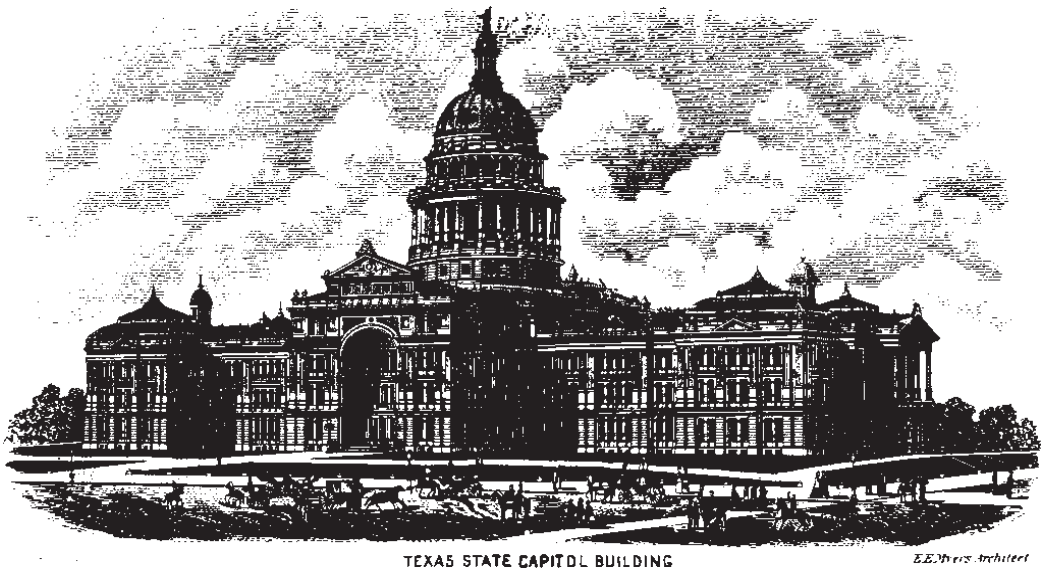
Sunset Advisory Commission



Texas Department of Health

Center for Rural Health Initiatives

Staff Report

1998

SUNSET ADVISORY COMMISSION

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In 1977, the Texas Legislature created the Sunset Advisory Commission to identify and eliminate waste, duplication, and inefficiency in government agencies. The 10-member Commission is a legislative body that reviews the policies and programs of more than 150 government agencies every 12 years. The Commission questions the need for each agency, looks for potential duplication of other public services or programs, and considers new and innovative changes to improve each agency's operations and activities. The Commission seeks public input through hearings on every agency under Sunset review and recommends actions on each agency to the full Legislature. In most cases, agencies under Sunset review are automatically abolished unless legislation is enacted to continue them.

TEXAS DEPARTMENT OF HEALTH

CENTER FOR RURAL HEALTH INITIATIVES

SUNSET STAFF REPORT

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EXECUTIVE SUMMARY

Executive Summary

Texas Department of Health (TDH) is responsible for protecting and promoting the health of all Texans. The Department administers a wide-variety of programs to accomplish this mission. For example, TDH administers a number of programs designed to improve the health of the population as a whole, including epidemiology and disease surveillance, and the Texas Poison Center Network. The Department also regulates a number of health professions, such as EMS personnel, and health facilities, such a hospitals. In addition, TDH administers other health-related programs such as Medicaid and the county indigent health care program to ensure that low-income Texans receive medical care. To carry-out such a wide variety of programs, TDH had 5,737 employees and a budget of $6.6 billion in fiscal year 1997. The Department also contracts with 66 local health departments to provide health services throughout the state. The Department is overseen by the six-member Board of Health.

The Center for Rural Health Initiatives (the Center) is the primary state resource and leader in assisting government and rural communities in planning, coordinating, and advocating for continued access to health care services for three million rural Texans. The Center accomplishes its mission mainly by providing forgiveness loans, scholarships and sponsoring annual health professional recruitment fairs. The Center's nine-member Executive Committee is responsible for overseeing the annual budget of $1.5 million and a staff of six employees, while the Department of Health is responsible for providing administrative services.

The Sunset review of TDH primarily focused on increasing the degree of planning and integration among TDH programs while improving the efficiency of those programs. The review also looked at improvements to the regulatory functions of the agency, rule-making, and Medicaid contract performance monitoring. This report also focused on the operations of the Center for Rural Health Initiatives and its administrative relationship with TDH. The following material summarizes the results of our review.

Texas Department of Health

1. Require the Department of Health to Develop a Comprehensive Blueprint to Allow More Effective Service Delivery.

Despite over 50 mandated individual planning documents, TDH has no coordinated and integrated approach to improve the health of Texas citizens. The lack of cohesive health planning results in program and service overlap, and a system that is difficult to navigate for both service providers and recipients. In addition, TDH does not provide enough up-to-date, usable data that is critical to effective planning efforts by both the Department and local health departments. Further, TDH does not have well-developed methods for regional and community-based interaction, thereby hindering opportunities to develop a more coordinated state health system. Recognizing the need for strong statewide plans and goals, other state agencies have developed blueprints for enhancing the delivery of services. Designing program integration has proven helpful in efficiently carrying out those agencies' programs and could similarly help TDH.

Recommendation: Require the Board of Health to develop and implement a comprehensive blueprint designed to minimize program overlap and increase administrative efficiencies.

2. Integrate Health Care Delivery Programs to Achieve Administrative Efficiencies, Reduce the Burden for Providers, and Improve Services to Clients.

The Texas Department of Health is responsible for delivering health care services to low-income Texans, primarily pregnant women and children. These services are not well coordinated, causing administrative duplication across programs. TDH often sends separate staff to monitor and audit contracts with a provider who participates in more than one program. Claims for similar services are handled differently depending on which TDH program is paying for the service. Providers must separately apply to several programs to perform similar services. Clients are not always made aware of needed and available services. As a result, TDH clients have little management of their care and sometimes miss out on services that would improve health outcomes, thus increasing health care costs to the State.

Recommendation: Require TDH to integrate health care delivery programs, including Medicaid and non-Medicaid programs, to the maximum extent possible.

3. Strengthen Enforcement Activities through Re-Engineering and Improved Sanctions.

The Sunset staff overview of the 55 TDH regulatory programs revealed indicators of possible ineffective performance. Programs that inspect large numbers of facilities show unexpectedly few violations and enforcement actions. Other programs receive high numbers of complaints, yet few violations lead to enforcement actions. The problems leading to this lack of results are not clear, and bear more in-depth examination. In addition, TDH does not have all the statutory enforcement tools necessary to fully regulate several of the programs assigned to the Department.

While regulatory action is vitally important, public awareness is also an essential component of regulatory programs. However, TDH has not made broad efforts to provide regulatory information to the public. Consumers interested in the performance of health care providers or a regulated facility in most cases must make open records requests for information. Many other state regulatory agencies have found a better way to make information accessible.

Recommendation: Require TDH, with the assistance of the State Auditor's Office, to conduct a one-time comprehensive evaluation of the Department's regulatory functions. Change the statute to require TDH to use the Internet and toll-free telephone lines to disseminate enforcement action information on professionals and facilities regulated by TDH. In addition, authorize TDH to issue letters of reprimand and administrative penalties for certain regulatory programs.

4. Improve the Department's Methods for Soliciting Public Input in the Development of Rules.

As a result of the Department's enormous rulemaking responsibilities and diverse programs, the agency has not been able to maximize input from stakeholders and other experts. Although the Department complies with the minimum standards established in the Administrative Procedures Act, TDH has the responsibility to go beyond the minimum standards when a major or controversial change is contemplated.

Recommendation: Require TDH to establish a system for soliciting stakeholder input when developing rules. TDH should establish uniform methods to solicit input during the development of rules, such as creating lists by interest area, and using these lists to mail notices regarding the development of rules.

5. Improve Contractor Performance Monitoring to Ensure Best-Quality Services.

TDH does not ensure the best contractor performance across the agency. For its highest-risk contract, the $70 million NHIC Medicaid contract, audits are three years overdue, and are not conducted as an operational function of Health Care Financing. Further, TDH has not required an external audit of the NHIC contract. In addition, TDH has not consistently used past contractor performance

information for the procurement of contracts. These oversights in contract oversight and contractor selection leave the Department at risk for contractor abuses, including financial inaccuracies. TDH has made efforts to comply with statute by developing standard tools for contractor risk assessment, and performance and financial monitoring, but has not required agency-wide implementation of these tools.

Recommendation: Require an annual external audit of the Medicaid fiscal agent, currently NHIC, and require the Health Care Financing Division to take over the Department's on-going financial monitoring of NHIC from the Internal Audit Division. TDH should also seek expertise from the Medicaid single state agency, currently HHSC, and TDI for the development of Medicaid contracts to ensure the procurement of best quality services. In addition, TDH should ensure consistent use of performance-based contracting procedures throughout the agency. Lastly, TDH should provide incentives, when possible, for contractors to meet and exceed contract requirements.

6. Reimburse Medicaid Providers through Electronic Funds Transfer to Achieve Cost Savings and Administrative Efficiencies.

While TDH and NHIC have made significant strides toward converting aspects of the Medicaid claims process to an electronic format, 87 percent of providers still receive mailed paper checks. This practice results in unnecessary administrative costs and is inconsistent with both State and federal policies to move away from costly and inefficient paper-driven processes toward electronic systems.

Recommendation: Require TDH to use electronic funds transfer for all payments to Medicaid providers.

7. Designate the Department of Health as the Single State Agency Responsible for Licensing Narcotic Treatment Programs.

TDH and TCADA have dual regulatory authority over narcotic treatment programs, resulting in little additional oversight and creating an unnecessary financial and regulatory burden on providers. All parties agree that designating the Department of Health as the single state regulatory agency would be more efficient. Narcotic treatment programs would continue to be highly regulated at the state and federal levels.

Recommendation: Remove TCADA's role in regulating narcotic treatment programs, and clarify that TDH is the sole state authority to regulate these programs.

8. Maintain the Toxic Substances Coordinating Committee as a Resource for the Department of Health.

The Health Risk Assessment of Toxic Substances and Harmful Physical Agents Act expires on September 1, 1999. The Act creates the Toxic Substances Coordinating Committee, an interagency committee charged with coordinating communication among a variety of regulatory agencies whose decisions affect human health. The Committee provides an official forum for agencies to tap into TDH's public health expertise. During the past 10 years, the Committee has successfully promoted efficiency between agencies, reduced overlap and inconsistency, and allowed the State to respond with a clear and consistent voice concerning public health.

Recommendation: Repeal the expiration date for the Toxic Substances Coordinating Committee.

9. Improve the Administrative Hearings Process through Transfer to the State Office of Administrative Hearings.

The Legislature has clearly expressed its intent to consolidate the hearings functions of state agencies if such a transfer would improve the independence, quality, or cost effectiveness of hearings. The review of the Department's APA hearings process indicated that SOAH has the ability to conduct the hearings and that a transfer would provide more perceived independence, would provide an equal level of quality; and could improve the cost effectiveness of the hearings process. Federally required "fair" hearings, usually regarding benefit appeals, would remain at TDH.

Recommendation: Transfer the Department's Administrative Procedure Act hearings to the State Office of Administrative Hearings.

10. Decide on Continuation of the Texas Department of Health as a Separate Agency after Completion of Sunset Reviews of All Health and Human Service Agencies.

Most of the State's health and human service agencies are currently under Sunset review. While these agencies serve many unique purposes they also have many similarities that should be studied as areas for possible improvement through organizational change. This analysis should occur before decisions are made to continue the HHS agencies as separate entities, including the Department of Health.

Recommendation: Decide on continuation of the Texas Department of Health as a separate agency upon completion of Sunset reviews of all health and service agencies.

Center for Rural Health Initiatives

1. Maintain the Center for Rural Health Initiatives and Strengthen Administrative Ties to the Texas Department of Health.

While the State has made significant strides in improving the availability and quality of health care in rural communities, the job is not finished. As the Center approaches its tenth year, several adjustments to the statutory approach taken in 1989 are necessary to ensure the Center can effectively meet the challenges to come. The semi-independent operation of the Center within TDH has resulted in administrative inefficiencies, little use of TDH's vast knowledge and resources, and a lack of oversight.

In addition, the Center has not met the challenge set out in statute to proactively address the health care problems facing rural communities. Although the Center has been a valuable resource to communities seeking health care professionals, the Center does not have an action plan in place, or in some cases the expertise, to assist communities in facing other health care challenges. Developing a plan, accessing expertise of TDH and other agencies, and assessing the impact of proposed actions of other agencies all can go a long way to improving rural health care in Texas.

Finally, the three-way appointment system using the Governor, Lieutenant Governor, and Speaker to all make appointments to the Executive Committee does not allow the Governor authority to appoint the team of citizens most appropriate to lead this executive branch function. The Governor is further limited by the statutory prescription of the exact types of professions that must be represented on the Committee.

Recommendation: Continue the Center for Rural Health Initiatives within the Texas Department of Health and restructure the Center's Executive Committee to have nine members appointed by the Governor, including a majority from rural communities. In addition, clarify the relationship between the Center and TDH by removing the Center's authority to hire its own staff and specify that TDH shall provide staffing and other services necessary to support the functions of the Center. Furthermore, remove the Center's separate Sunset date and specify that the Center will be included in future reviews of TDH.

Fiscal Impact Summary

The recommendations of this report are intended to enable the Texas Department of Health and the Center for Rural Health Initiatives to better perform their functions within existing resources. The recommendation integrating health care delivery programs will result in approximately $2.2 million in savings each year to state and federal funds while requiring electronic funds transfer of funds to Medicaid providers will save about $550,000 per year to the State. Other recommendations will result in savings to the State but the savings cannot be estimated for this report. Those recommendations include requiring TDH to develop a comprehensive service delivery blueprint and transferring the Department's administrative hearings to the State Office of Administrative Hearings.

The recommendation relating to improving the Department's regulatory functions will result in costs of about $75,000 each fiscal year. Other recommendations will result in minimal costs to the State such as requiring TDH to improve methods for soliciting public input regarding the Department's rules. In total, the recommendations relating to TDH contained in this report will save the State about $2.7 million each year.

The recommendations relating to the Center will have a small direct fiscal impact totaling about $13,000 each year.

Approach and Results

Approach and Results

Approach

The mission of the Texas Department of Health (TDH) is to protect and promote the health of Texas residents. In a state the size of Texas, protecting the public health presents new challenges everyday. Recently, the Department contended with a Strep A bacteria known as the "flesh-eating" bacteria. The Department's doctors and scientists studied the traits of the bacteria, issued press releases to educate the public about warning symptoms, and operated a toll-free hotline for those experiencing worrisome symptoms. In addition, the Board of Health proposed rules in May 1998 that would restrict the sale of ephedrine, currently an ingredient in many diet pills and energy boosters, due to a risk of elevated blood pressure, seizures, and even death. The Department has also recently noted a rise in multi-drug resistant tuberculosis in Texas and is working with Mexican officials to try to better address the problem on both sides of the border.

The Department responds to major disease outbreaks such as the recent Strep A bacteria outbreak.

In addition to responding to health crises, TDH administers a multitude of federal and state programs that strive to assess health needs and address those needs through direct health care services, regulation, prevention, and education. For example, TDH administers 37 direct health care programs, including the $5 billion a year acute care Medicaid program transferred from the Department of Human Services in 1993. TDH also administers 55 regulatory programs for health professions, facilities, and industries, such as meat processors, that pose a threat to public health.

Although the Department's budget is heavily weighted toward direct health care services, the Department would like to see more emphasis on prevention and education programs that will improve the health of many. Prevention and education activities at TDH include disease and injury surveillance, outbreak investigations, and community health education designed to decrease the incidence of smoking complications, birth defects, and osteoporosis, just to name a few. Although recognizing the necessity of providing direct health care services to low-income Texans, the Department is also trying to educate the public about the benefits of public health programs that target whole groups of people.

TDH administers 37 health care programs and 55 health regulatory programs.

In 1997, the Office of Survey Research at the University of Texas at Austin conducted a statewide telephone survey of 759 Texans about their perceptions of public health. Many Texans associated public health exclusively with health care for the poor. When asked why life expectancy is greater now only two

percent attributed the improvement to vaccines, .9 percent to clean water, and .1 percent to better treatment of diseases. Although many of these improvements actually contributed far more to the increased life expectancy, 45 percent thought improvements in medical technology accounted for the increase. To generate public support for basic public health activities like immunizations, disease control and surveillance, and injury prevention, the Commissioner of Health, Dr. Reyn Archer, and other agency staff, recently traveled around Texas by train educating the public about the benefits of public health using the motto " everyone, everyday, everywhere."

The lack of public support and funding for public health services has also been a problem for local health departments (LHDs) in the state. Until recently, LHDs provided the majority of clinical services to low-income residents in the state, and these funds helped subsidize the LHD's population-based public health programs such as outbreak investigations and disease control measures. As Medicaid managed care and other programs have begun to emphasize the importance of a "medical home" for patients, funding has shifted away from LHDs and, as a result, the public health infrastructure is weakening. Although Sunset staff recognized the widening gap in the public health infrastructure, the staff did not want to duplicate the efforts of the working group formed specifically by House Concurrent Resolution 44 of the 75th Legislature to study the role of local governments in providing public health services. The House Concurrent Resolution working group, composed of local health department officials, academicians, associations, and TDH staff, will submit recommendations to the Legislature in January 1999.

The review excluded subjects currently being studies by the Legislature, such as the role of local health departments.

Sunset staff also chose not to focus on several additional areas being reviewed by other groups, as mandated by the Legislature. The Senate interim committee on Home Health and Assisted Living Facilities is reviewing the Department's regulation of home health facilities and the House Public Health Committee is reviewing the County Indigent Health Care Program and the educational and regulatory mechanisms currently in place to protect consumers from food-borne illnesses at restaurants and other retail outlets. The Legislature also directed the Department through a rider in the appropriations act to develop a long-range plan for the two TDH Hospitals in San Antonio and Harlingen. The Department hired a consultant and is planning to issue a report on the hospitals in June 1998.

In addition to not focusing on concurrent legislative review topics, we also delayed making a recommendation on whether to continue TDH in its current form. With most health and human service agencies under review together, the Sunset Commission has an unprecedented opportunity to look across agency lines—at types of services provided, types of clients served, and funding sources used. After reviewing all of the individual health and human service agencies, the Sunset staff will compile the information across agencies

and assess organizational and other alternatives at that time, and recommend any needed changes to the Sunset Commission.

Although these considerations narrowed the scope of the review, the Department administers a multitude of programs outside current legislative review exhibiting problems that should be addressed, regardless of the organizational structure of health and human services. In fact, the sheer number of programs administered by the Department became a focus of our review. Specifically, Sunset staff examined ways the agency could integrate its numerous programs to achieve administrative efficiencies and better service delivery. The review also focused on providing better oversight for regulatory programs and health care delivery contractors, improving public participation during the development of rules, and maximizing state resources.

The challenge of carrying out the sheer number of programs assigned to TDH became a focus of the review.

In addition to TDH, Sunset staff reviewed the Center for Rural Health Initiatives (the Center), the state's primary resource for planning, coordinating, and advocating statewide efforts for continued access to rural health care services. The review assessed the Center's operations to determine ways for the State to better address health care needs of rural communities. The review also focused on understanding the organizational and administrative structure of the Center, including studying examples of independent decision-making bodies attached to other state agencies.

Sunset staff also conducted a limited review of six independent boards administratively-attached to the Department—the Texas Council on Alzheimer's Disease and Related Disorders, the Interagency Council for Genetic Services, the Texas Radiation Advisory Board, the Advisory Board of Athletic Trainers, the Statewide Health Coordinating Council, the Texas Board of Licensure for Professional Medical Physicists, and the Texas Diabetes Council. Although TDH currently provides administrative support for 21 independent boards, Sunset staff focused only on the six boards that do not have a separate Sunset date and whose board members are appointed at least in part by the Governor. After a limited review, Sunset staff found no problems with the boards that would justify a full-fledged review, and thus focused on applying the appropriate Sunset Commission Across-the-Board recommendations. For the Advisory Board of Athletic Trainers and the Texas Board of Licensure for Professional Medical Physicists, an application of the ATBs would ensure the appropriate public membership so critical for regulatory boards with enforcement responsibilities.

The staff also studied the effectiveness of the Center for Rural Health Initiatives.

Review Activities

In conducting the TDH and CRHI reviews, several common activities were performed. The Sunset staff:

- Worked extensively with agency staff at TDH and the Center;
- Worked with staff of the Legislative Budget Board and State Auditor's Office;
- Researched agencies in other states with common functions;
- Reviewed legislative committee reports and attended hearings of the House Public Health Committee and Senate Interim Committee on Home Health and Assisted Living, and Senate Health and Human Services and Senate Finance committees;
- Reviewed state statutes, past legislative reports and studies, and reports by the State Auditor's Office, State Comptroller, and the Legislative Budget Board;
- Attended public meetings of the Texas Board of Health, Center for Rural Health Initiatives Executive Committee, and Statewide Health Coordinating Council; and
- Met, upon request, with members of the Texas Board of Health and Center for Rural Health Initiatives.

The staff met with personnel from local health departments, TDH regional offices, and rural hospitals around the state.

In addition to the above efforts, Sunset staff engaged in several activities specific to the two reviews.

Texas Department of Health

- Visited regional offices and discussed regulatory, health care delivery, disease control and prevention, and other public health activities with TDH staff in Arlington, Harlingen, Houston, San Antonio, and Tyler;
- Visited TDH health care delivery contractors, local health departments, and regulated facilities in Brownsville, Edinburg, Fort Worth, Galveston, Harlingen, Houston, Laguna Heights, Laredo, McAllen, Mission, San Antonio, and San Benito;
- Met with various interest groups and trade associations, including the Texas Medical Association, Consumer's Union, Center for Public Policy Priorities, Texas Fire Chief's Association, Texas Association of Local Health Officials, Pharmaceutical Manufacturing Association, Texas Hospital Association, Advocacy, Inc., Texas Pharmacy Association, and the National Heritage Insurance Company;
- Attended public meetings of the HCR 44 workgroup studying the role of local governments in providing public health services;
- Worked with agency staff from the Health and Human Services Commission, Texas Natural Resources Conservation Commission, Texas Department of Insurance, Texas Department of Human Services,

State Office of Administrative Hearings, the Texas Commission on Alcohol and Drug Abuse, and the federal Health Care Financing Administration;

- Interviewed members of the Council on Alzheimer's Disease and Related Disorders, the Interagency Council for Genetic Services, the Texas Radiation Advisory Board, and the Diabetes Council.

Center for Rural Health Initiatives

- Interviewed several of the Center's Executive Committee Members as well as members of the Center's advisory committee representing the Texas Higher Education Coordinating Board, Texas Council on Alcohol and Drug Abuse, and Texas Department of Mental Health and Mental Retardation;
- Met with rural hospital administrators from Hondo, Cameron, and Uvalde;
- Met with health professional recruiters for Paris, Cuero, Plainview, Athens, Carthage, Crockett, Jacksonville, Pittsburg, Rusk, Trinity, and Quitman;
- Attended the Center's HealthFind/ProFind Exchange;
- Attended public meetings of the Center's Executive Committee;
- Met with various interest groups such as the Texas Medical Association, Texas Rural Health Association, Texas Association of Rural Health Clinics, Texas Hospital Association, Texas Organization of Rural and Community Hospitals; and
- Examined the structure of rural health agencies in other states.

Results

Texas Department of Health

The Sunset review of the Department started with an evaluation of whether the functions TDH performs continue to be needed. Maintaining a healthy population is critical to keeping a productive workforce and maintaining the general well-being of the State. As long as disease outbreaks such as tuberculosis, Strep A, and other diseases and environmental contaminants continue to threaten the health of Texans, some state agency needs to address those problems. In addition, educating the public to prevent disease, regulating health professions, facilities, and industries, and providing direct services to low-income Texans are all important to maintaining a healthy population. However, many health and human services cross agency lines,

and an assessment of organizational alternatives needs to be performed before a decision can be made to continue the Department in its current form. After making this determination, the review focused on:

- integrate its services more efficiently;
- improve public participation during the rulemaking process;
- provide better oversight for regulatory programs and health care delivery contractors; and
- better maximize state resources.

Integrating health services — The multitude of programs at TDH is overwhelming. The Sunset review compared activities across programs to see if the services could be better integrated to achieve administrative efficiencies and smoother service delivery. Sunset staff broadly examined these areas and found opportunities for integration within all areas of the Department. For example, TDH maintains a multitude of data bases and produces county fact sheets, but much of the information is limited in value because it is difficult to access and often too outdated to be of much use. **Issue 1** provides TDH with a way to methodically assess opportunities to achieve integration throughout the agency.

Separate operating structures were created each time TDH received a new state or federal program.

Sunset staff took a more in-depth look at opportunities for integration within the health care delivery programs. Both Medicaid and non-Medicaid programs provide similar services to similar clients, and use many of the same providers. However, TDH, or the program's predecessor agency, created a separate administrative process every time a new state or federal health care delivery program was created. As a result, TDH administers separate contracting and claims processing functions for almost every program. Of particular note, the Legislature transferred acute care Medicaid programs to TDH in 1993 to complement its other health programs for women and children; however, only limited integration has occurred. **Issue 2** requires TDH to integrate health care delivery programs wherever possible and authorizes a managed care pilot that would result in administrative efficiencies and better coordination of care for clients.

Improving public participation —As a result of the Department's enormous rulemaking responsibilities and diverse programs, the agency has not been able to maximize input from stakeholders and other experts. Sunset staff found that, although the Department complies with the minimum standards of the Administrative Procedures Act (APA) by publishing proposed rules in the Texas Register, and uses advisory committees for a number of programs, TDH has a responsibility to go beyond those minimum standards when a major or controversial change is contemplated. In this way, TDH

would be able to garner better cooperation from contractors, clients, and the TDH-regulated community. **Issue 4** provides guidance to the Department on how to formalize solicitation of stakeholder and public input during contemplated rulemaking.

Improving regulatory and contractor oversight — The Department administers 55 regulatory programs, 118,000 professionals in 15 regulatory programs, and 129,000 facilities and industries through 40 programs. If a health care professional provides substandard care or a meat processing plant does not comply with food handling requirements, the public health is at risk. Regulating these professionals and industries is one of the Department's most important responsibilities, yet Sunset staff found an unwillingness from TDH staff to be viewed as the "regulator." In a few cases, Sunset staff found programs in which numerous violations had been reported, but no enforcement actions taken. In another program, files showed that similar violations resulted in different or contradictory enforcement actions.

Although a full investigation of the 55 regulatory programs was not possible, Sunset staff found enough significant concerns to recommend TDH conduct a comprehensive evaluation of its regulatory functions with assistance from the State Auditor's Office. This recommendation, contained in **Issue 3**, also provides a way for the public to access information regarding final enforcement actions taken against professionals or facilities, allowing citizens to make more informed decisions regarding their health.

Sunset found an unwillingness from TDH staff to be viewed as a "regulator."

Regulatory oversight of toxic and other harmful substances that affect public health are shared between a number of agencies. The Act that establishes the Toxic Substances Coordinating Committee, charged with coordinating communication between member agencies that regulate toxic substances, will expire September 1, 1999. Sunset staff found that the Committee provides a useful forum for these agencies that share responsibilities. Before TDH issues a fish advisory, for example, Committee members such as TNRCC and Parks and Wildlife share expertise on the water quality and fishing laws they enforce. In addition, the Committee allows agencies to respond to public health concerns with one voice. **Issue 8** provides for the maintenance of the Committee.

In addition to the importance of regulatory oversight, TDH must monitor a multitude of contractors who deliver about $6 billion in health care services for the Department. Although TDH has taken strides to improve its contract monitoring system as required by recent legislative directives, Sunset staff identified several areas that need improvement. For its biggest contract, the $70 million a year Medicaid claims administration contract with the National Heritage Insurance Company (NHIC), the review found that by using its

internal auditor to perform an operational financial monitoring function TDH does not comply with the Internal Audit Act. In addition, Sunset staff found that although TDH requires an external audit for HMOs and other states require an external audit of claims administration contractors, TDH has never employed an external auditor to examine the systems and profit and cost calculations performed by NHIC. **Issue 5** requires an external audit of NHIC and also provides guidance for fine-tuning contract performance monitoring for other health care delivery programs.

Maximizing state resources — NHIC processes about 34 million Medicaid claims per year but still prints and mails checks to 87 percent of providers, even though the State has greatly expanded use of electronic funds transfer in other areas. **Issue 6** provides for the payment of claims to Medicaid providers through electronic funds transfer for an estimated savings to the State of about $550,000 a year. These savings would be available to provide more Medicaid services.

Eliminating duplication is also an important step toward maximizing state resources. Sunset staff found that both TDH and the Texas Commission for Alcohol and Drug Abuse license about 30 narcotic treatment programs, generally methadone clinics. Both agencies agree that dual licensure is inefficient and that no regulatory oversight would be lost by making TDH the single state agency responsible for licensing narcotic treatment programs. **Issue 7** would provide for TDH to exclusively regulate methadone programs.

TDH does not require an external audit of its largest contract, a $70 million per year agreement with NHIC.

Sunset staff also examined the administrative hearings function at TDH to assure that these hearings meet the State's goals of independence, cost effectiveness, and quality. **Issue 9** discusses the advantages of transferring the APA hearings to SOAH, including the historical cost savings resulting from previous transfers. The Department's fair hearings associated with federal benefit programs are not APA hearings, and thus would not be subject to the transfer.

Center for Rural Health Initiatives

The Sunset review of the Center started by addressing whether functions performed by the agency continue to be needed. The Center's mission is to assist government and rural communities to plan, coordinate, and advocate for continued access to rural health care services. The Center has improved accessibility and availability of health care in rural communities by placing 109 health professionals in rural areas and by providing over 81 forgiveness loans and four scholarships. The functions of the Center, to improve access to health care for rural Texans, should continue.

While the Center's functions continue to be necessary, staff found that the Center has not fully met its responsibilities to improve access to rural health care. **Issue 1** requires the Center to develop a comprehensive rural health

work plan in coordination with TDH and other health and human services agencies, rural communities, universities and health care providers.

The review then focused on determining the most effective and efficient administrative structure to perform the functions. The Legislature established the Center as adjunct to the Department of Health to take advantage of TDH's administrative resources. The Center's failure to take full advantage of those resources raises concerns over the administrative efficiency of the Center. Issue 1 provides a framework for the Center and TDH to work together more effectively without affecting the independence of the Center to plan, adopt rules, and make decisions on grants, loans and scholarships. Issue 1 also restructures the Executive Committee to allow for greater rural representation and different professional expertise.

The Center has not fully met its responsibilities to improve access to rural health care.

Recommendations

Texas Department of Health

1. Require the Department of Health to Develop a Comprehensive Blueprint to Allow More Effective Service Delivery.

2. Integrate Health Care Delivery Programs to Achieve Administrative Efficiencies, Reduce the Burden for Providers, and Improve Services to Clients.

3. Strengthen Enforcement Activities through Re-Engineering and Improved Sanctions.

4. Improve the Department's Methods for Soliciting Public Input in the Development of Rules.

5. Improve Contractor Performance Monitoring to Ensure Best-Quality Services.

6. Reimburse Medicaid Providers through Electronic Funds Transfer to Achieve Cost Savings and Administrative Efficiencies.

7. Designate the Department of Health as the Single State Agency Responsible for Licensing Narcotic Treatment Programs.

8. Maintain the Toxic Substances Coordinating Committee as a Resource for the Department of Health.

9. Improve the Administrative Hearings Process through Transfer to the State Office of Administrative Hearings.

10. Decide on Continuation of the Department of Health as a Separate Agency After Completion of Sunset Reviews of All Health and Human Service Agencies.

Center for Rural Health Initiatives

1. Maintain the Center for Rural Health Initiatives and Strengthen Administrative Ties to the Texas Department of Health.

Fiscal Impact

Texas Department of Health

Integrating health care delivery programs is expected to save more than $2.2 million annually.

Both recommendations requiring integration of TDH programs would result in substantial administrative savings. However, precise savings cannot be estimated until the Department prepares the blueprint that will identify areas where administrative efficiencies can be achieved. No additional personnel should be necessary to develop the blueprint, although numerous current TDH employees from different programs will need to devote some time to its preparation. Actual integration of TDH programs, especially health care delivery programs, would likely require changes to information systems and forms, as well as retraining of personnel.

These costs, if necessary, would depend on the findings and actions identified in the blueprint once developed and should be more than offset by the anticipated savings. The potential for significant administrative savings through integration of health care delivery programs is substantial. TDH currently expends $21.5 million for administration of non-Medicaid health care delivery services. Since most of the TDH health care delivery services are purchased, coordination of provider selection, monitoring, auditing, payment, and claims reimbursement for Medicaid and non-Medicaid programs will greatly reduce operating costs. Sunset staff conservatively anticipates at least a 10 percent savings of non-Medicaid administrative costs if integrated with Medicaid administration. This would result in expected savings of about $2.2 million per year in state and federal funds. The 24 non-Medicaid health service programs are funded through a variety of State and federal sources, each with a different percentage of State and federal financial participation. For the purposes of this report, staff assumes that the State and federal government each pay about one-half of administrative costs and would, therefore, each receive about one-half of the $2.2 million in savings.

In addition, by moving toward incentive and performance-based contracting, TDH should achieve savings for the State, although the exact savings cannot be estimated at this time. By focusing performance monitoring efforts, including an external audit, on high-risk contracts such as NHIC, TDH will be able to ensure that state resources are used efficiently. In addition, increased monitoring and offering performance incentives ensures that the State receives the best quality services for its money. While hiring an independent, external auditor for the NHIC contract will create an additional expense for the Department, the amount cannot be determined until TDH identifies the appropriate scope of the audits.

Requiring TDH to pay all Medicaid providers through electronic funds transfer will have a positive fiscal impact on the State. This recommendation would result in a loss of revenue from interest earned on Medicaid funds being held while checks are mailed and processed. However, TDH staff note that any loss of interest earnings consequently lowers the State's federal Cash Management Improvement Act (CMIA) liability, money the State owes the federal government when it earns interest on federal dollars, which would more than offset lost interest earnings. The state would also achieve administrative savings from elimination of processing and mailing costs. After all the calculations, the State would net about $550,000 a year in cost savings.

Improving regulatory oversight would result in a minimal cost to the State. The evaluation of TDH regulatory activities would be performed with existing staff. However, start-up costs, including staff time and training, would be needed to develop and maintain a new portion of the TDH web site relating to regulatory enforcement actions. Costs would also be associated with establishing several toll-free telephone lines. No more than ten additional lines would be needed for a maximum cost of $75,000 per year. Revenue would be generated to the State by the recommendation authorizing TDH to collect administrative penalties for regulation of a few programs. However, the amount of revenue generated would vary depending on the number and amount of administrative penalties levied by TDH and therefore cannot be estimated for this report.

The recommendation requiring improved solicitation of stakeholder input during rulemaking would have a minimal fiscal impact. If the Department decides to increase the number of notices mailed, postage and related costs could minimally increase. Designating TDH as the single state agency responsible for licensing narcotic treatment programs would also have a minimal fiscal loss of about $9,600 per year currently generated by TCADA from licensing fees.

Fiscal Year	Savings to General Revenue Fund	Change in Number of FTEs from Fiscal Year 1997
2000	$1,404,400	0
2001	$1,375,400	0
2002	$1,367,400	0
2003	$1,367,400	0
2004	$1,367,400	0

Center for Rural Health Initiatives

The recommendation will have a small direct fiscal impact to the State. The savings gained from using TDH hiring and salary practices will save at least an additional $13,000 per year in salaries by using the TDH salary classification system. When TDH office space is made available, using state-owned space instead of commercial space will save the State approximately $46,068 per year. Additional financial benefits may accrue through increased coordination with TDH and other agencies, but cannot be estimated for this report.

TEXAS DEPARTMENT OF HEALTH

ISSUES

Issue 1

Require the Department of Health to Develop a Comprehensive Blueprint to Allow More Effective Service Delivery.

Background

In 1879, the Legislature created the post of State Health Officer who was charged with combating epidemics of yellow fever, smallpox and cholera. That position over the years evolved into the Texas Department of Health (TDH), which is responsible for all matters relating to the physical health of the citizens of the State.

Since its inception, the addition of numerous federal and state programs has incrementally increased the Department's responsibilities over the years, as shown in *The Texas Department of Health Growth Chart*. The chart shows that between 1920 and 1997, 44 programs were created or transferred to TDH, including programs on vital statistics, tuberculosis control, facility and professional regulation, preventive health services, the federal Women, Infants and Children (WIC) Nutrition Program, and acute care Medicaid.

The vast array of programs that TDH administers is staggering.

In fact, the array of programs that TDH administers is staggering. TDH operates 55 regulatory programs for facilities such as hospitals and food manufacturers, and for professionals such as massage therapists and emergency medical services providers. TDH also has numerous programs that promote the health of all Texans and large groups of Texans. For example, the agency has programs that through education and other efforts are designed to prevent osteoporosis, smoking, and prenatal defects.

The Department also provides medical services for low-income Texans, especially women and children, through 37 direct health care delivery programs in which clients receive care one-on-one from health care practitioners such as doctors, nurses, and nutritionists. Direct health care services account for $6 billion in state and federal funds, including $5 billion alone for Medicaid services. TDH also works with 149 local health departments (LHDs). Sixty-six LHDs, known as "participating LHDs," receive funding from TDH and spent about $55.1 million in state funding in fiscal year 1997.

As a result of the increased responsibilities, the Department's budget has also increased. In fiscal year 1980, TDH had a budget of $135.6 million. By 1997, that amount had increased to $6.6 billion.

Many of the Department's regulatory programs, prevention programs, and direct health care programs have similar components, including many of the same goals, clients, contractors and administrative requirements. Historically, however, the Department has created a new program, data base or management information system for each new program. The Sunset review focused on whether the health care system in the State has a clear strategic direction and a coordinated approach that maximizes health care and minimizes public health risks.

TDH currently produces over 50 mandated planning documents.

Texas Department of Health Growth Chart

Date	New TDH Programs	
Prior to 1930	Vital statistics General sanitation Maternal and child health Rural health sanitation Communicable disease control	Food and drug safety Public health education Laboratories Venereal disease control
1930-1950	Public health nursing Crippled children's services Bedding regulation School health services Mental health services	Hospital survey, construction Local health services Tuberculosis control Cancer control
1950-1960	Nursing and convalescent homes licensure Radiation Control Hospital licensure Emergency medical services regulation	Occupational health Water pollution control Chronic disease prevention Heart disease prevention
1960-1980	Vector control (mosquito control) Marine resources Nutrition Federal women, infants, and children's nutrition program	Wastewater technology and surveillance Veterinary public health Kidney health care
1980-1997	Professional licensing Home health agency licensing Birth defects monitoring Tanning facility and tattoo studio regulation Office of Minority Health Preventive health services (EPSDT, family planning) Medicaid direct care services (acute care)	Health care facility licensing (In addition to hospitals) HIV/AIDS services Indigent health care program Genetics screening and counseling Medically Dependent Children Program

Findings

▼ **Despite over 50 mandated individual planning documents, TDH has no coordinated and integrated approach to improve the health of Texas citizens.**

◗ TDH currently produces over 50 mandated plans. Each of these plans is limited in scope since they are designed for

individual programs within TDH, or required by the federal government or state law. For example, TDH produces a plan to increase the number of immunized children in the state and a federally-required plan to meet the needs of the maternal and child health population. However, none of the 50-plus plans developed by TDH addresses how the agency will comprehensively carry out its programs in an integrated manner.

- TDH, like other state agencies, also produces a strategic plan which outlines the goals, strategies, outputs, and outcomes of many individual programs and functions of the agency. However, the agency's strategic plan does not address *how* programs should fit together or should be integrated to achieve a higher level of effectiveness or accessibility.

TDH's strategic plan does not address how programs can fit together to increase agency effectiveness.

- TDH does help produce the Texas State Health Plan in coordination with the Texas Statewide Health Coordinating Council (TSHCC). However, this plan typically focuses on specific issues identified by TSHCC, such as the condition of managed care in the state, or the status of the health care professions in Texas. The plan does not help TDH to develop a method for ensuring its functions are carried out.

▼ **The lack of cohesive health planning results in program and service overlap, and a system that is difficult to navigate for both service providers and recipients.**

- Overlapping programs duplicate administrative functions, hinders programmatic integration, and decrease agency efficiency. TDH has developed numerous public health programs that overlap in scope. For example, the Neural Tube Defects (NTD) Program and the Birth Defects Monitoring Division both deal with identifying and investigating birth defects within Texas. The NTD Program identifies and provides women who have had anencephalic pregnancies, while the Birth Defects Monitoring Division primarily identifies and describes patterns in the occurrences of a variety of birth defects throughout the state.

  Another example of program overlap relates to the TDH Pharmacy Division. That division packages and distributes medications for most of the TDH medication programs such as the Immunizations Initiatives, the Tuberculosis Program and the HIV/STD Medication Program. However, each of these programs bulk-purchases its own medications.

- TDH administers several direct services programs all of which target overlapping populations. Medicaid, Title V Maternal and Child Health, family planning services, and the Women, Infants and Children Health Program all target low-income women and children but use different eligibility criteria. The Community Oriented Primary Care Program and the County Indigent Health Care Program both target indigent clients who are not served by other programs such as Medicaid or Title V. The chart, *Health Care Delivery Program Eligibility and Benefits* (Appendix A) offers a complete list of direct services programs administered by TDH along with each program's eligibility criteria.

- Program overlap has resulted in numerous problems. TDH has not maximized coordination among the programs to ensure clients receive all the benefits for which they are eligible. In addition, TDH does not make use of coordinated program monitoring or financial audits which has led to an inability to determine if administrative problems exist across programs.

Providers with multiple contracts often submit the same information to different TDH programs.

Further, requiring separate contracting submissions for each program compels TDH staff to spend additional time processing multiple applications from the same provider, thereby consuming more agency and contractor resources than necessary. Providers who contract with TDH to administer more than one health care delivery program may be required to complete different contracting processes, submit different RFPs and provide multiple reports, even though the information requested is similar.

▼ **Lack of up-to-date, usable data hinders effective planning efforts.**

- Although TDH has compiled significant patient encounter data from its Medicaid managed care program, no meaningful information has been derived from that data. For example, TDH cannot currently tell if Medicaid managed care clients have improved access to medical care through their medical homes, at what rate those clients are accessing specialty services, or whether any savings are accruing to the program as a result of the shift from fee-for-service to a managed care environment.

- Much of the information produced by TDH is limited in scope and dated. For example, information available from the TDH

web site[1] includes county facts sheets that provide basic demographic and general health-related statistics. However, the latest information compiled is for 1995.

The general health-related information on the fact sheets does not provide enough information to be of significant use by LHDs. Little, if any, information is readily available for areas smaller than a county. For example, the web site contains only municipal information relating to tuberculosis incidence and vital statistics. As a result, LHDs have difficulty obtaining detailed comparative health information relating to other communities. TDH has not focused resources on managing data to enhance its use by local communities.

