



Texas Health and Human Services Commission Self-Evaluation Report



TEXAS
Health and Human
Services

Submitted to the Sunset Advisory Committee
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I. Agency Contact Information

A. Please complete the following table.

Health and Human Services Commission

Exhibit 1: Agency Contacts

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HHSC Sunset Liaison	Joey Reed, Deputy Chief of Staff	North Austin Complex 4601 W. Guadalupe St. Austin, TX 78751-3146 P.O. Box 13247 Austin, TX 78711-3247	(512) 450-8349	Joey.Reed@hhs.texas.gov

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II. Key Functions and Performance

A. Provide an overview of your agency's mission, objectives, and key functions.

Mission and Vision

Mission: We serve Texas.

Vision: Making a positive difference in the lives of the people we serve.

The Health and Human Services Commission (HHSC), part of the Texas Health and Human Services system (HHS), provides essential acute and long-term services and supports to more than 7.5 million people every month through its almost 200 programs, including the state's Medicaid program, Children's Health Insurance Program (CHIP), the Supplemental Nutrition Assistance Program (SNAP), operation of 10 state psychiatric hospitals and 13 state-supported living centers (SSLCs), and licensing and regulating health care and childcare facilities and providers.

Additionally, HHSC and its contractors provide support for families in crisis through family violence and child advocacy programs, assist individuals with behavioral health needs, and offer family planning and preventive health services to Texas women.

This is made possible by more than 37,000 employees.

HHSC focuses on the following goals to support our mission and vision:

- Improving and supporting health outcomes and well-being for individuals and families;
- Ensuring efficient access to appropriate services;
- Protecting the health and safety of vulnerable Texans; and
- Continuously enhancing efficiency and accountability.¹

Objectives

HHSC's main objectives include the following:

¹ See [Health and Human Services Commission Strategic Plan for Fiscal Years 2025-2029](#).

- **Client Services Administration.** Administer the state’s Medicaid, women’s health, behavioral health, and other client services programs.
- **Policy and Eligibility.** Set policies, define covered benefits, and determine eligibility for client services programs.
- **State Health Facilities.** Operate state psychiatric hospitals and SSLCs.
- **Regulation.** Regulate healthcare and childcare providers and facilities.
- **Other Services:** Provide a comprehensive array of long-term services and supports for people with disabilities and people 60 and older.
- **HHS Oversight and Administration.** Provide oversight and administrative support for HHS agencies.
- **Financial Stewardship.** Ensure appropriated dollars for health and human services are used for their intended purposes.

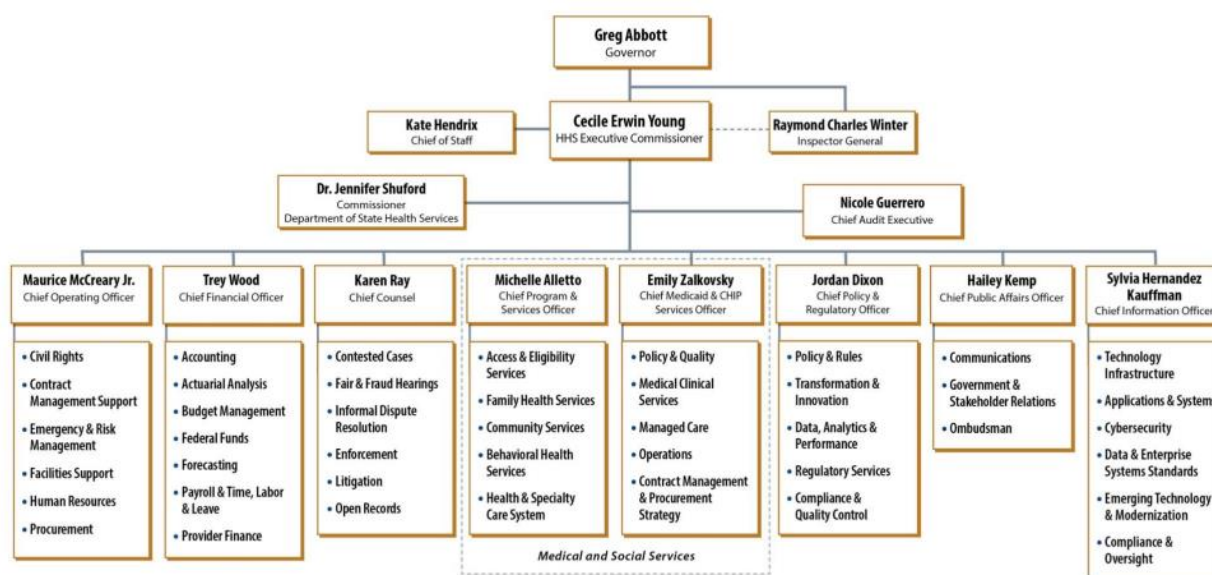
Key Functions

To achieve these goals and objectives, HHSC’s key functions are organized into ten Chief Offices, the Office of the Inspector General, and the Department of State Health Services² (DSHS) as shown in Figure 1 below.³

² The DSHS is part of HHS as a separate agency whose commissioner reports to the HHS Executive Commissioner.

³ See [HHS Business Functions Organizational Chart](#) for more detailed descriptions of each function.

Figure 1. HHS Functional Organizational Chart



- Chief Operating Officer (COO) oversees the planning and delivery of certain administrative support services to HHS, including procurement, human resources, and building and lease management.
- Chief Financial Officer (CFO) is responsible for the overall financial management of HHSC, including accounting, setting fee-for-service and capitated rates, forecasting client service case load and cost growth, processing Payroll and Time, Labor and Leave requests; and overseeing the state's directed payment programs.
- Chief Counsel (OCC) provides legal and related support services to HHS system partners, including appeals, litigation, privacy incidents, and ethics.
- Chief Program and Services Officer (CPSO) oversees public assistance programs, disability determination, and community-based programs and services accessed by millions of Texans; administers programs that serve as a safety net for Texans, providing health care, nutrition and support services; provides a unified and coordinated approach to the delivery of appropriate and cost-effective intellectual or developmental disability and behavioral health services; and oversees the operations of state hospitals and SSLCs across Texas.
- Chief Medicaid and CHIP Services Officer (CMCSO) oversees health care programs and long-term services that serve over 4.5 million low-income children and their families, pregnant women, former foster care youth, people with disabilities and older adults.

- Chief Policy and Regulatory Officer (CPRO) serves as a hub for process improvement throughout HHS; protects the health and safety of consumers of long-term care, childcare, acute health care facilities, and behavioral health services; enhances HHS' capacity for data-driven decision-making; and partners with and advises program areas to ensure a coordinated, systemwide approach to policy development, implementation, and evaluation.
- Chief Public Affairs Officer (CPAO) oversees internal and external communications, legislative relations and public complaint resolution.
- Chief Information Officer (CIO) is responsible for developing and delivering information technology (IT) services, including IT-related strategic planning, services that support HHS operational needs, and effective security for systems and data.
- Chief Audit Executive (CAE) oversees the Office of Audit and Compliance (OAC) to provide independent, objective assurance and consulting services designed to add value and improve HHS operations; and coordinate state and federal external audits and establish a centralized repository of audit recommendations to ensure that audit recommendations are addressed in a timely manner.
- Office of Inspector General (OIG) ensures HHS-appropriated funds are used for their intended purposes, recovers the funds lost to fraud, waste, and abuse, and holds those accountable that violate program requirements to safeguard tax dollars and the health and welfare of the people that HHS programs serve.
- DSHS is the state's public health agency, dedicated to improving the health, safety, and wellbeing of all Texans. DSHS provides resources and services to individuals, communities, and healthcare providers to improve overall health outcomes across the state of Texas.

More information about each of these functions is provided in Section VII Guide to Agency Programs and Functions.

B. What clear and ongoing objective(s) do the agency's key functions serve? Explain why each key function is still needed.

HHSC's key functions continue to serve clear and ongoing objectives by providing eligible clients with critical health, nutritional, and other social service assistance; ensuring the safety of Texans who seek care or services at hospitals, long-term care facilities, and childcare operations; operating psychiatric hospitals and facilities

that serve individuals with developmental disabilities; and overseeing the state's HHS System.

As envisioned by the Sunset Commission and required by the Legislature through Senate Bill (S.B.) 200, 84th Legislature, Regular Session, 2015, HHSC:

- Is an accountable, organized system that is easier to navigate for Texans seeking information, benefits, or services;
- Promotes a culture of shared responsibility for success through teamwork, effective communication, and support for HHS staff and programs;
- Has clear lines of accountability for decision-making; and
- Uses data to measure outcomes more clearly.

The current functions and organizational structure align programmatic and administrative areas by grouping similar programs and services under the same chief areas making it easier for clients and staff to navigate the system. The functional structure also clarifies the relationship between HHSC and OIG and outlines the roles and responsibilities of this unique governmental structure.

Key administrative functions, housed in the COO, CFO, CIO, CPAO, CPRO, OCC, and CAE, represent a comprehensive approach to overseeing HHS, preventing duplication of efforts and cost inefficiencies, and providing a coordinated service delivery system. Removing any of these key administrative functions and coordination responsibilities would likely result in wasted state and federal funds.

By organizing the CMCSO and CPSO under the umbrella of the Medical and Social Services section, HHSC aligns the system's mission, business needs, and statutory responsibilities by streamlining administration of HHSC programs making it easier for individuals seeking information, benefits, or services.

OIG improves HHS programs by ensuring sound use of state and federal funds and safeguarding the state from risk and, where appropriate, bring enforcement action against persons who violate program requirements. OIG ensures accountability in HHS programs, and the health and welfare of Texans by identifying and mitigating fraud, waste, and abuse.

C. Does your agency's enabling law continue to correctly reflect your mission, objectives, and approach to performing your functions? Does statute present any barriers or gaps in authority for your agency to carry out its mission? If so, please describe.

Yes, HHSC's enabling statute correctly reflects the agency's mission, objectives, and approach to performing its functions. Statute does not present any barriers or gaps in authority for HHSC to carry out its mission.

The Legislature created HHSC through House Bill (H.B.) 7, 72nd Legislature, First Called Session, 1991, and codified its enabling statutes in Chapter 531 of the Texas Government Code in 1995 through S.B. 959, 74th Legislature, Regular Session, 1993.⁴ Texas Government Code, Section 523.0001, charges HHSC with the primary responsibility for ensuring the delivery of state health and human services in a manner that uses an integrated system to determine client eligibility; maximizes the use of federal, state, and local funds; and emphasizes coordination, flexibility, and decision making at the local level. In addition, Texas Government Code, Section 524.001, designates HHSC as the state agency to administer federal medical assistance funds (Medicaid).

S.B. 200, 84th Legislature, Regular Session, 2015 consolidated the state's five HHS agencies into three: HHSC, DSHS, and the Department of Family and Protective Services (DFPS). H.B. 5, 85th Legislature, Regular Session, 2017 further transformed HHS by carving out DFPS as a separate, but administratively attached, agency. The 2014 and 2016 changes restructured HHS, improved connections between programs and services, allowed for easier navigation, streamlined service delivery, and improved accountability to the taxpayers we serve.

D. Have you recommended changes to the Legislature to improve your agency's operations in recent years? If so, briefly explain the recommended changes, whether they were adopted, and if adopted, when.

HHSC works closely with the Legislature to provide information on how to achieve programmatic, operational, and administrative efficiencies. Below are some examples.

Regulatory Clarification: HHSC regulates numerous entities to ensure the health and safety of vulnerable Texans. This is an ever-evolving landscape that requires frequent review of the agency's authority in this space. (H.B. 3079, 86th Legislature, Regular Session, 2019 – adopted; H.B. 4158, 87th Legislature, Regular Session, 2021 – adopted; S.B. 764, 87th Legislature, Regular Session, 2021 – adopted; S.B. 1103, 87th Legislature, Regular Session, 2021 – adopted; S.B. 681, 88th Legislature, Regular Session, 2023 – adopted; H.B. 4696, 88th Legislature,

⁴ Recodified during the 88th Legislative Session.

Regular Session, 2023 – adopted; S.B. 1242, 88th Legislature, Regular Session, 2023 – adopted).

Clarification on Background Checks: HHSC works with state and federal partners to ensure the agency can comply with evolving laws and regulations related to accessing data for necessary background checks for regulated entities. (S.B. 2200, 86th Legislature, Regular Session, 2019 – adopted; S.B. 1061, 87th Legislature, Regular Session, 2021 – adopted; S.B. 1192, 88th Legislature, Regular Session, 2023 – adopted).

Elimination of Obsolete or Redundant Required Reports: HHSC evaluates statutorily required reports that are redundant, outdated, or no longer useful to policymakers. Streamlining reporting requirements and eliminating obsolete reports results in operational and administrative efficiencies to agency staff time and resources. (S.B. 241, 86th Legislature, Regular Session, 2019 – adopted; S.B. 800, 87th Legislature, Regular Session, 2021 – adopted; S.B. 956, 88th Legislature, Regular Session, 2023 – adopted; H.B. 3265, 88th Legislature, Regular Session, 2023 – adopted.)

Modernization of Medicaid Fraud Enforcement Statutes: S.B. 1038, 89th Legislature, Regular Session, 2025, modernized Chapter 32 of the Texas Human Resources Code. These changes aligned Chapter 32 with the health care fraud violations outlined in Chapter 36 of the Texas Human Resources Code and in Chapter 35A of the Texas Penal Code, to enable consistent pursuit of misconduct across criminal, civil, and administrative domains. S.B. 1038 strengthens the OIG's Medicaid enforcement by clarifying the scope of impermissible activities that may subject an actor to administrative remedies, ensures the OIG authority effectively applies across different health care delivery systems, and provides a modernized remedy structure.

Sharing Recoveries with Managed Care Organizations: H.B. 2379, 85th Legislature, Regular Session, 2017, defined administrative support functions between HHSC and OIG and outlines sharing of recoveries between the OIG and managed care organizations (MCOs). Specifically, MCOs are permitted to retain 50 percent of any recovery resulting from a fraud or abuse investigation and remit the remainder to the OIG. The OIG pays a federal share of its 50 percent and deposits the remainder into the general revenue fund. If the OIG initiates the recovery based on a referral from an MCO, it retains 50 percent and sends the other 50 percent to the MCO.

Credible Allegations of Fraud Payment Holds: OIG proposed legislation in several legislative sessions to define important items related to credible allegations of fraud

(CAF) holds. A CAF hold is a temporary denial of a Medicaid reimbursement for items or services provided by a Medicaid provider. Current state law does not define important items such as “significant financial risk to the state” and “a threat to the integrity of Medicaid.”

E. Do any of your agency’s functions overlap with those of another local, state, or federal agency? If so, how do you coordinate to avoid duplication of efforts? Explain if, and why, each of your key functions is most appropriately placed within your agency.

No. While HHSC works closely with other state, federal, and local partners, the agency’s functions do not overlap or cause duplication of effort.

Oversight and Administrative Support: Unique to Texas’ HHS delivery system, HHSC’s leadership and system oversight function is not performed by other state or federal agencies. S.B. 200, 84th Legislature, Regular Session, 2015, clarified HHSC’s responsibility and authority for leading and overseeing health and human services agencies to ensure that they function as a system. Additionally, the Legislature mandated HHSC develop and implement consolidated administrative support services. HHSC provides some or all administrative support services to certain HHS agencies. Examples include, but are not limited to, human resources, civil rights, procurement and contracting, legal, information technology, advisory committee support, provider rate setting, and leasing and facilities management functions.

HHSC also plays a key role in state-level emergency response and recovery. Through its Emergency Management program, HHSC coordinates with the Texas Department of Emergency Management (TDEM) and other Emergency Management Council agencies such as DSHS on disaster response activities including ice and water distribution, Other Needs Assistance (ONA), and Disaster Supplemental Nutrition Assistance Program (D-SNAP). These efforts are facilitated through protocols such as the activation and staffing of Emergency Operation Centers (EOCs) and the deployment of personnel to Disaster Recovery Centers (DRCs) in coordination with TDEM and Federal Emergency Management Agency (FEMA). Oversight of programs like ONA currently involves both HHSC and TDEM, presenting an opportunity to assess and potentially streamline roles and responsibilities.

Eligibility Determination: HHSC is the sole agency responsible for determining program eligibility. Basic eligibility rules are established at the federal level and states cannot impose other eligibility conditions unless federally allowed as an

option or granted through waiver authority. Eligibility determinations for certain programs require coordination with other state and federal agencies, DFPS, Texas Workforce Commission (TWC), and the United States (U.S.) Social Security Administration (SSA). HHSC also coordinates Medicaid eligibility policies and benefits with DFPS and SSA. DFPS places children and youth under age 21 in conservatorship, which results in automatic Medicaid enrollment. Receipts of Supplemental Security Income through SSA also results in automatic Medicaid enrollment.

Medicaid Service Delivery: HHSC is responsible for implementing Medicaid and CHIP. As part of the shift from the fee-for-service (FFS) model to managed care, HHSC contracts with MCOs to coordinate services for most Medicaid members and all CHIP members. In addition, HHSC contracts with dental maintenance organizations (DMOs) to manage dental care. Certain aspects of implementing these federal programs also requires coordination with other state agencies. HHSC serves as the state's liaison with the federal government and coordinates with other state health and human services agencies and U.S. Department of Health and Human Services' (DHHS) Centers for Medicare & Medicaid Services (CMS) to develop and maintain the Medicaid State Plan and amendments.

Other Social Services: HHSC's efforts promoting self-sufficiency and safety functions do not overlap or duplicate functions performed by any other state agency.

Duplication of services does not occur because HHSC is the only agency that provides financial and social services such as the SNAP, Temporary Assistance for Needy Families (TANF), Medicaid, and home delivered meals. Following disasters, disseminating information to the populations affected, those concerned about loved ones, and volunteers, is especially important and frequent communication is needed. However, the information must be accurate. Contracted by HHSC, the 2-1-1 Information and Referral Service operates throughout the year and provides referral to social services provided by HHSC as well as other service agencies.

Detect and Deter Fraud, Waste, and Abuse: OIG is charged with administrative enforcement of violations in the provision and delivery of all health and human services in Texas. OIG works closely with the Texas Office of the Attorney General (OAG) Medicaid Fraud Control Unit and Healthcare Program Enforcement Division, who pursue criminal and civil violations in health and human services delivery. OIG refers cases to OAG as appropriate and assists as needed on OAG cases. OIG coordinates with local, state, and federal regulatory and law enforcement agencies while conducting provider, recipient, and other investigations. Additionally, OIG

collaborates with several entities, including the State Auditor's Office (SAO), OAC, and DFPS Internal Audit to avoid duplication of effort.

Regulating Federally Certified Facilities: CMS oversees compliance with federal regulations in facilities certified to receive Medicare or Medicaid funding. CMS delegates certain authority to HHSC to survey and investigate certain facility types, with HHSC Long Term Care Regulatory (LTCR) and Health Care Regulatory (HCR) serving as CMS contractors doing the work. No other local, state, or federal agency (including CMS) does the certification scope of work for providers to participate in the Medicaid and Medicare programs. HHSC Regulatory Services Division works with CMS to ensure complaint intakes, surveys, and enforcement activities involving federally certified providers are conducted in compliance with federal requirements.

- **HCR:** Health Care Facilities requiring federal certification are Rural health clinics, federally qualified health centers, outpatient physical therapy/speech therapy, comprehensive outpatient rehabilitation facilities, community mental health centers, portable x-rays, and Clinical Laboratory Improvement Amendments (CLIA) laboratories. Facilities that are licensed and federally certified are general hospitals, special hospitals, limited services rural hospital/rural emergency hospitals, psychiatric hospitals, ambulatory surgical centers and end stage renal disease ("dialysis") facilities.
- **LTCR:** Intermediate Care Facilities (ICFs) are federally certified, and some are also state licensed. Most nursing facilities are federally certified. Many Home and Community Support Services Agencies (HCSSA) (i.e., home health, hospice, etc.) are also federally certified in addition to being state licensed.
- **Regulatory Enforcement (RE):** RE is made up of different teams tasked with imposing state administrative penalties (APs) and licensure actions for entities regulated by LTCR, HCR and Child Care Regulation (CCR). RE coordinates with CMS on Civil Monetary Penalties (CMPs) for certain Long Term Care (LTC) providers. While potential for overlap exists because RE also assigns state APs for the same LTC providers, to avoid duplication, in addition to regular call and email coordination with CMS, LTC enforcement staff (1) input federal violation findings into the federally-owned database system of record; (2) never recommend both CMPs *and* APs; and (3) reduce APs imposed dollar-for-dollar if CMS decides to impose CMPs independently.

Regulatory Services Division also works with other entities including DFPS, the TWC, Texas Department of Insurance, OAG, and State Office of Administrative

Hearings to carry out regulatory activities, ensure efficiency and avoid duplication of efforts.

See CPRO – Regulatory Services - Section 07, Question H for more information.

F. In general, how do other states carry out similar functions?

While many of HHSC's functions are similar to those performed by other state health and human services agencies, Texas has consolidated virtually all health and human services programs and functions under a single agency. This includes the operation of state hospitals and SSLCs for individuals with mental health needs or intellectual or developmental disabilities, respectively. Texas has the largest number of state operated facilities, and similar to some other states like North Carolina, has placed the two facility types in the same organizational unit of the agency. Texas chooses to maintain its child support functions under a single statewide elected official, the OAG. While Texas separated its child protective services functions from HHSC, important linkages and coordination between DFPS and HHSC exists. Texas also has a high degree of consolidated administrative support functions, such as information technology and procurement and contracting services, as opposed to states that administer these functions within their separate health and human services agencies.

Medicaid Service Delivery: Over the last few decades, more states moved toward a capitated managed care model, which the overwhelming majority of states now use. Texas delivers most of its Medicaid services through the managed care model, where a single provider or organization oversees patient care. States have considerable flexibility around the design of their delivery systems, resulting in significant variation across Medicaid agencies in the structure, benefits, and number of patients enrolled in plans. States, including Texas, do deliver some programs under the fee-for-service model, in particular for certain populations including persons with fragile medical conditions, disabilities, or behavioral health conditions.

Community Service Program Delivery: States structure their service delivery systems differently. A variety of factors can determine how those structures are created – size of the state, types of services provided, centralized or decentralized, etc. Texas provides some services directly and contracts with community-based organizations healthcare providers, and quasi-governmental agencies. For example, long-term services and supports may be provided by aging and disability resource centers, Local Intellectual and Developmental Disability Authorities (LIDDAs), or private providers enrolled in a managed care organization.

Behavioral Health Program Delivery: Behavioral Health program delivery varies widely among states. States differ in the scope of safety net behavioral health services they provide and the populations they serve. For community-based service delivery, several states use a model like Texas which relies on Local Mental Health Authorities (LMHAs) or entities to ensure services are delivered in a coordinated way. Also, like other states, HHSC is statutorily required to provide services for civil and forensic populations. The CPSO division at HHSC is responsible for ensuring a continuum of care across community and inpatient services. Both Medicaid and CHIP cover screening and treatment services for mental health conditions and substance use disorders (SUDs).

Detect and Deter Fraud, Waste and Abuse: All states have a program integrity function to deter fraud, waste, and abuse in health and human services programs. These programs are typically administered through the health and human services agency, although some states, like Texas, have an OIG that may be appointed by the governor and operate independently. Core functions across state OIGs include ensuring program integrity, conducting audits and reviews, recovering improper payments, and investigating complaints. OIGs collaborate with state attorneys general, federal agencies, and other law enforcement organizations on investigations.

Regulatory Services: All states have varying requirements for regulating childcare operations, long-term care facilities and health care facilities.

- CCR: The [Administration for Children and Families](#) sets federal licensing standards for childcare. Based on the standards, all states must determine minimum health and safety standards that regulated childcare operations must meet to legally operate in their state. The requirements are set by the state's government, and regulation varies widely among states.
 - ▶ Abuse, neglect and exploitation (ANE): Some states operate similar to Texas where the childcare regulatory agency and the agency that investigates allegations of child ANE are separate. In other states, the two functions reside within the same agency.
 - ▶ Structure: Additionally, while all states have a regulatory function, each state's regulatory structure and childcare operation license types vary.
 - ▶ Funding: All states receive Child Care and Development Block Grant Act funds, the primary federal funding source devoted to supporting families with low incomes in affording child day care. All states also receive federal Social Security Act Title IV-E funding, which helps provide care for children in the state's conservatorship who may be placed in regulated

childcare settings. States direct the funds differently based on their state's need and funding structures.

- LTCR and HCR: Texas surveyors and investigators conduct state licensure and federal certification surveys and investigations into intakes—complaints and facility self-reported incidents, including those with ANE allegations. These staff are divided into teams at the front line (divided into regions) by program type. Some regions have a large number of providers and have specialized investigation teams due to the volume of intakes. Large states mimic the same organizational design as it lends itself to efficiency in completing the workload. Medium sized states and smaller states have fewer providers and usually cross-train their staff to complete work in all program types.
 - ▶ Federal certification and state licensure: Very few states have their state licensure and federal certification work in different agencies. This means two sets of staff complete surveys and investigations of providers that are both licensed and certified. Most states have staff completing the state licensure and federal certification scopes of work in one agency that is split into two divisions—one for acute care and another for long-term care providers.
- CII: Texas, like other states, adheres to the federal guidance regarding processing of long-term and acute care complaint and incident intakes, specifically, Chapter 5 of the CMS State Operations Manual (SOM.)
 - ▶ Hotline Functions: All states are federally required to have a hotline for intake of home health and hospice complaints; Texas has expanded hotline functions to serve all long-term and acute care provider types. Texas and other states also allow complainants to submit intakes online or via email.
 - ▶ Enforcement: In Texas, RE promotes positive outcomes by focusing on administrative and civil actions, not criminal prosecutions. This approach is different from Florida; the [Florida Health Medical Quality Assurance](#) works on referring regulated long-term care entities for criminal prosecution where probable cause is found. Although other HHSC Regulatory Services areas make referrals to law enforcement where appropriate, RE only works with law enforcement as needed.

G. Discuss any changes that could impact your agency's key functions in the near future (e.g., changes in federal law or outstanding court cases).

Changes in state and federal policies and funding may impact the administration and delivery of agency programs and services. In particular, changes to the structure of U.S. DHHS and the U.S. Department of Agriculture could impact Texas HHS programs.

Federal Law: In May 2023, CMS published notices of proposed rulemaking in the Federal Register for two access-related rules, “Ensuring Access to Medicaid Services” (Access) and “Managed Care Access, Finance, and Quality” (Managed Care). CMS issued the final Access and Managed Care rules on April 22, 2024.

These new rules are expansive and require HHSC to make substantial changes to various aspects of the Medicaid program. Implementation of the requirements involves multiple areas of HHSC. Key requirements include:

- Changes to appointment wait times: Enforceable standards for primary, OB/GYN, and mental health visits, monitored by secret shopper surveys.
- Payment transparency: States must publish fee-for-service rates and MCOs must disclose spending details.
- Increased medical loss ratio oversight: Stricter reporting to ensure funds go toward care, not administrative costs.
- New quality ratings: A new standardized system helps beneficiaries compare managed care plans.
- More beneficiary input: States must include enrollee voices through new advisory councils.
- Changes to home and community-based services (HCBS) oversight: Stronger quality controls and plan reviews for home and community-based services.

Rule effective dates range from 60 days to four years from the publication date of the final rules, with proposed stratification of certain HCBS quality measures phased in over seven years. HHSC has requested 141 FTEs for fiscal year 2026 for implementation of the rules.

In July 2025, the United States Congress passed H.R.1 – 119th Congress (2025-2026), the One Big Beautiful Bill Act (Act). The Act includes significant changes for health and human services programs, including:

- Modifying the age range, exemptions, and criteria for SNAP beneficiaries related to work and employment training requirements;

- Requiring states to pay a percentage of the costs incurred for SNAP benefits if the state's SNAP payment error rate exceeds federal standards beginning in fiscal year 2028;
- Requiring states to check the SSA's Death Master File (DMF) before enrolling or re-enrolling providers and on a quarterly basis during a provider's enrollment period;
- Tightening non-citizen eligibility rules for Medicaid and CHIP effective October 1, 2026, by limiting eligibility to only those immigrants who are lawful permanent residents, certain Cuban and Haitian entrants, and individuals lawfully residing in the U.S. in accordance with a Compact of Free Association (COFA);
- Setting the federal medical assistance percentage (FMAP) at the regular state rate for emergency Medicaid services provided to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the U.S. under color of law;
- Limiting retroactive coverage to two months for the non-expansion Medicaid group;
- Changing the 6 percent cap on provider tax rates for states and units of local government beginning October 1, 2026; and
- Directing CMS to revise federal regulations regarding directed payment programs (DPPs) to cap the total payment rate for certain DPPs at 110 percent of the total published Medicare rate.

Outstanding Court Cases: The following are cases that have the potential to impact agency operations. Exact impacts cannot be determined until cases are fully adjudicated.

- *Joseph Ward, by his next friend, et al. v. Cecile Young, in her official capacity as Executive Commissioner of the Texas Health and Human Services Commission, Defendant.* (United States District Court for the Western District of Texas, Austin Division). The plaintiff class alleges that the waitlist for admission to state hospitals for competency restoration treatment violates the U.S. Constitution. The case is set for a bench trial starting December 16, 2025.
- *M.D., By Next Friend, Sarah R. Stukenberg, et al. v. Greg Abbott, et al.* (United States District Court for the Southern District of Texas, Houston Division). Children's Rights, Inc., acting on behalf of a class of foster children who are in the permanent custody of the State filed a class action lawsuit

against DFPS, HHSC, and the Governor alleging violations of substantive due process rights under the Fourteenth Amendment. The Court found against all defendants and issued remedial orders. HHSC continues efforts to demonstrate compliance with all remedial orders.

- *Cook Children's Health Plan, Superior Health Plan, Inc., Wellpoint Insurance Company, and Texas Children's Health Plan, Plaintiffs v. Cecile Young, in her official Capacity as Executive Commissioner of the Texas Health and Human Services Commission.* (Travis County District Court). Unsuccessful bidders sued HHSC alleging that HHSC acted without legal authority (*ultra vires*) and failed to comply with state Medicaid managed care procurement law in a procurement for the STAR+PLUS Medicaid program. The case is ongoing.
- *Carla Frew et al., v. Cecile Erwin Young, in her official capacity as Executive Commissioner of the Texas Health and Human Services Commission, and Jennifer Shuford, M.D., in her official capacity as Commissioner of the Texas Department of State Health Services.* (United States District Court for the Eastern District of Texas, Sherman Division). This class action lawsuit brought by children under age 21 enrolled in Medicaid and eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits alleged the Texas EPSDT program known as Texas Health Steps (THSteps) did not meet the requirements of the Federal Medicaid Act. It was settled by consent decree in 1996. In 2000, the court found the State Defendants in violation of portions of the decree, and in 2007, the parties agreed to eleven corrective action orders (CAOs) to bring the state into compliance with the decree and increase access to EPSDT benefits. Five of the eleven CAOs and related decree paragraphs (Adequate Supply of Providers, Managed Care, Case Management, Checkups, and Health Outcomes Measures and Dental Assessment) remain active and require State obligations that are monitored by the Court.
- *Eric Steward, by his next friend and sister, Kelli Green, et al v. Cecile Young, in her official capacity as Executive Commissioner of the Texas Health and Services Commission.* (United States District Court for the Western District of Texas, San Antonio Division). The Department of Justice, Arc of Texas and Coalition of Texans with Disabilities represent a class of plaintiffs described as: All Medicaid-eligible persons over twenty-one years of age with intellectual or developmental disabilities or a related condition in Texas who currently or will in the future reside in nursing facilities, or who are being, will be, or should be screened for admission to nursing facilities. Plaintiffs allege they have been inappropriately and unnecessarily segregated in nursing facilities in violation of the Americans with Disabilities Act and that the State

has failed to: timely and appropriately conduct pre-admission screening and assessments (PASRR review); provide all needed specialized services; assess the appropriateness of alternative, less restrictive settings; and advise individuals of and provide a choice of community-based services and supports. On June 17, 2025, the district court issued Findings of Fact and Conclusions of Law, largely finding in favor of the Plaintiffs. The case is ongoing.

H. Overall, how does the agency monitor and measure its effectiveness in carrying out its functions and objectives?

HHSC's performance measures as set by the Legislative Budget Board (LBB) are included in Exhibit 2. HHSC reports quarterly data for key output and efficiency measures and reports annual data for key outcome and explanatory measures. "FY 2024 Actual Performance" reported in Exhibit 2 represents fourth quarter performance as reported to the LBB and "FY 2024 YTD" represent the average of all quarters for noncumulative measures (averages, ratios, unit costs, percentages etc.) or the sum of all four quarters for cumulative measures (counts such as number of people or number of services).

The explanation of variance statements for actual performance measures can be found in Attachment 24. Performance Reports Submitted to the LBB for fiscal year 2024.

As a contracting agency, HHSC's primary method for ensuring effectiveness is through contract oversight and monitoring of program and provider performance. Additional information about measures of effectiveness is included in Section VII.

Health and Human Services Commission

Exhibit 2: HHSC Performance Measures — Fiscal Year 2024

Table 2.1. Efficiency measures.

Efficiency Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 ⁵ Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
1-1-1-EF-1	Average Aged and Medicare-Related Cost Per Recipient Month	Average	1,303.94	1,279.61	1,261.39	96.74%
1-1-2-EF-1	Average Disability-Related Cost Per Recipient Month	Average	1,609.82	1,525.52	1,498.92	93.11%
1-1-3-EF-1	Average Pregnant Women Cost Per Recipient Month	Average	619.56	389.20	457.31	73.81%
1-1-4-EF-1	Average Other Adult Cost Per Recipient Month	Average	468.22	377.21	379.86	81.13%
1-1-5-EF-1	Average Income-Eligible Children Cost Per Recipient Month	Average	199.79	202.10	201.63	100.92%
1-1-5-EF-2	Average STAR Health Foster Care Children Cost Per Recipient Month	Average	991.49	1,076.02	968.72	97.70%
1-1-6-EF-1	Average Cost/Medicaid Recipient Month: Prescription Drugs	Average	75.73	73.17	74.75	98.71%

⁵ All final fiscal year 2024 performance measures will be reported in the fiscal year 2026 Operating Budget.

Efficiency Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024⁵ Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
1-1-7-EF-1	Average Cost per Texas Health Steps Early and Periodic Screening, Diagnosis, and Treatment Dental Recipient Months per Month	Average	30.80	27.83	27.81	90.29%
1-1-8-EF-1	Average Nonemergency Transportation (NEMT) Cost Per Recipient Month	Average	3.13	4.16	4.12	131.63%
1-2-1-EF-1	Average Monthly Cost Per Individual Served: Community Attendant Services	Average	1,457.99	1,503.29	1,484.46	101.82%
1-2-2-EF-1	Average Monthly Cost Per Individual Served: Primary Home Care	Average	1,423.31	1,437.85	1,427.41	100.29%
1-2-3-EF-1	Average Monthly Cost Per Individual Served: Day Activity and Health Services	Average	558.59	642.74	634.01	113.50%
1-2-4-EF-1	Net Nursing Facility Cost Per Medicaid Fee-for-Service Resident Per Month	Amount	4,460.45	4,597.99	4,564.31	102.33%
1-2-5-EF-1	Net Medicaid/Medicare Copay Per Individual Nursing Facility Services	Amount	2,756.13	3,076.13	2,918.84	105.90%
1-2-6-EF-1	Average Net Payment Per Individual Per Month for Hospice	Average	3,608.65	3,778.29	3,707.84	102.75%

Efficiency Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024⁵ Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
1-2-7-EF-1	Monthly Cost per Intermediate Care Facility for Individuals with Intellectual Disability Medicaid-Eligible Individual	Amount	5,026.39	5,140.64	5,107.48	101.61%
1-3-1-EF-1	Average Monthly Cost Per Individual Served: Home and Community-Based Services	Average	3,920.46	3,988.20	3,954.42	100.87%
1-3-1-EF-2	Average Monthly Cost Per Individual Served: HCS Residential	Average	5,809.36	6,209.34	6,247.46	107.54%
1-3-1-EF-3	Average Monthly Cost Individual: HCS Non-Residential	Average	3,075.22	3,021.78	2,962.97	96.35%
1-3-2-EF-1	Average Monthly Cost Per Individual: Community Living Assistance and Support Services (CLASS) Waiver	Average	4,716.63	4,770.69	4,761.41	100.95%
1-3-3-EF-1	Average Monthly Cost Per Individual: Deaf-Blind with Multiple Disabilities (DBMD) Waiver	Average	5,362.77	6,122.57	6,116.47	114.05%
1-3-4-EF-1	Average Monthly Cost Per Individual Served: Texas Home Living Waiver	Average	2,188.76	2,401.72	2,367.70	108.18%
1-3-5-EF-1	Average Monthly Cost Per Recipient: Program for All Inclusive Care (PACE)	Average	3,009.31	3,178.07	3,183.52	105.79%

Efficiency Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024⁵ Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
1-4-1-EF-1	Average Emergency Services for Non-citizens Cost Per Recipient Month	Average	3,390.56	529.13	1,967.49	58.03%
1-4-2-EF-1	Average Supplemental Medical Insurance Benefits (SMIB) Part B Premium Per Month	Average	185.51	174.70	171.26	92.32%
3-1-1-EF-1	Average CHIP Children Benefit Cost Per Recipient Month	Average	133.84	145.16	143.74	107.40%
3-1-1-EF-2	Average Perinatal Benefit Cost Per Recipient Month	Average	422.66	456.13	455.98	107.88%
3-1-1-EF-3	Average Cost Per CHIP Recipient Month: Pharmacy Benefit	Average	34.34	35.04	35.16	102.39%
3-1-1-EF-4	Average Monthly Cost of the Dental Benefit Per CHIP Program Recipient	Average	22.87	21.71	21.69	94.84%
4-1-1-EF-1	Average Monthly Cost Per Healthy Texas Women (HTW) Client Receiving Services	Average	179.34	151.44	170.19	94.90%
4-1-1-EF-2	Average Monthly Cost Per Family Planning Client Receiving Services	Average	304.29	189.23	187.85	61.73%
4-1-3-EF-1	Average Monthly Cost Per Child: Comprehensive Services/State and Federal	Average	440.49	414.68	447.15	101.51%

Efficiency Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024⁵ Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
4-1-5-EF-1	Average Monthly Cost Per Child: Children's Blindness Services	Average	153.00	189.84	187.54	122.58%
4-1-6-EF-1	Average Annual Cost Per Child Receiving Focused Autism Services	Average	6,000.00	7,474.00	7,474.00	124.57%
4-1-7-EF-1	Average Monthly Cost Per Children with Special Health Care Needs Clients Receiving Services	Average	2,400.00	2,573.01	2,573.01	107.21%
4-1-9-EF-1	Average Annual Cost Per Kidney Health Care Client	Average	600.00	630.67	519.60	86.60%
4-1-11-EF-1	Average Cost Per Primary Health Care Client (Non-Key) ⁶	Average	150.0	125.0	-	83.33%
4-2-1-EF-1	Average Monthly Cost Per Adult: Community Mental Health Services	Average	430.00	581.00	543.00	126.28%
4-2-2-EF-1	Average Monthly Cost Per Child Receiving Community Mental Health Services	Average	350.00	523.00	487.00	139.14%
4-2-3-EF-1	Average General Revenue Spent Per Person for Crisis Residential Services	Average	2,500.00	3,933.00	3,425.00	137.00%

⁶ The fiscal year 2024 target for non-key measures are budgeted amounts as reported in the fiscal year 2024 Operating Budget. Fiscal year 2024 actual performance for non-key measures is estimated. HHSC does not report on non-key measures quarterly.

Efficiency Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024⁵ Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
4-2-3-EF-2	Average General Revenue Spent Per Person for Crisis Outpatient Services	Average	425.00	480.00	490.00	115.29%
4-2-4-EF-1	Average Monthly Cost Per Youth for Substance Abuse Prevention Services	Average	28.00	36.56	24.97	89.18%
4-2-4-EF-2	Average Monthly Cost Per Adult for Substance Abuse Intervention Services (Non-Key)	Average	165.00	115.00	-	69.70%
4-2-4-EF-3	Average Monthly Cost Per Youth for Substance Abuse Intervention Services (Non-Key)	Average	164.00	169.00	-	103.50%
4-2-4-EF-4	Average Monthly Cost Per Adult Served in Treatment Programs for Substance Abuse	Average	625.00	781.86	804.05	128.65%
4-2-4-EF-5	Average Monthly Cost Per Youth Served in Treatment Programs for Substance Abuse	Average	920.00	701.72	809.67	88.01%

Efficiency Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024⁵ Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
4-2-5-EF-1	Average Monthly Cost Per Client Served in HCBS-AMH Program Average Monthly Cost Per Client Served in Home and Community-Based Services - Adult Mental Health (HCBS-AMH) Program	Average	6,684.54	6,745.30	6,734.02	100.74%
4-2-5-EF-2	Average Monthly Cost Per Client Served in Youth Empowerment Services (YES) Waiver	Average	805.47	780.56	739.98	91.87%
5-1-1-EF-1	Average Monthly Grant: TANF Basic Cash Assistance	Average	86.69	95.31	94.67	109.21%
5-1-1-EF-2	Average Monthly Grant: State Two-Parent Cash Assistance Program	Average	88.57	97.48	96.39	108.83%
6-1-3-EF-1	Average Mthly Cost Per Individual Receiving Community Services	Average	560.24	676.04	676.04	120.67%
7-1-1-EF-1	Average Monthly Cost Per Campus Resident	Average	26,293.00	29,227.68	29,493.07	112.17%
7-2-1-EF-1	Average Daily Cost Per Occupied State Mental Health Facility Bed	Average	663.00	854.00	854.00	128.81%
7-2-2-EF-1	Average Daily Cost Per Occupied Mental Health Community Hospital Bed	Average	758.00	632.00	561.73	74.11%

Efficiency Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024⁵ Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
8-1-1-EF-1	Average Daily Caseload Per Worker Provider Investigations	Average	11.00	31.88	21.50	195.45%
8-2-1-EF-1	Average Monthly Day Care Caseload Per Monitoring Worker	Average	81.06	79.73	80.86	99.75%
8-2-1-EF-2	Average Monthly Residential Caseload Per Monitoring Worker	Average	18.18	18.81	18.02	99.12%

Table 2.2. Explanatory measures.

Explanatory Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
1-3-1-EX-1	Number Individuals Receiving Services at the End of the Fiscal Year: HCS	Number	28,517.00	-	28,148.64	98.71%
1-3-1-EX-2	Percent of HCS Recipients Receiving Residential Services	Percentage	30.91	-	30.52	98.74%
1-3-2-EX-1	Number of Persons Receiving Services at the End of the Fiscal Year: CLASS Waiver	Number	6,282.00	-	5,996.60	95.46%
1-3-3-EX-1	Number of Persons Receiving Services at the End of the Fiscal Year: DBMD Waiver	Number	310.00	-	264.86	85.44%

Explanatory Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
1-3-4-EX-1	Number of Individuals Receiving Services at the End of the Fiscal Year: Texas Home Living Waiver	Number	2,934.00	-	0.00	0.00%
1-3-5-EX-1	Number of Persons Receiving Services End of Fiscal Year: PACE	Number	1,166.00	-	1,151.12	98.72%
4-1-3-EX-1	Average Monthly Number of Hours of Service Delivered Per Child Per Month	Average	2.74	-	2.32	84.67%
4-1-10-EX-1	Number of Epilepsy Program Clients Provided Services (Non-Key)	Number	4,500.00	4,500.00	-	100.00%
4-1-10-EX-2	Number of Hemophilia Assistance Program (HAP) Clients (Non-Key)	Number	5.00	1.00	-	20.00%

Table 2.3. Outcome measures.

Outcome Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
1-1-OC-1	Average Full Benefit Medicaid Recipient Months Per Month	Average	4,397,058.00	-	4,347,894.00	98.88%

Outcome Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
1-1-OC-2	Average Monthly Cost Per Full Benefit Medicaid Client (Including Drug and Long-Term Care)	Average	554.38	-	497.98	89.83%
1-1-OC-3	Medicaid Recipient Months: Proportion in Managed Care	Average	96.16	-	94.28	98.04%
1-1-OC-4	Average Number of Members Receiving Waiver Services through Managed Care	Average	68,118.05	-	69,382.00	101.86%
1-1-OC-5	Average Number Members Receiving Nursing Facility Care through Managed Care	Average	46,569.65	-	45,173.00	97.00%
1-1-OC-6	Average Number Served per Month: Medically Dependent Children Program (MDCP)	Average	6,069.00	-	6,136.00	101.10%
3-1-OC-1	Average CHIP Programs Recipient Months Per Month	Average	301,044.00	-	164,757.00	54.73%
3-1-OC-2	Average CHIP Programs Benefit Cost with Prescription Benefit	Average	219.59	-	246.87	112.42%
4-2-OC-1	Percent Adults Receiving Community Mental Health Services Whose Functional Level Improved	Percentage	51.00	-	51.28	100.55%

Outcome Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
4-2-OC-2	Percent Children Receiving Community Mental Health Services Whose Functional Level Improved	Percentage	50.00	-	49.52	99.04%
4-2-OC-3	Percent Receiving Crisis Services Who Avoid Psychiatric Hospitalization within 30 days	Percentage	97.00	-	98.25	101.29%
4-2-OC-4	Percent Adults Who Complete Treatment Program and Report No Past Month Substance Use	Percentage	90.00	-	90.93	101.03%
4-2-OC-5	Percent Youth Who Complete Treatment Program and Report No Past Month Substance Use	Percentage	92.00	-	91.02	98.93%
4-2-OC-6	Percent of Adults With Opioid Use Disorder Receiving Medication-Assisted Treatment	Percentage	65.00	-	72.33	111.28%
9-2-OC-1	Percent Long-Term Care Ombudsman Complaints Resolved or Partially Resolved (Non-Key)	Percentage	80.00	80.00	-	100.00%
11-1-OC-1	Net Dollars Recovered Per Dollar Expended from All Funds (Non-Key)	Amount	5.73	3.14	-	54.80%

Table 2.4. Output measures.

Output Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
1-1-1-OP-1	Average Aged and Medicare-Related Recipient Months Per Month: Total	Average	400,265.00	361,304.00	366,832.00	91.65%
1-1-2-OP-1	Average Disability-Related Recipient Months Per Month: Total	Average	425,624.00	370,732.00	382,920.00	89.97%
1-1-3-OP-1	Average Pregnant Women Recipient Months Per Month	Average	157,660.00	266,776.85	239,752.92	152.07%
1-1-4-OP-1	Average Other Adult Recipient Months Per Month	Average	150,747.00	133,944.22	167,883.28	111.37%
1-1-5-OP-1	Average Income-Eligible Children Recipient Months Per Month	Average	3,229,736.00	2,997,897.97	3,164,740.31	97.99%
1-1-5-OP-2	Average STAR Health Foster Care Children Recipient Months Per Month	Average	32,982.00	22,135.73	25,765.06	78.12%
1-1-7-OP-1	Average Texas Health Steps Early, Periodic, Screening, Diagnosis, and Treatment Dental Recipient Months Per Month	Average	3,250,939.00	3,170,246.00	3,337,764.67	102.67%
1-2-1-OP-1	Average Number of Individuals Served Per Month: Community Attendant Services	Average	67,329.00	63,081.03	61,870.31	91.89%

Output Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
1-2-2-OP-1	Average Number of Individuals Served Per Month: Primary Home Care	Average	1,500.00	1,107.67	1,097.14	73.14%
1-2-3-OP-1	Average Number of Individuals Per Month: Day Activity/Health Services	Average	1,023.00	947.73	957.19	93.57%
1-2-4-OP-1	Average Number Receiving Medicaid-Funded Fee-for-Service Nursing Facility Services Per Month	Average	5,254.00	8,668.18	8,198.88	156.05%
1-2-5-OP-1	Average Number Receiving Nursing Facility Copayments Per Month	Average	1,198.00	869.84	903.22	75.39%
1-2-6-OP-1	Average Number of Individuals Receiving Hospice Services Per Month	Average	7,294.00	7,824.17	7,644.46	104.80%
1-2-7-OP-1	Average Number of Persons in Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Condition Medicaid Beds per Month	Average	3,906.00	3,782.70	3,953.83	101.22%
1-3-1-OP-1	Average Number Individuals Served Per Month: HCS	Average	28,255.00	28,340.22	28,648.57	101.39%
1-3-2-OP-1	Average Number of Individuals Served Per Month: CLASS Waiver	Average	6,233.00	6,025.21	6,046.84	97.01%

Output Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
1-3-3-OP-1	Average Number of Individuals Served Per Month: DBMD Waiver	Average	308.00	276.51	292.32	94.91%
1-3-4-OP-1	Average Number of Individuals Served Per Month: Texas Home Living Waiver	Average	2,862.00	2,582.06	2,586.67	90.38%
1-3-5-OP-1	Average Number of Recipients Per Month: PACE	Average	1,166.00	1,150.91	1,143.30	98.05%
1-4-1-OP-1	Average Monthly Number of Non-Citizens Receiving Emergency Services	Average	8,547.00	51,309.23	29,640.17	346.79%
1-4-2-OP-1	Average SMIB Part B Recipient Months Per Month	Average	740,779.00	646,222.12	668,478.61	90.24%
3-1-1-OP-1	Average CHIP Children Recipient Months Per Month	Average	272,286.00	162,757.00	138,509.00	50.87%
3-1-1-OP-2	Average Perinatal Recipient Months Per Month	Average	28,758.00	26,412.67	26,248.17	91.27%
4-1-1-OP-1	Average Monthly Number Women Enrolled in Services through HTW Program	Average	461,526.00	363,277.00	375,397.67	81.34%
4-1-1-OP-2	Average Monthly Number of Family Planning Clients Receiving Services	Average	17,051.00	21,294.33	19,847.02	116.40%
4-1-1-OP-3	Average Monthly Number of Women Receiving HTW Services	Average	54,968.00	31,037.00	27,863.01	50.69%

Output Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
4-1-2-OP-1	Number of Persons Receiving Services as Alternative to Abortion	Number	137,276.00	39,089.00	150,032.00	109.29%
4-1-3-OP-1	Average Monthly Number of Children Served in Comprehensive Services	Average	36,974.00	36,063.82	35,376.77	95.68%
4-1-3-OP-2	Average Monthly Number of Referrals to Local Programs	Average	8,477.00	8,046.02	7,865.42	92.79%
4-1-3-OP-3	Average Monthly Number of Eligibility Determinations Completed	Average	4,713.00	4,203.62	4,262.59	90.44%
4-1-5-OP-1	Average Monthly Number of Children Receiving Blindness Services	Average	3,026.00	2,591.00	2,591.00	85.62%
4-1-6-OP-1	Average Monthly Number of Children Receiving Focused Autism Services	Average	625.00	307.00	307.00	49.12%
4-1-7-OP-1	Average Monthly Number of CSHCN Clients Receiving Services	Average	900.00	585.00	585.00	65.00%
4-1-8-OP-1	Number of Infants <1 and Children Aged 1-21 Years Provided Services	Number	32,000.00	6,438.00	32,352.00	101.10%
4-1-8-OP-2	Number of Women over 21 Provided Title V Services	Number	4,300.00	519.00	3,710.00	86.28%
4-1-9-OP-1	Number of Kidney Health Clients Provided Services	Number	11,500.00	13,562.00	50,445.00	438.65%

Output Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
4-1-11-OP-1	Number Primary Health Care Clients Receiving Services (Non-Key)	Number	115,000	115,000	-	100.00%
4-1-12-OP-1	Number of Persons Served in Abstinence Education Programs	Number	30,000.00	3,294.00	32,990.00	109.97%
4-2-1-OP-1	Average Monthly Number of Adults Receiving Community Mental Health Services	Average	96,500.00	97,376.00	96,748.00	100.26%
4-2-2-OP-1	Average Monthly Number of Children Receiving Community Mental Health Services	Average	28,800.00	25,897.00	26,835.00	93.18%
4-2-3-OP-1	Number Persons Receiving Crisis Residential Services Per Year Funded by General Revenue	Number	20,000.00	2,550.00	11,612.00	58.06%
4-2-3-OP-2	Number Persons Receiving Crisis Outpatient Services Per Year Funded by General Revenue	Number	85,000.00	18,910.00	83,846.00	98.64%
4-2-4-OP-1	Average Monthly Number of Youth Served in Substance Abuse Prevention Programs	Average	117,000.00	44,034.00	99,328.00	84.90%
4-2-4-OP-2	Average Monthly Number of Youth Served in Treatment Programs for Substance Abuse	Average	620.00	640.00	701.00	113.06%

Output Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
4-2-4-OP-3	Average Monthly Number of Adults Served in Substance Abuse Intervention Programs (Non-Key)	Average	6,305.00	8,597.00	-	136.35%
4-2-4-OP-4	Average Monthly Number of Youth Served in Substance Abuse Intervention Programs (Non-Key)	Average	666.00	170.00	-	25.53%
4-2-4-OP-5	Average Monthly Number of Adults Served in Treatment Programs for Substance Abuse	Average	10,000.00	11,643.00	11,436.00	114.36%
4-2-5-OP-1	Average Monthly Number of Clients Served in HCBS-AMH Program	Average	443.00	398.00	392.00	88.49%
4-2-5-OP-2	Average Monthly Number of Clients Served in YES Waiver	Average	1,230.00	701.00	701.00	56.99%
5-1-1-OP-1	Average Number of TANF Basic Cash Assistance Recipients Per Month	Average	17,720.00	18,823.87	17,581.93	99.22%
5-1-1-OP-2	Avg Number of State Two-Parent Cash Assist Recipients Per Month	Average	719.00	888.31	754.90	104.99%
5-1-2-OP-1	Number of WIC Participants Provided Nutritious Supplemental Food	Number	725,000.00	798,826.00	3,137,692.00	432.79%

Output Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
6-1-1-OP-1	Average Number of Wards Receiving Guardianship Services	Average	886.00	836.00	836.00	94.36%
6-1-2-OP-1	Average Number of Individuals Served Per Month: Non-Medicaid Community Care (Title XX/General Revenue)	Average	32,985.00	39,193.66	39,194.00	118.82%
6-1-3-OP-1	Average Monthly Number of Individuals with IDD Receiving Community Services	Average	4,942.00	5,164.00	5,164.00	104.49%
6-2-1-OP-1	Number People Receiving Services from Centers for Independent Living	Number	5,119.00	4,768.00	15,256.00	298.03%
6-2-1-OP-2	Number of People Receiving HHSC Contracted Independent Living Services	Number	2,310.00	2,744.00	8,949.00	387.40%
6-2-2-OP-1	Number of Individuals Receiving Treatment Services in the Blindness Education, Screening and Treatment (BEST) Program (Non-Key)	Number	112.00	112.00	-	100.00%
6-2-2-OP-2	Number of Individuals Receiving Screening Services in the BEST Program (Non-Key)	Number	2,452.00	2,452.00	-	100.00%

Output Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
6-2-3-OP-1	Average Monthly Number of People Receiving Comprehensive Rehabilitation Services	Average	550.00	358.00	348.00	63.27%
6-2-4-OP-1	Number of Interpreter Certificates Issued (Non-Key)	Number	1,765.00	1,765.00	-	100.00%
6-2-4-OP-2	Number of Equipment/Service Vouchers Issued	Number	25,000.00	6,481.00	21,937.00	87.75%
7-1-1-OP-1	Average Monthly Number of State Supported Living Center Campus Residents	Average	2,515.00	2,587.00	2,578.00	102.50%
7-1-1-OP-2	Number Unfounded Abuse/Neglect/Exploitation Allegations Against State Supported Living Center Staff	Number	1,900.00	13.00	250.00	13.16%
7-1-1-OP-3	Number Confirmed Abuse/Neglect/Exploitation Incidents at State Supported Living Centers	Number	120.00	168.00	361.00	300.83%
7-2-1-OP-1	Average Daily Census of State Mental Health Facilities	Average	2,412.00	1,908.00	1,908.00	79.10%
7-2-2-OP-1	Average Daily Number of Occupied Mental Health Community Hospital Beds	Average	1,107.00	876.00	794.00	71.73%
8-1-1-OP-1	Number of Long-Term Care & Health Care Regulation Licenses Issued	Number	6,972.00	1,494.00	6,253.00	89.69%

Output Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
8-1-1-OP-2	Number of Long-Term Care Regulation and Health Care Regulation Contacts	Number	27,161.00	7,624.00	27,917.00	102.78%
8-2-1-OP-1	Number of Childcare Facility Inspections	Number	37,122.00	7,989.00	34,493.00	92.92%
8-2-1-OP-2	Number of Completed Non-Abuse/Neglect Investigations	Number	13,617.00	3,762.00	14,294.00	104.97%
8-2-1-OP-3	Number of Childcare Regulatory Permits Issued	Number	10,965.00	2,599.00	10,729.00	97.85%
8-3-1-OP-1	Number of Licenses/Credentials Issued	Number	70,132.00	15,374.00	67,661.00	96.48%
8-3-1-OP-2	Number of Investigations Completed	Number	314.00	164.00	524.00	166.88%
9-1-1-OP-1	Average Monthly Number of Eligibility Determinations	Average	878,750.00	992,210.67	1,043,694.08	118.77%
9-2-1-OP-1	Average Monthly Number Individuals w/IDD Receiving Assessment and Service Coordination	Average	35,429.00	39,628.00	39,628.00	111.85%
10-1-1-OP-1	Number of Disability Cases Determined	Number	214,950.00	61,512.00	227,296.00	105.74%
11-1-1-OP-1	Number of Completed Provider and Recipient Investigations	Number	15,141.00	4,003.00	17,288.00	114.18%
11-1-1-OP-2	Number of Audits and Reviews Performed	Number	34.00	25.00	34.00	100.00%

Output Measure Number	Measure Title Detailed	Calculation (if applicable)	FY 2024 Target	FY 2024 Actual Performance (Q4)	FY 2024 YTD	FY 2024 % of Annual Target
11-1-1-OP-5	Total Dollars Recovered (Millions)	Amount	420.75	99.83	442.37	105.14%
11-1-1-OP-6	Total Medicaid Overpayments Recovered with Special Investigation Units	Amount	3,307,872.00	668,665.04	2,221,310.34	67.15%
13-1-1-OP-1	Number of Sex Offenders Provided Treatment and Supervision	Number	526.00	533.00	533.00	101.33%

I. Please list all “mission critical” data resources (e.g., spreadsheets, databases, IT systems, and cloud-hosted applications) your agency maintains to collect, track, or display agency program data. By “mission critical,” we mean the main systems necessary for the day-to-day functioning of core and/or client-facing agency functions and services. Please do *not* include any statutorily required data collection upon which agency funding is contingent but which does not impact daily program functionality. As a companion to the list below, please provide additional information on each data resource using the template provided for Attachment 21 in that section of the instructions.

