SUBJECT: Continuation and consolidation of long-term care agencies and services

COMMITTEE: Human Services — favorable, with amendments

VOTE: 8 ayes — Naishtat, Maxey, Chavez, Christian, J. Davis, Noriega, Truitt, Wohlgemuth

0 nays

1 absent — Telford

SENATE VOTE: On final passage, April 29 — voice vote

WITNESSES: For — Paula Russell

Against — None

On — Eric Bost, Texas Department of Human Services; Lesa Walker, Texas Department of Health

BACKGROUND: The two main client groups who receive long-term care services are the elderly and individuals of all ages with disabilities, which are mental or physical impairments that result in functional limitations in three or more life activities, such as self-care, language, and economic self-sufficiency.

At least seven different agencies deliver long-term care services to Texas clients or are involved with advocacy for the elderly and the disabled.

- The Texas Department on Aging (TDoA) manages programs and services for people 60 years of age and older. It does not provide services directly but relies on 28 locally based area agencies on aging (AAAs), which provide information and referral services for the elderly and contract with providers for support and nutrition services such as home-delivered meals, transportation, and respite care. The establishment of AAAs is required under the federal Older Americans Act, the primary funding source for TDoA, and AAAs must contribute a local match of at least 10 percent.
- The Texas Department of Human Services (DHS) provides Medicaid and state-funded community care for the aged and disabled and regulates

nursing homes, nursing home administrators, intermediate care facilities for the mentally retarded, and personal care homes.

- The Texas Department of Health (TDH) administers the Chronically Ill and Disabled Children's (CIDC) program, which provides services to low-income children with specific diseases, and the Medically Dependent Children's Program (MDCP), a Medicaid waiver program for medically complex children, which offers services as an alternative to nursing home care. TDH also regulates home health agencies.
- The Texas Rehabilitation Commission (TRC) administers rehabilitation programs for disabled individuals, such as the Personal Attendant Services (PAS) program and the Deaf-Blind with Multiple Disabilities (DBMD) program, and a Comprehensive Rehabilitation Services (CRS) program for individuals with brain and spinal cord injuries.
- The Texas Department of Mental Health and Mental Retardation (MHMR) provides long-term campus-based and community-based services for mentally retarded and mentally ill individuals.
- The Planning Council for Developmental Disabilities is a federally funded, governor-appointed group responsible for advocating for individuals with developmental disabilities. The council has an annual budget of $4 million and is attached administratively to TRC.
- The Texas Office for the Prevention of Developmental Disabilities (TOP) is responsible for minimizing the economic and human losses caused by preventable disabilities through the establishment of joint private-public initiatives. It operates with two full-time staff in an Austin office.

DIGEST:

SB 374, as amended, would continue TDoA until September 1, 2004, and would establish new requirements for the agency and its governing board. It also would transfer to DHS:

- on September 1, 1999, the licensing and regulation of home health agencies and medication aides from TDH;
- on September 1, 1999, the DBMD program, the PAS program, and the voucher-payment pilot project from TRC; and
- on September 1, 2000, the Medically Dependent Children's Program from TDH.

On September 1, 2003, TDoA would be abolished and DHS would be renamed the Department of Aging and Disability Services and would assume the duties of TDoA.

SB 374 also would require numerous studies, create a community assistance program for long-term care services, create two work groups, and require the Planning Council for Developmental Disabilities and TOP to prepare a joint biennial report to the Health and Human Services Commission (HHSC), the governor, the lieutenant governor, and the House speaker.

This bill would take effect September 1, 1999.

Community assistance. SB 374 would require HHSC, DHS, and TDoA to assist communities that request help in developing comprehensive, community-based systems for delivering long-term care services. HHSC or a relevant health and human services agency would have to provide resources to communities to help them:

- identify and overcome institutional barriers to the development of a comprehensive system;
- develop a system of blended funds from state and federal sources to customize services to community needs; and
- develop a system to provide local access to the full range of long-term care services.

HHSC would have to ensure the maintenance of no fewer than 28 AAAs to continue a local system of access and assistance that is sensitive to the elderly.