- TDH manages over 100 data bases it has developed to store and analyze data. As a result, TDH does not completely know what information it maintains. According to a TDH inventory of data bases, "...the data bases listed in this report are based on survey responses. This may not represent a comprehensive list of all data maintained by the Texas Department of Health."[2] The Department published the inventory in 1994 and the Sunset review found no indication that the situation has changed. Agency effectiveness suffers without a full understanding of what information the agency has available.

TDH manages over 100 data bases and has difficulty keeping up with the information it maintains.

- The lack of usable information hinders assessment of the State's public health needs. For example, in its self-evaluation report to the Sunset Commission, TDH raised an issue regarding the potential need for mandatory training of food managers in restaurants. Since local governments are not mandated to report foodborne illnesses, TDH was unable to provide information sufficient to demonstrate a public health threat to justify this additional regulatory authority.

- TDH does not have a timely and efficient way to determine whether pockets of unimmunized children exist to prevent epidemics of certain childhood diseases such as rubella. Currently, the Department relies on state-wide surveys to identify unimmunized populations. The surveys and resulting analysis may take several months to develop thereby delaying measures to minimize the number of unimmunized children.

▼ **Lack of regional and community-based interaction hinders opportunities to develop a more coordinated state health system.**

- Currently formal interaction between TDH and LHDs takes place only when an LHD participates in TDH programs, i.e. receives funds to provide services. LHDs are considered partners with TDH in meeting the public health, service delivery, and regulatory needs of Texans. Despite this, for most TDH programs the Department generally has no formal method, outside of the Administrative Procedure Act process, for local input into TDH activities, either at the programmatic level or in developing the state's health care policies.

- In addition, LHDs largely play a reactive role in response to TDH. For example, despite an attempt to proactively adopt TDH-consistent rules relating to retail food establishments, the City of Houston Health Department (CHHD) was unable to determine the Department's policy from TDH staff. As a result, CHHD staff indicated that implementation of the rules in Houston was delayed.[3]

TDH needs to improve its interaction with and the input received from local health departments.

During the 1996 conversion of Medicaid to managed care in Ft. Worth, the City of Ft. Worth Health Department was not contacted until after the conversion plan was designed, despite the fact that such a plan would directly affect the services and functions provided by the local department.[4]

- TDH needs community-based input since communities are most familiar with local needs and set local priorities. By not effectively interacting with LHDs, TDH runs the risk of establishing poorly coordinated or ineffective statewide policies. Such policies can adversely affect the health of individuals within the state and thereby defeat the overall goal of the agency.

- Currently, a task force, authorized by House Concurrent Resolution 44 of the 75th Legislature, is working to determine a better way to structure and fund LHDs in the State. Providing a better way to gather LHD input could also help ensure that the State's public health infrastructure is continuously examined and therefore better meets the needs of Texans.

▼ **Recognizing the need for strong statewide plans and goals, other state agencies have developed blueprints for enhancing the delivery of services.**

- The Texas Commission on Alcohol and Drug Abuse (TCADA) has developed an integrated service delivery plan to provide clear direction on how it plans to achieve its goals of substance

abuse and treatment. According to Dr. John Keppler, Service Systems Planner at TCADA, such a plan has, "...served as a rallying point for the agency and has helped to foster new ideas and substantive changes while building on the agency's past achievements."[5]

- The Department of Information Resources develops the State Strategic Plan for Information Resources to provide clear direction on how the State should achieve its goals relating to information management.

TDH needs a coordinated, integrated approach to planning the future of the State's health system.

Conclusion

Despite over 50 mandated individual planning documents, TDH has no coordinated and integrated approach to improve the health of Texas citizens. The lack of cohesive health planning results in program and service overlap, and a system that is difficult to navigate for both service providers and recipients. In addition, TDH does not provide enough up-to-date, usable data that is critical to effective planning efforts by both the Department and local health departments. Further, TDH does not have well-developed mechanisms for regional and community-based interaction, thereby hindering opportunities to develop a more coordinated state health system. Recognizing the need for strong statewide plans and goals, other state agencies have developed blueprints for enhancing the delivery of services. Designing program integration has proven helpful in efficiently carrying out those agencies' programs and could similarly help TDH.

Recommendation

Change in Statute

- **Require the Board of Health to develop and implement a comprehensive blueprint for services to include at least the following elements:**
  - **a statement of the mission, aim, and purpose of the agency's activities and how they relate to one another;**
  - **a proposal of how programs, including data-related services, can be integrated to minimize overlap, increase administrative efficiencies and simplify accessibility;**
  - **a determination of whether each area of data collected by TDH is needed, and if so, whether it is collected, analyzed, and disseminated efficiently;**

- **an assessment of existing TDH services that evaluates the future need for those individual services;**
- **a method for including local and stakeholder input in identifying and assessing the health-related needs of the state and how programs and data services can be better coordinated and integrated;**
- **a comprehensive inventory of health-related information resources meeting criteria developed by the Department regarding usefulness and applicability to local health departments, TDH contractors, and health-related not-for-profit entities, private businesses, and community groups;**
- **an action plan to coordinate with federal, state, local and private programs that provide services similar to those provided by TDH;**
- **a listing of state-mandated planning instruments developed by the Department along with a recommendation to remove the statutory requirements for those that are obsolete or redundant; and**
- **an assessment of the effectiveness of previous blueprints and why certain items within the blueprint have changed or been removed over time**.

■ **Require the blueprint to be submitted to the Governor, Lt. Governor, Speaker of the House, the Senate and House committees charged with overseeing TDH, and the Legislative Budget Board, by September 1, of each even-numbered year.**

■ **Require the blueprint to be posted on the TDH web site and copies made available to those persons or groups that do not have Internet access.**

This recommendation requires TDH to ask and answer questions that go beyond planning for operation of its many individual programs. In developing a "blueprint" for services, TDH must look beyond determining how to provide a service and ask why the service must be provided. TDH must also question what are the particular needs to be addressed and whether the Department is operating the right set of services to meet the needs. Does TDH make the best use of existing state and local infrastructure? Are clients fully aware of the array of services available? Do the delivery systems promote appropriate use of services, not only from the standpoint of efficiency, but also from the standpoint of client health? The answers to these and other similar questions will allow the Department to more broadly examine how services can be most effectively provided to the citizens of Texas.

This recommendation would require TDH to develop methods to integrate and coordinate all applicable agency operations, to best meet the health needs of the citizens of Texas. Such a blueprint would not address the goals, strategies, outcomes, and outputs used to

develop the agency budget in the current strategic planning process; nor would it simply apply to one program as many of TDH's current plans do. Rather, the blueprint would provide detail as to how related TDH services and activities from various programs can be accessed and integrated to provide a higher and more efficient level of service without overlap. The blueprint would also serve as a means to identify opportunities to increase administrative efficiencies agency wide, but especially in the health care delivery area. Issue 2 of this report addresses those opportunities.

Such a blueprint is critical in the changing environment of health and health-related services, given limited federal and state funding and the movement toward a managed care health delivery system. The blueprint would aid efforts such as those of the HCR 44 interim task force, which is examining ways to improve the public health infrastructure in the state. In addition, the blueprint would help coordinate related activities provided by other federal, state, local and private programs.

The blueprint would provide a way for stakeholders in health and health care, particularly local health departments, to have a single point of access to give input as to how TDH should integrate and provide services, including data compilation, analysis, and dissemination. Stakeholder input should not be limited to public hearings, but may also include round table discussions within each public health region that maximizes input from as many sources as possible. These sources may include participating and non-participating local health departments, service providers, interest groups, community-based groups, health care experts, recipients of health care from both the fee-for-service and managed care systems, and members of the general public.

Requiring TDH to prepare an inventory of health-related information according to TDH-developed criteria would help stakeholders obtain information to improve their own functions while facilitating data coordination with TDH and other entities. The criteria developed by the Department should ensure a comprehensive inventory of public, private and governmental sources of information, including TDH, and be available in hard copy and on the agency's Internet web site. The Internet web site should include links to other information sources. The inventory should also be updated on a periodic basis to ensure interested parties are made aware of those resources. Such an inventory would enhance the flow of information between TDH and stakeholders, thereby improving the overall effectiveness of the health infrastructure in the state.

Requiring the Department to identify statutorily-mandated state planning instruments made obsolete or redundant by the blueprint and recommending their elimination will help to ensure TDH does not waste time and resources in its planning process. The blueprint is not designed to be simply another mandated activity, but a comprehensive tool designed to increase the efficiencies of the Department's activities, including planning. Eliminating planning tools made obsolete by the blueprint would simplify the Department's planning efforts.

Additionally, by re-assessing the blueprint every two years, the blueprint would evolve as activities at TDH evolve. Such an assessment would help to illustrate the activities that have been successful and those that have failed to improve program integration and coordination both within TDH, and between TDH, local health departments and other health care providers.

TDH has recently begun to examine better ways to integrate its functions as they relate to some of its activities. Agency staff is currently developing a Public Health Infrastructure Pilot Program which includes identifying means to better integrate the agency's public health functions. However, by statutorily requiring a blueprint that incorporates all its related activities, TDH would continue to explore methods of program integration and coordination even after the conclusion of its pilot program. The blueprint would also cover TDH activities beyond those included in the pilot program.

The first blueprint would be required to be completed and submitted no later than September 1, 2000. Thereafter, the plan would become a biennial document due September 1st of each even-numbered year so that it would coincide with the State's fiscal year and be available for legislative sessions. Submitting the blueprint to the State's leadership, and legislative oversight committees and agencies, would ensure those groups routinely receive information on how TDH plans to integrate its services and carry out its programs. Such information could also be helpful in determining the State's policies regarding the health of the people of Texas.

Fiscal Impact

Developing and carrying out the blueprint would result in substantial administrative savings. Those savings would be based on administrative efficiencies identified through the development of the blueprint and therefore cannot be estimated at this time. The development of a blueprint would require the use of staff from numerous TDH programs including TDH executive administration. However, no additional personnel should be necessary to develop such a document. Program integration may also require changes to information systems as well as personnel retraining. These costs, if necessary, would depend on the findings and actions identified in the blueprint once developed and should be more than offset by the anticipated savings.

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[1] The TDH web site address is: http://www.tdh.state.tx.us

[2] Texas Department of Health Inventory of Health Related Data, 1994, page, ii. Bureau of State Health Data and Policy Analysis, Texas Department of Health, December 1994.

[3] Interview by Sunset staff with Dr. M. des Vignes-Kendrick and staff of the City of Houston Health Department, Houston, Texas, February 6, 1998.

[4] Interview by Sunset staff with Robert Galvan and staff of the City of Ft. Worth Health Department, Ft. Worth, Texas, March 26, 1998.

[5] Telephone interview with Dr. John Keppler, Service Systems Planner at the Texas Commission on Alcohol and Drug Abuse, Austin, Texas, April 23, 1998.

Issue 2

Integrate Health Care Delivery Programs to Achieve Administrative Efficiencies, Reduce the Burden for Providers, and Improve Services to Clients.

Background

The Texas Department of Health ensures the provision of health care services for low-income Texas residents, especially women and children. To achieve this goal, TDH administers 37 direct health care delivery programs. The Department primarily organizes health care delivery programs within two branches of the agency, the Health Care Delivery Associateship and Health Care Financing.

Health Care Financing is composed of 13 Medicaid programs, such as Medicaid, Medicaid Managed Care and Vendor Drug, plus three non-Medicaid programs, the Kidney Health Care program, the Indigent Health Care program, and the Adult Hemophilia Assistance program. To administer the Medicaid programs, TDH contracts with a traditional indemnity insurance company, National Heritage Insurance Company (NHIC); health maintenance organizations (HMOs); quality assurance contractors; and others to provide $5 billion in medical services for Medicaid-eligible clients.

TDH ensures the provision of health care services for low-income Texans.

The Associateship for Health Care Delivery administers 16 non-Medicaid programs, such as the program for Chronically Ill and Disabled Children (CIDC) and the Maternal and Child Health Block Grant (Title V) programs; and four Medicaid programs, such as the Texas Health Steps program and the Medical Transportation program. Six additional health care delivery programs, such as the HIV/STD programs and the immunization program, are located in the Associateship for Disease Control and Prevention. For these 22 health care delivery programs, the agency contracts directly with health care providers, including local health departments, for the provision of about $1 billion in medical services.

The Health Care Delivery Associateship and Health Care Financing both provide services to low-income Texans, but maintain, for the most part, separate administrative functions, including eligibility determination, contract administration, and claims processing. The separate administration of Medicaid and non-Medicaid programs resulted because the Medicaid program was

originally established at the Texas Department of Human Services (DHS), and the acute care portion was transferred to TDH in 1993. The Legislature transferred the Medicaid program with the intention of improving coordination of health services by placing all of the programs that target women's and children's health in the same agency. Although TDH has taken steps to integrate programs between some Medicaid and non-Medicaid programs — such as creating a children's health bureau that includes both Medicaid and non-Medicaid programs — administration remains separate.

Even within the Health Care Delivery Associateship, the agency administers many of the programs separately as a result of the programs' genesis. Historically, the Department has created a new program with new administrative constructs every time the state or federal government established a new health care funding source. Examples of TDH programs that developed as a result of federal funding streams are the Maternal and Child Health Block Grant (Title V) and family planning (Titles X and XX) programs. Examples of state programs include the County Indigent Health Care program and the Community Oriented Primary Care / Primary Health Care program (COPC).

TDH creates a new program with new administrative constructs for each new federal funding source.

Sunset staff examined opportunities for integrating the separate health care delivery programs to see whether administrative efficiencies and seamless service delivery for clients could be achieved.

Findings

▼ **The Department's various health care delivery programs serve similar clients, provide similar services, and use many of the same providers.**

◗ TDH health care delivery programs primarily target low-income women and children who are often eligible for benefits from different programs. Some examples of target populations who are eligible for similar services through different programs are shown in the chart, *Health Care Delivery Program Services Overlap*, and given below.

A pregnant woman whose family income is less than 185 percent of the federal poverty level (FPL) may be eligible for prenatal and delivery care through Medicaid, Title V Women's Health, and Primary Health Care.

Health Care Delivery Program Services Overlap							
Program		**Client Services**					
		Children		**Women**			
		Well Child Check-up	**Medically Needy Children**	**Prenatal Care**	**Family Planning**	**Breast / Cervical Cancer Screening**	**HIV / STD Treatment**
Medicaid Acute Care	Fee for Service		X	X	X	X	X
	Managed Care	X	X	X	X	X	X
Medically Needy Spend Down		X	X	X	X	X	X
Emergency Medicaid			X	X		X	X
Texas Health Steps (EPSDT)		X	X				
Medically Dependent Children's Program (MDCP)		X					
Maternal and Child Health Care Block Grant (Title V)	Children's Health	X	X				
	School Health	X	X				
	CIDC		X				
	Women's Health			X	X	X	X
	Family Planning				X	X	X
Family Planning	Title X				X	X	X
	Title XIX				X	X	X
	Title XX				X	X	X
Breast and Cervical Cancer Control Program	Breast Cancer Control					X	
	Cervical Cancer Control					X	X
WIC		X		X			
HIV Medication Program			X				X
Other HIV Services			X				X
Primary Health Care Program COPC		X			X	X	X
County Indigent Health Care		X	X	X	X	X	X

TDH operates duplicative administrative structures for many health care delivery programs.

The same woman's six-year old child may be eligible for health benefits through Medicaid Texas Health Steps; Title V Children's Health and School Health; Special Supplemental Nutrition for Women, Infants, and Children (WIC); and COPC.

A child with complex medical problems may be eligible for Medicaid, including Texas Health Steps, Comprehensive Care Program, Medically Dependent Children's Program; Title V Children's Health, case management, Chronically Ill and Disabled Children (CIDC), school health; and COPC.

- Other examples of programs that provide similar services include the COPC and the County Indigent Health Care Program. Both programs receive state funds to provide primary health care to indigent clients who are not served by other health care delivery programs, such as Medicaid or Title V.

- To provide these similar services, the agency contracts with providers who have multiple contracts with the Department to deliver health care services. For example, providers of maternal and child health services have contracts to provide services reimbursed through Medicaid, family planning, and Title V, while four of 12 providers of STD prevention services also have contracts to provide family planning services.

▼ **Although the services and clients are similar, separate administration results in inefficiencies and duplication.**

Although services and providers are often similar, TDH procures services separately by program.

- TDH operates separate, duplicative, administrative structures for many of its health care delivery programs. For example, a pregnant woman might go to one provider for prenatal care, a different provider for WIC services, and, after delivery, to a third provider for primary care including family planning services. TDH contracts would likely reimburse all three types of providers for the cost of salaries and benefits, as well as facilities and overhead costs. Most TDH programs also have separate contract procurement, contract monitoring, and claims reimbursement.

- Even though many services and providers are similar among TDH programs, TDH procures services separately by program. Each program uses different contract terms; thus, TDH staff duplicates efforts by continually reviewing multiple applications from the same provider. For Medicaid services, NHIC and HMOs contract with some of the same providers,

duplicating efforts of staff that contract directly with providers for non-Medicaid programs.

- The Department also duplicates efforts by monitoring many of the programs independently. For example, separate performance and financial audit teams evaluate Medicaid, Chronically Ill and Disabled Children, and HIV/STD service providers. TDH uses significant resources to audit a clinic twice, or more, for every service contract.

  For contractor performance monitoring, the Medicaid managed care program has contracted with the Texas Health Quality Alliance to evaluate services provided by HMOs, while the Health Care Delivery Associateship uses its Quality Assurance Division to monitor its programs. The TDH Internal Audit Division performs financial audits of NHIC, while financial audits of HMOs will be conducted by Coopers and Lybrand, through a newly procured contract. The Department's Grants Management Division monitors some Health Care Delivery Associateship program providers financially, while some financial monitoring is done by program staff. Again, providers may operate, and be reviewed, under multiple programs.

TDH has 15 claims processing systems for its 37 health care delivery programs.

- The claims processing function for TDH contractors is equally fragmented. TDH has established 15 systems to process provider claims for its 37 health care delivery programs. TDH has a contract with NHIC to process claims for Medicaid, Medicaid family planning, and some CIDC claims. Other programs at TDH that require claims processing are generally done within the division that administers the program. Programs process claims in a variety of ways, making integration of the systems difficult. For example, CIDC providers submit paper claims, causing the cost for processing claims for that program to be more than five times the cost of processing Medicaid claims, most of which are submitted electronically.

- TDH recently entered into a $68 million contract with NHIC to develop a new claims processing system that will, in addition to incorporating year 2000 modifications, verify client eligibility, process claims, and make payments to providers for various TDH programs. The agency is not currently planning to expand use of this new system to include claims processing for other TDH programs.

TDH is paying NHIC $68 million to develop a new claims processing system, but is not planning to expand its use to other programs.

▼ **Administering programs separately creates inefficiencies at the provider level, costing health care providers time and money that could be spent delivering more services to clients.**

- The health care service providers who contract with TDH to deliver services for multiple programs must use different eligibility systems, complete separate applications and negotiations for multiple contracts, undergo multiple performance and financial compliance audits, and submit different types of claims.

- Providers must determine eligibility for non-Medicaid programs using separate forms and separate computer programs even though the actual information provided regarding income and assets is similar. Although TDH and DHS developed Texas Eligibility Screening System (TESS), a system that would screen for potential eligibility in an attempt to streamline the process, TDH only requires a few programs to use the tool. Also, TESS is not compatible with many provider eligibility systems, such as those used by local health departments.

Health care providers with multiple contracts endure separate application, eligibility, audit, and claims processing requirements.

- Providers spend significant time preparing separate proposals in response to requests for proposals (RFPs) that are released by individual programs, even though some of the proposal information requested is similar. Contract terms range from one year to three years, so the process of submitting proposals is virtually continuous for some providers. The process becomes even more complicated if the provider applies to deliver services for clients through Medicaid managed care as well as non-Medicaid programs.

- Because TDH monitors many contracts independently, providers must spend time preparing separate reports for each program and preparing for multiple separate on-site reviews. Although the Health Care Delivery Associateship performs one performance audit for 11 programs, a provider receives separate visits from the HIV/STD, Breast and Cervical Cancer Control, and the Medicaid staff, in addition to separate financial audits. On average, health care providers with multiple contracts to provide Medicaid and non-Medicaid services receive some form of contract audit every couple of months.[1]

- Providers also spend significant time preparing multiple types of claims for Medicaid programs, Maternal and Child Health programs, and family planning programs, each with different reimbursement structures and computer systems. To submit a claim for providing Medicaid family planning services, the provider can use the TexMedNet electronic processing system. However, for similar non-Medicaid family planning services, the provider would need to submit paper claims and receive separate payments.

▼ Clients have difficulty maneuvering from program to program because TDH has no system to manage or coordinate their care.

- Clients have difficulty navigating the health care delivery system because clients access health care delivery services through multiple points of entry and may be unaware of other services for which they are eligible. TDH does not have a standardized eligibility determination system. For example, a low-income pregnant woman who is eligible to receive Title V prenatal care must rely on the clinic worker to tell her that she may also be eligible for WIC services. Programs such as WIC improve the health of mothers and their children by providing nutritional counseling and nutritious food, thus decreasing the overall cost of medical care.

  Clients must often rely on clinic staff to make them aware of other programs for which they may be eligible.

  Creating an effective link between programs would ensure that clients receive the appropriate services, including WIC services. At least partly due to the fragmented program structure, the WIC program is underused, serving only 65 percent of the eligible population in 1996.[2]

  For example, immunizations and WIC are two programs targeting the same population that have been effectively linked. WIC clinics offer education to mothers and vaccinations to children during nutritional visits. In an effort that is unique to Texas, WIC and Immunization staff have received federal approval to use WIC-funded clinic staff to deliver the immunizations, while the federally funded Immunization program pays for the vaccination.

▼ Integration of health care delivery programs would maximize state resources and improve service delivery.

- TDH could save administrative costs by decreasing duplication of functions and streamlining systems. For example, Medicaid program staff could conduct contract monitoring visits for the Texas Health Steps Medicaid children's program currently monitored by Health Care Delivery Associateship staff, maximizing the state's Medicaid contracts and saving a visit by TDH staff. TDH could also save administrative dollars by sending out a single request for proposal and aligning contract terms for similar health care delivery programs, such as women's health care programs (Title V) and family planning programs (Titles X and XX).

Integration of administrative functions would decrease paperwork so health care providers have more time and resources for clients.

Claims processing and provider reimbursement is another area of contract administration that also contains numerous duplicative functions across programs. Significant opportunities exist to reduce administration expenses by consolidating reimbursement methodologies for similar services. For example, TDH could examine the potential for efficient claims processing through the new claims processing system being developed by NHIC.

- In addition, integration of TDH health care delivery programs would improve contract administration. TDH does not use a standardized process for contract procurement and monitoring across the Medicaid and non-Medicaid health care delivery programs. Integration of health care delivery programs would promote uniformity of the contract administration process, resulting in consistent examination of best value services and performance measures, as well as monitoring.

- Integration of administrative functions across health care delivery programs would decrease paperwork so health care providers have more time and resources to spend on clients. Using a single RFP for multiple programs, streamlining monitoring efforts, and combining claims reimbursement systems would significantly reduce providers' administrative burden. As a result, provider participation could increase across all programs.

- Clients stand to benefit from health care delivery policy and procedure integration through increased opportunities for continuity of care and case management. Most importantly, clients would benefit from proper referrals and elimination of duplicative services, such as Texas Health Steps screens and WIC screens, that both require an evaluation of a child's growth and nutritional status.

- Ultimately, TDH may choose to integrate services in a managed care model. A managed care model offers the most integration of administrative functions and services. A managed care system would create a single system for providers, eliminating multiple contracts and reimbursement methodologies. In addition, clients, whose eligibility often changes between Medicaid and non-Medicaid programs, would be able to remain in the same service delivery system, benefitting from enhanced case management between programs.

▼ **TDH has preliminary plans for limited integration of health care delivery programs.**

- TDH recommended, in its self evaluation report to the Sunset Commission, that the Department be "authorized to explore using a managed care model to provide health services through a single delivery system combining Medicaid and direct services programs which serve similar populations."[3]

TDH should extend its integration plans to cover all programs where possible.

- Agency staff in non-Medicaid programs have begun integrating the contracting process in the Health Care Delivery Associateship. For example, the agency now combines applications for renewal for the Maternal and Child Health programs with the family planning programs. Although the agency has future integration plans, these plans are limited to a few programs and do not contemplate extensive program integration.

- Medicaid program staff is also working to better coordinate health care delivery programs. Starting with the Dallas/El Paso service area in 1999, the managed care contracts will require managed care organizations to subcontract with local health departments, including city and county health departments, and TDH regional offices, for the provision of personal health care services such as family planning, sexually transmitted disease services, HIV testing, immunizations, and tuberculosis treatment. Such subcontracts will provide continuity of care to Medicaid clients who receive services through local departments. If clients become ineligible to receive Medicaid benefits, they could qualify for family planning services through other federal funding, and would be able to receive services from the same providers.

Conclusion

The Texas Department of Health is responsible for delivering health care services to low-income Texans, primarily pregnant women and children. These services are not well coordinated, causing administrative duplication across programs. TDH often sends separate staff to monitor and audit contracts with a provider who participates in more than one program. Claims for similar services are handled differently depending on which TDH program pays for the service. Providers must apply separately to several programs to perform similar services. In addition, clients are not always made aware of needed and available services. As a result, TDH clients have little management of their care and sometimes miss out on services that would improve health outcomes, thus increasing health care costs to the State.

Recommendation

Change in Statute

- **Require TDH to integrate health care delivery programs, including Medicaid and non-Medicaid programs, to the maximum extent possible. At a minimum, health care delivery integration should include:**
  - **policy development and implementation; and**
  - **contract administration — procurement, monitoring, and reimbursement.**

- **Require TDH, within federal restrictions to implement a pilot project that integrates all appropriate health care delivery programs, both Medicaid and non-Medicaid, in a managed care model.**

- **To determine the best methods for integration, and minimize transitional impact, TDH should examine and report to the Legislature on the benefits of an integrated health care delivery system with regard to:**
  - **client benefits,**
  - **provider service improvements,**
  - **administrative savings, and**
  - **statutory changes that would remove impediments to an integrated delivery system.**

- **TDH should submit the report required above as a part of the blueprint recommended in Issue 1 of this report. The report should also include recommendations on statutory improvements that would remove impediments to an integrated health care delivery system.**

Management Action

- **The report on service delivery integration should focus on administrative efficiencies and savings that could be achieved through:**
  - **implementation of a uniform contracting process that incorporates the principles and process identified by the TDH Contract Leverage Team in its July 1996 *Contracting Guide for Client Services*,**
  - **combining the RFP processes to ensure that providers are able to complete one contract for multiple services at the same time,**
  - **coordinating contract performance monitoring, and**
  - **combining claims processing and contractor reimbursement processes.**

The purpose of these recommendations is to save time and money for both the State and those who provide health care to Texas citizens. At the same time, these changes will improve the availability of services and decrease confusion for clients attempting to navigate through a sea of TDH programs and providers.

Sunset staff recognizes that integration of services will be an extremely difficult task for the agency. If the task was easy, TDH would have long since implemented some level of integration. However, this recommendation, in conjunction with an operational blueprint for the agency's broad array of services (see Issue 1), would begin moving the State's large health care bureaucracy toward a more cost-effective system — a system that provides the best health care value for the State and its citizens.

Before integration is implemented, TDH should examine the benefits of integrating health care delivery programs with regard to administrative savings, provider service improvements, and client benefits. Obstacles, such as federal restrictions on funding expenditures, federal reporting requirements, and necessary management data requirements, should also be considered from the perspective of how to minimize barriers to integration. While initial administrative costs may be expected from the effort to integrate systems, greater savings would be achieved over the long run. TDH should examine and compare both costs and savings. Integration of programs should focus on increasing administrative efficiencies and reducing duplication across programs, decreasing administrative requirements for providers, and improving access to health care while maximizing continuity of care and moving toward a medical home for all clients.

The examination of administrative savings should focus on implementing a uniform contracting process. TDH should require agency-wide use of uniform contracting processes developed in response to legislative directives to improve contract administration. RFPs should be combined to decrease the administrative staff requirements for the development of RFPs and contracts, and review of responses. Contract terms should be uniform so providers with multiple contracts do not have to complete the contracting process numerous times each year. Contract performance monitoring should also be uniform for similar services, with core standards and uniform timing, especially for providers with numerous contracts.

Another major area of administrative savings that requires evaluation is claims processing. TDH should combine claims processing and provider reimbursement across programs, and maximize electronic technology for processing of claims and provider reimbursement. TDH has invested significant resources in a new claims processing system that is being designed by NHIC to process claims for multiple programs. TDH should maximize its investment in this system by using it across the agency as appropriate.

Provider benefits should focus on minimizing administrative or paperwork requirements through combining contracting requirements and reimbursement methodologies. Client benefits should focus on maximizing access to appropriate programs when eligible, and providing a case management environment when possible. TDH should examine the benefit of using a managed care model to afford the most integration, creating a single system for providers and clients, and TDH program administration.

The results of TDH's examination of developing an integrated health care delivery system should be reported as a section of the comprehensive blueprint recommended in Issue 1 of this report. This recommendation does not require a separate document.

Fiscal Impact

The evaluation of integrated health care delivery would require use of staff from various TDH programs, with coordination from TDH executive administration. No additional staff should be necessary for this effort.

Actual integration of programs would likely require changes to information systems and forms, as well as retraining of personnel. These costs are dependent on the results of the TDH examination of health care delivery integration and cannot be estimated at this time.

The potential for significant administrative savings through program integration is substantial. TDH currently expends $21.5 million for administration of non-Medicaid health care delivery services. Since most of the TDH health care delivery services are purchased, coordination of provider selection, monitoring, auditing, payment, and claims reimbursement for Medicaid and non-Medicaid programs will greatly reduce operating

costs. Sunset staff conservatively anticipates at least a 10 percent savings of non-Medicaid administrative costs if integrated with Medicaid administration and would result in expected savings of about $1.1 million per year in state funds, and an equal amount in federal funds.

[1] Interview by Sunset staff with Health Care Delivery staff, City of Houston, Health and Human Services Department, Houston, Texas, February 6, 1998.

[2] Legislative Budget Board, State of Texas, *Staff Performance Report to the 75th Legislature*, Fiscal Year 1997, p. 66.

[3] Texas Department of Health, *Self-Evaluation Report to the Sunset Advisory Commission*, September 1997, Sec. II, p. 6.

Issue 3

Strengthen Enforcement Activities through Re-Engineering and Improved Sanctions.

Background

To protect the health, safety and welfare of the public, the State regulates the activities of many professions, facilities and industries that pose a potential threat to the public. Such regulation is designed to guarantee that minimum standards are instituted and met by all entities subject to that regulation. TDH administers 55 regulatory programs overseeing health professionals, health care facilities, and industries affecting public health, such as food manufacturers. During fiscal year 1997, the Department regulated more than 118,000 professionals in 15 regulatory programs, and over 129,000 facilities through 40 regulatory programs, many of which are shown in the charts entitled *Selected Facilities* and *Selected Professionals.*

In general, TDH administers examinations to health professionals, inspects facilities, and assesses services before licensure occurs. Examinations are intended to demonstrate a mastery of the field to a level adequate to protect public health, while inspections or assessments are intended to determine if a facility's operating practices adequately protect public health.

After a facility, service or professional is licensed, TDH ensures public safety through continuing education, performing inspections, and investigating complaints. TDH received 6,608 complaints in fiscal year 1997 regarding the professionals, facilities and industries it regulates. TDH investigates these complaints, and if a person, service or facility is found to have violated statute or rules, the license or certification can be revoked, suspended, or probated, or an administrative penalty can be levied. Detailed information on the types of enforcement actions taken in fiscal year 1997 for each regulatory program can be found in Appendix B, *Background Information on TDH Regulation — Fiscal Year 1997.*

Selected Facilities

- Abortion Facility Licensing
- Ambulatory Surgical Center Licensing
- Birthing Center Licensing
- EMS Providers Licensing
- End Stage Renal Disease Facility Licensing
- General and Special Hospitals Licensing
- Home and Community Support Services Agency Licensing
- Private Psychiatric Hospitals Licensing/Crisis Stabilization Units Licensing
- Special Care Facility Licensing
- Trauma Center Designation
- Bedding Product Manufacturer Registration
- Drug Manufacturer/Distributor Licensing
- Food Manufacturer Licensing
- Food Salvage Licensing
- Food Wholesale Distributor Licensing
- Frozen Dessert Manufacturer Licensing
- General License Acknowledgment (Radioactive Materials)
- Hazardous Product Manufacturer Registration
- Mammography Facility Certification
- Meat/Poultry Inspections
- Medical Device Distributor Licensing
- Medical Device Manufacturer Licensing
- Medical Device Salvage Licensing
- Migrant Housing Licensing
- Milk Producer Permitting
- Milk Processor Permitting
- Narcotic Treatment Facility Licensing
- Radioactive Materials Licensing
- Radiation Producing Machine Registration
- Registration of Public Employers under Texas Hazard Communication Act

Selected Professionals

- Athletic Trainer Licensing*
- Contact Lens Dispenser Registry
- EMS Personnel Certification
- Health-Related Services Registry
- Massage Therapy Registration
- Medical Physicist Licensure*
- Medical Radiologic Technologists Certification
- Optician Registration
- Respiratory Care Practitioners Certification
- Asbestos Abatement Personnel
- Code Enforcement Officer Registration
- Food Service Worker Certification
- Food Service Worker Training Programs Accreditation
- Government Employee Pesticide Applicator Licensing
- Industrial Radiographer Certification
- Lead Abatement Personnel Certification
- Sanitarian Registration

* Administratively-attached independent board using TDH staff.

During the TDH Sunset review, staff examined the Department's regulatory programs to determine whether sufficient enforcement was occurring to achieve and maintain public safety. Staff also evaluated the programs to determine whether adequate and effective structures and policies were in place to ensure public access and oversight of the regulatory process. Finally, staff also surveyed the Department's regulatory programs to verify that each had a full range of enforcement tools to effectively regulate each given area.

The review identified problems in each of these areas that appear to reduce the effectiveness of the agency's regulatory activities. These problems are discussed in the findings below.

Findings

Enforcement

▼ **Review of TDH regulatory programs raised significant concerns regarding the effectiveness of the agency's regulatory functions.**

◗ Sunset staff conducted random examinations of the enforcement policies, results, and documentation of many TDH regulatory programs. The concerns identified in that review are listed below.

A review of TDH enforcement programs raised numerous concerns.

The Meat Safety Assurance Division cited a slaughterhouse in east Texas for 26 critical deficiencies in the last quarter of 1997 and 19 critical deficiencies in the first quarter of 1998. Although tainted meat products were never distributed, the plant operated for several months with critical problems before TDH issued a notice of intent to withdraw inspection.

Of the 509 inspections and 170 notices of violations issued to youth camps, none led to formal enforcement actions in fiscal year 1997.

Files relating to regulation of medical device salvage firms showed instances where an initial follow-up to a complaint was not conducted, similar violations resulted in different and contradictory enforcement actions, and in one case, TDH staff was unable to locate an entire enforcement file.

Despite statutory authority to adopt rules relating to re-sterilization and repackaging of single-use medical devices, TDH has not taken steps to regulate this potentially hazardous industry.

The Hazard Communication Branch does not practice risk-based inspections despite regulating more than 50,000 locations that store or use hazardous chemicals. The Hazard Communication Branch ensures communities, local fire departments, and workers are made aware of potentially dangerous chemicals in the work place.

Concerns noted warrant an in-depth examination of TDH's regulatory approach.

The Office of General Counsel (OGC) does not routinely track the length of time enforcement actions take from the time OGC receives a case from a regulatory program until final action is taken. Such information is vital to ensure quick and speedy resolution of enforcement proceedings.

- Despite examining a wide variety of regulatory programs, Sunset staff was not able to perform an in-depth analysis of all 55 regulatory functions at TDH. However, the findings above raise broad concerns about the overall effectiveness of the Department's regulatory activities. Such concerns warrant a more detailed examination of TDH's regulatory programs.

Public Access and Oversight

▼ **Information relating to the disciplinary history of professionals and facilities regulated by TDH is not readily available to consumers.**

- Each TDH regulatory program maintains information on the disciplinary history of the individuals and facilities it regulates. However, unlike a number of other regulatory agencies, a person can generally only obtain the disciplinary history of a health professional, industry or facility regulated by TDH through an Open Records request. Only a few TDH regulatory programs maintain information regarding trends in violations committed by health professionals, industries and health care facilities.

Access to complaint and enforcement information is critical for consumers.

- Consumer access to regulatory information allows the public to make informed decisions. In the area of health, access to complaint and enforcement information on professionals and facilities is critical for people to obtain quality health services. Regulatory programs maintain a great deal of information about individuals and facilities, including disciplinary action. Unlike many state regulatory programs, TDH does not routinely make

disciplinary information readily available to the public once final enforcement action has been taken.

Making such information available to the public is an important part of the disciplinary process so that the public, and those subject to regulation, can stay informed of potential hazards within a profession or facility, as well as the performance of individual professionals and facilities.

▼ **Other state agencies use toll-free telephone numbers and Internet web sites to allow access to disciplinary information on regulated entities.**

Only one of 55 TDH regulatory programs has a toll-free number for consumer information.

- The Texas Board of Medical Examiners uses a toll-free telephone line and an Internet web site to make disciplinary information on medical doctors in the state publicly available. The Board of Chiropractic Examiners uses a toll-free telephone number and is developing a web site that will contain this information. The Board of Nurse Examiners, the Physical Therapists Board and the Occupational Therapists Board all use a web site to publish enforcement information.

- Of 55 TDH regulatory programs, the only program that uses a toll-free telephone number to provide disciplinary information is the abortion facilities regulation program.[1] Similar information is not easily available for programs such as general hospital licensing, massage therapist registration, and slaughterhouse regulation.

▼ **The complaint filing system used by the Professional Licensing and Certification Division (PLCD) does not allow for easy public submissions of complaints.**

- PLCD is responsible for regulating health-related occupations such as massage therapists and respiratory care practitioners. Currently, PLCD issues a uniform complaint package to anyone who files a complaint by letter or telephone. Included in that packet is a complaint form that asks for information on the complainant, the alleged violator, and the details of the complaint. In addition, PLCD sends a copy of the statute and rules governing the profession to the complainant. The form requests the complainant to cite the rule or statute violated by the alleged violator and to summarize how the alleged action constitutes a violation of the program's rules or law.

Although TDH has a policy to accept and act on complaint packets returned without a citation of a possible rules violation, the complaint form does not specify that identifying the actual citation of a possible violation is optional.

A fairly complex complaint packet may keep people from filing complaints.

Many people are unfamiliar with the use of state statutes or administrative rules. As a result, navigating through a health profession's statute or rules to find a specific violation can make it very difficult to file a complaint.

- Some of the TDH health care regulatory programs received relatively few complaints from the public in fiscal year 1997, suggesting that the complaint process may be too burdensome or difficult.

  For example, in fiscal year 1997, the Massage Therapist Registration Program only received 91 complaints on over 12,500 registered massage therapists (.7 percent). The Medical Radiologic Technologist Certification Program only received 33 complaints out of a regulated population of over 15,300 (.2 percent) in fiscal year 1997. Other regulated professions of similar size such as physical therapists and veterinarians had complaints on 1.9 percent and 3.3 percent of the population respectively. One cause of the small number of complaints may be the result of a uniform complaint packet that is too complex or intimidating for some people.

Sanction Tools

▼ **Some TDH regulatory programs do not have authority to impose a full range of sanctions against persons or facilities that violate state law or related rules.**

- TDH has three programs that need statutory authority to issue a letter of reprimand and seven that need statutory authority to levy administrative penalties. Without such tools, these programs must rely on other more formal enforcement tools to enforce program rules, even though violations could be minor and not worthy of license revocation or suspension. The chart, *TDH Regulatory Programs Needing Additional Enforcement Tools*, shows which programs need these tools. By establishing the authority to issue letters of reprimand and administrative penalties within these programs, TDH could better tailor sanctions to rule violations.

TDH enforcement authority is unnecessarily limited in several regulatory programs.

TDH Regulatory Programs Needing Additional Enforcement Tools		
TDH Regulatory Program	**No Reprimand Authority**	**No Administrative Penalty Authority**
Ambulatory Surgical Facility Licensing		X
Athletic Trainer Licensing*	X	X
Birthing Center Licensing		X
EMS Providers Licensing	X	
Medical Physicists Licensing*	X	X
Hazardous Product Manufacturers Registration		X
Retailers of Abusable Glues and Paints		X
Special Care Facility Licensing (inpatient facilities for the terminally ill)		X

* Independent board staffed by TDH, and rules approved by the Board of Health.

▼ **Letters of reprimand and administrative penalty authority are commonly-used tools to enforce regulatory rules.**

- Of the 55 health-related regulatory programs at TDH, 25 have general enforcement authority used to issue letters of reprimand. Numerous other state agencies that regulate health professionals have this authority, including professional counselors, speech-language pathologists and audiologists.
- Of the 55 programs, 40 have the statutory authority to assess administrative penalties. Many other state agencies that regulate health professionals have administrative penalty authority programs including those that regulate chiropractors, nurses, optometrists, and psychologists.

Despite high numbers of complaints, few violations lead to enforcement actions.

Conclusion

The Sunset staff overview of the 55 TDH regulatory programs revealed indicators of possible ineffective performance. Programs that inspect large numbers of facilities show unexpectedly few violations and enforcement actions. Other programs receive high numbers of complaints, yet few violations lead to enforcement actions. The problems leading to this lack of

results are not clear, and bear more in-depth examination. In addition, TDH does not have all the statutory enforcement tools necessary to fully regulate several of the programs assigned to the Department.

While regulatory action is vitally important, public awareness is also an essential component of regulatory programs. However, TDH has not made broad efforts to provide regulatory information to the public. Consumers interested in the performance of health care providers or a regulated facility, in most cases, must make open records requests for information. Many other state regulatory agencies have found a better way to make information accessible.

Recommendation

Change in Statute

- **TDH, with the assistance of the State Auditor's Office, should conduct a comprehensive evaluation of the Department's regulatory functions. The evaluation should include an examination of the effectiveness of:**
  - **rules to support regulatory practices;**
  - **inspection efforts, including scheduling of inspections;**
  - **investigative practices, including those relating to complaints;**
  - **use of sanctions;**
  - **timeliness of enforcement actions; and**
  - **compliance efforts.**

This recommendation to closely examine the effectiveness of TDH's regulatory programs is a key part of the Sunset staff's recommended approach to strengthening TDH regulatory process. Data regarding some TDH regulatory programs indicates a lack of effectiveness, resulting in a lower level of public protection than envisioned by the Legislature. This recommendation would require TDH to examine all its regulatory policies and practices to identify problem areas and recommend solutions to the TDH Board and the Legislature, if necessary. The examination should also include evaluating the Office of General Counsel's enforcement role, particularly regarding the length of time between receipt of a case and final action. Having the assistance of the State Auditor's Office in developing the examination would provide external input from a qualified external source and would help ensure TDH takes appropriate corrective action. TDH would be required to report to the Legislature on the results of its evaluation, including any recommendations for needed statutory change.

