

HEALTH CARE

Texas Department of Human Services

Health Care

The health-care crisis affects every Texas family. Consider these facts compiled by the Texas Health Care Policy Task Force in 1992: Statewide, the cost of health care has spiraled from \$28 billion to \$44 billion in the past five years, and it's expected to reach \$49 billion in the coming year. Soaring insurance costs are leaving the working poor and more and more middle class Texans underinsured or not insured at all. Of the 6 million Texans without adequate health insurance, 35 to 40 percent are younger than age 18.

This social and economic nightmare hits hardest those Texans who need health-care services the most—children and pregnant women living in poverty. According to the University of Texas Child Studies Project, 42 percent of Texans living below the poverty line lack health insurance, and one in four of them are children. Half of all pregnant women living in poverty don't get adequate prenatal care. As a result, 12 to 15 percent of their children are born at risk for developmental delays.

And unless things change, the health-care crisis is only expected to worsen as the population ages. By the year 2025, one in five Texans will be 65 or older and possibly needing long-term care. Even over the next decade, the number of people age 85 and older—those in greatest need of costly nursing home care—will increase by about 40 percent.

Indisputably, the health-care system must be overhauled, and not just in Texas but nationwide. Confronted with very real dilemmas now and facing the likelihood of more serious ones to come, the Health Care Services Division of the Texas Department of Human Services (DHS) continued to move in two directions that are certain to guide national health-care reform: prevention and community-based services.

Preventive care not only keeps people healthy and productive, it saves money, too. For example, the Texas Health Care Policy Task Force estimated that every dollar spent on prenatal care saves about \$3 in newborn intensive care costs. In fiscal year 1992, DHS changed eligibility requirements so that more low-income Texans can get prenatal and early childhood preventive care. The number of preventive services funded by Medicaid also was increased.

The agency's move toward community-based services has been partly fueled by the desires of the people most affected: Elderly people and people with disabilities, given the support services they need, prefer to live in their own homes rather than institutions. But the shift to community-based services also makes economic sense. As the Texas population continues to age, the state will soon be unable to afford to keep the increasing number of people needing long-term care in nursing homes.

DHS continued to develop Medicaid waiver programs this past year as alternatives to nursing home care, and major changes made late in the year in the agency's two largest community care programs will allow more people with greater needs to live in their own homes. Successful community-based Medicaid waiver programs are expected to lead the way to overall change in national health-care policies.

By the year 2025, one in five Texans will be 65 or older and possibly needing long-term care.

Access to health care remained a pressing issue as well, and DHS made several policy changes that should increase the number of Medicaid providers. The agency adopted a resource-based reimbursement methodology, similar to the Medicare system, that is intended to pay doctors and other providers more fairly for the actual costs of services. DHS also increased the reimbursement rate for medical screenings to attract more providers willing to furnish preventive services.

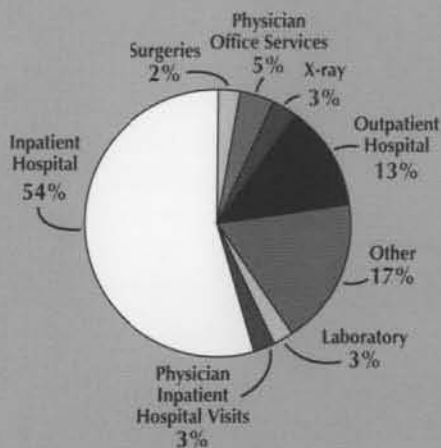
On Sept. 1, 1993, the agency's largest program—Purchased Health Services—will be transferred to the new Texas Department of Public Health. The move was mandated by House Bill 7, the Legislature's massive reorganization of health and human services intended to enhance coordination among agencies and improve client services. As staff began to prepare for the transfer, they continued to promote an integrated eligibility screening process and other collaborative efforts to improve client access to services.

Purchased Health Services

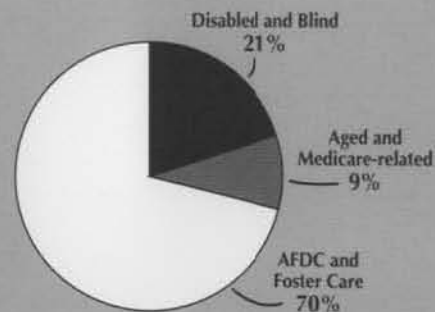
Purchased health services covered by the agency's contract with the National Heritage Insurance Company (NHIC) include hospital and physician care; laboratory tests and X-rays; and care by chiropractors, podiatrists, psychologists, family and pediatric nurse practitioners, opticians, optometrists, and other health-care providers for clients enrolled

Purchased Health Payments

Benefit Payments
FY 1992

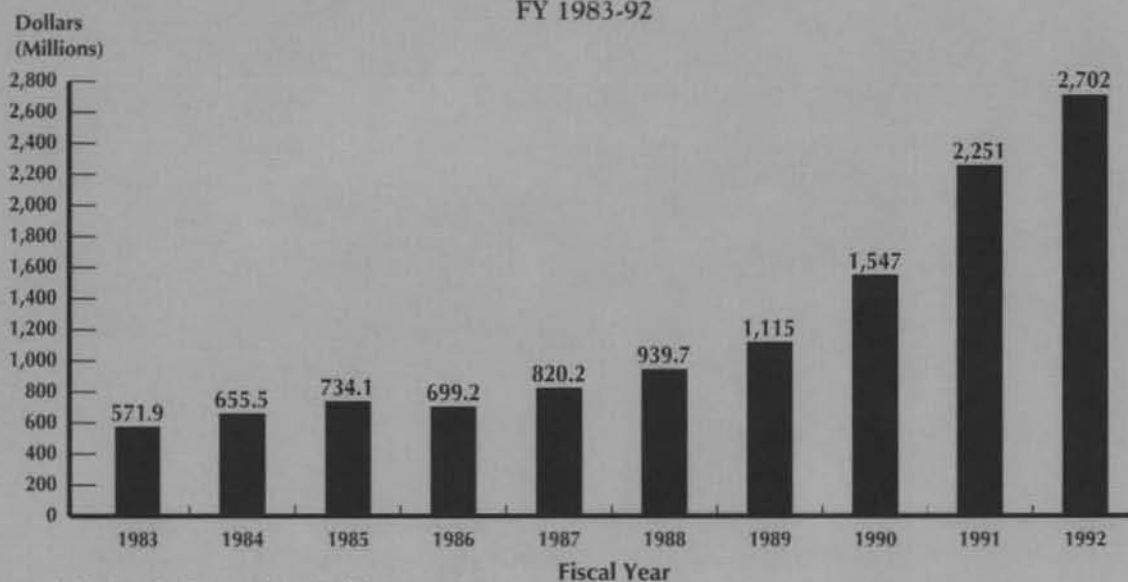


Payments by Recipient Group
FY 1992

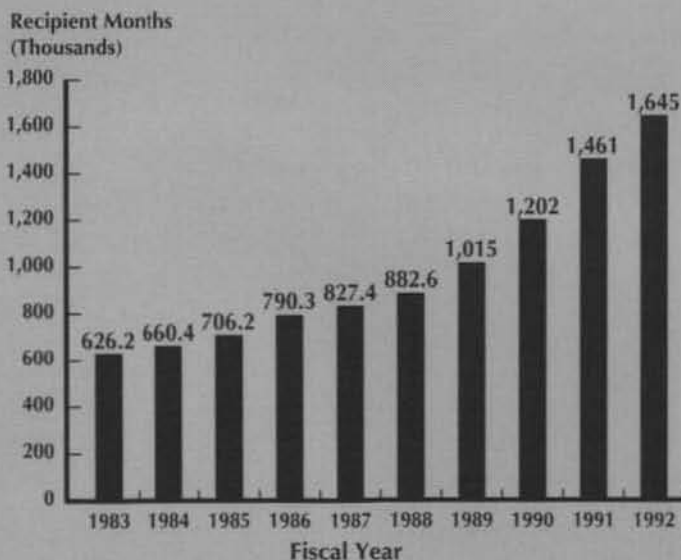


Purchased Health Expenditures

FY 1983-92

Purchased Health Recipient
Months per Month

FY 1983-92



in Medicaid. In fiscal year 1992, medical services for Medicaid clients cost about \$2.7 billion, compared to \$2.25 billion in fiscal year 1991.