Work groups. SB 374 would create an 18-member work group to help DHS and MHMR coordinate long-term care planning and service delivery. The work group would have to include representatives of DHS, MHMR, TDoA, HHSC, long-term care consumers and service providers, and advocates for the elderly, persons with disabilities, and people with mental health and mental illness.

The work group also would have to make recommendations on:

- regulation of residential and community long-term care services;
- setting rates for long-term care services;
- monitoring contracts with providers;
- intake, assessment, and coordinated case management; and
- administration of the In-Home and Family Support program.

SB 374 also would establish a work group on children's long-term care and health programs to assist DHS, HHSC, and TDH and to make recommendations on:

- access to services with a single case manager;
- the transition needs of children who age out of their eligibility of programs through TDH;
- blending funds for children who need long-term care and health services; and
- collaboration and coordination of children's services among state agencies.

The group would include representatives of a consumer and a relative of a consumer of long-term care and health programs for children, an advocate organization for children using long-term care and health programs, state agencies, private providers, and a person with expertise in funding for children's long-term care and health services.

The work groups would have to be appointed by December 1, 1999.

Department on Aging. The nine-member board that governs TDoA would be newly required to consist of experts in gerontology, medical professionals, consumer advocates, and three members of the general public. Board members would have to complete a board training program that would have to provide them specific information, including information about Texas administrative procedures laws, the federal Older Americans Act, and a history of funding sources for long-term care. Standard sunset provisions to prevent conflicts of interest on the part of board members also would be added to board statutes.

The bill would add new functions to TDoA's operations, including:

- making recommendations to the governor, Legislature, and state agencies regarding duplication and gaps in services for the elderly and opportunities for coordination of services;
- conducting research and long-range planning on long-term care for the elderly, including studies on transportation, insurance, and legal rights;
- using the DHS billing system and coordinating with DHS the monitoring of providers who contract with both agencies; and

- developing with DHS a Texas plan on aging as required by the Older Americans Act and conducting with DHS a statewide needs assessment for long-term care services.

When DHS took over TDoA's functions, DHS would have to appoint a nine-member Aging Policy Council to offer advice on the elderly, including policy, research, and planning. Members of the board on aging could serve on the council until the end of their terms. By December 1 of each even-numbered year, the council would have to report to the governor, the lieutenant governor, and the House speaker.

Studies. DHS would have to study the feasibility of a subacute care pilot project with the assistance of TDH and HHSC and to submit a report to HHSC by September 1, 2000.

By November 1, 2000, HHSC would have to evaluate and report to the lieutenant governor and the House speaker on the results of service coordination between TDoA and DHS, including the savings from administrative consolidation and improvements in client services. HHSC also would have to evaluate the feasibility of establishing an integrated local system of access and services for the elderly and persons with disabilities and would have to report to the lieutenant governor and the speaker by November 1, 2000.

SUPPORTERS SAY:

SB 374 would move the state closer to a more comprehensive, less duplicative, and easier-to-access system of providing long-term care services. It would be a first step, not the final step, in better organizing and delivering long-term care services. Such an undertaking needs to occur in stages over several years to address effectively the wide-ranging concerns of multiple providers, regulators, and interest groups.

Consolidating long-term care programs into a single state agency is necessary to create an identifiable agency that is responsible for and can coordinate more effectively the complex range of services required by aging and disabled individuals. This consolidation of long-term care services is especially important because Texas' population is growing in age as well as in number. Fragmentation of services is a long-standing problem in Texas, and consolidation has been recommended as far back as 1993 by the Task Force on Long-Term Care.

Program fragmentation among state agencies is confusing to clients and administratively expensive and drains available resources. Consumers have no single access point. HHSC has found among health and human services agencies 46 long-term care programs with varying eligibility requirements that often provide similar services, such as home-delivered meals, nursing, transportation, physical therapy, adaptive aids, and respite care. Some programs offer choices among an array of services, whereas others offer the clients no choice. Rates for services range considerably. For example, rates for nursing services can range from $24 to more than $58 per hour, and rates for respite services, from $8.63 to $21.80 per hour.