- **Provide TDH with the authority to levy administrative penalties for programs regulating:**

- **ambulatory surgical centers,**
- **birthing centers,**
- **hazardous product manufacturers,**
- **retailers of abusable glues and paints, and**
- **special care facilities.**

■ **Provide TDH with the authority to issue letters of reprimand for the program regulating EMS providers.**

■ **Provide the Advisory Board of Athletic Trainers and the Board of Licensure for Professional Medical Physicists with letter of reprimand and administrative penalty authority.**

■ **Require the Department to use electronic media, toll-free telephone numbers and other appropriate methods to:**

- **increase access to information regarding final enforcement actions against professionals or facilities regulated by TDH, and**
- **disseminate trend information regarding enforcement action taken by TDH regulatory programs.**

Several of the TDH regulatory programs do not have a sufficient array of enforcement tools available to ensure use of the most appropriate sanction for each situation. The recommendation would provide authority to TDH to impose administrative penalties in seven areas of regulation where such authority is not provided. Administrative penalties are often used by regulatory agencies to take enforcement action short of removing a person or facility's ability to do business. In this way, TDH will have the flexibility to apply sanctions appropriate to the seriousness of the violation. The letter of reprimand authority for the regulation of EMS providers gives TDH similar enforcement flexibility.

TDH presently provides limited access to information on the professions and facilities it regulates. This recommendation would enhance public access to that information by requiring TDH to post on the Internet histories of finalized enforcement actions regarding each health professional and health care facility the Department regulates. The recommendation would also require TDH to make the same information available via toll-free telephone numbers for people not able to access the Internet. As a result of posting such information, the public would be better aware of the behavior of those professionals and facilities from which they seek services and could therefore make a more informed decision as to how to obtain services with minimal risk. To enhance these new communications efforts, the information must be meaningful to the general public, not make use of technical jargon or terminology, keep confidential information regarding complainant identification, and be updated periodically.

Management Action

- **TDH should ensure that complaint forms clearly state that citation of statute or rules, when filing a complaint, is optional.**

The management recommendation to ensure complainants are not required to cite statute or rules when describing an alleged violation would make it easier to file a complaint. Descriptions of alleged activities usually provide enough information to investigators to determine the appropriate rule or statute in question. The department should also examine the complaint filing process to remove any other barriers to easy public access and use of the process.

Fiscal Impact

TDH would not need additional staff as a result of these recommendations. The evaluation of TDH regulatory activities would be performed with existing staff. However, start-up costs, including staff time and training, would be needed to develop and maintain a new portion of the TDH web site relating to regulatory enforcement actions. Costs would also be associated with establishing several toll-free telephone lines. Based on the costs of the toll-free line for enforcement information on abortion facilities, that cost would be approximately $7,500 per year for each line. No more than ten additional lines would be needed for a maximum cost of $75,000 per year.

Revenue would be generated to the State by the recommendation authorizing TDH to collect administrative penalties for regulation of the programs listed above. However, the amount of revenue generated would vary depending on the number and amount of administrative penalties levied by TDH and therefore cannot be estimated for this report.

Year	Cost to General Revenue
2000	$75,000
2001	$75,000
2002	$75,000
2003	$75,000
2004	$75,000

[1] HB 2856, 75th Legislative Session, among other things, requires TDH to establish a toll-free telephone line for consumers to obtain information on an abortion facility. This information is available for each abortion facility in the state by calling TDH at 1(888) 973-0022.

Issue 4

Improve the Department's Methods for Soliciting Public Input in the Development of Rules.

Background

The Administrative Procedure Act (APA) requires that every state agency adopt rules outlining formal and informal agency procedures.[1] Because clients receiving services and those who contract with an agency will ultimately be affected by the rules, and often have the most program expertise, the APA sets forth minimum standards to ensure their participation in the rulemaking process. For example, any interested person can petition a state agency to request the adoption of a rule. Within 60 days, the state agency must start the rulemaking process or give its reasons for denying the request. In addition, the APA authorizes use of informal conferences, negotiated rulemaking, and advisory committees to obtain advice and opinions regarding contemplated rulemaking.

The Administrative Procedure Act sets forth minimum standards to ensure stakeholder participation in the rulemaking process.

Once an agency has formulated a proposed rule, the APA requires the agency to solicit public participation in a number of ways. The APA provides that an agency must publish a proposed rule at least 30 days before it adopts the rule, giving anyone interested a reasonable opportunity to submit data, views, or argument, orally or in writing. In addition, an agency must hold a hearing on a proposed rule if requested by a government entity or at least 25 people. A person can even request advance notice of rulemaking proceedings to receive notice through the mail of a proposed rule of particular interest to that person. All state agencies must consider fully all written and oral comments about a proposed rule.

Sunset staff examined the challenges faced by TDH in trying to solicit public input given the agency's large number of service and regulatory programs. As part of the review, staff evaluated whether the minimum standards in the APA are sufficient given the Department's complexity.

Findings

▼ **TDH has enormous rulemaking responsibilities that affect a diverse group of stakeholders. As a result, soliciting appropriate rulemaking input is difficult.**

TDH Advisory Committees

- Advisory Council of the Optician's Registry
- Animal Friendly Advisory Committee
- Asbestos Advisory Committee
- Children with Special Health Care Needs Advisory Committee
- Community Oriented Primary Care Advisory Committee
- Device Distributors and Manufacturers Advisory Committee
- Emergency Health Care Advisory Committee
- Family Planning Advisory Council
- Hazard Communications Act Advisory Committee
- Home and Community Support Services Advisory Committee
- Hospital Data Advisory Committee
- Indigent Health Care Advisory Committee
- Kidney Health Care Advisory Committee
- Medical Radiological Technologist Advisory Committee
- Oral Health Services Advisory Committee
- Osteoporosis Advisory Committee
- Poison Control Coordinating Committee
- Prostate Cancer Advisory Committee
- Respiratory Care Practitioners Advisory Committee
- Sanitation/Code Enforcement Officers Advisory Committee
- Scientific Advisory Committee on Birth Defects
- TDH/Board of Nurse Examiners MOU Advisory Committee
- Texas HIV Medication Program Advisory Committee
- Wholesale Drug Distributors Advisory Committee

- In just three months, from January through March of 1998, the Board of Health has considered proposed rules and adopted rules for 44 widely varying programs, including rules on the safety of fish and crab meat, Medicaid disproportionate share hospitals, the County Indigent Health Program, medical radiologic technologists, emergency medical services personnel, HIV medication, and uranium recovery facilities. The Board considered proposed rules for 56 programs in 1997 and 57 programs in 1996.

- To develop rules on these widely diverse programs, TDH staff uses a number of different methods. The Department primarily relies on over 25 advisory committees, as shown in the chart, *TDH Advisory Committees,* to develop rules relating to specific programs. For those programs without an advisory committee, or in addition to the committee, TDH staff often informally contacts interest groups and interested persons that have worked with the agency over the years. The extent to which TDH works with outside sources depends on the TDH staff in that program, and the perceived complexity of the rules. In some cases, TDH holds a public hearing on proposed rules. In addition, to make the agency's rulemaking intent public, all regulatory rules are brought before the Board of Health's Regulatory Committee in a public meeting before being proposed.

- Each of the Department's programs has stakeholders and interest groups potentially affected by rules. With diverse interest groups to keep up with, developing a system to maximize input from interest groups has been challenging. In its self-evaluation report to the Sunset Commission, TDH listed over 400 interest groups and interested persons ranging from broad-based groups like the Texas Medical Association and the 66 participating local health departments in the state, to single-issue organizations like Bat Conservation International and the Bicycle Helmet Safety Institute. Although compiled, TDH does not have a formal way to use the lists of stakeholders to solicit input.

▼ **TDH has not maximized input from stakeholders and other experts during the development and evaluation of rules.**

- TDH does not always involve the critical stakeholders in the development of the rules, before rules are formally proposed in the Texas Register, thus potentially jeopardizing their

effectiveness. For example, the Department did not involve pediatricians or the Interagency Council for Genetic Services during the development of a change to newborn screening rules adopted in February 1998. These groups expressed frustration when they learned the rules had already been developed without their input.

The Interagency Council for Genetic Services expressed disappointment because the Council is charged with advising the Board of Health on genetic matters, and the rules pertain to the screening of five genetic conditions, including phenylketonuria (PKU) and sickle cell disease.[2] Certain pediatricians expressed concern because the rules in question affect payment for testing kits used to take blood samples for the newborn screenings.[3]

A number of stakeholders expressed frustration with the Department's rulemaking process.

- Similarly, the Texas Fire Chiefs Association stated that "in the past we have had very little input in the development of rules that directly affect the fire service and the manner in which we provide emergency services."[4] Specifically, the Association cited Project Alpha, a project to develop changes to the structure of emergency medical services regulation, as an example of rules that the Department developed without the benefit of the Association's input.

- All the local health departments (LHDs) visited during our field research in Fort Worth, Galveston, Houston, and Laredo, expressed concern about their lack of involvement in the development of rules that impact their programs and operations. In fact, the Harris County Health Department stated that "[i]n environmental health areas such as food protection local health departments expend far more resources than does TDH to enforce these rules yet they have no input until after the drafts are completed. TDH staff worked for almost two years on drafting the new Food Code without asking for input or providing copies to local departments or industry."[5] TDH indicated that a working group to develop the Code was not necessary because the agency based the Code on a national model with which the LHDs are familiar.

- Other groups that believed TDH had not maximized efforts to solicit public input during the development of rules came forward with a number of suggestions. A few groups suggested that TDH better publicize the development of rules—possibly through the Internet.[6] The Association of Texas Hospitals and Health Care

Organizations suggested that the agency submit draft proposed rules to interested stakeholders at least 30 days before the presentation of the proposed rules to the advisory committees and hold a stakeholders' meeting during the 30 day period.[7]

- TDH advisory committees, while often effective, cannot meet the rulemaking needs of all the programs. For many programs that affect numerous stakeholders, an advisory committee that remains manageable in size cannot include representatives from every stakeholder group. In addition, TDH staff indicate that the committees have had a difficult time retaining public members, who are not reimbursed for their travel expenses.

▼ **Other state agencies have a formal way to more actively solicit input from stakeholders during the rulemaking process.**

Both TDMHMR and the Texas Animal Health Commission formally solicit stakeholder input before rules are proposed.

- The Texas Department of Mental Health and Mental Retardation (TDMHMR) has implemented a system for soliciting public and stakeholder input on proposed rules. The agency has developed a list of stakeholders and other interested parties, and mails them a "Request for Comment" notice with the attached proposed rules, concurrently with publishing in the Texas Register. TDMHMR also sends out a draft, before the rules have been officially proposed, to the same group of stakeholders, if the rules would make a major change to policy or would be controversial. [8]

- To develop most of its rules, the Texas Animal Health Commission staff solicits input from stakeholders, makes changes to the rules as appropriate, and then presents them to the Commission for publication in the Texas Register.[9] To improve the solicitation of input, staff has developed about ten stakeholder lists focused on areas of interest. If the Commission changes the rules before publication, the staff sends the proposed rules to the applicable stakeholders once again to solicit their input. Commission staff indicated that since implementing the current system for soliciting input, the stakeholders have been more cooperative and supportive.

- The APA recognizes that when numerous stakeholders will be affected by rules, making an extra effort to give notice of new or changed rules is crucial. For example, the APA requires that before a proposed rule adopted by the Commission on Jail Standards and the Commission on Law Enforcement

Officer Standards and Education becomes effective, the agencies must mail the proposed rules to each law enforcement agency that may be affected.

Conclusion

As a result of the Department's enormous rulemaking responsibilities and diverse programs, the agency has not been able to maximize input from stakeholders and other experts. In fact, a number of groups expressed concern to Sunset staff about their inability to provide input to TDH during the development of rules that directly affect them.

Recommendation

Change in Statute

- **Require TDH to establish a system for soliciting stakeholder input when developing rules.**

TDH has not established a standard approach to solicit wide-ranging input into the development of rules before rules are proposed. Other state agencies have created systems to receive input before rules are proposed to ensure the effectiveness of their rulemaking processes. Although this recommendation exceeds the minimum standards set by the APA, it simply requires TDH to establish an appropriate system for seeking stakeholder input during the development phase. The statute should also clarify that failure to solicit stakeholder input would not invalidate an action taken or rule adopted.

Management Action

- **TDH should establish uniform methods to solicit input during the development of rules, such as creating lists of stakeholders, by interest area, and using these lists to mail notices regarding the development of rules.**

Involving stakeholders in the rulemaking process is critical to the development of effective and fair policies and ensures stakeholder support and cooperation once the rules are adopted. Because of the varied programs and complexity of the agency, the agency should take extra steps to ensure that all interested stakeholder representatives are notified when developing controversial rules or rules that would make a major change to a program. To facilitate this process, TDH should develop notification lists for the different interest areas within TDH and request comment from the stakeholders on the lists when appropriate. The lists should be developed and maintained regularly by agency staff, and should include key stakeholder representatives and interested members of the public.

In addition to facilitating this process through TDH staff whenever appropriate, TDH should consider requiring the advisory committees to assist in this process, especially with the development of the lists. TDH could also use this method, as does TDMHMR, to send out interpretations of new rules when the rules make a major change to current practices that could be confusing to providers or clients.

TDH should also consider using the negotiated rulemaking process authorized in Chapter 2008 of the Government Code, which also requires the identification of stakeholders, for the development of particulary controversial rules.

Fiscal Impact

This recommendation would require TDH to adjust and increase consistency of policies already in place. These adjustments would not have a direct fiscal impact. If the Department decides to increase the number of notices mailed, postage and related costs could minimally increase.

[1] Government Code Ann. ch. 2001, sec. 2001.004 (Vernon 1998).

[2] Interview by Sunset staff with Joseph Martinec, J.D., Chair, Interagency Council for Genetic Services, and (via teleconference) Celia Kaye, M.D., Ph.D., Chair, TEXGENE Steering Committee, Austin, Texas, March 10, 1998.

[3] Telephone interview by Sunset staff with Stephen Faehnle, M.D., Pediatrician, May 4, 1998.

[4] Letter from Randy Cain, Texas Fire Chiefs Association, to Sunset staff, January 23, 1998.

[5] Letter from John E. Williams, P.E., Assistant Director for Environmental Health, Harris County Health Department, to Sunset staff, December 19,1997.

[6] Letter from M. desVignes-Kendrick, M.D., M.P.H., Director, City of Houston Health and Human Services Department, to Sunset staff, January 20, 1998; Letter from Any Baby Can of Austin, to Sunset staff, February 9, 1998.

[7] Letter from Allen K. Horne, Director of State and Federal Relations, the Association of Texas Hospitals and Health Care Organizations (THA), to Sunset staff, January 5, 1998.

[8] Telephone interview by Sunset staff with Linda Logan, Director, Policy Development, Department of Mental Health and Mental Retardation, April 23, 1998.

[9] Telephone interview by Sunset staff with Kathryn Reed, General Counsel, Animal Health Commission, April 20, 1998.

Issue 5

Improve Monitoring of Performance to Ensure that Contractors Provide Best-Quality Services.

Background

TDH has approximately $6 billion in contracts for the delivery of Medicaid and non-Medicaid health care services. The Medicaid program, primarily through the Health Care Financing Associateships at TDH, contracts with insurance companies, health maintenance organizations (HMOs), and program administrators for health care services totaling approximately $5 billion.

The State has contracted with the National Heritage Insurance Company (NHIC), a wholly-owned subsidiary of Electronic Data Systems, to administer Texas' Medicaid program since 1977. NHIC operates under a $70 million per year contract that expires in fiscal year 1998. As the Medicaid fiscal agent, NHIC performs a number of functions, including claims processing, utilization review, and enrollment of providers in the traditional fee-for-service Medicaid program, in addition to performing some managed care functions. TDH awarded a $70 million per year contract to NHIC to begin in September 1998 to continue the Medicaid administrative functions. The Department also contracts with 11 HMOs and a managed care enrollment broker, among others, for Medicaid services.

TDH spends $6 billion on contracts to deliver health care services to Texans.

The TDH Internal Audit Division assigns an eight-member team to monitor the NHIC contract exclusively and continuously. The internal audit team conducts financial and performance monitoring of NHIC, including whether NHIC pays providers in a timely manner and assesses costs and profits appropriately. Health Care Financing is currently reorganizing to develop a Bureau of Reimbursement Analysis and Contract Compliance. Operational functions of this newly formed Bureau have not been defined. TDH currently monitors the HMOs through an evaluation of reports prepared by the HMOs. However, the Department recently contracted with Texas Health Quality Alliance (THQA) to monitor the quality, and Coopers and Lybrand, L.L.P. to monitor the financial performance of the HMOs. TDH anticipates the first report from THQA in September 1998, and the results of the Coopers and Lybrand, L.L.P. report in August 1998.

The Department administers most non-Medicaid programs through the Associateship for Health Care Delivery by contracting directly with health care providers, including local health departments, for approximately $1 billion in medical services. Included in the $1 billion, the Department administers services for six additional health care delivery programs outside the Health Care Delivery Associateship.

TDH has approximately 30,000 contracts for non-Medicaid programs. The majority of these contracts arise from the Maternal and Child Health Block Grant programs; the program for the Special Supplemental Nutrition for Women, Infants, and Children (WIC); the immunization program; and family planning programs.

For most programs within the Health Care Delivery Associateship, the Quality Assurance Monitoring Division conducts performance monitoring visits. The Division assesses the risk associated with each contractor at the beginning of the fiscal year to determine the frequency of monitoring visits. The six non-Medicaid programs outside of the Health Care Delivery Associateship monitor the performance of their contractors independently. The Grants Management Division of the agency conducts financial monitoring for all non-Medicaid programs, except WIC, which conducts financial monitoring internally.

In the area of contracts, the review focused on Medicaid because of the large financial investment.

Sunset staff compared the performance measures and monitoring of TDH contracts with monitoring guidelines recently established by the Legislature. The Legislature, through a rider to the 1997 General Appropriations Act, requires the following contract provisions:

- clearly defined goals, outputs, and measurable outcomes;
- clearly defined penalties and sanctions for noncompliance;
- specific accounting, reporting, and auditing requirements applicable to funds received under the contract; and
- a formal risk assessment program to ensure that contractors are monitored appropriately. [1]

In 1997, the Legislature also directed all health and human service agencies to consider contractor performance, financial resources, ability to perform, and experience and responsibility in making contractor selections.[2] The examination of the Department's implementation of contract requirements focused on performance measures and monitoring across programs; however, Sunset staff concentrated primarily on the Medicaid program because of the state's large financial investment in the program.

Findings

Contract Monitoring Problems

▼ **TDH does not adequately monitor the performance of its largest Medicaid contractor.**

◗ The TDH audit of the NHIC Medicaid contract is three years overdue. The Internal Audit Division's most recent report, released in October 1997, examined NHIC performance on its $70 million per year contract from September 1993 through August 1994.

The most recent TDH audit of its $70 million NHIC Medicaid contract is for fiscal year 1994.

The report contained significant findings, such as the failure of NHIC to submit final profit calculations for the year ending August 1992. Since the contract limits profits to a certain maximum amount, profits in excess of this cap belong to the State. Delays in auditing the profits can have serious fiscal implications to the State.

Although the TDH contract audit appears comprehensive and notes important findings, the significant delay prevents TDH from using the findings to improve its monitoring systems and NHIC performance in a timely manner. Instead, TDH must rely on meetings between internal audit staff and Health Care Financing staff to discuss concerns in lieu of formal audit results.

◗ Under the current structure, Health Care Financing staff does not adequately monitor performance of its largest contractor. The TDH internal audit team, responsible for auditing the NHIC contract, conducts the only on-site monitoring of NHIC performance. Health Care Financing, responsible for the development of Medicaid contracts and policy, does not have control or policy authority over the internal audit team that is under the management of the TDH Internal Audit Division. Health Care Financing staff's monitoring role is limited to examining reports submitted by NHIC regarding performance measures and financial statements.

The use of agency internal auditors to monitor an operational contract with NHIC is inconsistent with the Internal Auditing Act.

◗ The manner in which TDH monitors NHIC performance is inconsistent with the Texas Internal Auditing Act. The Act states that an internal auditor should "be free of all operational and management responsibilities that would impair the auditor's ability to review independently all aspects of the state agency's operations."[3] Having internal audit staff perform an operational activity, the everyday financial monitoring of NHIC, impairs the

internal auditor's ability to objectively analyze the adequacy of the monitoring. In short, the Internal Audit Division should be able to audit TDH contract monitoring activities without the conflict arising from the Division having to audit its own staff.

- The NHIC contract is the Department's highest-risk contract. NHIC, formed exclusively to administer the Texas Medicaid program, has held a contract with Texas for 21 years. TDH requested proposals for Medicaid claims administration in 1997, but NHIC was the only bidder. In addition to $70 million a year for performing various Medicaid administrative functions, NHIC will receive another $68 million to develop a new claims processing system—a significant amount of state and federal funding.

  According to current statutory contracting guidelines, the NHIC contract is high-risk and should be monitored closely. The State Auditor's Office, after a series of contracting investigations, cautioned that when an agency cannot procure a contract competitively, the State must take added performance monitoring measures to ensure that the State is receiving best value services.[4] TDH has not followed this basic tenet of closely monitoring its highest-risk contract.

Many states, other than Texas, require external audits of their primary Medicaid contracts.

▼ **TDH does not require an external financial audit of its largest and highest-risk contract.**

- Although the contract with NHIC is the agency's largest contract, TDH does not require an external financial audit of NHIC, even though external financial audits are required for the Department's HMO contracts. With TDH audits running three years behind and no external financial audit, the state bears an increased risk of financial loss.

  Numerous other states, such as California, Florida, and Virginia, require external audits of their Medicaid fiscal agents, and in most cases, require the fiscal agent to pay for the audit.

Contract Development Problems

▼ **TDH does not consistently solicit input from experts to ensure best quality services from complex, high-dollar Medicaid contracts.**

- TDH has not regularly consulted with the Health and Human Services Commission (HHSC) on contract development, and does not include HHSC legal staff in the preparation of Medicaid requests for proposals (RFPs) or contracts.[5] For the 1996 expansion of Medicaid managed care to Bexar, Lubbock and Tarrant counties, for example, the Commission did not receive the RFPs or contracts in time to make comments.[6]

  The Commission expressed concern regarding its lack of involvement and believes it should be more involved in the development of Medicaid contracts.[7] The federal Health Care Financing Administration (HCFA) requires the Commission, as the single state agency responsible for Medicaid, to "issue policies, rules, and regulations on [Medicaid] program matters."[8] HHSC has significant expertise regarding Medicaid contracts because it reviews the contracts for the three Medicaid operating agencies, the Department of Mental Health and Mental Retardation, the Department of Human Services, and TDH.

TDH has not consistently involved HHSC in Medicaid contract development and procurement.

- The Department has not regularly consulted with the Texas Department of Insurance (TDI) on the development and procurement of HMO contracts, even though TDI has the responsibility to monitor HMO solvency and quality of care. During the Harris County Medicaid managed care HMO procurement in 1997, TDH obtained HMO licensing and solvency information from TDI. Although the Department plans to include quality information collected by TDI in the Dallas County HMO contract procurement criteria in 1999, TDH has not developed a way to quantitatively factor HMO quality of care data into contractor selection.

  As the managed care industry matures, particularly with regard to Medicaid, HMOs will continue to undergo changes as both the industry and consumers determine the best structure. As the regulatory agency for HMOs, TDI is charged with interpretation of legislation affecting the managed care industry, such as the series of bills from the 75th legislative session that made major changes to HMO operations in the area of patient and provider protections.

  In addition, as HMOs increasingly report financial losses and declare bankruptcy, TDI collects and monitors data regarding HMO solvency. For these reasons, TDH should work more closely with TDI, the state regulatory agency that oversees the managed care industry.

▼ **Although required by statute, TDH does not include contractor performance as a factor in contractor selection decisions.**

- The Department does not formally include contractor performance as a factor in contractor selection; consequently, TDH frequently contracts with the same providers year after year. For example, contractors on accelerated monitoring or probation for substandard performance typically have their contracts renewed.[9] Occasionally contracts are not renewed based on a lack of clients served, but never for documented quality of care deficiencies.

- In addition, TDH does not use a formal method of communicating contractor performance problems across programs or the agency, but rather relies on memos or word-of-mouth. TDH has no formal way to ensure that, when a TDH licensing program or service delivery program documents problems with a contractor, a program in another associateship is made aware of those problems for contractor selection decisions.

  For example, the Tuberculosis Control Program and Immunizations Division in the Associateship for Disease Control and Prevention are not always aware of poor performance findings from the Quality Assurance Monitoring Division in the Associateship for Health Care Delivery, even though they contract with many of the same providers.[10]

Contractors on probation for substandard performance typically have their contracts renewed.

- TDH does not compare contractor performance between providers to determine which providers are achieving the best results. By comparing provider performance when making decisions, TDH could better ensure clients are receiving best value services.

- The Medicaid managed care program has never formally included the past performance of an HMO as a factor in contract selection, even though the quality of HMOs in Texas, as well as other states, has been documented. However, managed care staff report using anecdotal information, and are currently working with TDH legal staff to determine a formal way to incorporate a quantitative measure for past HMO performance in the selection process, using data from TDI as well as other states.[11]

Contractor Sanction Problems

▼ **Current sanctions for non-Medicaid programs are insufficient to improve provider performance.**

- In the past four years, financial sanctions have not been imposed on any of the 250 contractors monitored by the Quality Assurance Monitoring Division who provide health services for non-Medicaid clients. TDH has approximately 30,000 non-Medicaid contracts. For contractors who do not meet performance measures set in the contract, TDH imposes sanctions such as accelerated monitoring or probation that, in essence, amount to technical assistance to the provider. On just two occasions in the last four years, TDH extended the accelerated monitoring and probationary periods placed on contractors, but the Department never imposed financial sanctions for substandard care.

- TDH staff expressed concern that accelerated monitoring and probation do not provide sufficient incentives for contractors to improve performance.[12] Regional staff, charged with providing technical assistance to contractors placed on accelerated monitoring and probation, said that sanctions are generally too lenient. In one instance reported to Sunset staff, a long time contractor on accelerated monitoring told TDH regional staff that he did not need to change his practice because TDH would never remove his funding.[13] Central office staff also agree quality assurance could be improved and more closely linked to contractor payment.[14]

One long-time TDH contractor saw no need to improve his practices because TDH never withdraws funding.

- While financial sanctions are intended to make contractors comply with contract provisions, the Department can also use incentives to encourage contractors to excel in delivering services. TDH has successfully implemented an incentive program for one health care delivery program.

  The WIC program offers contractors financial incentives to exceed output requirements. For example, if a WIC contractor provides services to its clients before 8 a.m. or after 5 p.m., or to more clients than anticipated, TDH will provide the clinic with incentive funds that can be used to purchase furniture, supplies, or toys.

  The Department has also successfully incorporated financial incentives into some of its Medicaid contracts. For example, HMOs receive added weight in contract award consideration for providing value-added services, such as continuity of care for

clients who lose Medicaid eligibility, medical education, and essential public health services.

▼ **Although TDH has improved its system for conducting contractor performance monitoring, these improvement efforts need agency-wide implementation.**

- The Department has recently heightened its monitoring efforts for a number of programs. The Bureau of Managed Care has developed contracts to conduct performance and fiscal monitoring of its HMO contracts. The Texas Health Quality Alliance, when fully operational, will monitor the performance of the HMOs, including health care outcomes. Coopers and Lybrand, L.L.P. will monitor HMO financial compliance. The Quality Monitoring Division uses a standard risk assessment and performance monitoring tool to evaluate its 11 programs.

- Recent legislation has focused on contracting practices, including the State Auditor's Office recommendation to use a formalized risk assessment to select contractors for review, and standardized criteria to evaluate contractor performance to protect against potential contractor abuses.[15] In response, TDH formed a Contract Leverage Team, with representatives from Medicaid and non-Medicaid programs. The Contract Leverage Team developed standard contracting procedures that were compiled in the *Contracting Guide for Client Services*. The *Contracting Guide* includes methods for competitive procurement, as well as formalized tools for risk assessment and contract monitoring incorporated from the Quality Assurance Monitoring Division.

TDH has not required agency-wide implementation of its recently revised contracting guidelines.

- While some of the programs competitively bid contracts and use the monitoring tools, TDH has not required agency-wide implementation of the contracting guidelines. Thus, these programs are at risk of contractor abuses, such as improper use of state funds and not providing best value services. For example, the WIC program does not currently use a competitive process to select contractors, and therefore must monitor contractors more closely to ensure best contractor performance. Programs such as immunizations and HIV/STD do not use the risk assessment tool or standardized performance monitoring tools included in the *Contracting Guide.*

Conclusion

TDH does not ensure the best contractor performance across the agency. For its highest-risk contract, the $70 million NHIC Medicaid contract, audits are three years overdue, and are not conducted as an operational function of Health Care Financing. Further, TDH has not required an external audit of the NHIC contract.

In addition, TDH has not consistently used resources available for contract administration, such as HHSC and TDI, in the development of Medicaid contracts. TDH also does not consistently use past contractor performance information for the procurement of contracts. These oversights in contract development and contractor selection leave the Department at risk for contractor abuses, including financial inaccuracies.

TDH has made efforts to comply with current statute by developing standard tools for contractor risk assessment, and performance and financial monitoring, but has not required agency-wide implementation of a uniform contracting system. Failure to implement an agency-wide standard for contract administration also leaves the agency vulnerable to contractor abuses.

Recommendation

Change in Statute

- **Require an annual external audit of the Medicaid fiscal agent, currently NHIC.**

With TDH audits running three years behind and no required external audits of the largest TDH contract, the State needs to increase its oversight of NHIC to reduce financial risk. An external audit of the Medicaid fiscal agent would provide TDH with timely, objective information about NHIC's financial condition and would ensure the financial accuracy of NHIC's cost and profit calculations.

The Department should employ an independent, external auditor to conduct performance and financial audits of the NHIC contract. The scope of the audits should be defined by TDH based on a risk assessment of the NHIC contract. The information provided would serve as an interim check for TDH while its own audits are running several years behind.

Management Action

- **TDH should transfer the operational function of NHIC contract performance and financial monitoring from the Internal Audit Division to Health Care Financing.**

Health Care Financing is the TDH division currently responsible for Medicaid contract and policy development, and should directly monitor the performance and finances of the largest Medicaid contractor. Under the current structure, a team of eight TDH Internal Audit Division auditors conducts ongoing financial and performance monitoring of the NHIC contract. Transferring the operational function of contract monitoring would improve contract oversight of this high-risk contract.

Under the current structure, Health Care Financing has no authority to direct the contract monitors to focus on specific weaknesses in the contract. Health Care Financing develops the NHIC contract and relies on NHIC performance to carry out many day-to-day Medicaid operations. As a result, Health Care Financing staff is aware of areas of performance that need improvement, and could direct routine contract monitoring more effectively than the Internal Audit Division.

In addition, once NHIC contract monitoring is transferred to Health Care Delivery staff, the Internal Audit Division would be able to examine the effectiveness of NHIC contract monitoring systems. Currently, the TDH Internal Audit Division cannot objectively evaluate the eight-member internal audit team that monitors NHIC contract performance because they are not independent of each other. Furthermore, as currently structured, the NHIC contract monitoring system is inconsistent with the Internal Auditing Act.[16] Once NHIC contract monitoring becomes an operational function of Health Care Financing, the TDH Internal Audit Division would be able to independently analyze TDH systems for quality assurance as directed by state law.

One option for implementation of this management action would be to transfer the eight internal auditors, currently monitoring the NHIC contract, to Health Care Financing. This team of internal auditors has developed valuable expertise about the NHIC contract and the complex relationship between TDH and NHIC. Once the transfer occurs, the remaining Internal Audit Division auditors would periodically audit the NHIC contract monitoring staff in the same fashion they audit the other Health Care Financing staff and functions.

- **TDH should seek expertise from the Medicaid single state agency, currently HHSC, and TDI for the development and monitoring of Medicaid contracts to ensure the procurement of best quality services.**

TDH has not adequately used expertise of other state agencies in creating its Medicaid contracts. HHSC, currently the Medicaid single state agency, must issue all Medicaid policies, rules, and regulations according to federal law, and should therefore be consistently

included in the development, procurement, and amendments of Medicaid contracts. At a minimum, HHSC should receive RFPs and contracts with enough time to be able to make necessary contributions, such as experience gained from contract development with the other Medicaid operating agencies, the Department of Human Services and the Department of Mental Health and Mental Retardation.

TDH should also include the Texas Department of Insurance (TDI) in HMO contract development and contractor selection. Using TDI expertise in contract development would ensure that TDH includes necessary provisions in managed care contracts, particularly as federal and state laws change for HMOs. In addition, information about HMO solvency and performance, collected by TDI, should be formally included in HMO contractor selection to ensure that TDH chooses the most financially stable contractors to provide services for its clients.

- **TDH should ensure consistent use of performance-based contracting procedures throughout the agency.**

Although TDH has developed contracting standards that incorporate principles established in law, agency-wide implementation of these standards has not occurred. Agency-wide implementation of standard contracting procedures would ensure that each program uses the best contracting procedures and obtains the best value for money spent. TDH should evaluate all contracting processes, provide consistency where appropriate, and ensure that best contracting practices are in place throughout the agency.

Agency-wide contracting procedures should include competitive contract procurement. The agency should formally consider past contractor performance in subsequent contractor selection, including contractor performance information obtained across programs. TDH should also ensure that a formal method exists for programs across the agency to communicate contractor performance findings to other programs that contract with the same providers. In addition, the contractor selection procedure should include a process to compare contractor performance, and include the comparison as a factor in awarding contracts.

TDH should ensure that contractor sanctions are used to encourage contractors to deliver best-quality services. The TDH central office should strengthen ties with regional staff for contract monitoring to ensure that once contractors are placed on accelerated monitoring or probation, noncompliant contractors progress to the next level of sanctioning when appropriate.

- **TDH should provide incentives, when possible, for contractors to meet and exceed contract requirements.**

TDH should set goals for each provider and tie funding to provider achievement of performance goals where appropriate. The performance measures used must be under the providers' control—they can directly affect their performance under the measure. The

measures must also be closely linked to the mission of TDH. The Department would require providers to submit timely reports that display the progress toward the primary performance goals.

Fiscal Impact

By moving toward incentive and performance-based contracting, TDH should achieve savings for the State. Risk-based financial and performance monitoring ensures that state resources are used efficiently to focus efforts toward contracts that pose the greatest threat to state clients and funds. As a result, state dollars are saved through efficient monitoring systems that ensure improved contractor services. However, the impact of these recommendations would vary depending on the level of implementation; thus, the fiscal impact of this recommendation cannot be estimated for this report.

Use of outside auditors for Medicaid contracts should identify additional opportunities for savings. While hiring an independent, external auditor for the NHIC contract will create an additional expense for the Department, the amount cannot be determined until TDH identifies the appropriate scope of the audits.

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[1] Texas Legislature, General Appropriations Act, 75th Leg., Art. II, *Special Provisions Relating to All Health ad Human Services Agencies*, Rider 13.

[2] Tex. Gov. Code Ann. ch. 2155, sec. 2155.144 (Vernon 1997).

[3] Tex. Gov. Code Ann. ch 2102, sec. 2102.007 (Vernon 1997).

[4] Interview by Sunset staff with Cindy Reed, Office of the State Auditor, Austin, Texas, March 12, 1998.

[5] Telephone interview by Sunset staff with Linda Wertz, Texas State Medicaid Director, Health and Human Services Commission, Austin, Texas, April 16, 1998.

[6] Interview by Sunset staff with Dr. Michael McKinney, Commissioner, Health and Human Services Commission, Austin, Texas, December 19, 1997.

[7] Telephone interview by Sunset staff with Linda Wertz, Texas State Medicaid Director, Health and Human Services Commission, Austin, Texas, April 16, 1998.

[8] Health and Human Services, Health Care Financing Administration, 42 C.F.R. sec. 431.10.

[9] Interview by Sunset staff with TDH Regional office Health Care Delivery staff, Arlington, Texas, March 26, 1998.

[10] Telephone interview by Sunset staff with Hilda Mikan, Director, Quality Assurance Monitoring Division, Texas Department of Health, Austin, Texas, April 17, 1998.

[11] Interview by Sunset staff with Stacey Hull, Director of Program Development, Bureau of Managed Care, Texas Department of Health, Austin, Texas, April 13, 1998.

[12] Interview by Sunset staff with TDH Regional office Health Care Delivery staff, Arlington, Texas, March 26, 1998.

[13] Interview by Sunset staff with Ann Hayward, TDH, Region 2/3, Dallas / Fort Worth, March 26, 1998.

[14] Telephone interviews by Sunset staff with Debra Stabeno, Associate Commissioner, Health Care Delivery, and Hilda Mikan, Director, Quality Assurance Monitoring Division, Texas Department of Health, Austin, Texas, April 17, 1998.

[15] Office of the State Auditor, State of Texas, *An Audit Report on Contract Administration at Selected State Agencies - Phase Four*, September 1996.

[16] Tex. Gov. Code Ann. ch 2102, sec. 2102.002 (Vernon 1997).

Issue 6

Reimburse Medicaid Providers through Electronic Funds Transfer to Achieve Cost Savings and Administrative Efficiencies.

Background

Limited state and federal resources make pursuing cost savings an important factor in efforts to increase health services for many of the neediest Texans. Electronic commerce, the paperless exchange of business information, is one way that government and businesses heighten productivity and efficiency. Paper-driven processes are being re-engineered to meet the demands of an increasingly competitive world. Electronic funds transfer (EFT), commonly called direct deposit, is widely used in the government and private sectors to save administrative and transaction costs.

TDH contracts with the National Heritage Insurance Company (NHIC) to process approximately 34 million Medicaid claims per year. Providers submit claims to NHIC for clients enrolled in traditional fee-for-service Medicaid and also for those enrolled in the primary care case management (PCCM) model of Medicaid managed care. Even with the conversion to Medicaid managed care, NHIC will continue to process claims for PCCM clients and for many of the costliest traditional fee-for-service Medicaid clients, such as Medically Needy Children.

The National Heritage Insurance Company processes about 34 million Medicaid claims a year for TDH.

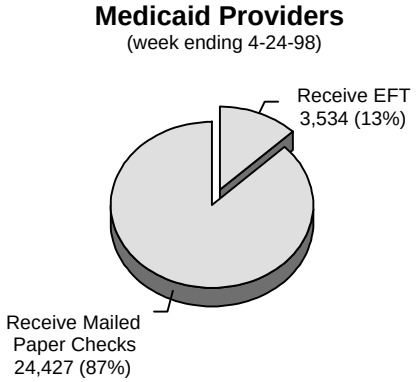
In 1996, NHIC designed and implemented TexMedNet (Texas Medical Network), a paperless system that allows Medicaid providers to file and appeal claims, verify client eligibility, conduct claim status inquiry, receive reimbursement statements, and access the electronic bulletin board system. When providers enroll in TexMedNet, they can choose to receive reimbursements through electronic funds transfer or can continue to receive paper checks.

As part of the claims administration contract, NHIC is currently developing a new Medicaid management information system called *Compass 21*. The new system will expand TexMedNet's capabilities to include year 2000 compliance as well as the capacity to process encounter information for Medicaid managed care.

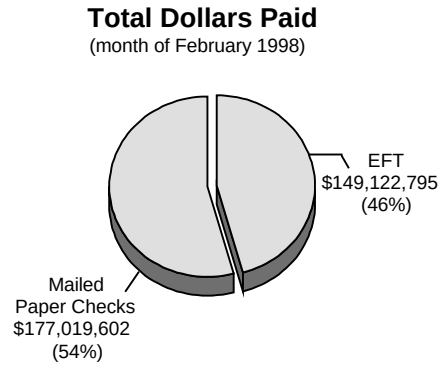
The Sunset review focused on cost savings associated with electronic funds transfer to Medicaid providers in traditional fee-for-service and PCCM models.

Findings

▼ Significantly increasing electronic funds transfer to Medicaid providers would result in savings to the State.



- Mailing paper checks to Medicaid providers is inefficient and costly. NHIC believes that mailing paper checks to providers "costs multiples more than EFT."[1]
- For each month from May 1997 through February 1998, less than half of the total dollars paid to providers was reimbursed electronically. More importantly, in an average week, only 13 percent of providers are paid electronically. For example, in the week ending April 24, 1998, only 3,534 of the 27,961 Medicaid providers that received payments were paid through EFT. Conversely, 24,427 providers received mailed paper checks.[2]



- Any significant cost savings to NHIC accrue to the State. A new TDH-NHIC contract, which begins in September 1998, is primarily for claims administration and provider enrollment. This contract allows TDH to pay the lesser of a fixed contract fee or actual costs.
- Increasing the number of electronic funds transfers would allow TDH to achieve contract savings. NHIC estimates that if all claims were paid through EFT, administrative costs would drop by $1 million per year.[3]

▼ Although TDH has set goals to enroll providers in TexMedNet, it has not set goals for increasing EFT.

- Recognizing the importance of moving Medicaid providers into electronic systems, the NHIC contract sets goals of 75 percent fee-for-service electronic claims submission by August 1998, and 84 percent by August 2002. Additionally, NHIC is required to process 100 percent of PCCM claims electronically by August 1998. Because the contract price is partly based on these goals, both TDH and NHIC are working to increase the number of electronic claims submissions. However, the contract is silent on EFT increases.

▼ The federal government has identified significant cost savings in Medicare through increasing EFT.

- In 1996, the federal Department of Health and Human Services Office of Inspector General (OIG) evaluated the cost-effectiveness of electronic claims processing and electronic funds transfer for Medicare. The study found that "additional savings, perhaps of a greater magnitude [than savings associated with electronic claims], are available through increased use of electronic fund transfers, instead of checks, to reimburse providers."[4]

  Citing an earlier study by the Workgroup for Electronic Data Interchange, a voluntary public-private task force, the Inspector General found that conventional paper payments cost between three and four times as much as electronic payments.[5]

- The 1996 report pointed out that while the Health Care Financing Administration (HCFA), the federal agency responsible for administering Medicare and overseeing states' administration of Medicaid, had recognized the cost-effectiveness of overall electronic transactions, it had not adequately addressed EFT.

  Like Texas, HCFA has historically encouraged higher utilization by setting electronic claims goals for its contractors, but failed to set similar goals for EFT.[6]

- HCFA responded to the 1996 OIG report by removing barriers and providing incentives to providers to enroll in EFT.

The U.S. Inspector General found that paper payments cost three to four times as much as electronic payments.

▼ Texas has recognized the benefits of expanding the use of electronic commerce.

- Several Texas agencies are extensively engaged in forms of electronic commerce, including electronic funds transfer.

  The State Comptroller of Public Accounts has paid state employees by direct deposit for several years. Recent legislation requires all payments to vendors to be made by direct deposit after September 1, 1998. The Comptroller also has a system to receive sales tax returns electronically. The Texas Department of Insurance receives the majority of insurance fees through electronic funds transfer. The Texas Department of Transportation has established an electronic bidding system for highway construction and maintenance contracts.

Conclusion

Eighty-seven percent of Medicaid providers still receive paper checks.

While TDH and NHIC have made significant strides toward converting aspects of the Medicaid claims process to an electronic format, 87 percent of providers still receive mailed paper checks. This practice results in unnecessary administrative costs and is inconsistent with both State and federal policies to move away from costly and inefficient paper-driven processes toward electronic systems.

