGs) are another example of an initiative that successfully brings together different entities to improve services. CRCGs are local groups comprised of staff from public and private child-serving agencies that work together, in partnership with the family, to develop service plans for children whose multiple needs can not be met through a single agency. Designed to serve children that would have otherwise "fallen through the cracks," it was initially piloted in four Texas communities in 1988, and now has groups operating in 150 communities statewide, serving children in all 254 counties. This initiative, like the I&R Network, involves a partnership between the public and private sectors and, while supported by staff at HHSC, is a locally-based system.

▼ **HHSC pilots to develop more comprehensive local service delivery systems have shown success, but no plan exists to ensure cooperation across state agencies in support of implementing and sustaining changes on a broader, statewide basis.**

- The Children's Finance Initiative at HHSC, funded through an interagency contract with the Department of Mental Health and Mental Retardation, as well as a Robert Wood Johnson grant, is responsible for developing "blended funds" projects for high-risk youth. The purpose of the initiative is to develop local organized service delivery systems for children with multiple needs which are family based, accountable for outcomes and which maximize all funding sources, including state, local and federal dollars. HHSC is working in Travis County, Brown County (south of Houston), and the Dallas area to pilot the blending of funds from child-serving agencies to provide services for children, using managed care techniques to improve access, continuity and quality outcomes.

HHSC is piloting the blending of funds to better serve high-risk youth in three Texas counties.

- HHSC is also working with The Annie E. Casey Program for Urban Youth, housed in the Third Ward of Houston. The program consists of a school-based Family Resource Center, and a network of providers of children's services, governed by an elected neighborhood board. The program is funded by the Casey Foundation and is one of four such programs nationally promoting local control of programs for at-risk youth in inner-city neighborhoods.

- In addition, numerous efforts across other agencies have aimed at integrating services and/or increasing local control. For example, the Department of Protective and Regulatory Services' Community Youth Development Program, created by the Legislature in 1995, is an interagency effort to coordinate youth services across local juvenile probation departments, child protective units, and other community youth service agencies. Program decisions are made by local neighborhood CYD boards.

  Another example is the Texas Children's Mental Health Plan, an interagency initiative created by the Legislature in 1992 to focus on services for children and adolescents with mental health needs. The plan is based on a continuum of services provided through interagency and private sector coordination;

flexibility in funding, decision-making, service delivery and structure; and community-level decision-making about service and funding priorities.

- While these initiatives and pilots show the benefits of integrated services and the potential for improving services at the local level, HHSC does not have any clear plans on how the successful things learned from these pilots can be implemented on a broader, statewide basis. In addition, Sunset staff found little, if any, coordination across state agencies regarding different plans to increase local input and involvement in improving the local service delivery system.

Texas has no cross-agency plan for increasing local involvement.

▼ Other states have adopted legislation to promote more comprehensive community-based service systems.

- State legislation to promote the development of more comprehensive community-based support systems varies. Some states, such as Missouri, have enacted major legislative reforms that set up entirely new governance, financing, and administration structures. Others, such as Georgia, have taken a more incremental approach by setting up a process for changes to be implemented over several years.[3]

  Community Partnerships — California and Oregon statutes create broad-based community governance boards to design and administer a wide range of child and family services. Virginia's law provides for local governance bodies to operate at the county level, while Iowa allows for governance by some cities and by groups of counties working together. Indiana's Step Ahead program brings together social service, health, religious, and school system organizations in all 92 counties in the state.

  Finance Reforms — Many states blend certain funding streams to maximize the effectiveness of their health and human services system. Virginia's Comprehensive Services Act combines nine state funding sources into a single pool for the use of community-based collaboratives. In Missouri's Caring Communities, five state agencies redirect funds to support community efforts to assess and address the range of local needs, as well as developing partnerships with private foundations.[5] The Maryland System Reform Initiative pools all state funds for out-of-home care to facilitate the shifting of

funds to reduce these types of placements. In California, the state provides $400,000 three-year grants to local collaboratives as start-up money or "glue" money for community-provided integrated services.[6]

Ensuring a continuum of care on the local level requires state agencies to work closely with local officials, as well as the private and non-profit sectors.

Accountability — While most states have emphasized achieving measurable results from these changes, only a few states have adopted explicit outcome goals for the state in the legislation (Minnesota, Oregon and West Virginia). Frequently, performance measures are required in law, but both state and local officials have flexibility to decide on the best measures. In addition, the National Governor's Association has established guidelines for decentralizing decision making that stress establishing measurable benchmarks to chart progress.[7]

Consumer, Family Representation — Many states laws attempt to involve consumers, parents, care givers, or family members on the membership of new community-level governing boards (Florida, Georgia, Maryland, Minnesota, North Carolina, Ohio and Virginia).

Conclusion

The organization of health and human services in Texas is fragmented. Ensuring a continuum of care at the local level, where services are actually delivered, will require initiatives to bring local communities to the table. Communities that are taking these steps are finding many barriers to successfully planning to integrate local assets and resources to meet priority needs and gaps in services. Categorical state and federal programs, policies and funding restrictions are often a major obstacle. Funding is often available only for specific problems or only when problems reach a crisis stage.

While Texas has piloted many efforts to improve these services locally, the state has no cross-agency plan to guide how the numerous state health and human services agencies can best work with local officials and non-profit and private sector groups to begin to ensure a continuum of care on the local level. Many state agencies are taking steps independently, creating a multitude of coordinating bodies on the local level for each program they fund. Pilots continue to be developed, but with no clear plan for how or when these changes will be taken to a broader, statewide level.

Other states have taken major steps to work more closely with local communities to improve the delivery of human services. Given that reforms

to federal funding streams and organizational structures at the state level will take time, one of the most promising initiates for more immediate change is the development of a system for the blending of programs and funds for more flexible local use.

Recommendation

Change in Statute

- **Designate the Health and Human Services Commission as the lead agency responsible for developing more comprehensive, community-based support systems for health and human services.**
- **Require health and human services agencies to work with HHSC in supporting the development of more comprehensive local services; and to submit any proposals for new community initiates to HHSC for review and approval to ensure consistency and guard against duplication.**
- **Require HHSC to be a single point of contact for communities to work with to overcome institutional barriers to more comprehensive community support systems, particularly barriers tied to state agency policies and procedures.**
- **Require HHSC to develop a system of blended funds from state health and human services agencies to allow local communities to customize services to fit the individual community's needs.**

The intent of these recommendations is to provide the means for state government to work in partnership with communities to strengthen local capacity to identify community needs and assets, and to address them in ways appropriate to those individual communities. HHSC would be the single state structure for local communities to contact; as well as the lead agency for bringing together the different state agencies to develop a common plan for improving local service delivery.

HHSC would have to develop a plan for ensuring that interested communities could obtain assistance, as needed. The contacts HHSC has established through the I&R Network, CRCGs and its local pilots should provide the means for ensuring the appropriate level of local involvement in the plans for improving coordination between the state and local level. All health and human services agencies must cooperate if a consistent state approach is to be implemented. Local officials, providers, and most importantly, consumers of these services, should be involved in the planning process of developing a framework for more comprehensive community-based services.

HHSC should set up a clear process for local communities to bring forward barriers; with involvement of each of the 11 state health and human services agencies in quickly addressing these barriers. Other states have set up similar systems that could be modeled, but tailored to fit Texas. The system should include a means for forwarding needed changes to federal and state laws or rules to the appropriate entity.

In deciding the type of community planning entities that should be designated to receive blended funds, flexibility is important to allow existing collaboratives to take on this role. At a minimum though, the entities should include a broad representation of business, education, local government, health, non-profit, religious, and consumers active in the community. In addition, at least one of the entities involved should have general governmental responsibilities (e.g. a city or county) and legal authority to accept state or federal funds. Many models exist for how local communities can organize to take a stronger role in planning and designing services.

Each locality would be free to determine how much of a role to take in this process. Some communities may take no new role, while others may opt to collaborate and apply to blend funds across several aspects of the local service delivery system, with strong oversight and support from the State for improving results. Whatever decisions local entities make, however, the role of the State should be one that facilitates greater local involvement at the point that services are actually delivered, rather than being another one of the barriers.

Fiscal Impact

No fiscal impact is anticipated from this recommendation. HHSC's existing authority to draw on the expertise and assistance from staff from the 11 health and human services agencies should be used in implementing these changes.

[1] Telephone interview by Ginny McKay with Dawn Franks, President, United Way of Tyler/Smith County, Tyler, Texas, November 3, 1998.

[2] The Georgetown Project, *A Snapshot of Georgetown Children and Youth,* (Georgetown, Texas, 1998).

[3] Telephone interview by Ginny McKay with Barbara Pearce, Executive Director, The Georgetown Project, Georgetown, Texas, November 9, 1998.

[4] The Georgia Policy Council for Children and Families, *On Behalf of Our Children: A Framework for Improving Results,* (Atlanta, Georgia, November 1994).

[5] Mary M. O'Brien, *Financing Strategies to Support Comprehensive, Community-based Services for Children and Families*, (Washington, D.C., March 1997), (http://www.financeproject.org/strategies.html). (Internet document.)

[6] The Finance Project, *Building Strong Communities: Crafting A Legislative Foundation*, (Washington, D.C., December, 1996), pp.4-1 to 4-20.

[7] National Governor's Association, *Decentralizing Decision making for Family and Children Services,* (Washington, D.C., July 1995), p.3.

Organization and Delivery of Health and Human Services

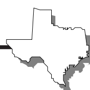
Overseeing the Change Process

This section of the report addresses the importance of legislative oversight when further integrating service delivery of HHS services in Texas. The issue reviews the history of legislative oversight and provides a new opportunity for the Legislature to influence health and human services integration. These changes propose an incremental approach to keep the change process steady and on-track to fulfill the long-standing goals of the Legislature.

Issue 18. Implementing the Agenda Proposed in This Report to Change the Texas Health and Human Services System will Require Transitional Legislative Oversight.

Issue 18

Implementing the Agenda Proposed in This Report to Change the Texas Health and Human Services System will Require Transitional Legislative Oversight.



Discussion

The organizational changes proposed in this report represent significant departures from the status quo in the area of health and human services (HHS). Reformulating the role of the Health and Human Services Commission (HHSC) to provide combined operational functions and stronger integration of service delivery will be an immense challenge. However, with more than $12 billion spent annually on health and human services in Texas and about 55,000 HHS employees, the citizens of Texas could significantly benefit from the State's effective implementation of the administrative and service delivery changes described throughout this report.

The changes proposed in this report will be implemented incrementally and require support of the Legislature.