Combining the administration of long-term services would not alter program eligibility but would maximize the use of available funding in agency contracts with providers and would improve public access by providing a single point of entry for all programs. Clients' medical and support needs often change as they age, and the consolidation of programs would provide a continuum of services to help disabled individuals from birth through death obtain needed services without having to reapply to program after program.

Combining the Medically Dependent Children's Program into DHS would provide the continuum of services needed by disabled and medically complex children. Under the current system, children who reach the age of about 21 have to go through a new eligibility determination process to seek services from a different agency and program. Also, MDCP as administered by TDH has been based largely on a "medical model" of care in which patients' symptoms and conditions are recognized and treated but not their social, environmental, and other conditions, which often are equally important in addressing long-term health conditions. Since MDCP contracts with the same providers that other long-term care programs contract with, moving it to DHS also would help create efficiencies in contracting and contract monitoring. Finally, past efforts to improve MDCP program problems through TDH and better interagency coordination have not been successful, so a physical relocation to DHS is necessary.

A floor amendment is expected to be introduced to move MDCP in 2001 instead of in 2000 so that the program would have an additional year to stabilize after having undergone significant changes the past couple of years

and to manage the additional appropriations it is expected to receive in fiscal 2000-01 from tobacco settlement receipts.

The CIDC program, an acute-care program for children, would remain at TDH where it could benefit from the agency's medical and administrative expertise in other health programs.

Directing DHS to study by September 2000 the feasibility of a subacute care pilot project could add coherency to the continuum of services in the future. Subacute care is more intensive than traditional nursing home care but less intensive than hospital care and is needed by medically complex patients who are stable enough to be discharged from a hospital but too sick to go home. Subacute care may be a way to stretch Medicaid dollars while giving appropriate care in nursing homes or other facilities to patients who otherwise would be hospitalized.

When TDoA's functions were transferred to DHS, TDoA's outstanding characteristics and programs would be maintained through continued use of the AAAs and by the establishment of a special Aging Policy Council. The special focus of the TDoA board on *healthy* as well as infirm elderly would be enhanced by converting it into an Aging Policy Council, because the board would be freed from the daily concerns of program administration and could advise on overall direction and policy regarding the aging. Also, its influence would be strengthened by attaching it administratively to the new Department of Aging and Disability Services, where it would have a direct line to board decisions and department information.

The ombudsman program would not lose its objectivity on nursing home oversight by being placed in the same agency that regulates nursing homes. The program operates with a very small central staff, which would be located in a different division of the agency from nursing home regulation, and the program largely depends on the work of the AAAs, which are outside of the agency. Other states run their ombudsman programs this way, and there is no reason to think that it would not work for Texas as well.

MHMR would be involved in coordination and consolidation efforts by the establishment of a special work group that would study the coordination of services between MHMR and DHS. However, it would continue as a free-standing agency because it has the necessary professional specialists and

expertise to respond to the needs of people with mental retardation and mental illness, which could be lost in an agency that served other people with disabilities. Coordination between MHMR and other state agencies also would be enhanced by the direction given in its sunset bill this session.

Retaining welfare and emergency assistance programs at DHS would not be a problem for the board when it assumed oversight of new long-term care programs, because in only two more years, the Legislature will have an opportunity to evaluate at the same time the effect of the changes made both by this bill and by welfare-reform measures enacted in 1995. At least two more years are needed to allow the local workforce development boards to become fully implemented and to better assess the administration of welfare and emergency assistance programs.

OPPONENTS SAY:

Moving programs around is unnecessary and disruptive and would not necessarily result in greater coordination. With the new powers proposed this session in the HHSC sunset bill, HB 2641 by Gray, the commission could coordinate long-term care services and make rate setting and provider contracting more consistent without the expense and disruption of forming a new agency.

Requiring programs to locate in closer physical proximity and under the direction of one board would not ensure coordination and communication. Since the proposed Department of Aging and Disability Services still would be responsible for running cash assistance and other welfare or emergency assistance programs, its focus would be divided.

TDoA in particular should not be folded into another agency. It is a small agency that enjoys the widespread support of elderly Texans and has done an outstanding job with limited staff and resources. Its focus and services would have to compete against other priorities in the new agency, which most likely would mean that the needs of the elderly — especially the healthy elderly — would receive less attention.