Recommendation

Change in Statute

- **Require TDH to use electronic funds transfer for all payments to Medicaid providers.**

This recommendation would lead to significant administrative efficiencies for the National Heritage Insurance Company, the Medicaid claims administrator. Cost savings will be passed on to the State because the contract allows TDH to pay either a fixed price or actual costs, whichever is lower.

All providers will be required to accept payment through EFT. Receiving EFT payments simply requires the payee to have a bank account. By eliminating mail and manual processing time, this recommendation would result in quicker payment of claims to Medicaid providers. Providers who are not currently enrolled in TexMedNet, the electronic claims system, will also be paid through EFT, although they will continue to receive mailed paper status reports. TDH and NHIC should pursue further incentives to encourage providers to enroll in the electronic system.

This recommendation would not burden NHIC. Any changes in reimbursement practices resulting from the 1999 legislative session will coincide with the implementation of Compass 21, the enhanced Medicaid management information system.

Fiscal Impact

The EFT requirement will have a positive fiscal impact on the State. If all Medicaid payments are done through EFT, NHIC estimates that it will save approximately $1 million a year in administrative costs. NHIC estimates that contract savings to the State would be approximately $350,000 a year.

NHIC points out that electronic funds transfer would result in a loss of revenue from interest earned on Medicaid funds being held while checks are mailed and processed.[7] However, TDH staff note that any loss of interest earnings consequently lowers the State's federal Cash Management Improvement Act (CMIA) liability, money the State owes the federal government when it earns interest on federal dollars. According to TDH staff, the CMIA benefit, which is based on the total loss of earned interest, would more than offset the State's share of lost interest earnings.[8]

Fiscal Year	Contract Savings	Loss of Interest Earnings	CMIA Benefit	Net Savings: General Revenue
2000	$350,000	($366,000)	$605,000	$589,000
2001	$350,000	($323,000)	$533,000	$560,000
2002	$350,000	($310,000)	$512,000	$552,000
2003	$350,000	($310,000)	$512,000	$552,000
2004	$350,000	($310,000)	$512,000	$552,000

[1] Written response to Sunset staff questions by Dennis Vaughan, Chief Financial Officer, National Heritage Insurance Company, Austin, Texas, April 23, 1998.

[2] Written response to Sunset staff questions by Sally Ward, Chief Operating Officer, National Heritage Insurance Company, Austin, Texas, April 29, 1998.

[3] Written response to Sunset staff questions by Dennis Vaughan, Chief Financial Officer, National Heritage Insurance Company, Austin, Texas, May 1, 1998.

[4] U.S. Department of Health and Human Services, Office of Inspector General, "Review of Medicare Providers and Electronic Claims Processing (A-05-94-00039)," May 1996, Summary p. i.

[5] Ibid., p. 24.

[6] Ibid., p. 22.

[7] *Analysis of Potential TDH Interest Lost on EFT*, prepared by Dennis Vaughan, Chief Financial Officer, National Heritage Insurance Company, Austin, Texas, May 6, 1998.

[8] Telephone interview by Sunset staff with Joe Moritz, Bureau Chief, Health Care Financing Budget and Support Services, TDH, Austin, Texas, May 14, 1998.

Issue 7

Designate the Texas Department of Health as the Single State Agency Responsible for Licensing Narcotic Treatment Programs.

Background

In Texas, 59 narcotic treatment programs administer a federally approved drug, methadone, to treat narcotic addicts. The U.S. Food and Drug Administration (FDA) and the U.S. Drug Enforcement Administration (DEA) regulate these programs at the federal level. Every program must have a permit issued by FDA and must register with DEA to operate. Additionally, FDA requires states to provide oversight. On the state level, both the Texas Department of Health and the Texas Commission on Alcohol and Drug Abuse (TCADA) regulate these facilities.

TDH has statutory responsibility for, and currently licenses, all of the State's 59 treatment programs. TDH's statute prohibits a person, including a physician, from operating a narcotic treatment program without a permit.

Both TDH and TCADA regulate 30 of the State's 59 narcotic treatment programs.

TCADA licenses a wide array of drug and alcohol treatment facilities, a small fraction of which are narcotic treatment programs. Since physician-owned programs are exempt from TCADA licensure, TCADA only has licensing authority over 30 of the State's 59 programs. In addition to licensure, TCADA administers federal and state funds for the prevention and treatment of substance abuse by contracting with community-based providers. In fiscal year 1997, TCADA provided about $4.5 million to 10 narcotic treatment programs throughout the state.

The Sunset review focused on whether both TDH and TCADA should continue to dually regulate narcotic treatment programs.

Findings

▼ **Conflicting statutory provisions have led to both TDH and TCADA regulating narcotic treatment programs.**

- TDH regulates all 59 of the State's treatment facilities by issuing permits for operation. TCADA also has statutory authority to

license the approximately 30 programs not owned by a physician. TCADA's licensing statute also specifically exempts facilities licensed by TDH. Despite this exemption, TCADA currently licenses 16 of these programs.

TCADA Licensed Sites
Center for Health Care Services (San Antonio)
Aliviane (El Paso - 2 sites)
Garland Treatment Center (Garland)
Houston Maintenance Clinic (Houston)
Houston Substance Abuse Clinic (Pasadena)
Houston Substance Abuse Clinic (Houston)
St. Joseph's Psychiatric Day Treatment Center (Laredo)
Riverside General Hospital (Houston)
Gulf Coast Center (Texas City)
Austin-Travis County MHMR (Austin)
Lubbock Regional MHMR (Lubbock)
Private Rehabilitation Outpatient Services (Dallas)
STEP MED (Dallas)
South Texas Substance Abuse Recovery Services (Corpus Christi)
Tejas Recovery and Counseling (San Antonio)

- TDH's statute adds confusion to the regulatory picture by referring to TCADA's licensing role. Both statutes require TDH and TCADA to coordinate on regulatory matters and to enter into interagency agreements to reduce duplication if necessary. For the 16 dually-licensed providers, the agencies have not reduced unnecessary regulatory duplication.

▼ TDH, TCADA, and narcotic treatment program providers agree that designating TDH as the single licensing agency would result in more efficient and effective regulation.

- Staff of TCADA[1] and TDH[2], as well as narcotic treatment providers contacted during the review, agree that designating TDH as the sole licensing entity would be more efficient. Furthermore, these staff also indicate that federal and state oversight would continue to be sufficient, and confusion and financial burden among program providers would be reduced.

- Elements of TCADA's regulatory requirements could be included in TDH rules. TCADA's facility licensure rules include a "Client Bill of Rights." Additionally, TCADA's funding rules contain detailed counseling requirements consistent with FDA guidelines. TDH has indicated that it would either adopt and enforce those rules or formulate similar rules specific to narcotic treatment patients if clearly designated as the single state agency responsible for licensing narcotic treatment programs.[3]

▼ Narcotic treatment programs would continue to be highly regulated at the state as well as the federal level.

- TDH is the state methadone authority. TDH conducts FDA-approved inspections of all 59 facilities on an annual basis, with additional investigations prompted by complaints. TDH inspections, which are unannounced, last two to three days and focus on federal requirements as well as staff credentials.

- TDH actively regulates these narcotic treatment programs. In 1996, 1997, and the first quarter of 1998, TDH conducted

150 inspections, issued 29 warning letters, held three compliance meetings, assessed one administrative penalty (program closed voluntarily), and revoked two permits. Since 1993, a total of nine programs have been closed either through enforcement action or voluntary surrender of their permits. Some of these closures were in cooperation with the DEA.

- Federal law requires programs to file formal applications with FDA. FDA approval is contingent upon a showing that the program is in compliance with the state authority (TDH) and DEA requirements. The FDA also retains the right to suspend or revoke its approval.
- All narcotic treatment programs must also register with DEA. DEA inspects each site every three years to ensure facility security, and may inspect programs more frequently if needed.

Narcotic treatment programs would continue to be highly regulated if TDH were the single state regulatory authority.

Conclusion

TDH and TCADA have dual regulatory authority over narcotic treatment programs, resulting in little additional oversight and creating an unnecessary financial and regulatory burden on providers. TDH, TCADA, and providers agree that designating the Department of Health as the single state regulatory agency would be more efficient. Narcotic treatment programs would continue to be highly regulated at the state and federal levels.

Recommendation

Change in Statute

- **Remove TCADA's role in regulating narcotic treatment programs, and clarify that TDH is the sole state authority to regulate these programs.**

Although several provisions in the TDH statute referring to TCADA licensing are intended to promote interagency coordination, the language has resulted in regulatory duplication. By deleting references to TCADA's licensing role, TDH would become the single state agency responsible for regulating narcotic treatment programs. TCADA would continue to maintain contractual oversight of the programs that it funds. TDH would continue to inspect each program on an annual basis, and the Commissioner of Health would continue to have broad enforcement powers, including the pursuit of administrative, civil, and criminal penalties. By eliminating TCADA's licensure, the State would eliminate duplication, confusion, and a financial burden on providers, and would not adversely affect oversight.

Management Action

- **The Board of Health should adopt rules for the regulation of narcotic treatment programs consistent with TCADA's current rules.**

To ensure that no oversight is lost when TDH becomes the single state regulatory agency for narcotic treatment programs, the Board of Health should review TCADA's rules and, where applicable, adopt similar rules.

Fiscal Impact

This recommendation will have a minimal fiscal impact. Currently, TCADA generates $9,600 per year by licensing 16 narcotic treatment programs which will be lost once TCADA ceases its oversight efforts. This recommendation would lessen the financial burden on certain program providers.

[1] Interview by Sunset staff with Karen Pettigrew, General Counsel; George Loney, Program Manager; and Calvin Holloway, Program Administrator, Texas Commission on Alcohol and Drug Abuse, Austin, Texas, February 26, 1998.

[2] Interview by Sunset staff with Dennis Baker, Deputy Chief, TDH Bureau of Food and Drug Safety; Cynthia Culmo, R.Ph., Director; and Gary Coody, R.Ph., Senior Pharmacist, TDH Drugs and Medical Devices Division, Austin, Texas, February 18, 1998.

[3] Ibid.

Issue 8

Maintain the Toxic Substances Coordinating Committee as a Resource for the Department of Health.

Background

In 1987, the Legislature responded to public concern about the health effects of harmful substances in the environment. Numerous state agencies enforce laws that impact human health, and the lack of one clear authority or a clear state voice on human health risks added to the public's concern. Realizing that interagency cooperation is essential to the effective coordination of regulatory programs that have an impact on public health, the Legislature created the Toxic Substances Coordinating Committee (Committee), an interagency effort between TDH, Texas Department of Agriculture, Railroad Commission, Texas Parks and Wildlife Department, Department of Public Safety, and Texas Natural Resource Conservation Commission (TNRCC). Before passage, the House amended the bill by adding a September 1, 1999 expiration date. The expiration date does not require a Sunset review.

The Committee fosters communication between several agencies whose decisions affect human health.

The Committee, which meets quarterly, coordinates communication between member agencies on efforts to regulate toxics and other harmful substances. For example, even though TDH is responsible for issuing fish advisories to protect human health, other agencies like TNRCC and Parks and Wildlife, which enforce water quality and fishing laws, must also be involved. The Committee allows member agencies to share their resources and expertise before a decision is reached.

As the lead state health agency, TDH is responsible for conducting a wide variety of investigations, health studies, risk assessments, and consultations. These terms, often referred to generically as health risk assessments, all reflect various ways TDH staff determine the human health effects of a condition or activity. Occasionally, TDH conducts investigations when citizens raise concerns that the incidence of a particular disease in a community is too high, or that an environmental exposure poses a health risk. TDH also conducts comprehensive health studies for the federal government. More commonly, though, health risk assessments are the result of another agency's request for TDH assistance. This coordination is expedited by the Committee. For example, TNRCC regularly consults with TDH epidemiologists to make permitting decisions.

Since TDH has primary responsibility for assessing and minimizing health risks, the Sunset review focused on whether TDH continues to need the services of the Toxic Substances Coordinating Committee.

Findings

▼ **The need for the Toxic Substances Coordinating Committee to ensure interagency coordination and reduce public health risks still exists.**

- Before the creation of the Committee, a lack of coordination between agencies heightened public concern over environmental health issues, and hampered the agencies' regulatory efforts. The Legislature created the Committee as a way to reduce gaps, overlaps, and inconsistencies between a multitude of regulatory programs.[1]

- Today, the agencies represented on the Committee continue to play regulatory roles that have an impact on public health and safety. TNRCC, for example, permits a wide variety of industries that pose potential public health risks.

  Regulatory agencies need to be aware of the public health aspects of the environmental, agricultural, or industrial laws they enforce, and the Committee provides a forum for this purpose.

The Legislature created the Committee to reduce gaps, overlaps, and inconsistencies between agencies.

- TDH is the only state agency with the expertise to perform epidemiologic and toxicological investigations on public health risks. In fiscal year 1997, the TDH Bureau of Epidemiology conducted a total of 472 surveillance activities and field investigations covering issues such as birth defects and other adverse reproductive outcomes, cancer, potential fish advisories, Superfund sites, and pesticide-related illness.

  Many of these TDH-led investigations were brought to the Department's attention by agencies that serve on the Committee, including TNRCC, the Texas Department of Agriculture, and the Texas Parks and Wildlife Department.

▼ **The Toxic Substances Coordinating Committee is the only official forum for TDH and the public to communicate with other agencies on the public health risks related to toxic substances and harmful physical agents.**

- Although TDH staff currently have excellent informal relationships with other agencies, the Toxic Substances Coordinating Committee is the only official forum for such coordination. Thus, if informal communication between TDH and another agency were to break down, or if an agency were to overlook the potential health consequences of a policy decision, the law creates a permanent and effective communication channel.

- A statutory forum also guarantees public access. Committee meetings are subject to open meetings laws. Interest groups, as well as agencies not represented on the committee, have regularly attended committee meetings. For example, representatives from the General Land Office and the Structural Pest Control Board have attended committee meetings when they were interested in specific issues. Representatives of the chemical industry have also regularly attended committee meetings since its creation in 1987.

TDH is the only state agency with the expertise and authority to perform public health risk assessments.

▼ **The federal government encourages interagency coordination on the regulation of toxic substances and harmful physical agents, and designates TDH as the lead agency for conducting health risk assessments.**

- TDH performs health risk assessments under the federal Comprehensive Environmental Response, Compensation, and Liability Act. Federal regulations require data to be collected from state and local health and environmental agencies.[2] The Committee allows efficient exchange of information between the state agencies involved.

- Under a cooperative agreement with the federal Agency for Toxic Substances and Disease Registry, TDH has conducted surveillance of hazardous substance emergency events since 1993. Depending on the type of hazardous substance, TDH coordinates with numerous agencies such as the Texas Department of Transportation for transportation-related emergency events.[3]

- **The Toxic Substances Coordinating Committee has successfully fostered interagency coordination.**

- Numerous examples of the Committee's success exist. When unusually high rates of birth defects were discovered along the Texas-Mexico border in 1991 and 1992, TDH, through the Committee, called upon the Air Control Board, now a component of TNRCC, to perform air monitoring.[4] Also, the Railroad

Commission relied on the Committee to find out if recent mercury-related fish advisories in East Texas were linked to the oil and gas industry, which it regulates.[5]

- In addition to its statutorily required efforts, the Committee has been proactive in its role. A recent example is the fish sampling advisory subcommittee, which facilitates the sharing of information between TNRCC, the Texas Parks and Wildlife Department, the Texas Department of Agriculture, Texas river authorities, and TDH, as well as several federal agencies.[6] The subcommittee has developed sampling protocols and conducted joint fish contamination projects.

Texans expect a clear and consistent response from State government on issues of public health.

- The Toxic Substances Coordinating Committee allows State government to respond to public health concerns with one voice. For example, East Texans who are worried about high levels of mercury in fish, should not be required to understand the different roles that the Railroad Commission, Parks and Wildlife Department, and TDH play. Houston residents concerned about smog should not be required to know that TNRCC enforces air quality laws while TDH protects public health. When a public health concern arises, Texans expect a clear and consistent response from State government.

Conclusion

The Health Risk Assessment of Toxic Substances and Harmful Physical Agents Act expires on September 1, 1999. The Act creates the Toxic Substances Coordinating Committee, an interagency committee charged with coordinating communication among a variety of regulatory agencies. The Committee provides an official forum for agencies to tap into TDH's public health expertise. During the past ten years, the Committee has successfully promoted efficiency between agencies, reduced overlap and inconsistency, and fostered uniform state policy on the regulation of toxics and other harmful substances. The continuation of the Committee would assist TDH in performing its statutorily mandated duties.

Recommendation

Change in Statute

■ **Repeal the expiration date for the Toxic Substances Coordinating Committee.**

This recommendation would allow the Toxic Substances Coordinating Committee to continue promoting interagency coordination on the regulation of toxic substances and harmful physical agents. The Committee is the only official forum for TDH, the State's lead health agency, to discuss potential health risks related to these harmful substances. Furthermore, this recommendation would allow Texas state agencies to continue tapping into Health Department expertise in the area of public health epidemiology and toxicology.

Fiscal Impact

This recommendation would have no fiscal impact. The members of the Committee are all state agency employees whose salaries are paid for by their respective agencies.

[1] S.B. 537 Committee Report, House Committee on Environmental Affairs, 70th Legislature - Regular Session, 1987.

[2] U.S. Department of Health and Human Services, Agency for Toxic Substances and Disease Registry, *Preliminary Public Health Assessment for ALCOA (Point Comfort)/Lavaca Bay* (August 24, 1995), Note of Explanation citing 42 U.S.C. 9604 (i)(6), and 42 C.F.R. Part 90.

[3] Texas Department of Health, Associateship for Disease Control and Prevention, "Epidemiology in Texas, 1996 Annual Report," pp. 24-25.

[4] Telephone Interview by Sunset staff with JoAnn Wiersema, Health Effects Branch, Texas Natural Resource Conservation Commission, March 30, 1998.

[5] Telephone Interview by Sunset staff with Leslie Savage, Underground Injection Control Division, Texas Railroad Commission, March 30, 1998.

[6] Telephone interview by Sunset staff with David Sager, Ph.D., Resource Protection Division, Texas Parks and Wildlife Department, April 6, 1998.

Issue 9

Improve the Administrative Hearings Process through Transfer to the State Office of Administrative Hearings.

Background

The Texas Department of Health set 287 hearings governed by the Administrative Procedure Act (APA) in fiscal year 1997, as shown in the chart, *Types of APA Hearings Set — Fiscal Year 1997.*

Types of APA Hearings Set Fiscal Year 1997	
Medicaid Provides	225
Emergency Medical Care	21
Consumer Health Protection	9
Meat/Poultry Inspection	6
Wholesale Drug Distributors	5
Vital Statistics	4
Hazardous Substance Registration	3
Health Care Facilities	3
Radiation Control/Radioactive Material/Waste	2
Nursing Facility Administrators	2
Massage Therapists	2
Medical Radiologic Technologists	2
Community Health Services	1
Home Health Care	1
Medical Physicists	1
Total APA Hearings Set	**287**

Two hundred and twenty-five APA hearings in fiscal year 1997 were brought by Medicaid providers, most of whom felt they did not receive adequate payment for their services. Due to a recent change in TDH policy, the majority of these cases would no longer be conducted as formal APA hearings if held today. Statute requires an APA hearing only if cancellation of a Medicaid provider's contract is proposed, not when payment has been reduced or denied. These Medicaid provider hearings are now conducted as fair hearings, established through federal case law to resolve disputes regarding federal benefit programs. These hearings are less formal than APA hearings and do not require APA-type findings of fact and conclusions of law, or adherence to the rules of evidence. The fair hearings are not governed by the APA, and thus are not subject to transfer.

TDH also conducted fair hearings for Medicaid recipients, WIC recipients, and recipients of other federal benefit programs. Recipients of benefits under these federal programs are entitled to fair hearings when services are denied, suspended, reduced, or terminated. TDH set 207 fair hearings in fiscal year 1997.

The 62 non-Medicaid APA hearings set in 1997 were primarily related to TDH's regulatory enforcement programs. Last year, TDH conducted hearings related to the regulation of athletic trainers, food and drugs, asbestos, EMS personnel, radiation facilities, meat processing facilities, home health facilities, and massage therapists. TDH also conducted APA hearings to resolve disputes regarding the issuance of birth certificates. The Commissioner of Health makes final decisions on APA cases, and a dissatisfied party may appeal in district court.

In 1991, the Legislature created the State Office of Administrative Hearings to conduct administrative hearings for state agencies. The Sunset Commission has routinely reviewed administrative hearings conducted by agencies to determine whether this service could be better performed by SOAH. The review focused on whether transferring the Department's APA hearings to SOAH would increase the independence, quality, and cost effectiveness of the hearings.

Findings

▼ **TDH's administrative hearings process would be more independent if located at SOAH.**

Independence, particularly for enforcement hearings, would improve if SOAH conducted the Department's APA hearings.

- The majority of the participants in TDH regulatory hearings—the administrative law judge (ALJ), the Department's attorneys, and the staff that investigates and brings the charge of a regulatory violation—are all employed by TDH. This relationship provides the opportunity for ex parte communication and creates the perception that the hearings process and the ALJ's decision are not independent and fair.
- The perceived lack of independence would not exist if APA hearings were conducted by an ALJ employed by SOAH. The ALJs assigned to perform hearings for TDH would be housed with SOAH. Transferring administrative hearings would separate the Department's role as a party in hearings from its responsibility to conduct the hearing.
- In response to a Senate interim survey in 1996, when asked about the transfer of certain hearings functions to SOAH, TDH responded that "the public is more favorable to hearings at SOAH."[1]

▼ **SOAH has the experience and ability to hold quality administrative hearings.**

- SOAH serves as the central administrative hearings office for the State and hires qualified ALJs. SOAH currently employs 54 ALJs who receive, on average, more than 73 hours each of continuing education and in-house training on hearings and law-related topics every year.[2] In addition, new legislation from the 75th Legislative Session requires SOAH to provide 30 hours of continuing legal education and judicial training within the first year of employment to any new ALJ with less than three years of presiding experience.

- SOAH docketed 18,515 hearings in fiscal year 1997 for about 50 agencies, including a number of health and human service agencies such as the Texas Department of Mental Health and Mental Retardation and the Texas Commission on Alcohol and Drug Abuse.[3] In addition, SOAH has shown its ability to conduct complex hearings through its work for the Public Utility Commission, and its hearings on environmental regulations for the Texas Natural Resource Conservation Commission.

- Five of the 12 professional licensing boards administratively attached to TDH already have their hearings at SOAH, and those hearings are similar to many of the regulatory hearings conducted at TDH. The Texas State Board of Examiners of Perfusionists, the Texas State Board of Social Work Examiners, the Texas State Board of Examiners of Marriage and Family Therapists, the Texas State Board of Examiners of Professional Counselors, and the Council on Sex Offender Treatment Providers all refer their APA hearings to SOAH.

Non-Austin Hearings Fiscal Year 1997	
Abilene	1
Arlington	1
El Paso	1
Harlingen	1
Houston	1
San Antonio	2
Sealy	1
Tyler	1

▼ **SOAH would provide better access to regional hearings than TDH.**

- TDH ALJs traveled to eight Texas cities in fiscal year 1997 to hold administrative hearings on nine cases. The chart, *Location of TDH Hearings — Fiscal Year 1997*, shows the locations outside Austin where hearings have been conducted. TDH spent about $2,500 on travel costs associated with those hearings.

- By hearing cases regionally, SOAH would give affected persons convenient access to the hearings process and would reduce costs by eliminating travel time of an ALJ sent from TDH in Austin. In 1997, SOAH employed 21 ALJs at nine regional offices in Corpus Christi, Dallas, El Paso, Fort Worth, Houston, Lubbock, San Antonio, Tyler, and Waco.[4] The ALJs travel to locations within their regional areas to hold hearings.

Transferring hearings to SOAH has resulted in a 38.9 percent reduction in the cost of hearings.

▼ **SOAH has reduced overall hearing costs for state agencies that have transferred their hearings functions to SOAH.**

- SOAH has consistently been able to reduce the overall hearing costs to the State. SOAH estimates that it saved more than $727,000 in hearings costs that would have been incurred by 50 State agencies had the hearings been conducted in-house. This savings represents a 38.9 percent reduction in the cost of hearings.[5]

- Because TDH and SOAH use a different method for recording and calculating hearings costs, directly comparable cost information was not available.

▼ **SOAH has provided state agencies and citizens with a fair and efficient administrative hearings process.**

- Results from a survey conducted by the Senate State Affairs Committee in 1996 indicated that 43 out of 46 agencies for which SOAH held hearings, including TDH, believed that SOAH was fulfilling its mission as the State's hearing office.[6]
- Eighty-five percent of the participants surveyed by the Legislative Budget Board for fiscal year 1997 were satisfied with the overall process of SOAH.[7]

In keeping with the intent of the Legislature, the Department's APA hearings should be transferred to the State Office of Administrative Hearings.

Conclusion

The Legislature has clearly expressed its intent to consolidate the hearings functions of state agencies if such a transfer would improve the independence, quality, or cost effectiveness of hearings. The review of the Department's APA hearings process indicated that SOAH has the ability to conduct the hearings and that a transfer would provide more perceived independence, would provide an equal level of quality, and could improve the cost effectiveness of the hearings process.

Recommendation

Change in Statute

■ **Transfer the Department's Administrative Procedure Act hearings to the State Office of Administrative Hearings.**

This recommendation would transfer the Department's APA hearing function to the State Office of Administrative Hearings. TDH held 68 APA non-Medicaid hearings in fiscal year 1997, some of which were carried over from the previous year. These are the hearings subject to transfer. TDH employed three full-time ALJs to conduct the 360 APA and fair hearings held in fiscal year 1997. As a result of the approximately 68 fewer formal, complex, and presumably more time-consuming APA hearings each year, TDH should consider a reduction in ALJs.

In conducting hearings, SOAH would consider TDH's applicable substantive rules or policies. In this way, the Department would still determine how broader policy matters or recurring

issues would be treated by administrative law judges. As with the current TDH hearings process, SOAH would issue proposals for decision to the Commissioner of Health. The Commissioner must make the final decision, but could alter the ALJ's proposal only if (1) the ALJ did not properly apply or interpret applicable law, agency rules, written policies, or prior administrative decisions, (2) the ALJ relied on a prior administrative decision that is incorrect or should be changed, or (3) a technical error in a finding of fact should be changed. The agency must state in writing the specific reason and legal basis for a change to the proposal for decision.

In 1997, the Legislature, for the first time, appropriated a lump sum to SOAH from the General Revenue Fund, to conduct hearings. In addition, some agencies choose to pay SOAH a lump sum based on an estimated case load for the agency. Traditionally, agencies have paid SOAH an hourly rate to conduct its hearings. If the Legislature transferred the hearings, any of these options could be considered.

Fiscal Impact

Historical data indicates that costs related to administrative hearings transferred to SOAH have been reduced by approximately 39 percent. However, the fiscal impact of this transfer of duties cannot be determined because the specific costs for TDH related to the hearings will depend on the payment structure determined by the Legislature and whether TDH is able to reduce its number of ALJs. Any savings would be reallocated within TDH.

[1] Data derived from Senate State Affairs survey of state agencies regarding SOAH performance, February 28, 1996.

[2] Information provided by Sheila Bailey Taylor, Chief Administrative Law Judge, the State Office of Administrative Hearings, March 12, 1998.

[3] Ibid.

[4] Ibid

[5] Memorandum from Sheila Bailey Taylor, Chief Administrative Law Judge, State Office of Administrative Hearings, April 10, 1998.

[6] Data derived from Senate State Affairs survey of state agencies regarding SOAH performance, February 28, 1996.

[7] Summary Assessment of Agency Performance, Fiscal Year 1997, Legislative Budget Board, Page VIII-6.

Issue 10

Decide on Continuation of the Texas Department of Health as a Separate Agency After Completion of Sunset Reviews of all Health and Human Service Agencies.

Background

The Legislature scheduled most of the State's health and human service agencies for Sunset review in 1999. Health and human services (HHS) is the second largest function of State government. With a combined appropriation of $26.1 billion for the 1998-99 biennium, these agencies account for almost 30 percent of State government's budget.

With most HHS agencies under review together, the Sunset Commission has an unprecedented opportunity to study how the State has organized this area of government. Currently, 13 separate agencies have primary responsibility to carry out the numerous state and federal programs, services, assistance, and regulations designed to maintain and improve the health and welfare of the citizens of Texas. Reviewing these agencies together will enable a look across agency lines — at types of services provided, types of clients served, and funding sources used. Assuming any organization changes are needed, this information will prove valuable in the analysis of how best to make those changes.

TDH is one of 13 health and human service agencies currently under Sunset review.

Central to the Sunset review of any agency is determining the continuing need for the functions it performs and whether the current agency structure is the most appropriate to carry out those functions. Continuation of an agency and its functions depends on certain conditions being met, as required by the Sunset Act. First, a current and continuing need should exist for the State to provide the functions or services. In addition, the functions should not duplicate those currently provided by any other agency. Finally, the potential benefits of maintaining a separate agency must outweigh any advantages of transferring the agency's functions or services to another agency.

The Sunset staff evaluated the continuing need for the Texas Department of Health (TDH) and its functions in light of the conditions described above. This approach led to the following findings.

Findings

▼ **Texas has a continuing need for the services provided by the Texas Department of Health.**

◗ The Department's main functions, assessing health needs and developing policies and programs to address those needs, are critical to the State's goal to protect and promote the health of Texans. Assessing the health needs of Texans is essential for prioritizing and developing appropriate public health policies. The agency accomplishes this by collecting and analyzing health information and conducting health-related studies.

The Department's main functions - assessing and addressing the State's health needs - should be continued.

For example, TDH compiles statistics on diseases such as cancer, HIV, diabetes, and tuberculosis that all pose serious health risks to the public. As the State's collection point for health data, TDH can take action to respond to unusual events. For example, in January 1998 the Department investigated a higher than expected number of invasive Strep A infections, known as the "flesh-eating bacteria," that required a quick response. By May, 41 deaths from Strep A had been confirmed. TDH compiled information for medical professionals and operated a toll-free hotline. The Department also obtained very limited supplies of human gamma globulin shown to reduce mortality rates from Strep A up to 50 percent.

Also critical to its assessment functions, TDH operates a laboratory with a staff of more than three hundred scientists and other staff that perform important genetic, cholesterol, and glucose screens, conduct 33,000 tuberculosis tests a year, and test drinking water to ensure water quality.

◗ Once the State's health needs have been assessed, TDH has developed a variety of educational, regulatory, and direct service programs to address those needs, including the programs described below.

The agency operates prevention-based programs that educate the public on topics such as nutrition, dental health, smoking, diabetes, and birth defects. For example, TDH staff provide counseling and folic acid supplements to decrease the risk of birth defect recurrences in the fourteen Texas-Mexico border counties. TDH also educates health care professionals in clinical settings about the benefits of prevention through a program called *Put Prevention into Practice*.

TDH also regulates 15 different health professions, such as massage therapists and emergency medical services providers, as well as 40 health facilities and industries, including home health agencies, hospitals, and food and drug manufacturers. The Department regulated over 118,000 professionals and more than 129,000 facilities during fiscal year 1997. TDH received and investigated 6,608 complaints in fiscal year 1997, and took enforcement actions, as detailed in Appendix B, *Background Information on TDH Regulation.*

The Department also has responsibility to take regulatory action to prevent potential harm to the public. For example, the Department recently proposed rules that would restrict the sale of ephedrine, currently an ingredient in many diet pills and energy boosters, due to a risk of elevated blood pressure, seizures, and death.

The Department administers 37 direct health care delivery programs for many low-income Texans, especially women and children. Eligible Texans receive direct health care services one-on-one from health care providers, including doctors, nurses, and nutritionists. TDH administers about $5 billion a year for comprehensive acute care Medicaid services for low income Texans, and approximately $1 billion for non-Medicaid health care delivery programs.

Medicaid programs include the fee-for-service program, Medicaid managed care program and Texas Health Steps, a program that provides comprehensive screening and treatment for eligible Texas children. Non-Medicaid programs include the county indigent health care program, and family planning, immunization, HIV/STD, and nutrition programs, in addition to other specialized programs for children with complex medical problems. For all of these programs, TDH functions as a contract manager, administering funds, directing policy, and monitoring contract compliance.

▼ While the agency's current functions should continue, organizational alternatives exist that should be explored.

- TDH is one of 13 separate agencies that perform the State's health and human service functions. These agencies' responsibilities are generally unique, but the types of services offered, clients served, and funding sources used are sometimes very similar. For example, many of the same clients that are

eligible to receive Medicaid services from TDH are also eligible for Temporary Assistance for Needy Families (TANF) provided by the Texas Department of Human Services.

- Because of these similarities, many options to the current system have been and should continue to be considered. For example, the interim work of the Legislature during the past four years has yielded more than 550 recommendations for change in HHS policies and operations. Many of these recommendations have not been implemented and should be considered in the Sunset process.

- Continuation of an agency through the Sunset process hinges on answering basic questions about whether duplication of functions exists between agencies and whether benefits would result from consolidation or transfer of those functions. The Sunset staff has identified several instances where organizational change may be warranted. Examples include consolidation of core administrative functions, collocation of field offices, collapsing of contracting functions, better alignment of similar services to similar clients, and a close look at how planning and budgeting could be improved. These changes should be looked at before the Sunset Commission makes decisions to continue an HHS agency under review.

The Sunset Commission should decide on continuation of TDH once all HHS agency reviews are completed.

▼ **Continuation of TDH as a separate agency should be decided after completion of all HHS agency Sunset reviews.**

- The Sunset reviews of the HHS agencies are scheduled for completion at various times before the end of 1998. The Sunset staff will use the results of this work in its review of the Health and Human Services Commission, the umbrella agency for HHS. The staff will also study the overall organizational structure of this area of government. Finally, the staff will evaluate issues that cut across agency lines, such as the need for a single agency for long-term care, consolidation of services to persons with disabilities, the need for a single agency to administer Medicaid services, and streamlining regulatory functions.

- The Commission's schedule sets the review of the Health and Human Services Commission and HHS organizational and cross issues for the Fall of 1998. Delaying decisions on continuation of all HHS agencies, including TDH, until that

time allows the Sunset staff to finish its work on all the agencies and base its recommendations on the most complete information.

Conclusion

Most of the State's health and human service agencies are currently under Sunset review. While these agencies serve many unique purposes they also have many similarities that should be studied as areas for possible improvement through organizational change. This analysis should occur before decisions are made to continue the HHS agencies as separate entities, including the Department of Health.

Recommendation

Change in Statute

- **Decide on continuation of the Texas Department of Health as a separate agency upon completion of Sunset reviews of all health and service agencies.**

Sunset review of several other HHS agencies are ongoing. Sunset staff recommends that the Sunset Commission delay its decision on continuation of TDH as a separate agency until those reviews are completed. The results of each agency review should be used to determine whether changes are needed in the overall organization of health and human services.

The staff will issue a report to the Commission in the Fall of 1998 that will include recommendations for each HHS agency—to continue, abolish and transfer functions, or consolidate specific programs between agencies. This report will also include, for possible action, three agencies under the HHS umbrella not scheduled for specific review this cycle, the Department of Protective and Regulatory Services, the Texas Commission on Alcohol and Drug Abuse, and the Texas Juvenile Probation Commission. These agencies were reviewed by the Sunset Commission in 1996 and continued by the Legislature last year. Possible reorganization of health and human services may affect the continuation of these agencies as independent entities.

ACROSS-THE-BOARD RECOMMENDATIONS

INTRODUCTION

The following is a listing of the Sunset Commission's Across-the-Board recommendations followed by charts indicating their application to the TDH Board and the other attached boards under review.

The Across-the-Board recommendations (ATBs) are broken into two categories - general and licensing. To decide which general ATBs to apply, staff evaluated the statute of the Texas Board of Health and the statutes of the six administratively-attached boards appointed by the Governor that do not have a separate Sunset date. To decide which licensing ATBs to apply, we evaluated the professional licensing statutes administered by TDH and those of the administratively-attached boards mentioned above.

General Across-the-Board Recommendations
1. Require at least one-third public membership on state agency policymaking bodies.
2. Require specific provisions relating to conflicts of interest.
3. Require that appointment to the policymaking body be made without regard to the appointee's race, color, disability, sex, religion, age, or national origin.
4. Provide for the Governor to designate the presiding officer of a state agency's policymaking body.
5. Specify grounds for removal of a member of the policymaking body.
6. Require that information on standards of conduct be provided to members of policymaking bodies and agency employees.
7. Require training for members of policymaking bodies.
8. Require the agency's policymaking body to develop and implement policies that clearly separate the functions of the policymaking body and the agency staff.
9. Provide for public testimony at meetings of the policymaking body.
10. Require information to be maintained on complaints.
11. Require development of an equal employment opportunity policy.
Licensing Across-the-Board Recommendations
1. Require standard time frames for licensees who are delinquent in renewal of licenses.
2. Provide for notice to a person taking an examination of the results of the examination within a reasonable time of the testing date.
3. Authorize agencies to establish a procedure for licensing applicants who hold a license issued by another state.
4. Authorize agencies to issue provisional licenses to license applicants who hold a current license in another state.
5. Authorize the staggered renewal of licenses.
6. Authorize agencies to use a full range of penalties.
7. Revise restrictive rules or statutes to allow advertising and competitive bidding practices that are not deceptive or misleading.
8. Require the policymaking body to adopt a system of continuing education.

General Across-The-Board Recommendations											
	ATB 1	ATB 2	ATB 3	ATB 4	ATB 5	ATB 6	ATB 7	ATB 8	ATB 9	ATB 10	ATB 11
Texas Board of Health	U	S	S	S	U	S	A	S	S	U	S
Advisory Board of Athletic Trainers	A*	A/M	A	A	A	A/M	A	A/M	A	A	NA
Texas Radiation Advisory Board	NA	A/M	A	A	A	A/M	A	A/M	A	A	NA
Texas Council on Alzheimer's Disease and Related Disorders	NA	A/M	A	A	A	A/M	A	A/M	A	A	NA
Statewide Health Coordinating Council	S	A/M	A	A	A	A/M	A	A/M	A	A	NA
Texas Diabetes Council	S	S	U	A	S	A/M	A	A/M	A	A	NA
Texas Board of Licensure for Professional Medical Phycisicts	A**	U	U	A	U	A/M	A	A/M	A	A	NA

* Two athletic trainers would be replaced by two public members.
**The non-certified medical physicist and one physician would be replaced by two public members.

Licensing Across-The-Board Recommendations								
	ATB 1	ATB 2	ATB 3	ATB 4	ATB 5	ATB 6	ATB 7	ATB 8
Advisory Board of Athletic Trainers	U	S	S	S	S	U	A	U
Respiratory Care Practioners	A	A	S	S	A	S	A	S
Optician's Registry	A/M	A	NA	NA	S	U	A	U
Medical Radiologic Technologist	A	A	S	A	A	S	A	U
Disease and Related Disorders	S	S	S	A	S	S	A	U
Texas Board of Licensure for Professional Medical Phycisicts	S	S	U	A	S	A/M	A	A/M
Massage Therapy Registration Program	U	A	U	A	S	U	A	A
Emergency Medical Services (EMS)	U	S	S	S	A	U	A	A
Asbestos Licensure	U	A	S	A	A	U	A	S
Lead Certification	A	A	S	NA	A	U	A	NA

Updated in Issue 3

A	Applied
A/M	Apply/Modify
U	Update
S	Already in Statute
NA	Not Applicable

BACKGROUND

Background

AGENCY HISTORY

The Texas Department of Health (TDH) is responsible for protecting and promoting the health of all Texans. The Department administers a variety of health programs to accomplish its mission. For example, TDH has a number of population-based public health programs that perform a range of functions such as controlling the outbreak of rabies, monitoring statewide health data, and inspecting children's toys for safety. These programs are intended to improve the health of the population as a whole or a large group of Texas citizens. The Department also regulates a number of health professions, such as dietitians and massage therapists, and health facilities, such as home health agencies and hospitals. In addition, TDH administers programs such as Medicaid acute care services and several other programs including the county indigent health care program that purchase medical care for low-income Texans. In addition, TDH works with other components of the health care system attempting to understand and address the underlying causes of poor health status in Texas.

The Department has its roots in the position of the State Health Officer, created in 1879.

Since the position of State Health Officer was created in 1879 to combat epidemics of yellow fever, smallpox, and cholera, the responsibilities of the Department have increased dramatically. The *Texas Department of Health Growth Chart* shows that between 1920 and 1997, 44 programs were created or transferred to TDH, while only nine programs have been transferred from TDH.

This dramatic growth can be attributed in part to new interventions designed to prevent and control the spread of disease, growing health risks from environmental contaminants, and emerging infectious diseases. In addition, the creation of new federal health programs, starting in 1920 with the creation of the Federal Board of Maternity and Infant Hygiene, has contributed to the increased responsibilities. In fiscal year 1997, federal funds accounted for about 62 percent of the agency's budget of $6.6 billion. The lion's share of federal funds, or $3.5 billion, are used to fund the acute care Medicaid program that the Legislature transferred from the Texas Department of Human Services in 1993.

Texas Department of Health Growth Chart		
Years	**Added to TDH**	
Prior to 1930	Vital statistics General sanitation Maternal and child health Rural health sanitation Communicable disease control	Food and drug safety Public health education Laboratories Venereal disease control
1930-1950	Public health nursing Crippled children's services Bedding regulation School health services Mental health services	Hospital survey, construction Local health services Tuberculosis control Cancer control
1950-1960	Nursing and convalescent homes licensure Radiation Control Hospital licensure Emergency medical services regulation	Occupational health Water pollution control Chronic disease prevention Heart disease prevention
1960-1980	Vector control (mosquito control) Marine resources Nutrition Federal women, infants, and children's nutrition program	Wastewater technology and surveillance Veterinary public health Kidney health care
1980-1997	Professional licensing Home health agency licensing Birth defects monitoring Tanning facility and tattoo studio regulation Office of Minority Health Preventive health services (EPSDT, family planning) Medicaid direct care services (acute care)	Health care facility licensing (In addition to hospitals) HIV/AIDS services Indigent health care program Genetics screening and counseling Medically Dependent Children Program
Transferred to Other State Agencies		
1960-1980	Mental health services Industrial water pollution control	Air pollution control
1980-1997	Solid Waste disposal Drinking water regulation Long term care licensing, certification, survey and investigation	Sewage waste disposal Radioactive waste disposal Occupational Safety

As TDH has grown, it has gradually become more proactive than reactive. While TDH began as an agency to protect the public from ongoing cholera outbreaks, more and more the agency's programs focus on promoting public health through education and prevention, such as educating the public about the health risks of smoking, and promoting the benefits of prenatal care and good nutrition.

In keeping with this trend, TDH is currently shifting its emphasis from providing clinical services to individuals, to providing more population-based public health services. Many factors have contributed to this shift. For example, although the federal government has been giving more responsibility to the states for developing public health programs in recent years, it has decreased funds to the states for some of those programs. In addition, the growth of managed care has shifted patients from the traditional safety net of health clinics administered by TDH and local health departments into a "medical home" for comprehensive health care, making the health clinics less cost-effective. As a result, TDH is now redirecting its efforts toward population-based services that will improve the health of many, such as community health education, disease and injury surveillance, outbreak investigations, and quality assurance for clinical and population-based services that it funds.