As health-care costs continue to rise, the agency's challenge is to meet the needs of its clients within the limits of the Medicaid budget. In fiscal year 1992, DHS continued to focus on maximizing state and federal dollars to ensure better access to medical services by clients who need them.

DHS provides medical care reimbursement for more than 1 million Medicaid clients each month through purchased health services and is committed to providing the best possible Medicaid program for the people of Texas.

Medical Services Policy and Program Development Unit

Although many purchased health services changed in the past year to meet the requirements of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), other changes were initiated by DHS to improve clients' access to health care and the quality of services they receive.

On April 1, 1992, the agency changed its reimbursement methodology to encourage more providers to serve Medicaid clients. The new methodology reimburses physicians and some other practitioners, such as radiologists, physical therapists, podiatrists, chiropractors, optometrists, dentists, psychologists, and nurse practitioners, based on the resources needed to provide individual services. Agency staff and the Physician Payment Advisory Committee worked together to define the new reimbursement methodology, which is similar to Medicare's resource-based relative value system.

In compliance with the 72nd Texas Legislature, the agency eliminated the 5.5-percent budgetary reduction factor that had been applied to Medicaid reimbursement rates. The agency also established a fourth disproportionate-share category to provide additional reimbursement to rural hospitals that serve many Medicaid clients.

DHS worked with several other agencies to extend Medicaid coverage to more Texans, and interagency collaborations are expected to increase in coming years. For example, DHS joined with the Texas Department of Mental Health and Mental Retardation (TXMHMR) to provide Medicaid funding for case management services for clients with chronic mental illness or mental retardation and related conditions. Procedures to diagnose mental retardation and rehabilitative services for people with mental illness are also now covered by Medicaid. And through a joint initiative of DHS and the Texas Commission for the Blind, case management services for children younger than age 16 who are blind or visually impaired are now covered by Medicaid.

To improve access to health care in rural areas, DHS removed the limitation of no more than 12 visits per client to a rural health clinic in a 12-month period beginning with the date of the first visit.

Pharmacy Services

This year, the Vendor Drug program underwent several important changes in response to federal legislation and interpretations.

In fiscal year 1992, \$52.8 million was collected under drug rebate provisions of OBRA 1990. Staff are continuing to improve the billing and collection process, and they anticipate that these revenues will significantly contribute to the program budget in future years.

Some of the money collected this year was used to start up the prospective and retrospective Drug Utilization Review (DUR) mandated by OBRA 1990. A contract for data analysis was completed with the University of Texas School of Pharmacy, and the federally mandated DUR board was ap-

pointed by the Texas Board of Human Services. The DUR board is charged with determining review criteria and reviewing potential cases of inappropriate drug use.

Prospective drug utilization reviews will be incorporated as part of the on-line, real-time electronic claims adjudication system to be implemented in January 1993. This system, administered by program staff and supported by Management Information Systems, will allow immediate adjudication of and response to pharmacy claims, prevent costly retroactive denials, and save administrative costs for pharmacy providers and DHS.

A new policy removed the limit on the number of prescriptions Medicaid covers for nursing facility clients and clients younger than age 21. The number of prescriptions dispensed since the policy was implemented on Nov. 1, 1991, has increased noticeably.

The average prescription price was \$22.23 in fiscal year 1992, compared with \$21.83 in fiscal year 1991. The number of clients served increased from 434,005 per month in fiscal year 1991 to 532,936. In fiscal year 1992, 15.5 million prescriptions were dispensed, compared with 11.3 million in fiscal year 1991. Total expenditures increased from \$245.6 million in fiscal year 1991 to \$345.0 million in fiscal year 1992.

Integrated Eligibility

The Integrated Eligibility program began in 1985 as a part of the indigent health-care legislation passed by the 69th Legislature, which required DHS and the Texas Department of Health (TDH) to coordinate intake and referral for various health-care programs. Coordinating services and streamlining eligibility processes continue to be DHS' goals.

Integrated eligibility makes it easier for clients to access health and human services by locating eligibility staff of numerous agencies in one office. Using automated screening and referral processes, staff can quickly assess clients' situations, direct them to appropriate services, and help them apply for benefits.

Program staff coordinate the use of a common application form for seven different state and county assistance programs. Using a common form eliminates the need for clients to complete numerous applications. Staff also developed manual and automated screening and referral processes that include all the programs on the common application form, as well as the Women, Infants, and Children's Nutrition program and Supplemental Security Income (SSI).

More than 200 locations across the state reported using the integrated eligibility screening process during fiscal year 1992, including local DHS offices, county health program eligibility sites, local health departments, state health department clinics, community health centers, primary health-care providers, public hospitals, and hospital districts. House Bill 7 increased efforts to promote use of the screening process in more locations, such as Early Childhood Intervention sites, eligibility sites for Chronically Ill and Dis-

abled Children Services, and rural health clinics. During fiscal year 1992, DHS spent \$1.05 million on integrated eligibility, compared with \$912,233 in fiscal year 1991.

County Indigent Health Care

Counties spent more than \$30 million in local funds for mandatory services for eligible residents during fiscal year 1992.

In 1985, the 69th Texas Legislature enacted the Indigent Health Care and Treatment Act to provide basic health care for low-income people who do not qualify for Medicaid. One provision of the act assigns financial responsibility for indigent health care to all counties not fully served by public hospitals or hospital districts. These counties are required to operate a County Indigent Health Care Program (CIHCP) that provides health-care benefits to the poorest county residents. DHS is responsible for developing CIHCP guidelines.

The act also requires public hospitals to provide inpatient and outpatient services to eligible people who live within their service areas. Public hospital eligibility requirements cannot be more restrictive than CIHCP guidelines developed by DHS. There are 38 public hospitals statewide.

Hospital districts are required to provide low-income residents with the health-care services specified by the state constitution and enabling legislation. The 71st Legislature enacted laws eliminating the need for specific legislation establishing a hospital district, and minimum eligibility standards are addressed in specific hospital district constitutional and statutory requirements. There are 113 hospital districts statewide.

During fiscal year 1992, CIHCP covered 139 counties that were not fully served by public hospitals or hospital districts. Laws passed in 1987 and 1989 increased the number of counties liable for health care by eliminating the responsibilities of some public hospitals. Hospital authorities and certain hospitals that are leased or owned by cities or counties were exempted.

A CIHCP county is legally liable for spending up to 10 percent of its general revenue tax levy for mandatory medical services for county residents who meet Aid to Families with Dependent Children (AFDC) income and resource limits, which are about 20 percent of the federal poverty level, but are ineligible for Medicaid.

Once a county reaches the 10-percent limit, DHS reimburses 80 percent of its additional medical expenditures. CIHCP county liability is unlimited as long as state assistance funds are available. Liability for each eligible resident is limited to \$30,000 or 30 days of hospital or skilled nursing facility care per year.

Eligible county residents receive medically necessary inpatient and outpatient hospital care, physician services, laboratory services, X-rays, family planning services, skilled nursing care, rural health clinic services, and up to three prescribed drugs per month. Physician services provided by dentists and podiatrists are also covered.

DHS develops rules used by counties to operate the program and also pro-

vides technical assistance and support. Service definitions and payment rates are based on Medicaid guidelines. Although DHS has no enforcement authority, it is responsible for resolving residency disputes between governmental entities and providers. A health-care coordinator in each DHS region serves as liaison between the agency and local health-care programs and providers. DHS staff work with the Texas Foundation for Human Services to sponsor an annual statewide indigent health-care training workshop. Nearly 400 people representing counties, medical providers, and other agencies attended the 1992 workshop.

