



Transition Document Summary (Tier 1)  
**Department of Social and Health Services**

*Our mission is to improve the quality of life for individuals and families in need.  
We help people achieve safe, self-sufficient, healthy and secure lives.*



Washington State  
Department of Social  
& Health Services

**Dennis Braddock**  
Secretary  
September 17, 2004

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## AGENCY RESPONSIBILITIES

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As described in RCW 43.20A.010, the Department of Social and Health Services (DSHS) was created in 1970 to integrate and coordinate all activities involving provision of care for individuals who, as a result of their economic, social or health condition, require financial assistance, institutional care, rehabilitation or other social and health services.

Currently, DSHS serves more than 1.5 million (25%) of residents in Washington State. We provide and manage a wide array of services to vulnerable children, families, elders, people with disabilities, and people with medical and mental health issues. Listed below are the main responsibilities of DSHS.

### Improve the Health of Washington Residents

DSHS purchases medical services for over one million children, adults and elders mainly through Washington's Medicaid program – health-care coverage that is financed by a combination of state and federal funding. Summarized below are highlights of services.

- **Medical assistance** programs reimburse community health-care providers and hospitals for their treatment of qualified low-income families, seniors, pregnant women and children as well as special populations: refugees, alien emergency care, the homeless, and persons with disabilities. DSHS also determines disability status for the state and the federal Social Security Administration.
- **Healthy Options** is a managed care form of Medicaid covering families that qualify for welfare under Temporary Assistance for Needy Families (TANF) – a client base with high numbers of infants, children and pregnant women. The State Children's Health Insurance Program and Basic Health Plus also provide health care coverage for children in families of the working poor.
- **Washington State hospitals** receive Medicaid funding to help offset the cost of the uncompensated care they provide to low-income individuals. Medicaid also funds programs to support Outreach and Linkage activities at public schools, health departments and Indian tribes. Other Medicaid access programs include transportation and interpreter services.
- **Alcohol and substance abuse treatment and prevention** services improve the health of Washington low-income residents at risk of chemical dependency. The expansion of these services can reduce utilization of emergency room, medical care, medical and psychiatric hospitalization, nursing home care, and overall medical costs.

### Improve Safety and Well-being of Children

DSHS provides services to vulnerable children and youth. In FY 2003, over 18,000 children were in the state's care through out-of-home placements. The following represents key services for children.

- **Child Protective Services** provides 24-hour, 7-day a week intake, screening and investigative services for reports of suspected child abuse and neglect. Law enforcement, courts, and community teams are critical members of the child protective system.
- **Child Welfare Services** provides permanency planning and intensive treatment services to children and families when long-term services are needed beyond those available through Child Protective Services or Family Reconciliation Services. Both in-home and out-of-home services may be provided to address abuse and neglect issues.

- **Family Reconciliation Services** are voluntary services devoted to prevent out-of-home placement of adolescents.
- **Other services** are also available to **strengthen families** that are in crisis and to promote children's safety, permanency and well-being. Many services for children and families are provided by community agencies.
- **Adoption Services** recruits and screens families interested in adopting children who are in the care and custody of the department. The focus is on placing special needs children in foster care into adoptive homes. **Adoption Support** helps families offset the additional expenses involved in caring for these children.
- **Foster Care Licensing** inspects and licenses family foster homes, residential group care facilities, crisis residential services, overnight shelters, maternity services providers, and child placing agencies which license foster homes.
- **The Infant Toddler Early Intervention Program** coordinates services to enhance the development of approximately 6,500 (per year) eligible children age birth-to-three and to enhance the capacity of families to meet the special needs of their children.
- **Health insurance, subsidized child care and mental health** services are available for children in low-income families.
- **Evidence based treatment and intervention services** are provided to juvenile offenders to reduce reoffending and address treatment needs for mental health, substance abuse, sexual offending and cognitive impairments.

### **Improve Self Sufficiency to Reduce Poverty**

In FY 2002, more than 883,000 (13.6%) of Washington State residents received DSHS' assistance that helped them meet their basic needs and achieve economic independence. Described below are some of these core services.

- DSHS provides low-income people with cash grants, food and medical assistance, employment services, and subsidized child care. Major programs include **WorkFirst** (TANF program), **Basic Food** (formerly Food Stamp Program), **General Assistance for the Unemployed, Refugee Assistance**, and **Working Connections Child Care**.
- To protect children from unsafe child care, DSHS enforces **child care licensing** and regulation by requiring child care providers to meet health and safety standards. Currently there are over 2,200 licensed child care centers and approximately 7,300 family child care homes in Washington State.
- **Child support enforcement** services ensure non-custodial parents meet their financial and medical responsibilities to their children. In FY 2004, DSHS collected over \$634 million for more than 400,000 children.
- **Vocational Rehabilitation Services** are provided to eligible people with disabilities to obtain, regain, or retain integrated, competitive employment in order to improve self-sufficiency and reduce dependence on public support.

### **Improve Health and Safety of Vulnerable People**

DSHS brings together the major long-term care and supportive service programs designed for children, adults and seniors with physical disabilities, developmental delays or disabilities, cognitive impairment, chronic illness and related functional disabilities.

