KRONKOSKY CHARITABLE FOUNDATION
ROUNDTABLE DISCUSSIONS

TOPIC: Government Funding (state agencies)

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PARTICIPANTS

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Overview of Agencies

Texas Department of Health

The Texas Department of Health (TDH) oversees and funds multiple health care programs throughout the state of Texas. Primarily, TDH is interested in providing the necessary resources for normal physical and environmental development of a child. Included in this is medical, behavioral and environmental services.

- TDH distributes around 6.5 billion dollars to health care providers around the state. This number is expected to rise to 7 billion in the relatively near future.
- 5 billion dollars are used directly to purchase services. The remaining 2 billion are diverted toward Medicaid programs.
- TDH routinely distributes money through Request for Proposals (RFPs), a method in which a set amount of money is allocated for a certain program/service, and independent agencies (either for or not-for profit) competitively bid for the contract. Some RFPs do overlap.
- A majority of the RFPs are for one year and renewable for three.
- While a majority of RFPs are awarded through merit-based considerations such as cost-efficiency, other RFPs are awarded through politics.

- With a massive bureaucratic management system and a limited ability to accurately store records, TDH has encountered numerous problems in trying to track and measure the effectiveness of their expenditures.
- Like many other state agencies, TDH has an extensive monitoring program in place.

Texas Rehabilitation Council

The Texas Rehabilitation Council (TRC) provides employment services for residents with disability, whether it be physical, behavior related, sensory deficiencies or drug/alcohol related. Under such a premise, the TRC therefore provides a wide range of services from counseling, to job placement and training.

- TRC has offices throughout the state. San Antonio has an office that provides service through much of the South Texas area.
- The services that TRC offers are very customized for the individual.
- The lengths of services offered are one, two and four year programs.
- The first phase of TRC assistance is assessment: how is the person limited by the disability? Does the person have documentation that this disability is an impediment to employment?
- Then TRC explores the person's interest, skills testing, ability to transfer skills, living arrangements and job market. TRC tries to cross-reference these to compile a profile of the best possible employment and living conditions possible.
- Therefore, the services TRC provides are very diverse and requires them to subcontract out to other agencies/providers, some of which are non-profit agencies.
- The providers must be approved venders or designated as a Community Rehabilitation Provider (CRP). Clients can choose the vendor of service, and the TRC has caps amount of money they can provide for a particular service and client (set amount of time, set amount of dollars).
- The grant-type of contract is no longer used. TRC pays by time and cost of service provided. Along with client choice, this often favors cost-efficient providers and name-brand providers. Non-profit agencies have had a difficult time keeping costs low and adjusting to the new compensation method.
- Many CRPs have closed because of their inability to adjust to this change in state policy.
- Transportation is a problematic issue for TRC that impacts the outcomes of their services. In many rural areas, a lack of transportation effectively renders the person immobile. It is not as major a problem in urban areas.
- TRC follows progress for 90 days after placement before closing the case.

Texas Commission on Alcohol and Drugs

The Texas Commission on Alcohol and Drug's (TCADA) primary purpose is to provide treatment, intervention and prevention services to the state.

- Each year, TCAD spends approximately 160 million dollars in direct purchases of service.
- Contracts for service run three years in length. Ninety percent of the contracts are open for competition.
- Twenty to forty million are spent on intervention and prevention programs. The remaining goes toward treatment.