The proposed changes are long-term in nature and designed to be implemented incrementally to ensure that they are done correctly. The Commissioner of Health and Human Services will have the major responsibility to carry out the changes envisioned in this report and will yield considerably more authority while agency boards, commissions and executive directors would need to significantly adjust their approaches to handling administrative issues, overseeing staff, developing programs, and providing services.

The Commissioner and the agencies will need support, both from the Governor's Office and the Legislature to successfully integrate services. Typically, the Legislature provides oversight and direction to state agencies through the passage of legislation. The study and discussion of that legislation in standing committees, interim committees and specially-designated commissions, councils, and task forces allow the Legislature to monitor and work in concert with state agency personnel to effectively apply state policies. The Legislature has been very active in creating and shaping the health and human services system through oversight. The chart, *Health and Human Services Legislative Directives*, summarizes some of these legislative directives regarding the health and human services system.

Starting in 1976, the Joint Advisory Committee on Government Operations was established to review state government structure. This effort included a

Health and Human Services Legislative Directives	
Services Areas	**Legislative Directives**
Health and Human Services Oversight and Coordination	Created HHSC to oversee and coordinate the 11 health and human service agencies, maximize federal funds, and improve the coordination and delivery of human services. Required HHSC to: ● review and comment on LARs, agency strategic plans, and interagency fund transfers; ● prepare a consolidated budget for health and human services; and ● approve HHS agency automated systems and information resources plans. Expanded and delineated HHSC's oversight duties regarding operating budgets of HHS agencies, federal funds, automated systems, coordination of caseload estimates and the integration of health and human services.
Long-Term Care	Transferred the long-term care function from TDH to DHS. Established a vision statement and guiding principles for long-term care services. Formalized state policies regarding integration of various long-term care systems. Identified HHSC's coordination and development responsibilities regarding long-term care. Transferred the requirement of preparing a long-term care plan from TDoA to HHSC. The House Committee on Human Services Interim Report to the 74th Legislature directed the following: ● DHS to develop a voucher system for long-term care services as a pilot; ● an interagency work group to develop a long-term care capacity plan for nursing home beds, personal care facilities, adult day care, and other long-term care services; ● the creation of a statewide guardianship program; ● DHS, TDoA, and appropriate agencies to develop a uniform functional assessment tool; and ● the establishment of a single point of entry for the long-term care system.
Medicaid	Directed HHSC to: ● redesign the Medicaid health care delivery system, ● seek federal authorization to allow Texas to implement Medicaid managed care ● permit local control of the health care delivery system, ● provide a toll-free Medicaid help number, ● establish Medicaid provider reimbursement rates, ● improve Medicaid managed care contract administration, and ● establish Regional advisory Committees for Medicaid managed care.
Texas Integrated and Enrollment Services (TIES)	The TIES Legislative Oversight Committee is currently: ● analyzing, monitoring, and evaluating TIES, and recommending action by the HHSC Commissioner, and ● advising the HHSC Commissioner in the development and implementation of a plan for the integration of services and functions relating to eligibility determination and services delivery by HHS agencies, TWC, and other agencies.

subcommittee on Health and Welfare that concluded that service systems should be designed and implemented with a focus on definable groups of people in need of services. The committee also recommended that these service systems should promote the greatest degree of independence from state services by meeting needs in a comprehensive manner.

To address the concerns reported by these committees, the Legislature established the Special Committee on Delivery of Human Services in 1978. This Committee continued to study the human services delivery system in Texas, including the use of state funds for services and programs. In 1980, the Committee produced a report with 72 recommendations focused on improving the health and human services delivery system through planning and coordination.[1] As a result of these recommendations, the Legislature created the Texas Health and Human Services Coordinating Council in 1983 to coordinate the activities of the health and human services agencies. However, in 1991 the Sunset Commission concluded that the Council had not been able to achieve meaningful coordination across the agencies and the Council was abolished.

Legislative oversight will keep the change process steady, on-track, and help get the job done.

In that same year, the Legislature looked at the performance of all areas of state government and concluded that the delivery of health and human services by multiple state agencies was inefficient and confusing. Therefore, the Legislature created the Health and Human Services Commission (HHSC) as an oversight agency and gave the Commissioner fairly substantial authority to direct the health and human services agencies toward consolidation and streamlined service delivery.

In considering the past legislative oversight provided to health and human services, Sunset staff assessed the best opportunities and methods to accomplish the improvements charted within this report. Although legislative oversight may not have always achieved intended goals, legislative oversight remains critical. In the past, change in this area of government focused on coordination, but the changes proposed in this report go well beyond coordination and focus strongly on actual integration. In this case, intensive, transitional legislative oversight will be a key element in meeting the State's long-intended goals for health and human services.

During the potential six-year period for implementation of these changes, the legislature will need to meet periodically to make significant modifications to the agenda adopted this legislative session. This will help keep the change process steady and on-track with immediate accountability for getting the job done. This agenda for change calls for strong leadership, a forum for ongoing public input, and a mechanism to generate extensive objective

information to guide continued improvements to health and human services. Specifics on the need for transitional legislative oversight appear below.

Successful integration of the health and human services requires a transition process that needs legislative oversight.

- Successful restructuring of the health and human services system requires changes to be made gradually, over a specific period of time. Although this report offers a tentative calendar on which to base these changes, adjustments will be needed as the process progresses and the impact of the proposed changes is more carefully assessed and scrutinized. For example, the creation of a long-term care agency will require extensive planning and coordination between HHSC and agencies with long-term care programs to achieve consistency among agency rules and infrastructure.

Direct involvement through legislative oversight allows for early detection and appropriate action to deal with emerging problems and changes before hardships occur.

- As changes to the health and human services system are proposed for implementation, the Legislature will need to determine which components of the process to pursue most diligently and provide guidance as problems arise. Numerous important issues affect the health and human services system including the co-implementation of state and federal welfare reform measures, the trend toward block granting in welfare and Medicaid, and efforts to make public assistance systems more efficient. Legislative oversight would allow the health and human services system to be adapted to address any necessary changes.

State and federal welfare reforms, block granting, and changes to Medicaid make legislative guidance necessary.

Public input that addresses the integration and consolidation of the health and human services system would be most effective if received through a legislative oversight committee.

- Changes to the health and human services system will greatly affect services, agency clients and service providers. Because the changes in the health and human services system deal with issues that involve multiple agencies, the Legislature is the appropriate entity to hear public concerns. In addition, most health and human services are provided locally, thus public input is critical for legislators to obtain insight on local issues and service delivery aspects. Legislators want to know if proposed changes would negatively affect consumers, plus public input from citizens, service providers, and advocacy groups is often the best source for identifying additional options to improve the service delivery system. Establishing sufficient legislative oversight during

the transition to a more integrated health and human services system should offer a means for channeling input to policymakers, increasing the objective evaluation of public input, and targeting changes to the health and human services system.

- Although the public has access to each individual HHS agency board, HHSC does not have a board, nor is it required to hold public meetings. With the current structure, stakeholders do not have an avenue to provide input on operational consolidation. In addition, the cross-agency changes proposed in this report require advanced system-wide analysis. A lack of sufficient legislative oversight during the transition may create concerns on the part of clients and advocacy groups about whether legislative directives would be effectively implemented by HHSC.

Public input is critical for legislators to obtain insight on local issues and service delivery aspects.

The relationship and interaction between the HHSC Commissioner, agency executive directors, and agency boards should be closely monitored and facilitated to ensure effectiveness.

- Even with clear statutory direction, HHS agencies and boards have been reluctant to coordinate various aspects of the health and human services system. The transition to a more integrated management structure will make agency directors more accountable to the HHSC Commissioner. Transitional legislative oversight would provide the opportunity to develop a more satisfactory climate of accountability. A legislative oversight committee could direct and oversee the agencies efforts to work together and assess agency response to the leadership coming from the Commissioner. The committee could also ensure that the Commissioner is sufficiently addressing its concerns as well. Although the recommendations in this report do require HHSC to oversee system-wide endeavors, during the transition period the Legislature will be instrumental in promoting, setting the tone for, and facilitating these critical relationships.

Transitional legislative oversight would help develop a satisfactory climate of accountability between HHSC and the agencies.

The large and complex nature of health and human services requires legislative oversight and involvement that is based on reliable, objective research information.

- The complexity of health and human service delivery results in a need for first-rate, objective, in-depth, system-wide information. Each biennium, the Legislature is faced with critical decisions about policy areas such as long-term care, nursing home care and facilities, and Medicaid managed care. The agenda for change contained in this report will require even more extensive amounts of information, data analysis, and resources than are currently available. With the proposed changes in this report, in addition to the existing extensive list of legislative priorities in health and human services, the need for high-quality information and data will be more pressing than ever.

Health and Human Services Research Needs

As part of the review of the Health and Human Services Commission, the 75th Legislature directed the Sunset Commission to study and consider:

- the need for objective research and analysis of health and human services needs and programs,
- options for objective development of a long-range strategic plan for health and human services in this state,
- whether existing resources available to the Legislature include safeguards needed to maintain the quality of research and promote greater accountability to state leadership, and
- the most appropriate means for providing to the Legislature the research information necessary to manage Texas' health and human services system and plan for its future.

HHSC provides some system-wide information such as consolidated appropriations requests and generalized strategic planning. However, the 1997 State Auditor's report on HHSC found that the Commission has not met the State's need for comprehensive health and human services information, including statewide needs assessments and performance evaluations.

◗ The Legislature has repeatedly expressed the need to improve the health and human services system based on objective research. The text box, *Health and Human Services Research Needs*, describes the most recent legislative charge regarding the need for objective health and human services research.

Transitional legislative oversight combined with improved means for obtaining information would allow HHSC and legislators to better assess, direct, monitor, and evaluate the integration and consolidation of the health and human services system.

Conclusion

This report recommends a number of very significant, difficult changes in the State's organization of health and human services. These changes include shifting the balance of power between the HHSC Commissioner, the HHS agency boards, and agency directors. Also included are numerous changes in the way services are provided and agencies are organized. If adopted, the resulting HHS system will represent a dramatic departure from the status quo. This effort will require dedicated, strong leadership; on-going opportunity for input; much information; and a way to refine the change process as it unfolds. Sunset staff concluded that on-going legislative oversight is the best approach to ensure that what is needed to make change possible actually occurs.