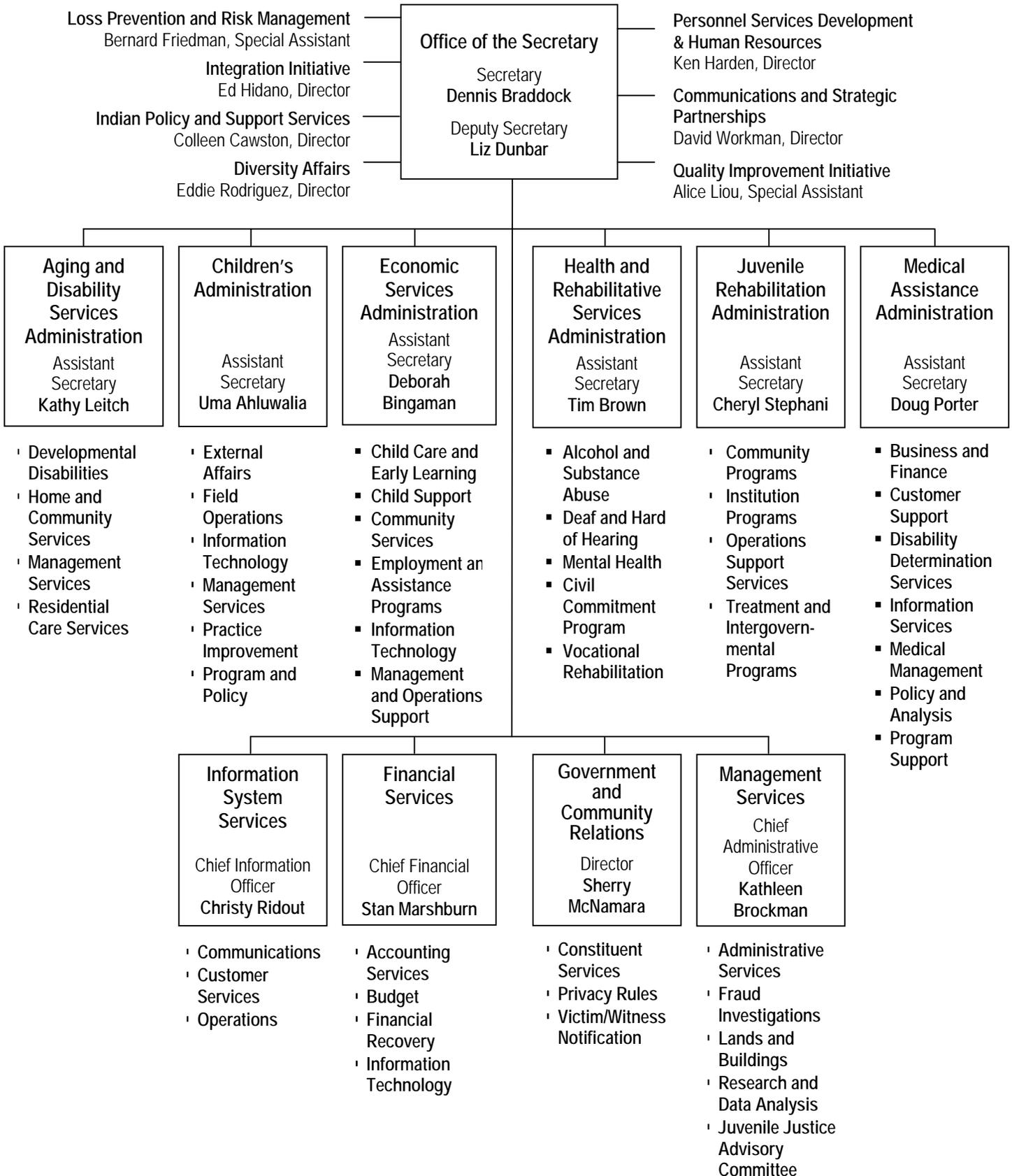
- **Long-Term Care services** help informal caregivers to meet the client's needs including supervision, assistance with daily activities, personal care, nursing, or other supportive services. These services are available in the client's own home or institutional settings such as nursing homes or Residential Habilitation Centers.
- **Adult Protection Services** investigates complaints of abuse or neglect of vulnerable adults in their own home or in a residential setting.
- **Residential Care Services** licenses and/or certifies adult family homes, boarding homes, and nursing homes statewide. Other **Community residential options** include adult assisted living, and supported living for persons with developmental disabilities.
- **Information and Assistance Program** services, through contracts with Area Agencies on Aging, provide information to individuals and families who need to learn about long-term care options and resources. **Case Management** services ensure client care is appropriate, of good quality and cost-effective.
- **Employment and Day Program** services, through contracts with county governments and their service providers, provide ongoing support for persons with developmental disabilities with paid jobs, and help the unemployable develop social, communication and leisure skills.
- **Mental health services** are provided to individuals with acute and chronic mental illness and to children with serious emotional disturbance, in community settings and in state owned and operated hospitals. Under a managed care model, the Regional Support Networks are contracted to provide treatment, support, employment, and residential services to persons meeting statutorily defined categories.
- **Services for the deaf, hard of hearing, and deaf-blind communities** include provision of telecommunication relay services, video telecommunications access, distributions of specialized telecommunication equipment, real-time captioning, and provision of human services through contracts with the six Regional Service Centers.

### **Foster Public Safety through Rehabilitation Services**

DSHS provides the following rehabilitation services in a secure environment as a protection for staff, residents and the public.

- **Chemical dependency treatment** is provided to thousands of offenders in community-based settings in lieu of incarceration. During the 2001-2003 Biennium, approximately 323,223 individuals participated in prevention programs.
- **Mental health services** are provided to civilly committed patients found not guilty by reason of insanity. Services include evaluations, care, and restoration of competency to stand trial.
- A **sex offender treatment program** is for civilly committed sex offenders who have completed their prison terms. This program offers the offenders an opportunity to change and manage their behaviors so they can return to their families and community without reoffending.
- About 1,200 youth are committed annually to DSHS' **juvenile rehabilitation** program by county juvenile courts. Evidence-based interventions are the foundation for **Secure Residential Care, Community Based Residential Care** and **Functional Family Parole Aftercare** programs. Youth in residential care are taught cognitive behavioral skills to successfully manage their own behavior and reduce their risk to reoffend. As youth return home, the focus shifts to improving the functioning of the family.