POLICYMAKING BODY

The Texas Department of Health is governed by a six-member Board appointed by the Governor with the advice and consent of the Senate. Four members of the Board must have a demonstrated interest in the services provided by TDH, and two members must represent the public. Board members serve staggered six-year terms, and the Governor designates a Chair and Vice-Chair every other year.

The Health and Safety Code sets out the duties and responsibilities of the Board. Twenty-five advisory committees assist the Board with its varied responsibilities. The Board created most of these through rule, although the Legislature has created three advisory committees through statute — the Osteoporosis Advisory Committee, the Prostate Cancer Advisory Committee, and the Animal Friendly Advisory Committee.

The Board oversees the operation of the Department and hires the Commissioner of Public Health, with the approval of the Governor. The Board may delegate to the Commissioner any power or duty granted to the Board except rulemaking authority. The Board members serve on five standing committees — strategic management, health and clinical services, regulatory, human resources, and health financing. The Board typically meets about 10 times a year, but met 14 times in fiscal year 1997 due to the time-consuming process of choosing a new commissioner.

Board Members and Advisory Committees

Four members with demonstrated interest in services:
Walter D. Wilkerson, Jr., M.D. (Chair) (Conroe)
David L. Collins, P.E. (Houston)
Mario Anzaldua, M.D. (Mission)
Ruth F. Stewart, M.S., R.N.C. (San Antonio)

Two public members
Mary E. Ceverha, M.P.A. (Vice-chair) (Dallas)
J. C. Chambers (Lubbock)

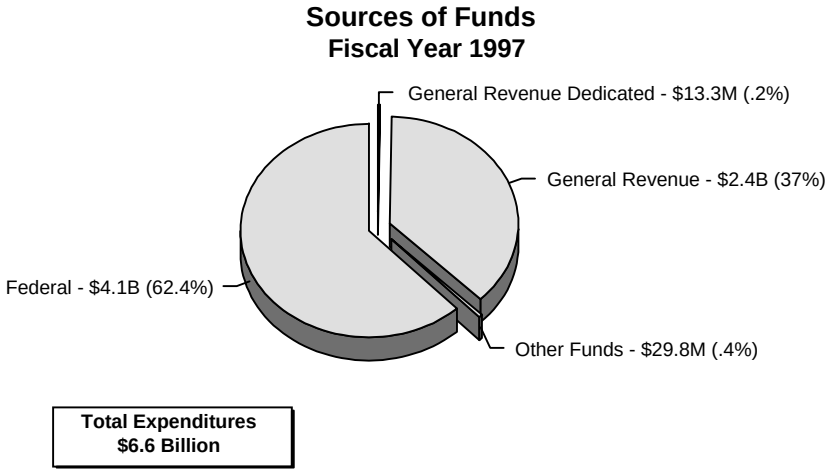
Current Advisory Committees
Advisory Council of the Optician's Registry
Animal Friendly Advisory Committee
Asbestos Advisory Committee
Children with Special Health Care Needs Advisory Committee
Community Oriented Primary Care Advisory Committee
Device Distributors and Manufacturers Advisory Committee
Emergency Health Care Advisory Committee
Family Planning Advisory Council
Hazard Communications Act Advisory Committee
Home and Community Support Services Advisory Committee
Hospital Data Advisory Committee
Indigent Health Care Advisory Committee
Kidney Health Care Advisory Committee
Medical Radiological Technologist Advisory Committee
Oral Health Services Advisory Committee
Osteoporosis Advisory Committee
Poison Control Coordinating Committee
Prostate Cancer Advisory Committee
Respiratory Care Practitioners Advisory Committee
Sanitation/Code Enforcement Officers Advisory Committee
Scientific Advisory Committee on Birth Defects
TDH/Board of Nurse Examiners MOU Advisory Committee
Texas HIV Medication Program Advisory Committee
Texas Radiation Advisory Board

FUNDING

Sources of Funding

The Department receives the largest appropriation of any health and human service agency. The Department's total funding of $6.6 billion in fiscal year 1997 includes both state and federal dollars, detailed on the following page.

More than 62 percent, or $4 billion, of the annual budget came from federal funding sources. The primary federal funding sources shown in the chart, *TDH Primary Sources of Funds — Fiscal Year 1997*, include Medicaid, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), HIV/STD, Maternal and Child Health Block Grant (Title V of the Social Security Act), Family Planning (Titles X and XX of the Social Security Act), Childhood Immunizations, Tuberculosis Control, Preventive Block Grant, Breast and Cervical Cancer Control, State Survey and Certification, Meat and Poultry Inspection, and CDC Investigations & Technical Assistance.

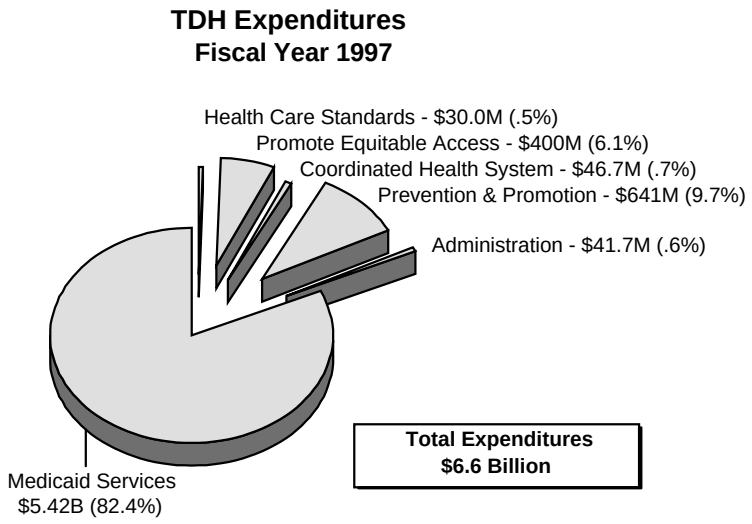


State revenue funds the balance of the Department's budget, a significant portion of which matches federal funds for Medicaid. Over $2.4 billion of the budget is supported by general revenue, $13.3 million from dedicated general revenue, including fees generated by TDH programs, and $29.8 million from interagency contracts, the State Highway Fund, and appropriated receipts from Medicaid, the two TDH Hospitals and other programs.

TDH Primary Sources of Funds Fiscal Year 1997	Amount in Millions
Federal Funds	
Medicaid • The state/federal match ratio is 37.46%: 62.54% to provide a broad range of federally mandated services including medical and dental screenings for children, outpatient and inpatient hospital services, physician visits, family planning, and transportation. • For the same match rate, Texas has chosen to provide optional services such as prescription drugs and chiropractic services.	$3,520.2
WIC • A categorical grant to provide food vouchers, immunizations, nutrition education, and health care referrals for children under 5, pregnant women, breast-feeding women, and women who have recently had a baby. Includes rebates from manufacturers for a percentage of the cost of infant formula purchased with WIC federal funds.	$438.8
HIV and STD • Provides for the purchase and distribution of medications for the treatment of HIV/AIDS and other sexually transmitted diseases (STDs). • Funds site reviews, technical assistance, and consultations to community-based organizations that contract with TDH for HIV and STD services.	$34.5
Maternal & Child Health Block Grant (Title V) • A $3 state match is required for every $4 of federal funding spent on a broad range of clinical and educational programs designed to improve the health of women and children in the state, including children with special health care needs.	$39.4
Family Planning (Titles X and XX) • Grants (categorical-block) for family planning services, including breast exams, cervical cancer screening, testing for HIV and STDs, and referrals for prenatal and other care.	$23.2
Childhood Immunizations • TDH purchases vaccines and distributes them through contracts with local health departments, community health centers, and private providers. • Federal Vaccines for Children provides vaccines for Medicaid enrolled, uninsured, underinsured, and Native American children.	$12.7
Tuberculosis Control • Funds preventive activities such as the TB registry, out reach, and the bi-national project with Mexico. • Refugee health screening.	$5.8
Preventive Block Grant • Funds many TDH disease prevention programs including Adult and Community Health, Border Environmental Health, Tobacco Prevention, Continuing Nursing Education, Trauma Registry, Fluoridation Program and Public health promotions. • Many of these funds pass through TDH to local health departments to provide public health services on a community level.	$6.4
Breast & Cervical Cancer Control • Provides screenings for eligible low income women through contracts with local health departments and private providers.	$4.6
State Survey & Certification • Survey of health care facilities/agencies that participate in the federal Medicare certification program and/or are regulated under state licensing statutes.	$3.2
Meat & Poultry Inspection • Federal match of state funds used to enforce the state's meat and poultry regulations, which must be comparable to or stricter than federal rules.	$3.2
CDC Investigations & Technical Assistance • Pays for surveillance, risk assessments, and health consultations relating to Texas' National Priorities List (Superfund) sites, state hazardous waste sites, emergency events, and potential disease clusters.	$1.8
Other Federal	$6.8

TDH Primary Sources of Funds Fiscal Year 1997	Amount in Millions
General Revenue Funds	
GR Match for Medicaid • General Revenue for services to Medicaid eligible clients; these funds are "matched" by the federal government.	$2,070.5
General Revenue Fund - Public Health • General Revenue for the traditional public health strategies of the Department.	$269.4
Vendor Drug Rebates • The federal government has negotiated an arrangement whereby drug manufacturers are required to rebate to state Medicaid programs a percentage of the cost of pharmaceuticals paid for by the federal government. The state's share of these rebate revenues are appropriated to TDH as a method of finance for the Medicaid program.	$46.8
Earned Federal Funds (EFF) • EFF is generated in the following ways: recoveries from the federal government of costs previously paid from a non-federal source; charges to the federal government for recoveries of indirect costs; interest earned on federal funds; and other minor sources such as the sale of fixed assets purchased with federal funds.	$20.6
Premium Credits • The amount of premiums refunded by NHIC to TDH in excess of Medicaid costs.	$25.1
General Revenue Dedicated	
Food and Drug Registration • Fees, set by the Board of Health, related to licensing and inspection of food and drug manufacturers and wholesalers. • TDH is required to use not less than one-half of registration fees for inspection and enforcement of food and drug manufacturers and wholesalers.	$2.2
Vital Statistics • Fees, set by the Board of Health, are generated by providing certified copies of birth and death records. • Fees are used to defray the expenses incurred in the enforcement and operation of the vital statistic law.	$2.4
Public Health Services • Fees charged to persons who receive public health services from the Department including, but not limited to, distribution and administration of vaccines and serums.	$2.0
Asbestos Removal • Fees, set by the Board of Health, for the purpose of asbestos health protection.	$1.6
Home Health Services • Fees, set by the Board of Health, related to licensing home and community support service agencies in amounts reasonable to meet the costs of administering the chapter.	$1.7
Food Service Establishments • Fees, set by the Board of Health, relating to permitting and inspection of food service establishments, retail food stores, mobile food units or temporary food services establishments.	$.9
Emergency Management • Fees, set by statute, for the administration of the Emergency Medical Services Act.	$.9
Hospital Licensing • Fees based on the number of beds in hospitals and used by TDH in the administration and enforcement of the "Texas Hospital Licensing Law".	$.7
• Crippled Childrens' Refund • Mammography Systems Certification • Oyster Sales • Sexual Assault Program • Workplace Chemical List	$.91
Other Funds	$29.8

The agency spent the $6.6 billion in fiscal year 1997 for six strategic goals — prevention and promotion, Medicaid services, health care standards, the promotion of equitable access, a coordinated health system, and administration. The chart, *Expenditures by Strategy — Fiscal Year 1997*, shows the expenditures by strategy within each goal.



Expenditures by Strategy Fiscal Year 97	Millions
Prevention and Promotion	
WIC Food and Nutrition	$438.8
Preventable Diseases	$56.6
Sexually Transmitted Diseases	$55.9
Immunizations	$42.5
Chronic Disease Services	$20.2
Food and Drug Safety	$14.4
Environmental Health	$11.3
Border Health and Colonias	$1.3
Medicaid Services	
Premiums: Aged and Disabled	$1,378.0
Premiums: Children/Medically Needy	$1,181.3
Premiums: Temporary Assistance for Needy Families (TANF)	$777.6
Vendor Drug Program	$757.0
Premiums: Pregnant Women	$509.4
Medicare Payments	$391.0
EPSDT - Comprehensive Care	$174.0
Cost Reimbursed Services	$224.7
Medical Transportation	$23.5
Health Care Standards	
Laboratory	$14.5
Health Care Standards	$15.5
Promote Equitable Access	
Texas Health Steps (EPSDT) Dental	$124.9
Family Planning	$82.7
Texas Health Steps (EPSDT) Medical	$65.5
Maternal and Child Health Services	$50.7
Special Needs Children (CIDC)	$43.5
Community Health Services	$19.2
Medically Dependent Children Waiver	$12.4
Rural Health Care Access	$1.3
Coordinated Health System	
TDH Hospitals	$25.2
Health Care Coordination	$11.6
County Indigent Health	$4.4
Vital Statistics	$3.2
Health Data and Policy	$1.8
Health Care and Outcomes	$.5
Administration	
Central Administration	$13.6
Other Support Services	$9.8
Information Resources	$9.6
Regional Administration	$8.7

HUB Expenditures

The Legislature encourages agencies to increase their use of Historically Underutilized Businesses (HUBs) in purchasing goods and services, and requires the Sunset Commission to consider agencies' compliance with laws and rules regarding HUB use in its reviews. In 1997, TDH purchased 18 percent of goods and services from HUBs. The chart, *Purchases from HUBs — Fiscal Year 1997*, provides detail on HUB spending by type of contract and compares these purchases with the statewide goal for each spending category.

Purchases From HUBs
Fiscal Year 1997

Category	Total $ Spent	Total HUB $ Spent	Percent	Statewide Goal
Heavy Construction	NA	NA	NA	NA
Building Construction	$32,223	$0	0%	25.1%
Special Trade	$1,002,413	$156,657	15.6%	47.0%
Professional Services	$295,515	$0	0%	18.1%
Other Services	$106,633,691	$23,469,503	22.0%	33.0%
Commodities	$55,373,392	$6,056,147	10.9%	11.5%
Total	**$163,337,234**	**$29,682,307**	**18.0%**	

As shown in the chart, TDH did not achieve the statewide goals for purchases from HUBs. In one area, Other Services, TDH fell well below state goals, even though spending more than $100 million in this category.

ORGANIZATION

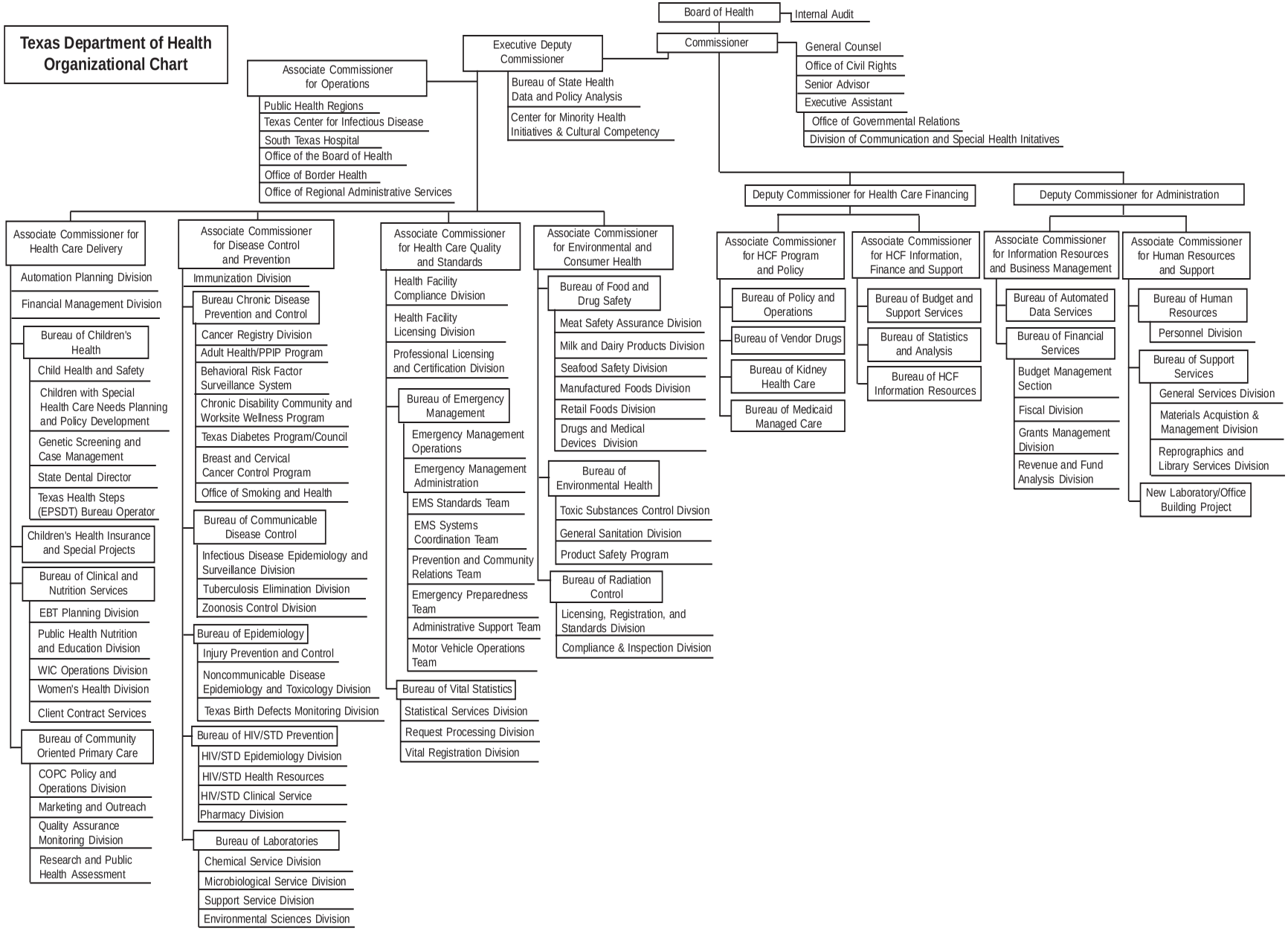
The Texas Department of Health is the 11th largest agency in the State in terms of staff. On August 31, 1997, TDH employed 5,758 employees, of which 2,886 were in the central office in Austin, 2,128 were in the eight regional offices, 626 were in the two hospitals administered by TDH, and 118 were in local health departments. The agency organizes the central office into eight primary branches called Associateships—Health Care Delivery, Disease Control and Prevention, Health Care Quality and Standards, Environmental and Consumer Health, Health Care Financing Program and Policy, Health Care Financing Information and Support, Information Resources and Business Management, and Human Resources Suppport.

In 1997, the Board of Health hired a new Commissioner of Health, Dr. William "Reyn" Archer III, and also created a new position, the Executive Deputy Commissioner, now filled by Dr. Patti J. Patterson. The chart, *Texas Department of Health Organizational Chart*, illustrates the agency's organizational structure. The chart, *Texas Department of Health Equal Employment Opportunity Statistics*, shows a comparison of the agency's workforce composition to the state's minority civilian labor force. TDH workforce percentages exceed civilian labor force levels of employment in most of the agency's job categories.

Texas Department of Health
Equal Employment Opportunity Statistics
Fiscal Year 1997

Job Category	Total Positions	Minority Workforce Percentages					
		Black		Hispanic		Female	
		Agency	Civilian Labor Force %	Agency	Civilian Labor Force %	Agency	Civilian Labor Force %
Officials/Administration	272	7%	5%	9%	8%	35%	26%
Professional	2,629	8%	7%	18%	7%	64%	44%
Technical	671	9%	13%	26%	14%	44%	41%
Protective Services	13	15%	13%	38%	18%	0%	15%
Para-Professionals	747	12%	25%	48%	30%	91%	55%
Administrative Support	1,203	15%	16%	36%	17%	87%	84%
Skilled Craft	78	13%	11%	33%	20%	3%	8%
Service/Maintenance	124	5%	19%	85%	32%	52%	27%

Texas Department of Health Organizational Chart



Administratively-Attached Boards
Texas Council on Alzheimer's Disease and Related Disorders
Interagency Council for Genetic Services
Texas Radiation Advisory Board
Advisory Board of Athletic Trainers
Statewide Health Coordinating Council
Licensure for Professional Medical Physicists
Texas Diabetes Council
HIV/AIDS Interagency Coordinating Council
Health Professions Council
Medical Advisory Board
Midwifery Board
Council on Sex Offender Treatment Providers
State Committee for Examiners in Fitting and Dispensing of Hearing Instruments
State Board of Examiners for Speech-Language Pathology and Audiology
Texas Medical Disclosure Panel
Texas State Board of Examiners of Dietitians
Texas State Board of Examiners of Perfusionists
Texas State Board of Examiners of Professional Counselors
Texas State Board of Social Work Examiners
Texas State Board of Examiners of Marriage and Family Therapists
Texas Board of Orthotists/Prosthetists

The Department's central office develops policy and rules for the Board's approval; oversees and coordinates program operation in the regions; and provides public information, information technology, and legal services. In addition, the central office performs an array of support functions, such as, administrative, investigative, and general counsel services for the boards listed in the chart, *Administratively-Attached Boards*. The Legislature attached these boards, which regulate certain health professionals and address specific diseases, to attain administrative efficiencies.

The eight regional offices—in Lubbock, Arlington, Tyler, Houston, Temple, San Antonio, El Paso, and Harlingen—cover the 11 health and human service regions in the state, as shown on the map on the following page. Each regional office has slightly different functions depending on the needs of the region. For instance, the Harlingen, San Antonio, and Houston regions have Seafood Safety programs that other regions do not have, and only Harlingen and El Paso have Border Health programs. However, several programs are common to all regions, such as Environmental and Consumer Health Protection, Disease Control and Prevention, Health Promotion, Dental Health Services, Food Safety Assurance, and Zoonosis Control.

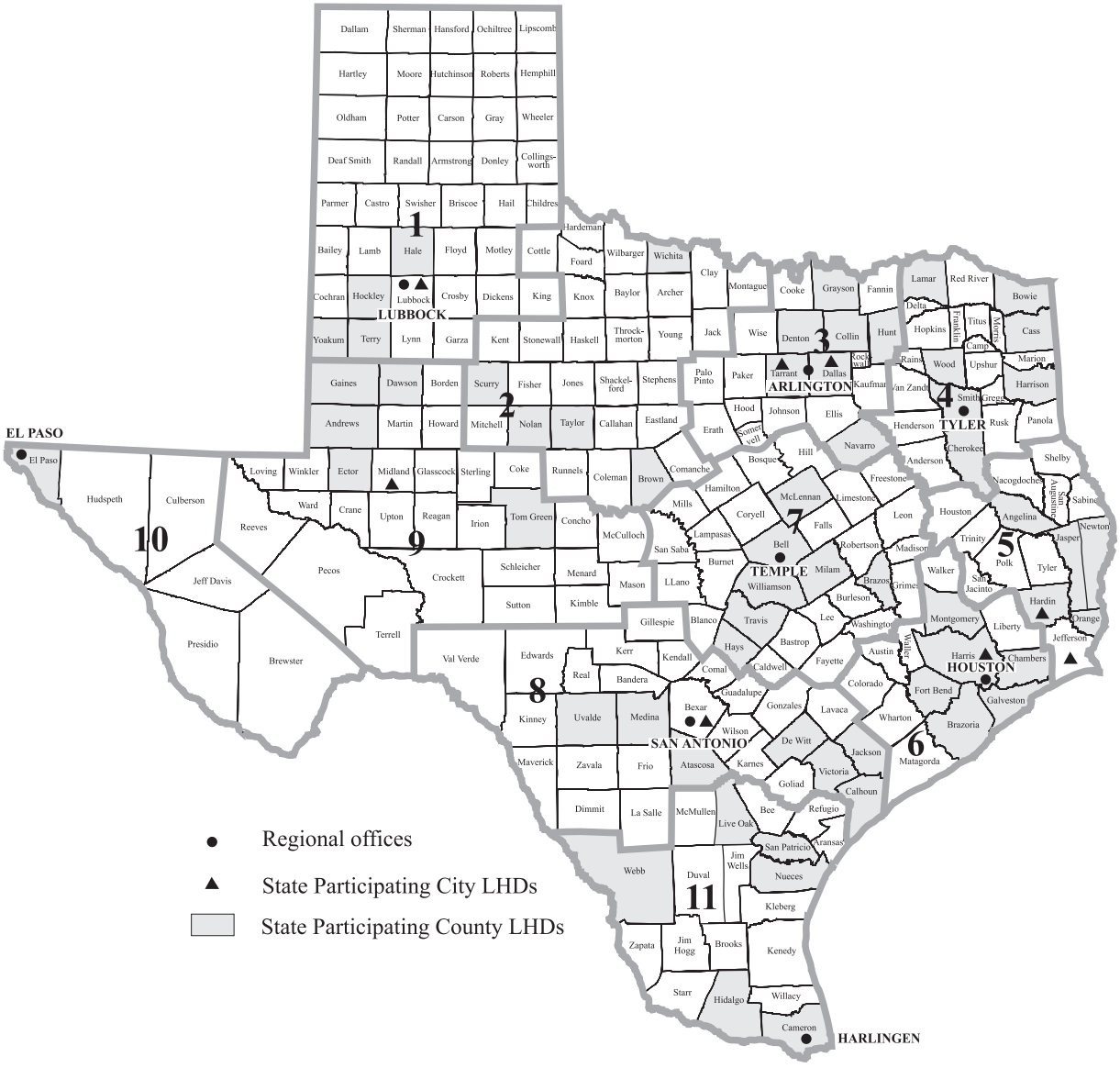
Each regional office is operated by a regional director hired by the Commissioner of Health. In general, the regional directors staff the regional programs according to the needs of each region. Regional program management staff are hired in coordination with the program staff in the central office. Regional staff are supervised by the regional director, but take policy direction from the central office program staff.

Although local public health departments (LHDs) are not part of TDH, understanding TDH's relationship with LHDs is key to understanding the overall organization of the public health infrastructure in Texas. LHDs that contract with TDH to receive state and federal pass-through funds for public health services are called "state participating" LHDs. Currently, Texas has 66 state-participating LHDs in 62 counties (as shown on the map on the following page), and 83 nonparticipating LHDs in 48 counties.

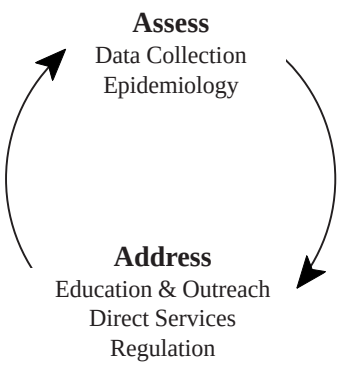
Local health departments are not part of TDH, but play a key role in public health services across the State.

TDH provides public health services in areas where an LHD does not or cannot provide the service. In areas with state participating LHDs, the LHD may perform many public health services (funded by both TDH and local governments), such as restaurant inspections, disease outbreak investigations, and health care for its low income residents. However, nonparticipating LHDs generally provide only environmental services such as septic tank inspections, and provide few, if any, public health services, necessitating greater involvement by TDH.

Texas Department of Health
Public Health Regions
and Participating Local Health Departments



AGENCY OPERATIONS



The mission of the Texas Department of Health is to protect and promote the health of all Texans. The Department accomplishes this mission through two primary functions — assessment of health needs, and development of policies and programs to address those needs.

To assess health needs, TDH collects and analyzes health information, and conducts health investigations and other health studies. These activities enable the State to prioritize and develop appropriate policies to deal with its needs. The agency then addresses Texans' health needs by educating the general public as well as targeted populations, funding health care services for the most needy Texans, and regulating industries that directly affect health.

The public health cycle is a dynamic process. The role of the Department of Health, therefore, is to constantly assess, address, and then re-assess public health in Texas.

ASSESSING THE STATE'S HEALTH NEEDS

The first step in fulfilling the Department of Health's mission to protect and promote the health of all Texans is to get a good picture of the state's overall health. To do this, TDH collects, analyzes, and disseminates health information, and conducts epidemiologic and other health studies. Although almost all Department of Health activities, including regulatory and service delivery programs, have data collection or other assessment components, this discussion focuses primarily on the Associateship for Disease Control and Prevention, the hub of the Department of Health's assessment activities. The chart, *Assessment Programs*, provides a brief discussion of TDH's programs in this area.

Data Collection

One of TDH's long standing duties is maintaining the State's vital statistics.

One of the long-standing functions of the Department of Health is collecting and maintaining the State's vital statistics. As the role of public health in society has evolved, data collection has come to mean much more than simply warehousing birth and death records. Today, TDH collects vital statistics, injury information, communicable and chronic disease data, and other statistics on the overall health of Texas' residents.

The Department collects data in several ways—surveys, disease registries, mandatory reporting, vital statistics, and informal channels. Generally, these methods of data collection are either active or passive.

Assessment Programs				
Program	**Target Population**	**Primary Function(s)**	**FY 97 Expenditures**	**FTEs Central (Regional)**
Zoonosis	Statewide: focus on South Texas	Surveillance and investigation of emerging zoonotic diseases such as Hantavirus and rabies. Animal Control Officer training. Oral Rabies Vaccination Program, which prevents the northward spread of canine rabies by air-dropping vaccine-laden bait.	$8,346,972	20 (27)
Texas Poison Center Network	Statewide	Administers grants to six regional poison centers. Collects data through coordination with the 911 Commission.	$5,622,081	1
HIV/STD Epidemiology	Statewide	Collects, analyzes, and disseminates statewide HIV, AIDS, and sexually transmitted diseases (STD) data. Active data collection is accomplished by checking hospital records and vital statistics, and passive collection occurs through mandatory reporting by providers.	$3,047,580	47 (2)
Cancer Registry	Statewide	Gathers statewide incidence data and maintains the State's central cancer databank.	$1,354,505	26 (18)
Environmental Epidemiology and Toxicology	Statewide; populations exposed or potentially exposed to toxic substances	Investigates and consults with communities on occupational exposures and disease clusters. Tracks four reportable occupational diseases (elevated blood lead levels, asbestosis, silicosis, pesticide poisoning) as well as elevated lead levels in children.	$1,174,115	30
Injury Prevention & Control	Statewide	Collects information and conducts investigations on traumatic injury. Maintains the Trauma Registry. *Saferiders* coordinates interagency efforts to provide information and education on traffic safety, particularly child safety seats.	$1,007,366	16
Refugee Health Screening	Newly arrived official refugees	Contracts to provide general health assessment and screening for TB and other communicable diseases.	$878,746	1
Birth Defects Monitoring	Statewide	Collects statewide birth defects data by maintaining the Birth Defects Registry and facilitates research activities to help identify the causes of birth defects	$1,714,419	10 (40)

Assessment Programs* (cont.)				
Program	**Target Population**	**Primary Function(s)**	**FY 97 Expenditures**	**FTEs Central (Regional)**
Infectious Disease Epidemiology and Surveillance	Statewide	Active surveillance of more than 30 communicable diseases. Investigations of reportable communicable disease outbreaks such as ebola, meningitis, tuberculosis and botulism.	$702,622	19 (6)
Neural Tube Defect (NTD) Project	Residents of the 14 Texas-Mexico border counties	An ongoing case-control study is attempting to decrease the risk of NTD recurrences among border residents. Provides counseling, referrals, and folic acid supplements.	$363,180	*
Hansen's Disease	Persons diagnosed (appx. 600)	Reimburses providers for office visits, lab work, and diagnostic testing for sufferers of Hansen's disease (leprosy).	$238,499	2
Behavioral Risk Factor Surveillance System	Statewide	Collects statewide data through random telephone surveys on topics such as tobacco use, diabetes, and HIV/AIDS.	$156,532	2
Child Fatality Review Teams	Texas children	Identification of risk factors in child deaths. TDH representative serves as the Chairman of an interagency committee overseeing teams of law enforcement officers, PRS, district attorneys, and others that share information and consolidate investigatory efforts when a child dies.	$35,812	1
Tuberculosis Elimination	Statewide	Surveillance and assessment of tuberculosis disease rates and drug resistance rates on a statewide and community basis.	$715,620	17 (11)
Maternal and Child Health Care Block Grant (Title V) Population-Based Activities	Statewide: mothers and children	Conducts community resource assessments. Maintains database on local health status indicators (e.g., violence, teen sexual behavior and pregnancy)	$8,040,307	.5 (1.6)
Family Planning	Statewide	Conducts community resource assessments. Collects data on local health status indicators (e.g., family violence, teen pregnancy)	$3,092,919	.5 (.25)

* This program is part of the Infectious Diseases Epidemiology and Surveillance Division.

Passive Data Collection

Most information-gathering at the Department is passive data collection. Passive data collection occurs primarily through mandatory reporting of certain diseases to TDH by local health departments and health care providers. Currently, Texas has over 50 reportable conditions. The agency relies on health care providers, laboratories, and local health departments to report these cases, and distributes information on the conditions that require mandatory reporting. These include rare conditions like Hansen's disease (leprosy) and hantavirus infections, occupational diseases such as lead poisoning and asbestosis, food-borne illnesses such as botulism and *E. coli* infection, as well as sexually transmitted diseases (STDs), traumatic injuries, tuberculosis (TB), and many others.

For example, the Tuberculosis Elimination Division maintains a registry on statewide cases of TB. Texas law requires health care providers to report these cases to local authorities who, in turn, report periodically to TDH. Similarly, the Trauma Registry compiles data from hospitals and ambulance firms on spinal cord, submersion, and brain injuries as mandated by the Injury Prevention and Control Act. The Cancer Registry, although mandated by law, relies heavily on hospitals to adequately report statewide incidence data to the Department of Health.

Passive data collection is the primary way TDH develops information about the health status of Texas citizens.

One of the largest data collection systems within the Department compiles information on vital statistics. The Texas Constitution of 1869 first required the state to keep birth, death, and marriage records. Today, the Bureau of Vital Statistics also compiles geographic, demographic, and medical data to be used for health programs, medical research, and population estimates. The Legislature appropriates about $4 million a year to the Bureau, of which approximately $2.5 million is fee generated, mostly from requests for birth certificates.

Many other state agencies access the state's vital statistics records. The Department of Human Services uses on-line birth records for verifying public assistance eligibility and for tracking the incidence of nursing home deaths. A paternity registry is currently being developed to aid the Attorney General's Office in enforcing child support. The Department of Protective and Regulatory Services accesses vital statistics to review suspicious child fatality information. TDH also contracts with the Social Security Administration to allow parents to request a social security number for their child at the hospital.

Active Data Collection

Active data collection occurs when TDH personnel solicit specific information. Health surveys are a prime example of active data collection. For example, TDH recently reported dramatic differences in the prevalence of diabetes between minority and Anglo Texans. Data for this study was actively solicited through telephone surveys administered by the Behavioral Risk Factor Surveillance System (BRFSS), a monthly telephone survey on health issues.

Another way TDH actively collects data is by reviewing hospital and provider records. For example, the Neural Tube Defect Project, which tracks cases of a seriously debilitating or fatal birth defect along the Texas-Mexico border, checks hospital records to locate these cases. The Birth Defects Monitoring Division collects statewide incidence data and maintains the Birth Defects Registry. Although most disease registries represent passive data collection, birth defect information is gathered through active surveillance of hospital records.

Epidemiology

Epidemiology attempts to answer three basic questions—what causes disease, how is it spread, and how can we prevent it? Data collection is an important part of epidemiology, because without good data, epidemiologic studies are impossible. But epidemiology goes well beyond data collection and analysis; the epidemiologist's role is to investigate the root causes of disease through activities such as screening and laboratory analysis.

Epidemiology answers three basic questions: What causes disease? How is it spread? How can we prevent it?

According to The Institute of Medicine's 1988 study, *The Future of Public Health*, the substance of public health "rests upon the scientific core of epidemiology."[1] Only by identifying the causes of certain diseases can state health officials take steps to prevent costly and debilitating conditions.

Discussion of the following programs illustrates the real-world link between data collection and epidemiology. The Texas Birth Defects Registry (discussed above) collects and maintains data on cases of birth defects throughout the State. Epidemiologists in the Birth Defects Monitoring Division use this data as a tool to investigate the causes of birth defects and design statewide measures to prevent the occurrence of these conditions. Similarly, the Trauma Registry collects data from hospitals and ambulance firms. This data enables the Injury Prevention and Control Program to conduct investigations and devise methods of injury prevention.

Epidemiology focuses heavily on communicable disease control such as preventing the spread of HIV/AIDS and sexually transmitted diseases (STDs). The HIV/STD Epidemiology Division collects, interprets, and disseminates statewide HIV/AIDS and STD data.

Many Texans face potential health threats from toxic chemicals and hazardous materials in their homes, neighborhoods, and workplaces. Epidemiologic investigations are important for determining the causes of health problems from these environmental exposures. The Environmental and Occupational Epidemiology Program tracks cases of four reportable work related diseases (elevated blood lead levels, asbestosis, silicosis, and pesticide poisoning) as well as elevated lead levels in children. The Health Risk Assessment and Toxicology Program consults with communities and agencies in response to toxic releases and hazardous waste sites. The Health Studies Program conducts investigations of noncommunicable diseases and disease clusters in populations potentially exposed to toxic substances.

By screening certain segments of the population for specific diseases, TDH epidemiologists help prevent occurence of disease in Texas. Examples of programs that screen certain high-risk groups include:

- the Refugee Health Screening Program provides federal and state funds to local health departments to screen newly arrived official refugees for tuberculosis and other contagious diseases;
- the Diabetic Eye Disease Program provides free annual eye exams to eligible recipients; and
- the Breast and Cervical Cancer Control Program contracts to provide screening to high risk, low-income women.

Laboratory analysis is a vital component of epidemiology. The laboratory facility, located on the main TDH campus in Austin, has a staff of more than 300 scientists, technicians, administrative, and support personnel. The chart, *TDH Laboratory,* shows the four major functions of the facility. In 1995, the Legislature approved the sale of revenue bonds to build a new laboratory/office facility. The new facility is scheduled for completion in the Fall of 2000.

TDH Laboratory

Division	Primary Functions	FY $ 97	FTE's
Chemical Services Division	Receives 1.1 million samples, and performs more than six million analyses for parental and newborn screening, Texas Health Steps, and adult glucose, cholesterol and genetic screening. Newborn testing is conducted 24 hours a day.	$3,696,095	70
Microbiological Services Division	Examines over 400,000 bacteriology, parasitology, serology/immunology, virology, and entomology specimens annually. Certifies other labs that test water, milk and shellfish. Conducts 33,000 TB tests annually.	$4,580,832	102
Environmental Sciences Division	Performs approximately 114,000 analyses and 36,600 samples annually to monitor environmental quality. Primary drinking water testing lab for the state, performing the federal Safe Drinking Water Act compliance tests for 7,200 drinking water systems.	$2,392,524	61
Support Services Division	Provides operational and administrative functions including billing, specimen acquisition, and test result reporting.	$3,729,611	120

Addressing the State's Health Needs

Once the State's public health needs have been assessed, the Department takes positive action to address these needs. This positive action comes in three main forms—education, direct services, and regulation. Educational activities allow the State to intervene in the health of all Texans to prevent costly diseases before they occur. Direct Service "safety net" programs like Medicaid and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) target Texas' most needy population by providing direct, one-on-one services to eligible recipients. Regulatory efforts not only ensure minimum standards within the health care industry, but also protect the public from potential food-related illnesses, radiation, and other environmental hazards.

Education

In recent years, education has become a primary focus of public health. Health professionals know that limited resources are best spent by targeting a wide audience with an "ounce of prevention" message rather than spending scarce dollars on costly one-on-one interventions. For example, by convincing children that it is unwise to start smoking today, the State will prevent needless disease and avoid expensive medical treatments in the future.

Broad "ounce of prevention" education is more cost effective than one-on-one services and treatment.

Education plays an important role in numerous public health programs, including the assessment activities discussed above. For example, many data collection programs disseminate information to the public and to health care providers. Since education is clearly the most cost-effective way to prevent many diseases, it is discussed here as one of the Health Department's primary methods of addressing Texas' health needs. The following discussion, as well as the chart, *TDH Educational Programs,* details these activities.

Educating Providers

Doctors, nurses, and other health professionals are the "front line" in the battle against so many preventable diseases. For this reason, TDH focuses much of its educational efforts on health care providers. The Public Health Program promotes this effort by sponsoring Continuing Medical Education classes on public health and preventive care. Similarly, the Dental Health Program provides continuing education to school nurses to integrate dental health programs within schools. Dental Health offers *Train-the-Trainer* classes to health professionals and social services staff on baby-bottle tooth decay.

TDH Educational Programs				
Program	**Target Population**	**Primary Function(s)**	**FY 97 Expenditures**	**FTEs central (regional)**
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	Eligible women and children	TDH contracts with local providers to perform nutrition education and breast-feeding promotion.	$21,328,410	5 (20.8)
Diabetes Program/ Council	High risk groups	Training and awareness through preventive and population-based programs. Also funds eye exams for eligible (uninsured) diabetes patients.	$3,711,836	13 (6)
Adult Health	Statewide	Community and Worksite Wellness provides technical assistance, outreach, and education to schools, worksites, restaurants about healthy life-style choices focusing on physical activity and nutrition. Clinical Prevention Specialists provide technical assistance to health care providers in clinical settings through a program called *Put Prevention into Practice*.	$2,893,841	11 (40)
Office of Tobacco Prevention & Control	Statewide; Texas children	Focuses efforts on education and public awareness through media campaigns and other outreach activities.	$902,991	5 (12)
Public Health Promotion	Statewide	Serves as the core public health promotion and education program for TDH and acts as a catalyst for effective public health promotion.	$811,944	7 (8)
Centers for Minority Health Initiatives	Statewide	Promotes public health services to targeted minority groups. Provides training for TDH staff to become culturally competent. Hosts annual Minority Health Conference.	$583,888	8 (4)
Dental Health Program	Health care providers	Educates clients, providers, school nurses and teachers on dental health.	$474,398	1 (8)
Neural Tube Defect (NTD) Project	Texas-Mexico border residents	Provides counseling, referrals, and folic acid supplements to decrease the risk of NTD recurrences in the 14 Texas-Mexico border counties.	$410,680	*
Public Health Providers Education	Health care providers	Provides and/or approves Continuing Medical Education geared to preventive health care. Publishes newsletter Disease Prevention News.	$186,387	4
Osteoporosis	Statewide	Educates the public on causes and risk factors, and publicizes the value of early detection.	$104,149	0

TDH Educational Programs (cont.)				
Program	**Target Population**	**Primary Function(s)**	**FY 97 Expenditures**	**FTEs central (regional)**
Alzheimer's Disease	Statewide	Administrative assistance to Alzheimer's Council, which provides support to Alzheimer's patients and their caregivers.	$79,696	2
Prostate Cancer	Statewide	Coordinates education and awareness activities with organizations like Texas Cancer Council and American Cancer Society. Publicizes the value of early detection.	$20,028	0
Community Oriented Primary Care Marketing and Outreach	Statewide	Coordination of all Health Care Delivery education and outreach programs including WIC, Dental Texas Health Steps, and Family Planning. Goal is to stress the importance of regular preventive health care.	**	3 (5)
Maternal and Child Health Care Block Grant (Title V) Population-Based Projects	Statewide: mothers and children	Develops public awareness, health promotion campaigns on maternal and child health public health and safety topics (Take Time for Kids; the Sounds of Texas).	$8,040,307	5 (1.6)
Family Planning	Statewide: adolescents and adults, including teachers, and health care providers	Provides education and awareness to target population about family planning.	$7,795,539	1 (.50)
Immunizations	Statewide	Increases awareness and knowledge about immunizations.	$2,271,863	33 (0)

* This program uses Infectious Disease Epidemiology and Surveillance staff.
** Charged directly to specific programs' budgets.