Counties spent more than \$30 million in local funds for mandatory services for eligible residents during fiscal year 1992, up from \$28 million in fiscal year 1991. More than 28,000 people were approved for health-care services, compared with more than 26,364 people in fiscal year 1991. Eighteen counties received \$4.1 million in state assistance funds in fiscal year 1992, whereas 16 counties qualified for \$3.1 million in fiscal year 1991.

In fiscal year 1992, DHS continued to distribute federal funds to counties through the State Legalization Impact Assistance Grant (SLIAG). SLIAG was established under the federal Immigration Reform and Control Act of 1986 to help defray costs to state and local governments for providing health, public assistance, and educational services to eligible legalized aliens. Through SLIAG, counties providing health-care services to legalized aliens may be eligible for up to 100-percent federal reimbursement for direct service and administrative costs. More than \$1.2 million was paid to counties in fiscal year 1992 through SLIAG, compared with \$700,000 paid in fiscal year 1991.

The Indigent Health Care Advisory Committee, formed during fiscal year 1990 to better respond to local needs, continues to play an active role in developing new CIHCP policies and procedures. Eleven voting members represent elected county officials, CIHCP administrators, and consumers in each DHS region. Five non-voting members represent the Texas Association of Counties, the County Judges and Commissioners Association of Texas, the Texas Medical Association, the Texas Hospital Association, and the Texas Pharmaceutical Association.

Early and Periodic Screening, Diagnosis, and Treatment

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a federally mandated preventive health-care program that provides Medicaid coverage for medical and dental health problems for clients who are younger than 21. EPSDT includes the following services:

- medical screening—a comprehensive history of the client's physical and mental health and development; a physical examination; developmental and mental health assessments; laboratory tests, including the level of lead in the blood; immunizations; health education; tuberculin testing; and sensory screenings;

In fiscal year 1992, the EPSDT program adopted the medical screening schedule recommended by the American Academy of Pediatrics.

- vision services—diagnosis and treatment of vision problems, including eyeglasses;
- hearing services—diagnosis and treatment of hearing problems, including hearing aids;
- dental services—comprehensive dental care, including emergency, preventive, therapeutic, and orthodontic services; and
- the EPSDT Comprehensive Care Program (CCP)—all federally allowable Medicaid services that are not currently covered under the Texas Medicaid state plan, such as durable medical equipment and supplies like wheelchairs and artificial limbs; private duty nursing; and therapy services. CCP benefits also include expanded coverage of Medicaid services that are subject to limitations.

The emphasis of EPSDT is finding and treating health problems before they become chronic or irreversible. In fiscal year 1992, the program adopted the medical screening schedule recommended by the American Academy of Pediatrics. Eligible clients are encouraged to use preventive medical and dental services, and DHS provides help with scheduling and transportation to make it easier for clients to get the services they need. The agency's goal is to double the total number of preventive medical screenings EPSDT clients receive during fiscal year 1993.

During fiscal year 1992, 447,639 medical screenings and 262,229 dental services were provided to eligible clients, representing increases of 87,056 medical screenings and 15,127 dental services over fiscal year 1991. Medical screenings and dental services cost about \$56.2 million in fiscal year 1992, compared with \$43.5 million in fiscal year 1991. The number of vaccines administered in fiscal year 1992 increased by 85 percent over the previous year. The number of laboratory tests performed in 1992 increased by 284 percent over the number in fiscal year 1991. EPSDT CCP, implemented in fiscal year 1990 by federal mandate, expended \$50 million in fiscal year 1992, an increase of \$36 million over the \$14 million expended in fiscal year 1991.

Client Services

Client Services operates the Medicaid hotline, answering client inquiries about Medicaid services, problems with paying bills, and the spend-down process. According to an October 1991 survey, the Medicaid hotline was receiving about 3,000 calls a day. With four operators answering calls six hours a day and one operator answering calls four hours a day, staff couldn't possibly handle the volume of calls received. These staff members were also completing more than 750 pieces of correspondence each month.

In January 1992, the agency hired eight additional hotline staff and installed 12 more lines to help handle more calls and improve customer service. A survey done after the staff and lines were added indicated that the hotline was receiving 5,879 calls a day, and about 57 percent of the calls were an-

swered. With planned automation and more thorough staff training, the unit expects to be able to answer 80 percent of the hotline calls.

During fiscal year 1992, the unit automated its correspondence activities, allowing staff to compose letters on personal computers and track correspondence from receipt to mailing of responses. Staff can also view all the information about medically needy cases online, which means they can respond more quickly and knowledgeably to clients' questions.

Through June 1992, hotline calls numbered 87,454, compared with 58,981 in fiscal year 1991; telephone inquiries numbered 3,303, compared with 2,740 in fiscal year 1991; and medically needy calls numbered 1,417, compared with 1,466 in fiscal year 1991. The unit handled 812 pieces of hotline correspondence, 5,845 pieces of inquiry correspondence, and 649 pieces of medically needy correspondence through June 1992.

Family Planning and Genetic Services

In 1969, federal regulations required DHS staff who work directly with clients to discuss family planning with them and refer people who wanted birth control services to community resources. In 1972, in an effort to reduce the number of births occurring out of wedlock, the Social Security Act mandated that every state offer family planning services to clients, including sexually active minors, and provide services promptly upon request. Failure to comply can result in a penalty against the state's AFDC funding.

In 1973, Texas began contracting with family planning agencies statewide to provide medical services, as well as counseling and education, to encourage clients to voluntarily limit family size, prevent unintended or out-of-wedlock pregnancies, space their children's births, and make informed reproductive choices.

In 1981, with federal approval, DHS also began to offer Medicaid-funded genetic services—including testing, diagnosis, and counseling—to help eligible clients who are at risk of genetic disorders make decisions about having children. It is estimated that half of all mental retardation could be prevented through use of genetic services.

In fiscal year 1992, DHS paid genetic services claims for 6,817 Medicaid clients at a cost of \$1,513,233. The average annual cost per client in fiscal year 1992 was about \$222. In contrast, in fiscal year 1991, genetic services claims were covered for 3,721 Medicaid clients, with an average cost of \$235 per client and a total cost of \$874,769.

DHS contracts with 78 family planning agencies operating 350 clinic sites covering all but 40 Texas counties. In addition, about 11,000 private physicians offering family planning services and 13 genetic services contractors are certified for reimbursement through Medicaid.

During fiscal year 1992, the Legislature allocated \$30.1 million in Social Services Block Grant (SSBG) family planning funds, an increase of \$6.2 million

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over fiscal year 1991. As a result, 322,195 people received SSBG-funded family planning services. An additional 162,234 people received Medicaid family planning services at a total cost of \$51.8 million. SSBG family planning funds were composed of 52.5-percent federal funds and 47.5-percent state funds. Medicaid family planning funds were matched at a 90-percent federal, 10-percent state rate.

Because of limited funding, 77 percent of the 2,120,230 people who need family planning services in Texas are not getting them. Teen-age pregnancy continues to be a tremendous problem. This past year, Texas held two rankings of dubious distinction—it was second among states in births to girls ages 15 to 19 and in births to girls 14 and younger.

In fiscal year 1992, 385,008 girls and women ages 13 to 44 were eligible for family planning services through Medicaid. Of these, 36.5 percent, or 140,669, had Medicaid-funded births. Because of expanded Medicaid services, the increased number of Medicaid-funded deliveries cost \$257.7 million. In addition, the cost of newborn care paid by Medicaid was \$501.2 million in fiscal year 1992, with \$142.6 million of that total for services to teen mothers.