Recommendation

Change in Statute

■ **Create a Legislative Oversight Committee on Health and Human Services to:**

- **monitor the integration and consolidation efforts of HHS agency programs and HHSC's efforts to improve health and human services operational functions;**

- **recommend, as needed, adjustments to the proposed schedule for HHS system changes;**
- **recommend legislation to further consolidate health and human services agency functions where appropriate;**
- **collect, analyze, and report information about the health and human services system; and**
- **ensure public input in the process to change the health and human services system.**

■ **Specify the duties of the Health and Human Services Commission in support of the Legislative Oversight Committee.**

■ **Specify the duties of the health and human services agencies in support of the Legislative Oversight Committee.**

■ **Authorize the Legislative Oversight Committee for six years, with an expiration date of September 1, 2005.**

The following discussion provides detail on the recommendations listed above.

Legislative Oversight Committee Structure

The Legislative Oversight Committee would be composed of 10 members. The Lieutenant Governor would appoint four members of the Senate and one public member, and the Speaker of the House of Representatives would appoint four members of the House and one public member. Each appointing authority could designate himself or herself as one of the legislative appointees.

Legislative Oversight Committee Responsibility

Specify in statute the responsibilities of the Legislative Oversight Committee, including:

- *overseeing the reorganization and transition of the HHS system,*
- *ensuring that laws are implemented consistent with legislative direction,*
- *seeking input from local constituents and advocacy groups,*
- *carrying out statewide health and human services needs surveys and forecasting,*
- *producing progress reports to be submitted to the Legislature and the Governor, and*
- *making recommendations and recommending legislation to subsequent Legislatures.*

Public Access to the Legislative Oversight Committee

Specify in statute that the Legislative Oversight Committee must provide a means for public access regarding previous and proposed changes to the health and human services system. To accomplish this, the Committee should hold meetings around the state and take public testimony.

Duties of the Health and Human Services Commission

Specify in statute the responsibilities of the Health and Human Services Commission, including:

- *providing staff and resources to support the Legislative Oversight Committee,*
- *developing sufficient capacity and staff resources to analyze and recommend changes consistent with the objectives and directives of the Legislative Oversight Committee,*
- *providing information as requested by the Legislative Oversight Committee, and*
- *providing the Legislative Oversight Committee with an annual plan that addresses topics identified by the Committee.*

Duties of the Health and Human Services Agencies

Specify in statute the responsibilities of the health and human services agencies, including requiring the agencies to assist the Legislative Oversight Committee by providing information in areas under the Committee's charge. The HHS agencies shall report, in a manner prescribed by the Committee, on agency progress in addressing legislative and statutory directives, and the directives developed by the HHSC Commissioner.

Fiscal Impact

This recommendation will have a fiscal impact to the State. The Committee will require staff resources and administrative support, to be provided by HHSC. In addition, the Committee's public hearing requirements will also result in some costs. HHSC, with budget transfer authority, should share these expenses between the HHS agencies on a pro-rata share basis. These costs could not be estimated for this report.

Health and Human Services Commission

Across-the-Board Recommendations

Health and Human Services Commission		
Recommendations	**Across-the-Board Provisions**	
	A. GENERAL	
Not Applicable	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.
Not Applicable	4.	Provide for the Governor to designate the presiding officer of a state agency's policymaking body.
Not Applicable	5.	Specify grounds for removal of a member of the policymaking body.
Not Applicable	6.	Require that information on standards of conduct be provided to members of policymaking bodies and agency employees.
Not Applicable	7.	Require training for members of policymaking bodies.
Not Applicable	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.
Modify	10.	Require information to be maintained on complaints.
Modify	11.	Require development of an equal employment opportunity policy.

Health and Human Services Commission

Background

Background

The Health and Human Services Commission (HHSC) was created in 1991 by the 72nd Legislature to oversee and coordinate the activities of 11 health and human services agencies. The following agencies are subject to HHSC oversight:

- Department on Aging
- Commission on Alcohol and Drug Abuse
- Commission for the Blind
- Commission for the Deaf and Hearing Impaired
- Interagency Council on Early Childhood Intervention Services
- Department of Health
- Department of Human Services
- Juvenile Probation Commission
- Department of Mental Health and Mental Retardation
- Department of Protective and Regulatory Services
- Texas Rehabilitation Commission

HHSC was created in 1991 to oversee and coordinate the activities of 11 HHS agencies.

Agency History

In the 1960s, a federally-driven expansion of health and human services (HHS) encouraged an increase in the size and complexity of the Texas service delivery system. By 1983, 20 separate state agencies were responsible for delivering health and human services in Texas. These 20 state agencies, along with numerous local and federal agencies, generally used their own approaches to determine client eligibility and provide services. The growth in the cost and complexity of health and human services, together with the perception that services were fragmented and unnecessarily confusing, contributed to the view that the HHS delivery system should be improved.

Creation of the Health and Human Services Coordinating Council

In 1983, the Legislature created the Texas Health and Human Services Coordinating Council (the Council) to coordinate the activities of HHS agencies and assist in developing a more effective service delivery system. The Council was given broad statutory authority to study, analyze, review, and advise state health and human services agencies. The Council was composed of 21 members including the chairs of eight health and human services boards, the Governor, the Lieutenant Governor, the Speaker of the House of Representatives, two Senators, two House members, and six appointed public members. Although the Council was not given policymaking authority over other HHS agencies, the ex officio status of the Council's members was intended to promote cross-agency analysis and decision making. The activities of the Council, largely directed by the Governor and the Legislature, focused on children's needs, the cost and availability of health care, automation, and case management.

In a 1991 review of the Council, the Sunset Commission found that ". . . the current structure of [the Council], the broad reach of its mandates, and the diverse number of projects it has been assigned have not allowed it to serve as a definitive and practical forum for the coordination of health and human services."[1] In 1991, the Legislature abolished the Council, as recommended by the Sunset Commission, and moved its functions to the Governor's Office.[2]

HHSC was born out of legislative consideration of TPR's first report, *Breaking the Mold*.

Creation of the Health and Human Services Commission

Before the 1991 legislation to abolish the Health and Human Services Council became effective, the 72nd Legislature passed Senate Bill 111.[3] This bill mandated a thorough analysis of the financing, organization, and operation of all Texas government, with particular attention to the health and human services system. The performance review was directed by the Comptroller of Public Accounts and staffed by an interagency team of policy analysts and auditors. The Texas Performance Review (TPR) issued its report, *Breaking the Mold*, in July 1991. The report proposed creating a single state agency directed by one governing board to deliver health and human services in Texas. The proposed Board was to contain six public members and deliver services through an agency organized by function into six divisions. The report determined that a single unified system could improve health and human services through:

- comprehensive statewide planning and development,
- a continuum of care for families and individuals,
- integration of services to improve client access,
- effective use of management information systems,
- incentives to maximize existing resources,
- system-wide accountability,
- an environment that promotes teamwork and creativity, and
- mechanisms that foster innovation at the agency and local levels.

The report also recommended that the state be divided into geographic regions, with a planning board in each region responsible for local public input, community-based budget development, and strategic HHS planning.

In 1991, the Legislature passed House Bill 7. Through House Bill 7, the Legislature implemented many of the recommendations contained in *Breaking the Mold*, but did not create a single health and human services agency. Instead, the Legislature retained separate boards and agencies to deliver services, while creating a new agency, the Health and Human Services Commission, with "primary responsibility for ensuring delivery of state health and human services in a manner that uses an integrated system to determine client eligibility; maximizes the use of federal, state, and local funds; and emphasizes coordination, flexibility and decision making at the local level."[4] The text box, *HHSC Goals, Powers, and Duties*, shows the goals and responsibilities assigned to HHSC in House Bill 7.

The Legislature has expanded and further defined the responsibilities of HHSC since its creation in 1991. The table, *HHSC Legislative History*, shows significant legislation passed since 1991.

HHSC Goals, Powers, and Duties

Goals

- Maximize federal funds through the efficient use of available state and local resources
- Provide a system that delivers prompt, comprehensive and effective services to the people of Texas
- Promote the health of the people of Texas
- Foster the development of responsible, productive, and self-sufficient citizens
- Provide needed resources and services to the people of Texas when they cannot provide or care for themselves
- Protect the physical and emotional safety of all the people of Texas
- Improve the coordination and delivery of human services

General Powers and Duties

- Arbitrate and render final decisions on interagency disputes
- Facilitate and enforce coordinated planning and delivery of HHS, including compliance with the coordinated strategic plan, co-location of services, integrated intake, and coordinated referral and case management
- Request budget execution for the transfer of funds from one agency to another
- Establish a federal HHS funds management system and maximize the availability of those funds
- Develop with the Department of Information Resources automation standards for computer systems to enable HHS agencies to share pertinent data
- Establish and enforce uniform regional boundaries for all HHS agencies
- Carry out statewide HHS needs surveys and forecasting
- Perform independent special outcome evaluations of HHS programs and activities
- Adopt rules necessary to carry out the Commission's duties
- Develop a formula for the distribution of funds that considers such need factors within the regions of this state

POLICYMAKING BODY

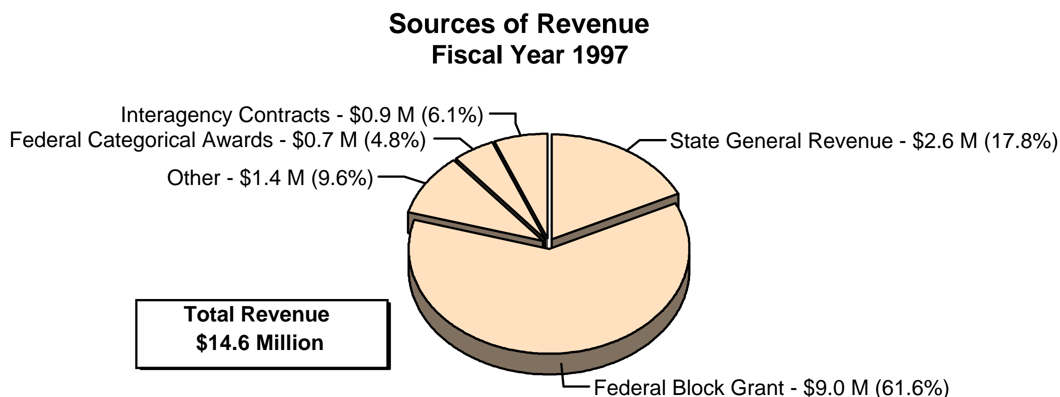
HHSC is overseen by a single Commissioner, appointed by the Governor.

The Health and Human Services Commission is governed by a single Commissioner who is appointed by the Governor with the advice and consent of the Senate. The Commissioner, who serves a two-year term, develops agency policy, conducts meetings, and proposes and adopts rules consistent with the requirements of the Administrative Procedure and Texas Register Act, and other applicable state requirements.