Section 2.I and Attachment 21 list mission critical data resources. However, HHSC’s data landscape is vast, and the agency continues to identify and evaluate data that may meet the mission critical data resource definition but are not included in Exhibit 3. These may include systems managed by third party vendors such as the Texas Medicaid & Healthcare Partnership (TMHP) or other data resources used by smaller programs. HHSC has ongoing data governance initiatives intended to obtain and document information about all HHSC data systems and plans to use the information gathered for Sections 2.I and Attachment 21 to further efforts to document and catalogue the entire landscape of HHSC data systems.

Health and Human Services Commission
Exhibit 3: Mission Critical Data Resources

Data Resource Name	Chief Division	Data Owner
2-1-1 Contact Data	Chief Program and Services Officer	HHSC
2-1-1 Internet System (2-1-1)	Chief Program and Services Officer	HHSC
2-1-1 Resource Data	Chief Program and Services Officer	HHSC
Abbott FreeStyle Precision (Abbott)	Chief Program and Services Officer	Abbott
Abbott FreeStyle Precision Web	Chief Program and Services Officer	Abbott
Accounts Receivable Tracking System (ARTS)	Chief Financial Officer	HHSC
Activity Tracker - Abilene (AT - Abilene)	Chief Program and Services Officer	TBC Software

Data Resource Name	Chief Division	Data Owner
Activity Tracker Austin State Supported Living Center (SSLC) (AT - Austin)	Chief Program and Services Officer	TBC Software
Activity Tracker Brenham SSLC (AT - Brenham)	Chief Program and Services Officer	TBC Software
Activity Tracker Corpus Christi SSLC (AT - Corpus)	Chief Program and Services Officer	TBC Software
Activity Tracker Denton SSLC (AT - Denton)	Chief Program and Services Officer	TBC Software
Activity Tracker Health and Specialty Care System (AT HSCS)	Chief Program and Services Officer	TBC Software
Activity Tracker Lubbock SSLC (AT - Lubbock)	Chief Program and Services Officer	TBC Software
Activity Tracker Lufkin SSLC (AT - Lufkin)	Chief Program and Services Officer	TBC Software
Activity Tracker Richmond SSLC (AT-Richmond)	Chief Program and Services Officer	TBC Software
Activity Tracker San Angelo SSLC (AT - San Ang)	Chief Program and Services Officer	TBC Software
Activity Tracker San Antonio SSLC (AT-San Anto)	Chief Program and Services Officer	TBC Software
AdministratorRx	Chief Medicaid and CHIP Services Officer	HHSC
Adverse Action Record Sharing (AARS)	Chief Policy and Regulatory Officer	HHSC
Advisory Committee Application	Chief Policy and Regulatory Officer	HHSC
Advisory Committee Coordination Office Advisory Committee Member Tracker	Chief Policy and Regulatory Officer	HHSC
ASPEN Central Office (ACO) - Automated Survey Processing Environment Complaint Tracking System	Chief Policy and Regulatory Officer	U.S. Centers for Medicare & Medicaid Services
Autism Program Data Reporting System	Chief Program and Services Officer	HHSC
Automated Complaints/Incident Tracking System- Automated Survey Processing Environment Complaint Tracking System	Chief Policy and Regulatory Officer	U.S. Centers for Medicare & Medicaid Services

Data Resource Name	Chief Division	Data Owner
Automated Survey Processing Environment (ASPEN) Enforcement Module (HW/AEM)	Chief Policy and Regulatory Officer	U.S. Centers for Medicare & Medicaid Services
Automated Survey Processing Environment Central Office (HW/ASPEN)	Chief Policy and Regulatory Officer	U.S. Centers for Medicare & Medicaid Services
Automated Survey Processing Environment Complaint Tracking System (HW/ACTS)	Chief Policy and Regulatory Officer	U.S. Centers for Medicare & Medicaid Services
Automated System for the Office of the Inspector General (ASOIG)	Office of Inspector General	HHSC
Beneficiary Investigations Tracker (BIT)	Office of Inspector General	HHSC
BMC Helix	Chief Information Officer	HHSC
Board Evaluation of Interpreters (BEI)	Chief Program and Services Officer	HHSC
Budget Planning and Financial Data Warehouse	Chief Financial Officer	HHSC
Career Center - SuccessFactors	Chief Operating Officer	HHSC
Case Management System (CMS_DSHS)	Chief Counsel	HHSC
Centers for Medicare and Medicaid Services 1915(c) Waiver 372 Reports	Chief Medicaid and CHIP Services Officer	HHSC
Central Data Repository (CDR)	Chief Policy and Regulatory Officer	HHSC
Centralized Accounting & Payroll/Personnel System Human Capital Management (CAPPS HCM)	Chief Operating Officer	HHSC
Centralized Accounting and Payroll/Personnel System (CAPPS) Financials	Chief Financial Officer	HHSC
Child Safety Data for Licensed Day Care Centers	Chief Policy and Regulatory Officer	HHSC
Childcare Licensing Automated Support System (CLASS)	Chief Policy and Regulatory Officer	HHSC
CHIP Annual Report	Chief Medicaid and CHIP Services Officer	HHSC
Claims II System (Claims II)	Chief Program and Services Officer	HHSC

Data Resource Name	Chief Division	Data Owner
Claims Management System - Service Authorization System Online (MG/SASO)	Chief Program and Services Officer	HHSC
Clearwell E-Discovery (Clearwell)/Clearwell eDiscovery Platform – vendor Veritas	Chief Counsel and Chief Information Officer	HHSC
Client Assignment & Registration System (CARE)	Chief Program and Services Officer	HHSC
Client Trust Fund (CTF)	Chief Program and Services Officer	HHSC
Clinical Management for Behavioral Health Services (CMBHS)	Chief Program and Services Officer	HHSC
Clinical Management for Behavioral Health Services Data Warehouse	Chief Program and Services Officer	HHSC
Closed Foster Homes Database	Chief Policy and Regulatory Officer	HHSC
CMS ICF/MR Provider Payment System (ARSP-CMS)	Chief Program and Services Officer	HHSC
CMS-416 (Annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Participation Report)	Chief Medicaid and CHIP Services Officer	HHSC
Cognos Community Services Interest List	Chief Program and Services Officer	HHSC
Cognos Program Payment	Chief Program and Services Officer	HHSC
Cognos Service Authorization System Online	Chief Program and Services Officer	HHSC
Community Services Interest Lists (HY/CSIL)	Chief Medicaid and CHIP Services Officer	HHSC
Comprehensive Rehabilitation Services (CRS) Post-Acute Rehabilitation Services Data Reporting System	Chief Program and Services Officer	HHSC
Comprehensive Rehabilitation Services Waiting List (CRS WL)	Chief Program and Services Officer	HHSC
Computer-aided Facility Management (CAFM)	Chief Operating Officer	HHSC
Computer-Aided Facility Management Software (CAFM 10/TRIRIGA)	Chief Program and Services Officer	HHSC
Consolidated Access Control Tracking System (CACTS)	Chief Information Officer	HHSC

Data Resource Name	Chief Division	Data Owner
Contract Administration and Provider Monitoring (CAPM)	Chief Medicaid and CHIP Services Officer	HHSC
Critical Incident Management System (CIMS)	Chief Medicaid and CHIP Services Officer	HHSC
DADS SAS-TIERS Interop	Chief Program and Services Officer	HHSC
Data Broker System (DBS)	Chief Program and Services Officer	HHSC
Data Management System (DMS)	Chief Medicaid and CHIP Services Officer	HHSC
Day Care Operation Monthly Status Changes	Chief Policy and Regulatory Officer	HHSC
Deaf and Hard of Hearing Services - Senior Citizen Program (SCP)/ Last Resort Communication Services (LRCS)/ Communication Services for State Agencies (CSSA) Contract Reporting	Chief Program and Services Officer	HHSC
Deaf and Hard of Hearing Services (DHHS) Specialists Contract Reporting (SCR)	Chief Program and Services Officer	HHSC
Deconfliction Dashboard	Office of Inspector General	HHSC
Delivery Supplemental Payment Processing (DSPP)	Chief Medicaid and CHIP Services Officer	HHSC
Dell Data Security (DDS / DDPE)	Chief Information Officer	HHSC
Disaster Assistance Payment Program	Chief Operating Officer	HHSC
Driving Records Request System (DRRS)	Chief Program and Services Officer	Department of Public Safety
Early Childhood Intervention (ECI) Early Intervention Specialist (EIS) Registry	Chief Program and Services Officer	HHSC
Early Childhood Intervention (ECI) Financial Database	Chief Program and Services Officer	HHSC
EBT Data Storage and Retrieval System (HE/EBT)	Chief Program and Services Officer	HHSC
ECI Early Intervention Specialist (EIS) Registry	Chief Program and Services Officer	HHSC
EIM Proxy	Chief Information Officer	HHSC

Data Resource Name	Chief Division	Data Owner
Electronic Certificate of Information (eCOI) Portal	Chief Medicaid and CHIP Services Officer	HHSC
Electronic Visit Verification Data	Chief Medicaid and CHIP Services Officer	HHSC
Eligibility Services Portal (ESPortal)	Chief Program and Services Officer	HHSC
Eligibility Workload Management System (EWMS)	Chief Program and Services Officer	HHSC
Employee Misconduct Registry (EMR)	Chief Policy and Regulatory Officer	HHSC
Encounter Data Warehouse (Encounters)	Chief Medicaid and CHIP Services Officer	HHSC
Enrollment Broker Financial Application (MAXeb Finance)	Chief Medicaid and CHIP Services Officer	HHSC
Enterprise Data Warehouse Staging Environment (EDW)	Chief Medicaid and CHIP Services Officer	HHSC
E-Verify	Chief Operating Officer	U.S. Department of Homeland Security and U.S. Social Security Administration
External Quality Review Organization (EQRO) Datasets on Emergency Department Utilization and Member Survey Information	Chief Medicaid and CHIP Services Officer	HHSC
Family Violence System (FV Net)	Chief Program and Services Officer	HHSC
Fee for Service Claims Data: Acute Care	Chief Medicaid and CHIP Services Officer	HHSC
Fee for Service Claims Data: Long-term Care	Chief Medicaid and CHIP Services Officer	HHSC
Field Utilization Review (Field UR)	Chief Medicaid and CHIP Services Officer	HHSC
Finance Manager	Chief Medicaid and CHIP Services Officer	HHSC
GAVEL	Chief Counsel	HHSC
Genesys	Chief Information Officer	HHSC
Guardianship OnLine Database (GOLD)	Chief Program and Services Officer	HHSC

Data Resource Name	Chief Division	Data Owner
Hearing Appeals Legal System	Chief Counsel	HHSC
HHS Active Directory Forest (AD)	Chief Information Officer	HHSC
HHS Administrative Report and Tracking System- Complaints and Grievances Reports	Chief Program and Services Officer	HHSC
HHS EDG Axon Data Governance	Chief Policy and Regulatory Officer	HHSC
HHS EDG Enterprise Data Catalog	Chief Policy and Regulatory Officer	HHSC
HHS Enterprise Administrative Report and Tracking System (HEART)	Chief Counsel; Chief Operating Officer; Chief Public Affairs Officer; Chief Policy and Regulatory Officer	HHSC
HHS Enterprise Portal	Chief Information Officer	HHSC
HHS Enterprise Single Sign-On	Chief Information Officer	HHSC
HHS Learning Portal	Chief Operating Officer	HHSC
Hospital Utilization Review Application (HUR)	Office of Inspector General	HHSC
Hospital Utilization Review System (HURS)	Office of Inspector General	HHSC
IAMOnline (IAMO)	Chief Information Officer	HHSC
IDD Operations Portal	Chief Medicaid and CHIP Services Officer	HHSC
IDD-BHS Portal	Chief Program and Services Officer	HHSC
Identity Management (IDM)	Chief Information Officer	HHSC
IEE - Identity and Access Management (IAM)	Chief Information Officer	HHSC
iLearn	Chief Program and Services Officer	HHSC
Independent Living Services Data Reporting System (ILDRS)	Chief Program and Services Officer	HHSC

Data Resource Name	Chief Division	Data Owner
Induced Termination of Pregnancy (ITOP)	Chief Policy and Regulatory Officer	HHSC
Infoblox DDI (DDI)	Chief Information Officer	HHSC
Information Management Protecting Adults and Children in Texas (IMPACT)	Chief Information Officer	Department of Family and Protective Services
Integrated Business Information System (IBIS)	Chief Program and Services Officer	HHSC
Integrated Resident Information System (IRIS)	Chief Program and Services Officer	HHSC
Intelligent Retinal Imaging System (IRIS2)	Chief Program and Services Officer	University of Texas Health Services at San Antonio
Internet Quality Improvement and Evaluation System	Chief Policy and Regulatory Officer	U.S. Centers for Medicare & Medicaid Services
Involuntarily Closed Operations	Chief Policy and Regulatory Officer	HHSC
Jenkins Automation Server	Chief Information Officer	HHSC
Legal Case Management System-Contracts	Chief Counsel	HHSC
Legal Services Division Case Management (Salesforce)	Chief Counsel	HHSC
Legislative Tracking System	Chief Public Affairs Officer	HHSC
Lenel OnGuard system (Basis)	Chief Program and Services Officer	MCA
Litigation System	Chief Counsel	HHSC
Long Term Services and Supports (LTSS) Community Services Interest List (CSIL)	Chief Medicaid and CHIP Services Officer	HHSC
Long-term Care Case Scheduler (LTCCS)	Chief Program and Services Officer	HHSC
Long-term Care Online Portal Reporting Database	Chief Medicaid and CHIP Services Officer	HHSC
Long-term Care Provider System (NE)	Chief Program and Services Officer	HHSC

Data Resource Name	Chief Division	Data Owner
Long-term Care Services Intake System (JN/NTK)	Chief Program and Services Officer	HHSC
LTC CSIL Slot Web Service	Chief Program and Services Officer	HHSC
LTSS NTK Services	Chief Program and Services Officer	HHSC
Managed Care Encounter Data	Chief Medicaid and CHIP Services Officer	HHSC
Materials Inventory Management System (MIMS)	Chief Program and Services Officer	HHSC
MAXeb (MAXeb)	Chief Medicaid and CHIP Services Officer	HHSC
MCO/SIU Case Tracker (MCOSIU)	Office of Inspector General	HHSC
Medicaid for the Elderly and People with Disabilities (MEPD)	Chief Program and Services Officer	HHSC
Medicaid Identification Cards System (MED ID)	Chief Medicaid and CHIP Services Officer	HHSC
Medicaid Occupancy Report (MORT)	Chief Policy and Regulatory Officer	HHSC
Medicaid Occupancy Report-Admin (MORT Admin)	Chief Policy and Regulatory Officer	HHSC
Medicaid Occupancy Report-Public (MORT Public)	Chief Policy and Regulatory Officer	HHSC
Medical Record Module (MRM)	Chief Program and Services Officer	HHSC
MediMAR	Chief Program and Services Officer	HHSC
Med-IT Breast & Cervical Cancer (Med-IT)	Chief Program and Services Officer	HHSC
Member Level Service Authorization Data	Chief Medicaid and CHIP Services Officer	HHSC
Mental and Behavioral Health Outpatient Warehouse Client Assignment and Registration System	Chief Program and Services Officer	HHSC
Mental and Behavioral Health Outpatient Warehouse Consumer Analysis Data Warehouse	Chief Program and Services Officer	HHSC

Data Resource Name	Chief Division	Data Owner
Metasys Building Automation System-Denton (Metasys)	Chief Program and Services Officer	HHSC
Modus E-Discovery (Venio/Relativity) (Modus)/Relativity/Venio eDiscovery Platform SaaS Solution – vendor Modus/Repairio	Chief Counsel and Chief Information Officer	HHSC
Monitoring and Tracking System (MATS)	Chief Program and Services Officer	HHSC
myAvatar (myAvatar)	Chief Program and Services Officer	HHSC
Nursing Facility Utilization Review (NFUR)	Office of Inspector General	HHSC
Nursing Facility Utilization Review (NFUR) 3.0 Desktop	Office of Inspector General	HHSC
Nursing Facility Utilization Review (NFUR) 3.0 Sampler	Office of Inspector General	HHSC
Occupational Employment and Wage Statistics	Chief Operating Officer	U.S. Bureau of Labor Statistics
Office of the Inspector General Case Management System (OCMS)	Office of Inspector General	HHSC
Office of the Inspector General Portal (External Facing)	Office of Inspector General	HHSC
Office of the Inspector General Referral System (ORS)	Office of Inspector General	HHSC
Office of the Inspector General Texas Exclusions Database	Office of Inspector General	HHSC
Office of Transformation and Innovation (OTI) Worklist	Chief Policy and Regulatory Officer	HHSC
OKTA (OKTA)	Chief Information Officer	HHSC
One Identity Password Manager (OIPM)	Chief Information Officer	HHSC
OpenText Project and Portfolio Management (OT PPM)	Chief Information Officer	HHSC
PACE Print Shop Job Ordering Data	Chief Operating Officer	HHSC
PASRR Individual Review Monitoring (PIRM)	Chief Medicaid and CHIP Services Officer	HHSC
Patient Billing Module (PBM)	Chief Program and Services Officer	HHSC

Data Resource Name	Chief Division	Data Owner
Payment Authorization Tracking System (PATS)	Office of Inspector General	HHSC
Performance measure data for reporting on the Deaf Blind with Multiple Disabilities, Community Living and Support Services, Home and Community-Based Services, Medically Dependent Children's Program, Texas Home Living, and STAR+PLUS Home and Community-Based Services 1915(c) Medicaid Waiver Programs	Chief Medicaid and CHIP Services Officer	HHSC
Pharmaceutical Rebate Information Management System (PRIMS)	Chief Medicaid and CHIP Services Officer	HHSC
Pickle COLA Multiplier (COLA)	Chief Program and Services Officer	HHSC
Practice Partner Patient Records System Electronic Medical Records	Chief Program and Services Officer	HHSC
Premiums Payable System (MA)	Chief Medicaid and CHIP Services Officer	HHSC
Prevention and Early Intervention Reporting System (PEIRS)	Chief Program and Services Officer	HHSC
Privacy Incident Management (ARC-Privacy)	Chief Counsel	HHSC
Program Integrity Case Tracker (PICT)	Office of Inspector General	HHSC
Provider Enrollment and Credentialing Data	Chief Medicaid and CHIP Services Officer	HHSC
Public and Provider (PP)	Chief Policy and Regulatory Officer	HHSC
Quality Assessment Performance Improvement Reports	Chief Program and Services Officer	HHSC
Quality Assurance and Improvement Datamart (QAI/NQ)	Chief Policy and Regulatory Officer	HHSC
Quality Monitoring Visit (QMVisit)	Chief Medicaid and CHIP Services Officer	HHSC
Quarterly and Annual 1115 Waiver Monitoring Reports: Healthy Texas Women Program	Chief Medicaid and CHIP Services Officer	HHSC

Data Resource Name	Chief Division	Data Owner
Quarterly and Annual 1115 Waiver Monitoring Reports: Texas Healthcare Transformation and Quality Improvement Program	Chief Medicaid and CHIP Services Officer	HHSC
Regulatory Services Online Licensing System: Facility Licensee Registries	Chief Policy and Regulatory Officer	HHSC
Regulatory Services Online Licensing System: Occupational Licensee Registries	Chief Policy and Regulatory Officer	HHSC
ReHabWorks II (RHWII)	Chief Program and Services Officer	HHSC
RSA Archer Continuity of Operations Planning (COOP)	Chief Operating Officer	HHSC
Rule Project Tracking Information (Salesforce)	Chief Policy and Regulatory Officer	HHSC
Rx Online Provider Portal	Chief Medicaid and CHIP Services Officer	HHSC
RXExplorer	Chief Medicaid and CHIP Services Officer	HHSC
RXPert	Chief Medicaid and CHIP Services Officer	HHSC
Sailpoint Identity IQ-Life Cycle Manager (Sailpoint)	Chief Information Officer	HHSC
San Antonio State Hospital Pyxis System	Chief Program and Services Officer	HHSC
Search Texas Child Care	Chief Policy and Regulatory Officer	HHSC
Self Service Portal (SSP) (YourTexasBenefits.com website)	Chief Program and Services Officer	HHSC
Serious Injuries Report	Chief Policy and Regulatory Officer	HHSC
Service A SYSTEM (MG/SAS)	Chief Program and Services Officer	HHSC
Service Authorization System Online (MG/SASO)	Chief Program and Services Officer	HHSC
Service Authorization System Online Case Merge System (SASO CMS)	Chief Program and Services Officer	HHSC
Service Authorization System Online Caseload Realign (HX/CCAD)	Chief Program and Services Officer	HHSC

Data Resource Name	Chief Division	Data Owner
Service Authorization System Online LTC Notifications (SASO LTCN)	Chief Program and Services Officer	HHSC
Service Authorization System Online Prospector (SASO PROSP)	Chief Program and Services Officer	HHSC
Service Authorization System Online Web Services and Rules Engine Dads SAS Redirect (SAS Redirect)	Chief Program and Services Officer	HHSC
SharePoint Online (SPO)	Chief Information Officer	HHSC
Slot Tracking (SLOT)	Chief Program and Services Officer	HHSC
Software Asset Management (SNOW)	Chief Information Officer	HHSC
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Management Information System (WIC Mosaic)	Chief Program and Services Officer	HHSC
SSLC Statewide Performance Indicators	Chief Program and Services Officer	HHSC
SSLC Unusual Incident Report Data	Chief Program and Services Officer	HHSC
SSLC Workers' Compensation Reports	Chief Program and Services Officer	HHSC
SSLC Workforce Fill Rates and Vacancy Rates	Chief Program and Services Officer	HHSC
STAP Telephone Assistance (STAP-TA)	Chief Program and Services Officer	HHSC
State Auditor's Office E-Class (Electronic Classification Analysis System)	Chief Operating Officer	State Auditor's Office
State Hospital Dangerousness Review Board Decision Report	Chief Program and Services Officer	HHSC
State Hospital Forensic Waitlist Report	Chief Program and Services Officer	HHSC
State Hospital Maximum-Security Unit Waiver Report	Chief Program and Services Officer	HHSC
State Hospital Medication Cost Report	Chief Program and Services Officer	HHSC
State Hospital Medication Usage	Chief Program and Services Officer	HHSC

Data Resource Name	Chief Division	Data Owner
State Hospital Non-Formulary Drug Usage	Chief Program and Services Officer	HHSC
State Hospital Patient Discharge Needs Form	Chief Program and Services Officer	HHSC
State Hospital Risk Management Reports	Chief Program and Services Officer	HHSC
State Hospital Sentinel Events and Patient Deaths	Chief Program and Services Officer	HHSC
State Hospital Statewide Performance Indicators	Chief Program and Services Officer	HHSC
State Hospital Trial Competency Evaluation Timelines	Chief Program and Services Officer	HHSC
State Hospital Waitlist Numbers	Chief Program and Services Officer	HHSC
State Hospital Walk-In Numbers	Chief Program and Services Officer	HHSC
State Hospital Workforce Fill Rates and Vacancy Rates	Chief Program and Services Officer	HHSC
State Hospital Workplace Violence Reports	Chief Program and Services Officer	HHSC
State Hospitals Workers' Compensation Reports	Chief Program and Services Officer	HHSC
State Portal (STP)	Chief Program and Services Officer	HHSC
State Supported Living Centers (SSLC) Risk Management Reports	Chief Program and Services Officer	HHSC
Sunquest Healthcare Laboratory System (Sunquest)	Chief Program and Services Officer	HHSC
Surrogate Decision Making (SDM)	Chief Program and Services Officer	HHSC
System of Automated Records (SOAR)	Chief Operating Officer	HHSC
System of Contract Operation and Reporting (SCOR)	Chief Operating Officer	HHSC
TeamMate	Chief Policy and Regulatory Officer	HHSC
Terrell PACS System (TSHPACS)	Chief Program and Services Officer	HHSC
Texas Cares Prescription Drug Savings Program Navigator Portal (TCNP)	Chief Program and Services Officer	HHSC

Data Resource Name	Chief Division	Data Owner
Texas Cares RX Drug Assistant (TCRX)	Chief Program and Services Officer	HHSC
Texas Community Partner Program	Chief Program and Services Officer	HHSC
Texas HHS Enterprise Administrative Report and Tracking System - Long Term Care Regulation Open Records Assignment Tracking System	Chief Policy and Regulatory Officer	HHSC
Texas Integrated Eligibility Redesign System (TIERS)	Chief Program and Services Officer	HHSC
Texas Inventory of Respite Services (TIRS)	Chief Program and Services Officer	HHSC
Texas Medical Transportation System (TMTS)	Chief Medicaid and CHIP Services Officer	HHSC
Texas Review Oversight and Coaching System (TxROCS)	Chief Program and Services Officer	HHSC
Texas Unified Licensure Information Portal (TULIP)	Chief Policy and Regulatory Officer	HHSC
Texas Unified Licensure Information Portal/Waiver Survey and Certification Provider Portal	Chief Policy and Regulatory Officer	HHSC
TexConnect (MCCO Portal)	Chief Medicaid and CHIP Services Officer	HHSC
The Joint Commission Website	Chief Program and Services Officer	The Joint Commission
The Safety Net	Chief Program and Services Officer	HHSC
Thriving Texas Families Database System	Chief Program and Services Officer	HHSC
TIERS Historical Case Report (THCR)	Office of Inspector General	HHSC
Twogether In Texas (TwoIT)	Chief Program and Services Officer	HHSC
Utilization Management Review (UMR)	Chief Medicaid and CHIP Services Officer	HHSC
Vendor Drug Program Data	Chief Medicaid and CHIP Services Officer	HHSC
Verint Recording Integration Servers (V-RIS)	Chief Information Officer	HHSC

Data Resource Name	Chief Division	Data Owner
Verint Workforce Optimization (WFO)	Chief Information Officer	HHSC
VERSA, Regional Administrative Services, and HYLAND OnBase Systems	Chief Policy and Regulatory Officer	HHSC
Virtual Asset Tracker	Chief Operating Officer	HHSC
Virtual Asset Tracker 2 Go (VAT2Go)	Chief Operating Officer	HHSC
VIVIX-S Qxlinks (SH -VIVIX)	Chief Program and Services Officer	HHSC
VUE360Rx	Chief Medicaid and CHIP Services Officer	HHSC
VURV	Chief Operating Officer	HHSC
Waiver Survey and Certification	Chief Policy and Regulatory Officer	HHSC
WellSky Aging and Disability (IMS SPURS)	Chief Program and Services Officer	HHSC
WellSky Data for Office of Area Agencies on Aging	Chief Program and Services Officer	HHSC
WellSky Ombudsman Manager	Chief Public Affairs Officer	HHSC
WIC EBT (WIC EBT)	Chief Program and Services Officer	HHSC
WIC Electronic Benefit Transfer System Solutran Online Account Reporting (SOAR)	Chief Program and Services Officer	HHSC
WIZARDS (KL)	Chief Program and Services Officer	HHSC
Work Flow Management/Task Flow Manager (WLM/TLM)	Chief Program and Services Officer	HHSC
WORx Drug Therapy Management System (WORx)	Chief Program and Services Officer	HHSC
Your Texas Benefits (YTB) (Mobile)	Chief Program and Services Officer	HHSC

J. Does the agency use any analytics software or platforms to collect, store, transform, or analyze agency data?

HHSC uses analytics software and platforms (analytics platforms) to collect, store, transform, and analyze agency data. Exhibit 4: Data Analytics Platforms contains a

list of mission critical data analytics platforms used by the agency and mission critical data resources associated with these analytics platforms.

Health and Human Services Commission

Exhibit 4: Data Analytics Platforms

Analytics Platform	Associated Data Resources
ARCHER	Privacy Incident Management (ARC-Privacy); RSA Archer Continuity of Operations Planning (COOP); Cybersecurity incident management and information security risk management (CISO)
Business Objects - Medicaid Management Information System (MMIS)	Managed Care Encounter Data; Fee for Service Claims Data: Acute Care; Fee for Service Claims Data: Long-term Care
Business Objects (Bus. Obj.)	Managed Care Encounter Data; Annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Participation Report; Fee for Service Claims Data: Acute Care; Fee for Service Claims Data: Long-term care
Cognos	COGNOS Service Authorization System Online; Cognos Program Payment; Cognos Community Services Interest List; Budget Planning and Financial Data Warehouse
Office of Data Analytics and Performance Data Repository (ODAPDR)	Induced Termination of Pregnancy (ITOP); Vendor Drug Program Data; Encounter Data Warehouse (Encounters); Medicaid Identification Cards System (MED ID); Fee for Service Claims Data; Long-term Care; Provider Enrollment and Credentialing Data; Managed Care Encounter Data; Childcare Licensing Automated Support System (CLASS); Texas Integrated Eligibility Redesign System (TIERS); Premium Payment System (PPS); Enrollment Broker (Maximus); Licensure data from the Texas State Board of Dental Examiners, Texas Board of Nursing, Texas Medical Board; Birth Data (Texas Department of State Health Services (DSHS) vital stats)

Analytics Platform	Associated Data Resources
Performance Management & Analytics System (PMAS)	Automated Survey Processing Environment Central Office (HW/ASPEN); Texas Unified Licensure Information Portal (TULIP); Childcare Licensing Automated Support System (CLASS); Client Assignment & Registration System (CARE); Integrated Resident Information System (IRIS); Centralized Accounting & Payroll/Personnel System Human Capital Management (CAPPS HCM); Provider Enrollment and Management System (PEMS); Utilization Review - Master Provider (MC/UR); Texas Integrated Eligibility Redesign System (TIERS); Work Flow Management/Task Flow Manager (WLM/TLM); Eligibility Workload Management System (EWMS); Prevention and Early Intervention Reporting System (PEIRS); VERSA, Regional Administrative Services, and HYLAND OnBase Systems; myAvatar (myAvatar); Centralized Accounting and Payroll/Personnel System (CAPPS) Financials ; Emergency Department Encounter Notification (EDEN); Enrollment Broker Financial Application (MAXeb Finance); Texas Medical Board Licensure; Information Management Protecting Adults and Children in Texas (IMPACT); Analytical Data Store (ADS); Healthcare-Associated Infections (HAI) reporting system; Health Care Regulation (HCR) facility licensing; Regulatory Event Table; Texas WIC Information Network - TXIN (TXIN); Early Childhood Intervention (ECI) Reporting System; Texas Kids Intervention (TKIDS); Texas Medicaid Analytics System - Production (TMASP)
Quality Services Oversight for Clinical Performance Indicators (QSO-CPI)	Clinical Performance Indicator (CPI)-Quality Systems Oversight (QSO) application; Monitoring and Tracking System (MATS)
RehabWorks Reporting System	ReHabWorks II (RHWII); Texas Review Oversight and Coaching System (TxROCS)
State of Texas Automated Information Reporting System (STAIRS)	Provider Enrollment Data; Provider Cost Data; Provider Accountability Data; Random Moment Time Study Data

III. History and Major Events

Historical Overview

In 1983, the Legislature created the Texas Health and Human Services (HHS) Coordinating Council tasked with coordinating services across a myriad of separate agencies. Since then, through several Sunset reviews and ongoing legislative action, the Texas Legislature has consolidated health and human services under the Health and Human Services Commission (HHSC) with an executive commissioner authorized to direct 321 programmatic and support business areas.

To improve client navigation, enhance service coordination, and improve continuity of care, all client services are now within a single Medical and Social Services division, under the leadership of two Chief executives. The Department of State Health Services (DSHS) has a singular public health focus and the Office of Inspector General (OIG) is responsible for combatting fraud, waste, and abuse in HHS programs. In 2017, the legislature separated the Department of Family and Protective Services (DFPS) from HHSC, centralizing regulatory functions within HHSC. For additional information on HHSC's organizational structure see the [HHSC Organizational Chart](#).

Date	Events
1935	Congress passes the Social Security Act establishing Aid to Families with Dependent Children (AFDC), a grant program enabling states to provide cash welfare payments for needy children.
1961	Congress passes Social Security Act amendments, including Title XVI, Medical Services for the Aged, which provides increased grants to states for medical assistance to older adults. As a result, the Legislature passes House Bill (H.B.) 1048, 57th Legislature, Regular Session, the Medical Assistance Act of 1961, establishing the Medical Assistance Program.
1964	Congress passes the Food Stamp Act to provide food assistance and improve nutrition for low-income households.

Date	Events
1965	Congress passes Social Security Act amendments, including adding Title XIX which creates Medicaid as a state-administered program. Congress transforms Medicaid from a narrowly defined program for individuals eligible for cash assistance into a large insurance program with complex eligibility rules. The Social Security Act amendments allow states to waive various Medicaid requirements and implement different service delivery models, eligibility criteria, and benefits. Congress passes the Older Americans Act, creating the federal Administration on Aging and providing federal funding for aging services separate from other social welfare services. The Legislature passes H.B. 3, 59th Legislature, Regular Session, 1965, the Texas Mental Health and Mental Retardation Act which creates community centers. Most Local Intellectual and Developmental Disability Authorities (LIDDAs) are designated as community centers, and the Legislature funds services for individuals with mental health (MH) and Intellectual and Developmental Disability (IDD).
1967	Texas begins participation in the federal Medicaid program.
1972	Congress passes Social Security Act amendments, including Title XVI of the Social Security Act, establishing the Supplemental Security Insurance program to provide federally funded cash assistance to low-income individuals aged 65 and older and those with disabilities.
1973	Texas implements the Food Stamp Program statewide, now known as the Supplemental Nutrition Assistance Program (SNAP).
1974	The United States Department of Agriculture (USDA) implements a Special Supplemental Nutrition Program for Women, Infants and Children (WIC) pilot program. Texas participates in the pilot and opens its first WIC clinic in Montgomery County.

Date	Events
1975	Congress passes the Education for All Handicapped Children Act which includes the right for children with disabilities to a free and appropriate education regardless of their disability. This Act creates the foundation for states to create Early Childhood Intervention (ECI) programs. In 1990, Congress renames the Act the Individuals with Disabilities Education Act. Congress passes an amendment to the National School Lunch Act and Child Nutrition Act of 1966, establishing WIC as a permanent program.
1977	The United States Department of Health, Education and Welfare, now known as the United States Department of Health and Human Services (DHHS), creates the Health Care Financing Administration (HCFA) to oversee the Medicare and Medicaid programs. HCFA is later renamed the Centers for Medicare and Medicaid Services (CMS).
1981	Texas settles the RAJ v. Miller class action lawsuit. The lawsuit, first filed in 1974, challenged the conditions and treatment of patients in state mental hospitals. Pursuant to the settlement Texas Department of Mental Health and Mental Retardation (TDMHMR) implemented reforms to improve the quality of life and care for residents. The Legislature passes Senate Bill (S.B.) 630, 67th Legislature, Regular Session, 1981, and creates the ECI program, which the Interagency Council on Early Childhood Intervention administers.
1983	The Legislature passes H.B. 1238, 68th Legislature, Regular Session, 1983 and creates the Texas HHS Coordinating Council to coordinate HHS agencies and foster development of a more effective delivery system. In 1974, Texas is challenged over the adequacy of care in several of its state operated facilities for individuals with intellectual disabilities. A settlement was approved in 1983. As a result of the <i>Lelsz v. Kavanagh</i> lawsuit, TDMHMR shifted its focus from serving this population primarily in institutional-based settings to finding more community placements for individuals with intellectual disabilities.

Date	Events
1984	Texas Medicaid begins the Medically Dependent Children's Program (MDCP), a 1915(c) waiver program that provides home and community-based services (HCBS) to children and youth aged 20 and younger as a cost-effective alternative to a nursing facility.
1985	Texas Medicaid begins Home and Community-based Services (HCS), a 1915(c) waiver program that provides individualized services to people of all ages who qualify for Intermediate Care Facility for Individuals with an Intellectual Disability or related condition (ICF/IID) level of care, yet live in their family's home, their own home, or other settings in the community as an alternative to living in an ICF/IID.
1986	The Omnibus Budget Reconciliation Act of 1986 requires states to cover emergency care services, including labor and delivery, for undocumented immigrants and individuals who are experiencing homelessness; and increases access to Medicaid services for pregnant women and infants.
1987	The Omnibus Budget Reconciliation Act of 1987 further extends Medicaid coverage and mandates enhanced nursing facility standards including creation of the Preadmission Screening and Resident Review (PASRR) process – whereby all nursing facility clients must be screened for mental illness, intellectual disability, or related conditions.
1989	The Omnibus Budget Reconciliation Act of 1989 prohibits states from limiting the amount, duration, and scope of state plan services to children in the Medicaid program. The Legislature passes S.B. 482, 71st Legislature, Regular Session, 1989, creating the Options for Independent Living program which helps older individuals with limited self-care capabilities remain home and avoid institutionalization.

Date	Events
1991	The Legislature passes S.B. 379, 72nd Legislature, Regular Session, 1991, abolishing the Texas HHS Coordinating Council. Texas implements the Frail Elderly 1929(b) attendant program, now known as Community Attendant Services, allowing individuals with income up to 300 percent of Supplemental Security Income limit to receive services. Texas Medicaid begins Community Living Assistance and Support Services (CLASS), a 1915(c) waiver program, to provide home and community-based services. The Legislature passes H.B. 7, 72nd Legislature, First Called Session, 1991, creating HHSC overseeing 12 Texas HHS agencies: ● Texas Department on Aging ● Texas Commission on Alcohol and Drug Abuse ● Texas Commission for the Blind ● Texas Commission for the Deaf and Hearing Impaired ● Interagency Council on Early Childhood Intervention ● Texas Department of Health (TDH) ● Department of Human Services (DHS) ● Texas Juvenile Probation Commission ● TDMHMR ● Texas Department of Protective and Regulatory Services (PRS) ● Texas Rehabilitation Commission ● Texas Youth Commission (TYC) Each agency has a separate governing board and HHSC provides general oversight. HHSC is designated as the state agency to administer Medicaid. Investigations of abuse and neglect in TDMHMR facilities transfer from TDMHMR to PRS. The bill creates the determination of intellectual disability process.

Date	Events
1993	The Legislature passes H.B. 810, 73rd Legislature, Regular Session, 1993, separating TYC from the HHS Enterprise. The Legislature passes H.B. 1510, 73rd Legislature, Regular Session, 1993, transferring adult protective services and childcare licensing from DHS to PRS. The bill also transfers long-term care regulation and investigation of abuse and neglect in facilities from TDH to DHS. The bill further transfers preventive health services programs, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, family planning, purchased health services program, and indigent health care program from DHS and the genetic screening and counseling program from TDMHMR to TDH. The Legislature passes House Concurrent Resolution 74, 73rd Legislature, Regular Session, 1993, directing DHS to seek a Medicaid waiver to expand services administered by the Options for Independent Living programs. The <i>Frew</i>¹ lawsuit is filed alleging that the EPSDT program did not meet the requirements of the Medicaid Act. The lawsuit was settled by consent decree in 1995, and 11 Corrective Action Orders (CAOs) were entered in 2007.
1994	Texas Medicaid begins its first Medicaid managed care program in Travis County and the Tri-County Area (Chambers, Jefferson, and Galveston counties), State of Texas Access Reform (STAR) for low-income families, children without disabilities, and pregnant women. HHSC implements the Texas Electronic Benefit Transfer (EBT) system to electronically distribute SNAP benefits.

¹ Originally filed as Jeneva Frazar, as next friend of her minor children, et al. v. Richard Ladd, HHSC Commissioner, in his official capacity, et al., United States District Court, Eastern District of Texas, Paris Division, Civil Action No. 3:93-CV-00065.

Date	Events
1995	Texas Medicaid begins the Deaf Blind with Multiple Disabilities (DBMD) 1915(c) waiver program to provide home and community-based services (as an alternative to residing in an ICF/IID) to people of all ages who have deaf blindness or have a condition that will result in deaf blindness and who have an additional disability. The Legislature passes H.B. 1863, 74th Legislature, Regular Session, 1995, directing HHSC to operate a cash assistance program that provides services to help families become self-dependent. Texas received waiver approval to transition the existing Aid for Families with Dependent Children (AFDC) cash assistance program to a modified Temporary Assistance Needy Families (TANF) program (referred to as Achieving Change for Texans (ACT) demonstration waiver).
1996	Congress passes the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, ending welfare as an entitlement program and creating the federal TANF program. PRWORA delinks TANF cash assistance from Medicaid and requires households to separately apply for both programs.
1997	Texas implements the TANF program under the federal waiver and per the requirements of H.B. 1863. Congress passes the Balanced Budget Act of 1997 creating a State Children's Health Insurance Program (CHIP) and allows states to require most Medicaid-eligible individuals to enroll in managed care plans.
1998	Texas Medicaid begins the STAR+PLUS managed care pilot in the Harris service area.

Date	Events
1999	As a result of 1998-99 Sunset Commission review, the Legislature passes H.B. 2641, 76th Legislature, Regular Session, 1999, increasing HHSC's authority to direct the operations of HHS agencies, including strengthening contract oversight, information resources planning, and regional management. Filed in 1995 and settled 1999, the United States (U.S.) Supreme Court decision <i>Olmstead v. L.C.</i>, requires states serve individuals with intellectual disabilities or serious mental illnesses in community-based settings for long-term services and supports instead of institutions, when such services are appropriate and can be reasonably accommodated. As a result, Texas Medicaid expands coverage for a broad range of long-term services and supports.
2000	Texas begins participating in CHIP for children and youth who do not qualify for Medicaid due to family income.
2001	The Legislature passes S.B. 368, 77th Legislature, Regular Session, 2001, establishing the family-based alternatives (FBA) project, which provides FBA services for children with disabilities who live in institutions. The Promoting Independence Initiative, which includes the "Money Follows the Person" demonstration, was established in response to the US Supreme Court ruling <i>Olmstead v. Zimring</i>.
2002	Governor Rick Perry signs Executive Order RP 13, establishing the Promoting Independence Plan. The plan outlines a structure for HHSC to provide a system of services and supports that foster independence for people with disabilities so they may live in their chosen communities.

Date	Events
2003	The Legislature passes H.B. 2292, 78th Legislature, Regular Session, 2003, consolidating the 12 HHS agencies into five including HHSC and four agencies under HHSC oversight: • Department of Aging and Disability Services (DADS) • Department of Assistive and Rehabilitative Services (DARS) • DFPS • DSHS The HHSC executive commissioner replaces stand-alone boards and holds rule and policymaking authority over the five HHS agencies. H.B. 2292 mandated a centralized system of administrative support services for all health and human services agencies and made the performance of those services the responsibility of HHSC. To effect this change, the Texas Legislature transferred authority for all administrative support services to HHSC from the agencies abolished. H.B. 2292 creates the OIG and directs OIG to investigate HHS fraud, waste, and abuse. The Governor separately appoints the Inspector General.
2004	Texas Medicaid begins Texas Home Living (TxHmL), a 1915(c) waiver program, to provide selected services and supports to people with IDD who live in their own home or their family's home.
2005	Congress passes the Deficit Reduction Act of 2005 which establishes the Aging and Disability Resource Centers (ADRCs) with a grant award from CMS and the U.S. Administration on Aging.
2007	Texas Medicaid begins the Medicaid Women's Health Program after federal approval of the 1115 waiver.

Date	Events
2008	Congress passes the Mental Health Parity and Addiction Equity Act of 2008. HHSC implements the substance use disorder benefit and integrates behavioral health into Medicaid managed care including mental health benefits. Congress changes the Food Stamp Program to SNAP. Texas Medicaid begins the STAR Health managed care program for children in foster care.
2009	The Legislature passes S.B. 643, 81st Legislature, Regular Session, 2009, renaming state schools to State Supported Living Centers (SSLCs), creating the Office of Independent Ombudsman for SSLCs, and putting in place a framework for protection and care of individuals with IDD residing in SSLCs.
2010	Congress passes the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, together referred to as the Affordable Care Act (ACA).
2012	Texas Medicaid expands STAR statewide, bringing almost 80 percent of the Medicaid population into managed care. Pharmacy benefits are carved into all managed care programs, and inpatient hospital benefits are carved into STAR+PLUS. Children’s Medicaid Dental Services program is implemented statewide.
2014	Texas Medicaid begins the STAR+PLUS HCBS program, an 1115 waiver, to provide a cost-effective alternative to living in a nursing facility for adults aged 21 and older who have disabilities or who are elderly. HHSC establishes the Chief Privacy Officer as a distinct position within the HHS system.

Date	Events
2015	The Office of the Governor’s Strike Force issues a report focused on the OIG and HHSC contracting, organization, management, and leadership. HHSC expands STAR+PLUS statewide and non-dual eligible clients in IDD waivers and nursing facility benefits are carved into STAR+PLUS, bringing about 87 percent of the Medicaid population into managed care. The Dual Demonstration program launches a fully integrated managed care model for people who are dually eligible for Medicare and Medicaid. Mental health services are carved into managed care. HHSC hires its first Chief Operating Officer (COO). As a result of the 2014-15 Sunset Commission review, the Legislature passes S.B. 200, 84th Legislature, Regular Session, 2015, consolidating the five HHS agencies into three including HHSC and the two agencies under HHSC oversight: • DFPS; and • DSHS. HHSC establishes the HHS Ethics Office as a distinct office within the HHS system.

Date	Events
2016	HHSC submits a series of HHS transition plans to the Texas Legislative Oversight Committee (TLOC) approach to restructuring HHS, including functionally aligning organizational areas including DSHS and DFPS; and transitioning staff and functions from DADS and DARS to HHSC as these agencies sunset. HHSC implements transformation Phase One (of two) which includes the following: ● Further consolidates administrative support services. ● Abolishes DARS and transfers vocational rehabilitation programs and the Criss Cole Rehabilitation Center to the Texas Workforce Commission, and client services programs to HHSC. ● Transfers DADS client services programs to HHSC and creates the Office of Aging Services from the DADS Volunteer and Community Engagement Office. ● Transfers certain DSHS regulatory programs to HHSC and the Texas Department of Licensing and Regulation and abolishes several other regulatory programs. ● Abolishes the five HHS agency Councils. ● Consolidates the Internal Audit divisions from DADS and DARS with the HHSC Internal Audit division. ● Creates the Medical and Social Services Division with departments for: ▶ Medicaid and CHIP Services ▶ Access and Eligibility Services ▶ Health, Developmental, and Independence Services ▶ Intellectual and Developmental Disability and Behavioral Health Services HHSC develops Support Services Agreements (SSAs) to ensure that HHS programs receive adequate support and provide a means to evaluate delivery and performance of these services.
2017	Texas Medicaid begins STAR Kids statewide, bringing about 92 percent of the Medicaid population into managed care. This managed care program is for children and youth with disabilities.