# ORGANIZATION CHART

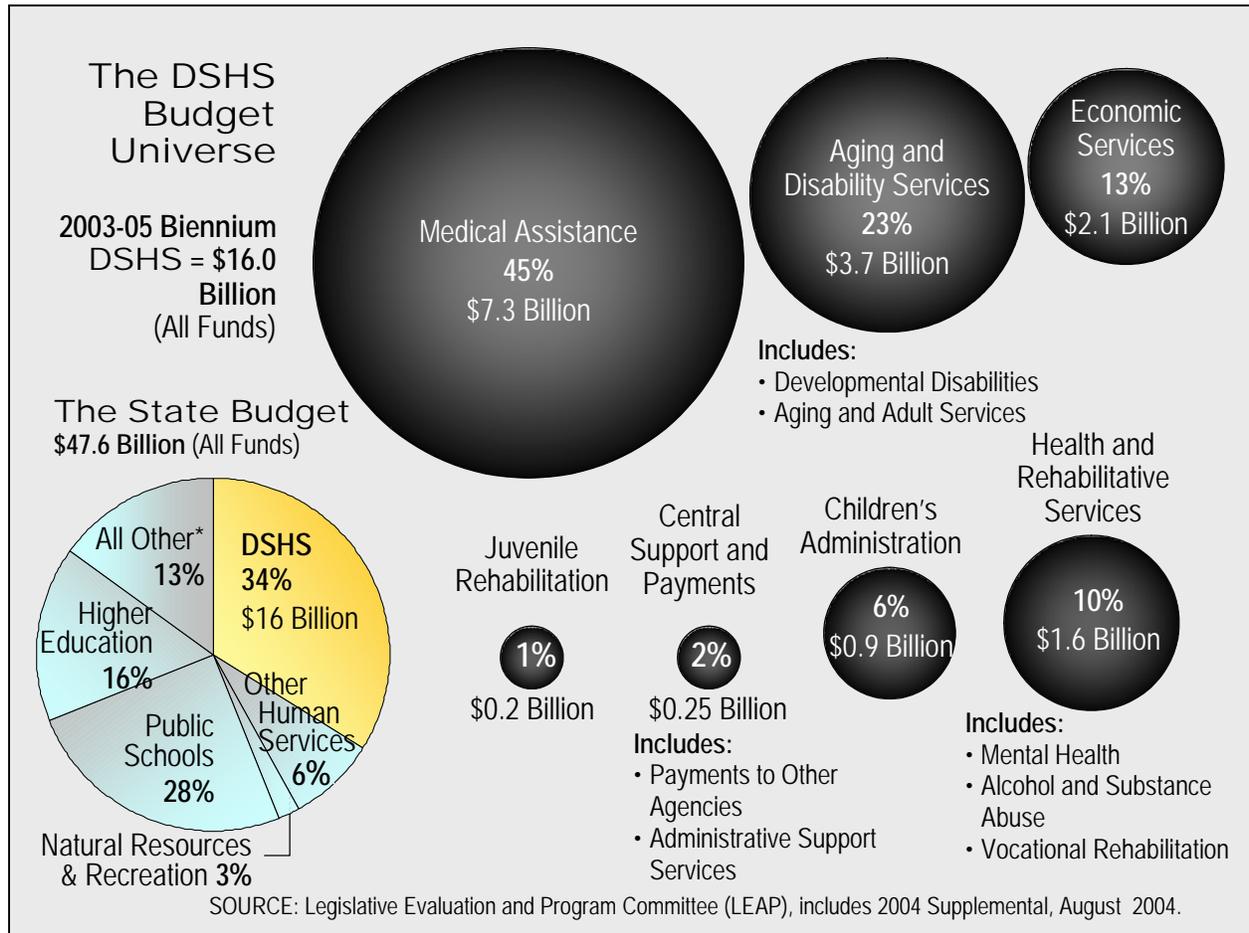


## BUDGET BY SOURCE AND PROGRAM

### Budget Universe

Since the 2001-2003 Biennium, the DSHS budget has grown by two percent to become 34 percent of the state budget for 2003-2005 Biennium. Chart A shows the percentage and the amount of the 2003-2005 budget for each of the DSHS administrations.