FUNDING

Revenues

The Commission's activities are financed through three basic components - federal categorical awards, state general revenue, and interagency contracts. In fiscal year 1997, the Commission's funding totaled $14.6 million, with the majority from federal categorical awards. The Commission's revenue is shown by source in the chart, *Sources of Revenue—Fiscal Year 1997*.



Expenditures

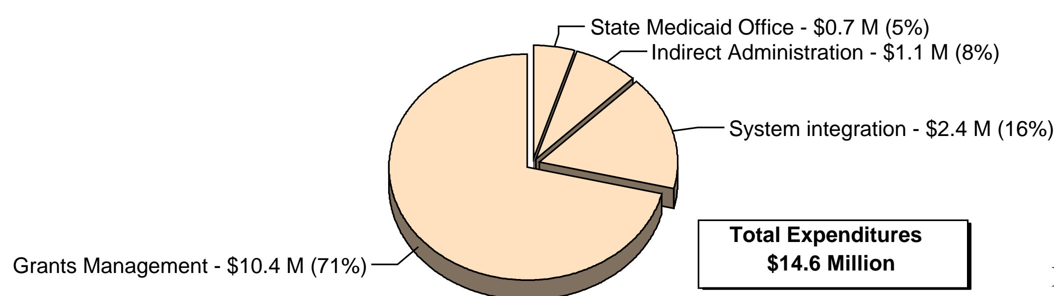
HHSC's main goals as identified in the Commission's strategic plan are to facilitate and enforce coordinated delivery of health and human services and to improve the efficiency and effectiveness of the state Medicaid system.[5]

The Legislature makes appropriations to HHSC in the General Appropriations Act to achieve two goals. The first goal is to implement a coordinated delivery

HHSC Legislative History	
73rd Legislature – 1993	
House Bill 1510	Transferred long-term care functions from the Department of Health to the Department of Human Services, removed the Texas Youth Commission from the HHSC umbrella, transferred the Runaway and Youth at Risk programs from the Department of Human Services to the Department of Protective and Regulatory Services, and deleted the September 1, 1995 deadline for completion of a "permanent governing structure" from HHSC's enabling legislation.
74th Legislature – 1995	
House Bill 869	Required HHSC to consider priorities and plans submitted by governmental entities that coordinate the delivery of services to different regions, counties, and cities as part of the strategic planning process.
House Bill 1863	Required HHSC to review and comment on Legislative Appropriations Requests, agency strategic plans, and interagency fund transfers; prepare a consolidated budget for HHS; develop and implement plans for integrated eligibility determination and integrated service delivery; approve HHS agency automated systems and information resources plans prior to submittal to Department of Information Resources; and mediate interagency disputes.
House Bill 2698	Established a vision statement and guiding principles for long-term care services, formalized state policies regarding integration of various long-term care systems, and identified HHSC's coordination and development responsibilities regarding long-term care.
House Bill 2891	Transferred the requirement of preparing a long-term care state plan for the elderly from the Department on Aging to HHSC.
Senate Bill 10	Directed HHSC to redesign the Medicaid health care delivery system, to seek federal waivers or other authorizations which would allow Texas to implement managed care for Medicaid clients, to use local dollars to draw federal matching funds, and to permit local control of the health care delivery system.
Senate Bill 509	Clarified the authority of HHSC to give agencies under its jurisdiction the responsibility to operate components of the state Medicaid program, and validated the transfer of the residential care program for the mentally retarded to the Department of Mental Health and Mental Retardation.
Senate Bill 601	Required HHSC to provide a toll-free number to people enrolled in or applying for Medicaid who experience barriers to receiving health care, to publish quarterly reports on calls received on toll-free lines, and to correct problems with the toll-free lines.
Senate Bill 604	Required HHSC to develop a plan for piloting the use of Medicaid funds to establish medical savings accounts for acute care Medicaid recipients.
Senate Bill 1428	Abolished the Legislative Health and Human Services Committee; recreated the Texas Commission on Alcohol and Drug Abuse.
Senate Bill 1675	Expanded and delineated the oversight duties of HHSC regarding operating budgets of HHS agencies, federal funds, automated systems, coordination of caseload estimates, and the integration of HHS.
75th Legislature – 1997	
House Bill 2913	Authorized HHSC to establish Medicaid provider reimbursement rates; required HHSC to improve Medicaid managed care contract administration and to establish Regional Advisory Committees for Medicaid managed care.

system for health and human services. This delivery system should use an integrated process for client eligibility determination; make efficient use of available funds; and emphasize flexibility, local control, and self-reliance. The Legislature has directed that this system be in place by 2003. The second goal of HHSC is to improve the efficiency and effectiveness of the state Medicaid system. The Legislature has given HHSC the objective of reducing waste, fraud, and abuse; ensuring adoption of fair rates; and providing policy guidance and oversight for the state Medicaid system by 2003.

Expenditures by Strategy
Fiscal Year 1997



The two goals of the agency are funded through four appropriations strategies. In fiscal year 1997, HHSC received approximately $14.6 million to implement its strategies. The chart, *Expenditures by Strategy — Fiscal Year 1997*, summarizes HHSC's expenditures for fiscal year 1997.

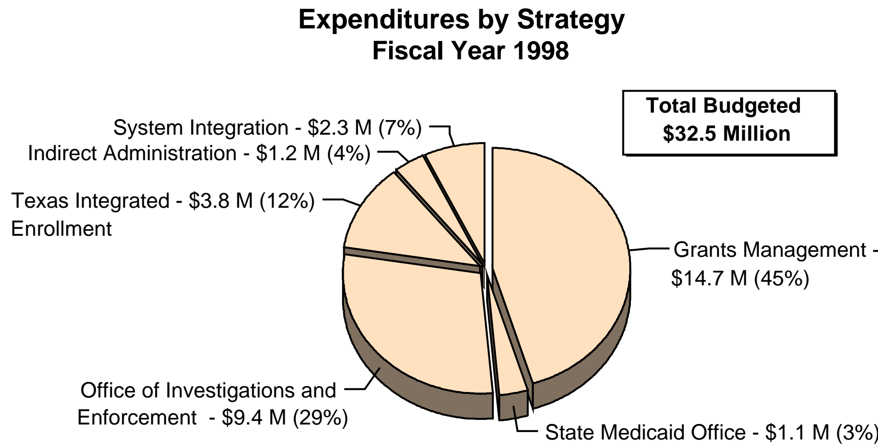
HHSC allocates appropriations made in its four strategies to fund six agency programs. The chart, *HHSC Expenditures by Program — Fiscal Years 1997–1998*, shows the fiscal year 1997 expenditures and fiscal year 1998 budget for each agency program.

HHSC Expenditures by Program
Fiscal Years 1997 - 1998

HHSC Program	Expended Fiscal Year 1997	Budgeted Fiscal Year 1998
Agency Oversight	$1,320,346	$1,846,025
Integrated Enrollment	$551,397	$3,796,229
Service Integration	$10,541,664	$15,114,624
State Medicaid Office	$694,204	$968,254
Medicaid Rate Setting	N/A	$115,610
Office of Investigation and Enforcement		
OIE Administration	$401,184	$4,540,365
Medicaid Program Integrity	N/A	$850,283
Utilization & Assessment	N/A	$3,538,247
Compliance Monitoring		
and Referral	N/A	$507,705
Indirect Administration	$1,096,850	$1,225,308
TOTAL	$14,605,645	$32,502,650

Between fiscal years 1997 and 1998, HHSC's budget increased 123 percent, to $32.5 million. Federal funds increased from $9.7 million in fiscal year 1997 to $22.5 million in fiscal year 1998 due to a $5 million increase in Empowerment Zone grant funds, $6 million for the Medicaid Office of Investigation and Enforcement (OIE), and $1.8 million for developing the Texas Integrated Enrollment System (TIES). The chart,

HHSC Expenditures by Strategy — Fiscal Year 1998 shows how HHSC has budgeted these increased amounts.



For 1998, HHSC has an added $18M to carry out its responsibilities.

Purchases from Historically Underutilized Businesses

The Legislature encourages agencies to purchase goods and services from Historically Underutilized Businesses (HUBs) and has set a goal for the State to spend 30 percent of its purchasing dollars with HUBs. In fiscal year 1997, HHSC purchased 14.5 percent of its goods and services from HUBs and consequently did not meet the State's goals. The chart, *Purchases from HUBs—Fiscal Year 1997*, shows HUB spending by category and compares agency purchases with the statewide goal.

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	N/A	N/A	N/A	57.2%
Professional Services	$11,640	0	0	20.0%
Other Services	$2,115,415	$342,454	16.1%	33.0%
Commodities	$583,003	$50,233	8.6%	12.6%
TOTAL	$2,710,058	$392,687	14.5%	

ORGANIZATION

HHSC has 162 employees, including 36 staff in regional field offices.

HHSC employs approximately 162 staff, with the majority located at two sites in Austin. Approximately 36 staff who perform Medicaid-related duties are stationed in 12 regional field offices in Abilene, Amarillo, Arlington, Beaumont, Burnet, Corpus Christi, Harlingen, Houston, Lubbock, Odessa, San Antonio, and Tyler.

The Commission's staff is organized into six main program areas — legal and legislative affairs, fiscal policy, integrated enrollment, information resource management, State Medicaid Office (including investigations and enforcement, and reimbursement), and service integration. The organizational structure of the Commission as well as the current number of FTEs, funding level, and major activities for each area is illustrated in the chart, *Health and Human Services Commission Organizational Chart*.

A comparison of the Commission's workforce composition to the minority Civilian Labor Force is shown in the chart, *Health and Human Services Commission Equal Employment Opportunity Statistics*. HHSC met or exceeded the Civilian Labor Force levels of employment in 10 instances, with the Commission's female workforce most reflective of the Civilian Labor Force. The agency's technical and para-professional positions are least representative of the Civilian Labor Force.