Date	Events
	HHSC holds the first meeting of the newly created HHS Executive Council to advise the executive commissioner. HHSC implements transformation Phase Two which includes the following: • Creates the Chief Program and Services Officer (CPSO) position overseeing services for women, children and families; and individuals with disabilities and older adults. • Transfers state hospitals from DSHS to HHSC. State Hospitals and SSLCs are moved under the HHSC State Operated Facilities division, which is under the purview of CPSO and re-named Health and Specialty Care System. • Establishes the Chief Policy Office to oversee the Office of Transformation and Innovation, Office of Performance, and Office of Policy and Rules. • Abolishes DADS and transfers its regulatory programs and SSLCs to HHSC. • Transfers DSHS' WIC program to HHSC. • Transfers DSHS' Health Care Regulation to HHSC and other select regulatory programs to the Texas Department of Licensing and Regulation. • Further consolidates administrative support services such as information technology and legal services. • Consolidates the HHSC Internal Audit division with the DSHS Internal Audit division, creating the HHS Internal Audit Division. The Legislature passes H.B. 5, 85th Legislature, Regular Session, 2017, separating DFPS from HHS with childcare regulatory functions remaining at HHSC, and child protective services investigative functions remaining at DFPS. The agencies execute a memorandum of understanding, and an interagency contract for payment of ongoing administrative support provided by HHSC to DFPS. The Legislature passes H.B. 2, 85th Legislature, Regular Session, 2017, outlining a three-phased approach to expand, renovate, and transform HHSC State Hospital system. HHSC begins the Quality Incentive Payment Program, a state directed payment program to improve quality of care for Medicaid managed care clients in nursing facilities.

Date	Events
	HHSC begins a pilot of the Uniform Hospital Rate Increase Program (UHRIP), a state directed payment program to increase Medicaid hospital reimbursement rates and improve quality of care for Medicaid clients.
2018	Texas Medicaid carves the Medicaid for Breast and Cervical Cancer program into STAR+PLUS. The Regulatory Services Division is transferred to the newly re-named Chief Policy and Regulatory Officer (CPRO) to provide greater separation and independence in regulatory decision making. HHSC creates the Compliance and Quality Control (CQC) unit under the COO to ensure integrity in contracting, procurement, and monitoring processes. HHSC expands UHRIP statewide.
2019	The Legislature passes H.B. 1501, 86th Legislature, Regular Session, 2019, creating the Texas Behavioral Health Executive Council and assumes the regulation of psychologists, marriage and family therapists, and professional counselors.
2020	On January 31, 2020, the DHHS Secretary declares the COVID-19 public health emergency (PHE) in the United States. On March 13, 2020, the President declares COVID-19 a national emergency. These declarations authorize the DHHS Secretary to waive or modify certain Medicare, Medicaid, and CHIP eligibility requirements. The PHE allows continuous Medicaid coverage for clients. CMS approves a 1115 Demonstration Waiver for the Healthy Texas Women (HTW) program and HHSC begins receiving federal funds in February 2020. HHSC implements HTW Plus which provides postpartum benefits covering outpatient services for major physical and mental health conditions that contribute to maternal morbidity and mortality in the postpartum period, as well as chronic conditions, such as asthma and diabetes. HHSC streamlines its executive leadership structure and clarifies functional responsibilities.

Date	Events
	• HHSC creates the Chief Public Affairs Officer (CPAO), and consolidates Government and Stakeholder Relations, Communications, and Office of the Ombudsman under CPAO. • HHSC eliminates the Financial Services Deputy Executive Commissioner position and consolidates oversight of all financial functions under the Chief Financial Officer. This position is elevated to chief position and reports to the executive commissioner. • HHSC moves CQC from COO to CPRO to provide greater separation and independence from Procurement & Contracting Services (PCS). • HHSC submits an application to renew the Texas Medicaid Quality Improvement and Transformation 1115 Waiver to seek continuation of Medicaid Managed Care and the Uncompensated Care Program on an expedited basis in November 2020 to ensure stability for Medicaid providers and clients through the COVID-19 Public Health Emergency.
2021	CMS approves the Texas Medicaid Quality Improvement and Transformation 1115 Waiver to continue Texas' Medicaid Managed Care models for a 10-year period. In addition to authority to continue Managed Care, the renewal includes: • Continuation of the Uncompensated Care program; • Creation of the Public Health Provider Charity Care Program, to reimburse uncompensated charity care costs for local behavioral health and local public health departments; and • A framework for negotiating directed payment programs. In April 2021, CMS notifies HHSC that they are rescinding the approval of the 1115 Waiver that had been authorized in January. Texas sues to require reinstatement of the waiver and prevails in being granted a preliminary injunction. The Medicaid and CHIP Services (MCS) division, led by the State Medicaid Director is elevated to a Chief Medicaid and CHIP Services Officer (CMCSO) position reporting to the executive commissioner. Together, CPSO and CMCSO make up the HHSC Medical and Social Services division. HHSC creates the Office of Disability Services Coordination to oversee implementation of the Promoting Independence Plan. The Delivery System Reform Incentive Payment Program (DSRIP) ends, as

Date	Events
	required by the 1115 Waiver Special Terms and Conditions. HHSC carves in non-emergency medical transportation (NEMT) services for Medicaid members to managed care.
2022	CPSO realigns programs serving similar populations to streamline service delivery, creating the new Family Health Services (FHS) and Community Services (CS) divisions. FHS focuses on building stronger families by serving women, children, and families through a range of health and social services programs. CS serves people who are aging, have a disability, or are providing respite as family caregivers. CMS withdraws their prior attempted rescission of the 1115 Waiver and approves the creation of five directed payment programs that serve as the previously approved transition plan for the end of DSRIP. The programs are: • The Quality Incentive Payment Program; • The Comprehensive Hospital Increased Reimbursement Program; • The Texas Incentives for Physicians and Professional Services Program; • The Directed Payment Program for Behavioral Health Services; and • The Rural Access to Primary and Preventives Services Program. Construction of the John S. Dunn Behavioral Sciences Center in Houston’s Texas Medical Center finishes with the first unit opening in April 2022.
2023	Congress passes the Consolidated Appropriations Act, making changes to Medicaid and CHIP including requiring states to provide 12 months of continuous eligibility for children aged 18 and younger in these programs. The Act delinks requirements for Medicaid continuous coverage from the COVID-19 PHE. Continuous Medicaid coverage ends on March 31, 2023. The DHHS Secretary ends the COVID-19 PHE on May 11, 2023. The Legislature passes S.B. 24, 88th Legislature, Regular Session, 2023 directing HHSC to transfer the Prevention and Early Intervention (PEI) division from DFPS to HHSC. The Legislature passes H.B. 728, 88th Legislature, Regular Session, 2023, establishing the Statewide Interagency Aging Services Coordinating Council to ensure a strategic approach to aging services statewide. HHSC completes construction of the replacement Rusk State Hospital in May 2023. The new state hospital adds a maximum-security unit with 100 beds,

Date	Events
	up from the previous 40 beds, a non-maximum-security unit with 100 beds, and an administration building. HHSC completes Kerrville State Hospital renovations and adds 70 maximum-security beds to the facility.
2024	HHSC expands postpartum coverage for Medicaid by an additional 10 months, going from two months to 12 months for eligible women as directed by the Legislature. HHSC also implemented the extension of continuous Medicaid coverage for children from six months to 12 months. In April 2024, HHSC completes the 12-month Medicaid enrollment unwind. In April 2024, HHSC completes construction of the San Antonio State Hospital and in May 2024, HHSC completes construction of the Austin State Hospital. In October 2024, HHSC elevates the Information Technology Deputy Executive Commissioner to a Chief Information Officer position (CIO) and makes the CIO a direct report to the executive commissioner. On September 1, 2024, HHSC completes the transfer of PEI program from DFPS to HHSC.

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IV. Policymaking Structure

A. Complete the following table to provide information on members of your policymaking body.

Health and Human Services Commission

Exhibit 5: Policymaking Body

Member Name	Current Term / Appointment Dates / Appointed By	Previous Terms Served	Qualification	City
Cecile Erwin Young	Indefinite / August 14, 2020 / Governor Greg Abbott	June 2018-October 2018 (Acting)	Health and Human Services (HHS) Executive Commissioner	Austin

B. Describe the primary role and responsibilities of your policymaking body.

Appointed by the governor, with the advice and consent of the Senate, the executive commissioner is the rulemaking and policymaking authority for the Health and Human Services (HHS).

A unique feature of HHS is the HHSC Executive Council (Council) established by [Texas Government Code Section 523.0101](#). It receives public input and advises the executive commissioner. The Council reviews policies related to the operation of HHS and its programs, and seeks and receives public comment on:

- Proposed rules;
- Recommendations of advisory committees established under Title 1, Texas Administrative Code, Chapter 351, Subchapter B;
- Legislative appropriations requests or other documents related to the appropriations process;
- The operation of HHS programs; and
- Other items the executive commissioner determines appropriate.

C. How is the chair selected? Not applicable.

D. List any special circumstances or unique features about your policymaking body or its responsibilities.

The executive council is not a “governmental body” as defined by the Open Meetings Act, exempting it from requirements that do not appropriately apply, given that the Council does not deliberate or make decisions as a group but operates as a committee formed to take public input. The executive commissioner retains all decision-making authority. Its current configuration consists of the HHSC’s Chief Medicaid and CHIP Services Officer (CMCSO), Chief Program and Services Officer (CPSO), Chief Policy and Regulatory Officer (CPRO), Chief Operating Officer (COO), HHS Inspector General (IG), Commissioner of the Texas Department of State Health Services (DSHS), and Commissioner of the Texas Department of Family and Protective Services (DFPS).

E. In general, how often does your policymaking body meet? How many times did it meet in fiscal years 2020 through 2024? Explain if the policymaking body met in-person or virtually during this time.

Although not a policymaking body, the Executive Council meets regularly. Until June 2025, the Council met at least quarterly. Between 2020 through 2024 the Council met 20 times.

Ensuring the timely processing and adoption of rules, especially those implementing legislation, is a top priority of the agency.

Beginning in July 2025, Executive Council meetings will be held monthly. In 2025, Executive Council will meet eight times.

Monthly meetings will enable the agency to publish proposed rules in the *Texas Register* as soon as they are ready. This will result in a more efficient rulemaking process, enabling the agency to implement legislation and other priorities more quickly, while ensuring the public will still be able to provide comments on proposed rules at these meetings.

The Council held hybrid meetings with members attending virtually and in-person.

F. Does the policymaking body broadcast and archive its meetings?

The Council broadcasts and archives meetings on the [Health and Human Services Commission Executive Council | Texas Health and Human Services](#) website. Meeting

broadcasts are available from March 2021 through the most recent Council meeting.

G. Briefly describe all the training the members of the agency's policymaking body receive. How often do members receive this training or updated materials?

New Member Orientation includes ethics and open meetings training, and an overview of authorizing statute, Council rules, and what to expect in Council meetings. Council members also receive HHS Executive Council Guidelines.

Training materials are updated as needed, pursuant to updates in rule, statute, or other agency guidelines.

H. What information is regularly presented to your policymaking body to keep them informed about the agency's operations and performance?

The Council's meeting agendas may include:

- Executive commissioner's welcome and remarks;
- Chief officers' remarks;
- DSHS commissioner's remarks;
- DFPS commissioner's remarks;
- Office of Inspector General quarterly report;
- Agency updates;
- Rule proposals;
- Public testimony;
- Advisory committee recommendations; and
- Legislative Appropriations Requests.

I. How does your policymaking body obtain input from the public regarding issues under the agency's jurisdiction? How is this input incorporated into the operations of your agency?

Open Meetings: Seeking public input and stakeholder feedback is a key function for the Council, advisory committees, and task forces.

Executive Council: The Council is focused on hearing the concerns and interests of stakeholders. Public testimony on rule proposals and advisory committee

recommendations is a standing agenda item. Input is considered and incorporated into agency rules or operations upon recommendation from area chiefs to the executive commissioner or upon executive commissioner direction.

Advisory Committees and Task Forces: Numerous advisory committees and task forces make recommendations to the executive commissioner, the Governor and the legislature. A listing of all advisory committees follows in Section J.

J. If your policymaking body uses subcommittees, advisory committees, councils, or other groups to carry out its duties, fill in the following table. See Exhibit 6 Example. For any advisory committees established in statute, please note the date of creation for the committee as well as the abolishment date as required by Texas Government Code, Section 2110.008.

In addition, please attach a copy of any reports your agency filed under Texas Government Code, Section 2110.007 regarding an assessment of any statutory advisory committees as Attachment 28.

In addition to Exhibit 6 provided below, the [Advisory Committees | Texas Health and Human Services](#) webpage provides information about each of the HHS advisory committees.

Health and Human Services Commission

Exhibit 6: Subcommittees and Advisory Committees

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
Aging and Disability Resource Center (ADRC) Advisory Committee	Size: 13 members, no more than 15. Composition: - Organizations that provide services to individuals served by the ADRC program. - Governmental and non-governmental agencies effected by the ADRC program. - At least two individuals who represent the populations served by the ADRC program, including individuals who have a disability, or a chronic condition requiring long-term services and supports. - Two members who are nominated by the ADRC Coalition. How appointed: By executive commissioner appointment.	The committee assists HHSC in developing and implementing an ARDC program; advises HHSC on ADRC program and policy development, including designing and operating ADRCs; obtaining stakeholder input; and achieving the goals and vision of the ADRC program. - Support HHSC to develop and implement the mission, vision, and values statements to support the ADRC and the “no wrong door” system of access to long-term services and supports. - Assist HHSC to identify ADRC target populations and establish meaningful goals and objectives for those populations. - Assist HHSC to develop and implement a service delivery model supported by appropriate administrative and management information systems and information technology resources.	Texas Government Code, Section 523.0201 40 Texas Administrative Code, Section 89.3	Creation date: 03/20/2016 Abolishment date: 03/01/2026

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
		- Assist HHSC to position ADRCs to take advantage of current and future initiatives. - Support HHSC to use ADRCs as a point of access to long-term services and supports.		
Aging Texas Well Advisory Committee	Size: 14 members; 11 voting members, 7 non-voting ex officio members. Composition: - A representative from an Area Agency on Aging. - A representative from an ADRC. - Nine representatives from any of the following groups: - The academic community. - Advocates for older adults, including family and/or caregivers. - Older adults. - Faith-based organizations. - Non-profit organizations. - The aging service-delivery network. - Providers from a residential setting. - Providers from a community setting. - Providers serving persons with disabilities. - Providers of community services.	The committee advises and makes recommendations to HHSC and state leadership, including the Legislature, the Governor, and other state agencies, on the following matters: - The Aging Texas Well initiative. - The Aging Texas Well Strategic Plan. - State government readiness to meet the needs of an aging population. - Increased community preparedness for an aging population in Texas. - State policies, concentrating on critical aging trends affecting older Texans. - State agency legislative appropriation requests. The Committee makes recommendations through: - The Aging Texas Well Strategic Plan.	Executive Order RP-42 Texas Government Code, Section 523.0201 1 Texas Administrative Code, Section 351.847	Creation date: 04/01/2005 Abolishment date: 03/01/2026

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	Non-voting or ex officio members are employees of other state agencies who are designated by their agency heads. Agencies may include: • DSHS • Department of Housing and Community Affairs • Texas Workforce Commission (TWC) • Department of Public Safety • Department of Transportation • Higher Education Coordinating Board • DFPS How appointed: By executive commissioner appointment.	• Policy briefs and documents disseminated to state leadership and the public. • Member testimony to the Council and the Legislature. • Written reports submitted to the executive commissioner, Council, and the legislature. With the advice of the committee, HHSC reviews and/or comments on state policies, concentrating on current critical trends including but not limited to: • Improving services and supports for informal caregivers. • Promoting ways to increase evidence-based disability and disease prevention activities. • Increasing the recruitment and retention of health care providers trained in geriatrics. • Improving the provision of services and supports to persons with intellectual and developmental disabilities and who are aging. • Reviewing options to expand the mobility of older adults through affordable, accessible, and integrated transportation services.		

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
		- Improving the provision of behavioral health services and supports to older persons. - Reviewing federal changes in health care policy, particularly the impact of the Medicare D prescription drug benefit, on the ability of older Texans to access medications.		
Behavioral Health Advisory Committee	Size: 19 members Composition: - One adult who received, or is receiving, services for mental health or co-occurring mental health and substance use issues. - One adult who received, or is receiving, services for substance use or co-occurring mental health and substance use issues. - One youth/young adult who received, or is receiving, services for mental health, substance use, or co-occurring mental health and substance use issues. - One family representative of someone who has received, or is receiving services for mental health, substance use, or co-occurring mental health and substance use issues.	The committee advises the executive commissioner on mental health and substance use disorder services in Texas. Per federal law governing the Substance Abuse and Mental Health Services Administration (SAMHSA) block grant, the committee: - Reviews the combined Mental Health and Substance Abuse Block Grant Plan and makes recommendations to HHSC. - Serves as advocates for adults and children with substance use disorders, serious mental illness, serious emotional disturbance, and other individuals with substance use issues, mental illnesses, or emotional problems. - Monitors, reviews, and evaluates at least once each	42 United States Code, Section 300x-3 Texas Government Code, Section 523.0201 1 Texas Administrative Code, Section 351.807	Creation date: 04/01/2016 No abolishment date set.

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	• One parent of a child who has received, or is receiving, services for serious emotional disturbance. • One certified peer provider. • One representative nominated by the Texas Council of Community Centers. • One representative nominated by the Association of Substance Abuse Programs. • Two independent community behavioral health service providers, one of which provides services to families. • Two behavioral health advocates or representatives of behavioral health advocacy organizations. • One representative from a faith-based community organization. • One representative of a managed care organization that contracts with HHSC. • Two representatives of local government. • One representative from a federally recognized Native American tribe located in Texas (Alabama-Coushatta Tribe of Texas, The Kickapoo Traditional Tribe of Texas, or Ysleta Del Sur Pueblo). • Up to two additional members who have demonstrated an interest in mental and substance use	year the allocation and adequacy of behavioral health services within the state. (42 United States Code, Section 300x-3(b)). • Per rule: The committee considers and makes recommendations to the executive commissioner consistent with the committee's purpose. Per bylaws: The committee provides recommendations regarding the adequacy of Texas behavioral health services and programs as described below: • The promotion of cross-agency coordination, state/local and public/private partnerships in the funding and delivery of behavioral health services. • The promotion of data-driven decision-making. • The prevention of behavioral health issues and the promotion of behavioral health wellness and recovery. • The integration of mental health and substance use disorder services in prevention, intervention,		

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	disorders health systems and a working knowledge of mental and substance use disorder health issues. Non-voting, ex officio members: • A member of the Statewide Behavioral Health Coordinating Council, representing state agencies providing behavioral health services or funding. How appointed: By executive commissioner appointment.	treatment, and recovery services and supports. • The integration of behavioral health services and supports with physical health service delivery. • Access to services and supports in urban and rural areas of the state. • Access to services and supports to special populations.		
Board for Evaluation of Interpreters (BEI) Advisory Committee	Size: 7 members. Composition: • At least two members who are deaf, a consumer of interpreting services, and demonstrates knowledge of the field of interpreting and linguistics and has a unique understanding for the demographics and dynamics of Texas' deaf community. • At least one member who is hearing and holds a valid BEI Advanced or Master certificate. • At least one member who has effectively engaged in the profession of interpreting for at least three of the immediate past five years.	The committee advises the executive commissioner on administering the interpreter certification program and developing the qualifications for each level of certification based on proficiency. Per bylaws, the committee advises HHSC on: • The administration of the statewide sign language interpreter certification program, including assisting Office of Deaf and Hard of Hearing Services (ODHHS) with the evaluation and certification of sign language	Texas Human Resources Code, Section 81.007 (b) 26 Texas Administrative Code, Section 360.207 1 Texas Administrative Code, Chapter 351, Division 2	Creation date: 04/02/2015 No abolishment date set.

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	How appointed: By executive commissioner appointment, or designee.	interpreters for Texans who are deaf and hard of hearing. • Developing, subject to ODHHS's approval, qualifications for each of several levels of certification based on proficiency. • Complaints, as identified by ODHHS, filed against BEI-certified interpreters and providing recommendations on revoking or suspending a certificate or placing a certificate-holder on probation for a violation of a statute, rule, or departmental policy. • Local, state, and national trends in the interpreting profession. The committee submits recommendations on: • Rules and policies as proposed by HHSC. • Certification levels and the appropriateness of various scenarios for each certification level. • Complaints and whether ODHHS should propose disciplinary actions. • ODHHS recruitment efforts to fill the state-wide shortage of		

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
		qualified and certified interpreters.		
Chronic Kidney Disease Task Force	Size: 24 members; 20 voting members, 4 non-voting ex-officio members. Composition: • One family practice physician. • One pathologist. • One nephrologist from a nephrology department of a state medical school. • One nephrologist in private practice. • One representative from the National Kidney Foundation. • One representative from the Texas Kidney Foundation. • One representative from the South Plains Kidney Foundation of West Texas. • One representative from the Texas Renal Coalition. • One representative from the commission's Kidney Health Care Program. • One representative of an insurer that issues a preferred provider benefit plan or of a health maintenance organization. • One representative of clinical laboratories.	The task force advises the governor on: • Implementation of the state's cost-effective plan for prevention, early screening, diagnosis, and management of chronic kidney disease for the state's population through national, state, and local partners. • Educating health care professionals on the use of clinical practice guidelines for screening, detecting, diagnosing, treating, and managing chronic kidney disease, its comorbidities, and its complications based on the Kidney Disease Outcomes Quality Initiative Clinical Practice Guidelines for Chronic Kidney Disease.	Texas Health and Safety Code, Section 83.002	Creation date: 09/01/2019 No abolishment date set.

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	• One representative of private renal care providers. • One pediatrician in private practice. • One kidney transplant surgeon. • One primary care physician. • One licensed and certified renal dietitian. • One certified nephrology nurse. • One representative from a health care system. • One representative of the commission whose duties involve the state Medicaid program. • One end stage renal disease expert. Non-voting, ex-officio members: • Two members of the senate are appointed by the lieutenant governor. • Two members of the house of representatives are appointed by the speaker of the house of representatives. How appointed: By Governor, Lieutenant Governor, and Speaker of the House.			
Drug Utilization Review (DUR) Board	Size: 21 members. Composition: At least 17 physicians and pharmacists providing services across the entire population of Medicaid	The board develops recommendations for preferred drug lists, suggests restrictions or clinical prior authorizations on prescription drugs, recommends	42 United States Code, Section 1396r-8 42 Code of	Creation date: 02/09/2016 No

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	recipients representing at least one of each of the following physician types: • Provider of pediatrician services. • Primary care physician. • Provider of obstetrician and gynecologist services. • Provider of child and adolescent psychiatry services. • Provider of adult psychiatry. • One consumer advocate representing the Medicaid population. • Three representatives of managed care organizations, all of whom must be physicians or pharmacists. Physician and pharmacist members must: • Have experience in developing or practicing under a PDL. • Have recognized knowledge and expertise in one or more of the following: ▸ Clinically appropriate prescribing of outpatient drugs. ▸ Clinically appropriate dispensing and monitoring of outpatient drugs. ▸ DUR, evaluation, and intervention. ▸ Medical quality assurance. ▸ Be licensed and in good standing with the Texas Medical	educational interventions, and reviews drug utilization across Medicaid. The board advises HHSC on: Federally required Medicaid DUR Program duties under 42 Code of Federal Regulations, Section 456.703. Prospective DUR in compliance with 42 Code of Federal Regulations, Section 456.716(d)(2) of use of restrictions or clinical prior authorization criteria on covered prescription drugs using recommended predetermined standards to monitor potential drug therapy problems. • Retrospective DUR in compliance with 42 Code of Federal Regulations, Section 456.716(d)(3) to identify standard care provided by healthcare professions with prescribing authority while allowing permitting sufficient professional prerogatives to allow for individualized drug therapy. • Educational interventions for Medicaid providers to improve prescribing and dispensing	Federal Regulations, Section 456.716 Texas Government Code, Section 549.0301 1 Texas Administrative Code, Section 351.809 1 Texas Administrative Code, Section 354.1941	abolishment date set.

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	Board (TMB) or the Texas State Board of Pharmacy and actively provide services across the entire population of Medicaid in Texas. How appointed: By executive commissioner appointment.	practices and effectively improve the quality of drug therapy in compliance with 42 Code of Federal Regulations, Sections 456.716(d)(5) and 456.716(d)(6). Texas Medicaid preferred drug lists by HHSC under Texas Government Code, Section 549.0202, which considers the drugs' efficacy, clinical significance, cost-effectiveness, and safety. • Other matters may be specified by law and within the Board's jurisdiction. In addition, the Board: • Develops and submits to HHSC recommendations for preferred drug lists. • Suggests to HHSC restrictions or clinical edits on prescriptions drugs. • Recommends to HHSC educational interventions for Medicaid providers. • Reviews drug utilization across Medicaid. • Performs other duties that may be specified by law and otherwise make recommendations to HHSC.		

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
e-Health Advisory Committee	Size: 24 members; 21 voting members and 3 non-voting ex-officio members. Composition: Representatives of HHS agencies, other state agencies, and HHS stakeholders concerned with the use of health information technology, health information exchange systems, telemedicine, telehealth, and home telemonitoring services, including: • At least two non-voting ex officio representatives from HHSC. • At least one non-voting ex officio representative from DSHS. • At least one representative from the TMB. • At least one representative from the Texas Board of Nursing. • At least one representative from the Texas State Board of Pharmacy. • At least one representative from the Statewide Health Coordinating Council. • At least one representative of a managed care organization. • At least one representative of the pharmaceutical industry. • At least one representative of a health science center in Texas.	The committee advises the executive commissioner and HHS agencies on strategic planning, policy, rules, and services related to the use of health information technology, health information exchange systems, telemedicine, telehealth, and home telemonitoring services. The committee: • Advises HHS agencies on the development, implementation, and long-range plans for health care information technology and health information exchange, including the use of electronic health records, computerized clinical support systems, health information exchange systems for exchanging clinical and other types of health information, and other methods of incorporating health information technology in pursuit of greater cost-effectiveness and better patient outcomes in health care and population health. • Advises HHS agencies on incentives for increasing health care provider adoption and	Texas Government Code, Section 523.0201 1 Texas Administrative Code, Section 351.823	Creation date: 07/01/2016 Abolish date: 12/31/2025

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	• At least one expert on telemedicine. • At least one expert on home telemonitoring services. • At least one representative of consumer health services provided through telemedicine. • At least one Medicaid provider or child health plan program provider. • At least one representative from the Texas Health Services Authority established under Chapter 182, Texas Health and Safety Code, Electronic Exchange of Health Information. • At least one representative of a local or regional health information exchange. • At least one representative with expertise related to the implementation of electronic health records, computerized clinical support systems, and health information exchange systems for exchanging clinical and other types of health information. How appointed: By executive commissioner appointment.	usage of an electronic health record and health information exchange systems. • Advises HHS agencies on the development, use, and long-range plans for telemedicine, telehealth, and home telemonitoring services, including consultations, reimbursements, and new benefits for inclusion in Medicaid telemedicine, telehealth, and home telemonitoring programs. • Makes recommendations to HHS agencies through regularly scheduled meetings and verbal or written recommendations communicated to HHSC staff assigned to the committee. • Performs other tasks consistent with its purpose as requested by the executive commissioner.		
Early Childhood Intervention Advisory	Size: No more than 25 members. Composition:	The committee assists and advises HHSC on its responsibility to provide early childhood intervention services to eligible	20 United States Code, Section 1441	Creation date: 03/17/2022

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
Committee	- Parents: Not less than 20 percent of the members shall be parents of infants or toddlers with disabilities or children with disabilities aged 12 or younger, with knowledge of, or experience with, programs for infants and toddlers with disabilities. Not less than one such member shall be a parent of an infant or toddler with a disability or a child with a disability aged 6 or younger. - Service providers: Not less than 20 percent of the members shall be public or private providers of early intervention services. - State legislature: Not less than one member shall be from the State legislature. - Personnel preparation: Not less than one member shall be involved in personnel preparation. - Agency for early intervention services: Not less than one member shall be from each of the State agencies involved in the provision of, or payment for, early intervention services to infants and toddlers with disabilities and their families and shall have sufficient authority to engage in policy planning and implementation on behalf of such agencies.	infants and toddlers and their families. The committee: - Advises and assists HHSC on developing and implementing the policies that constitute the statewide early childhood intervention system. - Advises and assists Texas Education Agency (TEA) regarding appropriate services and the transition of toddlers with developmental disabilities to services provided under Individuals with Disabilities Education Act (IDEA), Part B. - Assists HHSC in achieving: the full participation, coordination, and cooperation of all appropriate public agencies; effective implementation of the statewide system, by establishing a process that includes: seeking information from service providers, service coordinators, parents, and others about any federal, state, or local policies that impede timely service delivery; and taking steps to ensure that any policy problems are resolved; and	34 Code of Federal Regulations, Part 303, Subpart G Texas Human Resources Code, Section 73.004 1 Texas Administrative Code, Section 351.843	No abolishment date set.

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	- Agency for preschool services: Not less than one member shall be from the State educational agency responsible for preschool services to children with disabilities and shall have sufficient authority to engage in policy planning and implementation on behalf of such agency. - State Medicaid agency: Not less than one member shall be from the agency responsible for the State Medicaid program. - Head Start agency: Not less than one member shall be a representative from a Head Start agency or program in the State. - Childcare agency: Not less than one member shall be a representative from a State agency responsible for childcare. - Agency for health insurance: Not less than one member shall be from the agency responsible for the State regulation of health insurance. - Office of the Coordinator of Education of Homeless Children and Youth: Not less than one member shall be a representative designated by the Office of Coordinator for Education of Homeless Children and Youths.	- resolution of disputes to the extent appropriate. - Advises and assists HHSC in certain administrative duties including identifying sources of fiscal and other supports for services for early intervention programs; assigning financial responsibility to the appropriate agency; and promoting interagency agreements. - Advises and assists HHSC in preparing applications for funds under IDEA, Part C and amendments to those applications. - Advises and assists HHSC by preparing an annual report to the governor and to the secretary. HHSC may appoint ex officio members to perform specific, time-limited tasks as needed. HHSC determines voting status of ex officio members.		

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	- State foster care representative: Not less than one member shall be a representative from the State child welfare agency responsible for foster care. - Mental health agency: Not less than one member shall be a representative from the State agency responsible for children's mental health. - Other members: The council may include other members selected by the governor, including a representative from the Bureau of Indian Affairs (BIA), or where there is no BIA-operated or BIA-funded school, from the Indian Health Service or the tribe or tribal council. How appointed: By governor appointment.			
Hospital Payment Advisory Committee	Size: 14 members Composition: The committee members include individuals with knowledge of and interest in hospital payment issues within the state. Membership categories include: - Hospital administrators - Hospital finance administrators - Health professional organizations	The committee advises HHSC and Managed Care Advisory Committee on: - Hospital reimbursement issues for inpatient and outpatient hospital payment rates. - Other Medicaid supplemental payment programs for hospitals.	Texas Government Code, Section 523.0201 1 Texas Administrative Code, Section 351.803(h)	Creation date: 07/01/2016 No abolishment date set.

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	• Consumers • Advocacy Groups How appointed: By executive commissioner appointment.	• Adjustments for disproportionate share hospitals. • Ensuring reasonable, adequate, and equitable payments to hospital providers. • Addressing the essential role of rural hospitals.		
Intellectual and Developmental Disability System Redesign Advisory Committee	Size: 24 members. Composition: • Individuals with an intellectual or developmental disability who are recipients of services under the Medicaid waiver programs, individuals with an intellectual or developmental disability who are recipients of services under the ICF-IID program, and individuals who are advocates of those recipients, including at least three representatives from intellectual and developmental disability advocacy organizations. • Representatives of Medicaid managed care and non-managed care health care providers, including: ▸ Physicians who are primary care providers and physicians who are specialty care providers.	The committee: • Advises the commission on the implementation of the acute care services and long-term services and supports system redesign under Texas Government Code, Chapter 542. • Provides recommendations for the continued implementation of and improvements to the acute care and long-term services and supports system. • Performs other tasks consistent with its purpose as requested by the HHSC executive commissioner.	Texas Government Code, Section 542.0052 1 Texas Administrative Code, Section 351.811	Creation date: 07/01/2016 Abolish date: Two-year anniversary of the date HHSC completes the transition required Government Code, Section 542.0201.

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	▶ Nonphysician mental health professionals; and ▶ Providers of long-term services and supports, including direct service workers. • Representatives of entities with responsibilities for the delivery of Medicaid long-term services and supports or other Medicaid service delivery, including: ▶ Representatives of ADRCs established under the Aging and Disability Resource Center initiative funded in part by the federal Administration on Aging and the Centers for Medicare and Medicaid Services (CMS). ▶ Representatives of community mental health and intellectual disability centers. ▶ Representatives of and service coordinators or case managers from private and public home and community-based services providers that serve individuals with an intellectual or developmental disability. ▶ Representatives of private and public ICF-IID providers. ▶ Representatives of managed care organizations contracting with the state to provide services to individuals with an			

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	intellectual or developmental disability. How appointed: By executive commissioner appointment.			
Joint Committee on Access and Forensic Services	Size: 19 members; 17 voting members, Two non-voting ex-officio members. Composition: • One representative designated by Texas Department of Criminal Justice (TDCJ). • One representative designated Texas Association of Counties. • Two representatives designated by Texas Council of Community Centers, including one representative of an urban local service area and one representative of a rural local service area. • Two representatives designated by County Judges and Commissioners Association of Texas, one of which is the presiding judge of a court with jurisdiction over mental health matters. • One representative designated by Sheriffs' Association of Texas. • Two representatives designated Texas Municipal League, one of which is a municipal law enforcement official.	The committee: • Makes recommendations to the executive commissioner consistent with the committee's purpose. Makes recommendations and monitors implementation of updates to a bed day allocation methodology. • Makes recommendations and monitors implementation of a utilization review protocol for state funded beds in hospitals and other inpatient mental health facilities. • Makes recommendations to improve access to mental health services for both civil and forensic patients throughout the full continuum of care from institution to community-based settings.	Texas Health and Safety Code, Sections 533.051(c) and 533.0515 1 Texas Administrative Code, Section 351.841	Creation date: 2015 No abolishment date set.

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	• One representative designated by Texas Conference of Urban Counties. • Two representatives designated by Texas Hospital Association-designated representatives, one of which is a physician. • One representative designated by an organization identified by HHSC representing individuals with lived experience receiving publicly funded mental health services. • Four representatives designated by the HHSC Behavioral Health Advisory Committee (BHAC), or its successor including the chair of the BHAC. • One representative of the BHAC's members who is a consumer of or advocate for mental health services. • One representative of the BHAC's members who is a consumer of or advocate for substance abuse treatment. • One representative of the BHAC's members who is a family member of or advocate for persons with mental health and substance abuse disorders. Non-voting, ex-officio: • HHSC forensic director			

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	State hospital chief of forensic medicine How appointed: By executive commissioner appointment.			
Long-Term Care Facilities Council	Size: 11 members Composition: - At least one member who is a for-profit nursing facility provider. - At least one member who is a nonprofit nursing facility provider. - At least one member who is an assisted living services provider. - At least one member responsible for survey enforcement within the state survey and certification agency (ex officio/non-voting member)*. - At least one member responsible for survey inspection within the state survey and certification agency (ex officio/non-voting member)*. - At least one member of the state agency responsible for informal dispute resolution (ex officio/non-voting member)*. - At least one member with expertise in Medicaid quality-based payment systems for long-term care facilities (ex officio/non-voting member)*.	The council studies and makes recommendations regarding: - A consistent survey and informal dispute resolution process for long-term care facilities, Medicaid quality-based payment systems for those facilities, and the allocation of Medicaid beds in those facilities. - Best practices and protocols to make survey, inspection, and informal dispute resolution processes more efficient and less burdensome on long-term care facilities. - Uniform standards for those processes. - Medicaid quality-based payment systems and a rate-setting methodology for long-term care facilities. - The allocation of and need for Medicaid beds in long-term care facilities, including: - The effectiveness of rules adopted by the executive commissioner relating to	Texas Government Code, Section 526.0203	Creation date: 2019 No abolishment date set.

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	- At least one member who is a practicing medical director of a long-term care facility. - At least one member who is a physician with expertise in infectious disease or public health. - At least one member who is a community-based provider at an intermediate care facility for individuals with intellectual or developmental disabilities licensed under Health and Safety Code, Chapter 252. *Although the statute was written to include HHSC staff as voting members, subsequent discussions with the bill author in 2019 clarified that the intention was for staff to be non-voting members. How appointed: By executive commissioner appointment.	the procedures for certifying and decertifying Medicaid beds in long-term care facilities; and ▶ The need for modifications to those rules to better control the procedures for certifying and decertifying Medicaid beds in long-term care facilities.		
Medical Care Advisory Committee	Size: 12 members Composition: Board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care.	The committee: Advises HHSC regarding strategic planning, policy, rules, and services related to newborn screening and additional newborn screening tests for each disorder included in the list described by Texas Health and Safety Code, Section 33.011(a-1).	Social Security Act, Section 1902(a)(4) 42 Code of Federal Regulations, Section 431.12 Texas Human Resources	Creation date: 2016 No abolishment date set.

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	- Members of consumers' groups, including Medicaid beneficiaries, and consumer organizations such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others. - The director of the public welfare department or the public health department, whichever does not head the Medicaid agency. How appointed: By executive commissioner appointment.	Reviews the necessity of requiring additional screening tests, including an assessment of the test implementation costs to the department, birthing facilities, and other health care providers.	Code, Section 32.022 1 Texas Administrative Code, Section 351.803	
Nursing Facility Administrators Advisory Committee	Size: Nine members Composition: - Three licensed nursing facility administrators, at least one of whom shall represent a not-for-profit nursing facility. - One physician with experience in geriatrics who is not employed by a nursing facility. - One registered nurse with experience in geriatrics who is not employed by a nursing facility. - One social worker with experience in geriatrics who is not employed by a nursing facility; and - Three public members with experience working with the chronically ill and infirm as provided by 42 United States Code, Section 1396g.	The committee: - Advises HHSC on the licensing of nursing facility administrators, including the content of applications for licensure and of the examination administered to license applicants under Texas Health and Safety Code, Section 242.306. - Reviews and recommends rules and minimum standards of conduct for the practice of nursing facility administration. - Reviews all complaints against administrators and make recommendations to the department regarding disciplinary actions.	Texas Health and Safety Code, Section 242.303 40 Texas Administrative Code, Section 89.6	Creation date: 2016 Abolishment date: 03/01/2026

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	How appointed: By the Governor.			
Palliative Care Interdisciplinary Advisory Council	Size: 18 members. Composition: • At least five physician members, including two who are board certified in hospice and palliative care and one who is board certified in pain management. • Three palliative care practitioner members, including two advanced practice registered nurses who are board certified in hospice and palliative care and one physician assistant who has experience providing palliative care. • Four health care professional members, including a nurse, a social worker, a pharmacist, and a spiritual care professional, with: ▶ Experience providing palliative care to pediatric, youth, or adult populations; ▶ Expertise in palliative care delivery in an inpatient, outpatient, or community setting; or ▶ Expertise in interdisciplinary palliative care. At least three members with experience as an advocate for patients and the patients' family caregivers and who are	The council assesses the availability of patient-centered and family-focused, interdisciplinary team-based palliative care in Texas. The council: • Consults with and advises HHSC on matters related to the establishment, maintenance, operation, and outcome evaluation of the palliative care consumer and professional information and education program. • Provides direction to HHSC and program staff on content and governance for the palliative care information website. • Studies and makes recommendations to remove barriers to appropriate palliative care services for patients and families facing serious illness in Texas of any age and at any stage of illness. • Pursues other deliverables consistent with its purpose as requested by the executive commissioner or adopted into	Texas Health and Safety Code, Chapter 118 1 Texas Administrative Code, Section 351.827	Creation date: 2015 No abolishment date set.

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	independent of a hospital or other health care facility, including at least one member who is a representative of an established patient advocacy organization. • Ex officio representatives of the commission or another state agency as the executive commissioner determines appropriate. How appointed: By executive commissioner appointment.	the work plan or bylaws of the council.		
Pediatric Acute-Onset Neuropsychiatric Syndrome Advisory Council	Size: 19 members. Composition: • One member designated by the executive commissioner. • Two members of the senate appointed by the lieutenant governor. • Two members of the house of representatives appointed by the speaker of the house of representatives. • 14 members appointed by the governor with the following qualifications: ▸ One member who is a licensed health care provider with expertise in treating persons with pediatric acute-onset neuropsychiatric syndrome, including pediatric autoimmune	The council advises HHSC and the legislature on research, diagnosis, treatment, and education related to pediatric acute-onset neuropsychiatric syndrome. The council submits an annual written report that includes recommendations.	Texas Health and Safety Code, Chapter 119A	Creation date: 2019 Abolishment date: 09/01/2031

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	neuropsychiatric disorders associated with streptococcal infections, and autism. ▶ One member who is an osteopathic physician with experience treating persons with pediatric acute-onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections. ▶ One member who is a pediatrician with experience treating persons with pediatric acute-onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections. ▶ One member who is a child psychiatrist with experience treating persons with pediatric acute-onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections. ▶ One member who is an immunologist with experience treating persons with pediatric acute-onset neuropsychiatric syndrome, including pediatric			

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	autoimmune neuropsychiatric disorders associated with streptococcal infections, and the use of intravenous immunoglobulin. ▶ One member who is a dietician or nutritionist who provides services to children with autism spectrum disorders, attention-deficit/hyperactivity disorders, and other neuro-developmental conditions. ▶ One member with experience in conducting research on pediatric acute-onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections, obsessive-compulsive disorder, tic disorders, and other neurological disorders. ▶ One member who is licensed by this state to practice as a social worker. ▶ One member who is a representative of TEA with expertise in special education services. ▶ One member who is a psychologist licensed under Chapter 501, Occupations Code.			

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	▶ One member who is a representative of a professional organization in this state for school nurses. ▶ One member who is a representative of an advocacy and support group in this state for individuals affected by pediatric acute-onset neuropsychiatric syndrome, including pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections. ▶ One member who is a representative of an advocacy and support group in this state for individuals affected by autism. ▶ One member who is a parent of a child who has been diagnosed with pediatric acute-onset neuropsychiatric syndrome or autism. How appointed: By Governor, Lieutenant Governor, and Speaker of the House.			
Perinatal Advisory Council	Size: 19 members; 18 voting members, one non-voting ex-officio member. Composition:	The council: • Develops and recommends criteria for designating levels of neonatal and maternal care, respectively, including	Texas Health and Safety Code, Section 241.187	Creation date: 2013 Abolishment

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	- Four physicians licensed to practice medicine under Subtitle B, Title 3, Occupations Code, specializing in neonatology: - At least two of whom practice in a Level III or IV neonatal intensive care unit. - At least one of whom practices in a neonatal intensive care unit of a hospital located in a rural area. - One physician licensed to practice medicine under Subtitle B, Title 3, Occupations Code, specializing in general pediatrics. - Two physicians licensed to practice medicine under Subtitle B, Title 3, Occupations Code, specializing in obstetrics-gynecology. - Two physicians licensed to practice medicine under Subtitle B, Title 3, Occupations Code, specializing in maternal fetal medicine. - Two physicians licensed to practice medicine under Subtitle B, Title 3, Occupations Code, specializing in family practice who provide obstetrical care in a rural community, at least one of whom must provide such care at a hospital that has 50 or fewer patient beds and that is:	- specifying the minimum requirements to qualify for each level designation. - Develops and recommends a process for the assignment of levels of care to a hospital for neonatal and maternal care, respectively. - Makes recommendations for the division of the state into neonatal and maternal care regions. - Examines utilization trends relating to neonatal and maternal care. - Makes recommendations related to improving neonatal and maternal outcomes.	1 Texas Administrative Code, Section 351.813	date: 09/01/2027

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	▸ Located in a county with a population of 60,000 or less; or ▸ Designated by CMS as a critical access hospital, rural referral center, or sole community hospital. • One registered nurse licensed under Subtitle E, Title 3, Occupations Code, with expertise in maternal health care delivery. • One registered nurse licensed under Subtitle E, Title 3, Occupations Code, with expertise in perinatal health care delivery. • One representative from a children's hospital. • One representative from a hospital with a Level II neonatal intensive care unit. • Two representatives from a rural hospital, at least one of whom must be an administrative representative from a hospital that has 50 or fewer patient beds and that is: ▸ Located in a county with a population of 60,000 or less; or ▸ Designated by CMS as a critical access hospital, rural referral center, or sole community hospital. • One representative from a general hospital.			

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	One ex officio representative from the office of the HHSC medical director. How appointed: By executive commissioner.			
Policy Council for Children and Families	Size: 24 members; 19 voting members and 5 non-voting ex-officio members. Composition: 11 voting members appointed by the executive commissioner from families with a child under the age of 26 with a disability, including: - At least one adolescent or young adult under the age of 26 with a disability receiving services from an HHS agency. - At least one member of a family of a child with mental health care needs. - At least one member of a family of a child with autism spectrum disorder. - Eight voting professional members, appointed by the executive commissioner, one each to represent the following types of organizations or areas of expertise: - A faith-based organization. - An organization that is an advocate for children with disabilities.	The council works to improve the coordination, quality, efficiency, and outcomes of services provided to children with disabilities and their families through the state's health, education, and human services systems. The council: - Studies and makes recommendations to improve coordination between the state's health, education, and human services systems to ensure that children with disabilities and their families have access to high quality services. - Studies and makes recommendations to improve long-term services and supports, including community-based supports for children with special health and mental health care needs, as well as children with	Texas Government Code, Section 523.0201 1 Texas Administrative Code, Section 351.815	Creation date: 2001 Abolishment date: 12/31/2028

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	▶ A physician providing services to children with complex needs. ▶ An individual with expertise providing mental health services to children with disabilities. ▶ An organization providing services to children with disabilities and their families. ▶ An organization providing community services. ▶ An organization or professional that advocates for or provides services or resources to children and the families of children with autism spectrum disorder. ▶ One at-large position for an individual with expertise or experience relevant to the Council's purposes and tasks. • Five non-voting, ex officio members, one from each of the following state programs and agencies or their successors, as selected by the represented agency: ▶ HHSC Medicaid and CHIP Services. ▶ HHSC Community Services. ▶ Texas Council on Developmental Disabilities. ▶ DFPS. ▶ DSHS. How appointed: By executive	disabilities and their families receiving protective services from the state. • Studies and makes recommendations regarding emerging issues affecting the quality and availability of services available to children with disabilities and their families. • Studies and makes recommendations to better align resources with the service needs of children with disabilities and their families. • Studies and makes recommendations to ensure that the needs of children with autism spectrum disorder and their families are addressed, and that all available resources are coordinated to meet those needs. • Makes recommendations regarding the implementation and improvement of the STAR Kids managed care program. • Performs other tasks consistent with its purpose as requested by the executive commissioner.		

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	commissioner appointment.			
Psychiatric Executive Formulary Committee	Size: 23 members	The committee maintains and updates the Psychiatric Drug Formulary by: • Recommending standards of drug use that discourage unnecessary duplication of therapeutic alternatives and encourage the highest standards of medical and pharmacy practice. • Reviewing periodically the drugs listed in the formulary to ensure consistency with need, effectiveness, risk and cost. • Consulting with experts in clinical pharmacy, pharmacology and other medical specialties as needed to objectively assess drugs under consideration. • Adding new drugs to the formulary. • Making other recommendations about drug use and policy as requested. • Designating the formulations allowed for general use by	TAC Title 26 Part 1 Chapter 306 Subchapter G 306.356	Creation date: February 24, 2021 Abolishment date: No abolishment date set.

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
		service system components and their contractors.		
State Medicaid Managed Care Advisory Committee	Size: No more than 24 members. Composition: Ten people enrolled in Medicaid managed care appointed from one or more of the following subcategories: • A person who is low-income, a family member of the person, or an advocate representing people with low-income. • A person aged 21 or older with an intellectual, developmental, or physical disability, including a person with autism spectrum disorder, or a family member of the person, or an advocate representing people with an intellectual, developmental, or physical disability, including persons with autism spectrum disorder. • A family member of a child who is a Medicaid recipient or an advocate representing children who are Medicaid recipients, except for a child with special health care needs listed in clause (iv) of this subparagraph. • A family member of a child with special health care needs or an	The committee: • Advises HHSC on the statewide operation of Medicaid managed care, including program design and benefits, systemic concerns from consumers and providers, efficiency and quality of services, contract requirements, provider network adequacy, trends in claims processing, and other issues as requested by the executive commissioner. • Assists HHSC with Medicaid managed care issues. • Disseminates Medicaid managed care best practice information as appropriate.	Texas Government Code, Chapter 540 Texas Government Code, Section 523.0201 1 Texas Administrative Code, Section 351.805	Creation date: 2019 Abolishment date: 12/31/2028

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	advocate representing children with special health care needs. • A person who is 65 years of age or older, the person's family member, or an advocate representing persons who are 65 years of age or older. • A person 21 or older who is dually enrolled in Medicaid and Medicare, a family member of the person, or an advocate representing people 21 or older who are dually enrolled in Medicaid and Medicare. A person using mental health services, a family member of the person, or an advocate representing people who use mental health services. • A person using non-emergency medical transportation services, a family member of the person, or an advocate representing persons using non-emergency medical transportation. Ten providers contracted with Texas Medicaid managed care organizations, appointed from one or more of the following subcategories: • Rural providers • Hospitals • Primary care providers • Pediatric health care providers			

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	• Dentists • Community-based organizations either: ▸ Serving children enrolled in Medicaid who are low-income and their families. ▸ Serving people aged 65 or older and people with disabilities. ▸ Engaged in perinatal services and outreach. ▸ Obstetrical care providers. ▸ Providers serving people dually enrolled in Medicaid and Medicare. ▸ Providers serving people who are 21 years of age or older and have a disability. ▸ Non-physician mental health providers. ▸ Long-term care services and supports providers, including nursing facility providers and direct service workers. Four managed care organizations participating in Texas Medicaid, including: • Both national and community-based plans • Dental maintenance organizations (for the purpose of this section) How appointed: By executive commissioner appointment.			

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
Statewide Behavioral Health Coordinating Council	Size: At least 26 members. Composition: At least one representative from each of the following entities: • Office of the Governor • Texas Veterans Commission • HHSC • DSHS • DFPS • Texas Civil Commitment Office • University of Texas Health Science Center at Houston • University of Texas Health Science Center at Tyler • Texas Tech University Health Sciences Center • TDCJ • Texas Correctional Office on Offenders with Medical or Mental Impairments • Commission on Jail Standards • Texas Indigent Defense Commission • Court of Criminal Appeals • Texas Juvenile Justice Department • Texas Military Department • TEA • TWC • Health Professions Council, representing: ▶ State Board of Dental Examiners ▶ Texas State Board of Pharmacy	The council ensures a strategic statewide approach to behavioral health services. The council: • Develops and monitors the implementation of a five-year statewide behavioral health strategic plan. • Develops a biennial coordinated statewide behavioral health expenditure proposal. • Annually publishes an updated inventory of behavioral health programs and services that are funded by the state that includes a description of how those programs and services further the purpose of the statewide behavioral health strategic plan. • Creates a suicide prevention subcommittee and include statewide suicide prevention efforts in its five-year statewide behavioral health strategic plan. The council may: • Create subcommittees to carry out the council's duties under this subchapter.	Texas Government Code, Section 547.0151	Creation date: 2015 No abolishment date set.