Family planning services are remarkably cost-effective. For each dollar spent on Medicaid family planning services, the state saves an estimated \$4 in first-year welfare costs, including AFDC, food stamps, and Medicaid. For teens, each dollar spent on family planning services saves \$15 in first-year welfare costs. Each dollar spent on SSBG family planning services saves about \$6 in first-year welfare costs, with \$8 saved by family planning services provided to teens. In fiscal year 1992, DHS family planning services averted an estimated 66,544 births, saving an estimated \$392.1 million in first-year welfare costs.

During fiscal year 1992, the Family Planning and Genetic Services program continued to promote client self-sufficiency by empowering clients to voluntarily limit family size, prevent unintended or out-of-wedlock pregnancies, and make informed reproductive decisions. Norplant, the new long-acting contraceptive implant that's effective for five years, was a popular choice among clients. More than 25,000 clients received Norplant this fiscal year.

Under House Bill 7, family planning and genetic services now administered separately by DHS and TDH will be consolidated into the new Texas Department of Public Health effective Sept. 1, 1993. DHS and TDH family planning staff have begun work to facilitate the transition.

DHS and TDH continued efforts to coordinate family planning services under a legislatively mandated memorandum of understanding signed by both agencies' commissioners in 1987 and updated and extended every year since. In fiscal year 1992, DHS collaborated with TDH to revise joint service-delivery standards for contract agencies that provide family planning services. Staff from both agencies are developing a model for family planning billing

and reporting to coordinate data collection by all family planning providers, regardless of funding source. DHS and TDH have also continued jointly funded training for family planning providers, and each agency funded family planning training for nurse practitioners to increase the number of these qualified professionals available to family planning agencies.

DHS staff also reviewed the SSBG family planning procurement system in fiscal year 1992 and worked toward developing a new procurement methodology. Staff considered the use of a modified provider enrollment system that would be more consistent with the procurement of Medicaid health-care services. After extensive negotiations with TDH, provider groups, and the Family Planning Interagency Advisory Council, DHS mandated that SSBG family planning contracts be offered to existing qualified non-governmental family planning agencies that had not previously had access to SSBG funds. A proposed enrollment system for SSBG contractors has the potential of enhancing client choice of providers, broadening the provider base, and streamlining administrative procedures.

Through the Interagency Advisory Council for Genetic Services, DHS, TDH, and TXMHMR improved coordination of genetic services in Texas. Similarly, DHS and TDH worked together with the Family Planning Interagency Advisory Council to enhance coordination among state agencies, service providers, clients, and other interested parties.

Medical Transportation

The Medical Transportation program, implemented by court order in 1974, provides Medicaid clients non-emergency transport to receive health-care services if they have no other means of transportation. (Ambulance transport is provided under the Medicaid contract with NHIC.) Medical transportation is provided through contracts with metropolitan transit systems, taxi companies, school districts, community service organizations, private corporations, and other entities. Volunteers, who are reimbursed for their mileage and donate their time, continued to provide a significant portion of transportation services in fiscal year 1992.

Toll-free numbers allow DHS staff to quickly authorize appropriate transportation and help clients with provider-related problems. Staff arrange the most cost-effective transportation for clients to the nearest Medicaid-covered services to hold costs down. Medical transportation costs totaled \$7.1 million in fiscal year 1992 for 670,693 one-way trips.

Community Care

Community care services at DHS provide a broad array of supportive services to help people of all ages live in their communities instead of institutions. Most services are offered in people's own homes. These services range from meals and attendant care to nursing, therapies, and training in life skills. Other programs, such as Adult Foster Care and Residential Care, offer people a place to live in the community. An average of 69,376 people per month received community care services in 1992.

To qualify for most community care services, clients must meet financial criteria similar to those for nursing home care and need help performing routine activities such as bathing, dressing, preparing meals, eating, or going to the bathroom. For Medicaid-funded services, clients also must have a medical need for services.

Community care services must be cost effective—that is, services must cost the same or less than they would in an institution. Services are delivered by contract providers in the community. Case management, an integral part of community care, may be provided by DHS regional staff or, as in most Medicaid waiver programs, by contract providers. DHS streamlined the authorization process in fiscal year 1992 by reducing the paperwork necessary for Medicaid services and allowing annual authorizations and physicians' orders for the Day Activity and Health Services and the Primary Home Care programs.

DHS made two major changes this past year to encourage greater participation in its largest community care programs, Primary Home Care and Family Care. First, the agency increased from 30 to 50 the number of hours of attendant care services that an individual may receive each week. Second, DHS now requires attendant care agencies to make sure that clients with the highest needs, categorized as priority 1 clients, receive care on every scheduled service day.

Priority 1 clients are completely unable to perform certain activities, such as getting out of bed, eating, or using the bathroom, without assistance, and their health and safety would be in jeopardy if services were not provided on any given day. Provider agencies are reimbursed at a higher rate for priority 1 clients.

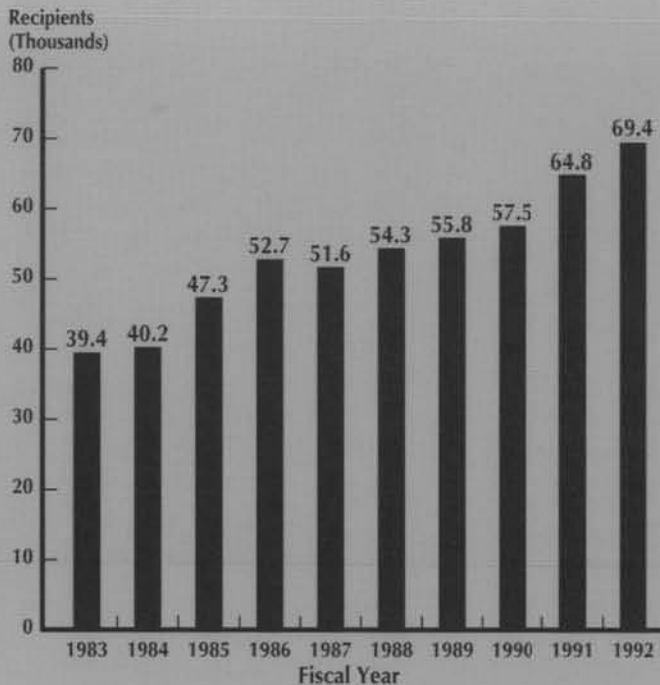
As a result of passage of OBRA 1990, also known as the Frail Elderly Act, DHS can continue to provide Primary Home Care services to people who otherwise could not qualify for Medicaid.

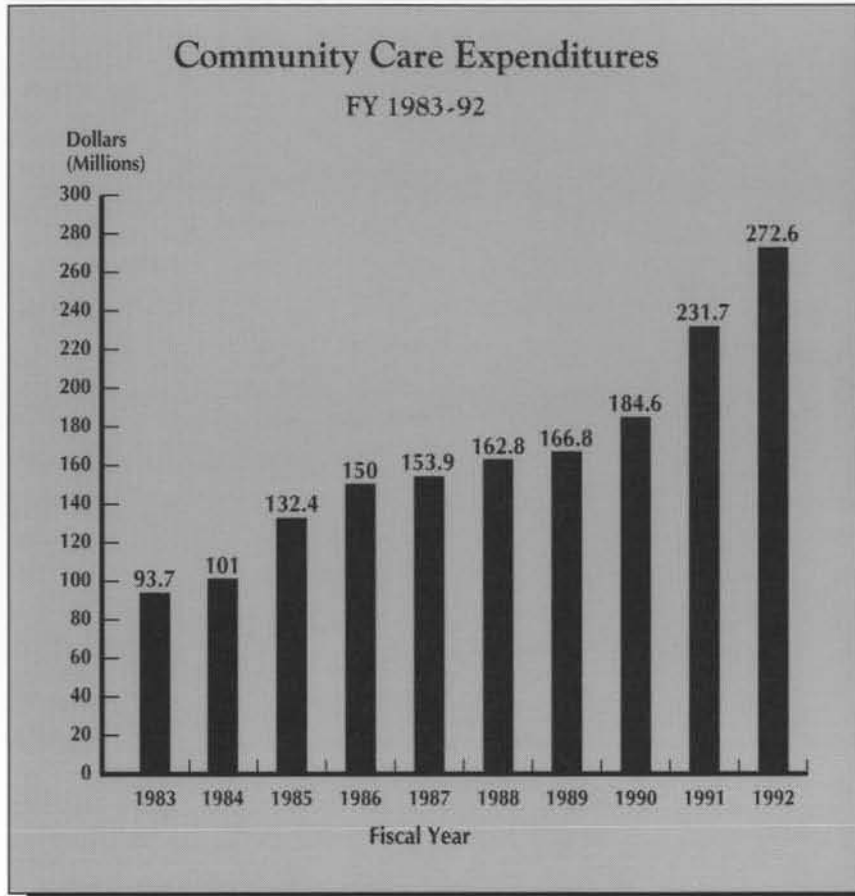
In fiscal year 1992, more than 59,500 people statewide received Primary Home Care and Family Care services from almost 200 provider agencies.