The MDCP program should not be folded into the new agency. It makes better sense to keep it at TDH with other children's programs and with the Medicaid program, where professional medical, nursing, and social-work expertise on children's health issues can be shared in policymaking among the programs. Moving MDCP also would eliminate cost-efficiencies the state

now experiences in children's health program administration, funding, and public education efforts. Problems that occur when children age out of their eligibility in TDH programs and need services from another program can be solved through better interagency coordination.

OTHER OPPONENTS SAY:

MHMR also should be consolidated into the new Department of Aging and Disability Services. MHMR is one of five major agencies involved in delivering long-term care services to elderly and disabled Texans, and its client population also experiences the problems of fragmentation of services across multiple state agencies. People with disabilities need the same basic support services regardless of their disability, and there is no need to have more than one agency administer and arrange for similar services.

More councils and agency programs should be transferred into the new agency if it is to become truly the central agency on long-term care and disabilities. For example, the Planning Council on Developmental Disabilities, TOP, and the CIDC program also would fit better in this new agency, especially since the MDCP program would be transferred there.

SB 374 would treat the Aging Policy Council only as an advisory committee, which would eliminate the special overall focus it has provided for 40 years on statewide issues related to both healthy and frail elderly. The council would be a more independent and influential watchdog if it were attached to and appointed by the Governor's Office or HHSC rather than attached to and appointed by the proposed Department of Aging and Disability Services. The elderly need a significant state-agency council just as the disabled have councils such as the Planning Council for Developmental Disabilities and TOP.

The TDoA ombudsman program should be transferred to the Department of Protective and Regulatory Services (DPRS) so that this program would not be placed in the same agency that regulates nursing homes and would retain its federally required objectivity. The ombudsman program, largely composed of volunteer advocates who oversee care in nursing homes, is more compatible with the goals and objectives of Adult Protective Services and could share the resources of DPRS.

The state should wait before eliminating TDoA and should assess the full impact of the new HHSC powers and the effect of other changes and long-term care coordination proposals called for this session.

The state also should wait at least another session before moving the MDCP program to the new agency. MDCP has been experiencing many changes, and a move would cause further disruption to families and children who need services.

NOTES:

The committee amendments would change the Senate-passed bill by:

- adding definitions of “family support services,” “independent living philosophy,” “long-term care services,” and “person with a disability” to the Human Resources Code;
- specifying the Planning Council for Developmental Disabilities as the lead agency in preparing a biennial report on disability services and specifying areas that the report’s recommendations must cover;
- specifying that community assistance concerning blended funds be consistent with the requirements of federal law and the general appropriations act; and
- creating the work group on children’s long-term care and transferring the MDCP program from TDH to DHS.

The status of related bills is summarized below.

- SB 369 by Zaffirini, which would continue the functions and operations of DHS, passed the Senate on April 30 and was considered by the House on May 13 and returned to the Human Services Committee after a point of order was sustained.
- SB 358 by Madla, which would continue the operation of MHMR, passed the House on May 14 as amended.
- HB 1402 by Gray et al., which would continue the functions and operations of TRC, has passed both the House and the Senate;
- HB 1151 by McCall, which would continue the operations of TOP, passed the House on May 12 and was reported favorably by the Senate Human Services Committee on May 14.
- HB 1610 by McCall, which would change the name but continue the functions and operations of the Texas Planning Council on Developmental Disabilities, has passed both houses and been signed into

law by the governor.

- HB 2641 by Gray, which would continue and expand the authority of HHSC, passed the House on April 20 and was reported favorably as substituted by the Senate Human Services Committee on May 12.
- SB 96 by Moncrief, which would transfer the licensing and regulation of home health agencies and medication aides to DHS, has passed both houses and been sent to the governor.
- HB 2148 by Maxey, which would make uniform certain long-term care Medicaid waiver programs, passed the House on April 28 and was reported favorably by the Senate Human Services Committee and recommended for the Local and Uncontested Calendar on May 12.
- HB 2873 by Maxey, which would require permanency planning for disabled children, passed the House on April 30 and was reported favorably as amended by the Senate Human Services Committee on May 13 and recommended for the Local and Uncontested Calendar.