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	▶ State Board of Veterinary Medical Examiners ▶ Texas Optometry Board ▶ Texas Board of Nursing ▶ TMB • Texas Department of Housing and Community Affairs. How appointed: By designation from each of the entities of listed above.	• Facilitate opportunities to increase collaboration for the effective expenditure of available federal and state funds for behavioral and mental health services in this state.		
Statewide Interagency Aging Services Coordinating Council (SIASCC)	Size: At least 12 members Composition: SIASCC is composed of at least one representative appointed by each of the following agencies and entities: • the governor's office; • the commission, including one representative of • the commission's aging services coordination office; • DFPS; • DSHS; • the Department of Agriculture's office of rural health; • the Texas Veterans Commission; • TWC; • the Office of the Attorney General; • the Barshop Institute for Longevity and Aging Studies at The	SIASCC ensures a strategic statewide approach to interagency aging services. Core duties include: • Developing and monitoring the implementation of a recurring five-year statewide interagency aging services strategic plan. • Developing biennial coordinated statewide interagency aging services expenditure proposal. • Annually publishing an updated inventory of state-funded aging programs and services.	Texas Government Code, Section 531.492	Creation date: 2023 Abolishment date: 09/01/2027

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	University of Texas Health Science Center at San Antonio; - the Texas Aging and Longevity Consortium at The University of Texas at Austin; and - the Center for Community Health and Aging at Texas A&M University. How appointed: Members are appointed by the agencies and entities listed above.			
Texas Brain Injury Advisory Council	Size: 15 members. Composition: - One representative from acute hospital trauma units. - One representative from post-acute rehabilitation facilities. - One representative of a long-term care facility that serves persons who have survived a brain injury. - One healthcare practitioner or service provider who has specialized training or interest in the prevention of brain injuries or the care, treatment, and rehabilitation of persons who have survived a brain injury. - One representative of an institution of higher education engaged in research that impacts persons who have survived a brain injury.	The council advises the executive commissioner and HHSC on strategic planning, policy, rules, and services related to the prevention of brain injury; rehabilitation; and the provision of long-term services and supports for persons who have survived brain injuries to improve their quality of life and ability to function independently in the home and community. The council: Informs state leadership of the needs of persons who have survived a brain injury and their families regarding rehabilitation and the provision of long-term services and supports to improve health	Texas Government Code, Section 523.0201 1 Texas Administrative Code, Section 351.825	Creation date: 07/2016 Abolishment date: 07/01/2028

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
	- Five persons who have survived a brain injury representing diverse ethnic or cultural groups and geographic regions of Texas, with: - at least one of these being a transition age youth (age 18-26); - at least one of these being a person who has survived a traumatic brain injury; and - at least one of these being a person who has survived a non-traumatic brain injury. - Four family members actively involved in the care of loved ones who have sustained a brain injury, with: - at least one of these being a person whose loved one has survived a traumatic brain injury; and - at least one of these being a person whose loved one has survived a non-traumatic brain injury. - One representative from the stroke committee of the Governor's Emergency Medical Services (EMS) & Trauma Advisory Council or other stakeholder group with a focus on stroke. How appointed: By executive commissioner appointment.	and functioning that leads to achieving maximum independence in home and community living and participation. - Encourages research into the causes and effects of brain injuries as well as promising and best practice approaches for prevention, early intervention, treatment and care of brain injuries and the provision of long-term services and supports. - Recommends policies that facilitate implementation of the most current promising and evidence-based practices for the care, rehabilitation, and the provision of long-term services and supports to persons who have survived a brain injury. - Promotes brain injury awareness, education, and implementation of health promotion and prevention strategies across Texas. - Facilitates the development of partnerships among diverse public and private provider and consumer stakeholder groups to develop and implement		

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
		sustainable service and support strategies that meet the complex needs of persons who have survived a brain injury and those experiencing co-occurring conditions.		
Texas Respite Advisory Committee	Size: No more than 24 members. Composition: • Family caregivers. • Primary caregivers. • Respite care advocacy organizations. • Faith-based organizations. • Members of the general public interested in the issue of respite care. Per bylaws, an additional category for "Providers of respite services" was added. How appointed: By executive commissioner appointment.	The committee assists HHSC develop strategies to reduce barriers to access respite services, improves the quality of respite services, and provides training, education, and support to family caregivers. The committee: • Assists HHSC to identify barriers and best practices for providing and coordinating respite services in Texas. • Responds to requests from HHSC for information about the respite needs of caregivers. • Advises HHSC about effective methods for expanding the availability of affordable respite services in Texas through the use of funds available from respite care programs. • Cooperates and shares resources and knowledge among community	Texas Government Code, Section 523.0201 15 Texas Administrative Code, Section 351.849	Creation date: 2009 Abolishment date: 03/01/2026

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
		stakeholders to facilitate barrier free access for primary caregivers. Educates the public on the need for community-based options for primary caregivers.		
Value-Based Payment and Quality Improvement Advisory Committee	Size: 22 members; 19 voting members, 3 non-voting ex officio members. Composition: HHSC solicits voting members from the following categories: - Medicaid managed care organizations. - Physicians. - Nurses. - Pharmacies. - Providers of long-term services and supports. - Academic systems. - Members from other disciplines or organizations with expertise in health care finance, delivery, or quality improvement. The committee may include non-voting, ex officio agency representatives as determined by the executive commissioner. How appointed: By executive commissioner appointment.	The committee provides a forum to promote public-private, multi-stakeholder collaboration in support of quality improvement and value-based payment initiatives for Medicaid, other publicly funded health services, and the wider health care system. The committee: - Studies and makes recommendations regarding: - Value-based payment and quality improvement initiatives to promote better care, better outcomes, and lower costs for publicly funded health care services. - Core metrics and a data analytics framework to support value-based purchasing and quality improvement in Medicaid/CHIP. - HHSC and managed care organization incentive and	Texas Government Code, Section 523.0201 1 Texas Administrative Code, Section 351.821	Creation date: 2016 Abolishment date: 12/31/2027

Name of Subcommittee or Advisory Committee	Size / Composition / How are members appointed?	Purpose / Duties	Legal Basis for Committee (statute or rule citation)	Creation and Abolishment Dates
		disincentive programs based on value. ▶ The strategic direction for Medicaid/CHIP value-based programs. • Pursues other deliverables consistent with its purpose to improve quality and efficiency in state health care services as requested by the executive commissioner or adopted into the work plan or bylaws of the committee.		

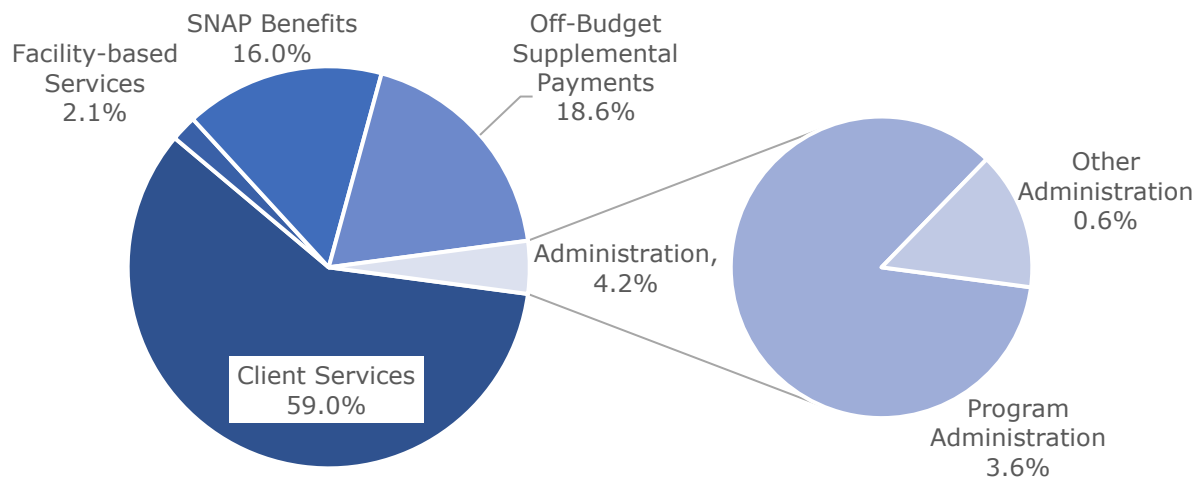
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V. Funding

A. Provide a brief description of your agency's major sources of funding.

The following chart shows the Health and Human Services Commission's (HHSC) available funding for the 2024-25 biennium broken down by funding purpose.

Figure 1. HHSC percentage of estimated total available funds. (2024-25 Biennium)



Notes: Does not include interagency contract funds in Goal K, Office of Inspector General (\$11.8 million), and Goal L, System Oversight and Program Support (\$357.6 million). The Program Administration category includes Access and Eligibility Services (AES) and Regulatory Oversight. Off-budget supplemental payments are 2024-25 estimates. Supplemental Nutrition Assistance Program (SNAP) benefits are 2022-23 estimates.

The majority of HHSC's funding is allocated to client services, including Medicaid, the largest program. Only 4.2 percent of funding is used for administration. HHSC's appropriations are provided in Article II of the General Appropriations Act, which included \$93.4 billion in All Funds for the 2024-25 biennium. HHSC manages funds not included in the General Appropriations Act, including SNAP benefits and supplemental and directed payment programs. The following sections describe HHSC's appropriations and off-budget funding.

HHSC General Appropriations Act Funding

HHSC's \$93.4 billion in appropriations in the 2024-25 biennium include:

- \$37.6 billion (40.2 percent) General Revenue or General Revenue-Dedicated funding;
- \$54.1 billion (57.9 percent) Federal Funds; and
- \$1.7 billion (1.9 percent) Other Funds.

HHSC's General Revenue funding is used to support state programs and initiatives and to meet state match or maintenance of effort requirements for federal programs. It includes direct appropriations and revenue HHSC generates, such as drug rebates, experience rebates from managed care organizations, and revenue from regulatory program fees.

HHSC Federal Funds cover a broad array of programs, including Medicaid, Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), SNAP, Early Childhood Intervention (ECI), mental health services, substance use services, and others. HHSC administers more than half of the state's appropriated federal funds.

Other Funds appropriated to HHSC include Interagency Contracts, including those related to indirect administration provided for the Department of State Health Services (DSHS) and the Department of Family and Protective Services (DFPS). Other Funds also include certain revenues collected by HHSC, including some used to match federal Medicaid funding.

HHSC's funding for administrative and program support functions is determined according to an annual federally approved cost allocation methodology, Public Assistance Cost Allocation Plan (PACAP). HHSC does not charge administrative federal funds through a flat indirect rate but through a plan in which factors are updated either monthly or quarterly, according to the PACAP. Each administrative or program support area in which more than one federal fund can be charged has a specific cost allocation factor or combination of factors that determines the state and federal share billed to each HHSC revenue source as well as DFPS or DSHS if they are benefiting from the area's services.

HHSC Off-Budget Funding

In addition to appropriated funding, HHSC also processes supplemental and directed payment programs, approximately \$13.3 billion annually, for the Medicaid program. These supplemental payments are not generally reflected in the agency's appropriations because the state's share is often provided through intergovernmental transfers from local governments and state entities. Federally funded SNAP benefits, approximately \$11.4 billion annually, are not included in

appropriations to HHSC as the agency passes the funding from the federal government to program recipients directly.

B. List all riders that significantly impact your agency's budget.

HHSC's bill pattern in the 2024-25 General Appropriations Act, House Bill (H.B. 1), 88th Legislature, Regular Session, 2023, has 175 riders. The agency is affected by numerous other provisions in Special Provision Relating to all Health and Human Services Agencies and Article IX, General Provisions.

HHSC thoroughly reviews its riders each biennium to request deletion, modification, and addition of riders as needed. In general, riders fall into one or more of the following categories:

- Adding or Directing Funding;
- Reporting Requirement;
- Transfer Authority;
- Financial Mechanics and Associated Authority;
- Informational; and
- Contingency Riders.

While riders that add or direct funding, have reporting requirements, or are contingency riders affect the way HHSC operates, they can change from biennium to biennium. HHSC has existing processes to implement such riders. For example, HHSC has numerous riders that provide informational listings of funding. While these do not impose requirements on the agency, they are important for providing information to the agency, Legislature, and stakeholders.

For this report, HHSC is focusing on a few key riders that provide transfer, authority, or financial mechanics and have significant impacts on our agency's budget. See the list below, which is organized by category. In the 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023, HHSC is subject to 175 agency specific riders and 27 Special Provisions relating to all health and human services agencies and is impacted by a number of Article IX General Provisions applicable to all agencies as well as certain provisions in other agency bill patterns.

For a full list of HHSC's riders, please see the 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023.

Medicaid and the Children's Health Insurance Program

Riders related to Medicaid and CHIP primarily add funding, direct funding, or provide information related to specific programs within Medicaid, including funding for Graduate Medical Education, and add-on payments for hospitals. Spending for Medicaid and CHIP comprises the majority of the agency's budget, and the following HHSC riders significantly affect how it can use funding:

- Rider 3, Cash Basis Expenditures Authorization, provides the agency with an exemption from the state's normal accrual basis of accounting to maintain efficiencies in the financial management of entitlement program.
- Rider 15, Supplemental Payment Programs Reporting and Appropriation Authority for Governmental Transfers, provides direction for off-budget funds that are not included in the General Appropriations Act.
- Rider 18, Use of Certain Additional Medicaid Revenues, and Rider 39, Use of Additional CHIP Revenue, restrict how the agency can use refunds, rebates, and revenue generated by the Medicaid and CHIP programs.
- Rider 20, Hospital Reimbursement, directs HHSC to maintain a value-based reimbursement system, which is a cost containment initiative.

Behavioral Health

Riders related to behavioral health primarily add or direct funding and require HHSC to report on specific behavioral health programs. While these riders are important, they do not significantly affect budget processes outside of normal program implementation.

Women's Health

Women's health riders provide direction for implementing various programs that support women's health services and crucial informational listings on program funding. While these riders are important, they do not significantly affect budget processes outside of normal program implementation.

Other Client Services

Riders relating to client services other than Medicaid, CHIP, behavioral health, and women's health fall into the Other Client Services category. Programs include, but are not limited to, ECI, Children with Special Health Care Needs, and TANF. While these riders are important, they do not significantly affect budget processes outside of normal program implementation.

Facilities

Riders relating to state-operated facilities, including mental health state hospitals and state supported living centers (SSLC), provide direction, restrictions, and authority for HHSC to operate such facilities. One rider that significantly affects budget processes is listed below:

- Rider 92, SSLC Oversight, requires HHSC to report SSLC expenditures and to request and receive approval before spending any additional funds above appropriations for SSLCs.

Revenue

HHSC has numerous riders that direct collection and expenditure of revenues, as well as related reporting. These riders clarify what authority HHSC has to expend and report such revenue and provide critical information for HHSC budgeting and accounting processes. While these riders all affect HHSC's budget, the following riders have a significant impact to budget implementation:

- Rider 124, Appropriation: Contingent Revenue, authorizes HHSC to expend additional revenue above projections by the Comptroller of Public Accounts (CPA) if CPA certifies there will be additional available revenue.
- Rider 125, Appropriations Limited to Revenue Collections, limits HHSC's appropriations to revenue collected for certain programs.

Transfers

HHSC has significantly more restrictions on transferring funding and full-time equivalents (FTE) than other agencies. Riders related to transfers provide these restrictions and additional authority and directions for transferring funding. The following riders significantly affect HHSC's budget:

- Rider 129, Limitations on Transfer Authority, is the primary rider affecting HHSC's ability to transfer funds and FTEs and authorizes HHSC to transfer with notification only between some strategies, prohibits certain transfers, and requires HHSC to request approval from the Legislative Budget Board (LBB) and Office of the Governor for most transfers.
- Rider 131, Appropriation Transfers between Fiscal Years, authorizes HHSC to carry back funds from the second fiscal year of the biennium to the first fiscal year to address funding shortfalls for Medicaid or CHIP client services with approval of the LBB and Office of the Governor.

- Rider 134, Unexpended Construction Balances, provides unexpended balance authority for HHSC to move funding between biennia for construction projects that have not been fully expended.
- Rider 136, Disposition of Appropriation Transfers from State-owned Hospitals, directs HHSC to use funding transferred from state hospitals to receive matching federal funds through hospital directed payment programs.

Administration

Riders also provide specific direction for how HHSC should administer its budget and specific areas of agency services. Riders that have a significant impact on the agency's budget include:

- Rider 21, Health and Human Services Cost Containment, directs HHSC to develop and implement cost containment initiatives to achieve savings of at least \$450.0 million throughout the health and human services system.
- Rider 140, Accounting of Indirect Support Costs, allows HHSC to transfer funding to separate accounts to pay for indirect support costs that affect multiple programs.
- Rider 151, Staffing in Lieu of Contracted Responsibilities, authorizes HHSC to increase its FTE cap if the agency determines it would be more effective to perform a contracted service by state personnel.

Special Provisions Relating to All Health and Human Services Agencies

Special Provisions Relating to all Health and Human Services Agencies outline funding mechanisms and authority associated specifically with Article II agencies, as well as informational listings summarizing funding across all three Health and Human Services agencies. The following riders directly affect how the agencies expend funding:

- Sec. 4, Federal Match Assumptions and Limitations on Use of Available General Revenue Funds, requires the agency to request authority to expend additional funds received due to an enhanced Federal Matching Rate.
- Sec. 6, Limitations on Transfer Authority, requires HHSC to request approval to transfer funding and FTEs over a certain threshold between health and human services agencies.
- Sec. 9, System Support Services, limits the expenditure and transfer of funding related to the operational support of the three Article II agencies.

- Sec. 20, Transfers of Appropriation – State-owned Hospitals, directs the transfer of appropriations used to support the state hospital system.

Article IX, General Provisions

Article IX, General Provisions, may broadly affect state agencies. The following three provisions significantly direct the operations and budget of HHSC:

- Sec. 6.10. Limitation on State Employment Levels, restricts the use of appropriated funding on FTEs that exceed the level appropriated by the Legislature.
- Sec. 14.03. Transfers - Capital Budget, restricts the use of appropriated funding on capital budget projects and is in addition to provisions that apply specifically to HHSC.
- Sec. 14.04. Disaster Related Transfer Authority, allows HHSC to transfer appropriations to respond to a disaster proclamation and enables an agency to transfer funding from another health and human services agency to the responding agency and between strategies and capital budget items to respond to the disaster.

C. Show your agency's expenditures, including transfers, broken down into clear and easy-to-understand categories.

Health and Human Services Commission

Exhibit 7: Expenditures — Fiscal Year 2024 (Actual)

Category	Amount Spent	Percent of Total	Contract Expenditures Included in Total Amount
Medicaid Client Services	\$35,347,097,997	49.90%	\$31,211,210,930
CHIP Client Services	\$522,069,098	0.70%	\$505,899,765
Behavioral Health	\$1,310,992,258	1.90%	\$1,291,025,163
Other Client Services	\$2,839,429,776	4.00%	\$1,853,160,137
Subtotal, Client Services	\$40,019,589,129	56.50%	\$34,861,295,996
State Supported Living Centers Operations	\$897,987,401	1.30%	\$85,258,315

Category	Amount Spent	Percent of Total	Contract Expenditures Included in Total Amount
State Hospital Operations	\$914,292,154	1.30%	\$127,393,005
Other Facility-based Services	\$283,183,175	0.40%	\$259,206,827
Subtotal, Facility-based Services	\$2,095,462,730	3.00%	\$471,858,147
Program Administration	\$2,329,383,649	3.30%	\$1,192,788,719
Other Administration	\$430,441,265	0.60%	\$163,393,940
Subtotal, Administration	\$2,759,824,915	3.90%	\$1,356,182,660
Off-budget Supplemental Payment Programs	\$17,597,466,000	24.90%	\$8,431,627,033
SNAP Benefits	\$7,192,388,204	10.20%	\$0
Other Off-budget	\$1,139,988,918	1.60%	\$0
Subtotal, Off-budget Expenditures	\$25,929,843,121	36.60%	\$8,431,627,033
GRAND TOTAL:	\$70,804,719,894	100.00%	\$45,120,963,836

Note: Program administration includes funding to directly administer programs, eligibility, and regulatory services. Other administration includes funding in Goal L, HHS Enterprise Oversight and Policy. Off-budget expenditures include funding not provided through the General Appropriations Act. Off-budget supplemental payment programs are Medicaid payments paid to health care providers to provide additional funding beyond base Medicaid payments not appropriated through the General Appropriations Act. SNAP benefits are off-budget, though SNAP administrative funding is on-budget administrative funding. Other off-budget expenditures include items not in HHSC's bill pattern such as employee benefits, federal pass-through funding, and the Special Olympics Texas Trust Fund.

D. Show your agency's sources of revenue broken down into clear and easy-to-understand categories, as shown in the examples provided. This information forms the basis of the "Agency at a Glance" section of Sunset's reports. Include all local, state, and federal appropriations; all professional fees (for licensure and certification) and operating fees (charged to agency customers for services); and all other sources of revenue collected by the agency, including taxes and fines.

Health and Human Services Commission

Exhibit 8: Sources of Revenue — Fiscal Year 2024 (Actual)

Source	Amount
General Revenue	\$18,700,541,816
General Revenue-Dedicated	\$80,619,002
Federal Funds	\$37,775,458,792
Other Funds	\$14,248,100,284
TOTAL	\$70,804,719,894

Note: SNAP Expenditures are included in Other Funds.

E. If you receive funds from multiple federal programs, show the source agency and type of federal funding.

Health and Human Services Commission

Exhibit 9: Federal Funds — Fiscal Year 2024 (Actual)

Type of Fund	State / Federal Match Ratio	State Share	Federal Share	Total Funding
10.535.000 SNAP Recipient Integrity Education Grant	0/100	\$0	\$220,157	\$220,157
10.551.000 Food Stamps	0/100	\$0	\$765	\$765
10.557.000 Special Supplemental Nutrition Program (WIC)	0/100	\$0	\$699,261,335	\$699,261,335
10.557.001 Special Supplemental Nutrition Program (WIC)	0/100	\$0	\$483,472	\$483,472
10.561.000 State Admin Matching Grants for Supplemental Nutrition Assistance Program (SNAP)	50/50	\$259,426,633	\$259,426,633	\$518,853,265
21.027.119 COV19 State Fiscal Recovery Funds	0/100	\$0	\$14,238,625	\$14,238,625
84.027.000 Special Education Grants to States	0/100	\$0	\$5,131,125	\$5,131,125
84.181.000 Special Education Grants for Infants & Families with Disabilities	0/100	\$0	\$48,599,501	\$48,599,501
84.325.000 Improving Retention of Special Education Teachers and Early Intervention Persons	10/90	\$29,945	\$269,508	\$299,454
93.041.000 Prevention of Elder Abuse, Neglect, and Exploitation	0/100	\$0	\$272,912	\$272,912

Type of Fund	State / Federal Match Ratio	State Share	Federal Share	Total Funding
93.042.000 Long Term Care Ombudsman	0/100	\$0	\$1,829,271	\$1,829,271
93.043.000 Disease Prevention and Health Promotion	0/100	\$0	\$2,841,031	\$2,841,031
93.044.000 Grants for Supportive Services and Senior Centers	0/100	\$0	\$45,195,630	\$45,195,630
93.045.000 Nutrition Services	0/100	\$0	\$73,107,666	\$73,107,666
93.048.000 Discretionary Projects	0/100	\$0	\$124,059	\$124,059
93.052.000 National Family Caregiver Support Program	0/100	\$0	\$16,444,476	\$16,444,476
93.053.000 Nutrition Services Incentive Program	0/100	\$0	\$8,970,218	\$8,970,218
93.071.000 MIPPA Priority Area 2 AAA	0/100	\$0	\$2,455,231	\$2,455,231
93.071.001 MIPPA Priority Area 3 ADRCs	0/100	\$0	\$507	\$507
93.072.000 Lifespan Respite Care Program	0/100	\$0	\$375,632	\$375,632
93.104.000 CMHS Child Mental Health Service Initiative	0/100	\$0	\$2,396,326	\$2,396,326
93.150.000 Projects for Assistance in Transition from Homelessness	0/100	\$0	\$4,492,671	\$4,492,671
93.235.000 Abstinence Education	0/100	\$0	\$5,595,165	\$5,595,165
93.243.000 Projects of Regional and National Significance	0/100	\$0	\$11,068,698	\$11,068,698

Type of Fund	State / Federal Match Ratio	State Share	Federal Share	Total Funding
93.324.000 State Health Insurance Assistance Program	0/100	\$0	\$2,771,578	\$2,771,578
93.361.000 Community of Practice for Bridging Aging and Disability Network	0/100	\$0	\$577	\$577
93.369.000 Independent Living	10/90	\$172,965	\$1,556,687	\$1,729,652
93.434.000 ESSA Preschool Development Grants Birth	30/70	\$1,331,413	\$3,106,629	\$4,438,042
93.497.119 Family Violence Prevention and Services	0/100	\$0	\$3,853,468	\$3,853,468
93.558.000 TANF	0/100	\$0	\$451,452,457	\$451,452,457
93.558.667 TANF to Title XX	0/100	\$0	\$43,681,144	\$43,681,144
93.575.000 Child Care and Development Block Grant	0/100	\$0	\$14,460,783	\$14,460,783
93.624.000 ACA State Innovation Models: Funding for Model Design and Model Testing	0/100	\$0	\$20,609	\$20,609
93.658.000 Foster Care Title IV	50/50	\$2,519,137	\$2,519,137	\$5,038,274
93.658.050 Foster Care Title IV-E Administration @ 50%	50/50	\$34,550	\$34,550	\$69,100
93.667.000 Social Services Block Grant	0/100	\$0	\$142,689,659	\$142,689,659
93.671.000 Family Violence Prevention & Services	0/100	\$0	\$19,387,173	\$19,387,173
93.687.000 Maternal Opioid Misuse Model	0/100	\$0	\$478,757	\$478,757

Type of Fund	State / Federal Match Ratio	State Share	Federal Share	Total Funding
93.747.000 Elder Abuse Prevention Program	0/100	\$0	\$414,047	\$414,047
93.767.000 CHIP	27.5/ 72.5	\$379,787,601	\$1,001,258,222	\$1,381,045,823
93.777.000 Survey & Certification: HC Providers & Suppliers Title XVI	0/100	\$0	\$49,502,966	\$49,502,966
93.777.003 Clinical Laboratory Improvement Amendments Program	0/100	\$0	\$15,607	\$15,607
93.777.005 Health Insurance Benefits (Medicare)	0/100	\$0	\$301,444	\$301,444
93.778.000 Medical Assistance Program	39.29/60.71	\$19,983,389,284	\$30,877,871,301	\$50,861,260,584
93.778.002 Medicaid Reimbursements for Administration	39.29/60.71	\$16,446,357	\$25,412,531	\$41,858,888
93.778.003 Medical Assistance Program 50%	50/50	\$409,688,473	\$409,688,473	\$819,376,947
93.778.004 XIX Medical Assistance Program Administration @ 75%	25/75	\$217,488,160	\$652,464,481	\$869,952,641
93.778.005 XIX Medical Assistance Program @ 90%	10/90	\$22,800,383	\$205,203,448	\$228,003,831
93.778.007 XIX Medical Assistance Program Administration @ 100%	0/100	\$0	\$1,573,737,315	\$1,573,737,315
93.778.009 SHARS	39.29/60.71	\$1,949,140	\$3,011,766	\$4,960,905
93.788.000 Opioid State Targeted Response	0/100	\$0	\$58,756,085	\$58,756,085
93.791.000 Money Follows the Person Rebalancing Demonstration	0/100	\$0	\$19,085,583	\$19,085,583

Type of Fund	State / Federal Match Ratio	State Share	Federal Share	Total Funding
93.796.000 St. Survey Certification of HC Providers & Suppliers Title XIX	25/75	\$12,187,692	\$36,563,076	\$48,750,768
93.898.000 Cancer Prevention and Control Programs	30/70	\$3,291,620	\$7,680,447	\$10,972,067
93.958.000 Block Grants for Community Mental Health	0/100	\$0	\$129,766,465	\$129,766,465
93.959.000 Block Grants for Prevention and Treatment of Substance Abuse	0/100	\$0	\$224,461,697	\$224,461,697
93.994.000 Maternal and Child Health Services Block Grants to the States	0/100	\$0	\$7,328,730	\$7,328,730
94.011.000 Foster Grandparent Program	0/100	\$0	\$2,044,108	\$2,044,108
96.001.000 Social Security Disability Insurance	0/100	\$0	\$7,793,033	\$7,793,033
97.032.000 Crisis Counseling	0/100	\$0	\$516,370	\$516,370
97.050.000 Federal Assistance - Individuals and Households Other Needs	25/75	\$197,922,256	\$593,766,767	\$791,689,023
97.088.000 Disaster Assistance Projects: Case Management Pilot	0/100	\$0	\$1,007	\$1,007
TOTAL		\$21,508,465,609	\$37,775,458,792	\$59,283,924,401

F. If applicable, provide detailed information on fees collected by your agency. Please explain how much fee revenue is deposited/returned to the General Revenue Fund and why, if applicable.

Health and Human Services Commission

Exhibit 10: Fee Revenue — Fiscal Year 2024

Fee Description/Program/ Statutory Citation	Current Fee/ Statutory Maximum	Fees Set by Statute or Rule?	Statutory Maximum or Minimum	Number of Persons or Entities Paying Fee	Fee Revenue	Where Revenue is Deposited (e.g., General Revenue Fund)
Voluntary Fees and Contributions - Local Funds						
Voluntary Fees and Contributions - Local Funds / Texas Home Visiting Program – Texas Health and Safety Code, Section 191.0048	\$5 voluntary contribution	Statute	\$5 voluntary contribution	Unknown, contributions collected by another agency	\$109,629	GR-Dedicated
Voluntary Driver License Contributions for Blindness, Education, Screening and Treatment						
Voluntary Driver License Contributions for Blindness, Education, Screening and Treatment Program – Texas Transportation Code, Section 521.008	\$1 or more voluntary contribution	Statute	\$1 or more voluntary contribution	Unknown, contributions collected by another agency	\$489,394	General Revenue
Motor Vehicle Registration Fees						

Fee Description/Program/ Statutory Citation	Current Fee/ Statutory Maximum	Fees Set by Statute or Rule?	Statutory Maximum or Minimum	Number of Persons or Entities Paying Fee	Fee Revenue	Where Revenue is Deposited (e.g., General Revenue Fund)
Motor Vehicle Registration Fees - Specialty License Plates, Texas Transportation Code, Sections 504.002 and 504.601. Deaf or Hard of Hearing - Section 504.204, Stop Human Trafficking – Section 504.675; Volunteer Advocate Program - Section 504.611	\$22	Statute	\$22	Unknown, fees collected by another agency	\$15,788	General Revenue
Health Regulation Fees						
Health Regulation Fees - Assisted Living Facility License Fees – Texas Health and Safety Code Sections 242.0975, 247.024, 247.0451, 247.045, 247.0211, and 247.0452	Initial and renewal: \$300 + \$15 per bed Capacity increase: \$15 per bed Relocation, change of ownership: \$300 + \$15 per bed Alzheimer's certification: \$300	Rule	up to \$2,250	913	\$1,076,129	General Revenue

Other Health Regulation Fees - Narcotic Treatment Program Fees – Texas Health and Safety Code, Section 466.023; Special Care Facilities Fees - Health and Safety Code Section 248.024; Prescribed Pediatric Extended Care Center – Texas Health and Safety Code Sections 248A.052, 248A.053, 248A.103, 248A.205, and 248A.251	Narcotic Treatment Programs - Initial \$1,000 application fee; \$60 for each new/initial patient; \$200 for hospital narcotic drug detoxification; \$150 for each medication unit; renewal fee \$60 for each licensed patient; various late fees Special Care Facilities License - Initial \$70 per bed; \$70 per bed renewal, change of ownership, or relocation Prescribed Pediatric Extended Care Centers - \$2,625 license fee for initial license and renewals; \$1,312.50 for a change in capacity; \$50 per day late renewal fee (\$500 max); \$2,625 relocation fee; \$2,625 for	Rule	Narcotic Treatment Programs: Amounts necessary to recover at least 50% of costs Special Care Facilities: Amounts necessary to administer Health and Safety Code Ch. 248 PPECCs: Amounts necessary to recover costs of administration	Varies	\$525,332	General Revenue

Fee Description/Program/ Statutory Citation	Current Fee/ Statutory Maximum	Fees Set by Statute or Rule?	Statutory Maximum or Minimum	Number of Persons or Entities Paying Fee	Fee Revenue	Where Revenue is Deposited (e.g., General Revenue Fund)
	change of ownership					
Health Care Facilities Fees						
Home & Community Support Services Agencies (HCSSA) License Fee - Parent – Texas Health and Safety Code, Section 142.010 and 142.0105	Initial and renewal: \$2,625 Change of ownership: \$2,625 Late renewal: 1/2 of basic renewal fee \$1,312.50	Rule	Min/Max: \$600/\$2,625	2,512	\$6,509,276	GR-Dedicated. Part of this amount appropriated to the Department.
HCSSA License Fee - Branch Office – Texas Health and Safety Code, Sections 142.010 and 142.0105	Initial and renewal: \$2,625 Change of ownership: \$2,625 Late renewal: 1/2 of basic renewal fee \$1,312.50	Rule	Min/Max: \$600/\$2,625	327	\$609,875	GR-Dedicated. Part of this amount appropriated to the Department.
HCSSA License Fee - Alternate Delivery Site – Texas Health and Safety Code, Section 142.010 and 142.0105	Initial \$1500; Renewal \$900 Change of ownership: \$1,500 Late renewal: 1/2 of basic renewal fee \$450	Rule	Min/Max: \$600/\$2,625	103	\$223,975	GR-Dedicated. Part of this amount appropriated to the Department.

Fee Description/Program/ Statutory Citation	Current Fee/ Statutory Maximum	Fees Set by Statute or Rule?	Statutory Maximum or Minimum	Number of Persons or Entities Paying Fee	Fee Revenue	Where Revenue is Deposited (e.g., General Revenue Fund)
Nursing Home License Fee – Texas Health and Safety Code, Sections 242.034 and 242.309	\$375 + \$15 per bed Initial and Renewal; \$125 + \$5 per bed (probationary); \$375 + \$15 per bed relocation and change of ownership; 1/2 of basic renewal fee \$187.50 for late renewal, \$300 Alzheimer's certification, \$50 background information; \$20 fee for nursing facility administrator change (within 30 days), \$500 penalty if not reported within 30 days.	Rule	\$375 + \$15 per bed (3 year) \$125 + \$5 per bed (probationary)	1,364	\$1,021,225	General Revenue. Unappropriated then Comptroller sweeps amounts.

Fee Description/Program/ Statutory Citation	Current Fee/ Statutory Maximum	Fees Set by Statute or Rule?	Statutory Maximum or Minimum	Number of Persons or Entities Paying Fee	Fee Revenue	Where Revenue is Deposited (e.g., General Revenue Fund)
Hospitals – Texas Health and Safety Code, Section 241.025, 241.059, 241.060, 241.302, 241.303, 241.055, and 241.405	General and Special Hospitals, Limited Service Rural Hospitals Initial and renewal: \$39 per bed Change of ownership and relocation: \$39 per bed Certificate of Public Advantage: \$75,000 Hospital at Home Program Initial, renewal, increased bed fee: \$390 per 10 beds designated for program.	Rule	Certificate of Public Advantage: up to \$75,000 application fee	As of March 4, 2025, HHSC licensed: - 654 general and special hospitals - 4 LSRHs -36 hospitals participating in the Hospital at Home program	\$3,105,428	General Revenue
Chemical Dependency Facilities, Texas Health and Safety Code, Sections 464.007 and 464.017	Basic fee: \$1,200 Site fee: \$125 Residential: add \$35 per bed	Rule	amount necessary to cover 50% of costs of the licensing program	Varies depending on the number of entities that apply for a license. In 2024 five (5) entities paid the fee.	\$592,693	GR-Dedicated

Fee Description/Program/ Statutory Citation	Current Fee/ Statutory Maximum	Fees Set by Statute or Rule?	Statutory Maximum or Minimum	Number of Persons or Entities Paying Fee	Fee Revenue	Where Revenue is Deposited (e.g., General Revenue Fund)
Intermediate Care Facilities for Individuals with an Intellectual Disability – Texas Government Code, Section 546.0551; Texas Health and Safety Code, Sections 252.010, 252.034, 252.0375, 252.064, 252.065, 252.095, 252.202, and 252.205	Initial and renewal: \$225 + \$7.50 per bed Capacity increase: \$7.50 per bed Relocation and change of ownership: \$225 + \$7.50 per bed Late Renewal: 1/2 of basic renewal fee \$112.50 Change in administrator: \$20	Rule	Initial and renewal: \$225 + \$7.50 per bed Change in administrator: \$20	Varies	\$0	
Day Activity and Health Services Facilities – Texas Human Resources Code, Sections 103.007, 103.0075, and 103.012	Initial and renewal: \$75 Relocation and change of ownership: \$75 Late renewal: \$25	Rule	License and renewal fees: \$75	Varies	\$0	
Freestanding Emergency Medical Care Facility – Texas Health and Safety Code, Sections 254.053, 254.205, and 254.207	Initial: \$14,820 Renewal: \$6,070 Change of ownership or relocation: \$14,820	Rule	Amounts necessary to defray costs of administration	Varies	\$1,488,185	

Fee Description/Program/ Statutory Citation	Current Fee/ Statutory Maximum	Fees Set by Statute or Rule?	Statutory Maximum or Minimum	Number of Persons or Entities Paying Fee	Fee Revenue	Where Revenue is Deposited (e.g., General Revenue Fund)
End Stage Renal Disease Facility – Texas Health and Safety Code, Sections 251.013, 251.065, and 251.066	Initial: \$3,000 - \$6,700 based on the total number of stations Renewal, change of ownership, relocation: same as initial	Rule	Amounts necessary to defray costs of administration	Varies	\$1,799,845	
Birthing Centers – Texas Health and Safety Code, Sections 244.007, 244.014, and 244.015	Initial and renewal: \$2,000 Change of ownership: \$2,000	Rule	Amounts necessary to defray costs of administration	Varies	\$96,320	
Ambulatory Surgical Centers – Texas Health and Safety Code, Section 243.007, 243.014, and 243.015	Initial and renewal: \$5,200 Change of ownership or relocation: \$5,200	Rule	Amounts necessary to defray costs of administration	Varies	\$1,214,376	
Abortion Facilities – Texas Health and Safety Code, Section 245.005, 245.007, 245.015, and 245.017	Initial and renewal: \$5,000 Change of ownership or relocation: \$5,000 Assessment fees: vary	Rule	Amounts necessary to defray costs of administration	Varies	\$0	

Fee Description/Program/ Statutory Citation	Current Fee/ Statutory Maximum	Fees Set by Statute or Rule?	Statutory Maximum or Minimum	Number of Persons or Entities Paying Fee	Fee Revenue	Where Revenue is Deposited (e.g., General Revenue Fund)
Quality Assurance Fees – Texas Health and Safety Code, Section 252.206	Calculated and variable based on statutory requirements	Statute	Amount necessary to produce annual revenues equal to an amount that is not more than six percent of the facility's annual gross receipts.	Varies	\$78,100,885	GRD 5080 - Quality Assurance Fee
Medical Examination and Registration						
Medical Examination and Registration - Medication Aide – Texas Health and Safety Code, Sections 142.026, 242.610, and 242.611	Permit application and examination fee - \$25 Renewal permit application fee - \$15 Late renewal: \$22.50 from 1-90 days; \$30 for 91 - 365 days \$5 permit replacement \$38.25 fingerprinting fee		Permit application and examination fee - \$25 Renewal permit application fee - \$15	Varies	\$178,465	General Revenue
Health Related Professional Fees						

Fee Description/Program/ Statutory Citation	Current Fee/ Statutory Maximum	Fees Set by Statute or Rule?	Statutory Maximum or Minimum	Number of Persons or Entities Paying Fee	Fee Revenue	Where Revenue is Deposited (e.g., General Revenue Fund)
Health Related Professional Fees – Texas Occupations Code, Sections 504.053, 504.203, 504.302, 504.058, and 504.351	TOC 504.053: Fees for Licensed Chemical Dependency Counselors (LCDCs) LCDC Intern Initial: \$65 Renewal: \$125 LCDL: Initial: \$85 Renewal: \$125 Late renewal up to 90 days after the license expiration date: \$37.50; 91 days - 1 year: \$75 Chemical Dependency Counselor Programs (Peer Assistance Programs) Current fee: \$10 for initial licensure and renewal application fees	Rule	LCDL License Renewal -90 days or less - one and one-half times the required renewal fee -more than 90 days but less than one year - two times the required renewal fee. Peer assistance programs - not more than \$10 surcharge	As of March 11, 2025, HHSC had: - 3,784 LCDL Interns -6,130 LCDLs	\$744,715	General Revenue
Support and Maintenance of Patients						

Fee Description/Program/ Statutory Citation	Current Fee/ Statutory Maximum	Fees Set by Statute or Rule?	Statutory Maximum or Minimum	Number of Persons or Entities Paying Fee	Fee Revenue	Where Revenue is Deposited (e.g., General Revenue Fund)
Support and Maintenance of Patients	Varies; Sliding fee schedule for parents of children under 18	Rule	Fees may not exceed the cost to the state to support, maintain, and treat a patient	Varies by facility and patient	\$30,247,36 5	General Revenue
Private Institutions License Fees / Child-Care Facility or Child-Placing Agency						
Private Institutions License Fees / Child-Care Facility or Child-Placing Agency – Texas Human Resources Code, Sections 42.0521, 42.054, 42.0715, and 42.078	Initial and renewal: \$35 + \$1 x Total Capacity Annual Fee: \$1 x Total Capacity	Rule	N/A	Residential Care Operations Private (0) General Residential Operation (406) Child Placing Agency (424) Day Care Operations Licensed Child Care Center (10797) Licensed Child Care Home (1943) Listed Family Home (2608) Registered Child Care Home (3160)	\$1,932,151	General Revenue

Fee Description/Program/ Statutory Citation	Current Fee/ Statutory Maximum	Fees Set by Statute or Rule?	Statutory Maximum or Minimum	Number of Persons or Entities Paying Fee	Fee Revenue	Where Revenue is Deposited (e.g., General Revenue Fund)
Welfare/Mental Health Service Fees						
Welfare/Mental Health Service Fees - Social Services – Texas Human Resources Code, Section 22.002(h)	Fees for various services at state hospitals and SSLCs at discretion of facility directors	NA	NA	2	\$20	General Revenue
Elderly Housing Set-Aside						
Elderly Housing Set-Aside – Texas Local Government Code, Section 394.902	1/10% of total principal amount of loan for residential development	Statute	1/10% of total principal amount of loan for residential development	Unknown	\$961,063	General Revenue
Civil Penalties						
Civil Monetary Penalties	Varies	NA	NA	Varies	\$11,528,217	Appropriate fund or account
Fees for Copies or Filing of Records						
Fees for Copies or Filing of Records - Informal Dispute Resolution Assisted Living Facilities – Texas Health and Safety Code, Section 247.051	Varies based on cost associated with preparation, copying, delivery, and redaction of information requested by the facility	Statute	Reasonable cost associated with preparation, copying, delivery, and redaction of information requested by the facility	Nursing facilities, assisted living facilities, intermediate care facilities, Home and Community- based Service and Texas Home Living waiver providers.	\$1,175,812	General Revenue

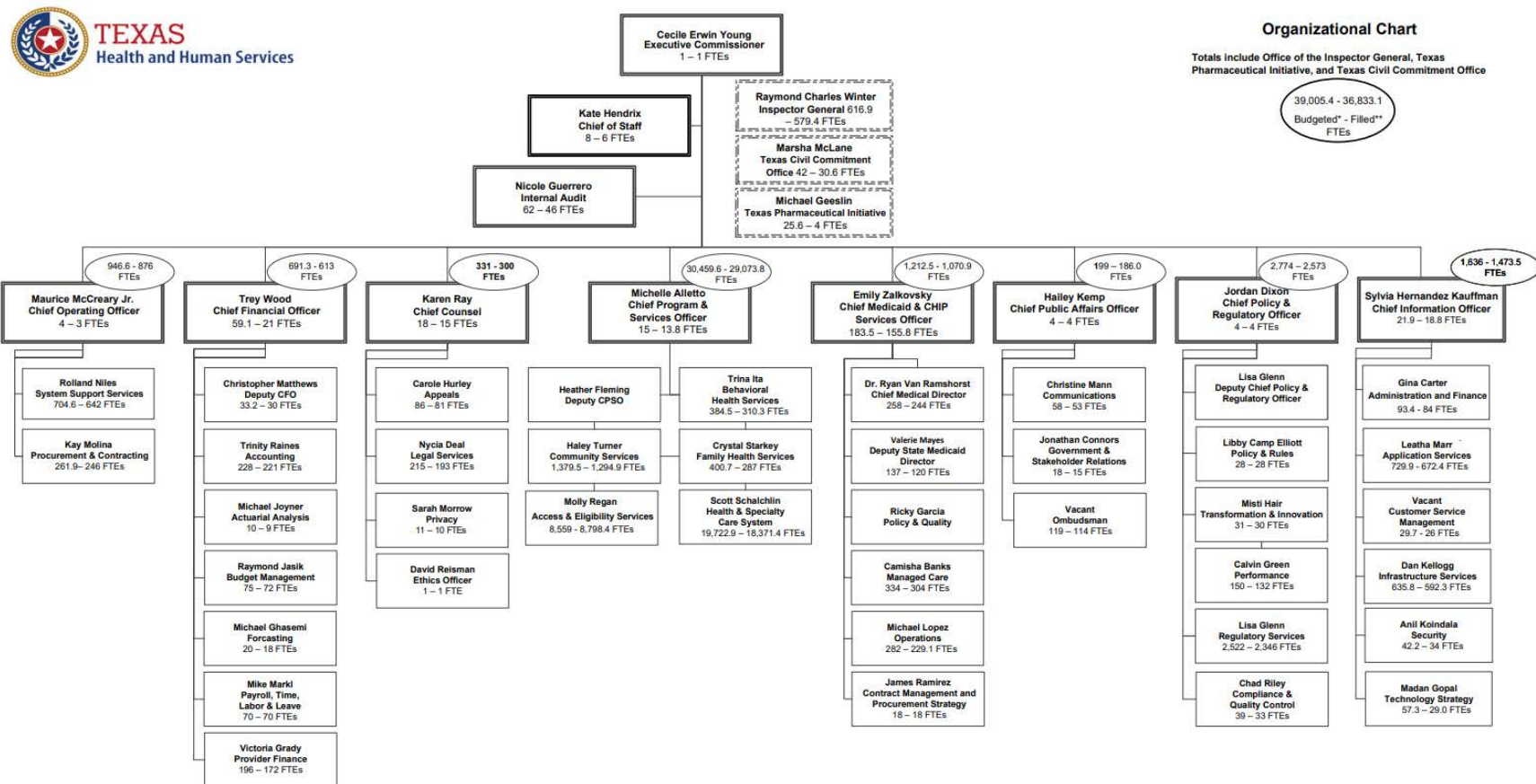
Fee Description/Program/ Statutory Citation	Current Fee/ Statutory Maximum	Fees Set by Statute or Rule?	Statutory Maximum or Minimum	Number of Persons or Entities Paying Fee	Fee Revenue	Where Revenue is Deposited (e.g., General Revenue Fund)
Fees for Copies or Filing of Records - General - Public Information Requests, Canteen Sales, Copies of Records, Fiscal Agent Record Requests, and other – Texas Government Code, Sections 552.261, 603.004, and 603.009	Varies	Statute	NA	Varies	\$79,284	General Revenue
Criminal History Check Fees – Texas Human Resources Code, Sections 42.0521, 42.054, 42.0715, and 42.078	\$2 per background check	Rule	Maximum per statute is not to exceed the administrative costs the department incurs in conducting a background and criminal history check.	Child Care Operations (FY22): 17,572 Number of Background Checks (FY22): 260,302 (Daycare: 242,118; Residential Care: 18,184)	\$558,807	General Revenue
Conference, Seminars, and Registration Fees						
Conference, Seminars, and Registration Fees	Varies	NA	NA	Varies	\$10,860	General Revenue
Deaf and Hard of Hearing Services Consumer Training and Camp Sign Fees – Texas Human Resources Code, Section 81.006	Varies	NA	NA	Varies	\$16,660	General Revenue
Administrative Penalties						
Administrative Penalties	Varies	Varies	Varies	Varies	\$2,974,158	

Fee Description/Program/ Statutory Citation	Current Fee/ Statutory Maximum	Fees Set by Statute or Rule?	Statutory Maximum or Minimum	Number of Persons or Entities Paying Fee	Fee Revenue	Where Revenue is Deposited (e.g., General Revenue Fund)
Fees for Administrative Services						
Fees for Administrative Services - CHIRP/QIPP/UC Application Fees	CHIRP Application Fee: \$15,000 QIPP Application Fee: \$10,000 Uncompensated Care Application Fee: \$10,000 for non-public providers	Rule	NA	Varies	\$6,627,000	General Revenue
Fees for Administrative Services - SHARS	1% administrative fee of total certified Medicaid allowable costs for SHARS services	Rule	NA	Participating school districts	\$2,658,937	General Revenue
Fees for Administrative Services - Council on Sex Offender Treatment	License fee: \$375 Renewal fee: \$275 Late renewal, reinstatement fees, request for criminal history evaluation letter: vary	Rule	NA	Vary	\$104,004	General Revenue

VI. Organization

A. Provide an organizational chart that includes major programs and divisions and shows the number of FTEs in each program or division. Detail should include, if possible, division heads with subordinates, and actual FTEs with budgeted FTEs in parentheses.

Figure 1. HHSC organizational chart with budgeted full-time employees (FTEs) as of June 1, 2025.



* FTE authority for Fiscal Year 2025 as of 2026-27 Legislative Appropriations Request (August 2024). ** Filled FTEs as of 2026-27 LAR reporting (August 2024).

B. Fill in the chart below listing the agency’s headquarters and number of FTEs and, if applicable, field or regional offices.

Texas Health and Human Services Commission

Exhibit 11: FTEs by Location — Fiscal Year 2025¹

Headquarters, Region, or Field Office	Location	Number of Budgeted FTEs FY 2025	Number of Filled FTEs FY 2025
0	State Office	7,891.5	6,992.8
1	High Plains	1,394.6	1,355.3
2	Northwest Texas	4,303.8	4,039.2
3	Metroplex	4,319.4	4,082.0
4	Upper East Texas	1,747.8	1,723.9
5	Southeast Texas	1,418.3	1,382.8
6	Gulf Coast	3,363.9	3,289.5
7	Central Texas	4,528.1	4,302.1
8	Upper South Texas	4,096.7	3,894.5
9	West Texas	821.9	778.0
10	Upper Rio Grande	1,588.8	1,584.6
11	Lower South Texas	3,462.9	3,373.9
	TOTAL:	38,937.8	36,798.6
TCCO		42.0	30.6
TPI		25.6	4.0
	GRAND TOTAL:	39,005.4	36,833.17

¹ FTE authority and filled FTEs for Fiscal Year 2025 are reported as of the 2026-27 Legislative Appropriations Request (August 2024).

C. What are your agency’s FTE caps for fiscal years 2023-27?

Table 1. Table of FTE caps.

Fiscal Year	FTE Caps
2023	38,509.30
2024	38,895.00
2025	38,998.40
2026	42,227.20
2027	43,562.00

Notes: Fiscal year 2023-24 represents Q4 FTE Limitation submitted to SAO. Fiscal year 2025 data is through Q1. Fiscal year 2026-27 amounts as of 2026-27 General Appropriations Act, Senate Bill (S.B.) 1, 89th Legislature, Regular Session, 2025 (Conference Committee Report). The FTE Cap includes all FTEs within HHSC's bill pattern.

D. How many temporary or contract employees did your agency have in fiscal year 2024? Please provide a short summary of the purpose of each position, the amount of expenditures per contract employee, and the procurement method of each position.