Health and Human Services Commission
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	8	13%	5%	13%	8%	63%	26%
Professional	102	12%	7%	16%	7%	75%	44%
Technical	7	0%	13%	0%	14%	43%	41%
Protective Services	N/A						
Para-Professionals	14	7%	25%	14%	30%	79%	55%
Administrative Support	34	12%	16%	26%	17%	97%	84%
Skilled Craft	N/A						
Service/Maintenance	N/A						

Agency Strategies

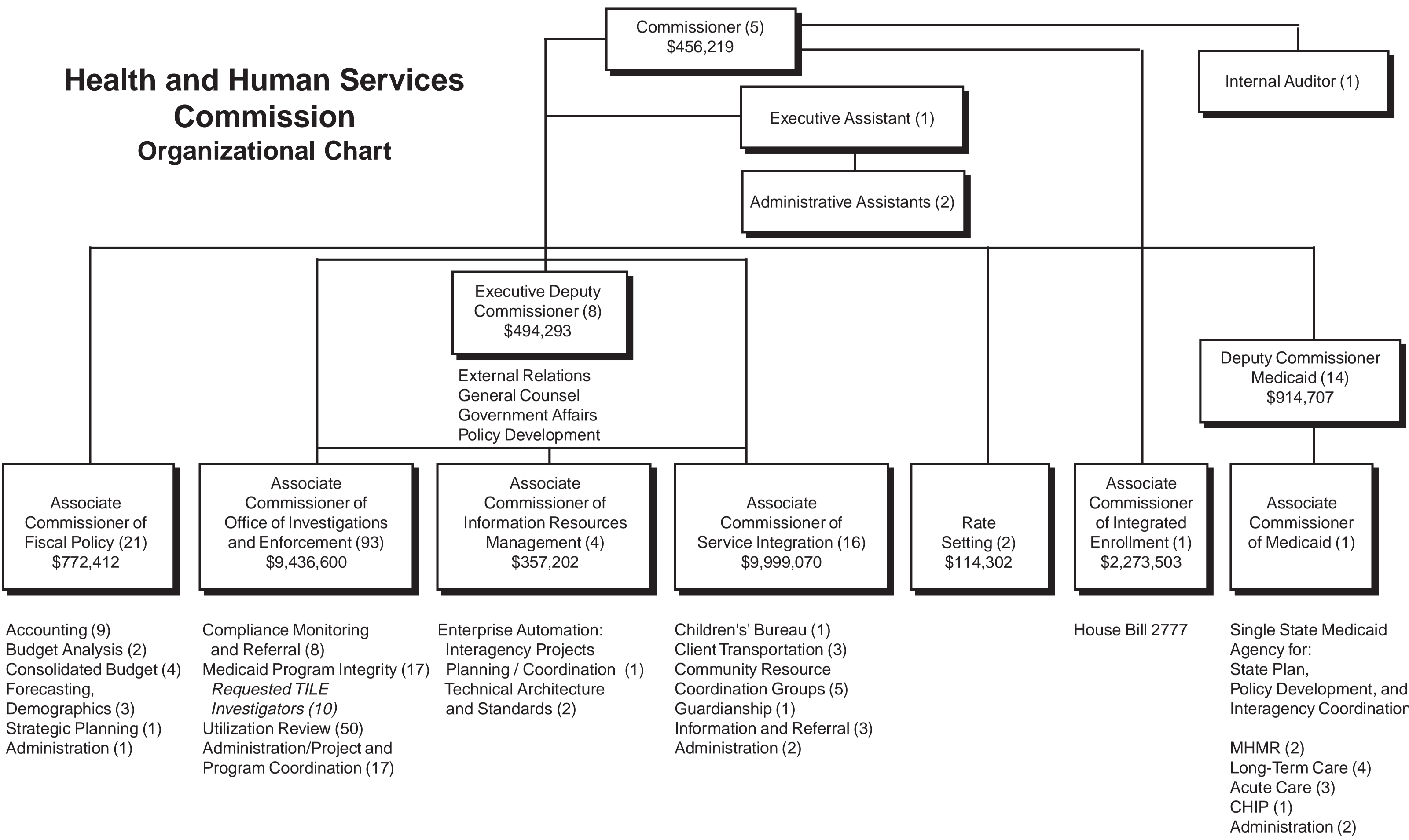
Office of Investigations and Enforcement
Investigate fraud, waste, and abuse in the provision of health and human services, enforce state law relating to the provision of those services, and provide utilization assessment and review of Medicaid claims and client assessments.

System Integration
Facilitate and enforce coordinated planning and integrated delivery of health and human services.

Integrated Enrollment
Develop and implement a plan for the integration of eligibility determination functions and service delivery by health and human services agencies, TWC, and other agencies.

Medicaid Administration
Set the overall policy direction of the state Medicaid program and manage interagency initiatives to maximize federal Medicaid dollars, and improve quality of services by serving as the single state Medicaid agency.

Health and Human Services Commission
Organizational Chart



Agency Operations

To accomplish its objectives, HHSC performs several planning functions and is responsible for a number of diverse state and federal programs. The following sections describe HHSC's activities relating to service integration, medicaid and community empowerment.

Service Integration

HHSC participates in several projects and studies that relate to the agency goal of coordinating and streamlining the delivery of health and human services.

Strategic Planning and Budgeting

The agency's Fiscal Policy Division is responsible for strategic planning, internal budgeting, agency accounting, and coordinating with HHS agencies on budgets, LARs, quarterly expenditures, caseload forecasting, and demographic data and research.

Coordinated Strategic Plan – HHSC develops a six-year Coordinated Strategic Plan for health and human services. HHSC, along with the 11 other HHS agencies, submitted its third biennial Coordinated Strategic Plan in June 1996. The fiscal year 1997-2002 Coordinated Strategic Plan is intended to provide a future direction for health and human services in Texas and a framework for development of the Consolidated Budget for health and human services. Public participation in development of the plan included a survey of over 600 respondents to prioritize HHS issues and a town meeting to develop cross-agency issues.

HHSC develops a consolidated HHS budget for use in the State's appropriations process.

Consolidated Budget – HHSC develops a Consolidated Budget for all HHS agencies to provide assistance to the Governor, Legislature, and oversight budget staff in the development of the General Appropriations Act. The fiscal year 1998-1999 Consolidated Budget grouped services through the use of service categories, allowing a functional approach to grouping services. HHSC also reviews and comments on HHS agency expenditures quarterly.

Caseload Forecasting Report – HHSC began developing and maintaining a Quarterly Caseload Forecasting Report for HHS agencies during fiscal year 1996. The current Forecasting Report includes 79 individual caseloads as well as four aggregated caseloads for AFDC/TANF, Medicaid, food stamps, and long-term care. The primary purpose is to establish consistent

methodologies across agencies, particularly in Medicaid, and separate forecasting from budgeting processes. The report also strengthens trend analysis and consistency among associated benefit programs.

Information Resources Management

The Information Resources Management (IRM) division is responsible for ensuring integrated information resources are acquired appropriately, implemented effectively, and comply with state and agency policies. In addition, staff are responsible for providing leadership to improve coordination and cooperation across the HHS enterprise including establishing architecture standards for the enterprise; establishing agency IR policies, procedures, and standards; planning and budgeting technology acquisitions; preparing the agency Biennial Operating and Information Resources Strategic Plans; providing technical guidance and assistance; and approving the 11 HHS agencies' automation plans. IRM also provides technical assistance in the management and/or oversight of interagency projects and initiatives, including those listed below.

Texas Integrated Enrollment and Services – The Texas Integrated Enrollment and Services (TIES) Project is part of the State's ongoing effort to integrate the enrollment and service delivery processes for a broad array of health, human services, and workforce programs. HHSC is the lead agency, with the Department of Health, the Department of Human Services (DHS), and the Texas Workforce Commission (TWC) participating in the project. The main goals of the TIES Project are to promote personal responsibility and move clients from welfare to work; improve client access and quality of services; produce long-term savings by investing in the health, well-being, and self-sufficiency of people; and continuously improve performance relative to defined standards for eligibility determination and service delivery.

HHSC is the lead agency in developing TIES, a system to integrate program enrollment of HHS clients.

Implementation of a plan for integrating eligibility will entail broad changes in the information systems and technology that support these business functions. Development and statewide implementation of TIES is planned to take place in three phases over five years. Each phase will include developing modules of the automated system and incorporating re-engineered business processes for selected programs and services.

HHSC expects the systems development to begin in the third quarter of calendar year 1999. The first pilot is scheduled to begin the first quarter of calendar year 2001 and full implementation of Phase 1 will take place throughout 2002. This schedule is dependent on timely federal approval of the advanced planning document and Request for Offers.

Integrated Database Network (IDBN) – The IDBN is an integrated index of clients receiving services from Texas HHS agencies. IDBN allows authorized users to access and share client information. Approximately 80 percent of the current HHS client population are represented in the IDBN. Information is available to enhance tracking client patterns of program participation over time, as well as across agencies and programs.

HHSC is responsible for the day-to-day management of the IDBN as well as managing the contract with the DHS. DHS is responsible for the maintenance and support of IDBN. HHSC develops and manages the interagency contracts with the 11 HHS agencies and TWC, who provide funding for the project.

IDBN will be maintained and supported as it currently exists until TIES has been implemented. The ability to share information created by the IDBN is a requirement for the TIES system.

Health and Human Services Consolidated Network – The Health and Human Services Consolidated Network (HHSCN) is a statewide telecommunications cooperative that connects and manages networks. HHSC created the partnership in 1994 to share network costs and services among the HHS agencies. Network planning has resulted in over $4 million in savings during fiscal year 1997. The HHSCN is governed by a board of agency representatives.

HHS Agencies' Automation Plan Approval – HHSC is required by statute to review and approve the HHS agencies' automation plans prior to their submission to the Department of Information Resources (DIR). HHSC has worked with the HHS agencies to develop standards and guidelines for automation plan development, and to coordinate the approval process with DIR. The Information Resources Managers from the HHS agencies meet on a monthly basis to seek ways to foster communication and cooperation across agencies. Before submitting agency automation plans to DIR, managers meet to present and discuss the automation plans. These meetings facilitate interagency coordination and cooperation and help identify opportunities for cost savings through the sharing of information technology resources.

HHSC works with communities to integrate state, local, and non-governmental services.

HHSC Interagency Initiatives

HHSC works with communities to integrate state, local, and non-governmental services to meet the needs of individuals and families. The Commission's focus is on building consumer and community-driven service delivery systems. At the local level, consumers and service providers are partners in the design and development of the local service delivery system. HHSC provides technical assistance, evaluation materials, information on

best practices, and other service integration tools to local sites and community collaborative groups. The chart, *Measures of Service Integration Efforts*, identifies efforts to integrate service delivery at the local level for fiscal year 1998.[6]

Programs in Service Integration Division	Number of Local Site Visits	Number of National Training Curriculums	Number of Participants in Trainings
CRCGs	47	8	355
Families are Valued	36	2	850
Texas Information & Referral	46	4	1,480
Guardianship Alliance of Texas	12	1	140
Texas Integrated Funding Initiative	62	1	158
Office of Community Transportation	123	2	N/A
General Services Integration	8	3	170

Measures of Service Integration Efforts

In addition, HHSC is involved in coordinating legislative initiatives across state agencies, such as the recently created federal Children's Health Insurance Program (CHIP). The text box, *Children's Health Insurance Program*, offers more detail about this federal initiative.