**Chart A**



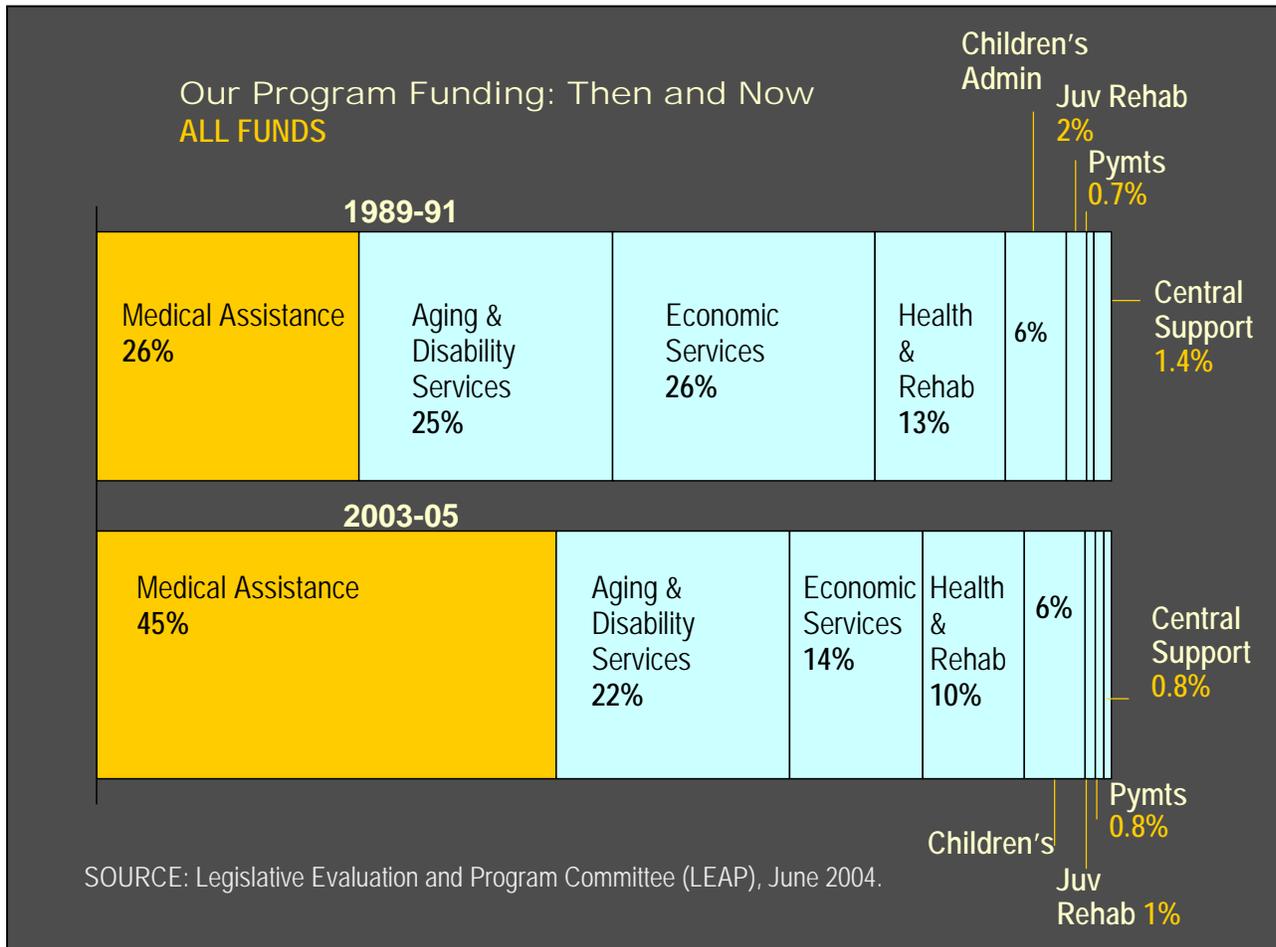
### Expenditure Growth

Expenditure growth has primarily been driven by the medical cost inflation in providing medical coverage to more low-income and disabled adults and children.

The state's stagnant economy and high unemployment continues to strain many of DSHS programs, including medical assistance, Temporary Assistance for Needy Families (TANF), Basic Food, General Assistance, child care licensing and monitoring, and child support collections.

Rapid growth in Medicaid enrollment has been matched in recent years by substantial increases in Medicaid costs. For the 03-05 Biennium, authorized spending for the Medical Assistance Administration is \$7,261 million (\$2,367.7 million General Fund-State). This represents 45% of the 03-05 DSHS budget, an increase from 26% of the DSHS budget for the 1989-1991 Biennium. See **Chart B**.

**Chart B**



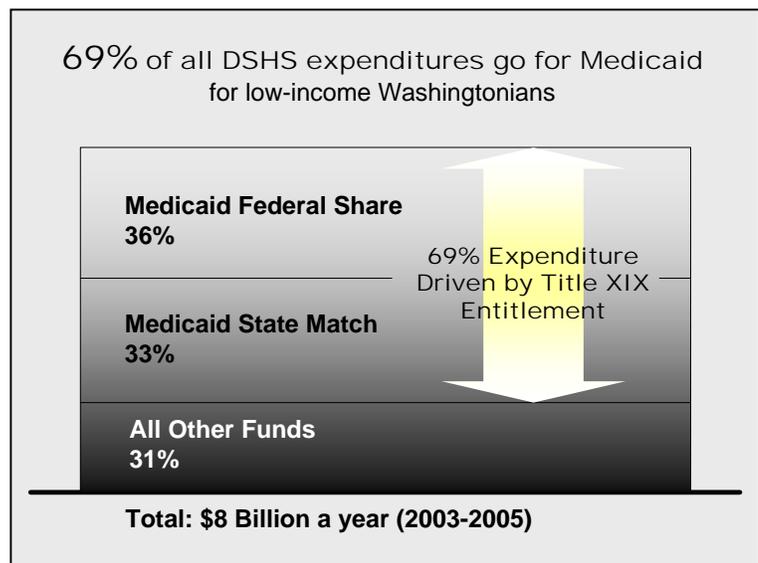
**Medicaid**

Originally enacted by the Social Security Amendments of 1965 and Public Law 89-97, Title XIX of the Social Security Act, popularly known as **Medicaid**, provides for federal grants to the states for medical assistance programs.

DSHS administrations depend on Medicaid dollars to pay for services provided to low-income people who meet income and resources eligibility criteria. Medicaid rules and interpretations govern 69% of DSHS expenditures. See **Chart C**.

In Washington State, Medicaid provides funding for acute and long term care (LTC) services to over 900,000 people per month.