Texas Health and Human Services Commission

Exhibit 12: Temporary/Contract Employees — Fiscal Year 2024

Type of Temporary Contract Employee	Purpose of Position	Number of Employees	Amount Expended	Procurement Method
Temporary	Disaster Response - BHS	3.0	\$352,605	NA
Temporary	Disaster Response - IT	3.0	\$418,220	NA
Temporary	Disaster Response - SSS	40.0	\$769,056	NA
Temporary	Behavioral Health Services (BHS) - American Rescue Plan Act (ARPA)/COVID-19 Positions received to implement Substance Abuse and Mental Health Services (SAMHSA) COVID-19 grants: • 1 Contract Administration Manager • 1 Contract Specialist • 1 Director • 10 Program Specialists • 9 Program Specialists The Bipartisan Safer Communities Act (BSCA) grant supports the enhancement of mental health care coordination, training, and emergency preparedness and response in Texas: • 12 Program Specialists • 1 Staff Services Officers	37.0	\$2,604,545	NA

Type of Temporary Contract Employee	Purpose of Position	Number of Employees	Amount Expended	Procurement Method
	9-8-8 State and Territory Improvement opportunity for 9-8-8 contacts (including calls, chats, and texts) originating in Texas: • 2 Program Specialists			
Temporary	AES Eligibility Operations - Eligibility Advisor I positions perform various functions to determine eligibility for HHSC programs including but not limited to the Supplemental Nutrition Assistance Program (SNAP) and Medicaid. The positions support the increased workload due to the unwinding of the continuous Medicaid coverage.	480.0	\$30,377,378	NA
Temporary	• 3 Financial Analysts assisting the Asset Management Office • 2 Volunteer Service Coordinators in Fort Worth and Temple supporting the Foster Grandparent Program • 2 Research Specialists supporting the Chief Financial Office • 1 Ombudsman supporting the Office of Ombudsman	7.0	\$524,265	NA

Type of Temporary Contract Employee	Purpose of Position	Number of Employees	Amount Expended	Procurement Method
Contract	IT Services, Staff Augmentation for the Chief Data Architect. Contractors provide essential services to support the establishment and maintenance of a robust and coherent data architecture for reporting and analytics across the agency: • 5 Business Analysts • 1 Cloud Solutions Architect • 1 Database Administrator • 12 Developer/Programmer Analysts • 6 Enterprise Architects • 1 Program Manager • 3 Project Managers • 1 Software Developer • 10 Systems Analysts	40.0	\$5,366,247	DIR Cooperative Contract
Contract	IT Services, Staff Augmentation for the Chief IT Operations. Provides critical support of Data Center Services, TIERS, Network, Telecom, System Services, and Customer Services including deskside support: • 3 Applications Architects • 2 Business Analysts • 1 Cloud Solutions Architect • 5 Database Administrators • 6 Developer/Programmer Analysts • 2 Network Administrators • 22 Product Support Analysts • 1 Program Manager	89.0	\$10,987,413	DIR Cooperative Contract

Type of Temporary Contract Employee	Purpose of Position	Number of Employees	Amount Expended	Procurement Method
	• 1 Project Lead • 14 Project Managers • 11 Software Developers • 2 Software Engineers • 1 Support Technician • 15 Systems Analysts • 1 Telecommunications Technician • 2 Web Administrators			
Contract	IT Services, Staff Augmentation for CAPPS Financials. Provides essential services to support the implementation of the CAPPS Human Capital Management (HCM) system Consolidated Application Control Environment (CACE): • 3 Applications Architects • 1 Database Administrator • 3 Developer/Programmer Analysts • 1 ERP Developer • 3 Instructor Trainers • 2 Network Administrators • 3 Project Managers • 4 QA Engineer Automated • 1 Security Administrator • 10 Software Engineers • 11 Systems Analysts • 1 Technical Writer	43.0	\$5,984,516	DIR Cooperative Contract

Type of Temporary Contract Employee	Purpose of Position	Number of Employees	Amount Expended	Procurement Method
Contract	IT Services, Staff Augmentation for Public Health. Provides essential services to support the software developmental lifecycle for software systems and business applications related to public health: • 16 Business Analysts • 2 Data Analyst/Report Writers • 2 Database Administrators • 4 Developer/Programmer Analysts • 2 Enterprise Architects • 2 Information Security Managers • 2 Instructor Trainers • 3 Network Security Analysts • 4 Program Managers • 2 Project Leads • 25 Project Managers • 2 QA Associate/Analysts • 1 Software Developer • 1 Software Engineer • 31 System Analysts • 1 Technical Writer	100.0	\$13,485,768	DIR Cooperative Contract
Contract	IT Services, Staff Augmentation for IT Applications. Provides essential support to the software developmental lifecycle for software systems and business applications, including but not limited to Medicaid Management Information System (MMIS), Regulatory Services	259.0	\$30,697,985	DIR Cooperative Contract

Type of Temporary Contract Employee	Purpose of Position	Number of Employees	Amount Expended	Procurement Method
	applications, TIERS, Special Supplemental Program for Women, Infants and Children (WIC) applications, HHS Enterprise Administrative Report and Tracking System (HEART), and SCOR: • 1 Agile Coach Specialist • 23 Business Analysts • 3 Business Intelligence Analysts • 2 Cloud Solutions Architects • 2 Data Security Analysts • 16 Database Administrators • 4 Database Architects • 42 Developer/Programmer Analysts • 15 DevOps Engineers • 7 Enterprise Architects • 3 Information Security Managers • 1 Program Manager • 2 Project Leads • 24 Project Managers • 8 QA Associate/Analysts • 15 QA Engineer Automated • 1 QA/Test Manager • 22 Software Developers • 43 Software Engineers • 23 Systems Analysts • 2 Technical Writers			
Contract	IT Services, Staff Augmentation for Medicaid and CHIP	38.0	\$3,944,469	DIR Cooperative

Type of Temporary Contract Employee	Purpose of Position	Number of Employees	Amount Expended	Procurement Method
	Administration. Supports MMIS related projects: • 26 Business Analysts • 2 Developer/Programmer Analysts • 1 Program Manager • 7 Project Managers • 2 Systems Analysts			Contract
Contract	IT Services, Staff Augmentation for Other IT Services. Includes contract security personnel that conduct cyber security tool implementation, prevention of data loss, advanced cybersecurity network analytics and defense, investigation of potential cyber threats, etc. The Project Management Office utilizes contractors to support technology automation, Power BI report design and development, project management and agile training and coaching: • 1 Agile Coach • 1 Business Analyst • 3 Data Scientists • 2 Data Security Analysts • 1 Database Administrator • 2 Database Architect Specialists • 1 Developer/Programmer Analyst • 5 Network Security Analysts • 1 Process Improvement Manager	34.0	\$3,881,442	DIR Cooperative Contract

Type of Temporary Contract Employee	Purpose of Position	Number of Employees	Amount Expended	Procurement Method
	• 2 Program Managers • 1 Project Lead • 9 Project Managers • 1 Software Developer • 2 Software Engineers • 1 Systems Analyst • 1 Technical Writer			
Contract	Facility-based Services (HSCS), State Hospitals: Medical professionals to provide services	132.0	\$3,822,620	Open Enrollment
Contract	Facility-based Services (HSCS), State Supported Living Centers: Medical professionals to provide services	221.0	\$3,878,453	Open Enrollment
Contract	BHS Operations - Plans and coordinates the business projects related to the BHS Management System (BHSMS): • 1 Director Children's Mental Health - The temporary contractor works to complete the Residential Treatment Center (RTC) Project policy manual as part of the implementation of Senate Bill (S.B.) 642, 87th Legislature, Regular Session, 2021, as well as any other priority assignments through the RTC Project: • 1 Program Specialist	2.0	\$195,374	Managed Service Provider/Peak Performers
Contract	Chief Financial Officer (CFO): Support implementation of CAPPS Financials system: • 1 Instructor Trainer	1.0	\$40,408	Managed Service Provider/Peak Performers

Type of Temporary Contract Employee	Purpose of Position	Number of Employees	Amount Expended	Procurement Method
Contract	Community Services - Deaf and Hard of Hearing Services: 1 providing administrative support for STAP and BEI	1.0	\$23,906	Managed Service Provider/Work Quest
Contract	Community Services - Policy and Strategy: 2 Program Specialists provided support to the MFP funded project to support the Direct Service Workforce	2.0	\$221,667	Managed Service Provider/Peak Performers
Contract	Medicaid & CHIP Services: Seven contractors working on ARPA-Home and Community-Based Services (HCBS) related projects and eight were supporting contract administration: 5 Administrative Assistants 5 Contract Specialists 3 Program Specialists 1 Project Manager 1 Relocation Contractor	15.0	\$1,262,351	Managed Service Provider/Peak Performers
Contract	OIG: Fraud Hotline Support	2.0	\$70,481	Managed Service Provider/Peak Performers
	TOTAL:	1,549.0	\$118,909,168	

Note:

- Headcount data is from fiscal year 2024, Q4.
- The category IT Services, Staff Augmentation includes contractors procured through Department of Information Resources contracts, per Texas Government Code, Section 2157.068. These employees are separate from headcounts reported to the State Auditor's Office quarterly.
- IT Services, Staff Augmentation expended considers year to date expended data for all contractors who worked more than 0 hours in Q4 fiscal year 2024.

E. List each of your agency’s key programs or functions, along with expenditures and FTEs by program. See Exhibit 13 Example. (If you have already completed the “Agency Program Information” spreadsheet in advance, you do not need to replicate any duplicative information below.)

Health and Human Services Commission

Exhibit 13: List of Program FTEs and Expenditures — Fiscal Years 2024 and 2025

Key Programs or Functions	Budgeted FTEs FY 2025	Budgeted Expenditures FY 2025
Chief Audit Executive		
Internal Audit Compliance Division	9	\$1,323,400
Internal Audit Division	53	\$4,828,016
Chief Counsel		
Appeals Division	1	\$202,776
Contested Case Department	7	\$829,421
COVID-19 Disaster Funding	0	\$0
Department of State Health Services Office of General Counsel	3	\$436,824
Enforcement Department	54	\$6,950,657
Ethics Office	1	\$198,511
Fair and Fraud Hearings Department	73	\$5,299,021
Guardianship Department	11	\$1,301,710
Informal Dispute Resolution	3	\$319,933
Legal Services Division	3	\$379,511
Litigation Department	28	\$2,788,327
Office of Chief Counsel	9	\$6,006,354
Open Records and Data Governance Department	13	\$1,299,643
Personnel Department	16	\$1,999,662
Policy Department	68	\$7,641,570
Privacy Division	11	\$1,131,191
System Contracting Department	34	\$4,092,741
Chief Financial Officer		
Actuarial Analysis	10	\$2,778,021
Agency Costs	0	\$29,418,558
Budget Management	75	\$7,884,947

Central Accounting	228	\$16,666,451
Chief Financial Officer Ancillary Support	74.3	\$5,157,258
DCFO CAPPs	3.2	\$11,550,508
Federal Funds Office	19	\$1,952,418
Forecasting	20	\$2,547,081
Payroll, and Time Labor and Leave	70	\$4,734,174
Provider Finance	198	\$136,098,714
Chief Information Officer		
Administration and Finance	89.1	\$8,779,160
Administrative Applications IT Services	97	\$58,225,918
Administrative Contracts - Claims Administrator	0	\$0
Applications	0	\$13,048,306
Budgets for IT Infrastructure Services & Administration	0	\$13,150,745
Chief Information Office	40.5	\$7,136,249
Chief Information Security Office	40.2	\$14,374,399
Chief Technology Office	22.5	\$2,865,936
COVID-19 Disaster Funding	153.4	\$33,866,296
Enterprise Resource Planning - Centralized Accounting and Payroll/Personnel System Human Capital Management and Financials	19.3	\$6,913,682
Family Health Services and Community Services Applications	54	\$26,664,382
Health and Specialty Care Applications	24.3	\$54,323,519
Information Technology Application Services	7.6	\$1,038,656
Infrastructure Services - Converged Services	46.5	\$87,475,687
Infrastructure Services - Customer Service & Support	302.4	\$19,898,138
Infrastructure Services - Data Center Operations	62.4	\$173,322,096
Infrastructure Services - Operations Management	101.2	\$12,852,124
Infrastructure Services - System Services	123.7	\$53,641,898
Inspector General Applications/Administrative Applications	15	\$8,409,065
Intellectual and Developmental Disabilities and Behavioral Health Applications	45.8	\$16,819,446
Medicaid and CHIP Systems	76.8	\$22,789,211

Medicaid Technology Modernization	1	\$0
Office of Chief Data Architect - Data Analytics Support	13.8	\$20,306,247
Procurement And Contracting Services	18.9	\$1,857,855
Provider Finance	0	\$0
Public Health Applications	11.6	\$10,498,311
Regulatory Services Applications	52	\$14,543,764
Social Services Applications	221.8	\$71,694,025
Chief Medicaid and CHIP Services Officer		
Administrative Contracts	2.8	\$30,555,763
Administrative Contracts - Claims Administrator	0	\$390,863,572
Administrative Contracts - Electronic Visit Verification	0	\$21,562,434
Administrative Contracts - Enrollment Broker	0	\$80,662,518
Administrative Contracts - External Quality Review Organization	0	\$13,256,832
Administrative Contracts - Vendor Drug Program	0	\$15,286,701
Children's Health Insurance Program	0	\$854,037,511
Children's Health Insurance Program - Perinatal	0	\$156,102,545
Children's Medicaid	0	\$9,643,557,630
Claims Administrator	0	\$11,898,750
Community Living Assistance and Support Services (CLASS)	0	\$382,953,464
Contract Administration and Provider Monitoring	105.6	\$7,310,725
COVID-19 Disaster Funding	1.4	\$14,572,855
Deaf Blind Multiple Disabilities (DBMD)	0	\$22,754,212
EC Ancillary Supports	0	\$0
Financial Reporting and Audit Coordination	28	\$2,648,795
IDD Program Eligibility and Support	35.1	\$2,144,892
Major Procurements	3	\$268,909
Managed Care Contracts and Oversight	123	\$8,621,903
Medicaid & CHIP Services	0	\$100,261,417
Medicaid and CHIP Services Division (Administration)	60	\$6,036,852
Medicaid Client Services	0	\$28,235,435,922
Medicaid for Pregnant Women	0	\$1,485,066,549

Medicaid Services Off-Budget	0	\$10,381,782,297
Medicaid Technology Modernization	1.2	\$174,202
Office of Policy	146.6	\$15,201,538
Office of the Medical Director	258	\$22,334,649
Operations Management	101.8	\$9,780,294
Program Enrollment and Support	183	\$9,028,376
Quality and Program Improvement	111.6	\$11,556,346
Texas Home Living (TxHmL)	0	\$86,629,051
Transportation Eval	0	\$0
Vendor Drug Program	58.3	\$3,940,071
Chief Operating Officer		
Asset Management Office	25	\$1,259,783
Business and Regional Services	274	\$150,541,802
Chief Operating Officer Admin	4	\$657,963
Civil Rights Office	70	\$4,556,251
Contract Management Operations	36	\$26,911,952
COVID-19 Disaster Funding	0	\$524,400
Facility Planning and Leasing	76	\$32,104,197
HHS Emergency Management Office	78	\$363,171
Human Resources and Workforce Operations Management	146	\$9,613,438
Learning Resource Network	22.6	\$1,928,265
Office of the Deputy Executive Commissioner	4	\$517,333
Printing Services	34	\$3,931,710
Procurement And Contracting Services	238	\$18,778,155
Risk Management and Safety	12	\$1,001,079
Chief Policy and Regulatory Officer		
Chief Policy and Regulatory Office	4	\$608,528
Child Care Enforcement	0	\$1,025,050
Child Care Regulation	760.5	\$54,637,309
Compliance and Quality Control	39	\$3,500,029
COVID-19 Disaster Funding	0	\$234,335
Health Care Facility Enforcement	4	\$394,419
Health Care Regulation	176	\$17,363,387

Long-Term Care Enforcement	82	\$6,645,128
Long-Term Care Regulation	1,399.5	\$105,466,540
Office of Data, Analytics, and Performance	150	\$14,263,197
Office of Policy and Rules	28	\$2,485,512
Office of Transformation and Innovation	31	\$3,097,426
Regulatory DEC Office, Operations, and Complaint and Incident Intake	100	\$15,748,849
Chief Program and Services Officer		
2-1-1 Texas Information and Referral Network	8.6	\$13,219,876
988 Suicide and Crisis Lifeline	0	\$10,100,000
A998 Substance Use Services	1	\$165,868,458
A999 Mental Health Services	6	\$850,228,569
Abstinence Education	0	\$6,376,760
AES Ancillary Supports - Project Management	16.3	\$1,612,770
AES Community Access - Texercise	0	\$134,120
Aging and Disability Resource Centers	14	\$6,635,778
Ancillary Supports - Strategic Engagement and Employee Supports	39.4	\$3,920,247
Ancillary Supports - Strategic Innovation and System Supports	29.8	\$2,864,468
Behavioral Health Medicaid Programs Administration	29	\$2,582,158
Behavioral Health Medical Director	1.5	\$140,186
BHS Contracts	0	\$150,459,079
Bipartisan Safer Communities Act	0	\$0
Blind Children's Vocational Discovery and Development Program	77.5	\$5,823,241
Blindness Education, Screening, and Treatment (BEST) Program	1	\$432,677
Brain Injury Programs	37	\$23,140,732
Breast and Cervical Cancer Screening	0	\$8,379,719
Breast and Cervical Cancer Services Support	5	\$734,568
Bridge to Star + Pilot	0	\$2,820,955
Business Operations	8	\$1,489,126
CBCAP Direct	0	\$13,623,856
Child Advocacy Program	0	\$41,775,897
Child Advocacy Program Support	0	\$104,996

Children with Special Health Care Needs Services Program	0	\$24,462,336
Children's Autism Program	3	\$7,154,076
Community Access - Community Engagement Management	1	\$0
Community Access - Community Partner Program	40.3	\$3,001,872
Community Access - Office of Assoc Comm	6.7	\$808,276
Community Access - Operations	1	\$800,659
Community Care Services Eligibility	815	\$149,373,278
Community Mental Health Grant	0	\$27,500,000
Community Services Ancillary Support	81	\$8,036,437
Contract Management	73.5	\$7,023,291
Contract Operations	51.9	\$4,676,476
Contracted Audits	0	\$344,891
County Indigent Health Care Services	2	\$676,806
Court Appointed Special Advocates	0	\$15,964,000
COVID-19 Disaster Funding	14	\$143,248,855
CPSO Ancillary Supports	15	\$2,006,123
Deaf and Hard of Hearing Services	10	\$2,655,094
Deaf and Hard of Hearing Services and Board for Evaluation of Interpreters	4	\$526,886
Decision Support Services	23	\$2,271,077
Disaster Behavioral Health Coordination Administration	26.2	\$2,732,975
Early Childhood Intervention	0	\$193,167,831
Early Childhood Intervention Support	35	\$3,270,363
Early Family Nutrition Development Support	1	\$168,698
Epilepsy Program	9.5	\$658,446
Facility Program Support	81.8	\$7,841,343
Family and Youth Services Program Support	10	\$1,729,228
Family Clinical Services Program Support- Women's Health	3	\$435,853
Family Health Services	0	\$2,602,581
Family Health Services (FHS) Operations and FHS Strategy	124.7	\$3,413,157
Family Planning	0	\$79,614,739

Family Planning Program Support	0	\$180,000
Family Violence Program	0	\$48,541,473
Family Violence Program Support	12	\$1,072,191
FAYS	0	\$31,871,171
Finance Operations	13.4	\$1,323,488
Foster Grandparent Program	20	\$2,835,511
FSS Contracting & Program Support	0	\$5,840,969
Healthy Community Collaboratives Grant Program	0	\$16,500,000
Healthy Marriage Program	2	\$242,587
Healthy Texas Women - Cost Reimbursement	0	\$13,786,529
Hemophilia Assistance Program	0	\$2,012,995
Home and Community-Based Services - Adult Mental Health	0	\$33,310,919
HOPES	0	\$38,040,421
Human Trafficking Support	1	\$159,672
IDD Services and PASRR - Family Based Alternatives	0	\$864,730
IDD Services and PASRR - Interest List Management	0	\$926,992
IDD Services and PASRR - Money Follows the Person	12	\$4,361,232
IDD Services and PASRR - Multi Assistance Center	0	\$7,500,000
IDD Services and PASRR - Oversight and Support	65	\$112,568,498
IDD Services and PASRR - Preadmission Screening and Resident Review	23	\$1,598,374
IDD Services and PASRR (General Revenue)	0	\$9,759,864
IDD Services and PASRR Crisis Services	0	\$14,004,040
Independent Living Services	24	\$14,556,180
Indigent Health Care Reimbursement	0	\$439,443
Innovation & Engagement	0	\$1,945,182
Innovation and Engagement Administration	4	\$2,458,904
Intellectual and Developmental Disabilities (IDD) Services and Preadmission Screening and Resident Review (PASRR) Access and Intake	0	\$41,089,273
Jail Diversion Centers	0	\$5,000,000
Judicial Bypass	0	\$382,712
Kidney Health Care Program for End Stage Renal	0	\$15,342,022

Disease		
Leadership Team Administration	80.3	\$9,104,068
Maintenance and Construction	51	\$91,053,742
Maternal and Child Health Fee-for Service Support	7	\$724,294
Maternal and Child Health Fee-for-Service	0	\$6,234,604
Maternal Mental Health and Substance Use Disorder	0	\$750,000
Mental Health First Aid	0	\$2,425,540
Mental Health Program for Justice Involved Individuals	0	\$40,000,000
Mental Health Program for Veterans	0	\$3,956,268
Mental Health Programs, Planning and Policy	37	\$4,123,914
MIECHV Direct	0	\$35,397,809
Multisystemic Therapy	0	\$15,225,000
Nurse Family Partnership	0	\$17,930,767
Office of Acquired Brain Injury - Brain Injury Programs	2	\$254,880
Office of Aging Services Coordination	7	\$562,144
Office of Area Agencies on Aging	25	\$111,486,310
Office of Disability Services Coordination	5	\$449,206
Office of Guardianship Services-Guardianship Services Program	116	\$8,457,076
Office of Mental Health Coordination	33	\$2,652,155
Office of the Associate Commissioner	23	\$14,974,621
Office of Veteran Services Coordination	4	\$350,464
Operations - Associate Commissioner for Operations	25	\$2,038,887
Operations - Data Broker Services Contract	0	\$13,107,353
Operations - Document Processing Services Contract	0	\$5,200,000
Operations - Electronic Benefit Transfer Contract	0	\$7,654,727
Operations - Eligibility Support	0	\$119,020
Operations - Eligibility Support Services Contract	0	\$133,749,844
Operations - Integrity Support Services	221.8	\$13,958,125
Operations - Lone Stare Business Services	8.6	\$825,738
Operations - State and Regional Ops	7,081.2	\$350,003,188
Operations - Strategy and Innovation	114.3	\$28,336,175

Operations - Temporary Assistance for Needy Families	0	\$20,892,987
PDG Direct	0	\$122,988
Peer Support and Recovery	8	\$690,245
Prevention Services for Military and Veteran Families	0	\$2,000,000
Primary Health Care	0	\$11,912,408
Primary Health Care Program Support	5	\$424,716
Program Policy	217.2	\$14,965,918
Project Advancing Wellness and Resilience in Education	2	\$87,739
Projects for Assistance in Transition from Homelessness Program	0	\$145,841
Promoting Integration of Primary and Behavioral Health Care	0	\$0
Residential Treatment Center Project	0	\$3,830,821
Safe Baby Campaigns	0	\$1,200,000
Special Projects	16	\$1,891,935
Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program)	0	\$773,212,674
Special Supplemental Nutrition Program for Women, Infants, and Children Support	171	\$44,687,521
Specialized Telecommunications Assistance Program (STAP)	0	\$343,708
State Hospital Oversight	71	\$66,276,423
State Hospitals	7,775.1	\$531,497,045
State Supported Living Center State Office	100.7	\$74,274,518
State Supported Living Centers	11,641.4	\$746,213,865
Statewide Youth Services Network	0	\$2,125,000
Substance Use Programs, Policy and Planning Administration	25	\$2,598,077
Suicide Prevention	0	\$0
Supplemental Nutrition Assistance Program (SNAP)	0	\$0
Supplemental Nutrition Assistance Program (SNAP) Education and Training	6.7	\$364,838
Supplemental Nutrition Assistance Program (SNAP) Nutrition Education	12.7	\$31,959,847
Supplemental Nutrition Assistance Program (SNAP)	0	\$9,140,388

Outreach		
Supporting Mental Health and Resilience in Texas (SMART) Innovation Grant	0	\$14,762,133
Texas Cares Rx Program	8.5	\$6,292,051
Texas System of Care	0	\$0
Texas Targeted Opioid Response	0	\$73,706,624
Texas Targeted Opioid Response Administration	16	\$1,290,298
Texas Targeted Opioid Response Treatment	1	\$136,797
Texas Veterans and Family Alliance Grant	0	\$10,000,000
Texas Works Paths to Success	1.9	\$99,466
Thriving Texas Families	0	\$69,603,994
Thriving Texas Families Support	6	\$1,123,127
Women's Health Support	16	\$1,589,378
Youth Empowerment Services	0	\$10,351,924
Chief Public Affairs Officer		
Chief Public Affairs Office	5	\$741,741
Government and Stakeholder Relations	18	\$1,720,938
Office of Communications	57	\$4,780,012
Ombudsman - Office of the State Long Term Care Ombudsman	7	\$721,299
Ombudsman Complaint and Specialized Services	34	\$1,937,882
Ombudsman Executive Operations and Reporting Team	35	\$2,333,113
Ombudsman for Behavioral Health	5	\$367,090
Ombudsman Managed Care Assistance Team	19	\$1,169,301
Executive Commissioner		
EC Ancillary Supports	9	\$1,392,455
Office of Inspector General		
OIG	616.9	\$97,043,354
Grand Total	38,379.7	\$59,525,036,942

Note: FTEs and expenditures related to Disability Determination Services, the Office of the Independent Ombudsman, the Texas Pharmaceutical Initiative, the Texas Civil Commitment Office, and various disasters have been excluded in the attached table. Does not include all service-level breakouts for Medicaid and CHIP Services, Behavioral Health services, provider-types for Regulatory services, or other sub-program detail. These items are included within another line item (e.g., Medicaid Client Services, Mental Health Services, Substance Use

Services, etc.). Table also includes breakouts for programs that were transferred to or implemented by the agency in fiscal year 2025.

VII. Guide to Agency Divisions and Programs

Office of the Executive Commissioner

A full-time Executive Commissioner (EC), appointed by the Governor with the advice and consent of the Senate, oversees operations of the Health and Human Services (HHS). The EC is responsible for all rulemaking and policy decisions throughout the system.

The Chief of Staff reports to the EC and oversees day-to-day agency operations, advises the EC, and works closely with the executive team on planning, cross-system issues, and special projects. Six team members report to the Chief of Staff and advise the EC and senior HHS leadership on policy and operational issues; assist with tracking and documenting commissioner-level decisions, contracts, and rules; manage external correspondence sent to the agency by legislators, stakeholders, and other interested parties; and manage the scheduling and activities of the Office of the Executive Commissioner.

Support Services Agreements

Texas Government Code Sections 524.0202 and 524.0203, require each HHS administrative support area (ASA) to have a Support Services Agreement (SSA) which outlines, at a high level, the centralized services they provide to areas within HHSC and the Department of State Health Services (DSHS) (if applicable). The SSA defines fundamental roles and responsibilities and is a means to ensure the ASAs are meeting the needs of the agency. HHSC has 12 designated ASAs. These include Chief Information Officer; System Support Services; Procurement and Contracting Services; Office of the Chief Auditor; Office of the Chief Counsel; Government and Stakeholder Relations; Communications; Chief Financial Officer, Data, Analytics and Performance; Office of Transformation and Innovation; Office of Policy and Rules; and Compliance and Quality Control. All currently-approved SSAs can be found [here](#). Several SSAs are under revision and will be available in Fall 2025.

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VII. Guide to Agency Divisions and Programs

Chief Operating Officer

Office of the Chief Operating Officer

The Office of the Chief Operating Officer (COO) serves as an executive division within the Health and Human Services (HHS). With approximately 974 employees, COO delivers high-quality, customer-focused administrative support services across all HHS programs and personnel including the Health and Human Services Commission (HHSC), Department of State Health Services (DSHS), and the Office of the Inspector General (OIG). COO also provides select support services to the Department of Family Protective Services (DFPS) through a Memorandum of Understanding, including procurement and contracting, civil rights, regional services, facility and warehouse services, and career development training.

COO oversees the System Support Services (SSS) and Procurement and Contracting Services (PCS) divisions. Together, these divisions provide critical support in the following areas:

- Civil Rights;
- Contract Management Support;
- Emergency and Risk Management;
- Facilities Support;
- Human Resources;
- Learning Resources; and
- Procurement and Purchasing Services.

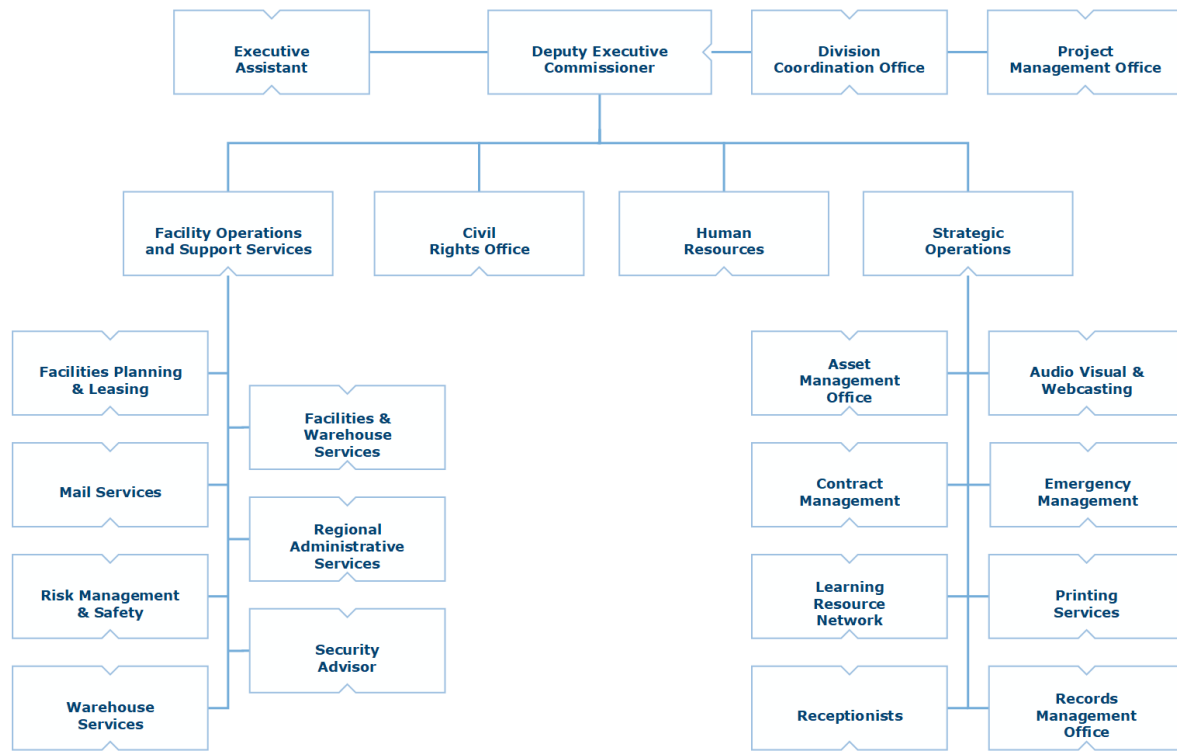
COO operates collaboratively with HHSC programs and divisions to fulfill its mission of providing high-quality, customer-focused administrative services to support the delivery of HHS programs.

System Support Services

SSS is composed of and oversees a wide variety of administrative support functions for HHS and select services for DFPS. SSS consists of Strategic Operations (SO),

Business and Regional Services, the Civil Rights Office (CRO), and Human Resources (HR).

Figure 1. SSS organizational chart.



Strategic Operations

SO supports all HHS operations by coordinating essential services across multiple program areas, including the Asset Management Office (AMO), Audio Visual & Webcasting, Contract Management, Receptionist Operations, Emergency Management (EM), the Learning Resource Network (LRN), Printing Services, and the Records Management Office (RMO). These teams collectively manage state assets, contracts, and records; provide professional development and training; support communication through print media; and lead disaster response and emergency preparedness efforts.

EM specifically oversees HHSC’s disaster coordination, volunteer management, and recovery programs. EM works closely with the Federal Emergency Management Agency (FEMA) and the Texas Division of Emergency Management (TDEM) to ensure continuity of essential services during emergencies.

Emergency Management

A. Division or Program Information:

Division or Program: Emergency Management

Location within the agency: COO

Contact: Russell D. Cook, Director of Emergency and Risk Management

Statutory Citation: Texas Government Code, Chapter 418

B. Objective and Major Activities:

EM ensures critical operations continue despite disruptive events such as natural disasters, accidents, or other emergencies. EM develops and maintains internal emergency management and continuity of operations plans and coordinates staff training and exercises to enhance preparedness.

EM fosters a culture of awareness by providing timely updates on events that may impact stakeholders and works closely with TDEM and other agencies to support state and federal disaster response efforts.

EM also manages FEMA Individual Assistance grant programs, including:

- Other Needs Assistance (ONA): Provides grants to individuals and families experiencing disaster-related losses; and
- Disaster Case Management (DCM): Connects eligible disaster survivors with services to address long-term unmet needs.

To ensure effective preparedness and response, EM updates key operational plans, performs business impact analyses, and coordinates with partners. This includes biennial updates to the Continuity of Operations Plan (COOP), annual updates to the Homeland Security Strategic Implementation Plan, and ongoing situational awareness during disaster events. EM leads after-action reviews and represents HHSC in local, state, and federal preparedness activities.

EM also collaborates with federal, state, and local partners, including International Social Services (ISS), to provide repatriation services for eligible U.S. citizens returning from abroad.

C. Effectiveness and Efficiency:

EM tracks performance through reports and program reviews. During disasters, EM develops dashboards to monitor claims processing and evaluates daily call center metrics to assess responsiveness and resource allocation.

- Timely and Accurate Completion of Business Impact Analysis for COOP Updates; and
- EM monitors the completion rate, timeliness, and accuracy of business impact analyses to support COOP and identify systems that support Mission Essential Functions.

D. History:

Following a functional reorganization of SSS in late 2024, EM was realigned from Emergency and Risk Management (ERM) to Strategic Operations. Risk Management and Safety (RMS) functions now reside under Facility Operations and Support Services (FOSS).

E. Qualifications or Eligibility Requirements:

Defined by FEMA under the federal Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 United States (U.S.) Code Section 5174, disaster survivors are vulnerable populations directly affected by a major disaster who qualify for individual and Household program (IHP) assistance.

F. Administration and Key Processes:

Preparedness and Response Functions:

- Ensure continuity of essential functions during disruptions;
- Maintain emergency management policies, plans, and training;
- Share timely information with stakeholders; and
- Collaborate with TDEM and other partners.

Mitigation and Recovery Functions:

- Administer and oversee ONA and DCM programs; and
- Support for the U.S. Repatriation Program for citizens returning from abroad.

G. Funding: See "Agency Program Information" spreadsheet.

FEMA provides funding for programs such as ONA and DCM.

H. MOUs and Interagency Agreements: Not applicable.

I. Relationship with Other Governmental Entities:

- TDEM: State partner and coordinating agency for disaster response.
- State Office of Risk Management: Partner in COOP oversight.
- FEMA: Oversees IHP awards and funding.
- U.S. Department of Health and Human Services (DHHS): Provides repatriation support during international crises.

J. Barriers and Challenges:

State and federal guideline challenges can impact the timing and delivery of disaster response activities. For example, FEMA's March, 2024 Interim Final Rule (IFR) introduced changes to simplify processes, remove barriers, and increase eligibility for its Individual Assistance (IA) program. These changes presented challenges to the HHSC ONA team, including a need to adjust to new eligibility criteria and benefits, integrate changes with Disaster Assistance Payment Program (DAPP), HHSC's ONA processing system, and update IT controls for efficient implementation. These challenges exacerbated hurdles the HHSC ONA team faced at the beginning of the Hurricane Beryl disaster declaration, when the team received over 450,000 approved ONA applications from FEMA within a two-week period.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Learning Resource Network

A. Division or Program Information:

Name: Learning Resource Network

Location within the agency: COO

Contact: Pollett Jones-Reasonover, Associate Commissioner for Strategic Operations

Statutory Citation: Not applicable.

B. Objective and Major Activities:

LRN focuses on agency-wide compliance training and reporting. LRN delivers general professional development to HHS and DFPS employees and facilitates four leadership development programs:

- Executive Leadership Academy (ELA);
- Rising Leaders Academy (RLA);
- Aspiring Leaders Program (ALP); and
- Extraordinary Contributor Program (ECP).

LRN offers agency-wide administrative and managerial courses and oversees management of training course data in Centralized Accounting and Payroll/Personnel System (CAPPS) Human Capital Management (HCM) by developing course codes, tracking course completions, running reports, and adding employees' external training on their transcripts. It consists of three teams:

1. Career Development;
2. Leadership and Innovation; and
3. Learning Systems and Design.

Career Development and Leadership and Innovation focus on training delivery and leadership development. Learning Systems and Design supports eLearning development and training technology. eLearning is the delivery of training and education via networked interactivity and a range of other knowledge collection and distribution technologies.

LRN develops and maintains HHS compliance and legislatively mandated training. LRN's Leadership Development Program (LDP) enhances HHS staff communication and stakeholder engagement skills by offering four focused leadership development experiences: ELA, RLA, ALP, and ECP. These months-long experiences are designed to challenge participants to learn and refine leadership qualities and skills. Hundreds of staff graduate annually from LRN's leadership academies.

ALP, launched in fall 2023, prepares high-performing staff for leadership roles. As of now, 61 percent of ALP graduates have advanced into management positions.

LRN supports over 300,000 program stakeholders who must complete required training to maintain licensure, certification, or registration. For example, the Human Trafficking course, developed by the HHSC Family Health Services (FHS) division, is hosted on the HHS Learning Portal.

LRN also offers professional development courses using modern adult learning principles. Topics include Project Management Foundations, Tableau, and Business Writing.

To assess training effectiveness, LRN adds evaluations to required courses and has automated systems to support reporting and data analysis.

C. Effectiveness and Efficiency Information:

Training effectiveness is assessed through post-training surveys. LRN compiles results into a real-time dashboard to evaluate performance and improve future offerings.

D. History: Not applicable.

E. Qualifications or Eligibility Requirements:

1. ALP and ECP: Participants selected on a first-come, first-served basis during open enrollment.
2. RLA and ELA: participants selected through a competitive executive review process.

F. Administration and Key Processes:

Each leadership program is managed by a designated LDP responsible for content, delivery, and facilitation.

The Learning Systems and Design team maintains all required HHS training and ensures deployment accuracy. CAPPS HCM stores training records. Career Development offers virtual and in-person training to HHSC and DSHS staff based on need assessments.

G. Funding: See "Agency Program Information" spreadsheet.

H-I. MOUs and External Relationships: Not applicable.

J. Barriers and Challenges:

Program demand exceeds resources. The Career Development team lacks the technology and staff capacity to reach all parts of Texas virtually. The Learning Systems and Design team supports over 300,000 external users with only one dedicated full-time equivalent (FTE).

K. Additional information:

The Career Development team offers soft-skill courses that support employee and manager success across daily functions.

L-M. Regulatory and Complaint Information: Not applicable.

Printing Services

A. Division or Program Information:

Name: Printing Services

Location within the agency: COO

Contact: Jennifer Rimes, Print Services Director

Statutory Citation: Not applicable.

B. Objective and Major Activities:

HHS Printing Services provides a variety of high-quality print products to internal and external state agency customers. Services are delivered efficiently, responsively, and cost-effectively, comparable to those from commercial print shops.

C. Effectiveness and Efficiency Information:

HHS Printing Services uses recycled materials when possible and responds promptly to inquiries with cost-saving recommendations. The team supports clients from order to delivery, maintaining excellent customer service.

Recent upgrades to the offset press and booklet bindery equipment have enabled HHS Printing Services to remain competitive with commercial vendors. In fiscal year 2024, the program provided services to 25 external state agencies in addition to its internal customers.

D. History:

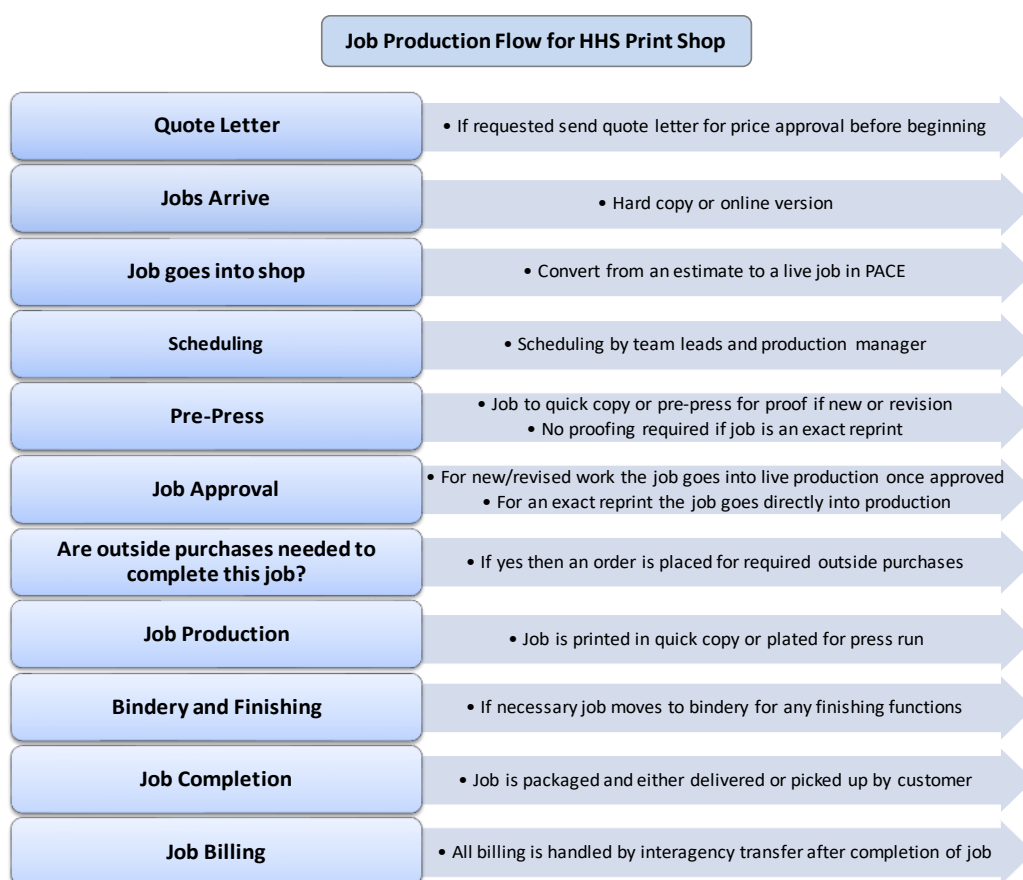
Originally focused on HHS internal printing needs, HHS Printing Services now serves external clients due to evolving needs and upgraded capabilities.

E. Qualifications or Eligibility Requirements: Not applicable.

F. Administration and Key Processes:

The chart below shows the print production flow. In addition, HHS Circular C-020, Print Shop Services, provides guidance to agencies in submitting requests.

Figure 2. Print production flow.



G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and Interagency Agreements:

The following state agencies also operate print shops that provide print services similar to HHSC:

- Texas Department of Transportation;

- Texas Correctional Institute;
- University of Texas (Austin and North Texas);
- Texas Workforce Commission (TWC); and
- Department of Public Safety (DPS).

Agencies typically complete their own print work, though HHSC prints internally whenever possible. Through the State Print Show Web Portal, agencies can request bids from state-approved shops, eliminating the need for individual memoranda of understandings due to existing agreements with the Texas Comptroller of Public Accounts (CPA).

I. Relationship with Other Governmental Entities: Not applicable.

J. Barriers and Challenges:

Challenges include the lack of replacement delivery vehicles, aging equipment, and the rapid changes in printing technology, which make competing with private-sector vendors more difficult.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Asset Management Office

A. Division or Program Information

Name: Asset Management Office

Location within the agency: COO

Contact: Chris Bergstrom, Asset Management Office Director

Statutory Citation: Texas Government Code, Chapter 403

B. Objective and Major Activities:

AMO is responsible for tracking and managing approximately 104,000 assets across their lifecycle, from acquisition through disposal. AMO manages capital, controlled, and construction-in-progress assets.

AMO coordinates surplus property disposal with the Texas Facilities Commission (TFC) and Texas Department of Criminal Justice (TDCJ), ensuring proper recycling or resale.

To improve accuracy and efficiency, AMO uses Bluetooth beacons, Radio Frequency Identification (RFID) readers, and the Virtual Asset Tracker—a digital system that monitors assets statewide.

Training is provided for inventory coordinators and requisitioners across the state to ensure proper coding and prevent errors that could affect financial reporting. AMO also collaborates with the HHSC Chief Financial Office's (CFO's) Property Accounting Unit to reconcile discrepancies in CAPPS Financials and the State Property Accounting (SPA) system.

C. Effectiveness and Efficiency Information:

AMO measures performance by tracking physical inventory completion using reports from CAPPS Financials and the Virtual Asset Tracker. The monthly goal is scanning 10 percent of assigned assets per program area.

D. History:

Prior to adopting RFID and barcode technologies, AMO conducted inventory using manual asset control sheets.

E. Qualifications or Eligibility Requirements: Not applicable.

F. Administration and Key Processes:

AMO conducts the annual physical inventory with support from Asset Management and property coordinators in 12 regions, including 12 state hospitals and 13 state supported living centers (SSLCs).

G. Funding: See "Agency Program Information" spreadsheet.

H-I. MOUs and Governmental Relationships: Not applicable.

J. Barriers and Challenges:

Challenge 1: The Governmental Accounting Standards Board issued Statement No. 87 in September 2024, requiring agencies to record all lease assets in the SPA system. The CPA provided implementation guidance in January 2025. Before adding

assets to SPA, AMO must first reconcile all lease assets in the system. Next step is to meet with IT to discuss automation to implement the new requirement. AMO plans to hire temporary employees to assist with the project if automation isn't feasible.

Challenge 2: HHSC programs, including requisitions, receiving, Information Technology (IT) purchases, IT asset deployment, local IT support staff, accounts payable, accounts receivable and others, have asset management processes that may create discrepancies in asset record data. The Office of Transformation and Innovation (OTI) is leading a cross-divisional Asset Acquisition and Management Lifecycle project whose goal is to identify and improve these processes. The project will streamline asset management in all aspects, from requisition to use and ultimately disposal.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Records Management Office

A. Division or Program Information:

Name: Records Management Office

Location within the agency: COO

Contact: Pollett Jones-Reasonover, Associate Commissioner for Strategic Operations

Statutory Citation: Texas Government Code, Chapter 441

B. Objective and Major Activities:

RMO establishes and maintains HHSC records management policies and standards. RMO administers the HHSC's records retention schedules in accordance with federal and state law; provides guidance on managing HHSC records, destroying eligible records, submitting archival records; develops and conducts records management training; and manages records stored off-site.

C. Effectiveness and Efficiency Information:

RMO regularly develops, reviews, and updates records retention schedules to ensure systematic organization and compliance. It provides comprehensive training and consultation on records management best practices to HHS staff and program areas.

In March 2024, HHS completed the transfer or eligible destruction of all remaining boxes previously stored with the vendor Iron Mountain, finalizing a project that began in 2018. Over 150,000 boxes of paper records were transferred to the State Records Center or destroyed. This consolidation eliminated multiple vendor contracts, standardized storage processes, and streamlined retrieval procedures, producing a one-time savings of approximately \$700,000.

RMO uses two primary systems for records tracking:

- TexLinx, provided by the Texas State Library and Archives Commission (TSLAC), tracks actively stored records; and
- System of Automated Records (SOAR), an HHS-owned system, tracks the storage and disposition of records.

RMO staff pull quarterly storage and destruction data from both systems. TexLinx provides new storage totals by accession date; SOAR provides destruction totals for on-site records. RMO compiles the data into quarterly destruction reports for HHS program areas, which determine whether to approve destruction or retain records beyond their retention date for business or legal purposes.

D. History:

In March 2019, RMO addressed over-retention of HHSC electronic records by implementing two key initiatives:

1. Required records management training for all HHS staff; and
2. Creation of the HHS Records Coordinator Network Hub.

E. Qualifications or Eligibility Requirements: Not applicable.

F. Administration and Key Processes:

See HHS Records Management Policy Circular C-065 included in Attachment 11.

Resources:

- [Records Management | Texas State Library](#)

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and Interagency Agreements: Not applicable.

I. Relationship with Other Governmental Entities:

TSLAC's State and Local Records Management (SLRM) division supports public agencies with training, guidelines, and infrastructure to ensure compliance with records storage, retention, and accessibility requirements. HHSC incorporates this guidance into Policy Circular C-065. RMO staff also coordinate document destruction services available within a limited region of Central Texas.

J-M. Barriers, Additional, Regulatory, Complaint Information: Not applicable.

Contract Management – Language Services

A. Division or Program Information:

Name: Contract Management - Language Services

Location within the agency: COO

Contact: Ludivina Swor, SSS Operations Contract Manager

Statutory Citation: Title VI of the Civil Rights Act of 1964; Americans with Disabilities Act (ADA)

B. Objective and Major Activities:

Language Services (LS) provides access to programs, services, and activities for individuals with limited English proficiency (LEP) and those with disabilities. LS oversees contracted services including:

- Over-the-Phone Interpreting (OTPI);
- On-site and virtual interpreting;
- Written, sight and audio translation;
- American Sign Language (ASL); and
- Communication Access Realtime Translation (CART), which transcribes spoken language into text.

C. Effectiveness and Efficiency Information:

LS uses a standardized process for staff to request services and serves as the centralized point of contact for tracking usage. Controls are in place to ensure only

HHSC-related requests are billed. Services are available on-demand or within a reasonable timeframe to ensure effective communication with LEP individuals who are deaf and hard of hearing. Service level agreements are included in OTPI contracts to monitor performance.

D. History: Not applicable.

E. Qualifications or Eligibility Requirements: Not applicable.

F. Administration and Key Processes:

LS supports HHSC program areas by resolving inquiries, validating invoices, and ensuring services are properly allocated and funded. LS establishes request procedures; oversees expenditures and usage; and monitors service performance.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and Interagency Agreements:

To ensure consistency and avoid duplicate services, LS developed the following request forms:

- HHSC-OPS003 – On-Site/Virtual Interpreting;
- HHSC-OPS002 – Written, Sight and Audio Translation; and
- HHSC-OPS004 – ASL and CART.

Other language services include:

1. Special Supplemental Nutrition Program for Women, Infants and Children (WIC): dedicated OTPI services and staff-specific 1-800 numbers.
2. DSHS: Offers interpretation services to DSHS staff.
3. HHSC uses Office of Deaf and Hard of Hearing Services contracts via Communication Services for State Agencies ([CSSA](#)) for ASL/CART requests.

I. Relationship with Other Governmental Entities: Not applicable.

J. Barriers and Challenges:

Challenges include geographic and technology limitations and the complexity of planning for equitable language access, all of which may delay access to services.

K-M. Additional, Regulatory, Complaint Information: Not applicable.

Civil Rights Office

A. Division or program information:

Name of division or program: HHS Civil Rights Office

Location within the agency: COO

Contact name: Dana Hess, Civil Rights Director

Statutory citation: Texas Labor Code, Chapter 21; Texas Government Code, Section 2054.457

B. Objective and major activities:

CRO nondiscrimination in employment and service delivery for HHSC, DSHS, and DFPS in compliance with state and federal law. It also manages reasonable accommodation requests (RARs) and facilitates the interactive process between programs and individuals.

The CRO director also serves as the Americans with Disabilities Act (ADA)/Section 504 Coordinator, responsible for ensuring equal access under Title II, including:

- Investigating discrimination complaints;
- Facilitating RARs;
- Conducting civil rights compliance reviews;
- Providing accessibility expertise and training;
- Analyzing civil rights data;
- Providing civil rights training; and
- Serving as subject matter experts to staff and programs.

C. Effectiveness and Efficiency Information:

CRO has performance measures to monitor the efficiency of its program functions related to complaint investigations and accommodation requests. CRO monitors output based on timely processing, managing, and closing of requests or complaints. CRO data analysts mine processing data captured in CRO systems through data queries and report performance against established category processing standards for inquiries, requests, and complaints weekly to leadership.

CRO also prepares quarterly reports for HHSC, DSHS, and DFPS, summarizing the work done for each agency and the results of complaint investigations and accommodation requests. Through surveys, CRO allows customers to provide feedback on staff availability, courtesy, friendliness, ability to address customer inquiries, and timely, clear explanation of policy and procedures.

CRO is procuring a new case management software program to streamline and digitize the employment discrimination and service-related investigations processes, and reasonable accommodation processing, making case management more efficient and transparent while improving access for customers and stakeholders.