The Client-managed Attendant Care program provides services similar to those of the two larg-

Community Care Recipients per Month

FY 1983-92





er programs, but enables clients to hire attendants and direct their own care. By empowering clients to make choices about their care, they can tailor services to better meet their needs. Services are available in 16 counties.

Congregate and Home-delivered Meals serves hot, nutritionally balanced meals to adults in their homes or central locations. Known as Meals on Wheels, Home-delivered Meals enlists thousands of volunteers statewide.

The Emergency Response System offers an electronic monitoring system for adults who are isolated or live alone. The client presses a call button to signal for help, and staff at a base station then alert a volunteer who has agreed to check on the client.

Day Activity and Health Services provides personal care, nursing, physical rehabilitation, meals, and transportation at facilities throughout the state, which are open 10 hours a day, five days a week.

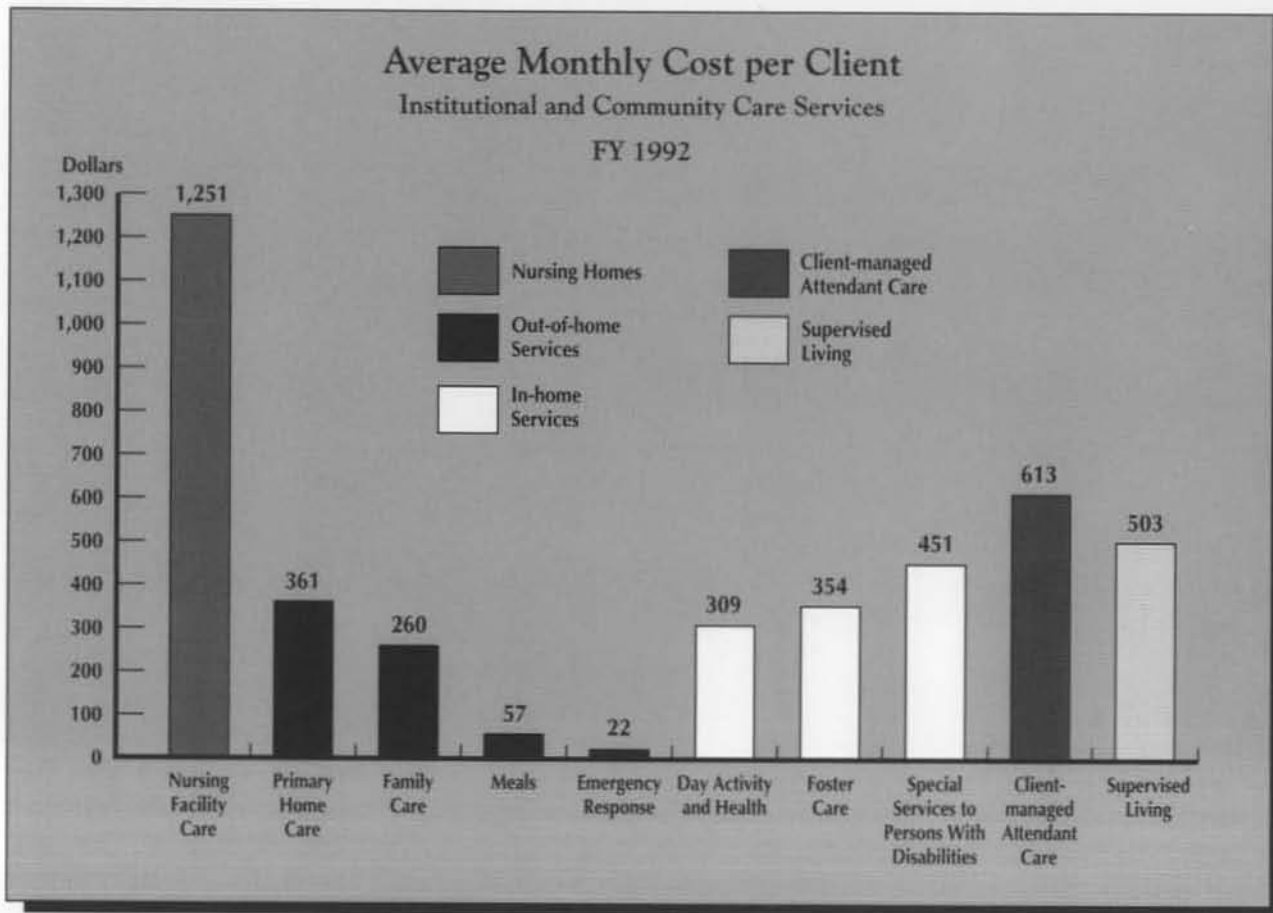
Residential Care services include room and board, 24-hour supervision, personal care, social and recreational activities, home management, escort services, and transportation. Residents live in a variety of settings, from apartments to converted nursing facilities.

Adult Foster Care offers supervision and assistance with daily activities in homelike settings. Clients pay for their own room and board, while DHS pays the caregivers for personal care and supervision. Care may be provided in family homes serving up to four adults or in licensed group homes serving five to eight people.

Tel-assistance helps elderly people with disabilities pay their telephone bills through a fund established by the Public Utilities Commission.

Special Services to Persons With Disabilities provides counseling, personal care, and help developing independent-living skills.

The In-home and Family Support program enables people with disabilities to select and purchase services or supplies with cash subsidies of up to \$3,600 a



year. Clients may also receive one-time subsidies of up to \$3,600 for architectural modifications or major equipment purchases. People with incomes at 105 percent of the state median income pay part of the cost of the items purchased. Copayments gradually increase to 100 percent, which is reached at 150 percent of the state median income (\$52,467 for a family of four).

Community care services are funded by federal block grants, state funds appropriated by the Legislature, and Medicaid (a mix of federal and state funds). Medicaid is becoming a more significant source of community care funding as DHS staff develop and expand services that use federal matching dollars to purchase services for people in their communities. For example, Texas' Primary Home Care program continues to be the second largest Medicaid-funded attendant care program in the country.

In fiscal year 1992, DHS expanded existing Medicaid waiver programs while pursuing new ones for people with disabilities. Waivers allow the state to use federally matched Medicaid money to implement individually tailored, flexible service plans so people with severe disabilities can live, work, and play in their communities instead of being confined to institutions.

The Community Living Assistance and Support Services (CLASS) waiver

In fiscal year 1992, DHS expanded existing Medicaid waivers while pursuing new ones for people with disabilities.

program can provide attendant care, training in daily living activities, nursing care, respite care, psychological services, physical therapy, occupational therapy, speech therapy, adaptive aids and supplies, minor home modifications, supported employment, and prevocational training to eligible people. Case managers, who are independent from the providers of other CLASS services, advocate for the clients, helping them define and achieve personal goals using CLASS services and other community resources. During fiscal year 1992, CLASS served more than 300 people in Bexar, Cameron, Dallas, El Paso, Harris, Hidalgo, Starr, and Willacy counties. As many as four new areas of the state will be added during the next fiscal year.