Put Prevention into Practice is another educational program that provides technical assistance to health care providers in clinical settings. This federal Preventive Health Block Grant funded program sends Clinical Prevention Specialists into communities to stress the importance of preventive health practices, and to incorporate system changes to improve delivery of precentive services.

Educating Special Groups

Some educational programs target very specific segments of the public. For example, because studies show that diabetes strikes almost twice as many African-American and Hispanic Texans as it does Anglos, the Diabetes Program focuses much of its public awareness, education, and training activities on minority populations.

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) targets just over a million eligible Texans. The program addresses the problem of inadequate diet by not only prescribing supplemental foods, but also providing nutrition education to this needy segment of the population. The program promotes breast-feeding by training nurses and physicians about the many benefits of breast-feeding.

In 1991, state officials began hearing reports of unusually high rates of anencephaly, a fatal birth defect, among Cameron County and other South Texas border residents. One of TDH's responses was the Neural Tube Defect (NTD) Project, which operates within the 14 Texas-Mexico border counties. Although the project's primary objective is an ongoing case-control study, the NTD project, through coordination with the Office of Border Health, has become an important outreach program. The Neural Tube Defect Project provides education and counseling, referrals, and folic acid supplements to high risk individuals to decrease the risk of NTD recurrences. The text box, *Health on the Border*, highlights other border health concerns.

Health on the Border

Many Texans, especially the estimated 390,000 Texans living in *colonias*, are vulnerable to diseases due to lack of infrastructure and other environmental hazards prevalent along the Texas-Mexico border.[2] In 1993, the Legislature created the Office of Border Health (OBH) to enhance agency efforts to protect the health of border residents. OBH is staffed by six FTEs in Austin and 22 in field offices in Harlingen, Laredo, Uvalde, and El Paso.

The Office of Border Health's primary initiatives have been:

- facilitating projects like the Texas Small Towns Environment Project, a self-help program that partners *colonias* with government and private agencies to hook-up water and wastewater facilities;
- administering a comprehensive health survey; and
- collaborating with Mexican health officials to develop binational strategies for reducing the spread of TB and other communicable disease.

In October 1996, The Office of Border Health Advisory Group, an *ad hoc* committee of physicians, public health professionals, and business and community leaders, identified the following priority concerns among border residents:

- waste management;
- air pollution;
- general access to health care, especially for children
- water quality;
- hazardous materials;
- pesticides;

Educating the Entire State

Tobacco use is the single largest cause of preventable disease in Texas.[3] The Office of Tobacco Prevention and Control (OTPC) focuses its efforts on education and public awareness through media campaigns and other outreach activities. With the passage of Senate Bill 55, the 75th Legislature created significant new anti-tobacco initiatives for the Department of Health. As a result of this legislation, OTPC will certify

tobacco awareness classes for minors caught possessing tobacco products and will also coordinate a massive public awareness advertising campaign targeting tobacco use.

Direct Health Care Services

In addition to ensuring provision of population-based health services across the state, the Department of Health provides a variety of direct health care services. Eligible Texans receive direct health care services from health care providers, including doctors, nurses, nutritionists, and other health practitioners. The agency's direct health care service programs, generally target low-income residents, especially women and children. The primary difference between many programs is eligibility criteria, including income and citizenship status, established for most programs by the federal government.

TDH purchases direct health care services for low-income Texans.

The Department's primary direct service delivery role is the purchase of health care for many Texas low-income residents by allocating federal and state funds for 38 direct health care programs through contracts with numerous health care providers. TDH administered more than $6 billion in federal and state funds for direct health care services in fiscal year 1997, including more than $5 billion for Medicaid services alone.

Benefits

Texas children from low-income families receive the majority of the Department's direct services through programs that offer an array of medical benefits from medical and dental screens to highly specialized care for diseases such as cystic fibrosis and hemophilia. Medicaid clients receive the most comprehensive of TDH's direct service programs, including both primary care and specialty care. Pregnant women and young children can receive nutritional counseling, prenatal care, and school-based primary care. Adults may receive specialty care such as family planning, dialysis, tuberculosis and treatment for primary care. Appendix A, *Health Care Delivery Program Eligibility and Benefits* lists the 38 TDH health care programs with their respective benefits and eligibility requirements.

In addition to many specialized services, TDH is moving toward providing clients with better primary care. Previously, clients could only access direct services when a health problem arose. Now, clients choose a primary care provider who oversees all of their care when enrolled in programs like Medicaid managed care and Community Oriented Primary Care (COPC). Clients receive annual check-ups and health screens, and are referred to

specialty care when necessary by their primary care physicians. Primary care is thought to improve health outcomes through coordinated care that emphasizes prevention.

Eligibility

Clients receive direct services by qualifying through different combinations of eligibility criteria, such as income, age, gender, citizenship, and diagnosis, as shown in the *Health Care Delivery Program Eligibility and Benefits* chart in Appendix A. Eligibility determination is conducted in two ways. For a client to receive Medicaid services, the Texas Department of Human Services (DHS) must determine eligibility and the TDH health care provider verifies eligibility before providing the services. For non-Medicaid programs, each program has its own client eligibility criteria established by statute or TDH, and eligibility is determined at the provider clinic when the client obtains services. Some providers determine eligibility by using software provided by TDH, while others use written forms. Verifying client information regarding assets is not required for non-Medicaid programs, although many state and local programs require that the client is screened for potential Medicaid eligibility before receiving services.

Because TDH funds 38 different programs with varying eligibility criteria and no single way to determine eligibility, clients may not always be aware of the different programs for which they may be eligible. House Bill 7, in 1991, introduced the initiative to streamline client service eligibility across all Texas health and human service agencies, and in 1995, House Bill 1863 directed the Health and Human Services Commission to develop an integrated eligibility system. For a more detailed discussion of this effort, see the text box, *Texas Integrated Eligibility and Services*.

The most commonly used eligibility factor is income. To be eligible for most programs, the client's income must be below a certain level. Income eligibility requirements for Medicaid and other TDH programs are primarily based on the Federal Poverty Level, as shown in the *1997 Federal Poverty Income Guidelines* chart. Assets are currently limited to $2,000 to $6,000 depending on program and family size. These assets include one or more cars, checking or savings accounts, stocks, or bonds. In general, clients

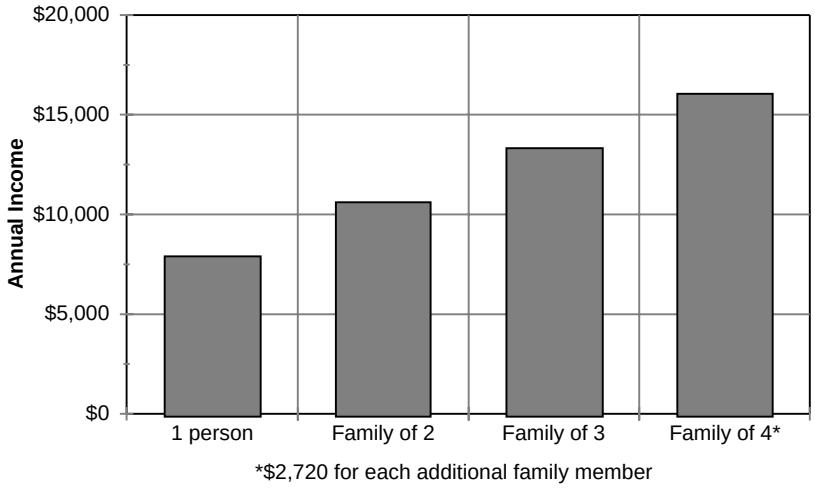
Texas Integrated Eligibility and Services

The Health and Human Services Commission (HHSC) is currently working on Texas Integrated Eligibility and Services (TIES) as directed by House Bill 1863 of the 74th Legislative Session and other subsequent legislation including HB 2777 from the 75th Legislative Session. TIES will integrate the various eligibility systems that are currently used for clients who access public assistance for medical care, food stamps, and job assistance, to name a few. As an example of the current structure, if a pregnant woman is eligible for prenatal care, she must obtain eligibility for Medicaid in a DHS office. If her six year old child has cystic fibrosis and the child is not eligible for Medicaid, she must obtain eligibility for Chronically Ill and Disabled Children for her child through TDH. She and her new infant, once born, will be eligible for Supplemental Nutrition for Women, Infants and Children (WIC), that must be determined at the WIC clinic.

TDH is currently part of an interagency working group, comprised of HHSC, TDH, Texas Workforce Commission, DHS and others, that, together with Electronic Data Systems (EDS), is developing a plan to re-engineer the health and human services customer service process.

with the least income qualify for Medicaid, while clients whose income rises slightly above the Medicaid limit are eligible for health care services funded through other TDH programs such as the Primary Health Care Program and the Maternal and Child Health Block Grant.

1997 Federal Poverty Income Guidelines (100% FPL)



Other eligibility criteria include age, residency, and diagnosis as listed by program in Appendix A, *Health Care Delivery Program Eligibility and Benefits*. In some instances, a person may qualify for a program on the basis of income, but may be excluded because of one of the other eligibility factors. For certain entitlement programs, such as Medicaid, non-U.S. citizens cannot receive services unless they are documented aliens. Other programs, such as Immunizations, Special Supplemental Nutrition for Women, Infants and Children (WIC) serve low-income clients regardless of citizenship status.

Service Delivery

In areas where resources are scarce, TDH staff "fill the gap" by providing direct services.

The Department delivers health care services to its clients in two primary ways — through Medicaid services and non-Medicaid services. Following a state and nationwide trend in government, TDH contracts for the majority of Medicaid and non-Medicaid services. For Medicaid services, TDH contracts with insurance entities to perform claims processing, client enrollment, and managed care functions. For non-Medicaid services, TDH contracts with health care providers directly. The chart, *Health Care Delivery Funding and Contracts* in Appendix A, provides detailed information about TDH contracts for health care delivery.

The agency provides limited services directly through the two TDH Hospitals in San Antonio and Harlingen. Infrequently, in a few areas of the state where health care providers are scarce, TDH "fills the gaps" by providing direct services with regional staff. However, for most of Texas' safety net services, TDH functions as a contract manager, administering funds, directing policy, and monitoring contract compliance.

Medicaid Services — The Department has administered acute care Medicaid services, that offer a comprehensive set of services primarily for women and children, since receiving the programs from the Department of Human Services in 1993. The comprehensive set of services includes primary and specialty care, early diagnosis and screening for children through the Texas Health Steps program, medical transportation, and prescription drug benefits, just to name a few. For a complete list of Medicaid services, see Appendix A, *Health Care Delivery Program Eligibility and Benefits*.

Medicaid provides a comprehensive set of services, primarily for women and children.

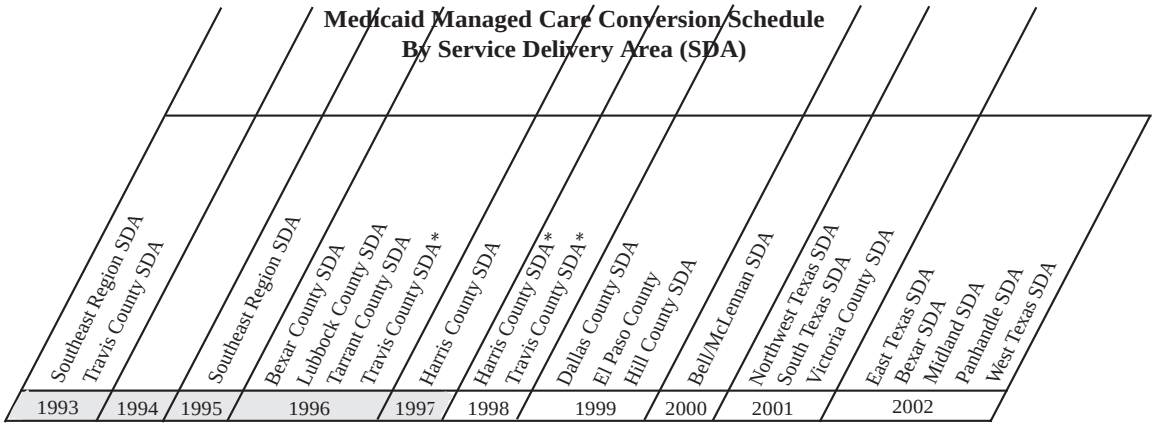
The Health Department administers the traditional Medicaid program, known as fee-for-service Medicaid, and the Medicaid managed care program through its Health Care Financing Associateship. Since taking over the Medicaid program from DHS in 1993, the administration of the program through National Heritage Insurance Company (NHIC) and other large contractors has remained similar, although TDH has steadily added contractors, including HMOs, since the introduction of Medicaid managed care in 1993.

Fee for Service — Fee for service refers to the traditional system in which a physician or other health care professional provides a service to a Medicaid client, submits a claim, and receives payment for that service. Within this fee-for-service system, TDH has an open enrollment policy, meaning that any health care provider who meets agency requirements and agrees to accept the Medicaid payment rate may provide services to Medicaid clients. The Department contracts with approximately 206,500 health care providers to deliver services to Texas' 1.7 million fee-for-service Medicaid clients.

Medicaid Managed Care — Under managed care, primary care providers oversee the medical care of Medicaid clients for a fixed fee by providing a medical home and monitoring access to specialty care. In September 1993, TDH started the state's first Medicaid managed care program, State of Texas Access Reform (STAR), in Travis County. The State also initiated pilot programs in Chambers, Galveston, and Jefferson counties by the end of the same year.

TDH contracts with the National Heritage Insurance Company (NHIC) to administer Medicaid payments.

In 1995, the 74th Legislature directed the Medicaid office in the Health and Human Services Commission to expand the implementation of managed care throughout the State. With the recent inclusion of the Harris County service delivery area, managed care comprises approximately 25 percent of the Medicaid population. The Texas Department of Health is planning to convert most of the Medicaid population from traditional fee-for-service Medicaid to Medicaid managed care by September of 2002, with the rural communities converting last. The *Managed Care Conversion Schedule* shows the timing of the conversion to managed care throughout the state.



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

* Expansion to surrounding counties

Texas operates two managed care models, the Health Maintenance Organization (HMO) and Primary Care Case Management (PCCM) models. In the HMO model, Texas contracts with private and publicly formed HMOs to provide health care for clients. The Department negotiates with the HMOs to provide a package of services for a set monthly rate, called a capitated rate, per client. Capitation rates are based on fee for service claim costs, discounted by the anticipated savings from managed care.

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

Medicaid Administrative Contracts — The State has contracted with NHIC to administer most of the Texas Medicaid program since 1989 through a five-year contract that has been extended three times. NHIC processes claims, enrolls providers in the Medicaid program, conducts utilization review

of claims, including determining medical necessity, obtains third-party reimbursement when possible, and provides a phone bank for providers and client queries for fee-for-service Medicaid.

For the 1.7 million fee-for-service clients, NHIC operates as a traditional indemnity insurance company. The Department pays premiums to NHIC each month based on the Medicaid fee-for-service claims anticipated per eligible client per month. NHIC assumes a risk, in accepting the premium, that clients' health care will not cost more than the amount paid by TDH. If health care claims for fee-for-service Medicaid clients are less than the amount paid in premiums by TDH, NHIC keeps the difference up to a cap of $6.5 million per year. Over the last eight years, NHIC has retained a median of more than $5 million annually under this arrangement.

NHIC has traditionally also played an important role in managed care by training HMOs in preparation for Medicaid managed care start-up, collecting patient outcome information from HMOs called encounter data, performing some quality monitoring of HMOs, and developing the PCCM provider network. In 1996, the Department hired The Lewin Group, a consulting firm, to evaluate the NHIC contract. The firm was hired due to concerns that NHIC had no experience in managed care and was having difficulty supporting the Department's managed care requirements.[4] The Lewin Group recommended that the contract be split into five functions and procured separately. This recommendation resulted in the division of labor between the four contracts mentioned in the table, *Medicaid Administrative Contracts*.

Over the last eight years, NHIC has retained $5 million annually from fee claim savings.

NHIC's new contract, which will become effective September 1, 1998, is primarily a claims processing and provider enrollment contract for the traditional fee-for-service system. The Department contracted with Maximus, Inc. to enroll clients in HMOs, with the Texas Health Quality Alliance to ensure the HMOs are providing quality care, and with Birch & Davis Health Management Corporation to further develop the PCCM provider network. A request for proposals to perform the fifth function, HMO oversight services, was withdrawn and has not been rereleased.

Contract Compliance — The Texas Department of Health Internal Audit Division monitors NHIC's performance on the fee for service contract by reviewing monthly reports from NHIC that include claims processing statistics, customer service data, and provider relations information among other reportable function data. The NHIC meets monthly with TDH leadership to discuss report results.

Medicaid Administrative Contracts				
Contractor	**Function**	**Reimbursement Methodology**	**Annual Contract Payments**	**Contract Term**
NHIC	provider outreach, provider enrollment, claims processing (34 million in FY 97), managed care assistance	• quota share: cap of $6.5 million on profit from premium payments that can be made above the cost of client care • fixed fee for processing claims and making HMO payments	$70 million	1989-1998 five years with three extensions*
	development of new Medicaid management information system (Compass 21), will include year 2000 changes	fixed fee based on expected costs, development is shared with DHS	$68 million	1998-2000
	provider outreach, provider enrollment, claims processing, managed care assistance	• quota share: cap of approximately $4 million on profit from premium payments that can be made above the cost of client care • the lesser of fixed fee or cost for processing claims, collecting HMO encounter data, and making HMO payments • Fixed profit	$70 million	1999-2002 with four one year extensions*
Maximus	enrolls clients in PCCM or the HMO of choice	• the lesser of base fixed price or cost of operations • fixed profit	$13.5 million	1997-1999 with two one year extension options*
Texas Health Quality Alliance (THQA)	ensures that HMOs provide quality care to Medicaid clients by auditing client records	• the lesser of base fixed price or cost of operations • fixed profit	$6 million	1998-2000 with two one year extension options*
Birch & Davis	PCCM provider network development, member services	• the lesser of base fixed price or cost of operations • fixed profit	$8 million	1997-1999 with two one year extension options*

* Extensions at State's discretion

Medicaid managed care staff conduct contract compliance in two ways—by reviewing HMO prepared reports and by contracting with the Texas Quality Health Alliance to review HMOs directly. The four managed care administrative contractors and the HMOs must submit periodic reports regarding the specific functions and expectations outlined in their contracts. If the contractor does not meet contract expectations, TDH develops a plan outlining how operations must change to better meet the requirements. The Department has the authority to withhold payments or terminate the contract depending on the severity of noncompliance. In 1997, TDH temporarily withheld client enrollment for two HMOs because one HMO did not reimburse its providers in a timely manner, and the other violated client marketing restrictions.

The Department also ensures HMO quality through the Texas Health Quality Alliance (THQA), composed of three entities, the Joint Commission on the Accreditation of Hospitals (JCAHO), Forensic Medical Analysis (FMA), and Texas Nurse's Foundation (TNF). When fully operational in the summer of 1998, THQA will audit Medicaid clients' medical records, prepare utilization management reports that track the appropriateness of health care, and analyze studies on specific quality issues that arise. FMA will serve as the data analysis consultant, preparing statistical analyses of client health outcomes. The Alliance will prepare quarterly and annual reports to TDH on monitoring and quality activities.

Non-Medicaid Services — The Department administers the 24 non-Medicaid programs through approximately 30,000 contracts with providers, including city and county health departments. These programs are administered differently than the Medicaid program, but generally employ many of the same contractors and serve similar clients. Non-Medicaid programs include the Maternal and Child Health Care block grant (Title V) programs such as Children's Health, Chronically Ill and Disabled Children, and Women's Health. Two new programs are underway to provide additional health care services to children, as discussed in the text box, *The Future of Children's Health Care in Texas*. In addition, TDH administers family planning programs, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the Community Oriented Primary Care program (COPC).

The agency uses a variety of methods to procure the contractors, pay the contractors, and monitor the quality of the contractors. For a description by program of the method of procurement and reimbursement, in addition to the funding source and specific contract information, see Appendix A, *Health*

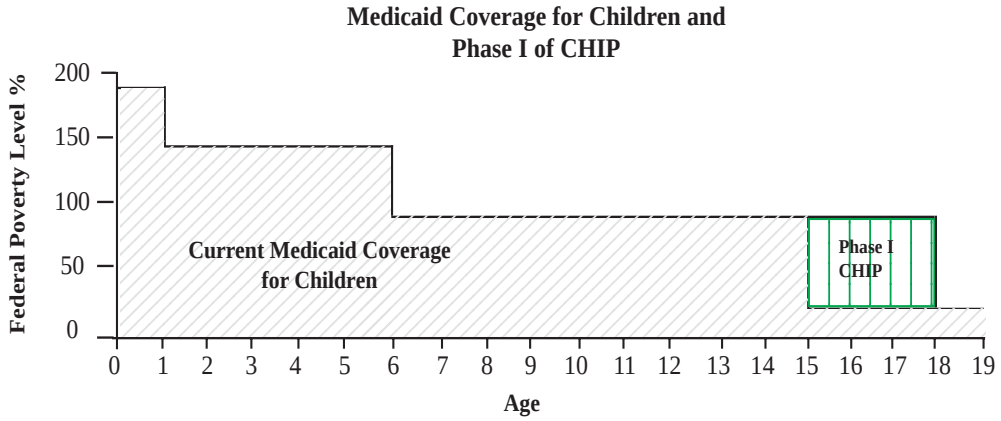
The Future of Children's Health Care in Texas

Medicaid and a few programs such as the program for Chronically Ill and Disabled Children (CIDC) have traditionally provided health care for Texas' low-income children. As a result, only children from families with very low incomes or with specific diseases such as cystic fibrosis could receive medical care—leaving 1.3 million children in the state without adequate medical coverage.[5]

House Bill 3 of the 75th Legislative Session created the Texas Health Kids Corporation (Healthy Kids) to provide the 1.3 million uninsured children in Texas access to health care through affordable insurance coverage. Healthy Kids is a public/private partnership that will contract with insurance companies and Health Maintenance Organizations (HMOs). Parents or other sponsors of the children will be responsible for payment of the premium. However, the Corporation will seek contributions from communities, businesses, and nonprofit groups in order to provide a sliding scale assistance program based on ability to pay. Benefits presently approved will include immunizations, well-child visits, primary care and specialty physician office visits, prescription drugs, laboratory tests and x-rays. Healthy Kids will target uninsured children. Coverage is expected to be available in August 1998.

Created by the federal Balanced Budget Act of 1997 after the creation of Healthy Kids, the Children's Health Insurance Program (CHIP) provides federal funds to allow states to expand health care benefits to low-income children. Current Medicaid coverage for children is limited to children whose families' income is below 185 percent of the federal poverty level (FPL) for infants, below 133 percent of the FPL for children one through five, below 100 percent for children six through 14, and below 17 percent for children 15 through 19. See the chart, *Medicaid Coverage for Children and Phase I of CHIP*, for a graphic depiction of the current coverage levels.

CHIP would provide up to $561 million per year through 2000 in federal matching funds to cover children up to 200 percent of the FPL, with the added incentive of a federal match of 74 percent rather than the current Medicaid match of 63 percent.



The Health and Human Services Commission, the Governor's Office, legislators, TDH, and legislative staff weighed various options to provide the best coverage within a seamless service delivery system to the newly covered CHIP children. The plan submitted to the federal goverment in March 1998 proposes expanding Medicaid coverage from 17 percent to 100 percent of the FPL for approximately 150,000 children 15 to 18 years old as a first step until the Legislature convenes again in 1999. Expanded coverage for the 15 to 18 years olds is known as Phase I of the plan, as shown in the graph, *Medicaid Coverage for Children and Phase I of CHIP*. The anticipated state contribution from general revenue to fund Phase I is $6.6 million for the remainder of FY 98 and $21 million for FY 99. Phase I of CHIP is estimated to make health care available to an additional 18,543 children at a total cost of $105 million for the biennium.

Phase II of the expansion will be decided by the Legislature during the 1999 Session. In addition to deciding on the appropriate coverage level and delivery system for the Phase II children, the Legislature is expected to address the relationship between Healthy Kids and CHIP.

Care Delivery Funding and Contracting. The following discussion outlines the different methods used for procurement, payment, and monitoring, and refers to examples for illustrative purposes.

Contract Procurement — The Health Department selects non-Medicaid providers using competitive, non-competitive and open enrollment methods, and some programs use more than one method of procurement. The Department's central office approves all contracts through the Grants Management Division and through the Office of General Counsel.

The agency uses competitive procurement for 12 of 25 non-Medicaid programs, or approximately 600 of the 30,000 non-Medicaid contracts. The best examples of programs with competitive procurement processes are the Title V programs and the COPC program. The agency uses competitive contract procurement to encourage potential contractors to provide the best services at the best price. The Department seeks proposals by publishing requests for proposals (RFPs) in the Texas Register and by sending the RFPs to interested parties. The Department's program director, regional staff, and other program experts evaluate the proposals and decide the appropriate level of funding for the selected contractors.

Six TDH service delivery programs use a non-competitive method of procuring contracts. For example, TDH programs, such as WIC, do not use the RFP process. The TB Control and County Indigent Health Care programs also use a non-competitive procurement process. For these programs, TDH continues to provide funds to current providers who meet program criteria.

TDH chooses to exempt governmental entities from competition in the service procurement process.

Twelve TDH non-Medicaid programs accounting for approximately 600 contractors have an initial competitive procurement process, but use a non-competitive renewal process. TDH requires renewing providers to complete the application process, even though applications are only sent to current providers. As a result, the agency maintains a provider unless noncompliant with state or federal standards. For example, the Department competitively procures initial contracts for its Title V programs, but upon expiration of the one-year contracts, successful providers complete continuation applications each year for the next two years. Contractors must compete again at the end of the third year.

Adding one more complication to the procurement process, governmental entities such as local health departments, counties, and other state agencies, from competition.[6] Thus, a program may seek competitive bids, but TDH can award a contract to any government entity that bids. State law also

affects the competitive bidding process. For example, the Children's Heart Outreach program must develop contracts with specific providers designated in the General Appropriations Act.

Open enrollment is TDH's least competitive contract procurement process, allowing any interested party who meets agency requirements to participate. Most of TDH's contracts are procured through open enrollment. Ten non-Medicaid programs, including the immunization program and the Kidney Health Care program use this method. Open enrollment is used to increase client access to services, allowing any physician or hospital willing to accept state reimbursement and restrictions to contract for the care of TDH clients.

Contract Payment Methodology — The Department pays contractors in a number of ways, including fee for service, cost-based reimbursement, and formula methods. The most common payment method is fee for service, in which the contractor provides a service for a TDH client, then bills the agency. Fee for service is a term frequently used in the insurance industry to refer to payment for professional services such as care provided by physicians or other health care providers. TDH determines the fee for service rate by calculating standard dollar amounts for treatments and assigning relative weights that reflect the intensity of the treatment. As discussed previously, Medicaid providers in the traditional fee for service program are reimbursed through this method, as are County Indigent Health Care providers and some of the Title V providers.

The Department reimburses on a cost basis primarily for non-physician services and goods such as immunizations and food. The agency also uses the cost-based method in programs with too little cost experience to forecast premium rates. Data is collected for a few years as the actual costs are reimbursed. Providers submit vouchers for the cost of the care provided which is reimbursed at full value.

The Department uses a formula to pay for services provided through a few programs, such as WIC and HIV services. For example, TDH allocates available resources, by formula, to a single provider in each HIV service delivery area, which is based on Council of Government regions. The formula is based on the population, poverty index, and number of AIDS cases in each service delivery area. The selected HIV provider in the service delivery area then tailors a program to best meet the needs of the HIV clients in that area.

Contract Compliance — For most non-Medicaid health care delivery programs, contract compliance is performed by the Quality Assurance Monitoring Division. The Division employs a variety of health professionals

to examine medical records to ensure quality of care. Contractors for programs such as the Maternal Child Health Programs, Primary Health Care, Children with Special Health Care Needs, Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and Targeted Case Management undergo monitoring visits every two years based on a risk assessment. The Division made 131 site visits in fiscal year 1997. Central office coordinates provider monitoring visits with the regional office. Regional staff make follow-up visits when contractors are sanctioned and placed on accelerated monitoring. Regional staff made 62 site visits for follow-up of compliance issues in fiscal year 1997 and offered technical support to providers in 119 visits.

During the on-site visit, the monitoring team checks to see that the contractor complies with state law and rules; and has documented policies in place for organization, planning, and quality assurance. Contractors who do not meet quality standards are assigned violation severity levels I through III, as shown in the chart, *Contract Compliance Violation Levels*, and are sanctioned accordingly. Level I violations involve a potential or direct threat to public safety, such as provision of clinical services by unqualified or inadequately prepared staff; or a threat to state funds such as fraudulent billing practices. Level I sanctions include 12 months of probation and suspension of funding or cancellation of a contract, although TDH found no Level I violations in fiscal year 1997. The Agency documented one Level II violation and six Level III violations in 1997.

Contract Compliance Violation Levels*

Violation		Sanction	Number of FY 97 Contractors
Severity	**Examples**		
Level I	provision of care or failure to provide care that may be potentially harmful to clients, fraudulent billing to Medicaid or to any source of state funding, misappropriation of funds provided by the state, failure to meet the terms of the contract, failure to provide services that the contractor is funded to provide, or provision of clinical services by unqualified or inadequately prepared staff.	12 months probation, at least two unannounced visits, suspension of funding, or termination of contract	0
Level II	noncompliance with standards, rules, or laws not of immediate danger to the public, noncompliance with facility requirements, refusal to allow authorized central or regional staff access to records or policy during site visits, failure to provide required data on outcomes and objectives, or failure to submit required agency reports after two requests	6 months probation, and at least two announced visits	1
Level III	failure to have effective clinic systems such as documented policies and procedures, failure to have an implemented quality assurance system, or failure to make corrections during the designated period	3 months accelerated monitoring, and at least one announced visit	6

* For contracts monitored by the Quality Assurance Monitoring Division.

The Grants Management Division performs financial monitoring for the non-Medicaid health care delivery programs. The financial monitoring team ensures that contractors comply with contract provisions for expenditure of state or federal grants using federal auditing guidelines. The audits are conducted independently of the Quality Monitoring Division; however, the Division notifies the financial auditors of contractor noncompliance when funding is at risk.

TDH Hospitals — Although the Department contracts for the provision of most services, it does provide a few services directly, primarily through the two TDH hospitals—the Texas Center for Infectious Disease in San Antonio and the South Texas Hospital in Harlingen. The State opened the hospitals in 1954 for the treatment and quarantine of TB patients. Since then, the scope of the hospitals' function was expanded to include other services such as laboratory testing for drinking water, clinical testing for women including diagnosis and treatment of cervical cancer, and treatment of Hansen's disease (leprosy). The combined operating budget for the hospitals was $25 million in fiscal year 1997.

According to TDH, the buildings at both hospitals have deteriorated over the years. The 75th Legislature directed TDH to develop a long-range plan for the hospitals to determine whether the State should continue their operation or redefine their purpose and functions. The Department has contracted with a consultant to develop the long-range plan, which is due June 1, 1998, to the Governor's Office and Legislative Budget Board.

In addition to these services, the South Texas Hospital is home to the TDH mobile health unit. The mobile unit travels to outlying communities to offer a number of services, including screening and treatment for diabetes, and dental and primary care services for children through the Texas Health Steps program. To allow consultation with physicians, the unit will employ the technology of telemedicine. TDH paid $370,334 for the mobile unit.

TDH has contracted for a long-range plan for the use of its two hospitals, due in June 1998.

Regulation

The Health Department has a wide variety of programs designed to regulate the practices and activities of health care facilities, professions, and industries affecting public health. Each program regulates a separate facility or profession and has differing statutes and rules governing that regulation. During fiscal year 1997, TDH regulated over 118,000 professionals in 15 regulatory programs, and over 129,000 facilities in 40 regulatory programs. Describing such a large number of regulatory programs does not lend itself well to textual discussions. As a result, the text box entitled *Examples of TDH Regulatory Programs*, provides basic information on four TDH regulatory activities. In addition, the charts in Appendix B provide more detailed background and performance information on each specific regulatory program administered by TDH. The charts are divided into separate sections for professions and facility regulation. Data is provided to show volume of persons or facilities regulated, complaints, inspections, and enforcement actions.

Types of Regulation

To protect the health, safety and welfare of the public, governments regulate the activities of many professions and facilities that pose a potential public health threat. Such regulation is designed to guarantee that all entities subject to that regulation conform to some level of state standards.

Examples of TDH Regulatory Programs

TDH performs a wide-range of regulatory activities. To get an idea of the range of those programs, four are described below. To see a complete listing and other information relating to TDH regulatory activity, see Appendix B of this report.

Hospital Regulation - TDH inspects and licenses 381 general hospitals within the state and performs Medicare certifications on those hospitals for the federal government. A hospital must meet federal Medicare requirements to receive Medicare funds for payment of services. Hospital inpections ensure the facility complies with rules regarding medical waste, infectious disease protocols, and laboratory practices. In addition, inspections determine hospitals compliance with state laws such as the Nursing Practice Act and ensure they have adopted and enforce a natural disaster preparedness policy. Hospitals are also required to adopt a policy ensuring patients' rights, including ease of access for disabled patients, visitors and staff.

Meat Safety Inspections - TDH inspects meat to ensure the meat processed in the state is safe for human consumption. In fiscal year 1997, 476 facilities statewide were regulated directly by TDH. Most of these facilities slaughter animals for in-state consumption and are therefore regulated by TDH. However, the federal government regulates facilities in Texas that slaughter animals for interstate distribution unless the federal government enters into an agreement with TDH for those services. In fiscal year 1997, TDH performed inspections for the federal government under a memorandum of understanding in an additional 30 plants.

EMS Personnel Certification - TDH regulates over 48,000 EMS personnel within the state. TDH recognizes three levels of certification for EMS personnel. Personnel in each level are under the direction of a medical director and the levels of certification are differentiated by the number of hours of training and internship required. Although many EMS personnel in smaller communities are volunteers, volunteers must also meet the same requirements of training and internship as professional EMS personnel.

Asbestos Abatement Personnel - TDH licenses over 6,000 asbestos abatement personnel. These personnel are trained in methods to properly remove and dispose of material containing asbestos. TDH enforces the national emission standards for asbestos during remediation and ensures personnel meet the EPA accreditation plan. EPA provides some grant funds to TDH to oversee the training accredation programs and for asbestos inspections of schools.

In Texas, essentially three forms of occupational regulation exist. Registration is the least restrictive form of regulation. Under registration, a person must agree to follow certain minimum standards and register with the state. Regulation through a title act is the next most restrictive form of occupational regulation in Texas. This form of regulation establishes minimum qualifications, competency examinations, and standards of conduct for practitioners who advertise and practice under a title regulated by the state. The next most restrictive form of regulation in Texas is the practice act. This form of regulation prevents people from performing the functions of a profession without first meeting state education and other requirements for licensure. The most restrictive form of regulation in Texas is regulation by both a practice and a title act, which prohibits use of a title as well as the performance of specific activities. TDH uses all types of regulatory authority. For example, dispensers of contact lenses are regulated by registration; Medical Radiologic Technologists (MRTs) are regulated by a practice act; and Athletic Trainers are regulated by both a practice and title act.

Selected Facilities

- Abortion Facility Licensing
- Ambulatory Surgica Center Licensing
- Birthing Center Licensing
- EMS Providers Licensing
- End Stage Renal Disease Facility Licensing
- General and Special Hospitals Licensing
- Home and CommunitySupport Services Agency Licensing
- Private Psychiatric Hospitals Licensing/ Crisis Stabilization Units Licensing
- Special Care Facility Licensing
- Trauma Center Designation
- Bedding Product Manufacturer Registration
- Drug Manufacturer/Distributor Licensing
- Food Manufacturer Licensing
- Food Salvage Licensing
- Food Wholesale Distributor Licensing
- Frozen Dessert Manufacturer Licensing
- General License Acknowledgment (Radioactive Materials)
- Hazardous Product Manufacturer Registration
- Mammography Facility Certification
- Meat/Poultry Inspections
- Medical Device Distributor Licensing
- Medical Device Manufacturer Licensing
- Medical Device Salvage Licensing
- Migrant Housing Licensing
- Milk Producer Permitting
- Milk Processor Permitting
- Narcotic Treatment Facility Licensing
- Radioactive Materials Licensing
- Radiation Producing Machine Registration
- Registration of Public Employers under Texas Hazard Communication Act
- Registration of All Non-Federal Facilities under Texas Community Right-to-Know Acts
- Rendering Licensing
- Retailer of Abusable Paints and/or Glues Permitting
- Retail Food (Food Service Establishment) Permitting
- Shellfish/Crabmeat/Handling/Processing Licensing
- Tanning Facility Licensing
- Tattoo Studio Licensing
- Youth Camps Licensing

Regulation of facilities also falls into similar categories. Under registration, facilities must file their names, addresses and qualifications with a government agency before opening a facility. Under certification, only facilities that meet state standards may advertise that fact. Under licensure, a facility may not operate without first meeting government standards and obtaining a license or permit. Most TDH-regulated facilities are required to hold a license. For example, general hospitals must hold a license to operate.

Governments use two basic tools to ensure that standards are met—examinations and inspections. When a government licenses or certifies a profession, persons are normally required to pass a standardized examination intended to demonstrate a mastery of the field to a level that minimizes public risk. Testing requirements can vary depending on the state, the risk to the public, and the profession. When regulating facilities, governments rely on inspections. Inspections are intended to determine if a facility's operating practices and policies minimize public risk. Frequency of inspections can also vary depending on the location, the risk to the public, and the type of facility.

Complaints by consumers or peers provide regulators with key information about the performance of licensed professionals or facilities. For example, the 55 TDH regulatory programs received 6,608 complaints in the last fiscal year. These complaints may allege activity or behavior that is inappropriate or poses a direct threat to public health. Once a complaint has been received, an initial review or investigation is held to determine if the complaint has merit. If a complaint is found to have merit, a more detailed investigation occurs to determine if a rule or statutory violation has taken place.

Enforcement

After an investigation, if a person or facility is found to have violated statute or rules, that person or facility can become subject to a number of enforcement actions. Enforcement actions are usually set by TDH staff or an advisory board, and finalized by the Commissioner of Health or in accordance with Board of Health rules. Enforcement action could include reprimand, often reserved for minor violations. However, more serious violations can result in an administrative penalty, license or certification suspension/revocation, or a combination of those enforcement actions. Informal or settlement conferences may be held between TDH staff and the alleged violator to remedy the alleged violation and or agree on any proposed enforcement actions. If both sides agree, then the Commissioner of Health may make a final determination and issue an agreed order. If requested by an alleged violator, a hearing may be held in accordance with the Administrative Procedures Act. A hearing officer then determines whether a violation occurred and recommends a penalty to the Commissioner of Health. The Commissioner makes a final determination as to any penalty. A final order under the Administrative Procedures Act may be appealed to District Court. In some cases TDH may also request that civil or criminal penalties be assessed or seek an injunction through the State Attorney General or county district attorney.

Selected Professionals

- Athletic Trainer Licensing*
- Contact Lens Dispenser Registry
- EMS Personnel Certification
- Health-Related Services Registry
- Massage Therapy Registration
- Medical Physicist Licensure*
- Medical Radiologic Technologists Certification
- Optician Registration
- Respiratory Care Practitioners Certification
- Asbestos Abatement Personnel
- Code Enforcement Officer Registration
- Food Service Worker Certification
- Food Service Worker Training Programs Accreditation
- Government Employee Pesticide Applicator Licensing
- Industrial Radiographer Certification
- Lead Abatement Personnel Certification
- Sanitarian Registration

* Administratively-attached independent board using TDH staff.

[1] The Institute of Medicine, *The Future of Public Health* (Washington, D.C.: National Academy Press, 1988), p. 41.

[2] Texas Department of Health, *Program Activity Self-Review (FY 97)*, Office of Border Health, p. 36.

[3] Interview by Sunset staff with Dr. Philip Huang, Chief, Bureau of Chronic Disease Prevention and Control, Texas Department of Health, Austin, Texas, November 14, 1997.

[4] The Lewin Group, *Managing Intergration Problems Between Fee-For-Service and Managed Care: Outline for a Possible Structure for the Texas Medicaid Administrative System*, (Fairfax, Virginia, September 11, 1996), p.2.

[5] U.S. Department of Commerce, Bureau of the Census, Current Population Survey, Texas Sample, (Washington, D.C., March 1995).

[6] Interview by Sunset staff with Melanie Doyle, Grants Management Division, Texas Department of Health, Austin, Texas, May 21, 1998.