D. History: Not applicable.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

CRO has three functional groups. The deputy director oversees records management, data analysis, and discrimination complaints filed with outside agencies. The operations director oversees employment discrimination complaints and reasonable accommodation requests. The compliance director oversees service-related discrimination complaints, civil rights compliance reviews of HHSC eligibility offices, and electronic information resource (EIR) accessibility. The Director's staff are responsible for preparing and updating state and federally mandated reports, maintaining civil rights training required for all staff by state and federal law and regulation, and providing subject matter expertise.

Prior to 2022, CRO operated within a function-by-region strategy, which limited each regional office to a particular CRO function. For example, the Houston office only processed reasonable accommodation requests, and the Austin office managed only employment discrimination complaints. In 2022, CRO moved from a function-by-region strategy, effectively using technology to recruit for all positions statewide. This has resulted in management's ability to build and retain effective teams with a broader range of expertise in Austin, Grand Prairie, Lubbock, Houston, Edinburg, and San Antonio.

G. Funding: See "Agency Program Information" spreadsheet.

Funding from federal agencies for HHS programs is contingent on compliance with federal civil rights laws such as providing assurances of non-discrimination, notifying participants of their rights to file discrimination complaints, educating staff

about providing services and benefits in a non-discriminatory manner, and providing equal access to services and benefits.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

HHS employees may file employment complaints with the TWC or the U.S. Equal Employment Opportunity Commission (EEOC). Service recipients may file with the U.S. Department of Agriculture, Food and Nutrition Service (USDA FNS) or the U.S. DHHS. CRO coordinates with these agencies on investigations, particularly with FNS on complaints related to the Supplemental Nutrition Assistance Program (SNAP).

CRO's internal processes are typically more efficient than federal investigations and often lead to earlier resolution. CRO collaborates with HHSC's Office of the Chief Counsel, HR, and program leadership to address findings or related workplace concerns.

J. Barriers and challenges:

CRO continues to address challenges related to:

- Challenge 1: Increased federal focus on EIR accessibility;
- Challenge 2: Evolving LEP guidance; and
- Challenge 3: Updates to EEOC regulations and interpretations.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Human Resources

A. Division or program information:

Name of division or program: Human Resources

Location within the agency: COO

Contact name: Ladawn Gray, Human Resources Director

Statutory citation: Texas Government Code, Chapters 531, 552, 657, and 664.

B. Objective and major activities:

HR provides centralized support services to the HHS system and limited services to the Cancer Prevention and Research Institute of Texas (CPRIT) and the Texas Civil Commitment Office (TCCO).

HR staff oversee compliance and records management functions and administer various employee programs. Core HR services include employee relations, workforce operations management (WOM), policy development, random drug testing administration, recruitment, veteran and military employee liaison, workforce reporting, and administration and operations.

Key HR Functions:

1. **Administration and Operations:** HR provides administrative support functions, guidance, and consultation for various HHSC programs on special projects. Administration and Operations collaborates with internal and external stakeholders to organize, plan, and implement HHSC programs and initiatives.
2. **Compliance and Records Management:** The HR records team serves as the central repository for the employees' Master Personnel File (MPF). This area maintains employment records, conducts prior state service verifications, responds to open records requests, and assists with the collection of new hire forms. The area ensures each new hire added to the system successfully passes the E-Verify screening process.
3. **Employee Programs:** HR Employee Programs support key talent management, engagement, and organizational development programs and initiatives throughout HHSC. The area provides system coordination of the State Employee Charitable Campaign (SECC), HHS employee engagement survey, and HHS Employee Advisory Committee (EAC), which is a forum for employees to share concerns with HHSC, promote staff involvement, and help improve the workplace environment. HR Employee Programs also manages the Talent Acquisition Office (TAO), which provides hiring support for short-term and strategic recruitment initiatives for hard to fill, high-turnover classifications.
4. **Employee Relations:** This team is the main contact for supervisors and staff to ask about HR issues, policies, and procedures. Services include analysis, problem solving, conflict resolution, and policy interpretation. Staff provide advice, guidance, and consultation to managers and employees with the goal of minimizing legal risk and ensuring compliance with federal and state laws, applicable rules and regulations, and HHS HR policies and procedures.

5. **Policy and Special Projects:** This area develops standardized policies, procedures, and forms for the HHS system. Staff provide policy guidance and interpretation, review legislation, and develop and implement policies to ensure compliance with all state and federal laws. This area develops the HHS System Workforce Plan, which analyzes current workforce demographics, expected workforce challenges, and strategies to meet workforce needs.
6. **Veterans/Military Liaison:** The veteran/military liaison is responsible for the recruitment, recognition, and retention of veterans within the HHS system. The Veteran program works with all sections of HR and serves as the point of contact for staff and supervisors on veteran-related HR issues, policy, and procedures. The veteran/military liaison also ensures HR policies adhere to veteran employment laws, and assists hiring managers and veterans with the hiring process.
7. **Workforce Reporting:** HR Reporting conducts detailed data analyses and performs extensive data research to ensure accurate results when developing custom demographic queries on turnover rates, vacancies, salary and staffing data, terminations, and other metrics as requested. This includes analysis in support of a wide variety of workforce initiatives and projects.

Workforce Reporting produces the HHS Fact Book, develops and maintains HR dashboards, and develops and generates recurring and ad-hoc reports to provide management and program staff with data extracted from the PeopleSoft/Oracle relational database. The area serves as the technical liaison on the development, modification, and upgrades to CAPPS HCM.
8. **WOM:** A component of HR, and provides hiring support to the large, direct-care divisions of HHSC, including SSLCs and state hospitals, Access and Eligibility Services (AES), and Eligibility Operations. WOM also supports parts of the Regulatory Services Division (RSD), including Long-Term Care and Child-Care Regulation. WOM supports hiring managers with recruitment, selection, hiring process, background checks, pre-employment testing, and coordination of local new employee orientation activities. WOM SSLC oversees and administers the statutorily mandated Random Drug Testing (RDT) program, which applies to all employees working at SSLCs and the Rio Grande State Center.

HR fosters workplace success by offering solutions and resources to support HHSC goals and employee well-being. HR promotes positive outcomes in all HHS

programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

C. Effectiveness and efficiency information:

In fiscal year 2025, HR replaced the existing hiring center with a new and improved, user-friendly HHS career center. This career center provides HHS, DFPS, and the public with enhanced features, including a modern user interface, mobile responsiveness, robust search capabilities, and improved workflow. HR WOM was a partner in the development, testing, and implementation of the new HHS career center. The new platform will help improve overall recruiting and hiring operations. WOM continues to work with HHS employees and managers as they transition to the new system.

The HR WOM team collaborates with hiring managers for SSLCs and state hospitals, AES Operations, and parts of RSD, including Long-Term Care and Child-Care Regulation, assisting them with analyzing job requirements, recruiting employees, and assisting hiring managers in screening, selecting applicants, and hiring. WOM SSLC hiring specialists oversee and administer the RDT program to support a drug-free and safer environment for the SSLC residents. WOM continues to assess customers' needs and develop resource materials and training to support HHS recruiting and onboarding activities.

Each HR team has specific quality assurance measures in place based on the services provided, the size of the team, and stakeholder expectations. These measures help ensure consistent delivery of HR services and support throughout HHSC. Quality assurance techniques used in HR include:

- Use of an RMS database to track receipt of new hire documents and verify the timely completion of E-Verify cases as quality assurance measures;
- Data verification techniques, which include reviewing personnel-related requests and associated documentation, and validating the parallel entry was made in the corresponding system, as applicable;
- Randomly selecting data to verify and/or validate compliance with certain requirements, e.g., Senate Bill (S.B.) 389, 84th Legislature, Regular Session, 2015 - compliance with Military Occupation Specialty Code on job postings and S.B. 805, 84th Legislature, Regular Session, 2015 - compliance with Veteran Employment Preference; and
- Tracking/monitoring metrics and using the data to make informed decisions regarding next steps.

D. History:

In October 2004, HR began using a service-delivery model which integrated outsourced and retained HR services. HHS outsourced most HR administrative and transactional HR-related services to a third-party vendor, freeing HHS staff to focus on the strategic aspects of HR. HHSC kept the staff necessary to provide retained HR and Payroll services.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

HR administers services through a hybrid or shared services business model, where a third-party vendor performs certain HR and payroll administrative services like processing benefits, conducting classification reviews, and performing recruiting and/or hiring activities or inquiries. The hybrid approach combines self-service functionality and access to knowledgeable, skilled HHSC HR staff who provide consultation and guidance as needed.

Under the hybrid business model, employees have access to CAPPS HCM, a web-based self-service portal that allows employees to perform basic administrative tasks such as viewing and updating personal information, viewing leave balances, editing timesheets, accessing paycheck stubs (earnings statements), and applying for open positions. Managers have an additional level of access, which allows them to process basic HR and/or payroll-related transactions including promotions, demotions, job audits, performance evaluations, and staff recruitment and hiring. The third-party vendor maintains a fully staffed HHS Employee Service Center to help employees navigate and process transactions through CAPPS HCM. The HHS Employee Service Center has two primary components:

- Tier 1: Service center representatives who function as HHS employees' first point of contact for all inquiries.
- Tier 2: HR subject matter experts and operations managers who conduct research and provide case resolution to those customer inquiries not resolved at the Tier 1 level.

HHSC HR employees (non-vendor staff) manage more complex policy and/or personnel related inquiries, maintain employee personnel records, ensure compliance with applicable laws and regulations, support HHS program initiatives, and serve in strategic partnership roles within HHSC.

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts:

HR collaborates with the following state agencies but does not have formal MOUs or interagency contracts (IACs).

- TWC to review and update existing materials such as the state of Texas application for employment.
- State Auditor’s Office (SAO) to complete assignments and respond to inquiries, as necessary.
- DPS to ensure compliance with statutorily mandated criminal history background checks.

I. Relationship with other governmental entities:

HR collaborates with the following federal agencies.

- Federal Bureau of Investigations (Criminal Justice Information System) to ensure compliance with the required training related to access and use of criminal history record information.
- U.S. Department of Labor, Bureau of Labor Statistics to fulfill occupation survey data requests pertaining to HHS positions.
- U.S. DHHS Office of Inspector General’s List of Excluded Individuals/Entities (LEIE) to ensure HHSC does not hire or employ an individual listed as excluded on the LEIE.

J. Barriers and challenges:

HR faces the following challenges that hinder the overall effectiveness of HR support.

Challenge 1, Criminal History Administration: HR needs a single, unified statutory authority that would consolidate employee accounts and streamline the background check process. This would simplify compliance and make internal employee transfers smoother.

The complexity and inconsistency of criminal background check requirements across multiple divisions within HHS is a challenge for HR as it relates to hiring practices and internal employee transfers. SSLCs, state hospitals, and various

specialized programs like the Blind Children's Vocational Discovery and Development Program, or Children's Autism Program, have differing bars to employment based on varying definitions of convictions and essential regulatory compliance. Multiple DPS accounts compound the fragmentation, necessitating manual account management as HR staff subscribe and unsubscribe account users based on their roles and criminal background check requirements. Internal transfer of employees who may fall under different background check standards leads to inefficient account management and errors.

Challenge 2, Outsourcing administrative services and functions: House Bill (H.B.) 2292, 78th Legislature, Regular Session, 2003, consolidated the HHS agencies and streamlined administrative services and functions. As part of this restructuring, HHS outsourced most human resources activities through a third-party vendor contract. This included the implementation of self-service capabilities for employees and managers. The outsourced functions include benefits administration, payroll, timekeeping and leave management, job postings, hiring, and applicant selection; HR also outsourced the call center for employee access to CAPPS HCM.

Outsourcing these HR functions introduced challenges. Employees struggle to distinguish between the service center and the internal HR team, leading to confusion about who to contact for specific issues. Additionally, inconsistent service quality and the need for ongoing vendor staff training at times hinders the overall effectiveness of HR support. Ensuring clear communication, accountability, and employee engagement while maintaining a strong relationship with the vendor is essential for achieving seamless service delivery.

K. Additional information:

The HR Policy Manual and HR Guidance Handbook have formal statements of principle or rule that HHS employees must follow. The HR Guidance Handbook provides guidance and instructions on how to implement policies. Each document outlines when it is most appropriate to consult with HR or a particular business partner, such as CRO, Legal Services, Payroll, Time, Labor and Leave (PTLL), or Strada/NorthgateArinso. In addition, HR developed policies, procedures, checklists, forms, and resource materials that align with the terms and conditions of the contract with the third-party vendor. HR policies, procedures, checklists, forms, and resource materials offer employees guidance to identify roles and responsibilities for handling certain HR-related transactions.

L-M. Regulatory and Complaint Information: Not applicable.

Facility Operations and Support Services

A. Division or program information:

Name of division or program: FOSS

Location within the agency: COO

Contact name: Melissa Rider, Associate Commissioner Business and Regional Services

Statutory citation: Not applicable.

B. Objective and major activities:

FOSS provides support services for HHS agencies and DFPS, and programs across Texas, including Facilities Planning and Leasing (FPL), Facility Services (FS), Warehouse Services (WS), Regional Administrative Services (RAS), Mail Services, and RMS, which oversees the Workers' Compensation Program. FOSS supports and manages facility-related contracted services like janitorial, security, and pest control. FOSS also provides emergency response and office closure notices through the HHS Emergency Notification and Alert System. FOSS consults on the creation and implementation of the Office Emergency Action Plans and personal safety plans and supports establishing policies and procedures regarding facility safety.

C. Effectiveness and efficiency information:

FOSS conducts quarterly facility reviews to assess each facility's overall condition regarding interior and exterior safety, heating, ventilation, and air conditioning (HVAC) systems, janitorial service efficiency, and regular routine facility maintenance.

The quarterly facility review is a point-based system with a score ranging from 0 to 100, categorized into four sections: Facility Interior, Facility Exterior, Interior Rooms, and Systems. The Computer Aided Facility Management (CAFM) database scores facility assessments. CAFM also stores facility review data and notes regarding resolution of identified issues. This information assists with effective management of facility deficiencies and provides historical performance data for use during lease review and renewal of each facility.

FOSS conducted Vulnerability Assessments (VAs) in 405 regional facilities between January and March 31, 2024. At the conclusion of each year's VAs, FOSS uses vulnerability scores to determine a course of action to enhance security in regional facilities. Overall, vulnerability scores consistently point to access control as an area of concern, prompting RAS to prioritize this area. Each year since VAs began in 2007, results reflect continued improvement in access control scores.

FOSS also provides lease management services, space planning, and contract management for all regional facility leases across the state and state-owned buildings in Austin. FOSS tracks all lease activity through CAFM, which staff use to effectively manage each lease. CAFM lease data ensures informed decisions regarding all lease management services.

FOSS provides RMS services through the development, implementation, and ongoing evaluation of risk management, safety, insurance, workers' compensation, and return-to-work programs.

These programs mitigate and manage losses incurred by the HHS System. FOSS acts as the liaison between HHS and the State Office of Risk Management (SORM). RMS does not provide oversight of SSLCs and state hospitals.

FOSS RMS tracks job injuries and motor vehicle accidents via CAFM and CAPPS HCM and uses the data to identify trending safety issues, educate staff on safety and safety awareness, and update or create topic-specific training for HHSC staff.

D. History:

To support the consolidation of many HHS agencies in 2003 as directed H.B. 2292, 78th Legislature, Regular Session, SSS developed a plan to integrate and streamline operations. The reorganization consolidated administrative functions into a division called Business and Regional Services (BRS), which included Facility Support Services, Facility Management and Leasing, Enterprise Risk Management and Safety, Enterprise Contract and Procurement Services, and Regional Administrative Services. Facility Support Services and its support functions later moved to Health and Specialty Care Systems (HSCS).

Beginning in August 2006, Circular C-014 defined the authority of various SSS offices and divisions to develop system-wide policies and procedures. S.B. 200, 84th Legislature, Regular Session, 2015, prompted additional restructuring within HHSC, including changes to BRS. SSS revised the circular in November 2015 to support a more streamlined and standardized service delivery model across HHS

agencies. This revision authorized SSS to continue evaluating and refining policies and procedures to support ongoing improvements in what is now known as FOSS (formerly BRS).

As part of an SSS functional reorganization in late 2024, SSS realigned functions within ERM, creating RMS, which continues to align under FOSS, and EM, which moved to SSS Strategic Operations.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

FOSS supports key stakeholders, including employees and programs of HHSC, DSHS, and DFPS.

FOSS manages state-owned and leased space across the state and delivers consolidated administrative support through an efficiency-driven model. Examples of support include:

- Facility Repair or Maintenance Services for the Office Location: Reporting problems with plumbing, air conditioning/heating, electrical/lighting, locks/keys, security, janitorial, general maintenance, and groundskeeping; and
- Contact with Lessor/Leasing Inquiries: Issues with current lease, inquiries regarding lease provisions. FOSS is the primary point of contact for all communication with the Lessors or TFC. FOSS is responsible for coordinating and resolving issues pertaining to the current lease or inquiries regarding lease provisions.

Contact with HHSC Facility Management: Issues with state owned building/offices, questions on usage of space. FOSS also supports all HHS programs and staff in regional locations. Staff at each of the ten HHSC regional headquarters operate a RAS center that provides services such as:

- Facility Services:
 - ▶ Building maintenance and repairs.
 - ▶ Office and building moves.
 - Existing lease issues and inquiries.
 - ▶ New space/lease acquisitions.
 - Building accessibility.

- Fleet management.
 - Shipping and receiving.
- ▶ Quick-copy and mail services.
 - Incident management.
 - Temporary office closures.
 - Business continuity planning.
 - Regional inter-agency issues.
- Financial Management of Regional Cost-Pool:
 - ▶ Administrative contracts.
 - ▶ Leases, utilities, postage.
 - ▶ Accounts receivable and payable.
 - ▶ Shared-use purchases.
 - ▶ Approval of cost-pool expenditures.
 - ▶ Surplus equipment and furniture removal.
- Facility Operational Support Services:
 - ▶ Surplus equipment and furniture removal.
 - ▶ Management of statewide leasing, renewals, and coordination of lease-related issues between regions and the TFC.

FOSS manages statewide facility information, lease documentation, changes, and floor plans in CAFM. Activities include:

- Coordination of building remodeling requests, including drafting blueprints, obtaining approvals, scheduling construction, coordinating budgets, and ensuring that construction is on schedule and adheres to construction plans and specifications;
- Management of IAC between HHSC and TFC for facility support services;
- Collaboration with HHSC division and program contacts to provide a safe work environment and to reduce injuries and incidents; and
- Prompt response to risk/safety/occupational exposure issues throughout HHS agencies.

FOSS provides safety planning for HHSC staff and contacts in response to workplace threats and hazards including:

- Coordination with RAS/WS statewide to identify workplace hazards and manage risk;
- Coordination with the SORM regarding all matters related to SORM's oversight responsibilities; and
- Coordination with HHSC division and program contacts to provide training related to risk management, safety, workplace violence, incident management team/threat response team, and workers' compensation.

FOSS supports HHS leadership with solutions for risk financing including development, implementation, coordination, and execution of continual evaluations of the risk management, safety, insurance, fire safety, workers' compensation, and facility inspection programs designed to mitigate and manage losses incurred by the HHS system.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts:

TFC manages HHSC-occupied state-owned buildings, while FOSS manages HHSC-occupied leased facilities. FOSS processes and submits requests to TFC for services required in HHSC-occupied state-owned buildings. FOSS works with TFC to obtain delegated authority for MOUs for space.

FOSS engages with other state agencies to support stakeholder relationships and address program space needs and partnerships. FOSS maintains direct communication with key stakeholders, including employees and programs in HHSC, DSHS, and DFPS.

To keep operations efficient and avoid duplication, FOSS coordinates with TFC, lessors, and contracted vendors.

FOSS also provides Disaster Response: Regional Disaster Area Coordinators (RDACs) represent HHSC at Disaster District Coordinator Emergency Operations Center (DDC EOC) and coordinate regional disaster response with the HHSC Emergency Services Program.

I. Relationship with other governmental entities:

FOSS engages with local county and city officials, as well as other state agencies, to support stakeholder relationships and address program space needs and partnerships. FOSS works with TFC to obtain delegated authority for memorandums of understanding for space.

FOSS also provides Disaster Response: RDACs represent HHSC at DDC EOC and coordinate regional disaster response with the HHSC Emergency Services Program.

FOSS works with the:

- TDEM to support request for property damage assessments and distribution of water and ice in a disaster.
- FEMA to assist with Property Damage Assessments (PDAs) when TDEM has exhausted their staffing resources.
- DPS to assist with security related incidents.

J. Barriers and Challenges:

FOSS faces two main challenges that hinder the overall effectiveness of FOSS support.

Challenge 1, TFC Owned and Maintained Facilities Deferred Maintenance: TFC maintains full authority and control over facility service functions for HHS state office headquarters as expressed Under Texas Government Code, Title 10, General Government, Subtitle D, State Purchasing and General Services, Chapter 2165. Although TFC is responsible for the buildings, HHSC funds building maintenance, utilities, and services through IACs. HHSC submits a portal request to TFC for all facility requests that range from minor construction to building maintenance and repairs.

While TFC receives funds for deferred maintenance projects to support state agency facilities. TFC must prioritize deferred maintenance projects to support all state agencies. At times TFC prioritized projects will shift due to unscheduled critical infrastructure maintenance needs. Thus, leaving facilities with maintenance needs or requiring the agency to provide funds through the agency allocated budget to ensure critical infrastructure needs are met and business operations can continue.

Challenge 2, Planning for Funds for Facility Maintenance: HHSC pays TFC for facility maintenance and services through several TFC managed IACs. These IACs include building maintenance, minor construction, janitorial, and security guard services.

The lack of visibility and complexity in deferred maintenance projects and TFC funded projects creates challenges for the agency when planning funding requests for building maintenance and operations.

The responsibility for funding building maintenance varies by building. For example, HHSC is responsible to fund maintenance, services, and utilities at the North Austin Complex (NAC), John H. Winters (Winters), and sole tenant buildings in the regions. By contrast, HHSC does not pay for building services in agency co-located regional locations and pays a minimal fee for the Brown Heatly Building.

L-M. Regulatory and Complaint Information: Not applicable.

Procurement and Contracting Services

A. Division or program information:

Name of division or program: Procurement and Contracting Services

Location within the agency: COO

Contact name: Kay Molina, Deputy Executive Commissioner

Statutory citation: Texas Government Code, Chapter 2155.144

B. Objective and major activities:

PCS consists of the following procurement teams:

- Goods;
- Services;
- Complex;
- Grants;
- Information Technology Procurements;
- Major Procurement Support; and
- Construction and Building Maintenance.

These PCS teams work with HHS staff to provide procurement advice and forms, determine procurement methods, plan procurements, develop solicitation documents, manage procurement timelines, conduct vendor conferences, evaluate

proposals, assist with negotiations, when requested, and assist with awarding and executing contracts.

The PCS Grants team provides strategic and collaborative grant services to the HHS system, serving as experts in facilitating the solicitation and selection of qualified applicants to implement grant-funded projects.

Additionally, the Historically Underutilized Business (HUB) team works closely with procurement and contracting staff to implement HUB initiatives. The HUB team's goal is to identify potential subcontracting opportunities, review solicitations with HUB requirements, review and approve HUB Subcontracting Plans (HSPs), and participate in pre-bid and post-award conferences.

C. Effectiveness and efficiency information:

PCS has taken significant steps to implement internal and HHS system-wide improvements and controls in both procurement and contract management. These efforts addressed recommendations from a procurement and contracting improvement consulting project, recommendations and issues noted in internal and state audits, and statutory/state oversight requirements.

PCS streamlined timelines for programs and divisions as a resource for procurement planning. PCS developed the Procurement Action Lead Time Schedule (PALTS) by examining HHSC history and other state and federal agency procurement timelines. PCS revises PALTS based on real data collected on procurements and grants processed by PCS to reflect current processing times.

PCS requires completion of an annual Procurement Forecast and Action Plan (PFAP) report each November with quarterly updates thereafter. Divisions and HHS agencies complete PFAP to forecast complex procurements, Department of Information Resources (DIR) procurements requiring a Statement of Work, and formal Invitation for Bids for a five-year period and to identify procurements that are in process or should be initiated in the current or upcoming two fiscal years. After submission of PFAP, PCS identifies issues and gaps to be addressed, begins to plan/calendar procurements, and assigns resources to ensure completion of the procurements.

The PCS Dashboard streamlines the publication of reliable, current, and historical data, and supports the continuous improvement of efficient procurement processes. Data is sourced from links to CAPPS Financials and System of Contract Operation and Reporting (SCOR) information, vendor supplied data files, the HHS CFOs Late Payments SharePoint site, and spreadsheets containing manually collected

statistics. The visuals generated from CAPPs-related data are refreshed multiple times a day. All others are refreshed at regular intervals according to the availability of the data. For example, PCS procurement teams process a high-volume of requisitions at a fast pace.

The monthly purchase orders (POs) processed performance measure is a good indicator for first-line managers to check the temperature of their team's monthly performance. The following metrics show the number and average of POs processed by month, per job title, and individual buyers by the Goods Team for fiscal year 2025. Managers use the data to realize the potential challenges of each buyer and job title. If a buyer continues to process below the average for others with the same job title, managers can quickly identify and address training needs or any other obstacle hindering performance. These measures and analysis are refreshed daily and used by managers in team meetings.

Figure 3. PCS Dashboard.

Count of PO	Month								
Title_Buyer	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	AVG
MGR	6	9	7	4	6	2	6	40	6
Amanda	1	1	1	2		2		7	1
Irene					5			5	5
Joe W					1			1	1
Julie	5	8	6	2			6	27	5
P3	190	375	341	321	180	179	134	1720	246
Chris	9	34	29	25	4	3	4	108	15
Desiree	14	31	25	17	23	22	14	146	21
Jocelynn	18	30	35	31	15	3	10	142	20
Kourtney	28	32	37	42	31	8	15	193	28
Lindsey		5				18	21	44	15
Maricella	20	29	24	25	17	29	12	156	22
Marissa	14	33	28	25	19	18	8	145	21
Nicole	16	28	27	25	11	27	5	139	20
Ron	43	81	61	64	30	3	22	304	43
Santino	14	27	35	41	29	27	15	188	27
Sharonda	9	33	28	18	1	10	2	101	14
Simon	5	12	12	8		11	6	54	9
P4	353	714	537	458	194	233	164	2653	379
April	11	30	12	14	4	9	3	83	12
Becky	17	35	28	23	10	14	11	138	20
Darryl	21	41	30	28	4	6	11	141	20
Debra	62	120	73	67	33	68	28	451	64
Dianne	35	54	53	40	4	4	15	205	29
Geneva	11	41	20	22	5	10	6	115	16
George	26	45	41	28	8	6	1	155	22
Joseph T	16	20	28	10	14	22	9	119	17
Lisa	10	31	37	19	7	2	7	113	16
Madison	12	62	52	40	16	8		190	32
Paige	29	50	30	15	16	13	6	159	23
Rick	22	28	35	29	17	25	10	166	24
Sam	28	57	42	45	24	17	29	242	35
Tracie	53	100	56	78	32	29	28	376	54
P5	111	151	152	119	48	48	31	660	94
Ana	20	30	17	22	3	13	13	118	17
Daniel	18	36	26	12	6	6	6	110	16
Gus	16	23	12	19	13	4	5	92	13
Jeffrey	23	40	73	38	15	10	1	200	29
Linda	15		2	11	6	10	1	45	8
Michael	19	22	22	17	5	5	5	95	14
P6	22	24	19	22	8	13	7	115	16
Courtney	6	7	2	6	2	1	1	25	4
Lilly	16	17	17	16	6	12	6	90	13
Total	682	1273	1056	924	436	475	342	5188	741

D. History:

In 2018, Ernst & Young delivered a series of improvement project recommendations to HHS to improve its complex and multi-faceted procurement processes. In

response to audit findings and Ernst & Young's assessment, HHS adopted a Procurement and Contracting Improvement Plan (PCIP) which included a portfolio of projects for implementation to improve the procurement and contracting system.

Projects were selected by the PCIP Executive Steering Committee (ESC) in accordance with key improvement objectives, including having efficient workflows and processes, collaborative communication and relationships, value-added impacts, risk-based mindset, technology enablement, flexibility and autonomy, and reporting and performance metrics. Projects were prioritized by ESC and the list of priority projects was formally approved by HHSC's executive commissioner.

PCIP concluded in 2020, and, in January 2021, Ernst & Young released their final report noting the improvements made since their first engagement with HHS. Of the 29 projects recommended by Ernst & Young, 16 were completed during PCIP, with an additional five projects undertaken to improve procurement and contracting at HHS.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

PCS is the administrative support division that handles procurement and contracting services for the HHS system. Procurement and contracting services are necessary to expend public funds and deliver system services. PCS partners with customer organizations, such as program partners and other administrative support divisions, to:

- Plan procurements;
- Develop solicitation documents;
- Navigate procurement oversight;
- Consult on compliance with procurement statute and rule; and
- Award and execute contracts.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts:

PCS maintains SSAs and MOUs with HHS programs and divisions. These agreements outline the services provided by PCS and the responsibilities of both parties to the agreement. PCS works with the following state agencies:

- CPA;
- DIR; and
- Legislative Budget Board (LBB).

PCS works with the CPA's Statewide Procurement Division and DIR as required by law for the purchase of commodities and services. PCS reports to LBB for contracts procured by HHS as required under the General Appropriations Act, Article IX, Section 7.04.

I. Relationship with other governmental entities: Not applicable.

J. Barriers and challenges:

PCS continues to improve the procurement process through more active involvement in the procurement planning phase through acquisition planning and drafting of the statement of work. This phase is vital to ensuring the procurement strategy is accurate, the requirements and performance measures are clear, and HHS programs receive support throughout the procurement process. However, despite significant efforts to establish policies and training for HHSC contract managers, HHSC maintains contract monitoring ratings from SAO of "additional monitoring warranted" for both the contract solicitation development phase and the contract management and termination phase, indicating the ongoing need for effective, recurrent oversight. A review of findings from recent HHS Internal Audit reports found issues primarily related to the development and lack of sufficient review of the statement of work during the solicitation planning process. HHS must improve statements of work, making them clearer to reduce the number of canceled procurements which may translate to bridge extensions.

K. Additional information:

PCS worked to identify ways to streamline procurement timelines. From reviewing completed procurements, PCS noticed the timeframe variance related to scope of work or solicitation development was an issue. PCS created the Major Procurement Support or PCS Liaison. This is a team of project managers who work with program areas to understand their needs and develop a scope of work and to include the solicitation, scope of work, cost proposal, evaluation criteria, and procurement library artifacts.

L-M. Regulatory and Complaint Information: Not applicable.

Contract Management Support

A. Division or program information:

Name of division or program: Contract Management Support (CMS)

Location within the agency: COO

Contact name: Kay Molina, Deputy Executive Commissioner

Statutory citation: Not applicable.

B. Objective and major activities:

PCS CMS provides assistance and oversight for HHS staff, leaders, and business units with contract management-related responsibilities. PCS CMS focuses on strengthening contract management practices by developing policies and procedures, creating tools and templates, monitoring and analyzing key success indicators, and working to support program contract management areas.

C. Effectiveness and efficiency information:

PCS holds quarterly executive briefings to provide information on procurement and contracting topics. These briefings focus on summarizing information from PFAPs submitted by divisions and agencies and as needed, updates on specific procurement risks and concerns. PCS CMS provides information on other topics such as vendor performance reporting and contracts valued at \$10 million or more, as well as regular updates on contracts identified as requiring enhanced monitoring and, beginning in 2025, remedies applied to contracts.

PCS also facilitates the Procurement and Contract Management Oversight Committee (PCMOC). PCMOC is an executive governance committee that focuses on continuous improvement, strategic direction, and high-level decision-making on procurement and contract management-related topics.

PCS improved HHS system processes for contract risk assessment, monitoring, including enhanced monitoring, remedies, and contract closeout. These improvements include strengthened baseline risk assessment requirements; clarified and developed HHS policy revisions for developing and maintaining a monitoring plan to outline key monitoring activities, follow-up, and documentation and executive reporting requirements; updated policies and tools for contract remedies including requiring executive reporting of imposed remedies; and an

automated contract closeout form within SCOR which requires comprehensive consideration of programmatic, financial, and administrative requirements to close out a contract.

PCS has achieved other accomplishments such as establishing the CMS Advisory workgroup, developing a contract manager's toolbox and a manager's toolbox, increasing communications on HHS contract management requirements and available tools, and creating contract management training sessions including monthly Spotlight sessions which are designed as quick lunch and learn type trainings on a variety of contract management or related topics.

D. History:

PCS CMS was created in May 2020 as a part of PCIP.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

PCS, through the PCS CMS team, provides baseline support described in this section to help ensure contract management practices comply with the Texas Procurement and Contract Management Guide, the HHS Procurement and Contract Management Handbook, and applicable laws, regulations, and rules.

The PCS CMS team works collaboratively with HHS programs and divisions to:

- Assess compliance with contract management requirements;
- Develop and update policies and procedures;
- Create tools and templates;
- Develop and deploy training; and
- Recommend improvements to contract management practices and systems (such as SCOR) to influence better contract management outcomes.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts:

PCS has an interagency contract with the University of Texas to design and develop a Contract Management Academy.

I. Relationship with other governmental entities: Not applicable.

J. Barriers and challenges:

Challenge 1: PCS recognizes HHSC must continue to improve its management, monitoring, reporting, and oversight of the entire contract lifecycle. PCS continues to make enhancements to SCOR application, HHS' system of record for contract management, to increase the efficiency of completing contract management tasks. These enhancements to SCOR are required as part of a multi-year modernization plan to allow PCS and HHSC contract managers to track and monitor contract activity more effectively by improving visibility into HHS financial and contractual obligations.

Challenge 2: PCS also identified trends with contract management in internal and state audits. PCS has worked to address many of the identified issues through system-wide policies and procedures, training, tools etc., in addition to frequent communications on contracting topics and requirements; however, one operational need is taking HHS contract management to the next level through an ongoing and comprehensive professional development program.

To elevate the importance of contract management as a profession, PCS has initiated a project to design a professional development program for contract managers that will be administered through contract with a university. This program would supplement the contract management certification program provided by the CPA and focus specifically on understanding and managing HHS contracts and meeting state and HHS expectations.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

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VII. Guide to Agency Divisions and Programs

Chief Financial Officer

The Chief Financial Officer (CFO) is responsible for the financial management of the Health and Human Services Commission (HHSC) and the Office of Inspector General (OIG). While the Department of State Health Services (DSHS) has their own CFO, CFO provides a narrow range of services for DSHS. CFO also provides support for two administratively attached agencies, the Texas Civil Commitment Office (TCCO) and the Texas Pharmaceutical Initiative (TPI). CFO's Provider Finance Department provides rate setting support for the Department of Family and Protective Services (DFPS) and the Health and Human Services (HHS) system. The major functions of the division are discussed in the sections below.

The CFO also supports internal CFO business areas. This support includes:

- Operations support;
- Contract management: The contract and procurement team advises CFO staff and manages contracts for CFO;
- Project management: CFO Support staff coordinate projects that affect all departments, for example evaluating project management software or coordinating the CFO spacing needs;
- Internal communications: CFO Business Support publishes internal newsletters and sends email messages to CFO as well as all-agency audiences;
- Rulemaking: CFO Business Support and Provider Finance staff review cost estimates for rules across the agency;
- Performance measurement: CFO Business Support collects Legislative Budget Board (LBB) performance measures from all agency areas and submits them to LBB;
- Financial policy; and
- Other ancillary functions.

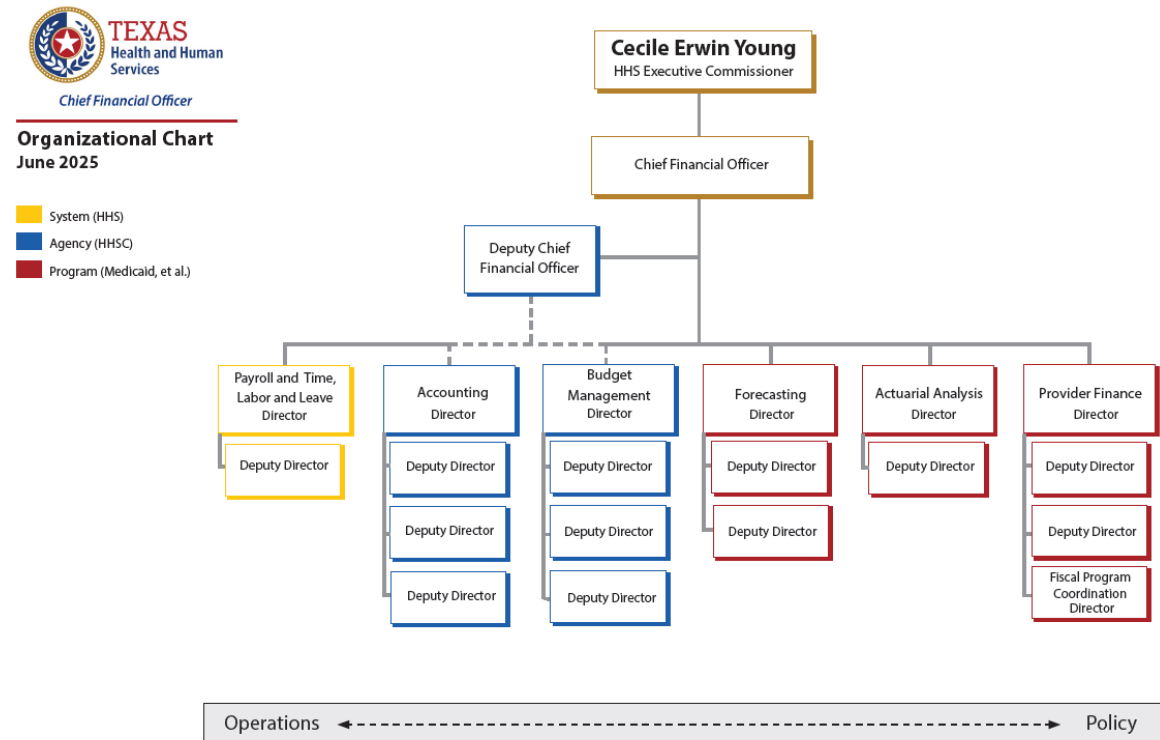
Senate Bill (S.B.) 200, 84th Legislature, Regular Session, 2015, directed HHS to adopt a plan reorganizing along functional lines, including consolidated financial

services. That meant integrating many financial functions including accounting and budget management from the abolished Department of Aging and Disability Services (DADS) and the Department of Assistance and Rehabilitative Services (DARS), and staff from DSHS and DFPS that supported transferred programs and functions. That reorganization took place over several years as HHS programs consolidated or transformed primarily in two phases in 2016 and 2017, though additional consolidation continued through 2019. The consolidated financial services at HHSC were under the purview of the deputy executive commissioner for finance, who oversaw the CFO, and to whom most departments directly reported.

By the time major consolidation efforts were complete in 2019, it was clear that financial services needed to be reorganized to drive the results envisioned in the Sunset process. In March 2020, the new structure went live. CFO began to report directly to the executive commissioner and to oversee:

- Payroll and Time, Labor and Leave (PTLL);
- The deputy CFO overseeing:
 - ▶ Accounting,
 - ▶ Budget Management,
 - ▶ Federal Funds Office;
- Forecasting;
- Actuarial Analysis; and
- Provider Finance Department (PFD).

Figure 1. CFO organizational chart.



The new structure reflects the unique size and scope of the CFO's role in HHSC compared to other state agencies. The division includes many specialized and technical staff with the expertise to set rates, project caseloads, and provide information to help the Governor and the Legislature make informed decisions including highly skilled actuaries and financial analysts responsible for setting more than 50,000 rates for Medicaid and non-Medicaid programs. In contrast to more compliance-based functions typically required of CFOs, the HHSC CFO also has substantial program responsibilities. PFD is responsible for administering several programs and programmatic functions discussed in detail in the section below.

System Support

CFO coordinates financial issues affecting multiple agencies by providing selected federal funds services to DSHS and DFPS, and a full array of payroll, time, labor, and leave related services on behalf of HHSC, including administratively attached agencies, DSHS, DFPS, and the Cancer Prevention and Research Institute of Texas (CPRIT).

Payroll and Time, Labor and Leave

A. Division or program information:

Name of division or program: Payroll and Time, Labor, and Leave

Location within the agency: CFO

Contact Name: Mike Markl, Director of PTLL

Statutory citation: Texas Government Code Chapters 437, 614, 656, 657, 658, 664, 667, 812, and 2177; Texas Constitution, Article 3, Section 44; Compensation of Public Officials and Contractors; Unauthorized Claims; Unauthorized Employment; Texas Labor Code, Chapters 21, 103, 402, and 412; 2024-25 General Appropriations Act, House Bill (H.B.) 1, 88th Legislature, Regular Session, 2023 (Article II, Special Provisions Relating to All Health and Human Services Agencies; and Article IX, Part 3)

B. Objectives and major activities:

PTLL provides timely and accurate salary payments, authorized voluntary and involuntary salary deductions as well as accurate time and leave keeping for HHSC, including administratively attached agencies, OIG, DSHS, DFPS, and CPRIT. PTLL processes payroll for more than 50,000 employees, or 24 percent of the state's total full-time employees (FTEs).

C. Effectiveness and efficiency information:

CFO uses survey results from the annual Feedback Assessment Improvement Review (FAIR) to measure customer satisfaction with the area's responsiveness, professionalism, and courtesy of communication, timeliness, and skills and expertise to offer appropriate solutions.

The nature of centralized enterprise support functions leads to a variety of binary measures of effectiveness. PTLL is effective when employees are paid on time for the proper amount and leave is managed according to agency policy and state law. PTLL reviews and assesses the accuracy of pay, time, and leave records to ensure effectiveness. PTLL also monitors data submitted by the vendor responsible for processing payroll. This includes the number of payrolls with an accurate pay date, the number of exceptions cleared before the deadline, and the number of reports

submitted by the established deadline. The expectation is that these metrics are met 100 percent of the time.

D-E. History, and Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

PTLL functions include management of pay and timekeeping, creation and implementation of payroll, timekeeping, and leave policies, support with United States (U.S.) Department of Labor investigations, management and review of requests for sick leave pool, extended sick leave, and sick leave donations for employees, submission of quarterly federal and state tax reports, and others. PTLL policies, management, and functions are interdependent systems that collectively ensure accurate time and pay for employees. PTLL follows HHS policies, state and federal laws, and participates in the legislative process when new legislation, revised policies, or business processes must be developed. The agencies, supported by PTLL, use an employee/manager self-service model to update all payroll and time management transactions.

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts:

PTLL works with multiple agencies and is responsible for all pay, overtime, and leave administration for HHSC, including administratively attached agencies, OIG, DSHS, DFPS, and CPRIT.

I-M. Relationship with other governmental entities; Barriers; Additional, Regulatory, and Complaint information: Not applicable.

Agency Support

Agency supports are functions primarily performed on behalf of HHSC divisions and the OIG. This section encompasses financial services including accounting, budgeting, and certain federal funds-related services.

Agency Finance (Accounting and Budget Management)

A. Division or program information:

Name of division or program: Agency Finance

Location within agency: Deputy CFO

Contact Name: Christopher Matthews, Deputy CFO

Statutory citation: Texas Government Code, Chapters 523-524

B. Objective and major activities:

CFO provides a full array of financial services to HHSC and OIG. Agency Finance includes the Accounting and Budget Management departments. In practice, Agency Finance also includes the Federal Funds Office. However, because of separate statutory authority and a different focus from other Agency Finance areas, the Federal Funds Office is discussed as a separate function in this report.

Agency Finance's primary objective is to manage and perform accurate and timely centralized financial functions in the most efficient, effective, transparent, and customer-centered manner possible.

Accounting creates and maintains financial records for state and federal compliance, ensures integrity of accounting records, and maintains adequate internal controls. Major responsibilities include:

- Payment processing;
- Travel management;
- Fund management; and
- State and federal funds reporting.

Budget Management ensures the allocation and use of resources are efficient and within the limits of appropriation authority. Major responsibilities include:

- Preparing the biennial legislative appropriations request and operating budgets;
- Preparing billing invoices for shared administrative services;
- Submitting other federal and state budget reports; and
- Preparing and analyzing annual organizational budgets.

C. Effectiveness and efficiency information:

CFO uses survey results from the annual FAIR to measure customer satisfaction with the area's responsiveness, professionalism, and courtesy of communication, timeliness, and skills and expertise to offer appropriate solutions.

Deliverable-based financial management creates binary measures of effectiveness for core functions. Either financial records and integrity are maintained so the agency can make and track its payments, or they are not. Either agency decisions are made with reliable and useful financial data, or they are not. However, agency and division performance for some functions can be compared and tracked over time. For example, Accounting tracks and reports monthly information on late payments. All CFO departments track completion of state and federal reporting requirements including statutorily required reports like the state Operating Budget and LBB performance measure reporting for the state and federal reporting requirements including the U.S. Health and Human Service's (DHHS) Centers for Medicare & Medicaid Services (CMS)-64 quarterly statement of expenditures for which states are entitled to federal Medicaid reimbursement. CFO departments also track information on recruitment and retention efforts. For operational tasks, like processing travel expenses and invoices, the agency maintains dashboards to track completion over time. Additionally, Accounting maintains the late payment dashboard that displays interest payments as a result of late payments. The dashboard assists leadership in identifying trends and shortfalls to timely payment processing.

Agency Finance departments receive annual State Auditor's Office (SAO) single audits and topic-specific audits to ensure compliance. The departments also complete annual business plans to establish goals and priorities, strategies to meet them, and milestones that are used to monitor improvements and accomplishments throughout each fiscal year.

D-E. History, and Qualifications or eligibility requirements: Not Applicable

F. Administrative and key processes:

The Agency Finance function is administered in accordance with HHS policies and state and federal laws.

Accounting is organized by function increasing specialization and scalability to maximize processing speed. Accounting tasks are typical of most private or public entities including, but not limited to:

- Cash management;
- Financial reporting;
- Accounts receivables processing;
- General ledger reconciliation; and
- Financial system support, position control, and accounts receivable.

Accounts Payable: The Accounts Payable function of accounting sometimes requires closer onsite coordination to provide immediate guidance, quick processing of physical documents, and cater to specific business needs. As a result, the Accounts Payable function is distributed among the three key business sectors of the agency:

- Central Accounting – State Office (CFO);
- Peripheral Accounting – Regional (System Support Services); and
- Facility (Health and Specialty Care Services).

Budget Management: Budget is organized by agency business area. Budget Management processes are tied to the legislative process and LBB reporting requirements. HHSC operates as a centralized budget unit in coordination with divisional program areas to develop base funding for continued operations and planning for any additional funding needs.

The Budget function associated with projections and expenditures of contracts and grants is complex, fast paced, and drives business decisions in each executive area. As a result, this responsibility is delegated to each business area in the agency. Budget within the business areas plans and monitors contract and grant amounts to ensure the allowability of expenditures and the efficient use of funds.

Budget Management in the CFO maintains high-level controls, approves appropriation changes, interprets appropriation authority, and verifies impacts for significant business area financial changes.

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts:

Agency Finance has both MOUs and interagency agreements (IACs) to coordinate financial activities and avoid duplication of administrative functions across state government. Accounting uses two MOUs with the Texas Comptroller of Public Accounts (CPA). One MOU authorizes HHSC to print Temporary Assistance for

Needy Families (TANF) warrants, and the second authorizes select employees to access the Comptroller's tax system. These MOUs eliminate the requirement for the Comptroller to print the TANF warrants and continually provide tax information requested by HHSC to conduct normal operations. The MOU's increase functionality and efficiency that would not exist if they were not in place.

I. Relationship with other governmental entities:

Agency Finance departments frequently work with local, regional, and federal units of government to complete reporting requirements, draw down federal funds, and pass-through grant awards. Local entities include county probation offices and district attorney offices throughout the state to process restitution funds. In addition to other HHS agencies, the departments interact with other state agencies, including the Texas Education Agency (TEA) and the Texas Workforce Commission (TWC), as well as institutions of higher education, to draw down and send federal funds and complete financial reporting required by state and federal law. Because of the number of federal grants received by the agency, Agency Finance departments receive, process, track, and report on funds from multiple federal partners, including CMS, the U.S. Department of Agriculture (USDA) Food and Nutrition Service (FNS), and the Federal Emergency Management Agency (FEMA).

J. Barriers and challenges:

Challenge 1: Technological barriers, including working with legacy systems, can hinder efficiency and productivity. For example, Accounting must work with the legacy Accounts Receivable Tracking System (ARTS) for accounts receivable collection. This system manages the agency's collection of approximately \$7 billion in revenue, but its limited functionality creates operational challenges. The system cannot be updated to meet the agency's ongoing accounting needs or to comply with previous audit findings.

Challenge 2: Another challenge is related to multiple reporting requirements. H.B. 4510, 88th Legislature, Regular Session, 2023, requires state agencies to complete the Annual Financial Report (AFR) on November 1. To complete the report, HHSC must coordinate with other state agencies, the CPA, and higher education institutions, in addition to internal agency business areas. This advanced submission deadline poses compliance risk and operational challenges for HHSC.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Agency Finance (Federal Funds Office)

A. Division or program information:

Name of division or program: Federal Funds Office

Location within agency: CFO

Contact Name: Racheal Kane, Federal Funds Director

Statutory citation: Texas Government Code, Chapters 525.0052 and 772.009.

B. Objective and major activities:

State law requires each agency to designate a staff member to serve as the federal funds coordinator. State law also makes HHSC responsible for establishing “priorities for use of federal money by all health and human services agencies” and reviewing and approving “all federal funding plans for health and human services in this state.” HHSC is responsible for planning and managing the use of federal funds received by HHS agencies with the goal of maximizing federal funding available to the state while promoting the optimal delivery of services.

The Federal Funds Office supports agency and system compliance with uniform guidance and all other federal and state requirements for federal funding. Federal Funds reviews and approves all federal funding plans for HHS in the state pursuant to Texas Government Code, Section 525.0052. It tracks all award opportunities for which HHS is eligible to apply, including those to which the agency did not apply, pursuant to Texas Government Code, Section 772.009, and submits two annual federal funds reports, pursuant to Texas Government Code, Sections 525.0052 and 772.009. Federal Funds also:

- Administers the indirect cost rate process for subrecipients of HHS subawards;
- Manages the Work Measurement, Random Moment Sampling, timekeeping, and sole source certification reporting for cost allocation;
- Develops and manages the Public Assistance Cost Allocation Plan; and
- Helps HHS manage grants.

C. Effectiveness and efficiency information:

CFO uses survey results from the annual FAIR to measure customer satisfaction with the area's responsiveness, professionalism, and courtesy of communication, timeliness, and skills and expertise to offer appropriate solutions.

Like Agency Finance, the Federal Funds Office has deliverable-based measures related to certain functions. Other operational tasks are evaluated through service and processing expectations. The Federal Funds Office aims to complete rate negotiations within three to four months; there can be outliers for more difficult negotiations and newer grantees. Rate negotiations from federal agencies can take a minimum of one year because of backlogs at the federal level. This affects program efficiency.

D-E. History, and Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

The Federal Funds Office develops and uses the Federal Award Management Manual to outline the policies, procedures, and suggested best practices to follow for federal and non-federal awards. There are five areas in the Federal Funds Office related to federal award administration and management.

- The Work Measurement and Random Moment Sampling Unit conducts work measurement and random moment time studies for the agency, performs sole source certifications, and supervises timekeeping for program areas to comply with federal regulations and to allow HHSC to claim federal funding for administrative costs.
- The Cost Allocation Team develops statistical methodologies used to assign and allocate costs among various state and Federal Fund Sources. The team is responsible for compiling and submitting a narrative summary of these methodologies called the Public Assistance Cost Allocation Plan.
- The Grant Management Team manages all grant submissions for HHSC. The team ensures departments and divisions comply with the Code of Federal Regulations (2 CFR Part 200) by providing training and guidance. The team is responsible for reviews, approvals, and submissions of applications to ensure continuity of funding.
- The Indirect Cost Rate Group (ICRG) works directly with grantees to calculate indirect cost rates, review and accept rate agreements issued by federal agencies as well as other state agencies, and accept requests to use the de

minimis rate from qualifying grantees. ICRG has tools and templates to expedite accurate processing and review rate negotiations. For example, the ICRG uses a review tool for its financial analysts to more easily and quickly identify adjustments needed for appropriate rate calculation, ensuring indirect cost rates accurately reflect the administrative burden on grantees.