Information and Referral – The Texas Information and Referral (I&R) Network is a public-private partnership working to build a statewide information and referral system that will provide consumers and professionals with access to current information on available services. The I&R Network ensures the adoption of common descriptions and definitions of health and human services among providers, and the adoption of national information and referral standards by information and referral providers.

HHSC manages the development of the I&R Network. Specific responsibilities include:

- collecting and analyzing information;
- facilitating, participating, and implementing the system design work;
- providing technical assistance and training for local information and referral providers; and
- researching other information and referral systems and practices in Texas and other states.

HHSC established the Information and Referral Task Force to guide development of the statewide information and referral system. HHSC directs and provides support to the task force and Network to guide developments of the statewide information and referral system. The text box, *Accomplishments of the Information and Referral Network*, shows the I&R Network's accomplishments.

Children's Health Insurance Program

The State Children's Health Insurance Program was created as part of the Balanced Budget Act of 1997 to provide states with additional resources to extend health care coverage to uninsured children. Under the terms of the statute, states receive an allocation of federal funds at an enhanced matching rate to cover uninsured children through an expansion of Medicaid, a state-designed program, or a combination of the two. CHIP could provide up to $561 million per year through the year 2000 in federal matching funds. These funds cover children up to 200 percent of the federal poverty level, with the added incentive of a federal match of 74 percent, rather than the current Medicaid match of 63 percent.

HHSC has directed interagency staff teams in the development of program options. HHSC staff have participated in the design of such elements as benefit packages, eligibility determination and enrollment operations, outreach, cost-sharing arrangements, and the program budget. HHSC has solicited public input into the design of the program through public hearings and presentations to provider and consumer groups across the state. HHSC is responsible for preparing the required State Plan submissions and negotiates on behalf of the State with federal agencies charged with CHIP plan approval and implementation oversight.

Accomplishments of the Information and Referral Network

- adoption of common descriptions and definitions of health and human services
- adoption and implementation of national information and referral standards by information and referral providers
- updating and publication of the HHS Reference Guide and *Finding Help in Texas: A Directory of Information and Referral Providers*
- conceptual system design for the statewide network which includes definition of roles, responsibilities, and standards for the statewide network by the Information and Referral Taskforce
- designation of 25 proposed Area Data Centers to provide and maintain the data necessary for the statewide system
- grants to local Community Information Centers to improve technology and telecommunications access (funds were provided by TWC through an interagency contract with HHSC)
- the Exchange, a technical assistance publication
- the IR-Networker, an internet mailing list for international communication about information and referral topics
- the I&R Network Web page

Co-Location – HHSC is responsible for implementing the legislative directive that state HHS offices must co-locate. The goal of co-location is to improve interagency coordination and client access to services, reduce agency overhead and administrative costs, and give the staff of participating agencies a broader understanding of HHS programs.

HHSC analyzes and reviews the HHS agencies' lease request data and forwards approval to the General Services Commission, or asks the agencies to further examine the potential for co-location. In fiscal year 1997, HHSC reviewed 109 lease requests. Of these, 48 requests (44 percent) involved co-location. Of the 109 requests reviewed by HHSC, 18 (16.5 percent) were returned for additional information, justification for choosing not to co-locate, or identification of plans to co-locate in these situations. HHSC also reports co-location data quarterly and annually as part of the agency's performance measures.

HHSC also directs the policy issues of the interagency Co-Location Workgroup. This includes advising workgroup members, scheduling meetings, setting the agenda items, and coordinating leasing activities. Recent accomplishments of the Workgroup include developing Facility Management Guidelines and a checklist that agencies use when terminating a lease at a co-located facility.

Office of Community Transportation Services (OCTS) – The goal of OCTS is to redesign currently fragmented, program-specific transportation funding and policy mechanisms to ensure that health and human services clients get the transportation necessary to access services. OCTS funds five transportation sites that coordinate transportation resources with state agencies, local communities, and consumers. OCTS produces technical assistance materials like the Texas Community Transportation Coordination Workbook for local transportation stakeholders, and promotes coordination among state agencies through the Agency Transportation Coordinating Council and the Transportation Collaborate. These are informal working groups of transportation providers and interest groups involved in health and human services transportation.

Children's Financing Initiative – The Children's Financing Initiative develops integrated funding strategies for children's services, including mental health, juvenile justice, child welfare, and related funding streams. The Initiative is building state and local infrastructure to pilot an integrated funding approach for children's mental health services. A grant from the Robert Wood Johnson Foundation provides funding. The purpose of the grant is to implement family-focused, community-based, capitated managed care systems of services for severely emotionally disturbed children and their families.

Two pilot projects currently exist in Travis County and in Brownwood. Between August 1998 and August 1999, the initiative will develop new pilot sites in El Paso and Amarillo. Delivery of services to children is scheduled to begin in September of 1998, as is an outcome evaluation of the pilot sites. A legislative report on the progress of the initiative is due in January 1999, and a second legislative report detailing the outcomes of the pilots is due in January 2000.

Community Resource Coordination Groups (CRCGs) – CRCGs are local interagency groups of public and private service providers who meet to develop service plans for children and adolescents who require services from multiple agencies. Agencies that provide services to children fund the State CRCG Office at HHSC. From 1994 through 1997, CRCG Office staff provided or directed 155 on-site technical assistance visits, 88 educational presentations, and training and technical assistance to 1,498 participants in CRCG conferences. State agencies and other partners have requested consultation from HHSC to potentially expand the model to selected adult services.

CRCGs meet to develop plans for certain clients receiving services from multiple agencies.

Children's Policy Team – This interagency group represents the agencies that serve children in Texas. The Children's Policy Team was established to provide a process for planning, coordination, and integration across education, juvenile justice, and health and human services agencies. The Policy Team provides a mechanism to link individual initiatives and serves as a forum to identify ways to improve the service delivery system for youth in Texas.

HHSC sets the overall policy directions and works closely with the Mental Health Association to provide administrative staff support to the Policy Team. HHSC's duties include advising the Policy Team, directing group meetings, drafting grant proposals, reviewing and coordinating appropriation requests, and reviewing interagency Requests for Proposals on related children's issues.

Long-Term Care – Initiatives in the area of long-term care for the elderly and disabled include development of a long-term care access plan,

development of rules regarding consumer information about community placement, and development of a Medicaid long-term care pilot. These initiatives address issues in long-term care services such as lack of community options, fragmentation of services, and lack of resources.

HHSC directs two interagency groups that focus on the coordination and planning for long-term care: the Community Based Services Action Team and the Children with Severe Disabilities Workgroup. HHSC chairs, facilitates, and provides staff representation and support for both groups. HHSC staff also draft the required reports, distribute the reports for review by the agencies, and finalize the reports.

Currently, HHSC is gathering extensive data to complete a detailed analysis of all HHS programs that provide long-term care to assess variation in the design and delivery of services across programs. This analysis will provide the basis for determination of potential benefits of coordination or alignment of long-term care programs, and for identification of methods to achieve consistency across organizational lines. HHSC and the appropriate agencies have begun to address the issues identified in the analysis.

Guardianship – HHSC, with the advice of the Guardianship Advisory Board, is responsible for adopting minimum standards for guardianship and related services, developing and implementing a statewide plan for guardianship, and facilitating the establishment and growth of volunteer guardianship programs around the state. The members of the Guardianship Advisory Board have been conducting meetings across the state to collect ideas and consider recommendations for developing the components of the statewide guardianship plan, including organization and standards of the plan.

HHSC Service Integration Model Sites

- Three integrated funding pilot sites that focus on systems of care for children with or at risk of emotional or behavioral disorders. The sites use blended funding, managed care approaches, wrap around/individualized service planning, cross-agency care coordination, and family partnerships in the delivery of care. HHSC provides technical assistance and is conducting evaluations in partnership with the University of Texas.
- Casey Mental Health Initiative in Houston's Third Ward. This initiative is designed to improve outcomes for troubled children, adolescents, and their families by demonstrating new ways of delivering culturally appropriate, family-focused mental health services. The Initiative is funded by the Annie E. Casey Foundation, and focuses on empowering families to participate in decisions regarding their needs and the use of resources. Key components of the Casey initiative include a neighborhood governance board, a Family Resource Center, co-located services, a family advocacy network, and family training programs.
- Five sites providing coordinated services to children with disabilities and their families. These include four family collaborative sights to focus on permanency planning for children with developmental disabilities and one site providing one-stop, comprehensive services for medically fragile children and their families.

Other Service Integration Efforts

Other examples of HHSC's efforts to integrate service delivery are described in the text box, *HHSC Service Integration Model Sites*. HHSC provides technical assistance at these sites. Technical assistance may include:

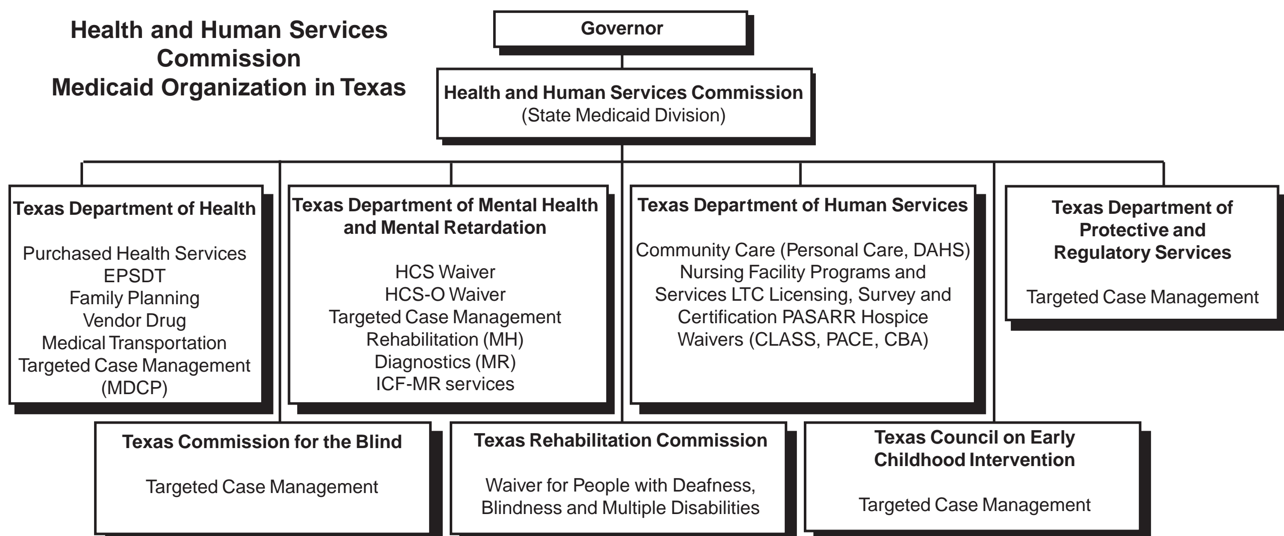
- arrangement of technical assistance and training from national experts, ensuring good matches between national consultants and local sites;

- facilitation and provision of consultation for collaborative groups to work through complex organizational and technical issues;
- provision of materials and information from other states that offer alternatives and innovative approaches;
- selection and development of training manuals and materials that meet the specific needs of the local sites; and
- provision of access to and consultation from collaborative groups at the state level and state decision makers to assist in addressing barriers to service integration.