- Treatment for drug and alcohol abuse remains a vastly unpopular task for state money. Many view addiction as a moral problem. Most treatment occurs in prisons.
- Extra money is often pushed into prevention, which has not proven to be very effective given the fact that historically, 10-15% of a population will consume drugs when available. Treatment is always needed.
- Contracts are no longer structured in a grant-type fashion but in a unit-cost manner. The logic behind the switch is that agencies do not want to be responsible for awarding a contract for three million dollars a year to a provider who only serves two people a year. It is a move to guarantee some cost-efficiency. This in line with the state's agenda of cutting cost through a managed-care type of medical model.
- This disbursement strategy tends to typically favor vendor-type operations and not non-profit organizations.
- TCADA is usually 140% over contracted for services during the year due to the inability of many providers to actually provide the services requested. Many providers and non-profit organizations are capable of writing a good contract or proposal but unable to actually provide.
- As part of the move toward cost-efficiency and better tracking methods, TCADA has stipulated that in certain areas like treatment, that all the providers come together under one management. All the money for treatment would be under the care of the management group, theoretically making it easier to account for the money spent on services.
- Political whims often force the TCAD to spend money in a profuse and rapid manner, thus undermining their ability to buy effective programs (note that TCAD had to funnel 20 million dollars into treatment quickly causing them to buy up services rapidly).

Interagency on Early Childhood Intervention

Early Childhood Intervention (ECI) serves children from 0-3 who are burdened with some developmental delay and their parents to alleviate the severe educational and environmental deficiencies that these children face at a pivotal period of development. ECI's goal is to foster an environment that will allow all children to develop to their highest potential.

- Currently, ECI has a budget of 85 million and that is expected to grow to approximately 100 million by 2001. Forty percent of the funding comes from the Federal government, another 40% from the state and the remaining 20% from Medicaid, community investment, United Way and the city.
- ECI formulates individual service plans, implements them and transitions the children to public schools or a Head Start program.
- Children must exhibit some sort of delay, either in educational, developmental or medical manners.
- ECI offers over 20 types of services including medical, diagnostic, nursing, speech and hearing.
- The number of people that ECI provides has been growing around 8% a year. This rate of growth is expected to continue. Approximately 27,000 families receive services a year, a very dynamic service population as children grow up and new ones are born.

- Each child undergoes assessment through an interdisciplinary team and the family to determine the needs of the individual channel. After referral, it goes to service coordinators.
- ECI has a network of service provides, of which one-third are non-profits.
- Contracts are on a cost-reimbursement basis. Eighty percent of cost in this field is staff. Providers need to keep the necessary specialist around to treat incoming children.
- Contracts are open to bid in only three areas: Dallas, Houston and Corpus Christi. ECI has found that there are not a lot of service providers that apply for contracts outside of their network; there are just not a great number of providers of these services out there due to the high cost of the field.
- Every year, providers must reapply for contracts.
- ECI reviews performance of the providers to see if the Individual Family Service Plans (IFSP) are being met.
- ECI has worked with Any Baby Can to try to identify delayed children in the hospital. With the rise of HMOs, it is harder to plug into the medical community.
- ECI is currently developing a client database and become more accessible through the Internet.

Issues

From the perspective of state agencies, there are fundamental problems with the structure and the methods of interaction between themselves, providers and the community. With the increasing cost-consciousness of the state government, pressure has been placed upon agencies to become more cost-effective and produce results that may be unrealistic given the resources they are provided.

While agencies can somewhat sympathize with the plight of some non-profit organizations, they cannot completely agree with them. Agencies are more concerned with the bigger picture of how can the agency affect a major benefit on communities around the state, while most non-profits are concerned about problems on a more localized level.

- State agencies have, at times, ridiculously stringent monitoring and tracking requirements that are burdensome to both the agencies and the providers. Providers waste too much time filling out forms while state agencies are inundated with impractical information that makes it more difficult to organize.
    - The impetus behind much of the extensive monitoring programs is political paranoia.
    - The amount of money and time spent on monitoring often detract vital resources that could be better utilized in achieving their goal. There is a belief that compliance equals performance, which is clearly a logical fallacy. This assumption underlies and undermines much of the state health policies. Instead of asking how money is being given out, agencies should be asking how can they do business better?
    - Lack of an inefficient tracking system leaves many agencies unable to account for the vast amount of money being spent. Are these programs working? Agencies are unable to answer this until they are able to keep track of the money they are

spending. Currently, some agencies do not know who receive what services where and why.