- Senior policy advisors review and analyze complex policy, federal regulations, and legislation to help manage federal awards and ensure compliance with policies, rules, regulations, and laws.

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements and contracts: Not applicable.

I. Relationship with other governmental entities:

The Federal Funds Office works with the Office of the Governor (OOG) on matters concerning federal funding and submits an annual report in accordance with the Texas Government Code, Section 772.009. Federal Funds communicates with awarding federal agencies for program or policy guidance, grant management guidance, financial management issues, audits, and programmatic and financial management reviews. It also communicates with local and regional units of government when negotiating indirect cost rate agreements with those entities.

J. Barriers and challenges:

The current System for Contract Operations and Reporting (SCOR) requires outdated manual processes to tie in grant requirements related to management and reporting. HHSC is developing a new Grant Management System to improve performance and increase efficiency related to grant making and compliance. The goal is for the new system to allow for interface functionality between HHS and its grantees, increasing operational efficiency in grant making, grant management, and required Federal Financial Accountability and Transparency Act reporting.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Program Supports

CFO also has a variety of centralized program supports related to client services operations and policy. HHSC provides Forecasting and Actuarial services for Medicaid and the Children’s Health Insurance Program (CHIP). In addition, PFD

provides rate-setting services for certain Medicaid and non-Medicaid programs at HHSC and other state agencies, monitors and administers payments for Medicaid supplemental and directed payment programs and runs certain grant programs.

Forecasting

A. Division or program information:

Name of division or program: Forecasting

Location/Division: CFO

Contact Name: Michael Ghasemi, Director of Forecasting

Statutory citation: Texas Government Code, Chapter 525; 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, Special Provisions Related to All Health and Human Services Agencies, Section 8)

B. Objective and major activities:

Forecasting provides timely and reliable monthly, quarterly, and annual client service caseload and cost reports for internal and external stakeholders related to multiple HHS programs, including Medicaid and CHIP. For routine interactions with HHSC divisions and other state entities, reports and data include standardized processes or automation to ensure consistency in quality and timeliness for deliverables. External stakeholders include members of the public who may make open records requests. Forecasting provides relevant client services data for open records requests and has processes to provide accurate and timely information with consideration for staff labor time/costs as required. The most common request for monthly enrollment data has been streamlined and data is posted online on a consistent basis.

Forecasting successes include operational efficiencies, additional quality assurance checks, and the modernization of forecasting tools to further automation and allow new initiatives. Forecasting continues to review current data governance and workflows to identify challenges and provide improvements to streamline the current processes with additional tools.

C. Effectiveness and efficiency information:

CFO uses the survey results from the annual FAIR to measure customer satisfaction with the area's responsiveness, professionalism, and courtesy of communication, timeliness, and skills and expertise to offer appropriate solutions.

Forecasting is required to submit quarterly forecasts and monthly caseload and expenditure data, per the 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, Special Provisions Relating to All Health and Human Service Commission Agencies, Section 8, Quarterly Forecasts). The quarterly forecasts provide historical and projected enrollment data, cost per client information, and total expenditures by program for Medicaid, CHIP, TANF cash assistance, Women's Health Programs, Early Childhood Intervention, as well as other programs upon request. Forecasting ensures that the entire agency is operating with the same data and information consistent with data reported to LBB and other external stakeholders, including reporting quarterly and annual client service General Appropriations Act performance measures.

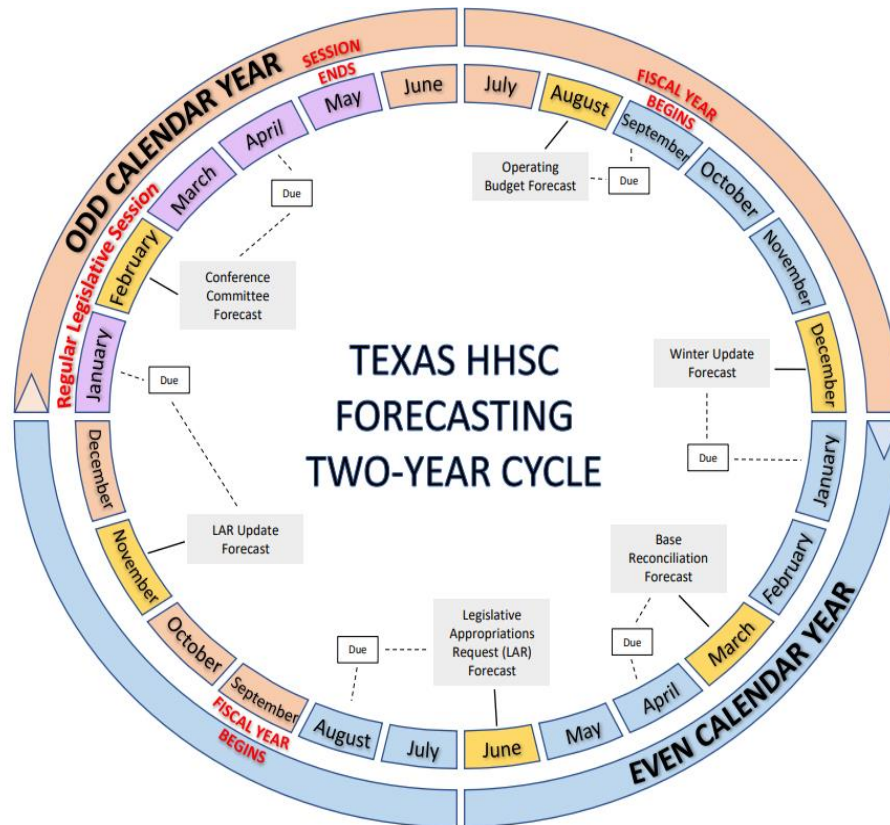
D-E. History, and Qualifications and eligibility requirements: Not applicable.

F. Administration and key processes:

Forecasting follows a two-year cycle in alignment with the legislative process, illustrated below. Ongoing monthly process includes monitoring and updating cost and caseload files with current data. It involves analyst reviews for all current data against historical data and expected trends for inconsistencies and outlier data points. Data types include caseload, cost, and utilization. The data used within Forecasting is not at a service or claim-specific level and is generally aggregated by overall service type (e.g. acute, Long-term Services and Supports, drug, dental) and by Risk Group or program. Historical data is subjected to a number of different types of models and series, in a number of different software modeling packages. Statistical testing then measures how well the model fits the actual historical data points.

Once data collection is finalized, a review process is completed to ensure files are accurate. Forecasts are performed and reviewed, typically every quarter, to ensure all identifiable trends and outliers from the monitoring process are accounted for and resolved in future forecasts. Forecast models may be adjusted up or down to account for planned changes (e.g. program carve-ins or rate changes). Reports are prepared for distribution and uploaded to the LBB File Transfer Protocol website. Monthly process and additional quarterly reporting follow the same process.

Figure 2. HHSC's Two-Year Forecasting Cycle



G. Funding: See "Agency Program Information" spreadsheet

H-M. MOUs and interagency agreements and contracts, Relationship with other governmental entities, Barriers and challenges, and Additional, Regulatory, and Complaint information: Not applicable.

Actuarial Analysis

A. Division or program information:

Name of division or program: Actuarial Analysis

Location within agency: CFO

Contact Name: Michael Joyner, Chief Actuary

Statutory citation: Not applicable

B. Objective and major activities:

Actuarial Analysis sets actuarially sound capitation rates for Medicaid and CHIP Managed Care Organizations (MCO) and Dental Maintenance Organizations (DMO) participating in the Medicaid and CHIP programs. Actuarial Analysis also helps respond to legislative inquiries about capitation-rate setting.

Actuarial Analysis sets capitation rates for Medicaid, CHIP, and the Program for All-Inclusive Care for the Elderly (PACE) with the help of contracted consulting actuaries. Capitation rates are set amounts paid to each MCO (Medicaid and CHIP) or PACE site for each member each month. For fiscal year 2023, the total dollar amount of capitation paid was \$41.5 billion. For fiscal year 2024, a total of 29,829 rates were set for the various managed care programs, including adjustments to the annual rates.

C. Effectiveness and efficiency information:

Actuarial Analysis pursues opportunities to bring analysis related to capitation rate-setting in-house and reduce reliance on contracted actuaries. The department calculates estimated contract dollars saved by doing more of the analyses in-house. For fiscal year 2024, Actuarial Analysis estimates a savings of approximately \$2.4 million in contract expenses. Actuarial Analysis focuses on the development of actuarially sound capitation rates and does not track formal measures of effectiveness.

D-E. History, and Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

Capitation rates are determined annually, using primarily managed care historical cost experience. Actuarial Analysis coordinates with multiple departments at the agency to include policy, benefit, and provider reimbursement changes in the rates. Rates are fixed for a 12-month period but may be adjusted between periods to recognize significant changes in policy or benefit coverage.

Rates are set by HHSC, but contractors can review and provide comments on the rates. After approval by the executive commissioner, rates and actuarial submissions are sent to the OOG, LBB, SAO, and CMS for approval.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements and contracts: Not applicable.

I. Relationship with other governmental entities:

Actuarial Analysis works with CMS to respond to questions from the Office of the Actuary (OACT) regarding capitation rates for MCOs. OACT helps CMS determine the actuarial soundness of the capitation rates for MCOs. The rates are required to be actuarially sound before CMS grants federal approval of the rates. Federal approval of the capitation rates is necessary for federal matching funds.

J. Barriers and challenges:

One of the biggest challenges in setting capitation rates is the timing of available information. Information on policy or benefit changes sometimes is not available in time to impact capitation rates effective September 1. This is especially true in session years when final passed bills are not known until after we have already set final capitation rates for the year. Depending on the impact, adjustments to the capitation rates are sometimes necessary.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Provider Finance

A. Division or program information:

Name of division or program: Provider Finance Department

Location within agency: CFO

Contact Name: Victoria Grady, Director of Provider Finance

Statutory citation: Texas Government Code Chapter 531; Texas Health and Safety Code; and U.S. Code Title 42, Public Health

B. Objective and major activities:

PFD is responsible for:

- Determining payment rates for Medicaid client services and non-Medicaid payment rates for programs operated by HHSC, DSHS, and DFPS, and provides consultative rate setting services for the General Land Office and the Texas Juvenile Justice Department; and
- Administering various financial programs, including:

- Supplemental payment programs;
- Directed payment programs;
- Certain grant programs; and
- Interpreting and overseeing compliance with state and federal statutes and regulations related to the use of local funds in Medicaid.

Key functions include:

- Analysis and calculation of reimbursement rates;
- Collection and financial examination of Medicaid and other provider cost reports;
- Design and administration of supplemental and directed payment programs;
- Oversight of the use of local funds in Medicaid;
- Facilitating rate hearings for public comment; and
- Drafting waiver updates, state plan amendments, and Texas Administrative Code rule updates.

PFD also administers the:

- Medicaid Administrative Claiming (MAC) program;
- School Health and Related Services (SHARS) program;
- The Disproportionate Share Hospital (DSH) program;
- The Uncompensated Care (UC) program;
- The Public Health Provider Charity Care Program (PHP-CCP);
- The Quality Incentive Payment Program (QIPP);
- Graduate Medical Education (GME) program;
- The Texas Incentives for Physicians and Professional Services (TIPPS) program;
- The Directed Payment Program for Behavioral Health Services (DPP-BHS);
- The Comprehensive Hospital Increased Reimbursement Program (CHIRP);
- The Rural Access to Primary and Preventive Services (RAPPS);
- The Hospital Augmented Reimbursement Program (HARP);

- Aligning Technology by Linking Interoperable Systems (ATLIS);
- Network Access Improvement Program (NAIP); and
- Rural Hospital Financial Stabilization Grant Program.

Additional information related to supplemental and directed payment programs can be found in the [CFO Reference Guide: An Overview of Key Financial Topics](#). PFD also provides technical assistance, and issues grant payments to rural hospitals, through the PFD Office of Rural Hospital Finance and Coordination (RHFC).

C. Effectiveness and efficiency information:

CFO uses survey results from the annual Feedback Assessment Improvement Review to measure customer satisfaction with the area's responsiveness, professionalism and courtesy of communication, timeliness, and skills and expertise to offer appropriate solutions.

PFD provides detailed analysis of payment rates to ensure economy and efficiency of Medicaid and non-Medicaid reimbursement rates. Along with the Medicaid program, PFD has received approval for multiple directed payment programs under the 1115 Medicaid Waiver and supplemental programs through the Medicaid State Plan. PFD has also created a new incentive program for MCOs and updated thousands of Medicaid and non-Medicaid reimbursement rates. PFD has completed more than 50 percent of all state plan amendments submitted by HHSC annually and increased communication through GovDelivery notifications. Stakeholder communication sessions and regular meetings with interested parties have increased external engagement.

D. History:

Before the 2015 Sunset Commission recommendations, the Rate Analysis Department, the predecessor to PFD, had fewer than 75 FTEs and was responsible for establishing Medicaid reimbursement rates. In 2016, approximately 50 FTEs were transferred from OIG so Medicaid provider cost report reviews would be performed within the department.

In 2016, CMS issued a disallowance related to the use of alleged non-bona fide provider related donations to certain public hospital districts. HHSC appealed the decision to the U.S. DHHS Departmental Appeals Board (DAB). The disallowance and appeal to the DAB resulted in the pursuit by the Texas Legislature of different

allowable local funding mechanisms for use in the Medicaid program – specifically related to the use of Local Provider Participation Funds (LPPFs).

In 2017, PFD began working with other non-Medicaid programs to transition rate setting responsibilities to PFD in cooperation with the Sunset Commission's management actions. Through these efforts, PFD has assumed responsibility for analyzing rates for most non-Medicaid client services programs through HHSC.

In 2018, recognizing the additional workload burdens created by the implementation of the 1115 Waiver, including the Uncompensated Care (UC) pool and the Delivery System Reform Incentive Payment (DSRIP) program, Rate Analysis received approximately 30 additional FTEs. These additional staff resources also supported the work to implement the analysis and rate setting activities for non-Medicaid client services programs throughout the HHS system. During this same time, two new state directed payment programs, QIPP and the Uniform Hospital Rate Increase Payment (UHRIP), were launched. Beginning at \$400 million for the first program period, QIPP reflected a transition of nursing facility supplemental funding from the legacy nursing facility upper payment limit program that was required to end-date when nursing facility services were carved into Medicaid managed care. The UHRIP program was intended to serve as a glide path for hospitals as the Uncompensated Care program was transitioned from paying for all uncompensated costs to charity care only. The program was authorized for less than \$1.25 billion for the first full year.

In 2019, the Texas Legislature began requiring the first local funding transparency reporting via the General Appropriations Act. These initial reports focused exclusively on the LPPFs that had been authorized to that point and created a first-of-its-kind local funding oversight requirement.

In 2020, the Rate Analysis Department was transferred to the same reporting structure as other financial departments, under the umbrella of the CFO, and became known as PFD. During that same time, the DSRIP program was scheduled to end-date, but with the unfolding of the COVID-19 public health emergency, transition planning had been extremely disrupted. The UC program began paying for charity care only. CFO determined it was unlikely there would be sufficient budget neutrality room under the then-existing federal budget neutrality calculation rules to continue DSRIP. PFD and the Medicaid and CHIP Services (MCS) DSRIP policy staff developed state directed payment programs that were intended to serve as successors for most of the DSRIP participants and funding.

In 2021, CMS approved the renewal of the 1115 Waiver, which included favorable terms for the creation of the directed payment programs, as well as authorization for PFD to create the Public Health Providers – Charity Care Program for more than \$500 million per year. The 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021, authorized additional staff to expand the local funding oversight efforts that had begun in 2019 and to authorize sufficient FTEs to support the programs that would be administered under the 1115 Waiver. With this staff expansion, PFD grew to more than 200 FTEs. The combined value of the new programs created under the Waiver grew to be more than \$8 billion.

In 2021, the Texas Legislature directed HHSC to establish a specific team of individuals focused on the rate analysis work for DFPS. These staff created the Foster Care Rate Modernization models, which created an entirely new reimbursement structure for Texas foster care services.

Through S.B. 8, 87th Legislature, Third Called Session, 2021, the legislature appropriated more than \$400 million in COVID-19 relief funding to be administered as grants for various providers in the state. PFD issued thousands of grants to hundreds of providers within a 12-month period. This work informed the idea for the new Office of Rural Hospital Finance and Coordination.

In 2022, HHSC received approval for the resizing of the UC pool. The program increased from approximately \$3.8 billion annually to \$4.6 billion.

In the 2024-2025 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023, following the successful implementation one-time grants authorized by S.B. 8, 87th Legislature, Third Called Session, 2021, the Legislature created the State Office of Rural Hospital Finance and appropriated \$25 million per year for ongoing rural hospital grants. This team was created within PFD to support this permanent function. Additionally, staff resources were further expanded to support the growing local funding oversight and 1115 Waiver programming needs. This increased the total number of FTEs to 261.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

PFD develops reimbursement rates for health and human services programs approved by the executive commissioner. PFD develops more than 50,000 different rates, primarily for the Medicaid program, but also includes recommendations on reimbursement rates for other non-Medicaid programs that HHSC administers. PFD

uses various methodologies, such as cost report-based systems, cost reimbursement services, and fee schedules/payment codes established by governmental or other professional fee entities to recommend reimbursement rates. Rates are typically prospective, cost-reimbursed, or based on a percentage of Medicare.

PFD reviews Acute Care rates at least once every two years through a quarterly system that reviews rates of a similar type. In addition to the quarterly reviews, staff also analyzes new rates for new procedure codes to conform to the federal Healthcare Common Procedure Coding System and conducts special rate reviews such as to support new benefits, to implement appropriation rate changes, and to address access to care issues. PFD reviews hospital rates upon rebasing, and Long-term Services and Supports rates biennially.

PFD also determines and processes supplemental payments, including the Medicaid DSH and UC programs and other programs covered by the 1115 Texas Healthcare Transformation waiver or as approved through the Medicaid State Plan.

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements and contracts:

HHSC and TEA have an MOU that outlines their roles in the SHARS program. HHSC manages SHARS, while TEA plays a role in supporting local educational agencies with SHARS-related matters.

I. Relationship with other governmental entities:

PFD works closely with the federal government through CMS. PFD also coordinates with units of local government, including hospital districts, throughout the state in developing program structures and goals. Through this coordination, PFD ensures that local funds transferred in support of the Medicaid program are compliant with all state and federal laws and regulations, and that program funds are used for non-duplicated costs. The Office of Rural Hospital Finance and Coordination similarly works closely with rural local governments to identify needs and provide supports that correlate to locally driven issues.

J. Barriers and challenges: Not applicable.

K. Additional information:

PFD will be responsible for implementing significant portions of the federal regulations commonly referred to as the "Access Rules." As a result of these rules required implementation activities, PFD anticipates the addition of nearly 100 FTEs in the 2026-27 biennium to implement expanded cost reporting and spending requirements for Home and Community-Based Services providers as well as other federally mandated reporting, transparency, and public comment processes.

L-M. Regulatory, and Complaint information: Not applicable.

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VII. Guide to Agency Divisions and Programs

Chief Counsel

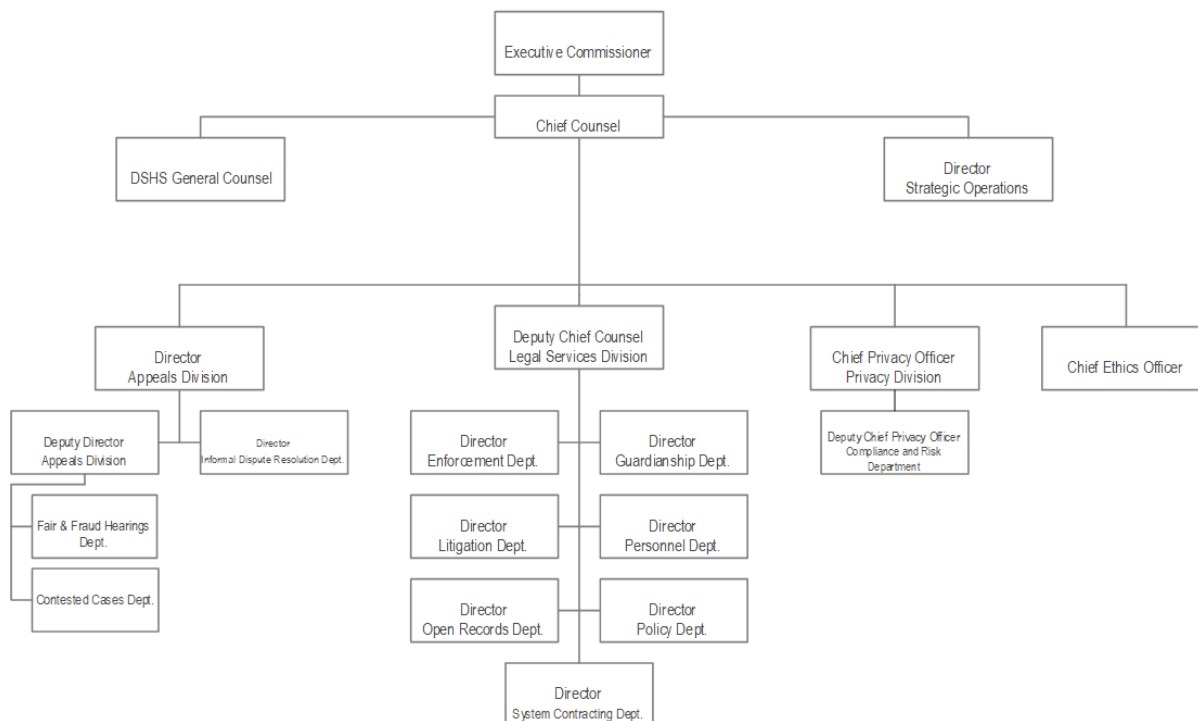
The Office of Chief Counsel (OCC) is a component of the centralized administrative support services within Health and Human Services (HHS), offering legal and compliance assistance in four main areas:

- Appeals;
- Ethics;
- Legal Services; and
- Privacy.

Together, these areas deliver comprehensive legal and compliance support to the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS).

OCC's leadership team reflects its functional structure. Each of the four divisions is led by a director who reports directly to the Chief Counsel. The leadership team also includes the DSHS General Counsel, who reports directly to the Chief Counsel and reflects OCC's commitment to ensuring consistent and effective support to the entire HHS system.

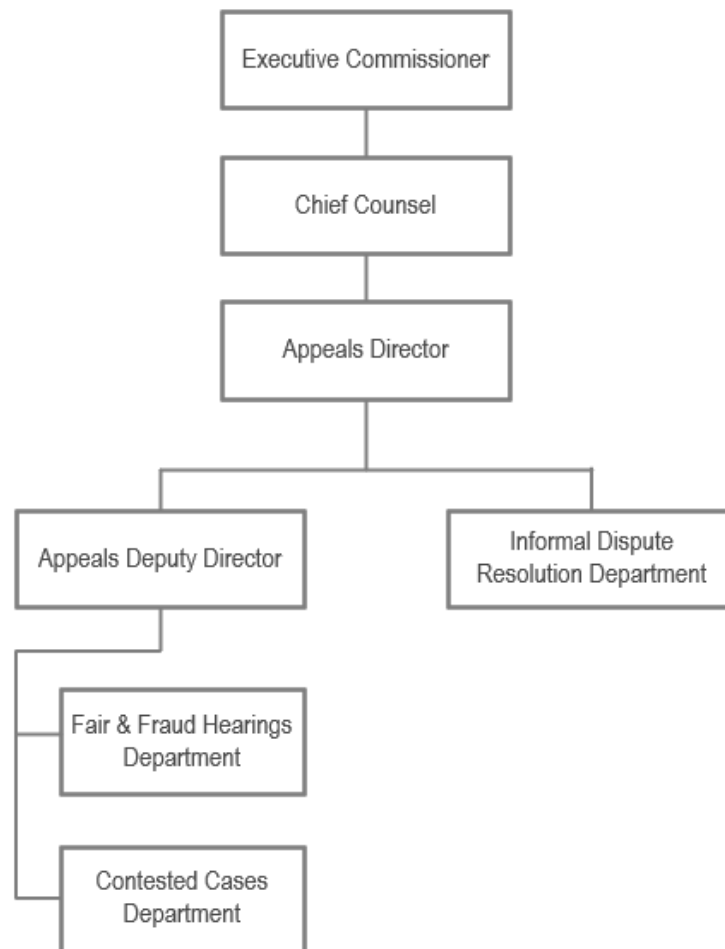
Figure 1. OCC organizational chart.



Appeals

OCC's Appeals Division (Appeals) includes three departments: Contested Case, Fair and Fraud Hearings, and Informal Dispute Resolution. Appeals is responsible for ensuring agency actions are consistent with state and federal law, the rules adopted by the executive commissioner, and the policies established by system decision makers. Appeals is led by Director Carole Hurley.

Figure 2. Appeals organizational chart.



Contested Case

A. Division or program information:

Name of division or program: Contested Case Department (CCD)

Location within the agency: OCC

Contact name: Shari Nichols, Deputy Director

Statutory citation: The state or federal law governing each program establishes whether, when, and to whom an appeal is available. In addition, CCD looks to Texas Government Code, Chapter 2001, and Title 1, Texas Administrative Code, Chapter 357.

B. Objective and major activities:

CCD consists of Administrative Law Judges (ALJs) and support staff who handle administrative appeals. ALJs provide impartial reviews required by federal and state programs, HHS policy and rules, and state statutes. The appeals result from actions taken by HHSC or DSHS. ALJs hear two types of appeals:

- Contested Cases: Cases conducted under the Administrative Procedure Act (APA).
- Administrative Cases: Non-APA cases where a hearing is required by other state or federal law.

C. Effectiveness and efficiency information:

In fiscal year 2025, CCD has averaged 33 new cases per month, with a total of 263 new cases as of May 1, 2025. This is down from fiscal year 2024, when CCD experienced a spike in appeals and finished the year with a total of 668 new cases.

CCD tracks the timeliness of its decisions according to the standards established in statute or rule for each case type. As of May 1, 2025, the department reports that 100 percent of cases in fiscal year 2025 were completed timely.

D. History:

The Legislature passed House Bill (H.B.) 2292, 78th Legislature, Regular Session, 2003, consolidating many CCD responsibilities within HHSC. However, DSHS continued to hear administrative cases related to its Vital Statistics functions, designating one of its attorneys to act as an ALJ for that purpose. HHSC and DSHS transferred this function to CCD effective September 1, 2018.

E. Qualifications and eligibility:

State or federal law governing each individual program establishes whether, when, and to whom an appeal is available.

F. Administration and key processes:

A written appeal filed by an individual or provider agency initiates a case within CCD. Appeals may be filed by mail, fax, or by email to a dedicated email box monitored daily. The appeal is docketed, an appeal number assigned, and the case is assigned to an ALJ.

Contested Cases: State law defines when a contested case hearing is available. CCD handles contested cases according to the APA, Texas Government Code, Chapter 2001.

Some APA cases are filed with CCD but transferred to the State Office of Administrative Hearings (SOAH) for the final hearing pursuant to Title 26, Texas Administrative Code, Section 110.5. At the conclusion of one of these cases, the SOAH ALJ issues a Proposal for Decision (PFD) which is forwarded to CCD where an ALJ, as designee of the executive commissioner, reviews the PFD and issues a final order for the case.

Administrative Appeals: Administrative appeals are available when the right to a hearing is provided by federal or state statute or rule. CCD conducts administrative appeals according to the procedures set out in the administrative rules applicable to the program.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationships with other government entities:

SOAH provides a similar and complementary service. As noted above, some APA cases are filed with CCD but transferred to SOAH for the final hearing. In these cases, the SOAH ALJ writes a PFD which is returned to CCD for review and finalization.

J-M. Barriers and challenges; Additional, Regulatory, and Complaint information: Not applicable.

Fair and Fraud Hearings

A. Division or program information:

Name of division or program: Fair and Fraud Hearings (FFH) Department

Location within the agency: OCC, Appeals Division

Contact name: Wendy Proctor, Director

Statutory citation: 42 United States Code (USC) Section 1396a(a)(3); 7 Code of Federal Regulation (CFR) Part 273, Subpart F; 42 CFR Part 431, Subpart E; 45 CFR Part 205; Sections 31.034 and 32.035, Texas Human Resources Code; Title 1, Texas Administrative Code, Chapter 357; and laws specific to other individual programs.

B. Objective and major activities:

FFH consists of lay hearings officers and support staff who provide an impartial review in fair hearings and administrative disqualification hearings.

Fair hearings are appeals by applicants for or clients of HHS assistance programs whose services have been delayed, reduced, or denied by HHSC. FFH receives fair hearing requests from applicants and clients in 169 HHS eligibility programs.

In cases where HHSC determines applicants, or clients, of the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Medicaid benefits committed an intentional program violation (IPV), these applicants or clients may file for an administrative disqualification hearing (ADH).

C. Effectiveness and efficiency information:

In fiscal year 2025, FFH averaged 2,853 new hearing requests per month, with a total of 22,824 new hearing requests as of May 1, 2025. This is down from fiscal year 2024, when FFH was contending with the influx of hearing requests following the end of the federal Public Health Emergency and finished fiscal year 2024 with a total of 47,367 new hearing requests.

FFH tracks the timeliness of decisions according to the standards established in statute or rule for each hearing type. As of May 1, 2025, FFH reports:

- Fiscal year 2025: 99 percent of decisions were issued timely.
- Fiscal year 2024: FFH issued 48,185 decisions with a timeliness of 99 percent.
- Fiscal year 2023: FFH issued 31,366 decisions with a timeliness of 97 percent.

D. History:

Beginning in May 2023, with the end of the COVID-19 Federal Public Health Emergency, FFH experienced a dramatic increase in fair hearing requests as pandemic-era eligibility rules ended. Pre-pandemic, FFH averaged under 30,000 new fair hearing requests each fiscal year.¹ FFH received 34,774 new fair hearing requests in fiscal year 2023 and 47,367 in fiscal year 2024.

E. Qualifications or eligibility requirements:

The state or federal law governing each individual program establishes whether, when, and to whom a hearing is available.

F. Administration and key processes:

FFH conducts administrative hearings for clients who appeal decisions from HHSC or its designees. FFH ensures that decisions comply with state and federal laws and that all participants receive a fair and impartial hearing.

FFH conducts fair and fraud hearings following rules in Title 1, Texas Administrative Code, Chapter 357. If a client disagrees with the result of the hearing, the client may request an Administrative Review.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

HHSC's approved state plans for federal assistance programs require that Texas have a fair hearing process. Through those state plans, FFH is accountable to HHSC's federal counterparts at the United States Departments of Health and Human Services and Agriculture.

J. Barriers and challenges:

¹ Fair Hearing data is maintained in TIERS, the Texas Integrated Eligibility Redesign System. In HHSC's Self-Evaluation Report in 2013, the agency erroneously reported that in fiscal year 2012, FFH "received 40,138 fair hearing requests and 1,464 client fraud appeal requests." This error was the result of a broken link in TIERS reporting. The correct number of fair hearing requests for fiscal year 2012 is 25,332.

As noted above, the workload increase following the end of the federal public health emergency has been a significant challenge for FFH.

K. Additional, regulatory, and Complaint information: Not applicable.

Informal Dispute Resolution

A. Division or program information:

Name of division or program: Informal Dispute Resolution (IDR) Department

Location within the agency: OCC, Appeals Division

Contact name: Allison Levee, Director

Statutory citation: 42 CFR Section 488.331; Texas Government Code, Section 526.0202; Texas Health and Safety Code, Section 247.051; 1 Texas Administrative Code, Sections 393.1, 393.2, and 393.3; United States (U.S.) Health and Human Services (DHHS), Centers for Medicare & Medicaid Services (CMS) State Operations Manual (SOM) Chapter 7 - Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities, 7212 - Informal Dispute Resolution

B. Objective and major activities:

The IDR Department provides an informal process for Long-Term Care (LTC) providers to appeal survey findings by HHSC's Regulatory Services Division. LTC providers include Nursing Facilities, Assisted Living Facilities (ALFs), Intermediate Care Facilities (ICFs), Texas Home Living (TxHmL) providers, and Home and Community-based Service (HCS) providers. As required by state law, an independent contracted entity conducts IDR reviews and provides recommendations of compliance or noncompliance with the state and federal regulatory requirements.

C. Effectiveness and efficiency information:

In fiscal year 2025, IDR averaged 22 new cases each month, with a total of 175 new cases as of May 1, 2025. This is down slightly from fiscal year 2024 when IDR finished the year with 343 new cases.

IDR manages the contracted entity's performance and compliance with federal and state standards. IDR also tracks timeliness according to contract terms and

statutory requirements. As of May 1, 2025, IDR reports that 100 percent of decisions in fiscal year 2025 have been delivered timely.

D. History:

The Legislature passes Senate Bill (S.B.) 304, 84th Legislature, Regular Session, 2015, requiring HHSC to contract for the IDR function for facilities licensed under Chapter 242, Texas Health and Safety Code (Nursing Facilities).

The Legislature passes S.B. 924, 85th Legislature, Regular Session, 2017, requiring HHSC to contract for the IDR function for facilities licensed under Chapter 247, Texas Health and Safety Code (ALFs).

E. Qualifications or eligibility requirements:

The IDR process is available to resolve disputes relating to enforcement action or related proceedings proposed by HHSC under Texas Human Resources Code, Section 32.021(d), or Texas Health and Safety Code, Chapters 242, 247, or 252.

F. Administration and key processes:

The IDR process is administered in accordance with HHS policies and federal and state laws. While the IDR process is the primary function, the IDR Department also oversees Independent IDR (IIDR) and Informal Reconsideration (IR) processes.

The IIDR is an informal administrative procedure that is only available to NF providers. It is intended to provide NFs an opportunity to refute cited deficiencies after any survey in which federal civil monetary penalties (CMP) are imposed, and that CMP is to be collected or placed in an escrow account under 42 CFR Section 488.431. If notified of the opportunity for an IIDR by CMS, NFs may submit a request for the IIDR process. The IIDR process is a federal process and only provides a review of federal deficiencies cited. State licensure violations are not able to be reviewed in the IIDR process.

The IR process affords NFs and ALFs an opportunity to dispute licensure actions proposed by HHSC Regulatory Services Division.

G. Funding: See "Agency Program Information Spreadsheet."

H-M. MOUs and interagency agreements or contracts; Relationship with other governmental entities; Barriers and challenges; Additional, Regulatory, and Complaint information: Not applicable.

Ethics

A. Division or program information:

Name of division or program: HHS Ethics Office (Ethics)

Location within the agency: OCC

Contact name: David Reisman, Chief Ethics Officer

Statutory citation: Chapter 523, Texas Government Code

B. Objective and major activities:

Ethics develops and maintains HHS ethics policies, advises on all related HHS policies and procedures, and provides ethics training to the HHS workforce. Ethics fields inquiries from HHS staff and serves as the HHS system's single designated resource on state ethics law, rules, and policies.

C. Effectiveness and efficiency information:

In fiscal year 2025, Ethics averaged 60 new inquiries each month, for a total of 480 new inquiries as of May 1, 2025. This is up slightly from fiscal year 2024, when Ethics finished the year with 649 new inquiries.

In addition, Ethics partners with the Institute for Organizational Excellence at the University of Texas to conduct an annual ethics survey of the HHS workforce. Survey results are used to grow and focus resources provided by Ethics, including new training programs, communication strategies, and policy initiatives.

D. History:

Ethics was established as a separate HHS function in February 2015 and the first Chief Ethics Officer was appointed to design and manage the office. Originally, Ethics was housed in the Office the Chief Deputy Executive Commissioner. It was later moved to the Chief of Staff and now resides in the Office of Chief Counsel.

E. Qualifications or eligibility requirements:

Anyone in the agency can contact Ethics for guidance on an ethics question or concern. Employees may contact the Chief Ethics Officer directly over Microsoft Teams, email, or phone.

F. Administration and key processes:

The Chief Ethics Officer formulates agency ethics policies, designs, and implements ethics awareness, training, and compliance programs.

Ethics trainings consist of webcasts, videos, podcasts, and live trainings. Quarterly training webcasts are available to HHS employees. The webcast trainings are hour long presentations that explore state ethics laws and agency policy. Informative videos are also published on various ethics topics on the HHS Connection and OCC SharePoint. Any member of management from across the system can request live trainings ranging from 20-90 minutes on various ethics topics. Ethics delivers trainings either in person or virtually.

The Chief Ethics Officer also receives, logs, and responds to questions received by phone, email, or in person from ethics agency personnel and leadership from around the state. Most questions are responded to the same day either by email or a phone conversation. The question topic and dates received and responded to are logged in an internal tracking system which is used to create monthly and annual reports.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts:

Through an IAC, the University of Texas's Institute for Organizational Excellence conducts an annual ethics survey of HHS employees and provides Ethics a written report of the survey results.

I. Relationship with other governmental entities:

The Texas Ethics Commission (TEC) maintains guidance documents and provides advisory opinions in response to questions concerning the application of laws within its jurisdiction. Ethics consults with TEC on questions within TEC's authority and coordinates referrals to TEC as appropriate.

J-M. Barriers and challenges; Additional, Regulatory, and Complaint information: Not applicable.

Legal Services

A. Division or program information:

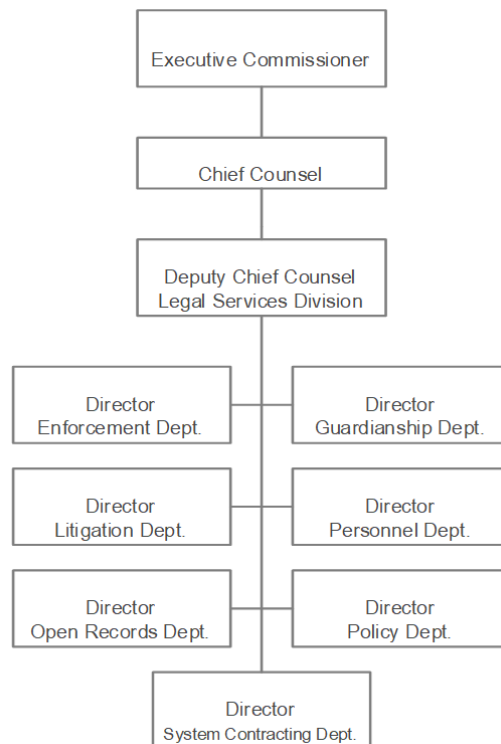
Name of division or program: Legal Services Division (LSD)

Location within the agency: OCC

Contact name: Nycia Deal, Deputy Chief Counsel

Statutory citation: Texas Government Code, Chapter 523

Figure 3. LSD organizational chart.



B. Objective and major activities:

LSD provides in-house, comprehensive legal support to HHS and entities administratively, or statutorily, attached to HHS. LSD refers to the agencies and entities it supports as its "clients," and has an attorney-client relationship with the

agencies and entities it supports. Legal support includes litigation support and representation in hearings, as well as legal reviews and risk analyses related to:

- Rulemaking and legislation;
- Procurement and contracting;
- Data sharing and information requests;
- Management and personnel matters; and
- Audits and compliance.

LSD is organized functionally and comprises seven departments of attorneys and legal support staff who specialize in their department's practice area. Attorneys are required to collaborate across the LSD departments to access their colleagues' expertise and support their shared clients with "one voice."

This functional alignment allows LSD to cultivate the legal expertise the high-complexity HHS system requires while maintaining a small footprint within it.

C. Effectiveness and efficiency information:

OCC consistently receives positive remarks from across HHS in employee feedback surveys including the SSA customer survey and OCC's own communications survey.

In the fiscal year 2024, SSA customer survey, OCC received over 4.00 out of 5.00 for every core customer service principle. For the "responsiveness of communication" measure, OCC was rated a 4.18 out of 5.00. In the "professionalism and courtesy of communication" measure, OCC received a 4.52 out of 5.00. And in "skill and expertise to offer appropriate solutions" OCC received a 4.41 out of 5.00. While these figures represent responses to all of OCC services offered, not just Legal Services, only about 4 percent of survey respondents indicated they had accessed OCC services that were not part of LSD, so it is fair to consider these ratings to apply mostly to LSD.

The greatest opportunity for improvement for LSD identified in both the SSA customer survey and the OCC communications survey is around providing more routine updates to clients throughout legal reviews. In the fiscal year 2024 SSA survey, "timeliness (of service/project/initiative delivery)" was rated 4.06 out of 5.00, and some of the open-ended comments support the idea that improved communications about ongoing legal reviews will help clients understand extended timelines or potential delays.

D. History:

September 2003: The Legislature passes H.B. 2292, 78th Legislature, Regular Session, 2003, abolishing legacy health and human services agencies and creating four new agencies under the oversight of the HHSC executive commissioner, including DSHS. H.B. 2292 required HHSC to centralize administrative support services for HHS agencies and transferred authority for administrative support services, including legal services, to HHSC from the abolished agencies.

December 2003: HHSC and the four new HHS agencies convened the Legal Services Consolidation Project to plan the consolidation of legal services, as required by H.B. 2292. The project produced a decentralized model for legal services with separate legal departments at each health and human services agency with a “dotted line” to the HHSC Chief Counsel.

December 2014: OCC submitted a plan to the executive commissioner for the restructuring and consolidation of legal services, consistent with the direction in H.B. 2292. To prepare the plan, OCC studied existing organizational and compensation structures for legal services at the HHS agencies and found significant disparity. For example, salaries for Attorney V positions at DSHS were 22 percent lower than salaries for Attorney V positions at HHSC.

The plan recommended a functional model for the consolidated delivery of legal services to all HHS agencies through seven areas of legal expertise and need: enforcement, litigation, open records, personnel, policy, regional support, and contracting. The plan identified the following priorities for consolidation of legal services:

- Ensure consistency of legal advice;
- Maintain continuity in legal support;
- Minimize institutional knowledge loss; and
- Address salary disparities across the consolidated legal team.

September 2015: The Legislature passes S.B. 200, 84th Legislature, Regular Session, 2015, which includes the Sunset Commission’s recommendation to further consolidate administrative support services, and reinforces direction to HHSC to consolidate and provide administrative support to HHS agencies.

September 2016: All Department of Assistive and Rehabilitative Services (DARS) and Department of Aging and Disability Services (DADS) legal staff transfer to OCC.

September 2017: All DSHS legal staff transfer to OCC. Some legal functions performed by the Department of Family and Protective Services (DFPS) and the Office of Inspector General (OIG) transfer to HHSC.

September 2018: OCC transitions all legal staff to the functional model for consolidated legal services, organized in seven departments, led by seven department directors. While the 2016 and 2017 staff transfers accomplished the consolidation of legal services at HHSC from a compliance perspective, OCC minimized disruption to existing reporting structures during the transition to stabilize the consolidated team and finalize LSD's organizational structure and leadership.

E. Qualifications or eligibility requirements:

LSD's clients are the HHS system agencies and entities administratively attached to or otherwise supported by the HHS system, including the Texas Civil Commitment Office, Office of the Independent Ombudsman, Texas Pharmaceutical Initiative, and others. Only clients can receive legal support from LSD.

However, the Texas Public Information Act (PIA) provides that a member of the public may request access to public information held by an agency or entity subject to the PIA. Open Records and Data Governance (ORDG) provides services to the public-at-large as it facilitates its clients' PIA compliance.

F. Administration and key processes:

Generally, LSD's clients engage LSD by contacting the attorney assigned to the client's system area or assigned to the specific rule, case, information request, contract, or other project.

Clients requesting new services can submit a request to the dedicated LSD mailbox, through the LSD online portal, or by contacting LSD through its general mailbox. The OCC partner SharePoint site includes information on current attorney assignments, how to make a portal request for certain services, and how to contact LSD's general mailbox if a client is unsure where to route a request.

While all areas of LSD are staffed with attorneys and professional staff to support its clients, as mentioned, each area of LSD specializes in a legal practice area:

- **Enforcement:** Represents HHS in settlements, hearings, and other actions related to regulatory sanctions and recoupment of payments made by HHS.
- **Guardianship:** Provides legal support to the HHSC Office of Guardianship Services, in its service as guardian for approximately 1,000 wards across Texas.
- **Litigation:** Manages all litigation against an HHS agency or HHS employee, including coordination with the Texas Office of the Attorney General (OAG) and outside counsel.
- **ORDG:** Receives, processes, and responds to requests for public information under the PIA. ORDG also provides HHS data governance support, including advising on data use, data release, and data breaches, and negotiating data-related contract terms.
- **Personnel:** Works closely with HHS Human Resources, the Ethics, and HHS supervisors to advise on personnel management and employment law.
- **Policy:** Supports clients in their policy development, rulemaking, legislative implementation, program operations, and other general legal needs.
- **System Contracting:** Provides legal support for procurement and contracting activities, including review of solicitation documents, contracts, and amendments, as well as supporting contract negotiation.

G. Funding: See “Agency Program Information Spreadsheet.”

H. MOUs and interagency agreements or contracts:

HHSC has an interagency contract (IAC) with OAG specific to OAG support of Medicaid related matters, as OAG requires HHSC seek and receive federal funds to reimburse OAG for its Medicaid-related litigation services.

A two-year IAC provides that SOAH conducts administrative hearings in contested cases under Texas Government Code, Chapter 2001, for HHS cases referred to SOAH by LSD.

An MOU with the OAG Medicaid Fraud Control Unit, the OAG Civil Medicaid Fraud Unit, and the HHS OIG provides written procedures for the involved agencies and areas to investigate allegations of fraud, waste, or abuse involving the state Medicaid program or any other HHS program. This contract is managed by HHSC OIG staff.

I. Relationship with other governmental entities:

LSD coordinates with OAG, as required by the PIA, to respond to requests for public information.

OAG provides some litigation services to HHS, in coordination with Litigation. In addition to coordination with OAG in its defense of the HHS agencies, OAG frequently requires legal support from LSD to assist in litigation OAG has initiated against the federal government and other entities.

LSD also coordinates with SOAH, as provided by its IAC with SOAH.

J. Barriers and challenges:

Texas law does not uniformly define or describe administrative attachment or the responsibilities of the agency or the entity administratively attached to the agency. As a result, HHS' statutory responsibility to provide legal support to entities administratively attached to HHS is unclear and inconsistent.

Similarly, Texas law does not uniformly address the relationship between a board, council, committee, or other body created by the legislature and an agency directed by statute to support the board, council, committee, or other body.

The attorney-client relationship imposes a number of legal duties on an attorney. Ambiguity and inconsistency in the statutory relationship between HHS and external entities can have professional and personal consequences for the attorneys in LSD – in addition to operational confusion and duplication.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Privacy

A. Division or program information:

Name of division or program: Privacy Division (Privacy)

Location within the agency: OCC

Contact name: Sarah Morrow, Director

Statutory citation: Texas Government Code, Chapter 523

B. Objective and major activities:

Privacy develops and maintains HHS privacy policies, procedures, standards, and guidelines, and provides privacy awareness training to the HHS workforce. Privacy conducts and coordinates investigations of privacy incidents involving HHS information, assists with responses and corrective actions, manages required notifications, and supports compliance efforts. Additionally, Privacy develops and evaluates Privacy Threat Assessments (PTAs), Privacy Impact Analyses, and responds to Software Review (SR) requests to help reduce and/or mitigate risk.

To support consistency across HHS, Privacy maintains HHS Circular C-057 (HHS Privacy Program Management, Protecting Confidential Information and Responding to Privacy Incidents). In addition, Privacy maintains and tracks compliance with the required HHS Privacy Training.

C. Effectiveness and efficiency information:

Privacy tracks the number of incidents that are substantiated as privacy breaches. To date in fiscal year 2025, 850 of the 3,530 reported incidents, or 24 percent, were substantiated. In fiscal year 2024, 1,529 of the 5,219 reported incidents, or 29 percent, were substantiated.

Privacy reports breaches according to the standards established in state and federal law. Violations of the federal Health Insurance Portability and Accountability Act (HIPAA) must be reported within 60 days of the date of discovery for events affecting over 500 individuals or 60 days from the end of the calendar year for those events affecting fewer than 500 individuals. In fiscal year 2025, Privacy has reported 100 percent of incidents by the HIPAA deadline.

For violations of Chapter 521, Texas Business and Commerce Code, or the Texas Identity Theft Enforcement and Protection Act (ITEPA), the timeline begins on the date a breach is confirmed. Entities must report incidents affecting more than 250 individuals within 30 days of confirmation and notify the affected individuals without delay, unless overly burdensome. In fiscal year 2025, Privacy reported 100 percent of incidents by the ITEPA deadline.

D. History:

In January 2014, the executive commissioner approved creation of an HHS Risk Management and Compliance Office, with the goal of implementing a structured approach to risk management and compliance in HHSC and across all HHS agencies. The HHSC Privacy Office as it then existed was transferred to the new

HHS Risk Management and Compliance Office and expanded. DSHS, however, elected to maintain a separate privacy function.

Following systemwide structural changes, Privacy transferred to OCC in April 2016.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

Privacy establishes agency privacy policies and procedures and in accordance with state and federal privacy laws such as HIPAA and ITEPA. Privacy reviews policies and procedures biennially and updates as needed to comply with state and federal privacy laws. Privacy developed and maintains a Privacy Incident Response Plan.

Privacy's key function is to investigate and respond to the suspected unauthorized use or disclosure of confidential HHS information. Privacy documents each potential privacy breach (incident) and tracks timelines from date of discovery to closure to maintain regulatory compliance with state and federal privacy requirements.

Privacy also performs Privacy Threat Analyses (PTAs), Privacy Impact Assessments, and software review requests. PTAs are a primary tool for assessing privacy risks to the HHS system and look at the involved data system and the categorization of system data. Privacy conducts a privacy impact analysis when PTA indicates a system creates, maintains, utilizes, stores, modifies, or destroys confidential information. A privacy impact analysis is a much more detailed process to analyze the system and determine the risk involved should a privacy incident occur within that system.

Similarly, after IT Security has performed an assessment of a request for new software, Privacy reviews the request for privacy concerns, weighs any privacy risk, and makes a recommendation according to the categorization of the information proposed or used by the software.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

The DSHS Privacy Office performs similar services for DSHS. Privacy coordinates with the DSHS Privacy Office as needed.

Privacy also coordinates with OAG as appropriate.

Privacy coordinates with the United States Department of Health and Human Services, Office for Civil Rights, the federal entity responsible for enforcing HIPAA and related regulations.

J-M. Barriers and challenges; Additional, Regulatory, and Complaint information: Not applicable.

VII. Guide to Agency Divisions and Programs

Chief Program and Services Officer

Overview

After the Sunset Commission's review of the Health and Human Services Commission (HHSC) in 2015, HHSC set out to establish a foundation that would integrate programs and services over time and continue to break down organizational silos, better connect similar functions, and continuously improve the HHS system. With client services consolidated under a clear line of accountability within the Chief Program and Services Office (CPSO), HHSC spent the following five years assessing the benefits and challenges that structure presented.

In 2021, CPSO underwent a 13-month internal review to identify ways to better align programs and services around a mission and vision for the populations the agency serves – creating a realigned structure that brings together expertise and fosters a focus on the continuum of care. Based on experiences, observations, and feedback from internal and external stakeholders shared during this review, CPSO established its current structure comprised of five divisions: Access and Eligibility Services (AES), Behavioral Health Services (BHS), Community Services (CS), Family Health Services (FHS), and Health and Specialty Care System (HSCS).

Realignment Changes

The decision to assess that structure and make potential changes stemmed from the need to ensure all these populations received the focus they need. To that end, CPSO created two new divisions and restructured two others:

- Programs from the former Health, Developmental and Independence Services (HDIS) that focused on women, children and families were grouped into a single new division, FHS. This division includes:
 - Health/medical services – programs providing health services for adults including Family Planning, Breast and Cervical Cancer Screening, Primary Health, and Title V Maternal and Child Health.
 - Trauma/crisis services and education – serves adults/families in crisis situations such as family violence or human trafficking and aligns with other educational programs.

- ▶ Early Childhood – programs geared toward children’s health, nutrition and early interventions.
- Programs focusing on older adults and people with disabilities and special health care needs were grouped to create the new Community Services Division. Programs creating CS were transferred from AES, BHS, and HDIS, altering the structure of BHS and AES. The new CPSO structure became effective November 1, 2022. This division established three main areas to develop goals and implement strategic initiatives to achieve better overall outcomes. The division includes:
 - ▶ Community care services – aligns community care services eligibility and foster grandparent program with other programs for people with disabilities and older adults.
 - ▶ Community support services – aligns community-based services for people with disabilities or specialty health needs, including Blind Children’s Program, Deaf and Hard of Hearing Services, Children with Special Health Care Needs, Epilepsy Services, and Kidney Healthcare Program.
 - ▶ Community connections and front door services – aligns front-door services by Area Agencies on Aging, Aging and Disability Resource Centers, local Intellectual and Developmental Disability Authorities, and Centers for Independent Living to streamline the state’s connection to the community and make the navigation of services easier for those who need them.
 - ◇ Guardianship Services was placed within the division but separate from a program area as its functions are unique.