During this fiscal year, other community-based waivers continued to grow. The Home and Community-based Services waiver served almost 900 people with mental retardation in 91 counties across Texas. Operated in cooperation with TXMHMR, the program is currently the largest community-based Medicaid waiver in Texas. The program will grow during the next fiscal year to provide options for people who are displaced as a result of state school closures.

The Medically Dependent Children's waiver serves families throughout the state who care for their medically fragile children at home, providing nursing and respite care to ease caregivers' burdens.

Two additional waivers were approved by the federal government in fiscal year 1992. The Program of All-inclusive Care for the Elderly (PACE) waiver is a national demonstration project providing comprehensive care for frail elderly people who would otherwise need to live in nursing homes. PACE provides all the services a client needs for a monthly per capita charge to Medicaid and Medicare that is lower than the cost of comparable care elsewhere. A team of health and social work professionals provides clients with intensive case management to ensure quality care. Bienvivir Senior Health Services in El Paso is one of 11 PACE test sites nationwide.

The OBRA-targeted waiver, which also became effective during fiscal year 1992, provides community-based services to people with mental retardation or other developmental disabilities who are living in nursing homes that are not designed to serve their special needs. This waiver, which is based on a provision of OBRA 1987, will serve as many as 900 people statewide.

Institutional Care

Nursing Facilities

DHS provides nursing facility services to eligible Medicaid clients in more than 1,050 institutions throughout Texas. Clients must meet three eligibility criteria to be certified for nursing facility services: financial need, medical necessity, and the preadmission screening and annual resident review.

In addition to room and board, clients receive services necessary to meet their highest practical levels of physical, mental, psychological, and social

well-being. DHS reimburses facilities for the care they give, basing payments on the level of effort necessary to adequately care for the clients.

During fiscal year 1992, an average of 64,227 people per day received care at an annual cost of \$963.8 million. The previous year, an average of 62,167 people per day were served at an annual cost of \$879.4 million.

This past year, the massive changes that went into effect during fiscal year 1991 under the mandates of OBRA 1987 and 1990 were fine tuned. As the new regulations were being implemented, growing concern focused on the quality of care being provided. During fiscal year 1993, DHS will concentrate on quality assurance, quality of care, and other issues to ensure that each nursing facility resident receives the best possible care.

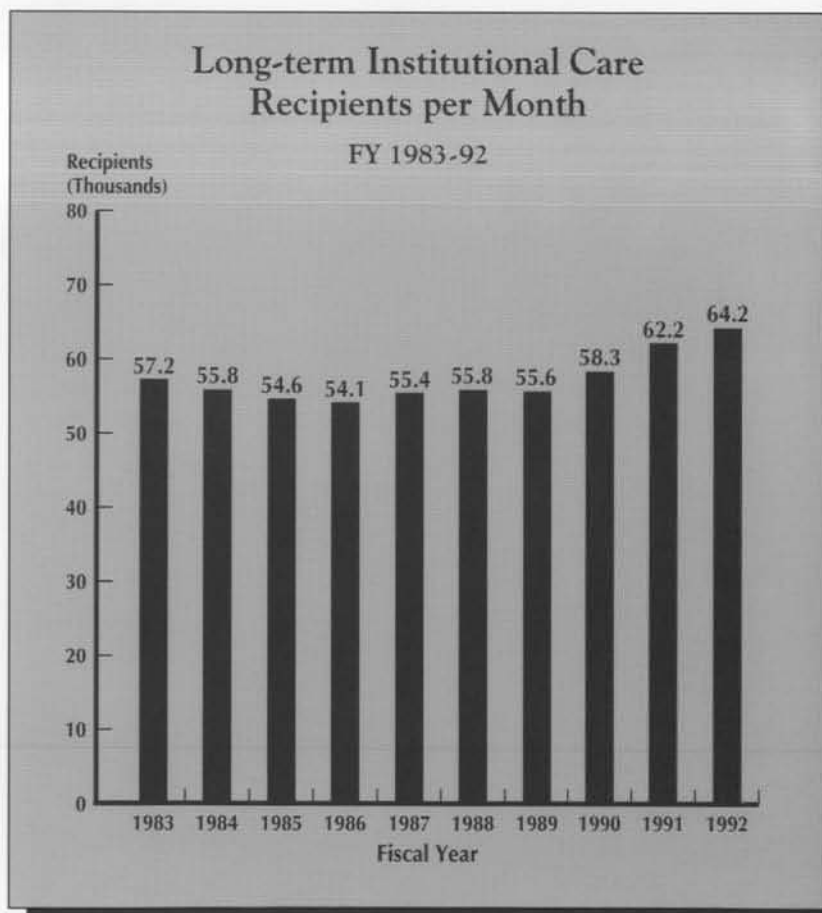
A major requirement implemented this year was the provision for advance directives. Effective December 1991, each nursing facility client must be given the opportunity to have a living will, a durable power of attorney, and a directive to physician.

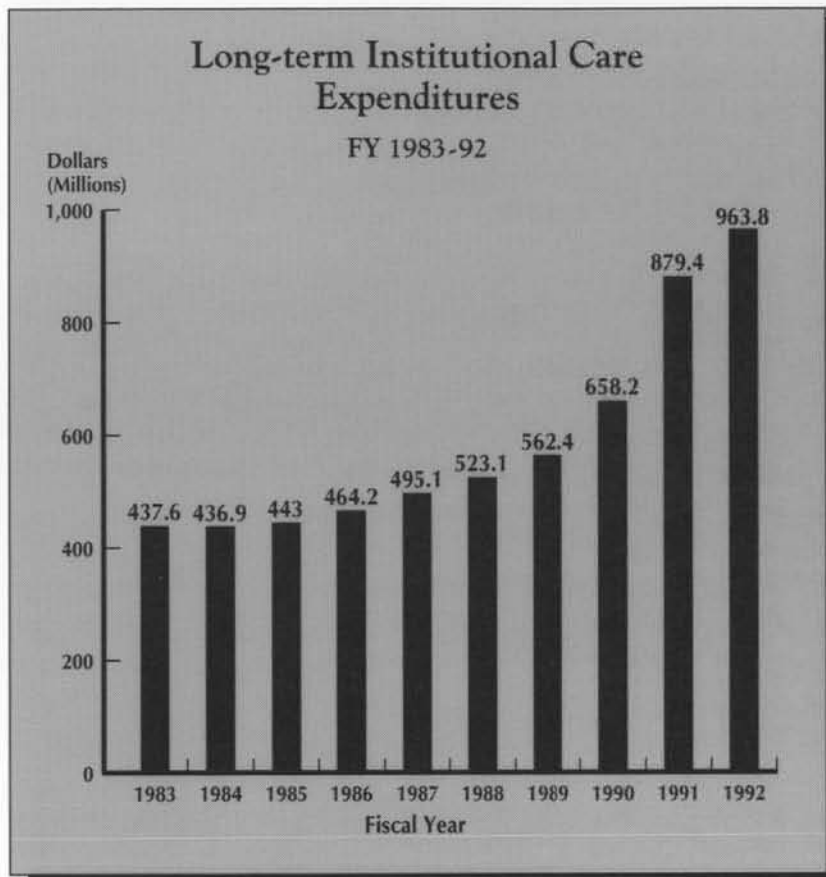
A Sanctions and Remedies Advisory Committee was established to help DHS develop financial penalties for nursing facilities that do not meet federal requirements.

This committee met throughout fiscal year 1992, and DHS rules become effective in fiscal year 1993.