- New laws continually alter the manner in which state agencies operate. Agencies continually face uncertainty.
  - The mandatory auditory tests will inevitably increase the rate of growth of the number of children that ECI must serve per year.
  - Sunset legislation has vested the Health and Human Services Commission (HHSC) with great powers of all state agencies. The HHSC can review and repeal strategies and laws of agencies as well as having the power to hire and fire heads of agencies.
- Such contrasting policies form a complex and confusing landscape that make it difficult for agencies to be effective.
- Impetus to become more cost-efficient has caused drastic structural changes in the operation of programs and agencies. The state has moved toward a more managed-care based medical model for these services. Cost and effectiveness are the bottom lines.
- The managed-care model has yielded population-based programs like the Northstar project in Dallas. Northstar operates similar to an insurance policy benefit package. It combines services and referrals to a smaller group of providers with a set amount of money and time. This model has been successful in terms of medical care in the private sector, but many have doubts about whether this model can successfully ensure success with behavioral and mental problems. Much of what many agencies deal with are increasingly behavioral in nature, where prevention is key. It is estimated that 75% of all health problems are behavioral in nature. Managed-care models cut costs, but can it solve behavioral problems?
- There may be little choice. Politicians have mandated this change without understanding that this model is not preventive, and prevention is the key.
- Yet, the old system has not worked either. RFPs often overlapped, and services were coordinated enough. Many people fell between the cracks of agencies and providers. The system was inefficient.

From the non-profit side

Non-profit public providers have faced a rough and changing landscape over the past years. Changing policy, rigorous monitoring/tracking controls and a lack of communication between them and state agencies have brought many providers to close their doors.

- With the consolidation in the number of RFPs, non-profit providers (NPP) are struggling to obtain state funding. Many are simply not cost-efficient enough as private providers and lose out on money.
- The constant process of having to renew one year contracts often leave NPPs unsure about the structure of their budget for the upcoming year. RFPs are not consistent.
- A lack of communication among NPPs and NPPs with state agencies and private providers creates an increasingly competitive landscape in which many organizations act for their own best interest, an act that often runs counter to the common goal of improved public health.

- From the state perspective, NPPs' lack of diversification of service also hinders them. By offering more services, NPPs can become more attractive and more competitive in the field. Many NPPs have closed down because of their lack of diversification.

Suggestions

- Simplifications of Records: Simple enough solution that would go a long way in making it easier for agencies to track where the money is going. Too often, money becomes "caught up" in one or two areas called silos. Better integrated system of records coupled with only requesting information that is needed would help agencies manage their programs better.
- Politicians need to understand the problems better. Though treatment is politically unfavorable, it is necessary. Though a simplification and integration of records would make people loss their jobs, it is necessary. Though eliminating or reducing monitoring efforts may lead to some abuses, it is necessary.
- A reduction in rules would clear up much of the confusion that surrounds certain programs.
- Essentially, the issues boil down to a problem of management. Agencies, to be successful, need to know the problems of a community, what providers there are, who are afflicted and how to organize an efficient system of service delivery. The current system leaves out the community, where recognition of problems are made from the top down, whereas it should be made from the bottom to the top.
- Recognition that population-based benefit packages are only a temporary solution that have many of the same problems that the current system has: neither account for incidences within a community nor do they account for the behavioral aspect of public health.
- Formation of a community-based medical home that can identify problems affecting the community, providers and form a flexible management group would be the most beneficial solution to the problem. With a management group within the community, there would be a vested interested in the well-being of that community. They would understand the dynamics and could account for changes better than a burdensome bureaucratic system could.
- This requires NPPs and other providers to network together and cooperate. This would ultimately lead to the closing of several providers, but it is for the best of the community. If a provider is inefficient and wasteful, then shape up or shut down.
- This system would minimize the necessary number of interactions between agencies and communities.
- Agencies would only provide direction while the communities manage themselves.
- Large community-based foundations could serve as a community conveyor, needs assessor and give direction to state-agencies through policy recommendations and programs.