APPENDICES

Appendix A

Health Care Delivery Program
Eligibility and Benefits

APPENDIX A

HEALTH CARE DELIVERY PROGRAM ELIGIBILITY AND BENEFITS

Program		Eligibility Requirements	Benefits	Clients Served in FY 97	Eligible Clients
Medicaid					
Acute Care	**Fee for Service**	**income and age:** pregnant women and infants ≤ 185% FPL parents of eligible children ≤ 17% FPL 1 - 5 y ≤ 133% FPL 6 - 14 ≤ 100% FPL 15 - 18 y ≤ 17% FPL (*limits based on family income and total assets*) **residency:** U.S. Citizens and legal aliens **diagnosis:** none	**federally mandated services:** ambulance, certified pediatric and family nurse practitioner, certified nurse midwife, Comprehensive Care Program, Texas Health Steps dental and medical screening, family planning, Federally Qualified Health Centers, home health, inpatient hospital, laboratory and radiology, medical transportation, newborn screening, nursing facilities, outpatient hospital, physician, renal dialysis, rural health clinic **optional programs provided by TDH:** advanced nurse practitioner, ambulatory surgical center, birthing center, certified registered nurse anesthetist, chiropractic, diagnostic and evaluation, emergency hospital, hearing aid service, in-home parenteral hyperalimentation, in-home respiratory care, social work advanced practitioner, licensed professional counselor, maternity clinic, mental health rehabilitation, optometrist, outpatient counseling for chemical dependency, physical therapy, podiatry, vendor drug, psychologist, school health, targeted case management services, tuberculosis clinic services	1,712,950	
	Managed Care			274,596	
Family Planning Title XIX			health histories and physical exams for women and men; birth control methods, supplies and counseling; sterilization counseling and referral for women and men; testing and treatment for sexually transmitted infections; screening for diabetes, anemia, breast and cervical cancer; referrals for prenatal and other medical care	90,298	475,947
Vendor Drug			three prescriptions filled per month for most Medicaid clients unlimited prescriptions for children < 21 years old, nursing facility residents, managed care clients, and clients enrolled in the Community Living and Support Services and Community-Based Alternatives waiver programs	1,987,547	
Medical Transportation			transportation to medical or dental appointments for clients who have no means of transportation	61,678	2,839,241
Medically Needy Spend Down		same as Medicaid, except family is able to deduct medical expenses before calculating financial eligibility	all Medicaid benefits	same as Medicaid acute care	
Emergency Medicaid		potentially eligible pregnant women who are delivering	all Medicaid benefits during delivery	305	

APPENDIX A

HEALTH CARE DELIVERY PROGRAM ELIGIBILITY AND BENEFITS

Program		Eligibility Requirements	Benefits	Clients Served in FY 97	Eligible Clients
Medicaid (cont.)					
Texas Health Steps (EPSDT)	**Medical**	**income:** Medicaid eligible **age:** 0 to 21 years **residency:** U.S. Citizens and legal aliens (undocumented aliens eligible for emergency medical services only) **diagnosis:** none **Qualified Medicare Beneficiaries (QMBs) ineligible**	medical screening, medical check-ups and related laboratory services, vision and hearing services, dental exams, diagnosis, and treatment (*services can be provided through managed care or fee for service*)	691,643	1,872,412
	Dental			682,989	1,610,742
	Comprehensive Care Program (CCP)	**income:** Medicaid eligible **age:** 0 to 21 years **residency:** Texas **diagnosis:** children with special health care needs	expanded Medicaid benefits, including medical equipment, braces and artificial limbs, private duty nursing, and therapy services	262,555	1,872,412
	Medical Case Management	**income:** Medicaid eligible **age:** 0 to 21 years **residency:** Texas **diagnosis:** children with special health care needs	Case management for children with special health care needs	new program, no contracts for FY 97	
Medically Dependent Children's Program (MDCP) *(Medicaid Waiver)*		**income:** child's income ≤ 300% FPL **age:** 0 to 20 years **residency:** Texas **diagnosis:** SSI eligible disability in need of skilled nursing care **ineligible for any other services**	respite care for families of medically complex children and young adults, alternative to nursing home care, minor home modifications, adjunct services for child care, case management	498	1,649 (1,151 waiting)
Medicare payments **Part A** **Part B**		**income:** Medicaid eligible **age:** Medicare eligible **residency:** U.S. citizen or legal alien **diagnosis:** Medicare eligible	premium co-pay, medications (allows Medicare to be the primary payor for health care)	A 43,165 B 352,190	

APPENDIX A

HEALTH CARE DELIVERY PROGRAM ELIGIBILITY AND BENEFITS

Program		Eligibility Requirements	Benefits	Clients Served in FY 97	Eligible Clients
Non-Medicaid Health Care Services					
Maternal and Child Health Care Bock Grant (Title V)	**Children's Health**	**income:** family income ≤ 185% FPL **age:** 0 to 21 years **residency:** Texas **diagnosis:** none **ineligible for Medicaid**	primary care for children including immunizations, health education, dental services, early diagnosis of hearing impairment and related medical services, school-based health centers, case management for high risk infants, newborn screening	46,299	46,299 certified 1,451,675 potential
	School Health	**income:** none **age:** school children **residency:** Texas **diagnosis:** none	preventive and selected primary health care services	7,299	26,584
	Chronically Ill and Disabled Children (CIDC) /Children with Special Health Care Needs (CSHCN)	**income:** family ≤ 200% FPL with spend down provisions **age:** 0 to 21 years and adults with cystic fibrosis **residency:** Texas **diagnosis:** disease specific **ineligible for Medicaid**	screening and medical treatment specific to diagnosis including hospitalization, limited dental services, habilitation and rehabilitation, durable medical equipment, medications and nutrition prescribed by a physician, meals, lodging and transport, case management for children with SSI or certain other children with special health care needs, respite care, insurance premiums	6,952	18,504 certified 45,390 potential
	CSHCN Case Management			44,261	
	Program for Amplification for Children of Texas (PACT)	**income:** family income ≤ 150% FPL **age:** 0 to 19 years **residency:** Texas **diagnosis:** permanent hearing loss that impacts language and learning	evaluations by audiologist and otologist, hearing aid evaluations, earmold - hearing aids, hearing aid counseling for child and family, follow-up check ups, hearing aid repair	6,757	23,088
	Women's Health	**income:** family income ≤ 185% FPL **age:** women of childbearing age **residency:** Texas **diagnosis:** none **ineligible for Medicaid**	prenatal care, family planning, dysplasia services, education, vitamins with folic acid for high-risk mothers, case management for high-risk mothers and pregnant women	52,650	52,650 certified
	Family Planning	**income:** family income ≤ 250% FPL, a sliding fee schedule is used for individuals whose income is ≥ 100% of poverty **age:** persons of reproductive age **residency:** none **diagnosis:** none	health histories and physical exams for men and women, breast exams and cervical cancer screening, pregnancy testing and counseling, birth control methods/counseling, testing and treatment for sexually transmitted diseases, diabetes and anemia screening, individual counseling and community health education, referrals for prenatal and other medical care, HIV antibody testing and counseling	62,701	62,701 certified 1,414,186 potential

APPENDIX A

HEALTH CARE DELIVERY PROGRAM ELIGIBILITY AND BENEFITS

Program		Eligibility Requirements	Benefits	Clients Served in FY 97	Eligible Clients
Non-Medicaid Health Care Services (cont.)					
Family Planning	**Title X**	**income:** family income ≤ 250% FPL, a sliding fee schedule is used for individuals whose income is 100% FPL **age:** none **residency:** none **diagnosis:** none	health histories and physical exams for women and men; birth control methods, supplies and counseling; sterilization counseling and referral for women and men; testing and treatment for sexually transmitted infections; screening for diabetes, anemia, breast and cervical cancer; referrals for prenatal and other medical care	90,298	475,947
	Title XX	**income:** family income ≤ 150% FPL **age:** none **residency:** Texas **diagnosis:** none		221,450	
Breast and Cervical Cancer Control Program	**Breast Cancer Control**	**income:** family income ≤ 200% FPL **age:** women ≥ 40 years old **residency:** none **diagnosis:** none **ineligible for other programs that provide the same service**	clinical breast exams, mammograms, biopsies	16,058	750,000
	Cervical Cancer Control	**income:** family income ≤ 200% FPL **age:** women ≥ 18 years old **residency:** none **diagnosis:** none **ineligible for other programs that provide the same service**	pelvic exams, pap screens, colposcopy, biopsies		
Special Supplemental Nutrition Program for Woman, Infants and Children (WIC)		**income:** family income ≤ 185% FPL **age:** pregnant women and women who have recently given birth of any age, and infants and children 0 to 5 years **diagnosis:** nutritionally at risk **residency:** none	immunizations, nutritional screening and counseling, breast feeding support, vouchers for supplemental foods including infant formula	683,585	778,253 certified 1,307,614 potential
	Farmer's Market Nutrition Program		fresh fruits and vegetables from farmer's markets	211,187	336,153
Immunization		**income:** none **age:** children **residency:** Texas **diagnosis:** none	immunizations, vaccine preventable disease control	1,695,750	all Texas children

APPENDIX A

HEALTH CARE DELIVERY PROGRAM ELIGIBILITY AND BENEFITS

Program	Eligibility Requirements	Benefits	Clients Served in FY 97	Eligible Clients
Non-Medicaid Health Care Services (cont.)				
Dental Health	**income:** family income ≤ 130% FPL **age:** 0 to 19 years **residency:** Texas **diagnosis:** children in need of dental care	dental exams, simple fillings, and extractions, crowns, root canals, dental sealants	23,051	378,319
Children's Heart Outreach Program/ Children's Heart Institute of Texas	**income:** family income ≤ 200% FPL **age:** 0 to 21 years **residency:** Texas **diagnosis:** heart disease or defect	pre-diagnostic and post diagnostic cardiac examinations, training to local physicians and public health nurses in screening and diagnostic procedures	6,371	
Kidney Health Care Program	**income:** adjusted gross income < $60,000 **age:** none **residency:** Texas **diagnosis:** end stage renal disease (ESRD) **ineligible for Medicaid**	$30,000 / client / year, medical expenses, dialysis, surgical expenses related to hemo-access or transplantation, medications, transportation (Medicare recipients eligible for medications and transportation)	16,781	
Adult Hemophilia Assistance Program (HAP)	**income:** family income ≤ 245% FPL **age:** 21 years or older **residency:** Texas **diagnosis:** hemophilia	blood, blood derivatives, or manufactured pharmaceutical products	18	
Epilepsy Program	**income:** family income ≤ 200% FPL **age:** 21 years or older **residency:** Texas **diagnosis:** seizures **Ineligible for Medicaid**	diagnosis and treatment, case management, and educational services	4,530	
HIV Medication Program	**income:** family income ≤ 200% FPL **age:** none **residency:** Texas **diagnosis:** HIV infection	medications including protease inhibitors and other antiretrovirals and medication for opportunistic infections	6,138	
Other HIV Services	**income:** none **age:** none **residency:** Texas **diagnosis:** HIV infection	clinical services, medications and durable medical equipment, attendant care and companion service, case management, emergency financial services, transportation, support group	20,994	
TB Control Program	**income:** none **age:** none **residency:** Texas **diagnosis:** TB infection	medications, outreach, clinical services, case management, education, laboratory testing	38,949	

APPENDIX A

HEALTH CARE DELIVERY PROGRAM ELIGIBILITY AND BENEFITS

Program	Eligibility Requirements	Benefits	Clients Served in FY 97	Eligible Clients
Non-Medicaid Health Care Services (cont.)				
Primary Health Care Program / Community Oriented Primary Care (COPC)	**income:** family income ≤ 150% FPL **age:** none **residency:** Texas **diagnosis:** no specific diagnosis required **ineligible for other programs that provide the same service**	primary health care, population based public health services	107,308	1,605,908
County Indigent Health Care	**income:** family income ≤ 17% FPL and assets < $1,000 **age:** none **residency:** county residents **diagnosis:** none **ineligible for Medicaid**	primary health care, inpatient/outpatient hospital expenses including physician, laboratory, and radiology fees, rural health clinic expenses, family planning, skilled nursing, three prescriptions per month	22,232	

APPENDIX A (continued)

HEALTH CARE DELIVERY FUNDING AND CONTRACTS

APPENDIX A

HEALTH CARE DELIVERY FUNDING AND CONTRACTS

Program	Fiscal Year 1997 Expenditures	Method of Finance	Service Provider with TDH Contract	Number of Contracts and/or TDH Employees	Contract Procurement Methodology and Contract Term	Contract Reimbursement Methodology
Medicaid						
Fee for Service (*including Medically Needy Spend Down and Emergency Medicaid*)	**Client Services** federal: $2,033,779,372 state: $1,305,038,327 total: $3,338,817,699 **Administration** $51,949,316	State/federal match requirement: **Client Services Premium** • federal: 62.54% • general revenue: 37.46% **Administrative Premium** • federal: 50% • general revenue: 50%	National Heritage Insurance Company (NHIC)	1 contract	• competitive statewide request for proposal (RFP) • five years, with three extending amend-ments	**Premium Payments for Medical Benefits** • fee-for-service: Medicaid premium per client per month • managed care: health maintenance organization (HMO) capitation rate, fixed rate, per client per month • Primary Care Case Management (PCCM), At-Risk: Medicaid premiums for six counties • Primary Care Case Management (PCCM), Non-Risk: cost for four service delivery areas (SDA) • cost: some specific services such as home health and substance abuse **Administrative Payments** • quota share: cap of $6.5 million on profit from premium payments that can be made above the cost of client care • per member per month administrative fee for processing PCCM and fee for service claims, and making HMO payments • fixed amount to process CIDC claims
			hospitals	450 contracts	• open enrollment • open ended	fee-for-service based on Medicare diagnosis related groups (DRG) taxonomy with a standard dollar amount per treatment and relative weights according to the intensity of the treatment or illness
			physicians and other health care providers	206,500 contracts	• open enrollment • open ended	
Managed Care	**Client Services** federal: $254,427,322 state: $163,261,272 total: $417,688,594 **Administration** $37,835,889		NHIC (*see Medicaid Administrative Contracts table for more detail about providers*)	1 contract	• competitive statewide RFP for regional providers • biennial	capitated premium rate, calculated with the Medicaid fee-for-service cost of providing service experience, using the changes in the consumer price index in the service area and discounting the anticipated savings from managed care
			Health Maintenance Organizations (HMOs), privately and publicly formed (*see Medicaid Administrative Contracts table for more detail about providers*)	12 contracts		

APPENDIX A

HEALTH CARE DELIVERY FUNDING AND CONTRACTS

Program	Fiscal Year 1997 Expenditures	Method of Finance	Service Provider with TDH Contract	Number of Contracts and/or TDH Employees	Contract Procurement Methodology and Contract Term	Contract Reimbursement Methodology
Medicaid (cont.)						
Family Planning	**Title XIX** **Client Services** federal: $37,760,329 state: $4,195,592 total: $41,955,921 **Administration** $1,503,820	• no match required • federal categorical grant • general revenue	• local health departments • private and nonprofit organizations • community-based organizations • medical schools • private practitioners	any Medicaid provider 0 TDH FTEs	• open enrollment • open ended	fee-for-service
Vendor Drug	**Client Services** federal: $467,557,423 state: $280,055,981 total: $747,613,404 **Administration** $9,069,059		pharmacies	3,649 contracts	• open enrollment • no formal renewal time • termination based on non compliance	• formula: $\frac{\$5.27+ \text{ Drug Cost}}{0.98}$ [*allows for 2% profit margin*] • pharmaceutical companies reimburse the state with rebates
Medical Transportation	**Client Services** federal: $12,298,946 state: $7,366,782 total: $19,665,728 **Administration** $3,834,532		• taxi services and other forms of commercial transportation • individuals • non-commercial transportation • hotels	103 contracts 53 contracts with hotels and hospitals 99.2 TDH FTEs	• competitive statewide RFP for regional providers of commercial transportation contractors • annual continuation application • open enrollment for noncommercial individual transportation • no formal renewal time	• cost • fee-for-service
Texas Health Steps (EPSDT)	**Medical** **Client Services** federal: $35,902,340 state: $24,009,232 total: $59,911,572 **Administration** $5,575961		• TDH regional clinics • local health departments • primary care physicians • HMOs • nonprofit agencies	1,873 contracts 234.7 TDH FTEs	• competitive statewide RFP for regional providers • noncompetitive governmental contracts • annual • open enrollment for health care providers	• fee-for-service for provider claims through the Medicaid claims contractor, in areas where Medicaid is not delivered through managed care • part of capitated fee in managed care contracts • cost for outreach providers

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HEALTH CARE DELIVERY FUNDING AND CONTRACTS

Program	Fiscal Year 1997 Expenditures	Method of Finance	Service Provider with TDH Contract	Number of Contracts and/or TDH Employees	Contract Procurement Methodology and Contract Term	Contract Reimbursement Methodology
Medicaid (cont.)						
Texas Health Steps (EPSDT) (cont.)	**Dental** **Client Services** federal: $77,942,057 state: $46,736,948 total: $124,679,005 **Administration** $259,970		local dentists	1,858 contracts 0 TDH FTEs	• open enrollment • open-ended terms	fee-for-service for provider claims through the Medicaid claims contractor
	Comprehensive Care Program (CCP) **Client Services** federal: $110,086,859 state: $63,383,579 total: $173,470,438 **Administration** $559,367		• primary care physicians • home health agencies • independent nurses • therapists • medical equipment providers • other health care providers	any Medicaid provider	• open enrollment • open-ended terms	fee-for-service for provider claims through the Medicaid claims contractor
	Case Management		new program, no contracts in FY 97			
Medically Dependent Children's Program (MDCP) (*Medicaid Waiver*)	**Client Services** federal: $7,151,781 state: $4,281,770 total: $11,433,551 **Administration** $996,380		• nurses • home health agencies • skilled nursing facilities	497 contracts 15.4 TDH FTEs	• open enrollment • open-ended terms	fee-for-service
Medicare payments Part A Part B	**Client Services** federal: $243,753,324 state: $146,052,751 total: $389,806,075 **Administration** $1,154,109		same as Medicaid fee for service and managed care	Medicaid and Medicare providers	n/a	fee-for-service for provider claims through the Medicaid claims contractor

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HEALTH CARE DELIVERY FUNDING AND CONTRACTS

Program	Fiscal Year 1997 Expenditures	Method of Finance	Service Provider with TDH Contract	Number of Contracts and/or TDH Employees	Contract Procurement Methodology and Contract Term	Contract Reimbursement Methodology
Non-Medicaid						
Maternal and Child Health Care Block Grant (Title V)	**Children's Health** **Client Services** federal: $7,270,625 state: $5,452,968 total: $12,723,593 **Administration** $296,233	State/federal match requirement: • Texas contributes $3 for every $4 of federal funding	• local health departments • nonprofit agencies • TDH regional clinics	107 contracts 41.5 TDH FTEs	• competitive statewide RFP for regional providers every three years • annual continuation application	fee-for-service
	School Health **Client Services** federal: $1,848,099 state: $174,829 total: $2,022,928 **Administration** $54,396		school-based clinics	16 contracts 0 TDH FTEs	• competitive statewide RFP • annual continuation application	annual grant to clinic
	Chronically Ill and Disabled Children (CIDC) / Children with Special Health Care Needs (CSHCN) **Client Services** federal: $9,772,685 state: $25,995,989 total: $35,368,674 **Administration** $2,309,762		• physicians • other health care providers • hospitals • pharmacies	25,945 contracts 0 TDH FTEs	• open enrollment with open-ended terms for health care providers • competitive RFP for hospitals and pharmacies • annual continuation application	fee-for-service for provider claims
	CSHCN Case Management **Client Services** federal: $0 state: $5,097,886 total: $5,097,886 **Administration** $814,604		• nonprofit agencies • TDH social work staff	17 contracts 112 TDH FTEs	• competitive RFP • annual continuation application	capitated rate based on contract

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HEALTH CARE DELIVERY FUNDING AND CONTRACTS

Program	Fiscal Year 1997 Expenditures	Method of Finance	Service Provider with TDH Contract	Number of Contracts and/or TDH Employees	Contract Procurement Methodology and Contract Term	Contract Reimbursement Methodology
Non-Medicaid (cont.)						
Maternal and Child Health Care Block Grant (Title V) (cont.)	**Program for Amplification for Children of Texas (PACT)** **Client Services** federal: $750,000 state: $891,772 total: $1,641,772 **Administration** $194,588		medical professionals	154 contracts 0 TDH FTEs	• open enrollment • annual continuation application	fee-for-service
	Women's Health **Client Services** federal: $5,347,420 state: $4,010,565 total: $9,357,985 **Administration** $190,624		• local health departments • physicians • other health care providers • TDH regional clinics	87 contracts 20.2 TDH FTEs	• competitive statewide RFP for regional providers every three years • annual continuation application	fee-for-service
	Family Planning **Client Services** federal: $4,549,158 state: $3,411,869 total: $7,961,027 **Administration** $190,225		• local health departments • other health care professionals • TDH regional clinics	87 contracts 178 TDH FTEs	• competitive statewide RFP for regional providers every three years • annual continuation application	fee-for-service
Family Planning	**Title X** **Client Services** federal: $141,000 state: $0 total: $141,000 **Administration** $11,280	ι no match required ι federal categorical grant ι general revenue	• local health departments • private and nonprofit organizations • community-based organizations • medical schools • private practitioners	30 contracts 0 TDH FTEs	• competitive statewide RFP for regional pro- viders every three years • non competitive governmental contracts • annual continuation application	cost
	Title XX **Client Services** federal: $11,774,102 state: $9,940,102 total: $21,715,057 **Administration** $1,737,205	ι no match required ι federal categorical grant ι general revenue		67 contracts 0 TDH FTEs	• competitive statewide RFP for regional pro- viders every three years • non competitive governmental contracts • annual continuation application	cost

APPENDIX A

HEALTH CARE DELIVERY FUNDING AND CONTRACTS

Program	Fiscal Year 1997 Expenditures	Method of Finance	Service Provider with TDH Contract	Number of Contracts and/or TDH Employees	Contract Procurement Methodology and Contract Term	Contract Reimbursement Methodology
Non-Medicaid (cont.)						
Breast and Cervical Cancer Control Program	**Client Services** federal: $3,365,020 state: $202,729 total: $3,567,749 **Administration** $1,344,079	federal categorical grant	• local health departments • county hospital districts • medical schools • physicians • TDH regional clinics • Federal Qualified Health Centers	40 contracts 1 TDH FTE	• competitive RFP initially • annual continuation application	fee-for-service
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	**Client Services** federal: $425,227,524 state: $0 total: $425,227,524 **Administration** $8,307,188	• no match required • federal categorical grant • general revenue	• local health departments nonprofit agencies • county hospital districts community-based organization • medical schools • city government • physicians • TDH regional clinics	82 contracts 135 TDH FTEs	• open enrollment • annual continuation application	formula: $7 to $9 per participant according to a sliding scale based on provider salaries, population density, number of clinics, and size of the provider and is included in the contract. There is no limit to the number of clients who can be served, therefore, there is no funds limit in the agreement.
			grocers	2,500 contracts	• open enrollment • must meet USDA requirements, evaluated for competitive cost in area • annual continuation application	cost for invoices for food provided at regular retail prices (not to exceed market average)
	Farmer's Market Nutrition Program (FMNP) **Client Services** federal: $935,174 state: $465,904 total: $1,401,078 **Administration** $20,045	• state/federal match requirement • federal: 70% • general revenue: 30%	local farmer's markets	40 contracts	• open enrollment to markets authorized by Texas Department of Agriculture • annual continuation application	formula: $1.40 fee per participant
Immunizations	**Client Services** federal: $9,932,082 state: $26,450,804 total: $36,382,886 **Administration** $3,525,306	• no match required • federal categorical grant • general revenue	ι community health centers ι local health departments ι county hospital districts	107 contracts 157 TDH FTEs	• open enrollment • annual continuation application	cost

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HEALTH CARE DELIVERY FUNDING AND CONTRACTS

Program	Fiscal Year 1997 Expenditures	Method of Finance	Service Provider with TDH Contract	Number of Contracts and/or TDH Employees	Contract Procurement Methodology and Contract Term	Contract Reimbursement Methodology
Non-Medicaid (cont.)						
Dental Health	**Client Services** federal: $0 state: $1,517,515 total: $1,517,515 **Administration** $690,127	general revenue	local dentists	470 contracts 24.9 TDH FTEs	• open enrollment	fee-for-service
Children's Heart Outreach Program/ Children's Heart Institute of Texas	**Client Services** federal: $0 state: $247,000 total: $247,000 **Administration** $0	general revenue	outreach clinics	1 contract	• non competitive contractor specified in General Appropriations Act • annual continuation application	grant to one hospital designated in General Appropriations Act
Kidney Health Care Program	**Client Services** federal: $0 state: $17,677,814 total: $17,677,814 **Administration** $1,429,064	ι general revenue ι appropriated receipts	dialysis facilities pharmacies	236 contracts 193 contracts	• open enrollment • annual continuation application	fee-for-service based on 60% of Medicaid rate Medicaid rate through Vendor Drug program
Adult Hemophilia Assistance Program (HAP)	**Client Services** federal: $0 state: $261,949 total: $261,949 **Administration** $1,483	general revenue	ι hemophilia centers ι home health agencies ι pharmacies	6 contracts	• open enrollment • annual continuation application	cost
Epilepsy Program	**Client Services** federal: $0 state: $469,575 total: $469,575 **Administration** $46,620	general revenue	treatment centers	5 contracts	• competitive statewide RFP per biennium • annual continuation application	cost

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HEALTH CARE DELIVERY FUNDING AND CONTRACTS

Program	Fiscal Year 1997 Expenditures	Method of Finance	Service Provider with TDH Contract	Number of Contracts and/or TDH Employees	Contract Procurement Methodology and Contract Term	Contract Reimbursement Methodology
Non-Medicaid (cont.)						
HIV Medication Program	**Client Services** federal: $7,261,527 state: $7,278,316 total: $14,539,843 **Administration** $184,339	• federal categorical grant • general revenue	• local pharmacies • TDH employees	212 contracts 10 TDH FTEs	• open enrollment • annual continuation application	$5 co-pay for medication to pharmacies by client
Other HIV Services	**Client Services** federal: $36,700,000 state: $37,900,000 total: $74,600,000 **Administration** $1,431,804	• federal categorical grant • state maintenance of effort required ($16,100,000) plus 1:2 match	• local health departments • physicians, hospitals • community-based organizations	88 contracts 32 TDH FTE	• competitive RFP • annual continuation application	formula based on population, poverty index, and number of AIDS cases within a service delivery area (SDA)
TB Control Program	**Client Services** federal: $4,090,241 state: $12,036,086 total: $16,126,327 **Administration** $1,116,631	• no match required • federal categorical grant • general revenue	• local health departments • medical schools • community-based organizations	61 contracts 75 TDH FTEs	• non competitive governmental contracts • annual continuation application	cost
Primary Health Care Program/ Community Oriented Primary Care (COPC)	**Client Services** federal: $0 state: $12,836,976 total: $12,836,976 **Administration** $112,009	• no match required • federal categorical grant • general revenue	• local health departments • county health districts • medical schools • hospitals • nonprofit agencies	58 contracts 1.6 TDH FTEs	• competitive statewide RFP for regional providers every three years • non competitive governmental contracts • annual continuation application	annual grants to communities
County Indigent Health Care	**Client Services** federal: $0 state: $3,760,702 total: $3,760,702 **Administration** $629,189	100% general revenue	counties	16 counties	• non competitive governmental grant • annual continuation application	fee-for-service at Medicaid rates

Appendix B

Background Information on Professionals and Facilities

APPENDIX B

Background Information on TDH Regulation of Health Care and Other Professionals - FY 1997

	Statutory Citation	Final Rulemaking Authority	# of Persons Regulated	# of Exams Given/ Passed	#of Com-plaints	# of Investi-gations	# of Notices of Violations	# of Letters of Reprimand	# and Total Amount of Administrative Penalties	# of Suspensions/ Revocations	# of APA Hearings	#of Cases Resolved thru Civil Litigation
Health Care Quality and Standards												
Athletic Trainer Licensing*	Vernon's Ann.Civ.St Art. 4512d	Advisory Board of Athletic Trainers (six athletic trainers)	1,227	198/133	5	3	3	0	NA	0/0	0	0
Contact Lens Dispenser Registry	Vernon's Ann.Civ.St. Art. 4552-A	Board of Health	NA[1]	NA/NA	NA	NA	NA	NA	NA	NA/NA	NA	NA
EMS Personnel Certification	V.T.C.A., Health and Safety Code Ch. 773	Board of Health	48,624	16,982/ 14,991	180	180	42	3	1-$250	5,714[8]	12	0
Health Related Services Registry[2]	V.T.C.A., Health and Safety Code Sec.12.014	Board of Health	108[2]	NA/NA	NA	NA	NA	NA	NA	NA/NA	NA	NA
Massage Therapy Registration	Vernon's Ann.Civ.St. Art. 4512k	Board of Health	12,567	2,846/ 2,203	91	75	27	0	NA[3]	1/3[4]	1	0
Medical Physicist Licensure*	Vernon's Ann.Civ.St. Art. 4512n	Board of Health	398	2/1	1	0	1	0	NA	0/0	0	0

*TDH staff, but administratively attached independent board

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	Statutory Citation	Final Rulemaking Authority	# of Persons Regulated	# of Exams Given/ Passed	#of Com-plaints	# of Investi-gations	# of Notices of Violations	# of Letters of Reprimand	# and Total Amount of Administrative Penalties	# of Suspensions/ Revocations	# of APA Hearings	#of Cases Resolved thru Civil Litigation
Health Care Quality and Standards (cont.)												
Medical Radiologic Technologists Certification	V.T.C.A., Health and Safety Code Sec. 4512m	Board of Health	15,341	222[5]/47[6]	33	20	14	NA[3]	0[3]	0/0	0	0
Optician Registration	Vernon's Ann.Civ.St. Art. 4551-1	Board of Health	1,096	NA[7]/NA	3	0	0	NA[3]	0[3]	0/0	0	0
Respiratory Care Practitioners Certification	Vernon's Ann.Civ. St. Art. 4512-1	Board of Health	10,465	NA[7]/NA	18	16	4	NA[3]	0[3]	0/0	0	0
Environmental and Consumer Health												
Asbestos Abatement Personnel	Vernon's V.T.C.A. Code Art. 4477-3a	Board of Health	6,477[9]	1,690/ 1,430	251	2,463[13]	856[13]	124[13]	230[13] - $353,125	0/0	3	0
Code Enforcement Officer Registration	Vernon's V.T.C.A. Code Art. 4447bb	Board of Health	1,152	230/ 165	0	0	NA	0	N/A	0/0	0	0
Food Service Worker Certification	V.T.C.A., Health and Safety Code Ch. 438	Board of Health	17,460[10]	18,756/ 17,460	0	0	0	NA	NA	0/0	NA	NA

	Statutory Citation	Final Rulemaking Authority	# of Persons Regulated	# of Exams Given/ Passed	#of Com-plaints	# of Investi-gations	# of Notices of Violations	# of Letters of Reprimand	# and Total Amount of Administrative Penalties	# of Suspensions/ Revocations	# of APA Hearings	#of Cases Resolved thru Civil Litigation
Environmental and Consumer Health (cont.)												
Food Service Worker Training Programs Accreditation	V.T.C.A., Health and Safety Code Ch. 438	Board of Health	141[10]	NA	1	0	3	0	NA	0/0	NA	NA
Government Employee Pesticide Applicator Licensing	V.T.C.A., Agriculture Code Ch. 76	Board of Health	435	601/ 210	0	0	NA	0	N/A	0/0	0	0
Industrial Radiographer Certification	V.T.C.A., Health and Safety Code Ch. 401	Board of Health	2,573	744/ 629	0	0	0	N/A	0	0/0	0	0
Lead Abatement Personnel Certification	Vernon's V.T.C.A., Code Art. 9029	Board of Health	889[11]	0/0[12]	0	0	0	N/A	0	0/0	0	0
Sanitarian Registration	Vernon's V.T.C.A. Code Art. 4477-3	Board of Health	1,816	119/ 95	5	5	N/A	0	N/A	0/0	0	0

Health Care Quality and Standards

1. Legislation effective January 1998.
2. No regulatory authority, registry is voluntary.
3. Administrative penalties legislation became effective Sept. 1, 1997.
4. Includes two surrenders and one revocation.
5. Used national exam for full certification, 222 given an exam for limited certification
6. Must pass the core exam plus at least one of five categories.
7. Used national exam.
8. Emergency suspensions for failure to do continuing education (CE).

Environmental and Consumer Health

9. Food Protection Management (Food Service Worker and Food Service Worker Training Programs) - This is a voluntary food manager training program. The Texas Board of Health is authorized to adopt standards and procedures for the accreditation of education and training programs for persons employed in the food service industry.
10. Asbestos Abatement Personnel include: Worker, Individual Management Planner, Individual Consultant, Management Planner Agency, Consultant Agency, Inspectors, Air Monitoring Technician, Project Managers, Laboratories, Contractors, Transporters, Supervisors, Operations & Maintenance Contractors, Operations & Maintenance Supervisor.
11. Lead Abatement Personnel include: Inspector, Risk Assessor, Abatement Project Designer, Abatement Supervisor, Lead Abatement Worker, Firm and Training Program Provider.
12. Requirement for exam effective June 1998.
13. Includes abatement projects and/or licensed abatement personnel.

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Health Care Quality and Standards[1]												
Abortion Facility Licensing[2]	V.T.C.A., Health and Safety Code Ch. 245	Board of Health	31	43/43	8	4	1	0	0	0/0	0	0
Ambulatory Surgical Center Licensing	V.T.C.A., Health and Safety Code Ch. 243	Board of Health	226	31/31	17	13	0	0	0	0/0	0	0
Birthing Center Licensing	V.T.C.A., Health and Safety Code Ch. 244	Board of Health	46	72/72	15	10	1/2[7]	0	0	0/0	0	0
EMS Providers Licensing	V.T.C.A., Health and Safety Code Ch. 773	Board of Health	713	886/663	107	107	21	NA	5 - $3,250	0/0	3	0
End Stage Renal Disease Facility Licensing[3]	V.T.C.A., Health and Safety Code Ch. 251	Board of Health	240	293/293	111	95	1	0[6]	0/1 - $15,750[3]	0/0	0	0
General and Special Hospitals Licensing	V.T.C.A., Health and Safety Code Ch. 241	Board of Health	472	158/158	1,387	1,126	4/6[7]	0[6]	0/4 - $90,250[4]	0/0	0	0

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	Statutory Citation	Final Rule-Making Authority	# of Facilities Regulated	# of Inspections Completed/ Passed	#of Com-plaints	# of Investi-gations	# of Notices of Violations	# of Letters of Reprimand	# and Total Amount of Administrative Penalties	# of Suspensions/ Revocations	# of APA Hearings	# of Cases Resolved thru Civil Litigation
Health Care Quality and Standards[1] (cont.)												
Home and Community Support Services Agency Licensing[5]	V.T.C.A., Health and Safety Code Ch. 142	Board of Health	4,527	2,460/ 2,440	1,704[10]	1,179[10]	1/14[7]	0[6]	NA[5]	1/6[9]	0	0
Private Psychiatric Hospitals Licensing/ Crisis Stabili-zation Units	V.T.C.A., Health and Safety Code Ch. 577	TDMHMR/ Board of Health	53	111/111	662[10]	652[7]	0/2[7]	0[6]	1-$24,000	0/0	0	0
Special Care Facility Licensing	V.T.C.A., Health and Safety Code Ch. 248	Board of Health	15	23/23	8	5	0	0	0	0/0	0	
Trauma Center Designation	V.T.C.A., Health and Safety Code Ch. 773	Board of Health	80	64/37	2	1	NA	NA	0	0/0	0	0
Bedding Product Manufacturer Registration	V.T.C.A., Health and Safety Code Ch. 345	Board of Health	2,577	1,412/766	18	18	646	NA	NA[11]	0/0	0[11]	NA

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Health Care Quality and Standards[1] (cont.)												
Drug Manufacturer/ Distributor Licensing	V.T.C.A., Health and Safety Code Ch. 431,439, 481, 482, 483	Board of Health	2,010	1,200/1,080	40	21	362[12]	NA	1 - $5,500	0/0	1	2
Food Manufacturer Licensing	V.T.C.A., Health and Safety Code Ch. 431	Board of Health	12,217	5,553/5,239	301	290	1,037[12]	NA	4 - $8,000	0/0	2	3
Food Salvage Licensing	V.T.C.A., Health and Safety Code Ch. 432	Board of Health	156	203/177	3	3	27[12]	NA	0	0/0	0	0
Food Wholesale Distributor Licensing	V.T.C.A., Health and Safety Code Ch. 431	Board of Health	2,290	986/843	26	24	151[12]	NA	0	0/0	0	0
Frozen Dessert Manufacturer Licensing	V.T.C.A., Health and Safety Code Ch. 440	Board of Health	52	416/387	40	40	416	8	NA	3/0	NA	0
General License Acknowledge-ment (Radioactive Materials)	V.T.C.A., Health and Safety Code Ch. 401	Board of Health	348	137/59	0	0	78	NA	0	0/1[13]	0	0

Background Information on TDH Regulation of Health Care and Other Facilities - FY 1997

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Health Care Quality and Standards[1] (cont.)												
Hazardous Product Manufacturer Registration	V.T.C.A., Health and Safety Code Ch. 439, 481, 482	Board of Health	1,380	4,783/4,184	12	11	599	NA	NA	0/0	0	NA
Mammography Facility Certification	V.T.C.A., Health and Safety Code Ch. 401	Board of Health	455	433/172	5	5	261	NA	1 - $10,000	0/0	0	1
Meat/Poultry Inspections	V.T.C.A., Health and Safety Code Ch. 433	Board of Health	476	73,477/ 73,461	83	107	73[12]	NA	13 - $32,500	0/0	13	1
Medical Device Distributor Licensing	V.T.C.A., Health and Safety Code Ch. 431, 483	Board of Health	150	25/20	18	21	82[12]	NA	0	0/0	0	1
Medical Device Manufacturer Licensing	V.T.C.A., Health and Safety Code Ch. 431, 483	Board of Health	345	75/65	7	10	25[12]	NA	0	0/0	0	0
Medical Device Salvage Licensing	V.T.C.A., Health and Safety Code Ch. 432, 483	Board of Health	168	20/20	13	13	49[12]	NA	0	0/0	0	0

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Background Information on TDH Regulation of Health Care and Other Facilities - FY 1997

	Statutory Citation	Final Rule-Making Authority	# of Facilities Regulated	# of Inspections Completed/ Passed	#of Com-plaints	# of Investi-gations	# of Notices of Violations	# of Letters of Reprimand	# and Total Amount of Administrative Penalties	# of Suspensions/ Revocations	# of APA Hearings	#of Cases Resolved thru Civil Litigation
Health Care Quality and Standards[1] (cont.)												
Migrant Housing Licensing	V.T.C.A., Health and Safety Code Ch. 147	Board of Health	85	87/85	0	NA	33	NA	NA	0/0	0	0
Milk Producer Permitting	V.T.C.A., Health and Safety Code Ch. 435	Board of Health	1,400	14,491/ 13,925	22	22	14,491	603	NA	566/0	NA	0
Milk Processor Permitting	V.T.C.A., Health and Safety Code Ch. 435	Board of Health	40	660/614	112	112	660	8	NA	6/0	NA	0
Narcotic Treatment Facility Licensing	V.T.C.A., Health and Safety Code Ch. 466	Board of Health	52	75/56	18	13	18[12]	NA	0	0/1	0	0
Radioactive Materials Licensing	V.T.C.A., Health and Safety Code Ch. 401	Board of Health	1,463	1,350/471	25	25	879	NA	0	0/5[13]	2	0
Radiation Producing Machine Registration	V.T.C.A., Health and Safety Code Ch. 401	Board of Health	13,976	2,432/781	44	44	1,651	NA	0	0/60[13]	0	0

Background Information on TDH Regulation of Health Care and Other Facilities - FY 1997

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Health Care Quality and Standards[1] (cont.)												
Registration of Public Employers under Texas Hazard Communication Act	V.T.C.A., Health and Safety Code Ch. 502, 506	Board of Health	6,000[14]	17/12	12	17	31	NA	0	NA / NA	0	NA
Registration of All Non-Federal Facilities under Texas Community Right-to-Know Acts	V.T.C.A., Health and Safety Code Ch. 505, 507	Board of Health	50,000[14]	87/79	20	87	7	NA	$3,000	NA / NA	1	NA
Rendering Licensing	V.T.C.A., Health and Safety Code Ch. 144	Board of Health	140	420/416	0	0	12[12]	NA	0	0/0	2	0
Retailer of Abusable Paints and/or Glues Permitting	V.T.C.A., Health and Safety Code Ch. 485	Board of Health	13,091	2,947/1,612	9	9	1,335	NA	NA	NA / 0	0	N/A
Retail Food (Food Service Establishment Permitting)	V.T.C.A., Health and Safety Code Ch. 437	Board of Health	11,434	6,119/5,335	906	599	1,383[15]	NA	0	0 / 0	1	1

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	Statutory Citation	Final Rule-Making Authority	# of Facilities Regulated	# of Inspections Completed/ Passed	#of Com-plaints	# of Investi-gations	# of Notices of Violations	# of Letters of Reprimand	# and Total Amount of Administrative Penalties	# of Suspensions/ Revocations	# of APA Hearings	#of Cases Resolved thru Civil Litigation
Health Care Quality and Standards[1] (cont.)												
Shellfish/ Crabmeat/ Handling/ Processing Licensing	V.T.C.A., Health and Safety Code Ch. 436	Board of Health	81	687/687	0	0	NA	NA	3 - $35,000	0/0	3	1
Tanning Facility Licensing	V.T.C.A., Health and Safety Code Ch. 145	Board of Health	1,850	125/105	133	45	247[12]	NA	0	0/0	0	0
Tattoo Studio Licensing	V.T.C.A., Health and Safety Code Ch. 146	Board of Health	350	293/265	110	67	102[12]	NA	0	0/0	0	0
Youth Camps Licensing	V.T.C.A., Health and Safety Code Ch. 141	Board of Health	600	509/448	10	NA	170	NA	0	0/0	0	0

1. The Bureau of Licensing and Compliance's Enforcement program began in the Fall of 1996. Due to the time required to implement this new program (hiring and training staff, forming an Enforcement Action Committee, developing an Enforcement Action Policy, and training Zone Office surveyors and staff in licensing enforcement) and to meet due process considerations in enforcement cases, the above categories for fiscal year 1997 do not reflect recent enforcement activities. Therefore, the following enforcement action numbers from September 1997 through December 1997 provide more current, accurate information in addition to the information listed in the chart. The number of active and finalized cases change since cases move through the enforcement process and reflect different activity at different times. Through December 1997, the total number of cases in or through the enforcement process by program are:
   HCSSA - 95 Hospitals - 23 ESRD - 33 Abortion - 2 Birthing - 4 Ambulatory Surgical Centers - 0 Special Care Facilities - 0 TOTAL CASES - 157

   In addition, the number of inspections and investigations conducted do not necessarily correlate to the number of actual visits conducted. To provide for cost efficiency, multiple types of inspections and multiple investigations may be conducted simultaneously for the following types — Special Care Facilities, Abortion Facilities, Ambulatory Surgical Centers, Birthing Centers, End Stage Renal Disease Facilities, Home and Community Support Services Agencies, General and Special Hospitals, and Private Psychiatric Hospitals/Crisis Stabilization Units. Inspections and investigations conducted solely for federal purpose at facilities which are not covered under state regulatory authority are not included.

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2. The 75th Legislature SB 407 authorized administrative penalties for abortion facilities. TDH is developing rules to implement that legislation.
3. Number and amount of administrative penalties for end stage renal disease (ESRD) facilities collected in FY 98: 1- $15,750.
4. Number and amount of administrative penalties for General Hospitals collected in FY 98: 4 - $90,250.
5. The 75th Legislature passed SB 1247 authorizing administrative penalties for Home and Community Support Services Agencies (HCSSAs). TDH's rules became effective 3/2/98.
6. Enforcement program began implementing letters of reprimand in FY 98.
7. Number of Notices of Violation for facilities from September 1997 through March 1998.
8. Crisis Stabilization Units are licensed within Psychiatric Hospitals.
9. Number of suspensions/revocations for FY 98.
10. Complaints and investigations are a composite of complaints that may comprise both a federal (HCFA) and state violation. However, the sanctions represented are state licensure only since that is the scope of the program's authority. Any remaining actions would have been the result of HCFA as it is the final authority for Medicare-certified entities.
11. The 75th Legislature SB 1284 authorized administrative penalties and administrative hearing process for bedding product manufacturers. TDH is developing rules to implement that legislation.
12. Notices of facility violations and warning letters.
13. Includes revocations for nonpayment of fees.
14. Estimate.
15. Notices of facility violations and notices for failure to permit as required.

CENTER FOR RURAL HEALTH INITIATIVES

ISSUE

Issue 1

Maintain the Center for Rural Health Initiatives and Strengthen Administrative Ties to the Texas Department of Health.

Background

For many years, rural counties have relied mainly upon state and federally funded hospitals to provide health care services. When more than 50 Texas hospitals closed in the mid 1980s, due to reduced federal funding and other market forces, many rural Texans were left without a source for vital health and medical services. Hospital closures only intensified problems that already existed in rural communities such as shortages in health professionals, few alternative health facilities, and inadequate emergency medical services. While many communities were independently trying to find ways to address these problems, no organized state-level coordination and assistance was available.