Since 1980, Medicaid clients in nursing facilities have been eligible to participate in the Goal-directed Therapy System, which provides physical therapy, occupational therapy, and speech and language pathology services. During fiscal year 1992, an estimated monthly average of 11,232 client visits were made at a total cost of \$715,000, an increase of \$105,000 over fiscal year 1991.

The Hospice program continued to grow, with about 57 providers serving a monthly average of 505 clients during fiscal year 1992. Hospice allows terminally ill clients to





be served in their own homes or nursing facilities. An alternative to traditional medical care, hospice helps clients and their families cope with the pressures and grief that accompany terminal illnesses.

The Medicaid Swing Bed program allows rural hospitals in counties with populations of 100,000 or less to use some beds interchangeably for acute hospital services and nursing facility care when there are no nursing facility beds available in the area. To be eligible for the Medicaid Swing Bed program, hospitals must be participating in the Medicare Swing Bed program and also meet other criteria. In fiscal year 1992, 5 rural hospitals contracted with DHS to participate in the program.

Intermediate Care Facilities for the Mentally Retarded

The Intermediate Care Facilities for the Mentally Retarded (ICF-MR) program provides institutional care and treatment for people with mental retardation or related conditions, which include severe developmental disabilities such as cerebral palsy, epilepsy, and head or spinal injuries that occurred before age 22. ICF-MR benefits include room, board, and specialized services to help clients function as independently as possible. Four levels of care are provided in residential settings ranging from small group homes to large state schools.

In fiscal year 1992, the ICF-MR community-based program served about 5,766 clients at an annual expense of \$155.8 million, compared with about 5,111 clients at an annual expense of \$125.8 million the previous year. State schools served an additional 6,781 clients, generating \$218.5 million in federal funds, compared with 7,030 clients and \$222.6 million in federal funds the previous year.

DHS reimburses providers in three ways: (1) Each provider in a class receives the same rate (flat rate) based on cost reports from that class. Rate classes include ICF-MR level-of-care 1, small facilities (six beds or less ICF-MR levels-

of-care 5 and 6), and state schools. An additional rate is paid to ICF-MR level-of-care 6 clients with high needs. (2) Each provider in the class receives the same rate (base rate) with additional rates for qualifying clients who have high needs. This is an experimental class for clients with related conditions. (3) Each provider in the class receives a rate unique to the provider based on reported expenses up to limits. This class is for large facilities (seven beds or more ICF-MR levels-of-care 5 and 6) that primarily serve children (at least 85 percent of all clients).

ICF-MR level 8 for clients with related conditions was introduced in fiscal year 1992. DHS allowed for 1,362 beds to be certified during fiscal years 1992-93; 877 beds were certified during fiscal year 1992.

DHS worked with other state agencies, providers, advocates, and consumer groups to revise the "six-bed rule" to make it more effective and efficient. This rule revision will go into effect in 1993.

The ICF-MR program continues to expand as small facilities are developed across the state in accordance with DHS' Plan for New Bed Development in the Texas ICF-MR Program. In addition, the state's provider application is being revised to encourage growth. With the anticipated closure of two state schools and identified needs in the community increasing, the community-based ICF-MR program will continue to grow.

Medicaid Eligibility

The monthly income eligibility limit for Medicaid benefits for institutional care and for several home- and community-based services increased from \$1,221 to \$1,266 on Jan. 1, 1992.

Medicaid now will help low-income elderly people pay their out-of-pocket Medicare expenses under the Qualified Medicare Beneficiary (QMB) program. To qualify, annual income cannot be more than \$6,810 for an individual or \$9,190 for a couple. Additionally, financial resources such as bank accounts, stocks, and bonds cannot exceed \$4,000 for one person or \$6,000 for a couple. In July 1992, 19,581 people were receiving QMB benefits.

Health Policy and Economics

In recent years, state and federal health and social services programs have been caught between two conflicting trends—as demand for services is increasing because of the nation's economic downturn, funding for such services is failing to keep pace with increasing costs. In addition, states must implement new mandates from Washington affecting these services that often cannot be anticipated in the state budgeting process and must be put in place without additional funding for start-up costs. As a result, states are searching for innovative ways to fund services and ensure that all citizens have access to basic health care.

Health Policy and Economics staff research and monitor developments in health care and related issues, inform DHS program staff about these developments, and help plan new services for Medicaid clients in Texas. During fiscal year 1992, staff were involved in five major health-care policy areas: the Texas Health Policy Task Force, which was charged with devising a health policy for the state that increases access to care and provides a coordinated health-care delivery system; the Governor's Border Working Group, which examined the needs of the 14 Texas counties that border Mexico; the Texas Early Childhood Intervention program, a cooperative effort between DHS, TDH, TXMHMR, and the Texas Education Agency (TEA) that furnished comprehensive services to more than 13,000 children from birth to age 3 with disabilities or developmental delays; the Texas Children's Mental Health Plan, which was developed in cooperation with eight other agencies to provide a broad range of services for children and adolescents with behavioral, emotional, and psychiatric needs; and a federal review of DHS policies regarding Acquired Immune Deficiency Syndrome.

Office on Services to Persons with Disabilities

DHS supports the philosophy that people of all ages who have disabilities can live in their communities when provided with appropriate services. The Office on Services to Persons with Disabilities (OSPD) is a focal point through which consumers, advocates, service providers, DHS staff, and other agencies can raise issues and concerns regarding services to people with disabilities.

OSPD collaborates with staff from all DHS program areas to develop initiatives that translate this philosophy into action. As of April 1992, a community impact statement is required for all action items presented to the Texas Board of Human Services. This impact statement serves as a guide in evaluating whether or not proposed policies support the agency's commitment to develop community services for people with disabilities.

During fiscal year 1992, OSPD's Interprogram Work Group on Services to Persons with Disabilities examined the feasibility of expanding and enhancing the availability and accessibility of DHS community-based services. Members of the Community Care Services Committee, the Interagency Medicaid Waiver Work Group, and the DHS Program and Service Accessibility Committee included representatives from provider, consumer, and advocacy organizations in their discussions. Two recommendations made by the interprogram work group have already been acted on by the board:

- As of May 1, 1992, no breaks in personal assistance services are allowed for priority 1 clients whose health and safety may be jeopardized by one missed shift of attendant service.
- As of July 1, 1992, the maximum number of hours of personal assistance

services a Primary Home Care or Family Care client may receive each week was raised from 30 to 50 hours.

OSPD helped child protective staff hold meetings to address the needs of children in DHS conservatorship who are in nursing facilities and, with help from advocacy groups, developed ways to care for these children in the most homelike settings possible consistent with their health and safety.