HHSC's Medicaid Responsibilities

The Commission serves as the federally required single state Medicaid agency and has final approval for all Medicaid policies, rules, and program direction. Federal law forbids the Commission from delegating to other agencies administrative discretion or the authority to issue policies, rules, and regulations on matters relating to the Medicaid program. Federal law also states that if other agencies have the power of review over the single state agency, this power must not impair the authority of the single state agency. Finally, other agencies that perform services for the single state agency must not have power to override the judgment of the single state agency.

Texas is unique among the states in that HHSC, the Medicaid policymaking agency, does not deliver any Medicaid services. Texas delivers Medicaid services through seven independent operating agencies that perform the day-to-day service delivery functions that ensure clients receive health care. The Medicaid operating agencies and their programs are shown in the table, *Medicaid Organization in Texas*.



While the operating agencies carry out program administration for the array of services available under the Medicaid package, HHSC's role is at a broader policy level. HHSC's Medicaid responsibilities include:

- developing and maintaining the Medicaid State Plan;
- managing the Medicaid waiver process;
- implementing Medicaid managed care systems;
- directing rate-setting processes that compensate fee-for-service Medicaid providers; and
- administering programs to detect waste, fraud, and abuse, and to ensure quality in the Medicaid system.

Developing and Maintaining the Medicaid State Plan

The Medicaid State Plan is the contract between a state and the Health Care Financing Administration (HCFA). The State Plan describes the provisions of the State's Medicaid program, including the client groups served, the services provided, and how service providers are reimbursed. The table, *Requirements of the Medicaid State Plan*, lists the major elements of the State Plan that are required by the federal government.

Requirements of the Medicaid State Plan

Federal Requirement	Description
Designation of a Single State Agency	The State Plan must include the designation of the Medicaid agency that is the final authority on policy decisions. In Texas, the Medicaid Single State Agency is HHSC.
Statewideness	The state Medicaid program must operate in all political subdivisions of the state. If it is administered by the political subdivisions, it must be a mandatory part of their operations.
Financial Participation by the State	State funds are used to pay all of the non-Federal share of total expenditures under the plan.
Client Eligibility	Certain groups must be eligible for Medicaid under the State Plan, and a number of groups may be eligible at the option of the State.
Charging for Services	States may not charge eligible recipients enrollment fees, premiums, or similar charges. Exceptions are provided for non-emergency services provided in an emergency room with evidence that recipients had non-emergency services available to them. States may impose nominal deductions, cost sharing, or similar charges, except for the following classes of services: ● services provided to individuals under 18 years of age, or a higher age set by the State; ● services provided to pregnant women, if the services relate to the pregnancy or another condition that might complicate the pregnancy; ● services to an individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such an individual is required to spend all but a minimal amount of his income as a condition for receiving such services under the State Plan; ● emergency or family planning services and supplies; and ● services to an individual receiving hospice care.
Freedom of choice	The State Plan must allow Medicaid recipients to use any qualifying Medicaid provider.
Comparability	Services provided under the Medicaid State Plan must be equal in amount, duration, and scope for all clients under the Plan.

MEDICAID WAIVERS

If a state deviates from the state plan, a waiver must be submitted to HCFA detailing the planned departure from the federal requirements. The waiver process allows states the flexibility to try new approaches to service delivery and to adapt state programs to meet the needs of specific groups or areas. The waivers obtained by Texas are listed in the table, *Medicaid Waivers.* For example, Texas has several waivers that allow clients who in traditional Medicaid would require institutional care, to be cared for in their own homes, such as the Community Living and Support Services, and Community Based Alternatives Program waivers. The benefits are seen by both the client, who is not removed from family and a familiar environment, and the State, which saves money under waiver alternatives of care. One of the requirements for federal approval of waivers is that the cost of providing services under the waiver may cost no more than the cost of serving the same population without the waiver.

IMPLEMENTING MEDICAID MANAGED CARE

One of the most significant waiver initiatives in Texas, as well as other states, has been the implementation of managed care for Medicaid clients. Fee-for-service is the traditional method of paying for Medicaid. In a fee-for-service system, a physician or other health-care professional provides health care to a Medicaid client, submits a claim for payment, and receives a fixed, predetermined amount. Over the last ten years, Texas and most other states have begun to replace fee-for-service payment strategies with managed care systems of payment. States view managed care as a way of controlling rising Medicaid costs and encouraging statewide availability of Medicaid providers. The text box, *Medicaid Managed Care Across the States*, discusses managed care initiatives throughout the United States.

The Texas Legislature authorized the first Medicaid managed care pilot in 1991.[7] The table, *Texas Medicaid Managed Care Implementation*, shows the major steps in the implementation of Medicaid managed care in Texas.

Texas Medicaid Managed Care Implementation

Year	Event
1991	Legislature authorizes two-year pilot program for AFDC recipients in Travis, Galveston, Jefferson, and Chambers counties, called State of Texas Access Reform (STAR).
1993	Texas Department of Health implements first STAR pilot project in Travis County on August 1; second project implemented in Gulf Coast region of Galveston, Jefferson, and Chambers counties on December 1.
1995	Legislature passes Senate Bill 10 which: • authorizes HHSC to restructure Medicaid system statewide to incorporate managed care delivery systems; and • authorizes additional managed care pilots. Legislature adopts Senate Concurrent Resolution 55, requiring HHSC to: • pilot the integration of behavioral health care in Medicaid managed care systems that also provide physical medicine services, and • develop and implement a long-term care integrated model in a demonstration pilot. Gulf Coast STAR project area expands to include Hardin, Liberty, and Orange Counties.
1996	Texas Medicaid expands managed care pilots to include San Antonio, Lubbock, and Fort Worth metropolitan areas, and their contiguous counties, beginning in September. Pursuant to Senate Concurrent Resolution 55, four behavioral health care pilot projects implemented in STAR managed care sites.
1997	STAR pilot implemented in Harris County in December.
1998	HHSC implements STAR+PLUS program in Harris County. • Services begin for voluntarily enrolled clients on January 1. • Enrollment becomes mandatory for eligible clients on April 1; eligible clients who have not already enrolled are assigned a health plan and a primary care provider.

Medicaid Waivers

Type of Waiver	Federal Allowances	Texas Waivers	Operating Agency
1915(B)	Waivers allowed under section 1915(b) of the Social Security Act authorize a state to: • implement primary care case management systems or a specialty physician system; • designate a locality to act as central broker in assisting Medicaid recipients to choose among competing health care plans; • share with recipients (through provision of additional services) cost savings made possible through the recipients' use of more cost effective medical care; • vary services and benefits across the state; and • limit recipients' choice of providers (except in emergency situations and with respect to family planning services) to providers that fully meet reimbursement, quality, and utilization standards. These standards are established under the State Plan and must be consistent with access, quality, and efficient and economical provision of care.	STAR managed care waivers: • Primary Care Case Management (PCCM) (Galveston, Jefferson, and Chambers Counties) • HMO (Travis County) • HMO/PCCM (Bexar County) • HMO/PCCM (Lubbock County) • HMO (Tarrant County) • HMO/PCCM (Harris County)	TDH
		• STAR+Plus HMO/PCCM (Harris County)	DHS
		• Inpatient Hospital Selective Contracting (LoneSTAR Select I)	TDH
		• Inpatient Psychiatric Services Selective Contracting (LoneSTAR Select II)	TDH
	Waivers under this section may suspend the requirements for statewideness, comparability of services, and the requirement that a single standard for income and resources be used to determine eligibility. These waivers allow a state to provide, through Medicaid, home and community-based services to recipients who would otherwise require institutional care.	• Home and Community Based Waiver	DHS/MHMR
		• Medically Dependent Children's Program	TDH
		• Community Living and Support Services (CLASS)	DHS
		• Community Based Alternatives (CBA)	DHS/MHMR
		• Texas Rehabilitation Waiver for People with Multiple Disabilities	TRC
		• Mental Retardation Local Authority Program	MHMR
		• State of Texas Access Reform (STAR+Plus)	DHS
		• Program of All-Inclusive Care for the Elderly Long-Term Care Capitation Model by Bienvivier Senior Health Services of El Paso	DHS

Medicaid Managed Care Across the States

Use of Medicaid managed care has grown rapidly as states attempt to improve access to Medicaid services while containing costs. Forty-nine states have implemented some form of Medicaid managed care, and enrollment in managed care programs has grown from 9.5 percent of total Medicaid enrollment in 1991 to 47.8 percent in 1997. In comparison, according to the Health Care Financing Administration, 13.3 percent of Texas' total 1997 Medicaid enrollment participated in managed care as of June 30, 1997.

Why Are States Adopting Managed Care?

States use managed care in hopes of improving access for beneficiaries, enhancing quality of care, and reducing program costs. Many studies indicate that clients have limited access to Medicaid providers who work in traditional fee-for-service settings. Managed care plans allow states to address availability of services through the managed care contract. Another force behind the increased use of managed care is the potential to control health care costs.

Who Is Enrolled in Managed Care?

Most enrollees in Medicaid managed care are from the Aid to Families with Dependent Children (AFDC) and related populations. This group has health care needs similar to the general population so their managed care plans are often similar to those available to commercial populations. States vary in their use of Medicaid managed care for the Supplemental Security Income population, the medically needy, and dual Medicaid/Medicare eligibles. Only a few states enroll the disabled population.

What Services Are Carved-Out Of Medicaid?