As a result, in 1989, the Legislature created the Center for Rural Health Initiatives (the Center), as part of Omnibus Health Care Rescue Act (H.B. 18), to serve as the primary state resource and leader in assisting government and rural communities in planning, coordinating, and advocating for the continued access to rural health care services. To accomplish this, the Center was charged with various duties such as:

The Center is the State's primary resource to plan and coordinate continued access to rural health care.

- leading governmental and private efforts in conducting and promoting research on rural health issues;
- disseminating information and providing technical assistance to communities and health care providers, and individual consumers of health care services;
- monitoring and working with state and federal agencies to assess the impact of proposed rules and regulations on rural areas and providing impact statements as deemed appropriate;
- promoting and developing community involvement and community support in maintaining, rebuilding, or diversifying local health services;
- promoting and developing diverse and innovative health care services models in rural areas, and
- submitting a biennial report to the Legislature regarding the activities of the Center and any findings and recommendations relating to rural issues.

To oversee the Center's activities, the Legislature established a nine-member Executive Committee with the Governor, Lieutenant Governor, and the Speaker of the House appointing three members each to serve staggered, six-year terms. The Executive Committee must be composed of two physicians, a registered nurse, an allied health professional, a pharmacist, a business or community leader, a hospital administrator, a rural health care expert, and a health economist. The members of the Executive Committee must be individuals who reside, work, or practice in rural areas of the state or have demonstrated knowledge and expertise in rural issues. In addition, appointments to the Executive Committee must provide for balanced representation of the geographic regions of the State.

The statute requires the Department of Health to provide administrative support to the Center.

The Executive Committee sets policy for the Center's operations, employs the Executive Director, and adopts rules governing the administration of the Center's programs. To assist the Executive Committee with its responsibilities, the Legislature created an advisory committee composed of representatives from the Texas Department of Health, Texas Department of Human Services, Texas Department of Commerce, and the Texas Higher Education Coordinating Board. The Executive Committee can also appoint additional advisory committees as needed.

The Department of Health (TDH) is charged with providing administrative support to help the Center carry out its duties. Administrative services include payroll, accounting, purchasing, grants management, and legal services. Programmatic services include statistical and demographic profiles of rural communities and assisting rural counties in obtaining federal health professional shortage area or medically underserved designations.

In a Sunset review, continuation of an agency and its functions depends on certain conditions being met, as required by the Sunset Act. First, a current and continuing need should exist for the state to provide the functions or services. In addition, the functions should not duplicate those currently provided by any other agency. Finally, the potential benefits of maintaining a separate agency must outweigh any advantages of transferring the agency's functions or services to another agency. The evaluation of the need to continue the Center and its current functions led to several findings that are discussed in the following material.

Findings

▼ **The functions of the Center for Rural Health Initiatives continue to be needed to ensure that health care services are accessible and available to rural citizens.**

- A state entity is needed to assist government and rural communities in coordinating, planning, and advocating for access to health care services for three million rural Texans. Barriers such as geographic isolation, low population density, and limited resources make attracting and retaining health professionals in rural areas more difficult than most urban areas. As a result, many of the 196 Texas rural counties are designated as Health Professional shortage areas.[1]

  The Center attempts to address the health needs of rural areas by 1) providing outreach and financial services to assist in the recruitment of health professionals, 2) promoting telemedicine and distance learning, and 3) providing information on rural health care issues to counties, state and federal government agencies, the Legislature, and the public.

Geographic isolation and low population density make attracting health professionals to rural areas difficult.

- The Center plays an important role in increasing the availability of health professionals serving rural communities primarily by providing loans and scholarships to students pursuing health careers in medicine, dentistry, optometry, pharmacy, and allied health. Students who receive this financial assistance must agree to work in rural areas upon completion of their training.

  Since 1991, the Center has awarded 81 forgiveness loans and four scholarships. Of the 81 loans, 29 scholars have completed or are currently serving their obligation, while the remainder are still receiving funds, or are in default or inactive. Of the four scholarships, one scholar has completed the service obligation, two scholars are active in the program, and one scholar is inactive.

- The Center provides funds to physician assistants, practicing in rural areas, to help repay their educational loans. Qualified applicants are eligible to receive a maximum annual award of $5,000 in loan reimbursement for each year of completed service for up to four years. In fiscal year 1997, 11 applicants received $51,544 in loan reimbursement awards.

The Center provides loans and scholarships to health professionals who agree to work in rural areas.

- The Center sponsors an annual recruitment fair that links rural communities with health professionals who are interested in working in rural areas. Since 1994, the Center reports that approximately 109 health professionals have been successfully placed in rural communities as result of the fairs.

- The Center provides information about health careers, academic requirements, and available scholarship and loan programs to high school students in an effort to get them to pursue a health

career in rural Texas. The Center's staff accomplishes this goal by collaborating with Area Health Education Centers, Health Education Training Centers, and the Texas Higher Education Coordinating Board to publish a directory of health careers.

- The Center promotes the use of technology to increase the availability of health care information. The Center assisted the Texas Tech University Health Sciences Center with establishing Tex-Link, a distance learning program that expanded the availability of continuing education for health professionals in rural areas. From fiscal years 1995 to 1997, the Center funded 82 Tex-Link sites for a total of $350,000.

  In addition to providing funding for distance learning, the Center provides a portion of funding, approximately $10,000 per year, for the maintenance of the Texas TeleHealth/ Education Consortium (TTEC). TTEC is a group of higher education institutions and state agencies working to develop a statewide strategic plan for telemedicine.

- Finally, the Center maintains an information clearinghouse and produces a quarterly newsletter that reports on rural health care issues. Topics discussed in the newsletter range from telemedicine to health careers opportunities.

The Center has not met planning requirements outlined in its statute.

▼ **While the Center's current functions continue to be needed, the Center has not effectively planned for and addressed the complex and changing health care needs of rural Texans.**

- The Center has not conducted thorough and integrated planning that clearly defines and describes how health care services should be organized, delivered, and managed to best meet the needs of rural citizens. The statute requires the Center to promote and develop diverse and innovative health care service models in rural areas. However, formal planning done by the Center has been limited to the statutorily-mandated biennial report to the Legislature. While the biennial report provides a useful overview on rural health issues and the Center's activities, the report does not provide the Legislature with a comprehensive approach needed for effective service delivery.

  For example, the Center's biennial report cites that managed care is an issue that should be addressed for rural communities,

but the report does not provide a framework on how the managed care system should be adapted appropriately for rural communities. In fact, in 1997, the Rural Health Consortium, composed of many interest groups and private entities, took responsibility for leading the establishment of the Statewide Rural Health Care System (through SB 1246, 75th Session) to provide rural communities an alternative to urban-based health maintenance organizations (HMOs). The Center does participate in the Rural Health Consortium, however, not in a leadership role.

Rather than comprehensively addressing future changes in rural health care, the biennial report concentrates on requesting that existing programs continue to receive funding from the State. Of the 22 recommendations in the report, 12 deal with requests to maintain or increase funding for state-supported programs that affect rural health efforts in the State.

- The Center has not established a comprehensive approach for coordinating the Center's services with those of other state and local health and human services agencies. While the primary mission of the Center is planning, coordinating, and advocating for rural health services, many communities may be in need of services beyond those offered by the Center, including services offered by other state agencies.

  For example, TDH operates a $14 million Primary Health Care program designed to increase access and availability of primary and preventive health care services to residents of the State, by partnering with local resources and building upon the existing level of resources and providers.[2] According to TDH staff, the Center has done little to coordinate with this program even though two-thirds of the counties served were rural.

The Center does not provide required impact statements about rules that affect health care in rural Texas.

- Without a plan for how rural health needs should be addressed, the Center has had difficulty meeting its statutory requirements to monitor proposed state and federal rules and provide impact statements on how the rules may affect rural health care. Responding to the impact of proposed rules is difficult if the Center has no plan or vision to compare to the changes proposed by other agencies' rules.

  For example, TDH adopted extensive rules relating to designating trauma centers throughout the State. The Center did not issue an impact statement or provide any input to TDH staff regarding the effect of those rules on health care in rural communities,

even though the rules clearly affected hospitals in rural communities, and the Center's statute requires such an assessment.

The Center also has not participated or provided input on major public health initiatives that have affected rural areas. For example, the Legislature recently directed TDH and universities to define the role state and local governments should play in providing essential public health services. The group has since expanded to include other state agencies and interest groups who are concerned about health services. The Center has not worked with this group even though 160 rural counties do not have local health departments.

▼ **The present structure of the Executive Committee does not ensure broad-based rural input and unnecessarily limits the Governor's appointment powers.**

- The Center is a state executive branch function administratively attached to a larger executive agency, the Texas Department of Health. No particular reasons exist to expand the appointment authority beyond the standard for most state agency boards and commissions. However, in the case of the Executive Committee, the statute requires appointments by the Lieutenant Governor and the Speaker of the House of Representatives.

- The statute unnecessarily prescribes the qualifications for each of the nine positions on the Executive Committee. The chart, *Membership of the Executive Committee*, describes the membership qualifications. Although most of the qualifications are generally appropriate to assist in the policymaking functions of the Committee, the appointing authority should have the discretion to build the team of citizens best suited to make appropriate policy decisions for improving the availability and quality of rural health care in Texas. For example, the appointing person may not feel a health economist is necessary for the best operation of the Committee, while a physician's

Membership of Executive Committee

Name	Position	Residence	Appointed By
Richard Murphy (Chairman)	Hospital Administrator	El Campo	Speaker of the House of Representatives
Timothy Allen Scroggins	Physician	Salado	Governor
Conny M. Moore	Pharmacist	Borger	Governor
Faye Rainey Thomas	Business/Community Leader	Katy	Governor
Myrna R. Pickard	Registered Nurse	Arlington	Lt. Governor
Kathy Dickson	Allied Health Professional	Maryneal	Lt. Governor
Ted Sparling	Rural Health Expert	San Antonio	Lt. Governor
Vernon C. Farthing, Jr	Physician	Lubbock	Speaker of the House of Representatives
Vacant	Health Economist		Speaker of the House of Representatives

assistant might be more appropriate. However, the statute presently prevents such an appointment.

- The statute does not ensure adequate rural representation on the Executive Committee. Of the nine members currently serving on the Committee, four members are from metropolitan areas, four are from rural areas and the remaining position is vacant. The chart, *Membership of the Executive Committee*, shows where Committee members reside.

  The statute requires all members of the Executive Committee to reside, work or practice in rural areas of the State, although the statute also allows those who have demonstrated knowledge and expertise in rural issues to serve. This provision has the potential to result in a majority, or even all, of the Executive Committee members to be from non-rural areas.

Half of the current members of the Executive Committee are from urban areas.

- The term "rural" is not adequately defined to assist in making appropriate appointments and may not result in true rural representation on the Executive Committee. Although appointments are not required to meet a particular definition of "rural", Texas generally uses the broad federal definition to define eligibility for their rural health programs. The federal government defines a rural county as one that is outside a metropolitan statistical area (MSA). An MSA is either: 1) a city with 50,000 or more persons, or 2) a Census Bureau urbanized area of one or more counties with a population center of at least 50,000 persons and a total population of at least 100,000.[3] If this standard was followed for appointments, 196 counties of the state's 254 counties would be considered rural.

  The Legislature, in other statutes, has already established criteria for defining rural areas as counties with 50,000 or less. For example, the Statewide Rural Health Care System statute states that Board members must be from counties of 50,000 or less. Also, based on a Sunset Commission recommendation, the Texas Commission on the Arts must include two members from counties of less than 50,000 population.

▼ **The Legislature established the Center as an adjunct to the Department of Health, but the Center has not taken full advantage of TDH's administrative resources.**

- In 1989, the Legislature linked the Center with TDH to take advantage of the administrative services already contained within TDH. The Center has used TDH for services such as payroll,

accounting, legal and purchasing. TDH has no administrative decision-making role or authority regarding these or any other administrative functions of the Center.

- The limited oversight role of TDH has resulted in the Center not taking advantage of this relationship in the following examples.

The Center administers staff and resources without TDH oversight. As a result, the Center's salaries are out of line with similar TDH programs and other health-related agencies with similar size and budget. While the Center's duties are no more or less difficult than other Health Department functions, the independence of the Executive Committee to set salaries has led to salaries higher than the TDH salary structure. For example, the salary of the Center's Executive Director is $78,000 per year while the salary range for TDH division directors is $60,000 -$64,000.[4] The salary for the Executive Directors of similar sized agencies such as the Cancer Council, Commission for the Deaf and Hard of Hearing, and the Children's Trust Fund averages $56,000 per year.[5]

Although TDH has attempted to keep the Center's salaries in line with the TDH salary structure, the Center's Executive Committee chose to ignore TDH's recommendations and insist on higher salaries for Center employees. In a letter to Dr. David Smith, former Commissioner of Health, the Executive Committee's former Chair disagreed with TDH's suggested salaries and stated "in the future, we would ask that any of our personnel actions be initiated at our request as opposed to management decisions at the Department."[6]

The Center has provided pay increases to staff without written employee evaluations.

In addition, the Center does not use state office space. The Center leases offices in downtown Austin at a cost of $3,839 month for its seven employees.[7] The Center has 3,615 square feet of office space equaling 516 square feet of space per employee.[8] By contrast, other state employees are limited to 153 square feet of space per employee.

- Although a 1993 TDH internal audit review noted that the Center should complete employee evaluations, the Center was unable to provide such written evaluations to the Sunset staff during the review. Apparently, the Center has given significant pay increases to several employees without formal documentation.

- The Center does not maintain job descriptions for employees. Job descriptions are an essential component of employee performance evaluation systems, as they provide the information for employees to know the basic expectations of job performance. Sunset staff requested detailed job descriptions of all employees. Instead, the Center provided copies of the State's broad classification descriptions. TDH maintains and uses detailed job descriptions for its positions.

The Center does not take full advantage of TDH services.

- Center staff does not view TDH legal staff as a resource of the Center. During the review, the Sunset staff asked the Center to evaluate the impact on the Center of applying the Sunset Commission's Across-the-Board (ATBs) provisions. In a letter responding to this request, the Center stated that since they did not have legal staff, they were not able to respond to the ATBs that had "statewide impact." However, in a previous letter to the Sunset staff, the Center staff stated that legal services is one of the services provided by TDH to the Center.

- Because the Center is attached to TDH, the State Auditor has not independently examined the activities of the Center. However, due in part to the Center's relative independence, TDH has not performed an internal audit in five years.

- The Executive Committee meets just four times a year to make all planning and policy decisions, adopt rules, and make other programmatic decisions. As a result, little time is available to oversee the administrative functions of the Center, particularly in comparison to the day-to-day management structure in place at TDH.

▼ **Texas has successfully linked other agencies with similar functions to achieve administrative efficiencies.**

TDH has effectively provided staff and services to other health-related councils.

- The clearest examples of strong administrative linkages are within TDH. The Texas Diabetes Council and Texas Council on Alzheimer's Disease and Related Disorders are responsible for establishing policy on diabetes and Alzheimer's disease treatment and education, and operate as independent boards within TDH. Both Councils, however, rely solely on TDH-employed staff to implement decisions. Interviews with Council members and staff indicated that the structure and services provided have worked well.

- Two additional examples of similar administrative linkages exist within TxDOT. As a result of Sunset review, the Automobile

Theft Prevention Authority was administratively linked to TxDOT during the last legislative session to take full advantage of the efficiencies available through attachment to a larger agency. The Authority Board retained the ability to make all decisions on issuance of grants and policy decisions, while TxDOT was given the authority to hire staff and carry out all day-to-day functions. The Texas Motor Vehicle Commission is similarly attached to TxDOT.

- Of the 49 other states that have functions similar to the Center, 38 operate within an agency similar to TDH, 10 are university-based and one is an independent, non-profit entity.

▼ **Clarifying the structure of the Center's administration would result in a more efficient program by maximizing the funds available for rural communities for health care services.**

- Clarifying that TDH is responsible for supporting the Center's activities would enhance administrative functions. Improvements would result from using employee personnel classification systems, and tapping existing staff resources within TDH. These measures could also reduce administrative costs and ensure that more money is available for rural health care services.

- By linking the Center more closely with the Health Department, the Center will be able to tap into the expertise that does not exist within the Center. For example, the Center could use TDH expertise in Medicaid managed care and data processing or use TDH's information resources to develop an Internet web page to advertise scholarship and loan repayment programs. The Center could also use TDH legal staff to help train rural providers on the intricacy of joining rural health care networks. In addition, the Center could work with the Health Department's Community Oriented Primary Care Program to maximize local resources with communities or take full advantage of TDH's primary and preventive health care services programs.

Conclusion

While the State has made significant strides in improving the availability and quality of health care in rural communities, the job is not nearly finished. Shortages of health care professionals continue in some areas. Distances

between patients and health care providers can be great. The operation of health care delivery systems continues to evolve, particularly towards managed care. The Center continues to play a role in assisting rural communities to address these problems, particularly by assisting communities to obtain health care practitioners.

However, as the Center approaches its tenth year since creation, several adjustments to the statutory approach taken in 1989 are necessary to ensure the Center can effectively meet the challenges to come. The semi-independent operation of the Center within TDH has resulted in administrative inefficiencies, little use of TDH's vast knowledge and resources, and a lack of oversight.

Statutory changes are needed to ensure the Center can effectively meet future rural health challenges.

In addition, the three-way appointment system using the Governor, Lieutenant Governor and Speaker to all make appointments to the Executive Committee does not allow the Governor authority to appoint the team of citizens most appropriate to lead this executive branch function. The Governor is further limited by the statutory prescription of the exact types of professions that must be represented on the Committee.

Finally, the Center has not met the challenge set out in statute to proactively address the health care problems facing rural communities. Although the Center has been a valuable resource to communities seeking health care professionals, the Center does not have an action plan in place, or in some cases the expertise, to assist communities in facing other health care challenges. Developing a plan, accessing expertise of TDH and other agencies, and assessing the impact of proposed actions of other agencies all can go a long way to improving rural health care in Texas.

Recommendation

Change in Statute

- **Continue the Center for Rural Health Initiatives within the Texas Department of Health.**
- **Restructure the Center's Executive Committee by:**
  - **specifying that the Governor shall make all appointments to the Executive Committee;**
  - **removing the requirement for specific positions to represent certain professions;**
  - **requiring at least six members to be selected from the list of health professions currently listed in statute;**

- **requiring three members to be locally-elected officials or have significant business expertise;**
- **requiring the majority of the Executive Committee membership to work or reside in counties with a population of 50,000 or less.**

■ **Clarify the relationship between the Center and TDH by:**

- **removing the Center's authority to hire its own staff and contract with state agencies other than TDH for support services;**
- **specifying that TDH shall provide staffing and services necessary to support the function of the Center, as determined by a formal agreement with the Center's Executive Committee; and**
- **providing the Executive Committee with final approval of TDH's selection of the Center's staff director.**

■ **Remove the Center's separate Sunset date and specify that the Center will be included in future reviews of TDH.**

■ **Require the Center to work jointly with TDH and other health and human services agencies, rural communities, universities and health care providers to develop a comprehensive rural health work plan. At a minimum, the work plan should include the following elements:**

- **the mission, goals, and objectives of how the Center will work to assist rural communities in meeting rural health needs;**
- **methods for the State to effectively and creatively address unmet health care needs of rural communities;**
- **coordination of administration and service delivery with federal, state, and local public and private programs that provide similar services; and**
- **the Center's priorities to accomplish the objectives of the plan.**

This recommendation would continue the Center's existing functions relating to coordinating, planning, and advocating for rural health care services. The recommendation would remove the requirement that the Speaker of the House and the Lieutenant Governor make appointments to the nine-member Executive Committee. The recommendation would also ensure that smaller rural counties are represented on the Committee by explicitly defining a rural area as a county with a population of 50,000 or less for the purpose of appointments. As a result of these changes to the structure of the Committee, the Governor would appoint (or re-appoint) nine members to the Committee on or after September 1, 1999. The members would be appointed to staggered terms.

The locally-elected officials and business experts would provide needed insight to assist with Executive Committee planning and policymaking. For example, government officials, such as county commissioners, and business leaders are often integrally involved in communities' efforts to improve the availability and quality of health care.

The Executive Committee would retain all authority over operation of the programs assigned to the Center, including planning, rulemaking, issuance of grants, and decisions on recipients of loans and other forms of financial assistance. As a result, the Executive Committee will be able to concentrate its efforts on improving health care in rural Texas, while TDH handles the day-to-day administrative activities.

By clarifying TDH's responsibility for staffing the Center and for providing all administrative services, the recommendation would strengthen the link between the Center and TDH, and increase access to the vast expertise available in TDH regarding subjects such as managed health care, epidemiology, and data services. The stronger link would also allow Center personnel to focus on coordinating the state's rural health efforts.

Finally, this recommendation would require the Center, with assistance from TDH, to develop a plan for coordinating and maximizing state, federal, and local resources throughout the State to best meet the health needs of the rural communities. A statewide plan would provide a forum to communicate the mission and goals of the agency, determine the objectives for rural health service delivery, and recommend statewide policy in key areas. Statewide planning also ensures that public funds are being used in a deliberate and coordinated manner, while laying a foundation for future initiatives. The Center should use the statewide plan for service delivery to communicate policies on which future operational decisions can be based.

Fiscal Impact

Establishing a statewide work plan is critical in the changing environment of rural health services, particularly with shifting federal and state funding limitations, and with the movement toward providing health related services through managed care systems. The Center's work plan should also be integrated into the Department of Health's comprehensive blueprint as proposed in the Sunset staff report on TDH.

The recommendations will have a small direct fiscal impact to the State. The savings gained from using TDH hiring and salary practices will save at least $13,000 per year in salaries by using the TDH salary classification system. When TDH office space is made available, using state-owned space instead of commercial space will save the State approximately $46,068 per year. Additional financial benefits may accrue through increased coordination with TDH and other agencies, but cannot be estimated for this report.

[1] Center for Rural Health Initiatives, *Rural Health in Texas: A Report to the 75th Legislature, January 1997*, p. 41.

[2] Texas Department of Health, *Primary Health Care Program, Annual Report, Fiscal Year 1996, July 1997*, p.1.

[3] Center for Rural Health Initiatives, *Rural Health in Texas: A Report to the 75th Legislature, January 1997*, p. 33.

[4] Data provided by TDH, Human Resources Office, April 1998.

[5] Sunset staff analysis of salaries listed in the General Appropriations Act, State of Texas, 75th Legislature Regular Session, 1997.

[6] Letter from Dr. Marion Zetzman, Chairman, Center for Rural Health initiatives, to Dr. David Smith, Commissioner of Health, September 25, 1996.

[7] Facilities Leasing Analysis, General Services Commission, April 7, 1998.

[8] Ibid.

ACROSS-THE-BOARD RECOMMENDATIONS

Center for Rural Health Initiatives		
Recommendations	**Across-the-Board Provisions**	
	A. GENERAL	
Not Applicable	1.	Require at least one-third public membership on state agency policymaking bodies.
Apply	2.	Require specific provisions relating to conflicts of interest.
Apply	3.	Require that appointment to the policymaking body be made without regard to the appointee's race, color, disability, sex, religion, age, or national origin.
Apply	4.	Provide for the Governor to designate the presiding officer of a state agency's policymaking body.
Apply	5.	Specify grounds for removal of a member of the policymaking body.
Apply	6.	Require that information on standards of conduct be provided to members of policymaking bodies and agency employees.
Apply	7.	Require training for members of policymaking bodies.
Apply	8.	Require the agency's policymaking body to develop and implement policies that clearly separate the functions of the policymaking body and the agency staff.
Apply	9.	Provide for public testimony at meetings of the policymaking body.
Apply	10.	Require information to be maintained on complaints.
Not Applicable	11.	Require development of an equal employment opportunity policy.

BACKGROUND

Background

AGENCY HISTORY

Ensuring access and availability of health care services for three million rural citizens is a continuing challenge for Texas state government and rural areas. For many years, rural counties have relied mainly upon state and federally funded hospitals to provide health care services. When more than 50 Texas closed in the mid 1980s, due to reduced federal funding and other market forces, many residents and travelers in rural areas were left without a source for vital health and medical services.

In response to this critical problem, the Legislature created a Governor's task force, in 1988, to examine the problems of access to health care in rural areas. The task force found that hospital closures produced a shortage in the number of physicians, nurses, and allied health professionals serving rural communities. In addition to manpower shortages, the State had few rural clinics, and inadequate emergency medical services and obstetric services to serve the rural population. The task force also identified the need for a state-level entity:

The Center was created in 1989 as part of an effort by the Legislature to address critical problems with rural health care.

- to coordinate the efforts of local communities trying to solve these problems;
- to ensure continuous attention and visibility to rural health needs; and
- to address the total rural health care delivery system.[1]

In 1989, the 71st Legislature passed the Omnibus Health Care Rescue Act (H.B. 18) to address the problems cited by the task force. The major provisions of the bill expanded health care services to rural Texans by facilitating the growth of rural clinics and establishing emergency medical care networks and the Center for Rural Health Initiatives (the Center). The Center was established to serve as the primary state resource in planning, coordinating, and advocating statewide efforts to ensure continued access to rural health care services. To accomplish this, the Center was charged with:

- integrating health care services and programs;
- researching and implementating innovative models to maximize area resources;

- providing leadership to consult with rural communities regarding current needs, analysis and access to government-funded initiatives; and
- leading interagency efforts on rural health care initiatives which include state agencies, universities, medical schools, and private entities.

POLICYMAKING BODY

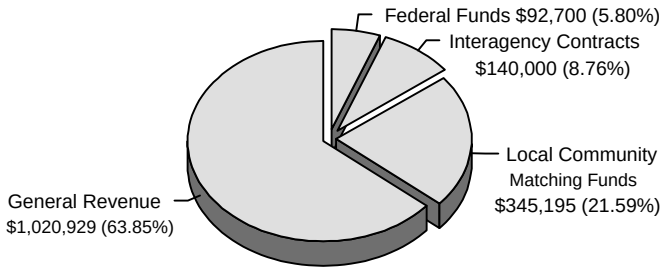
The Center is governed by a nine-member Executive Committee, with the Governor, the Lieutenant Governor, and the Speaker of the House each appointing three members. Members of the Executive Committee serve staggered six-year terms. The members of the Executive Committee must be individuals who reside, work, or practice in rural areas of the state or have demonstrated knowledge and expertise in rural issues. In addition, appointments to the Executive Committee must provide for balanced representation of the geographic regions of the State. The Committee annually elects one its members to serve as the presiding officer. The Executive Committee meets quarterly or at the call of the presiding officer. The Executive Committee met three times in fiscal year 1997.

The Executive Committee sets policy for the Center's operations, employs the Executive Director, and adopts rules governing the administration of the Center's programs. To assist the Executive Committee with its responsibilities, the Legislature created an advisory committee composed of representatives from the Texas Department of Health, Texas Department of Human Services, Texas Department of Commerce, and the Texas Higher Education Coordinating Board. The Executive Committee can also appoint additional advisory committees as needed.

FUNDING

The Center is funded through general revenue, federal funds, interagency contracts, and local rural community matching funds. Since the Center is administratively attached to the Texas Department of Health (TDH), the Legislature appropriates the Center's $1.4 million budget under the TDH strategy for rural health care access. The Center is also authorized, by rider, to receive an additional $90,000 through an interagency contract with the Texas State Board of Medical Examiners to fund its physician assistant loan reimbursement program. The chart, *Sources of Revenue — Fiscal Year 1997*, shows the funding data in more detail.

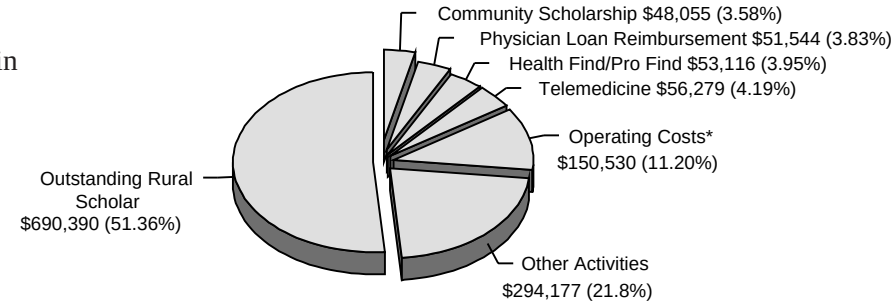
Sources of Revenue
Fiscal Year 1997



Total Revenue
$1,598,824

The Center spent $1.3 million in fiscal year 1997. Of this amount, $289,282 went towards salaries and other personnel costs. The graph, *Expenditures by Program — Fiscal Year 1997*, shows a breakdown of the agency expenditures.

Expenditures by Program
Fiscal Year 1997



Total Expenditures
$1,344,091

*** Operating expenses include non-grant expenditures, such as administrative and marketing expenses.**

HUB Expenditures

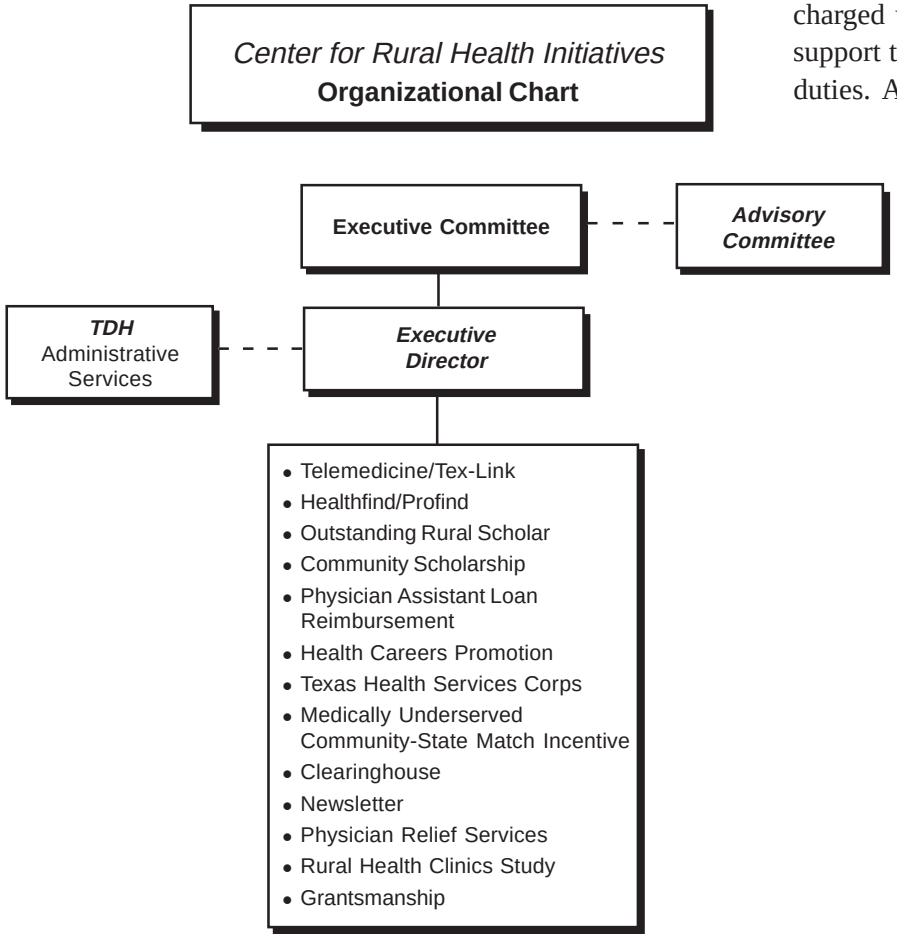
The Legislature has encouraged agencies to increase their use of Historically Underutilized Businesses (HUBs) in purchasing goods and services. The Legislature also requires the Sunset Commission to consider agencies' compliance with laws and rules regarding HUB use in its reviews. In 1997, the Center purchased 26.9 percent of goods and services from HUBs. The chart, *Purchases from HUBs — Fiscal Year 1997*, provides detail on HUB spending by type of contract and compares these purchases with statewide goals for each spending category. The chart shows that the Center exceeded the state goal in the purchase of commodities, while falling short in the purchases of other services.

Purchases From HUBs
Fiscal Year 1997

Category	Total $ Spent	Total HUB $ Spent	Percent	Statewide Goal
Heavy Construction	$0	$0	0.0%	11.9%
Building Construction	$0	$0	0.0%	26.1%
Special Trade	$0	$0	0.0%	57.2%
Professional Services	$0	$0	0.0%	20.0%
Other Services	$91,596	$19,790	21.16%	33.0%
Commodities	$88,972	$28,901	32.48%	12.6%
Total	**$180,568**	**$48,691**	**26.97%**	

ORGANIZATION

The Center employed six full-time equivalent employees in fiscal year 1997 and is authorized up to 12 employees. The Center is located in Austin and has no regional offices. The organizational structure of the agency is illustrated in the chart, *Center for Rural Health Initiatives Organizational Chart.* A comparison of the Center's workforce composition to the minority civilian labor force is shown in the chart, *Center for Rural Health Initiatives Equal Employment Opportunity Statistics — Fiscal Year1997.* The Center's workforce percentages for females exceed Civilian Labor Force levels of employment in most of the Center's job categories. The most significant level of under-representation is for Blacks and Hispanics in the job categories.



The Department of Health (TDH) is charged with providing administrative support to help the Center carry out its duties. Administrative services include payroll, accounting, purchasing, grants management, and legal services. Programmatic services include statistical and demographic profiles of rural communities and assisting rural counties in obtaining federal health professional shortage area or medically underserved designations.

Center for Rural Health Initiatives
Equal Employment Opportunity Statistics
Fiscal Year 1997

Job Category	Total Positions	Minority Workforce Percentages					
		Black		Hispanic		Female	
		Agency	Civilian Labor Force	Agency	Civilian Labor Force	Agency	Civilian Labor Force
Officials/Administration	1	0%	5%	0%	8%	100%	26%
Professional	4	0%	7%	0%	7%	100%	44%
Technical	NA	0%	13%	0%	14%	0%	41%
Protective Services	NA	0%	13%	0%	18%	0%	15%
Para-Professionals	NA	0%	25%	0%	30%	0%	55%
Administrative Support	1	0%	16%	0%	17%	100%	84%
Skilled Craft	NA	0%	11%	0%	20%	0%	8%
Service/Maintenance	NA	0%	19%	0%	32%	0%	27%

AGENCY OPERATIONS

While the Center has not developed a formal strategic plan that describes its agency goals, its primary function, as assigned by statute, is to assist rural communities in establishing a viable and accessible health care delivery system. The Center also produces a biennial report to the Governor and the Legislature that outlines rural health needs, describes agency objectives and accomplishments to meets these needs, and proposes changes to better meet rural health needs.

The Center accomplishes its statutory goals through the following functions:

- providing outreach and financial services that assist in the recruitment of health professionals;
- promoting telemedicine and distance learning; and
- providing information on rural health care issues to counties, state, and federal governmental agencies, the Legislature, and the general public.

The Center's primary function is to assist rural communities with health care delivery issues.

Outreach Activities

HealthFind/ProFind — The Center sponsors an annual recruitment program, the HealthFind Exchange, that links rural communities with primary care physicians who are interested in practicing in rural areas. ProFind, modeled after HealthFind, assists rural communities to recruit physician assistants

and advanced practice nurses, and is held in conjunction with HealthFind. In these programs rural community representatives meet with practitioners at an annual HealthFind/ProFind Exchange. Before this meeting, community representatives and health professionals complete a profile describing their needs and their interests. The Center compiles this information and distributes the completed profiles to both the practitioners and the community representatives prior to the meeting. At the Exchange, practitioners have an opportunity to discuss practice opportunities with local community representatives.

More than 650 health care professionals and 150 communities have participated in the Center's Health Find and ProFind programs.

The HealthFind program began in 1991 and ProFind began in 1996. Since 1991, 150 communities, 529 physicians, and 127 physicians assistants and advanced practice nurses have participated in the progams.

Health Careers Promotion for High School Students — The Center provides information about health careers, academic requirements, and available scholarship and loan programs to high school students in an effort to get them to pursue a health career in rural Texas. The Center's staff accomplishes this goal by collaborating with the State's three Area Health Education Centers and the Health Education Training Centers Alliance of Texas to produce a directory of health careers. The directory provides extensive information on health career fields. The directory is distributed to high schools, hospitals, universities, and at career fairs. In fiscal year 1998, the Center has distributed approximately 10,000 career directories statewide and has met with more than 1,100 rural students to discuss health career opportunities.

Financial Assistance

Outstanding Rural Scholar Recognition Program — The Center also assists rural communities in recruiting health professionals by providing loans to students pursuing careers in medicine, dentistry, optometry, pharmacy, and allied health. The Center provides 50 percent of the funds for the forgiveness loan and the sponsporing community contributes the other 50 percent. In return, the student agrees to practice in the sponsoring rural community. For each year of practice, one year's educational expenses are forgiven (not repaid).

The program covers the costs of tuition and fees, room and board, and other related educational expenses. Scholars awarded the forgiveness loans must sign a contract with the Center and the sponsoring community before the first disbursement.

Upon licensure or certification, students must return to the sponsoring rural community to practice health care for one year for each year the loan was received. If students fail to honor all provisions, they must pay back all funds disbursed plus 10 percent interest and the administrative costs for recovering the funds.

Since 1991, the Center has awarded 81 forgiveness loans. Of this total, 24 scholars have completed their service obligation, five are serving their obligation, 33 students are still receiving funds, six are pending licensure, four are completing physician residency training, three are completing cash repayment, two are in default, and the remainder are on inactive status. In fiscal year 1997, the Center disbursed loans that ranged from $1,000 to $30,000.

Community Scholarship Program **—** The Center assists rural communities in health professional shortage areas by helping pay for the final two years of education for medical students and the educational programs of physician assistants and advanced practice nurses. The scholarship covers the costs of tuition and fees, room and board, and other related educational expenses. The federal government requires that eligible students come from and return to the sponsoring rural health professional shortage area.

Before funds are disbursed, students must sign a contract with the Center and the sponsoring community, agreeing to return and practice in the sponsoring community. The Center provides 25 percent of the funds for the scholarships, the federal government provides 40 percent, and the sponsoring community contributes the remaining 35 percent. Once the contract is signed, the Center administers and enforces the provisions.

The Center has several loan and scholarship programs for students interested in working in rural communities.

Upon licensure, the student must return to the sponsoring community to practice health care full-time for the number of years equal to the number of years for which the scholarship was funded, or for two years, whichever is greater. Students who fail to honor all provisions must pay back all funds disbursed plus a penalty equal to three times the loan amount. Since the program's inception in 1994, one scholar has completed the service obligation, two scholars are active in the program, and one scholar is pending placement. In fiscal year 1997, the average scholarship distributed to each of the two active scholars was $24,000.

Rural Physician Assistant Loan Reimbursement Program **—** The Center provides funds to physician assistants, practicing in rural areas, to help repay their educational loans. Qualified applicants are eligible to receive a

maximum annual award of $5,000 in loan reimbursement for each year of completed service for up to four years. The $90,000 per year program is funded by physician assistant licensure fees that are received through an interagency contract with the Board of Medical Examiners.

In fiscal year 1997, 11 applicants received $51,544 in loan reimbursement awards. The amount disbursed annually is anticipated to increase, due to actions of the 75th Legislature which deleted the legislatively-mandated requirement for the physician assistant to receive training in a Texas institution.

Texas Health Services Corps Program **—** In 1997, the Legislature required the Center to administer the Texas Health Services Corps program in an effort to encourage primary care physicians to establish and maintain practices in medically underserved areas in Texas. To accomplish this goal, the Legislature appropriated $100,000 per year for the program. The Center will administer the program by providing stipends up to $15,000 per year to primary care physicians in residency training, who upon completion of the training, agree to provide services in medically underserved areas for one year for each year they receive the stipend. The Executive Committee adopted program rules in February 1998. The program is scheduled to begin April 1998, with the first payments issued in October 1998. The Center is disseminating information about the program to Texas primary care residency programs, medical schools, appropriate state agencies, interested physician professional associations, and medically underserved health care facilities, and associations representing these facilities.

Medically Underserved communities can receive funds from the Center for starting medical clinics.

Medically Underserved Community-State Matching Incentive Program **—** In 1997, the Legislature transferred the responsibility for administering the Medically Underserved Community-State Matching Incentive Program from the Department of Health to the Center. Originally created in 1995, this program will provide matching funds to medically underserved communities to cover start-up expenses for primary care physicians such as acquisition or renovation of clinic facilities, medical supplies and equipment or recruitment or salaries of professional staff, excluding the physician. The 75th Legislature appropriated $250,000 per year for the program. Communities can receive a dollar for dollar match between $15,000 and $25,000 per year from the state. Final rules were adopted by the Executive Committee in February 1998. The program begins in April 1998 with the first disbursements expected in the Summer 1998.

Telemedicine and Distance Learning

Tex-Link/Telemedicine — To fulfill the Center's 1989 mandate to "encourage the use of advanced communications technology to provide access to speciality expertise, clinical consultation and continuing education," the Center assisted the Texas Tech University Health Sciences Center with establishing Tex-Link. Through Tex-Link, the Center provided funding to the University's HealthNet program for the purchase of the satellite equipment which enables rural hospitals to use urban or academic expertise by satellite to facilitate health care effectiveness.

Between 1994 and 1997, the Center provided approximately $350,000 for 82 rural hospitals to purchase the necessary equipment to receive continuing programming transmitted by HealthNet, (including satellite dishes, cabling and monitors), as well as transmission time. Tex-Link assists rural hospitals to retain health care practitioners, contain or reduce administrative training costs, and provide improved patient care.

The Center provided funds for 82 rural hospitals to participate in Tex-Link, a satellite medical information system.

To implement a strategic plan for telemedicine for rural Texas, in 1994, the Center helped organize a consortium of the state's academic health education institutions and state agencies, called the Texas TeleHealth/Education Consortium (TTEC). TTEC includes representatives from 18 of the State's academic institutions and state agencies.

The original intent of TTEC was to expand the amount and scope of continuing health education programming broadcast over the HealthNet satellite to participating rural hospitals. In 1996, TTEC expanded its scope to include the development of a telemedicine strategic plan for clinical telemedicine. The consortium has published the first phase of the plan and work continues on the next phase of the plan.

Providing Information on Rural Health Care Issues

The Center maintains a clearinghouse to collect and provide information on rural health issues to the general public, as well as local, state, and federal organizations. The Center's staff receives approximately 1,000 inquiries a month requesting information on issues such as where a student might enroll in a physician assistant educational training program to the health resources of a rural community to the requirements for a rural health clinic.

In addition to maintaining a clearinghouse, the Center produces a quarterly newsletter that examines rural health care issues such as telemedicine, health career, and managed care. The newsletter is distributed to local hospitals, universities, and clinics in every rural Texas county, and has a total circulation of more than 5,000.

The Center also produces a biennial report to the Governor and the Legislature which describes rural health care in the state; identifies and analyzes rural health service issues; and proposes legislative policy or programmatic changes to address the needs. By law, each legislative report is due to the Legislature by January 1, of each odd-numbered year. To date, four legislative reports have been produced.

1. Special Task Force on Rural Health Care Delivery in Texas, Report to the 71st Legislature, Susan L. Wilson and Jeffrey Heckler, editors February 1989.

TEXAS DEPARTMENT OF HEALTH
CENTER FOR RURAL HEALTH INITIATIVES

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