**Chart C**

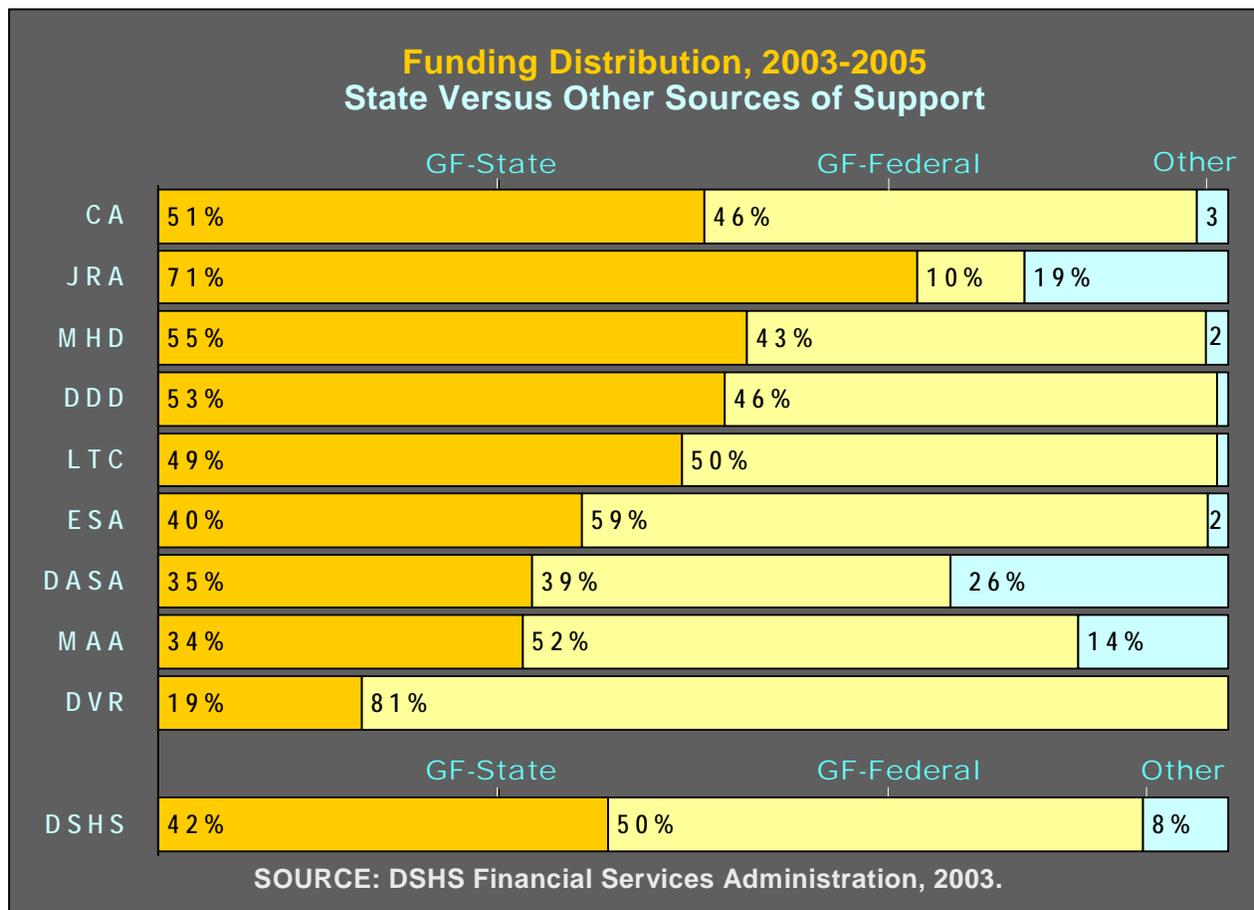


## Funding Sources

DSHS programs receive funding from General Fund-State, General Fund-Federal, and other funding sources. The portion of federal funding varies depending on the service program and its federal match rate. See **Chart D** for detail information on funding distribution within each major program.

For example, the Medicaid match rate is the percentage of total Medicaid spending paid for by the federal government. The remainder is paid for by the state. While the federal government covers about half of these total costs, the state's share has been rising as much as a half billion dollars a biennium, with the most dramatic increase felt in the state's pharmaceutical costs. The federal funding lost means that the state has to remedy the funding shortage by redesigning service programs. Considered options include reducing benefits and increasing cost sharing.