Medicaid programs have traditionally sought a broader range of services than private managed care plans can, or want to, deliver. Many states "carve-out," or exempt, certain services from managed care plans and pay for them on a fee-for-service basis or through separate capitation arrangements. Behavioral health care services are often carved out of managed care plans by some states because users tend to create high costs. These carve-outs direct clients to the network of existing fee-for-service providers, protecting their financial viability.

What Types of Plans Do States Use?

Three common approaches are used in Medicaid managed care — primary case management, full-risk HMOs, and prepaid health plans. Nationally, most Medicaid managed care recipients (about two-thirds) are enrolled with a full-risk HMO that provides comprehensive preventive, primary, and acute care services. Primary case management plans link a client with a provider who will take primary responsibility for coordinating care and approving and monitoring referrals. Most prepaid health plans such as clinics and large group practices do not bear full financial risk for the cost of patient care, although some are similar to full-risk HMOs.

What Are the Managed Care Issues For States?

State concerns about Medicaid managed care include quality assurance, setting capitation rates, protecting safety-net providers, and planning to provide nonmedical services. A universal concern is that payment based on capitation rather than reimbursement provides financial incentives for plans to underserve their members. Therefore, states are establishing mechanisms to deter poor-quality care, monitor plan performance, and provide recourse in the event of complaints. Most states are concerned about the impact of managed care on "safety-net" providers, such as community health clinics and public hospitals, who lose Medicaid dollars as the managed care plans direct enrollees to providers in their plan. These lost Medicaid dollars have often subsidized care for other needy patients or been used to pay for services not provided by managed care plans. States' methods of determining capitation rates for payment of managed care plans are linked to the existing fee-for-service payment level and may save between 5 and 10 percent of these levels. These modest savings expectations in part reflect the historically low Medicaid payment rates.

Sources: John Holahan, et al., "Medicaid Managed Care in Thirteen States," Health Affairs, vol. 17, no. 3 (May/June 98), pp. 43-63.

Health Care Financing Administration, "Medicaid Managed Care State Enrollment," in Welcome to HCFA [Health Care Financing Administration's web site] (Washington, D.C., 1998 [cited August 20, 1998]); available from INTERNET.

In 1995, the Legislature directed the Commission to expand managed care to other regions of the state in a phased-in process.[8] The STAR expansion was approved by the federal Health Care Finance Administration through 1915(b) Medicaid waivers, that allowed Texas to implement managed care pilots throughout the state. The STAR program is mandatory for TANF clients in areas served by pilot projects, and voluntary for individuals with disabilities who qualify for Supplemental Security Income (SSI).

The Travis County, Gulf Coast, and Harris County Pilots – The first pilot, in Travis County, included approximately 30,000 Medicaid clients. The pilot initially incorporated a Health Maintenance Organization (HMO) and a Prepaid Health Plan (PHP) in a single health care delivery system. The HMO and the PHP received a capitated monthly fee for providing covered health care services. On August 31, 1996, a new system in which three HMOs provided services replaced the original system.

The second STAR pilot initially included the Gulf Coast counties of Galveston, Jefferson, and Chambers, and was expanded to include Hardin, Liberty, and Orange counties in 1995. The project operates under a Primary Care Case Management model, and includes approximately 42,000 clients. Under this system, primary care providers receive fee for service reimbursement plus a monthly case management fee of $3 per client for providing primary care services.[9]

The Texas Department of Health (TDH) implemented a STAR pilot project in Harris County in December 1997. With the implementation of this pilot, approximately 25 percent of the Medicaid population in Texas receives services through managed care. TDH is planning to convert most of the Medicaid population from traditional fee-for-service Medicaid to Medicaid managed care by September 2002, with the rural communities converting last. The *Managed Care Conversion Schedule* shows the timing of the conversion to managed care throughout the state.

Behavioral Managed Care and Long-Term Care – In 1995, the Legislature adopted Senate Concurrent Resolution 55, which gave HHSC two responsibilities — to pilot a managed care model that would integrate behavioral health care with physical health care, and to develop and implement a long-term care integrated model in a demonstration pilot. An interagency team consisting of TDH, the Department of Mental Health and Mental Retardation (MHMR), and HHSC staff initiated four pilot projects in the fall of 1996 in sites that had received STAR managed care pilots. Services include inpatient and outpatient behavioral health services historically funded by Medicaid and additional value-added services such as

partial hospitalization, day treatment or intensive in-home services. Specialized rehabilitative and targeted case management services provided by MHMR were not included. As required by SCR 55, HHSC submitted a plan for integrating behavioral health services statewide to the Senate Health and Human Services Committee in November 1998.

STAR+PLUS is HHSC's program to pilot a managed care model that includes acute care and long-term care services for the elderly and persons with disabilities. The objectives of STAR+PLUS are to integrate acute care services and long term services into a managed care delivery system, ensure that clients receive an appropriate level of care in the least restrictive setting consistent with their personal safety, improve access to health care and improve quality of care, create accountability and controls on cost, and improve outcomes of care. Implementation of the project required two waivers, 1915(b) and 1915(c), in order to mandate participation and to provide home and community-based services. DHS is the operating agency for STAR+PLUS, but HHSC directs and has final approval over the program. HHSC has organized an interagency team to oversee and monitor STAR and STAR+PLUS implementation in Harris County. The interagency team includes HHSC, DHS, TDH, and MHMR.

The STAR+PLUS pilot operates in Harris County. Eligible participants include the majority of the SSI population and the Medical Assistance Only (MAO) population. The SSI population includes the elderly, children with disabilities, adults who are disabled, and people with mental retardation and mental illness. MAO clients are eligible only if they require nursing home care. The program also covers clients in the Community-Based Alternatives (CBA) waiver program. Clients in the other community waiver programs, clients in Intermediate Care Facilities for the Mentally Retarded, and clients who do not get a Medicaid card are not included.

Mandatory services covered under STAR+PLUS include medical services such as doctor, hospital, lab, and x-ray, as well as long-term care services including attendant care, adult day care, and nursing facility care. HMOs also offer value-added services not included in the capitation rates, including nutrition services, home delivered meals, health education, adjunct supports and parental support, and client-managed attendant care.

Medicaid Rate-Setting

Federal law requires the Medicaid State Plan to contain a description of the process used to set the amounts paid for Medicaid services. The rate-setting process must give the public a reasonable opportunity to review and comment on methodologies, proposed rates, and the justifications underlying the rates.

HHSC administers this requirement of the State Plan and has final authority over Medicaid rates. Approximately 50 Medicaid rate-setting methodologies are used across the seven operating agencies. In 1997, the Legislature directed HHSC to set Medicaid reimbursement rates for all Medicaid operating agencies.[10] HHSC's rate-setting goals are to foster uniformity in the definitions of allowable cost and inflation indices, and to adopt reasonable and defensible rate methodologies and rules.

HHSC's Medicaid Fraud, Waste and Abuse Programs

In 1997, the Legislature charged HHSC with the investigation and enforcement of fraud, waste, and abuse in health and human services.[11] Activities of the agency include:

Medicaid Program Integrity – This program investigates reports of Medicaid fraud, abuse, or misuse. Medicaid Program Integrity investigates allegations, imposes sanctions, processes provider exclusions, and coordinates provider education. In the first three quarters of fiscal year 1998, Medicaid Program Integrity had 18 staff, reviewed 877 cases (excluding those reviewed by the Medicaid Fraud and Detection System), and recovered $15 million.

Utilization and Review – The Utilization and Review program, with a staff of 50, monitors utilization review activities in Medicaid contract hospitals and nursing facilities. Utilization Review is developing and implementing a statewide nursing home case mix assessment review program to improve effectiveness and efficiency. In fiscal year 1998, Utilization and Review reviewed over 15,000 case mix forms for nursing facilities, and recouped almost $13 million. In the same period, Utilization Review recouped $41.6 million from 36,670 hospital cases.

Compliance Monitoring and Referral – The eight staff of the Compliance Monitoring and Referral program monitor and review Medicaid claims processing to ensure compliance with federal regulations and the state Medicaid plan requirements. In fiscal year 1998, Compliance Monitoring and Referral recouped about $18.3 million.

Medicaid Fraud and Abuse Detection System (MFADS) – The Office of Investigations and Enforcement (OIE) administers the MFADS technology services contract. MFADS uses learning and neural network technology to identify and deter fraud and abuse in the Medicaid program throughout the State. MFADS uses mathematical algorithms to analyze Medicaid claims data to identify suspects for further investigation by HHSC.

Between January 1 and August 31, 1998, three staff assigned to MFADS, with assistance from staff in Compliance Monitoring and Referral and MPI, identified 1,394 cases for review or investigation, with 244 of these cases producing recoupments. In addition, OIE completed settlement of a $2.2 million dollar case identified by a fraud detection algorithm and began review of two new neural network models. OIE recovered over $88.5 million in fiscal year 1998, on an operating budget of approximately $10 million. Cost savings identified exceeded $9.8 million, with a grand total of $98.3 million restored to the program.

Empowerment Zone/Enterprise Community Grant Administration

The Empowerment Zone and Enterprise Community programs are recent initiatives by the federal government to empower people in areas of high unemployment and poverty. Both programs allow local control of resources with minimal federal restriction in order to move people out of the public assistance system. The Empowerment Zone program has funded a 10-year project in the Rio Grande Valley with $40 million in Social Services Block Grant funds. The Enterprise Community program in Texas has provided ten-year grants of almost $3 million each to the cities of Dallas, Houston, San Antonio, Waco and El Paso. HHSC receives the federal funds and passes them on to the single nonprofit corporation and five cities that are funded through the programs. In addition, HHSC prepares and submits required financial reports to the federal government.

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[1] Sunset Advisory Commission, *Texas Health and Human Services Coordinating Council: Staff Report to the 72nd Legislature* (Austin, Tex., November 1990), p. 1.

[2] Tex. S.B. 379, 72nd Leg., R.S. (1991).

[3] Tex. S.B. 379, 72nd Leg., R.S. (1991).

[4] Tex. H.B. 7, 72nd Leg., 1st C.S. (1991).

[5] Health and Human Services Commission, *HHSC Strategic Plan for Fiscal Years 1999-2003* (Austin, Tex., June 15, 1998), pp. 33-36.

[6] Service Integration Division Memorandum (August 1998).

[7] Tx. H.B. 7, 72nd Leg., 1st C.S. (1991).

[8] Tex. S.B. 10, 74th Leg. (1995).

[9] Tex. H.B. 7, 72nd Leg., 1st C.S. (1991).

[10] Tex. H.B. 2913, 75th Leg. (1997).

[11] Tex. H.B. 30m 75th Leg (1997).

Health and Human Services Commission

Organization and Delivery of Health and Human Services

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