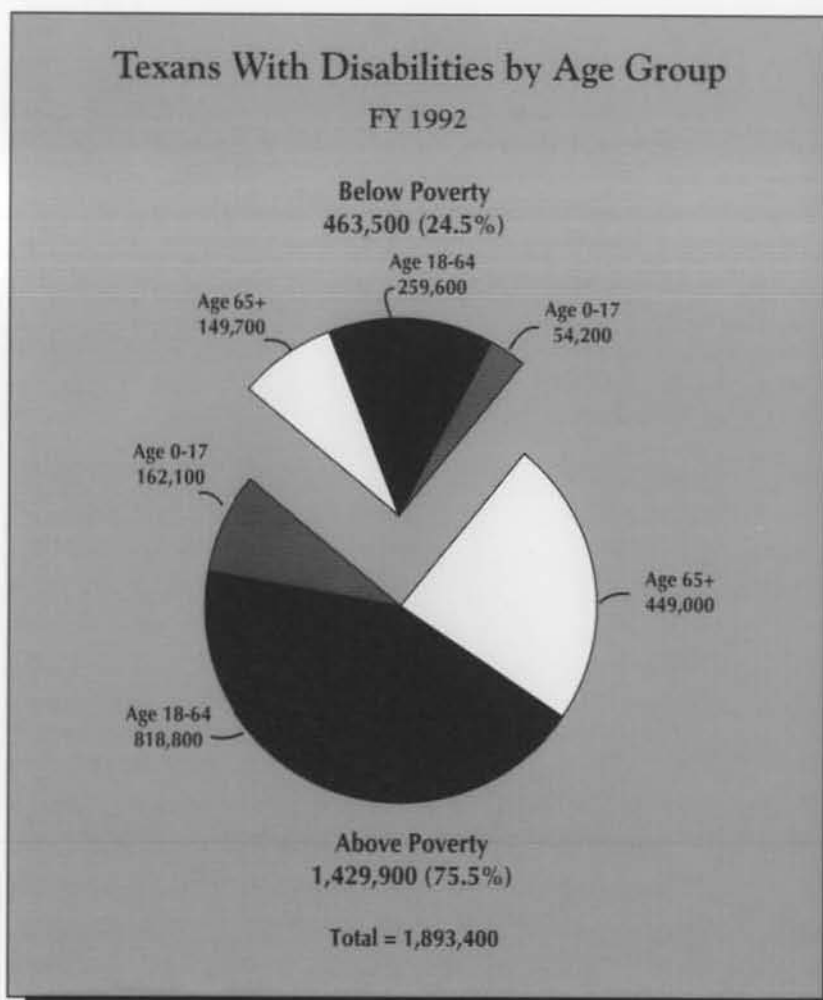
In addition, OSPD produced a comprehensive resource directory of DHS services available to children with disabilities and their families. Information about 23 medical services, 11 home- and community-based programs and services, and hotline numbers are included in the directory. More than 3,000 copies of the directory were distributed to DHS staff, parents of children with disabilities, other state agencies, and advocacy groups.

OSPD helped obtain several public and private grants during the year to test innovative service strategies, including a grant from the Texas Planning

Council for Developmental Disabilities to offer training and technical assistance to CLASS providers and a grant from the Donald D. Hamill Foundation to pay for emergency services and medical equipment needed by Medicaid clients with disabilities but not funded by other sources.

OSPD and Communication Services staff submitted a grant proposal in July 1992 in conjunction with the East Texas Human Development Corporation seeking federal funds to work with local communities to rehabilitate and repair housing units for people with physical disabilities residing in five Texas counties in rural East Texas.

DHS staff continued to develop Medicaid waiver programs and services as cost-effective alternatives to institutional care. A work group composed of consumers, members of advocacy groups for elderly people and people with disabilities, and ser-



OSPD staff cooperated with long-term care staff to conduct a bilingual consumer satisfaction survey of clients in the Primary Home Care program.

vice providers collaborated in designing a new community-based waiver program to serve people who are at risk of nursing facility placement or who reside in nursing facilities and have requested help in returning to their communities. Texas is expected to submit the waiver request to federal authorities early in fiscal year 1993. OSPD staff also participated with staff from the Federal Funds Analysis unit of the Legislative Budget Board in a project to survey other states regarding Medicaid waiver programs.

Believing DHS should treat its clients as customers, OSPD staff cooperated with long-term care staff to conduct a bilingual consumer satisfaction survey of clients in the Primary Home Care program in May 1992. The response rate was 75 percent, and more than 90 percent of the respondents said they were satisfied with the overall program. In the coming months, OSPD staff will survey consumer satisfaction with other DHS programs.

Following a recommendation made by the Task Force on Services to Persons with Disabilities, the Texas Board of Human Services created a standing subcommittee on services to people with disabilities under the Aged and Disabled Services Advisory Committee. The subcommittee will provide a permanent body for addressing issues related to DHS services for people with disabilities and serve as an advisory group to OSPD.

During fiscal year 1992, OSPD also:

- established regional contacts to serve as liaisons to OSPD;
- worked with other agencies at revising and updating a memorandum of understanding between DHS, TDH, TXMHMR, TEA, the Texas Rehabilitation Commission, the Texas Commission for the Blind, the Texas Commission for the Deaf and Hearing Impaired, and the Texas Interagency Council on Early Childhood Intervention to facilitate coordination of services to people with disabilities;
- helped revise and update the memorandum of understanding between DHS, TEA, TEC, TXMHMR, TRC, and the Texas Commission for the Blind on transition planning for students enrolled in special education;
- provided technical assistance to DHS staff on the Americans with Disabilities Act, including conference workshops and an informational letter sent to all DHS staff and clients on Relay Texas, the telephone relay service for people who are deaf, hard of hearing, or speech impaired;
- designed the curriculum for mandated disability-awareness training that all DHS staff statewide will receive over the next two years; and
- developed a brochure in English and Spanish to inform consumers, advocates, and other agencies about DHS' commitment to people with disabilities. A video on the needs of people with disabilities and the DHS services available to them will be completed in early fiscal year 1993.

Management Support Services

Management Support Services helps control costs in the Medicaid program by attempting to make sure services are used properly and only by people eligible to receive them. Staff review recipient utilization, third-party resources, provider sanctions, inpatient utilization, and case-mix assessments.

Recipient Utilization Review

Recipient utilization staff review clients' use of Medicaid to determine if services are being used excessively. During fiscal year 1992, an average of 4,462 clients were assigned to primary care physicians, who manage all care for their clients and make referrals to specialists as needed. In fiscal year 1992, recipient utilization reviews avoided an estimated \$8 million in unnecessary medical expenses.

Third-party Resources

Medicaid is the payor of last resort. When a caseworker identifies a third-party insurance policy or the Office of the Attorney General identifies court-ordered medical coverage in child support cases, DHS can have medical services paid for by that third party. This past year, DHS initiated data matches with other state agencies to identify absent parents who may be working for companies that provide medical insurance. If the parents have insurance, their companies are asked to include the children in their policies.

In fiscal year 1992, reviews of third-party resources avoided \$71.2 million in Medicaid costs and recouped \$34.8 million. In addition, reviews of third-party resources in the Nursing Home and Vendor Drug programs recovered \$2.3 million.

Provider Sanctions

All cases related to Medicaid provider fraud or abuse are reviewed for recovery of paid claims and imposition of civil monetary penalties. Sanctions and exclusions are an effective way to ensure that recipients are not mistreated by abusive providers. DHS recovered \$735,722 in fraudulent claims and sanctions in fiscal year 1992.

Inpatient Utilization Review

Inpatient hospital utilization reviews are performed to ensure that Medicaid admissions are medically necessary, payments are accurate, and quality care is provided. During fiscal year 1992, 35,818 admissions were reviewed. Of these, 4,350 resulted in denials for medical necessity, 5,118 had payment level changes, and 547 were denied because of technical reasons. Combined recoupment resulting from inpatient reviews during fiscal year 1992 was \$15.0 million.

Quality committees composed of practicing physicians from various specialties review Medicaid cases with potential quality-of-care concerns. There are

six regional quality review committees and one statewide committee. During fiscal year 1992, 777 admissions were reviewed by the regional committees and 53 by the statewide committee. Of those reviewed, 116 resulted in corrective actions. Corrective actions include required continuing medical education, presentation of inservice programs, required consultation, intensified case review, suggested literature readings, referral to the Texas State Board of Medical Examiners, referral to the Texas State Board of Nurse Examiners, and possible suspension or exclusion from participating in Medicaid.

Case-mix Assessment Review

Nursing staff perform reviews in nursing facilities to verify the accuracy of assessment forms that establish Medicaid payment rates for individual clients. In fiscal year 1992, 32,316 forms were reviewed, with payment levels changed in 9,698. These changes resulted in a recoupment for the year of \$9.13 million.

During the past year, staff focused on education for long-term care providers. Nurses conducted 42 training sessions with 990 participants statewide. Statewide training also was conducted for nursing facility staff on the procedures for completing the federally mandated Resident Assessment Instrument.