**Chart D**

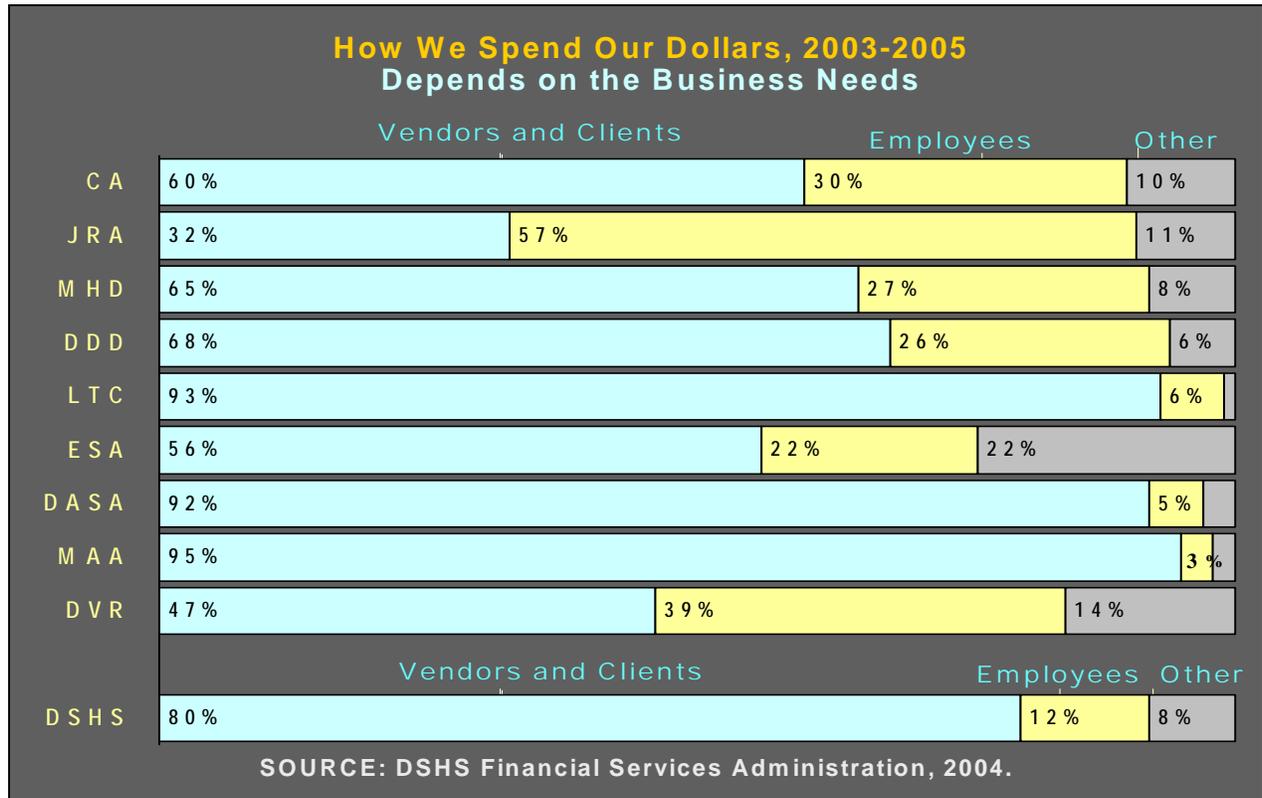


## Expenditure Distribution

Nearly 80% of DSHS dollars are paid to clients and contracted providers. To meet our clients' different needs, DSHS purchases client services from counties, cities, tribes, non-profit and for-profit private organizations, hospitals, clinics, pharmacies, and individual providers.

See **Chart E** for expenditure distribution of each major program.

**Chart E**

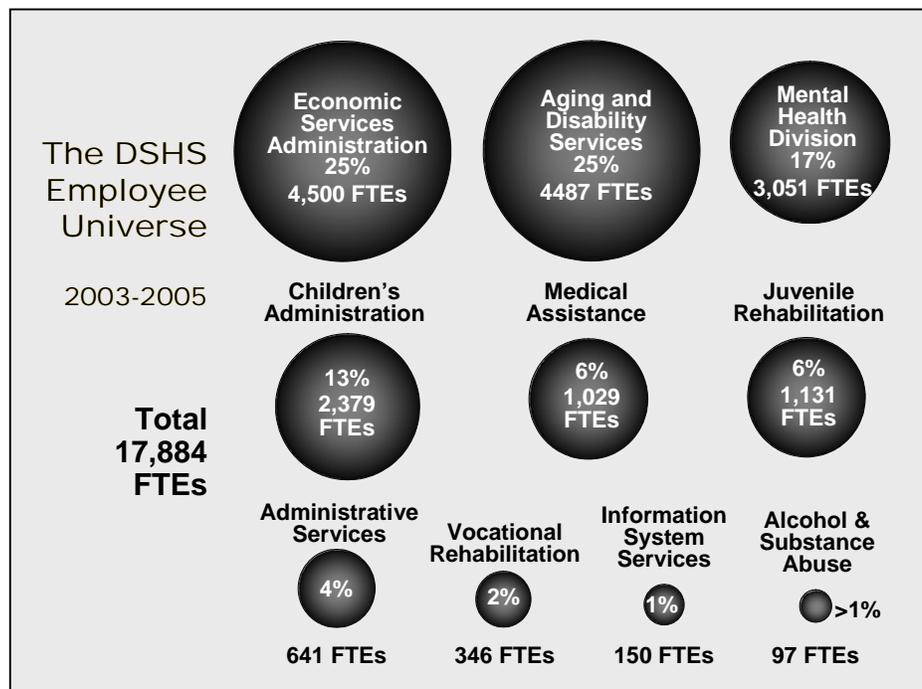


**Employees**

**Chart F**

During the 2003-2005 Biennium, DSHS is budgeted for 17,884 FTEs (Full-Time Equivalents) per year. Currently, the actual number of employees is approximately 18,000, including part-time and intermittent employees.

More than one-third of DSHS employees staff the state institutions for mental health, developmental disabilities, juvenile rehabilitation and sex offender treatment programs.



**Chart F** shows the FTE distribution within DSHS.

## MAJOR ISSUE: NO. 1

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- Issue:** **Decreased Federal (Title XIX) Funding Threatens Medicaid Program Sustainability – Mental Health Waiver Program Takes the First Hit**
- Urgency:** All Title XIX funding is subject to review and challenge from the Centers for Medicare and Medicaid Services (CMS). The mental health program is the first *“waiver program”* facing an estimated \$80 million shortfall for 2005–2007 without additional state only funding. Other Medicaid programs will be forced to change or cutback services if CMS continues aggressive audit of state programs.
- Background:** Of the \$16 billion DSHS spends per biennium, more than \$11 billion is controlled by Title XIX rules. Loss of federal financial participation through revised interpretation for non-Medicaid services and non-Medicaid eligible individuals threatens sustainability of Medicaid programs in mental health, long term care and medical services.
- The most urgent threat is to the managed care community mental health system administered by the Regional Support Networks (RSNs). Since 1993, CMS has permitted the state unrestricted use of savings from the Medicaid capitated rates, after all Medicaid enrollees seeking service have been served. RSNs have used the savings to fund, among other things, services for people and services not eligible for Medicaid.
- Beginning January 2005, CMS will no longer allow the use of savings from the Medicaid rates for any purpose except for Medicaid eligible persons and Medicaid covered services. At risk for loss of services are people who fall into the statutory priority populations, who don't qualify for Medicaid, are uninsured or under-insured, and are unable to purchase treatment and pharmaceuticals out of pocket. This has an estimated impact of \$20 million for January through June 2005 and \$80 million in the 2005-07 biennium.
- Federal auditors are reviewing all states for possible ineligible activities and where federal match may be disallowed. The current federal administration is pushing states to accept block grants for Medicaid programs that would cap Medicaid federal financial participation. Restrictions on use of federal Medicaid match funds are being proposed and enacted in other Medicaid programs as our Medicaid waivers are being reviewed. The Medicaid administrative match program that is used by school districts is one example. School administrative match reductions are approximately \$18 million for FY04.
- Controversy:** The state may want to consider the block grant approach to maintain flexibility if the current administration continues to tighten rules and reduce expenditures to these programs. If so, acceptance of block grant funding would give state programs greater flexibility, but would eventually erode entitlement status of the programs.
- Key Players:** Mental Health Task Force, Legislature, RSNs, Counties, Community Mental Health Providers, Mental Health Service Consumers and Consumer Organizations, All Health Care Providers
- Contact:** Karl Brimner, <mailto:brimnKR@dshs.wa.gov>, (360) 902-0790  
Doug Porter, <mailto:porteJD@dshs.wa.gov>, (360) 725-1863  
Stan Marshburn, <mailto:marshSB@dshs.wa.gov>, (360) 902-8181
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## MAJOR ISSUE: NO. 2

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- Issue:** **Limited Resource Threatens Welfare Reform Success**
- Urgency:** Revenue limitations within the Temporary Assistance for Needy Families (TANF) program present challenges in continuing the success of WorkFirst, Washington state's welfare reform program. The TANF block grant amount is insufficient to fund the current cash assistance caseload, the growing child care caseload, and the necessary employment and training supports to help families from welfare to self sufficiency.
- Background:** When the TANF block grant was first established, there were ample funds to cover the costs of cash assistance, child care, and employment and training services. The state is able to carry over any unused federal funds and so the program was budgeted to carry over funds to future years when deficits were projected.
- In the beginning, cash assistance caseloads declined dramatically and provided savings that were re-invested in services and child care, which grew dramatically. Since the recession began, cash assistance caseloads have leveled off, reducing the funds available for reinvestment. Child care caseloads also dropped, which allowed the "welfare box" to stay in balance.
- Child care caseloads are now rising again, threatening the funding balance. Congress has not reauthorized the TANF program although bills have been introduced to do so. The current federal administration wants to increase the work requirements, which would increase costs, particularly for child care.
- Controversy:** The "welfare box" has always been controversial with the Legislature since they do not have the authority to direct expenditures within the box which is controlled by the Governor.
- If the program is redesigned to stay within current revenue, the changes will likely be controversial. Possible changes include reducing eligibility for child care, terminating families from TANF who do not comply with the rules ("full family sanction") or reducing employment and training supports.
- Key Players:** State level – The WorkFirst Subcabinet: Office of Financial Management, DSHS, Employment Security Department, Department of Community, Trade and Economic Development, and the State Board for Community and Technical Colleges. National level – Congress and the U.S. Department of Health and Human Services
- Status:** The WorkFirst Subcabinet continues to monitor the welfare box expenditures closely and makes adjustments to the program as necessary to stay within the budget. Congress may act to reauthorize the program and change its requirements, although that is unlikely to occur in this session.
- Websites:** <http://www.workfirst.wa.gov/index.htm>  
[https://www2.wa.gov/dshs/onlinecso/TANF\\_Support\\_Services.asp](https://www2.wa.gov/dshs/onlinecso/TANF_Support_Services.asp)
- Contact:** Deb Bingaman, <mailto:bingaDL@dshs.wa.gov>, (360) 902-7808.

## MAJOR ISSUE: NO. 3

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- Issue:** **Lack of Resources Threatens Licensed Child Care Liability and Quality**
- Urgency:** The state faces the issue of risk management and the potential for liability when licensed providers intentionally or unintentionally cause harm to a child in their care. DSHS recently settled a tort claim for \$4.5 million for a child injured by her licensed child care provider. About 30 percent of the approximately 168,000 children in licensed child care are subsidized by DSHS.
- Background:** The licensing of child care facilities (centers and family homes) is mandated by state law and is intended to assure a basic level of health, safety and developmentally appropriate environment in all licensed child care facilities. The resources to monitor those facilities are limited: 145 licensing staff (including 96 licensors) oversee about 8,500 licensed facilities. The rates for state-subsidized child care providers are at the 38 percentile of the industry standards. Care quality is primarily affected by low rates for child care providers. In addition, the average monthly child care caseload has increased to 62,186 in FY 2004 from 41,018 in FY 1998 (52% growth). Number of child care related incidents also increased.
- Controversy:** The child care licensing system is pulled in various directions. Some ask for a stronger system with higher rates that better supports the early learning years as foundational to student achievement in the K–12 system. The Chair of the House Children and Family Services Committee is expected to introduce a major early learning initiative to strengthen child care in the next session.
- Others suggest that the child care regulations, recently revised, are too strong. The proposed family child home regulations were loudly contested by the statewide Family Home Child Care Association. Some legislators have suggested exemptions from basic health and safety regulations for providers in their communities. DSHS is concerned about the limited resources available to enforce licensing regulations in combination with the risk of being held liable for death, abuse or injury of a child in licensed care.
- Key Players:** The stakeholders include **state agencies** (Office of Financial Management, Early Childhood Education and Assistance Program, Office of Superintendent of Public Instruction, Head Start Collaboration project); **legislators** (Kagi, Brown, and Kohl-Wells); **community-based organizations** (Washington Association for the Education of Young Children, Resource and Referral, and the Child Care Coordinating Committee); and **provider associations** (both family home and center associations).
- Status:** DSHS is working on improving the licensing system through more clearly written regulations, an improved training system for licensors, and a revised procedural manual for licensors. DSHS hired 20 additional licensing staff last year, including several new supervisors. This has improved the timeliness in monitoring child care facilities. In addition, a new web-based tracking and reporting system for licensing provides new workload management and performance evaluation tools. The quality assurance staff are also developing a response protocol for facilities where children die or are injured and when a facility has an unusual number of complaints in a short period of time.
- Websites:** <http://www1.dshs.wa.gov/geninfo/childcare.html> (Internet)
- Contact:** Deb Bingaman, <mailto:bingaDL@dshs.wa.gov>, (360) 902-7808.

## MAJOR ISSUE: NO. 4

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- Issue:** **Financial and Regulatory Sustainability of Mental Health and Developmental Disabilities Institutions While Maintaining Community Placement Programs**
- Urgency:** While the department is expanding community program options to improve quality of life and cost effectiveness for clients needing mental health services and long term care, there is growing pressure on institutions as the per bed costs increase and federal regulatory oversight becomes more stringent.
- Funding levels, resulting from years of revenue shortfalls, have placed the hospitals and residential habilitation centers at risk of non-compliance with federal requirements necessary for maintaining federal revenues.
- Background:** DSHS operates five residential habilitation centers (RHCs) and three mental health hospitals (Western State Hospital, Child Study & Treatment Center, Eastern State Hospital). The department has been expanding community placement options to address judicial direction.
- The RHCs have approximately 1000 beds and the mental health facilities have approximately 1200 beds. There is a conflict in the public arena over institutions versus community placement as well as in the legislature. This conflict is reflected in the federal court "Olmstead Decision" that requires community placement as a choice for those with disabilities.
- The legislature has, through budget provisos, directed the downsizing of institutions and the transfer of funds from institutions to community placements. The budget provisos are subject to political as well as legal challenge by those who consider institution placement superior, as well as by state employees who have had a major stake in the institution's closed shop employment. They argue that budget proviso language is insufficient to reverse statutory language establishing the institutions.
- DSHS' most recent study of comparable RHC patient placement indicates that community beds are approximately 20% less expensive than institution beds.
- Key Players:** Residents and families of those residing in RHCs, mental health advocacy organizations, local governments, courts, state employees and federal agencies.
- Status:** Downsizing of Fircrest School (residential services for clients with developmental disabilities) continues through May 2005. At mental health hospitals, downsizing is continuing for transfer of those individuals who are appropriate for community placement. An exception to downsizing is the expansion of beds at the forensic units at the Western State Hospital and the Eastern State Hospital to meet growing demands of the courts for mental health competency assessment and treatment.
- Contact:** Kathy Leitch, <mailto:leitckj@dshs.wa.gov>, (360) 902-7797  
Tim Brown, <mailto:brownTR@dshs.wa.gov>, (360) 902-7799  
Karl Brimner, <mailto:brimnKR@dshs.wa.gov>, (360) 902-0790

## MAJOR ISSUE: NO. 5

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- Issue:** **Major Technology Upgrades and Conversions Impact Program Successes**
- Urgency:** DSHS has mission critical information technology systems and supporting infrastructure that must be replaced or upgraded. These changes are essential to support the successful management of Medicaid, child welfare, and child care programs.
- Background:** A newly procured **Medicaid Management Information System (MMIS)** will support all Medicaid functions across the department and provide better management tools to oversee Medicaid expenditures in excess of \$6 billion per year. The department has requested biennial funding of approximately \$51 million for MMIS system replacement costs.
- The **child welfare information system** is over 20 years old. It does not adequately support the technical needs of the complex child welfare program or the full implementation of the Kids Come First Agenda. The department has requested \$20 million to improve this system over the next biennium.
- Child Care** subsidies are a \$295 million program. Current systems are inadequate to provide timely and accurate payments to providers. The department is exploring alternatives to the current system and has requested \$5.4 million to fund implementation over the next biennium.
- In addition, other aging systems including the **core network** must be upgraded to support changing business requirements. The department is requesting a total of over \$120 million for IT improvements in the 2005-2007 budget.
- Controversy:** The challenge is dedicating resources to these improvements, when client services are also underfunded. However, the department believes that these technology improvements will enable better management of clients' needs and the federal and state funds, and also help reduce waste, inefficiency and fraud.
- Key Players:** The Information Services Board (ISB) that oversees all major IT projects in state government; the U.S. Department of Health and Human Services that must approve use of federal funds for IT improvements.
- Status:** The MMIS bidder proposals are being evaluated. The successful bidder should be announced in October. The feasibility study for the child welfare information system is nearly complete. The project will request approval from the ISB and federal partners in November. The feasibility study for the child care information system is in progress and should be complete in early 2005.
- Timeline:** The MMIS contract will be awarded by December 2004, with the first phase of the system in place by December 2006. The timelines for child welfare and child care information systems will be determined after feasibility studies are complete and funding is secured.
- Websites:** [http://techzone.dshs.wa.gov/tech\\_library/portfoliomgmt/home/home.stm](http://techzone.dshs.wa.gov/tech_library/portfoliomgmt/home/home.stm)
- Contact:** Christy Ridout, <mailto:ridouCJ@dshs.wa.gov>, (360) 902-7651
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