In the almost three years since these changes, CPSO program areas have seen internal and external benefits, including improvements to service delivery and an improved work environment. Despite the improved organizational structure and the progress CPSO is making towards the related goals, broader challenges still exist creating barriers to achieving some of our highest priorities.

Challenges

A challenge that CPSO faces is the aging IT infrastructure in which programs must work to provide services. Platforms such as Texas Integrated Eligibility Redesign System (TIERS) and YourTexasBenefits.com have had system outages and performance issues that periodically disrupt daily program operations or client

communication. Some areas have antiquated systems that lack interoperability leading to repetitive data entry into multiple platforms. Some programs are still trying to develop automation to eliminate highly manual processes for both staff and providers. Older systems lack the flexibility to address rapidly emerging or changing needs.

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VII. Guide to Agency Divisions and Programs

Chief Program and Services Officer

Access and Eligibility Services

Access and Eligibility Services (AES) oversees and supports eligibility determination functions for Medicaid, the Children's Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and other state-funded programs. AES provides administrative support to local resources and services such as the 2-1-1 Texas Information and Referral Network (2-1-1 TIRN), available to help Texans 24-hours a day, 365 days a year. AES leverages local partnerships with faith and community-based organizations to offer community partner programs and regional community relations throughout Texas. AES also oversees SNAP Nutrition Education and SNAP Employment and Training programs. In addition to the state program identified, AES completes federal disability determinations on behalf of the United States (U.S.) Social Security Administration (SSA) for Social Security Disability Insurance and Supplemental Security Income (SSI).

AES' organizational structure consists of four program and operational support service departments: Office of Administration, Strategic Engagement and Employee Support, Strategic Innovation and System Support, and Operations; and three programmatic departments: Disability Determination, Community Access, and Policy and Quality.

Office of Administration

The Office of Administration provides budget and financial management, contract management, contract monitoring, audit coordination, program compliance, and project management.

- Finance Operations (FO) is responsible for overall program financial management and program budget oversight functions, contract financial management, overall program position control, and serving as a liaison between AES and the Health and Human Service Commission's (HHSC's) Chief Financial Officer (CFO). FO performs financial management and analysis for Requests for Proposals (RFPs) for AES contracts. Additionally, FO

performs position-driven analysis that emphasizes FTE management to optimize resource allocation within AES.

- Contract Operations (CO) facilitates procurement activities, manages contracted services, and performs contract monitoring activities. Contract monitoring activities include monitoring contract performance, tracking deliverables and deadlines, completing risk assessments, coordinating and providing technical assistance, and facilitating contract renewals of amendments, as necessary.
- Audit Coordination and Program Compliance oversees AES audits and management responses and conducts annual program compliance risk-based reviews.

Strategic Engagement and Employee Support

Strategic Engagement and Employee Support provides eligibility field staff and state office staff with information, tools, and resources. These resources are delivered through the following teams: Change Management, Organizational Engagement and Support, Internal Communications, Organizational and Leadership Learning, and Organizational Development.

Strategic Innovation and System Supports

Strategic Innovation and System Supports (SISS) focuses on continuous improvement for business process analysis and improvement, technology strategy and prioritization, and AES IT portfolio management. In addition, SISS provides innovative solutions for technical needs, develops project requirements, streamlines processes, and provides data and reports for decision making. SISS consists of five areas: Business Process Improvement (BPI), Data Management and Reporting (DMR), Information Technology Strategy and Prioritization (ITSP), Project Management Organization (PMO), and Texas Integrated Eligibility Redesign System (TIERS) and DMR Portfolios.

- BPI: Works to enhance procedures and communication between various internal and external teams. BPI focuses on establishing relationships with other HHSC teams and their leadership by forming partnerships and advocating for more cooperative, efficient, and responsive involvement for crucial AES systems impacting AES initiatives, programs, and staff.
- DMR: Develops applications and data tools that assist AES manage workload and provide access to crucial data quickly and seamlessly to ensure federal

and state compliance, maintain operational efficiency and monitoring, and identify cost savings.

- ITSP: Performs a critical role in bridging the gap between technology and operations by leading various projects, focusing on improving automation for implementing policies, and streamlining business processes. ITSP designed its approach to ensure technological solutions align with the unique needs of AES business, thereby enhancing operational efficiency, effectiveness, and overall excellence.
- TIERS and DMR Portfolios: Responsible for the IT portfolios of projects impacting the TIERS and DMR systems and assist the ongoing development of IT project governance support for high-level HHS IT and telecommunications projects.
- PMO: Oversees project management, AES project governance, risk management, and AES global portfolio management to ensure projects follow industry best practices. PMO sets strategic goals, schedules projects, prioritizes tasks, and monitors progress across all areas of AES independently and as a whole division.

Operations

Operations oversees and supports eligibility determination functions for Texas Works (TW) and Medicaid for the Elderly and People with Disabilities (MEPD) programs. TW and MEPD encompasses financial and non-financial eligibility determination for SNAP, TANF, Medicaid, CHIP, and Healthy Texas Women (HTW). In addition, Operations provides direction, support, and oversight for various vendors, electronic benefit transfer (EBT), program integrity, pre-eligibility fraud prevention, complaints, and appeals, as well as department improvement and innovation initiatives.

- Integrity Support Services consists of two areas: Fraud Prevention Operations (FPO) and Appeals and Mitigation (A&M).
 - FPO aims to prevent inaccurate benefit issuance, provides case insight, and enhances case quality to ensure that program benefit amounts provided to SNAP, TANF, Medicaid, CHIP, and MEPD recipients are accurate according to federal and state policy. This section works to resolve discrepancies for clients and performs precertification case reviews and detailed data analysis to identify trends indicative of inaccurate benefit issuance. Furthermore, FPO processes referrals from

eligibility staff, providing additional analysis of potentially questionable eligibility points to prevent the issuance of erroneous benefit amounts. Since inception in 2017, FPO has prevented over \$193 million in erroneous benefit issuance. This amount of cost avoidance savings is the difference between the amount that would have been issued without the FPO analysis and the amount issued.

- ▶ A&M processes client appeals and represents the agency throughout the appeal process. A&M applies a segmented approach to appeal processing which promotes organizational efficiencies. This segmented approach allows staff to focus on one aspect of the appeal process (i.e., hearings, screening, review, and corrections) at a time, increasing efficiency in the individual elements and the entire process. Evaluating and redesigning the end-to-end appeal process has resulted in improved oversight. Active appeals for both TW and MEPD have decreased significantly since implementing the segmented process in fall 2023.
- Strategy and Innovation Team (SIT) supports ongoing continuous improvement of service delivery to Texans by designing, building, operating, and evolving structures, business processes, and metrics. SIT:
 - ▶ Leads workload data initiatives and performs data analysis;
 - ▶ Works to enhance the Eligibility Workload Management System; and
 - ▶ Provides performance management oversight in partnership with regional management to ensure federal timeliness requirements are achieved.
- State and Regional Operations (SRO) aims to strengthen leadership and oversight of regional operations so HHSC can effectively connect people, services, and supports through accurate and timely eligibility determination of cash, food, and medical assistance. SRO's main function is to oversee and support eligibility determination and reported changes related to Medicaid, CHIP, HTW, SNAP, and TANF.

Also, SRO provides centralized management, monitoring, and supports timeliness and performance, certain staffing and personnel functions, leasing and office relocations, and complaint resolution. SRO leads or participates in eligibility services projects that improve client access and experience, as well as making improvements for eligibility team members through automation, training, or process development for MEPD and TW programs.

Eligibility Support Vendor Operations

A. Name of division or program:

Name of division or program: Eligibility Support Vendor Operations (ESVO)

Location within the agency: CPSO

Contact name: Duane Pietsch, Director, Vendor Operations

Statutory citation: Not applicable

B. Objective and major activities:

ESVO directs and oversees operations of contractors that provide services critical to AES for administering public assistance programs (SNAP, TANF, and Medicaid) and temporary programs (Disaster SNAP and Pandemic EBT). ESVO competitively procures four independent contracts. Three of the contracts support eligibility determination processes and customer support, while the fourth contract serves to distribute cash and food benefits. The contracts under the ESVO umbrella include the following:

- Data Broker Services (DBS) acquires and delivers information to HHSC from a wide array of resources, including but not limited to the Texas Workforce Commission (TWC), Office of the Attorney General (OAG), Texas Department of Criminal Justice (TDCJ), Texas Lottery Commission, National Directory of New Hires, Department of Motor Vehicles, Systematic Alien Verification for Entitlements, Asset Verification System, and Federal Data Services Hub. This information is critical to the quality and expediency of determining eligibility for public assistance programs administered by AES. DBS allows AES to meet federal objectives related to using electronic data sources.
- Document Processing Services (DPS) provides management, staffing, and labor for processing incoming mail and the digital imaging of applications for public assistance programs and supporting documents. In fiscal year 2024, the DPS contractor processed 42,522,009 documents.
- The Eligibility Support Services (ESS) contract provides multiple services, including staffing, management, and labor for the eligibility support call center, outbound mail printing and distribution, outbound electronic notification (short message services (SMS) and text), administrative assistance for application processing, and other administrative services as

needed by AES. In 2024, call center agents handled 11,955,935 calls and the contractor mailed 12,960,144 outbound documents.

- The EBT contract serves to distribute and provide access to cash (TANF) and food benefits (SNAP) to recipients through an EBT system. Services include EBT account management, card processing and distribution, financial transaction management, financial settlement to retailers, financial reconciliation with banking and federal systems, call center services, and all other services required to achieve Title 7, Code of Federal Regulations, Part 274, objectives for EBT systems. Texas' EBT cards are known as the Lone Star Card. In 2024, program participants accessed over \$7.4 billion dollars in cash and food benefits.

Additionally, ESVO performs program monitoring to ensure contractor performance and compliance with established contract terms; establish retailer rules for participation in the EBT program through the Lone Star Operating Rules; and coordinate with other HHSC business areas for reporting and reconciliation requirements to ensure program integrity.

C. Effectiveness and efficiency information:

ESVO devises, establishes, and monitors adherence to key performance requirements (KPRs). ESVO partners with agency procurement support teams to solicit best value, cost-effective contracts to provide a wide scope of eligibility support services, monitors vendor performance for required customer service levels, and directs corrective action if performance falls below established standards.

Example KPRs for the EBT contract include requiring the EBT central computer to be available 99.9 percent of scheduled uptime (24/7); ensure card and Personal Identification Numbers (PINs) meet HHSC security specifications; ensure timely and secure distribution of cards and PINs to clients, and distribution of all secure card orders to HHSC offices; provide Interactive Voice Response (IVR) services; and meet call answer rates.

D-E. History and qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

HHSC administers contracts for services through the competitive selection process in accordance with Texas law. Contract terms cannot exceed five years. AES uses system-generated reports to monitor the vendor's performance based on contract requirements.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

To determine eligibility, AES systems interface with several governmental entities including OAG, TWC, TDCJ, Texas Juvenile Justice Department (TJJD), and SSA.

J. Barriers and challenges:

Challenge 1: EVSO encounters regular challenges in finding ways to allow the contractor to expand assistance with application support to ensure that the agency continues to meet federal guidelines. Current guidance from the U.S. Department of Agriculture (USDA), Food and Nutrition Service (FNS) regarding use of contract staff limits efforts to enhance application support services. The contracted vendor staff are often unable to assist due to these guidelines and the integrated eligibility determination system in Texas, since applications and redeterminations potentially include various programs.

Challenge 2: AES continues to leverage services provided by the ESS vendor as permissible by federal agencies to meet increased demand with limited agency resources. While federal agencies are becoming more amenable to allowing contract staff to perform duties historically restricted to state employees, the increased use of contract services may also increase contract expenditures.

Challenge 3: Ongoing reports and complaints by cardholders of stolen benefits remains a challenge for (LSBS) staff who manage the EBT contract and HHSC. The December 2022, federal law providing cardholders who were victims of fraud and unauthorized use with benefit replacement ended on December 20, 2024. This increases workload of disputes escalated to LSBS and agency staff.

K-M. Additional, regulatory, and complaint information: Not applicable.

Community Access

Community Access (CA) administers programs that provide services responsive to the needs of Texans and their families through strategic partnerships and with state and local agencies. CA provide technical guidance and operational support to program partners and are responsible for oversight and analyzing performance and compliance of program activities and outcomes. CA consists of three areas: 2-1-1 TIRN, SNAP Employment and Training, and Community Engagement, which includes SNAP-ED, SNAP Outreach, Community Partner Program (CPP), Texas Works Paths to Success (TWPS), and the Nutrition Incentive Program (NIP).

Across all CA programs, AES uses a collaborative team approach to conduct comprehensive contract, fiscal, program management, and oversight. In addition to the standard monitoring and contract management of deliverables, reports, budgets, invoices, expenditures, and key performance requirements, the approach includes the completion of an annual risk assessment which includes input from the contract, finance, and program staff. The Contract Fiscal Monitoring team analyzes the risk assessment data and uses it to develop a contract monitoring plan that is carried out by fiscal and program monitoring teams through desk and on-site reviews. The team also monitors grantees for compliance with state and federal rules and regulations.

2-1-1 Texas Information and Referral Network

A. Division or program information:

Name of division or program: 2-1-1 TIRN

Location within the agency: CPSO

Contact name: James Valdenegro, Director

Statutory Citation for Program: Texas Government Code, Section 531.0312(b); 2024-25 General Appropriations Act, House Bill (H.B.) 1, 88th Legislature, Regular Session, 2023

B. Objective and major activities:

2-1-1 TIRN serves as an entry point for information and referral resources that connect consumers to services, such as rent and utility payment programs, child care, food and medical assistance, and mental health and transportation services.

Information and referral (I&R) services are available 24 hours a day, seven days a week, 365 days a year. 2-1-1 TIRN has 24 grantees, with four grantees that provide Emergency Service and Escalation Services (ESEC). Each grantee, referred to as an Area Information Center (AIC), covers a geographic region in Texas.

C. Effectiveness and efficiency information:

To increase the effectiveness and program efficiency, the Legislative Budget Board (LBB) directed 2-1-1 TIRN to implement improvements to 2-1-1 IT systems. With this direction, AES implemented the Virtual Agent within the telephony system Genesys, to reduce call volume and improve customer service. The following KPRs, described in Table 1 below, ensure adequate and effective call handling by AICs.

Table 1. 2-1-1 Call Handling Performance Measures.

Measure*	Target
Calls handled within 60 seconds	80 percent or more
Calls rolled over and not answered	1 percent or less
Calls abandoned	10 percent or less
Quality assurance scores	80 percent or higher

* Performance measures align with the [Inform USA standards](#), defined by the national organization who accredits I&R services. The telephony percentages are industry standard for call centers.

D-E. History and qualification or eligibility requirements: Not applicable.

F. Administration and key processes:

AES administers the 2-1-1 TIRN program through 24 grant agreements awarded through a competitive process. Each grant funds an AIC to serve each of the HHSC 2-1-1 TIRN service regions.

Each multi-county regional AIC is responsible for collecting, providing, and updating accurate, well-organized, and accessible information from state and local Texas HHS programs. Service delivery and operations for I&R services are available by phone, web-based chat, outreach, and online at <https://www.211texas.org/>.

Options for 2-1-1 TIRN (I&R) include the following:

- **Option 1** for I&R, such as food pantries, housing, older adult services, help with utilities and rent, etc.;

- **Option 4** is the State of Texas Emergency Assistance Registry;
- **Option 5** is for Mental Health and Substance Abuse resources; and

See the following attachments for more details on 2-1-1 TIRN key processes:

- [S7 CPSO AES Att01 Call Handling Workflow](#)
- [S7 CPSO AES Att02 Chat Workflow](#)
- [S7 CPSO ES Att03 Emergency Escalation](#)
- [S7 CPSO AES Att04 Emergency Operations](#)
- [S7 CPSO AES Att05 Reporting Flowchart](#)
- [S7 CPSO AES Att06 Resource Management](#)
- [S7 CPSO AES Att07 Virtual Emergency](#)

G. Funding: See “Agency Program Information Spreadsheet.”

H. MOUs and interagency agreements or contracts:

HHSC TIRN has an MOU or interagency agreement with each of the following agencies to avoid duplication or conflict of services:

- TWC: Provides child care referrals statewide.
- My Health My Resource of Tarrant County (MRMRTC): Shares Tarrant County resource data to support similar information and referral services targeted for the county.
- Texas Department of Agriculture (TDA): Provides referrals for the summer nutrition programs which includes both Summer Food Program and the Seamless Summer Option.
- University of Texas at Austin on Behalf of the LBJ School of Public Affairs and RGK Center for Philanthropy and Community Services (UT): Facilitates data sharing of certain non-profit service provider resourced data for use in Texas Connector. Data provided by HHSC is displayed in Texas Connector as part of its directory and mapping functions which further the goal of empowering communities, governments, funders, and nonprofits to meet the growing needs in Texas.
- Texas Division of Emergency Management (TDEM): To provide services to enroll Texas residents into TDEM’s State of Texas Emergency Assistance Registry (STEAR).

TIRN has also established Interstate Agreements to engage other states' support to provide added disaster/event contact handling capacity for HHSC 2-1-1 TIRN. The parties provide 2-1-1 support when a particular event/disaster exceeds the capacity of their respective states.

The following interstate partners play a critical role in ensuring individuals have the information they need to get their needs met.

- United Way of Connecticut Inc.;
- United Way of North Carolina; and
- 2-1-1 Wisconsin.

I. Relationship with other governmental entities:

2-1-1 TIRN maintains collaborative relationships with TWC, TDA, TDEM, and UT to maximize information and referral resources used by AICs to connect people to services.

J-M. Barriers and challenges, additional, regulatory, and complaint information: Not applicable.

Supplemental Nutrition Assistance Program Employment and Training

A. Division or program information:

Name of division or program: Supplemental Nutrition Assistance Program
Employment and Training (SNAP E&T)

Location within the agency: CPSO

Contact Name: John Briscoe, Director

Statutory citation: Texas Labor Code, Chapter 302; Title 40 Texas Administrative Code, Chapter 813

B. Objective and major activities:

SNAP E&T empowers SNAP participants to develop competencies that enhance their employability and foster self-sufficiency. Through SNAP E&T, SNAP participants have access to training and support services to help them enter the workforce and

advance while employed. HHSC contracts with TWC to administer SNAP E&T services. The estimated contract budget for fiscal year 2024 is \$24,057,684.

SNAP E&T began developing third-party partnerships by onboarding three pilot service providers for federal fiscal year 2025. The program will continue to expand third-party partnerships over the next four years. These partnerships provide the initial funding for SNAP E&T services from non-federal funds. Subsequently, the service providers can receive reimbursement with 50 percent federal SNAP E&T funds. Third-party partnerships can include community-based organizations, community colleges, and other entities that provide employment-based training. These partnerships build program capacity and expand services to more participants in a cost-effective manner. Adding SNAP E&T service providers enhanced the partnership between HHSC SNAP E&T and TWC.

C. Effectiveness and efficiency information:

AES tracks national measures reported on SNAP E&T annual outcomes. Table 2 below provides the national measures reported for the fiscal year 2024 SNAP E&T annual outcomes measures report.

Table 2. National Reporting Measures.^a

Reporting Measure	Time Period	Data Source	Value	Numerator	Denominator
Unsubsidized employment in 2 nd quarter after completion of participation in E&T	Quarter 3 Federal Fiscal Year (FFY) 2023 – Quarter 2 FFY24	Quarterly Wage Records (QWR)	47.44%	6,899	14,543
Median quarterly wages in 2 nd quarter after completion of participation in E&T	Quarter 3 FFY23 – Quarter 2 FFY24	QWR	\$4,547.11	N/A	N/A

^aFrom the following data source: Revised FY24 TX Annual Outcomes Measures Report_02-06-2025.xlsx

Reporting Measure	Time Period	Data Source	Value	Numerator	Denominator
Unsubsidized employment in 4th quarter after completion of participation in E&T	Quarter 1 FFY23 – Quarter 4 FFY23	QWR	46.81%	6,910	14,761
Completion of an educational, training, work experience, or on-the-job training component	Time Period: Qtr1 FFY24 – Qtr4 FFY24	State Management Information System	23.65%	255	1,078

The SNAP E&T program is working to improve its effectiveness and efficiency and subsequently improve its annual outcomes and participation rate. Table 3 below describes the participation rate for those deemed mandatory to participate in the program from the last three federal fiscal years. Also, Table 3 indicates the sanction rate, which includes the number of those deemed mandatory to participate but do not comply or choose not to participate.

Table 3. Texas SNAP E&T program participation and sanction data.^b

Measure	FFY 2022	FFY 2023	FFY 2024
Number of required participants	454,635	472,670	367,708
Number of required participants who began participation in E&T program by attending orientation [percent of total number of required participants]	29,330 [6.45%]	20,792 [4.40%]	26,520 [7.21%]
Number of required participants participating in qualifying component [percent of total number of required participants]	22,329 [4.91%]	16,432 [3.48%]	12,529 [3.41%]
Number of required participants determined ineligible for failure to comply [percent of total number of required participants]	372,923 [82.03%]	240,874 [50.96%]	245,703 [66.82]

D. History

^b From the following data sources: 2022: USDA FNS-583 2022Q4-cert-revised (4).xlsx; 2023: USDA FNS-583 FY2023Q4-rev2.xlsx; 2024: USDA FNS583 FY24Q4rev3.xlsx

In several acts since 1985, the federal government has amended the Food Stamp Act of 1977 or its iterations, or established new laws, to create or make changes to the SNAP and SNAP E&T programs. Some of those changes include the following.

- Created Food Stamp Employment and Training (FSE&T) and defining components as job search, workfare, work experience, and training (1985).
- Imposed new work requirements on food stamp recipients aged 18 to 50 who have no dependents—known as Able-Bodied Adults Without Dependents (ABAWDs) (1996).
- Required states to target 80 percent of their federal FSE&T grant funds to services for ABAWDs and later eliminating this requirement (2002).
- Renamed the Food Stamp Program to SNAP and FSE&T to SNAP E&T (2008).
- Required USDA FNS to develop performance measures to monitor how well states prepare SNAP E&T participants for employment and employment retention after participation in SNAP E&T (2008).
- Added a new E&T program that incorporates activities FNS determined to have the most demonstrable impact on an individual's ability to find and retain employment, and that lead to increased household income and reduced reliance on public assistance (2014).
- Amended the purpose of SNAP E&T; changed the SNAP work requirement policy, including the exceptions from the ABAWD time limit; and reduced the number of discretionary exemptions state agencies will earn and carry over annually (2023).

H.B. 2292, 78th Legislature, Regular Session, 2003, moved food stamp eligibility and other services for low-income individuals from the Texas Department of Human Services (TDHS) to HHSC.

The administration of the SNAP E&T program under TWC functioned under a waiver from FNS through 2017. In 2017, FNS required Texas to move the administration of the program back to HHSC. From 2017 to 2024, HHSC and TWC administered the program in a joint governance format with HHSC and TWC collaborating on decision-making. In 2024, due to administrative requirements from FNS, HHSC now holds the sole administrative governance role of SNAP E&T federal funds and has executed a grant-based contract with TWC to operationalize the program as required by Texas Labor Code, Section 302.065(4).

E. Qualifications and eligibility requirements:

Individuals eligible for SNAP E&T must be receiving SNAP benefits and not be receiving TANF cash assistance. Texas is a mandatory state; therefore, SNAP recipients must participate in assigned SNAP E&T activities as a requirement for receiving benefits, for at least a minimum of 30 hours per week.

A person is exempt from SNAP work requirements if the person meets one of the following criteria:

- Child under 16 years of age, 16 or 17 years of age and not head of household, or 16 or 17 years of age and attends school, including home schooling or employment training program, on at least a half-time basis;
- Physically or mentally unfit for employment;
- 60 years of age or older;
- Caring for a child under six years of age;
- Caring for a person with a disability who is living in the home;
- In a drug and alcohol treatment program;
- Receiving or applying for unemployment benefits;
- Meets SNAP full-time employment requirement — Employed or self-employed:
 - ▶ At least 30 hours a week; or
 - ▶ Receiving earnings equal to 30 hours a week multiplied by the federal minimum wage. If the applicant's income is not enough to meet this exemption, the person must verify that they work at least 30 hours a week;
- Registered with Choices (the TANF employment and training program); or
- Student 18 years of age or older in school or a training program at least half time.

F. Administration and key processes:

HHSC administers this program through a grant agreement with TWC.

Relevant process maps:

- [S7 CPSO AES Att 08 Program Administration](#) describes the program administration process.

- [S7 CPSO AES Att 09 Participant Flow Process](#) reflects the process outlining the process for a SNAP recipient after referral for E&T.
- [S7 CPSO AES Att 10 TPP Onboarding](#) includes a graphic providing the engagement and onboarding annual timeline for E&T service providers interested in becoming third-party partners.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts:

TWC establishes MOUs with the 28 local workforce boards to provide SNAP E&T services. As the State's workforce agency, TWC has MOUs with the 28 workforce development boards (Boards), and the Boards have MOUs with the service providers. The Boards' sub-contractors and Third-Party Partners provide skill development, vocational services, and support services for SNAP E&T participants.

I. Relationship with other governmental entities:

FNS serves as the federal SNAP E&T program administrator and regulator.

TWC is HHSC's grantee and the Texas program operator.

J. Barriers and challenges:

Due to federal funding constraints and program capacity, participation levels are not at acceptable levels, and sanction levels are much higher than desired.

K. Additional, regulatory, and complaint information: Not applicable.

SNAP Nutrition Education

A. Division or program information:

Name of Program or Function: SNAP Nutrition Education (SNAP-Ed)

Location within the agency: CPSO

Contact name: Lydia Perez, Director

Statutory citation: Human Resources Code, Chapter 33

B. Objective and major activities:

SNAP-Ed offers nutrition education and obesity prevention services to families eligible for SNAP and low-income communities. These services help improve healthy nutrition habits and physical activity behaviors. Community-based providers across the state offer free, direct, nutrition education and exercise classes; distribute health educational materials; and coordinate social marketing campaigns and environmental change strategies. Services are delivered through 16 implementing agencies (IAs).

C. Effectiveness and efficiency information:

AES gathers data quarterly from all IAs on their contracted services and compiles it into an annual report for FNS displaying IA's reach and use of funds. Key metrics from the annual report include:

- Program Reach: Number of Participants reached through direct education, social marketing campaigns, and policy, systems, and environmental change strategies.
- Behavioral Changes and Outcomes: Survey-collected data to assess nutrition, physical activity, and food resource management outcomes among participants.
- Implementation Metrics: Program Evaluation and Reporting System (PEARS) sourced data, social marketing analytics, IA outcomes and outputs, and any independent evaluation conducted by IAs.

In addition to the key annual report outcomes, metrics, and data sources described above, SNAP-Ed works with UHealth to develop a streamlined, annual, statewide evaluation for all IAs. The evaluation uses pre- and post-test surveys on four key indicators that measure knowledge, growth, and behavioral changes based on the following FNS chosen medium term (MT) indicators and evaluation framework:

- MT1: Healthy Eating;
- MT2: Food Resource Management;
- MT3: Physical Activity and Reduced Sedentary Behavior; and
- MT4: Nutrition Support.

Within each of these indicators there is a subset of metrics captured. The [SNAP-ED Evaluation Framework and Interpretive Guide](#) contains additional information about the Evaluation framework.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

The SNAP-Ed target audience includes SNAP recipients, individuals eligible to receive SNAP benefits or other means-tested federal assistance, and individuals residing in low-income communities that meet the low-income standard. Demographic information is not maintained at the individual level.

F. Administration and key processes:

AES administers the SNAP-Ed program through multiple grants, Interagency Cooperative Agreements and Interagency Transfer of Federal Funds Agreements with sister programs including Special Supplemental Program for Women, Infants and Children (WIC), Early Childhood Intervention (ECI), and Texercise to provide SNAP-Ed Services. Agencies receiving grant funds include non-profits and universities. Grant funds are also used to fund the SNAP-Ed project evaluation and a social media and marketing campaign.

The SNAP-Ed program team provides administrative support to the IAs. HHSC staff review invoices, review data, assist in overseeing external evaluation data, provide technical assistance, conduct monitoring, and ensure administration of the grant follows FNS guidelines.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not Applicable.

I. Relationship with other governmental entities:

SNAP-Ed receives funding from USDA FNS.

Some SNAP-Ed contractors work with local health departments, cities, and other municipalities when offering programming.

J-M. Barriers and challenges, additional information, regulatory and complaint information: Not applicable

SNAP Outreach

A. Division or program information:

Name of division or program: SNAP Outreach

Location within the agency: CPSO

Contact name: Kelli Williams, Director

Statutory citations: Texas Human Resources Code, Chapter 33

B. Objective and major activities:

SNAP Outreach supports Texans pursue self-sufficiency. The program partners with Feeding Texas, community- and faith-based organizations, and the Community Partner Program to educate low-income individuals and households about the benefits, eligibility requirements, and application procedures for SNAP leading to process-ready application submissions. SNAP Outreach connects individuals and households submitting SNAP applications to a network of community organizations that provide information and referrals to other local, community resources to help with other needs, such as assistance with paying rent or utility expenses.

SNAP Outreach has successfully expanded access to essential services through quarterly application assistance events held across the state. These application assistance events provide vital, hands-on support by assisting potentially eligible individuals in completing SNAP applications and offering real-time eligibility determinations. By meeting Texans where they are, the program reaches those who may otherwise encounter barriers to accessing SNAP benefits such as technology limitations, lack of transportation, or limited awareness of their eligibility.

Application assistance events have proven effective in increasing participation among vulnerable populations such as older adults, veterans, and low-income families, who benefit from the program's proactive approach to service delivery.

C. Effectiveness and efficiency information:

SNAP Outreach demonstrated increased effectiveness and efficiency from fiscal year 2023 to fiscal year 2024, with a 26 percent increase in submitted SNAP applications — from 57,121 in fiscal year 2023 to over 72,000 in fiscal year 2024 — and sustained outreach across all 254 counties. Of the fiscal year 2024 applications, 82 percent of submissions were online, aligning with self-service access goals. AES compiles metrics through quarterly grantee submitted reports and agency-generated flash reports, which capture application activity by each subrecipient, including counts for online submission of applications and redeterminations. This

reporting structure allows the program to accurately calculate total applications submitted and evaluate year-to-year performance improvements, ensuring alignment with federal and state objectives.

D. History:

- In 2006, HHSC established SNAP Outreach to enhance access to SNAP benefits for low-income Texans and initially managed the program internally.
- In 2006, HHSC significantly expanded the program's reach by partnering with Feeding Texas to subcontract direct outreach services, leveraging their established network of potential participants.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

AES administers the SNAP Outreach program through a contract with Feeding Texas and its subrecipients. HHSC administers SNAP Outreach by managing policy, the contracts, and monitoring; while the program grantee and its network of food banks carry out regional implementation. Program operations follow a structured process that includes planning, implementation, and oversight, supported by tools such as the SNAP Outreach Operations Manual, USDA-FNS SNAP Outreach Plan Guidance, monitoring templates and timelines used to align expectations with grantees and their subrecipients.

Relevant process maps:

- [S7 CPSO AES Att11 SNAP Outreach Guide](#);
- [S7 CPSO AES Att12 SNAP Outreach Program Operations Manual](#);
- [S7 CPSO AES Att13 SNAP Outreach Monitoring Tool FY25](#);
- [S7 CPSO AES Att14 FY 2020 Quarterly Monitoring Timeline](#); and
- [S7 CPSO AES Att15 SNAP Outreach Monitoring Manual](#).

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts:

SNAP Outreach leverages several key agreements and contracts to ensure coordinated and efficient service delivery, while avoiding duplication or conflict with other entities that provide similar or identical services to the target population.

The program has MOUs with various community partners, including local food banks, faith-based organizations, and other non-profits. These MOUs outline the roles and responsibilities of each partner in the outreach and application assistance process. They ensure that there is a clear understanding of service delivery and resource sharing, thereby enhancing the overall effectiveness of the program. These agreements and contracts are essential in maintaining a cohesive and efficient outreach program that meets the needs of Texans across all 254 counties.

I-M. Relationships, barriers and challenges, additional information, regulatory and complaint information: Not applicable

Community Partner Program

A. Division or program information:

Name of division or program: Community Partner Program

Location within the agency: CPSO

Contact name: Marisela Saldana, Manager

Statutory citation: Texas Government Code, Section 531.752

B. Objective and major activities:

CPP collaborates with community-based organizations to enable people to apply for and manage their benefits online at YourTexasBenefits.com (YTB) and through the mobile app, promoting self-service.

Community Partners (CP) can join the program at one of the following four levels:

- Level 1: CP provides general information about the program and HHSC benefits. CP allows the client to use the CP's computer(s) to apply for HHSC benefits through YTB.
- Level 2: CP provides application assistance by helping the clients complete benefit applications and upload verification documents to YTB. CP also helps clients understand and manage HHSC benefits.

- Level 3: CP provides application assistance by helping the clients complete benefit applications and upload verification documents to YTB. CP also helps clients understand and manage HHSC benefits. Additionally, CP has limited case inquiry through YTB. In addition, level three partners can reset passwords for clients.
- Level 4: The CP provides application assistance and case management, helping clients apply for, renew, and manage benefits through YTB or paper applications. HHSC-certified Case Assistance Navigators assist with case inquiries, password resets, and verification uploads. CP also offers supplemental referrals to community resources, tracking outcomes. Clients must provide consent before receiving Level 4 services.

C. Effectiveness and efficiency information:

HHSC assesses the effectiveness and efficiency of CPP through various data collection and performance measures. Flash reports, monthly, and quarterly reports track the number of individuals served, demonstrating the program's reach and impact. Completion rates, monitored through internal tracking systems, measure the percent of successfully completed applications and benefit management tasks, indicating the program's success in assisting clients.

HHSC records training completions to CPs are well-equipped, enhancing service quality. The program verifies MOU compliance through checklists and reviews, maintaining program integrity. Furthermore, the program measures operational efficiency by tracking the average processing time for issues, helping to identify and address delays. Feedback from CPs, gathered through surveys and "Listen and Learn Sessions", identify areas for improvement and ensures the program continues to meet the needs of the community partners.

To evaluate and improve training effectiveness, the program conducts a statistical analysis of training outcomes gathered through participant feedback.

CPP uses case management and follow up logs to monitor site visit and CP request information, ensuring the tracking of providing necessary support to CPs. Using this data directly influences timeliness by expediting the processing of applications. By ensuring high completion rates and efficient issue resolution, the program reduces delays in the application process. Well-trained CPs and timely support from HHSC enable faster and more accurate assistance, ultimately leading to quicker processing of applications and benefits for clients.

D. History

CPP began as a workgroup involving internal and external partners in 2012, established by H.B. 2610, 82nd Legislature, Regular Session, 2011. Initially piloted with 36 sites statewide, the program contracted Baylor University School of Social Work Texas Hunger Initiative and Texas A&M AgriLife for outreach and implementation. Regional community relations staff from HHSC supported the program from the start, taking over recruitment responsibilities in 2016 when Baylor University's contract ended. In 2017, CPP contracted Texas A&M AgriLife to provide technical assistance. Recognizing the potential for greater efficiency, HHSC brought CPP in-house in August 2019, fully administering the program to enhance services and expand its network.

E. Qualifications or eligibility requirements:

Community organizations must successfully complete and pass [CPP screening process criteria](#) to participate in CPP. The criteria differ by partner level.

F. Administration and key processes:

The CPP team reviews invoices and data; provides training and technical assistance; conducts monitoring; and ensures administration of the grant follows state and federal guidelines.

Regional CPP staff employ a comprehensive outreach and engagement strategy to identify and collaborate with potential CPs. This strategy begins with holding informational sessions and community events designed to educate organizations about the program's goals, benefits, and requirements. CPP invites interested partners to submit an enrollment form, the initial step in the onboarding process.

Upon organization selection, CPP drafts a MOU, outlining the CP's roles, responsibilities, and expectations. After a CP becomes active in the program, CPP assigns a customer support specialist to the CP. The customer support specialist provides comprehensive information tailored to the partner's specific needs. The customer support specialist will guide the partner through onboarding and conduct detailed training sessions to ensure the partner is well-prepared to assist clients effectively.

CPP collects feedback from all stakeholders involved through surveys and "Listen and Learn" sessions. CPP uses this information to refine processes, enhance partnerships, and improve project outcomes.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts:

In fiscal year 2024, CPP established MOUs with 644 community partners for 1,754 sites to help people apply for and manage their benefits.

I-M. Relationships, barriers and challenges, additional information, regulatory and complaint information: Not applicable

Texas Works Path for Success

A. Division or program information:

Name of division or program: Texas Works Paths to Success

Location within the agency: CPSO

Contact name: Jacqueline Maldonado, Program Specialist and Danielle Brown, Program Specialist

Statutory citation: Not applicable

B. Objective and major activities:

TWPS is a career training program that prepares youth and young adults to enter the workforce as a Texas Works Advisor I within AES. Participants who successfully complete the TWPS program are hired at a local benefits office where they will help connect Texans to medical, nutritional, and cash assistance benefits through programs, such as Medicaid, CHIP, SNAP, and TANF.

TWPS complements rather than competes with programs offered by nonprofit organizations like Goodwill and the Urban League, or federally funded initiatives under the Workforce Innovation and Opportunity Act (WIOA) and SNAP E&T. While these programs share a mission of increasing workforce readiness and serving similar populations, they often have restrictive eligibility requirements and limited job placement guarantees.

In contrast, TWPS's broader eligibility criteria enable partner sites to expand program access and participation while leveraging existing funding streams to maximize impact. Unlike traditional job readiness programs, TWPS guarantees paid

employment upon successful completion of its job-specific training, designed, and delivered entirely in-house by agency staff. This approach ensures alignment with the exact duties of the Texas Works Advisor I role and creates a direct, sustainable employment pipeline.

C. Effectiveness and efficiency information:

TWPS measures its effectiveness in achieving its core goals of increasing economic self-reliance, housing stability, educational advancement, and quality of life through a combination of participant surveys and post-employment feedback from supervisors. These tools provide valuable insights into improvements in living conditions, access to reliable transportation, career progression within the agency, and participants' perceptions of their overall quality of life.

In addition to assessing outcomes, TWPS tracks participants from the start of training through their ongoing career development within the agency. TWPS uses Salesforce to collect, store, and analyze data on participant performance, program completion rates, tenure with the agency, and individual success outcomes. These metrics are internally defined milestones, such as successful program completion, job start dates, retention at six-, nine-, and 12-month intervals, and survey feedback.

To assess program efficiency, TWPS monitors program enrollment numbers, training duration, and staff-to-participant ratios to ensure optimal resource allocation. TWPS evaluates cost-effectiveness by comparing program outcomes (e.g., placement and retention) to internal staffing and training costs.

D. History:

TWPS launched in 2020 as an innovative SNAP E&T Third Party Partnership (TPP) program offering job training for qualifying Houston-area high school seniors and young adults to increase career opportunities and self-reliance. The original SNAP E&T TPP was with Goodwill Industries of Houston, which facilitated training and recruitment efforts through their job readiness program, Houston Independent School District, and Texans Can Academy. The removal of the SNAP E&T TPP component from TWPS resulted in the conclusion of the partnership with Goodwill Industries of Houston in 2021.

E. Qualifications or eligibility requirements:

TWPS eligibility requirements:

- Minimum Age Requirement: 17 years of age
- Additional Eligibility Information: Participants must be either a high school senior from a TWPS joint-venture high school or a former foster youth.

F. Administration and key processes:

AES administers TWPS through a structured, multi-phase approach focusing on recruitment, training, engagement with regional operations, and job placement. Administration of the program includes the following key processes:

- Recruitment and Enrollment;
- Training and Skill Development;
- Evaluation and Program Completion;
- On-the-Job Training and Field Support; and
- Post-Program Follow-Up.

To further streamline services and ensure coordination, TWPS actively participates in joint planning initiatives, aligns program timelines with partner agencies, and maintains open, transparent communication. This integrated model ensures TWPS enhances the overall workforce development ecosystem in Texas without duplicating existing services or creating conflicts with parallel programs.

G. Funding: See “Agency Program Information Spreadsheet.”

H. MOUs and interagency agreements or contracts:

TWPS holds MOUs and interagency agreements with community organizations, local government entities, and educational institutions such as local independent school districts to coordinate service delivery and avoid duplication of efforts. These agreements outline each partner’s roles and responsibilities, fostering collaboration and a shared commitment to improving employment outcomes across Texas.

I. Relationship with other governmental entities:

TWPS establishes partnerships with local government agencies using MOUs. TWPS partnerships include the Houston Independent School District, Rio Grande City Independent School District, Harris County’s The HAY Center, and DFPS.

J-M. Barriers and challenges, additional information, regulatory and complaint information: Not applicable

Nutrition Incentive Program

A. Division or program information:

Name of division or program: Nutrition Incentive Program

Location within the agency: CPSO

Contact Name: Kelli Williams, Director

Statutory citation: 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 89)

B. Objective and major activities:

NIP improves access to fresh, locally grown fruits and vegetables for Texas families, and boosts business for Texas farmers, retailers, and local economies. NIP aims to increase the purchase of fruits and vegetables by low-income households participating in SNAP by providing an incentive for the purchase of fruits and vegetables at the point of purchase.

NIP empowers SNAP recipients who visit participating local farmer's markets and other retailers, to double or match their purchase of fruits and vegetables enabling households to stretch their food budgets, improve their diets, address food insecurity and promote better health outcomes.

HHSC contracts with the Sustainable Food Center (SFC) to implement Texas' NIP. This contract enables SFC to engage and expand a network of SNAP authorized retailers who participate in the program, increasing access to more local fruits and vegetables.

C. Effectiveness and efficiency information:

NIP has a robust framework for monitoring and accountability, essential to the program's effectiveness and compliance. Key deliverables for NIP projects include submitting detailed project plans, quarterly progress reports, and final evaluation reports. These documents outline the project's activities, outcomes, and financial expenditures.

KPRs include expanding the NIP Project network to more farmers markets and grocery stores across Texas, expanding incentives offered by the retailer, increasing the number of customers receiving incentives and the number of fruits and vegetables purchased through incentives.

NIP performs regular assessments and desk reviews of deliverables and KPRs to monitor compliance, evaluate performance, and provide targeted support to grantees, ensuring the accurate tracking and management of NIP activities, maximizing resource efficiency and extending quality service to Texans in need.

D. History:

The foundational legislation for NIP is the Agriculture Improvement Act of 2018 (7 USC, Section 7517), which authorizes funding for nutrition incentive programs that connect low-income consumers with agricultural producers.

E. Qualifications or eligibility requirements:

Only SNAP recipients are eligible to receive nutrition incentives offered by Farmers' Markets and Retailers participating in the NIP.

F. Administration and key processes:

AES administers this program through a contract with SFC. NIP staff collaborate with the AES Office of Administration, specifically the Finance and Contracts sections, to ensure efficient and effective administration. The program's key processes include planning and procurement, where NIP selects grantees with demonstrated experience implementing nutrition incentive programs for SNAP recipients. Grant management involves fund disbursement and compliance monitoring to ensure grantees meet their deliverables and performance requirements.

NIP provides regular communication and organizes governance meetings to enhance collaboration and alignment among all stakeholders. NIP uses Quarterly reports to track progress and make data-driven improvements, ensuring the program meets its goals and effectively supports the communities it serves.

In fiscal year 2024, HHSC received general revenue for NIP project grants. HHSC initiated a procurement process to select and award organizations that met the eligibility criteria and demonstrated the ability and capacity to meet grant requirements. To be eligible for an award, organizations were required to

demonstrate experience in designing and implementing successful nutrition incentive programs that connect low-income consumers and agricultural producers, offer administrative and technological support to retailers to support uptake and participation in the program, and operate in at least two counties.

G. Funding: See " Agency Program Information Spreadsheet."

H-M. MOUs, relationships, barriers and challenges, additional information, regulatory and complaint information: Not applicable

Policy and Quality

The Policy and Quality team, consisting of Quality Management (QM), Field Policy Services and Support, and Program Policy, ensure programs and policies administered by AES are both effective and compliant with state and federal standards.

Quality Management

QM provides the overall quality assurance and quality control of AES Operations support functions, including data collection, performance monitoring, and reporting for programs administered and services delivered by AES. QM directs, plans, and makes recommendations to change AES and specific HHSC policies, processes, and internal operating procedures to comply with state and federal requirements. QM provides a bridge connecting regional staff, state office, and USDA FNS, allowing effective collaboration while promoting excellence through consistent quality. QM consists of three sections: Quality Control (QC) SNAP, Quality Assurance Field Services (QAFS), and Quality Improvement Support (QIS).

- QC SNAP analyzes SNAP determinations for benefit accuracy, case and procedural error reviews, and case action timeliness fulfilling the SNAP federal or state monitoring obligations. QC produces summary reports for state or federal entities including HHSC leadership. FNS uses QC data to rank state's performance for payment accuracy, case and procedural error review rate, and timeliness.
- QAFS develops data collection methods and implements monitoring processes to evaluate program performance. QAFS completes various special assignments and targeted case reviews (TCR) for Texas Works Advisor and Medicaid Eligibility team members based on business and program needs. The TCR process allows for correction of benefits in a timely manner,

provides a greater opportunity to reduce potential QC payment errors, improves staff development through well-timed feedback on performance, and reduces the likelihood of the same errors occurring in the future.

- QIS provides independent and objective reviews and monitoring to reduce or prevent financial risk to the state as mandated in Title 7, Code of Federal Regulations, Section 246.19(b), by establishing an on-going management evaluation system. This management evaluation system includes, at a minimum, the monitoring of local agency operations, review of local agency financial and participation reports, development of corrective action plans (CAP) to resolve program deficiencies, monitoring CAPs, and on-site visits. QIS documents these actions and provides documentation to FNS. QIS team members serve as quality management subject matter experts on projects with both internal and external stakeholders. QIS includes the Internal Revenue Services coordinator position responsible for inter-agency division coordination of key management and operational safeguards within the agency.

QM functions include:

- Completing QC reviews according to FNS requirements, completing the required sample size yearly producing the CAPER and Payment Error Rate (PER). FNS uses QC data to rank state's performance for payment accuracy, case and procedural error review rate, and timeliness.
- Analyzing QC error data and when error rate rises above 5 percent for either PER or CAPER, QM works with AES to create a CAP and then monitors for improvement.
- Completing Management Evaluation Reviews and requiring AES to create CAPs for elements that fall below 95 percent accuracy. QM provides technical assistance for the creation of the CAP and monitors for improvement.
- Monitoring and reporting AES timeliness for SNAP applications and recertifications to ensure compliance with federal guidelines. QM collaborates with all areas of AES to create and monitor timeliness CAPs when AES does not meet 95 percent accuracy and monitors for improvement.

Field Policy Services and Supports

Field Policy Services and Supports consists of policy specialists with backgrounds and expertise in MEPD and TW who serve as a resource for AES team members and

external stakeholders by providing policy clarifications and increasing policy knowledge.

Policy Integration (PI) serves as a central coordination point within the area, supporting the timely approval and publication of AES policy updates. The team maintains tracking and reporting for policy projects across the division and ensures bulletin and handbook revisions progress through the development cycle efficiently. By monitoring timelines, gathering key metrics, and elevating issues as needed, PI helps ensure policy updates are delivered accurately and on time.

Program Policy

A. Division or program information:

Name of division or program: Program Policy

Location within the agency: CPSO

Contact name: Olivia Cosby, Associate Commissioner of Policy and Quality

Statutory citation: Texas Government Code, Chapter 531; Texas Human Resources Code, Chapters 31-33

B. Objective and major activities:

Program Policy supports the mission of connecting Texans to services and supports by working with partners to develop policies to achieve HHSC and AES goals. Program Policy is a liaison for many of AES's external coordination efforts, including FNS, DHHS, CMS, and state agencies such as TWC, TDA, and TDCJ.

Program Policy provides policy clarifications for internal and external partners related to federal and state rules and regulations, implements projects, and develops policy bulletins, memos, broadcasts, and other documents designed to help communicate policy to AES staff and stakeholders. Program Policy is vital in AES legislative bill analysis and every policy implementation project. Program Policy analyzes the Code of Federal Regulations and other federal rules for policy changes and communicates these changes to stakeholders.

C. Effectiveness and efficiency information:

Program Policy manages critical projects and initiatives to ensure compliance with federal rules and regulations, including projects that impact multiple stakeholders.

Most tasks in Program Policy focus on research into rules and regulations at the federal and state levels to:

- Provide written responses to questions received about federal and state rules and regulations;
- Develop written analysis on federal and state rules and regulations; and
- Be a Subject Matter Expert (SME) on guidance coming from federal and state partners for internal and external stakeholders.

Program Policy does track internal performance through timeliness metrics for internal and external Policy Clarification Requests (PCRs) by tracking when a PCR is due, who is assigned for its completion, the type of inquiry, etc. This tracking allows Program Policy to measure how timely responses are.

Additionally, all responses and assignments go through a review process where at a minimum the team Manager reviews for accuracy. However, typically multiple levels of review occur up to the Director and Associate Commissioner depending on the question or assignment. This review process uses policy and federal and state regulations and plain language review.

Program Policy tracks performance goal metrics through evaluations. Tracking and performance measures will be improved for fiscal years 2026-27.

D-E. History and qualifications: Not applicable.

F. Administration and key processes:

Program Policy has codified many of the vital functions key to AES administration in the Program Policy and Procedures Manual. The manual serves as the overall guidance document for the internal team of Program Policy. Included is guidance on the process for analysis on policy reports, calls, webinars; providing policy clarification requests to internal and external stakeholders; how policy development takes place; and the process for developing policy bulletins, broadcasts, and updates to the Texas Works Handbook and Texas Administrative Code. Additionally, Program Policy assists with ensuring the agency remains in compliance with federal and state requirements, assists with the implementation of policy changes in projects updating the eligibility system; and monitors and determines any effects new state and legislative changes may have on HHSC.

G. Funding: See" Agency Program Information Spreadsheet."

H-I. MOUs and relationships: Not applicable.

J. Barriers and challenges:

Program Policy assisted HHSC Public Health Emergency unwinding efforts which required numerous updates and changes to the agency's eligibility and support systems which are older and less flexible. Challenges included ensuring compliance with numerous changes in federal guidance, implementing new federal rules, and identifying and addressing system issues while ensuring eligible Texans continue to receive services.

K-M. Additional information, regulatory and complaint information:

Not applicable

Supplemental Nutrition Assistance Program

A. Division or program information:

Name of division or program: SNAP

Location within the agency: CPSO

Contact Name: Aisha Crawford, Director of SNAP and TANF

Statutory citation: Texas Human Resources Code, Chapter 33

B. Objective and major activities:

AES uses an integrated and streamlined approach to connect millions of Texans to services and supports, including SNAP. SNAP provides nutrition assistance to eligible individuals and families by providing a monthly benefit that can be used to purchase food. SNAP food benefits are delivered through a Lone Star Card which can be used like a debit card at any store that accepts SNAP. People can also use their SNAP benefits to buy food online from certain retailers.

C. Effectiveness and efficiency information:

AES compiles caseload data, including active cases, age demographics, and total dollar amount of benefits per month. Additionally, AES tracks timeliness metrics to ensure compliance with federal and state regulations. See below for December 2024 data examples.

To qualify for SNAP, individuals aged 16-59 must meet work requirements unless exempt. Exemptions include being unfit for work, caring for a disabled household member, caring for a child under six, or working 30 or more hours weekly. Participation in SNAP E&T is also a requirement. Failure to meet these requirements without good cause may lead to disqualification. These requirements are monitored to ensure the efficiency of the program.

Table 4. SNAP December 2024 measures.

Measure	Output
Active SNAP Caseloads	1,653,564
Number of people served	3,605,204
Age of recipient: Number of people served who are 60 years of age or older	546,359
Age of recipient: Number of people served who are under 18 years of age	1,782,996
Total dollar amount of benefits per month	\$628,582,687

SNAP adds over \$7 billion in 100 percent federally funded benefits to the Texas economy each year, thereby creating additional jobs in almost every county in Texas.

Additional performance measures and outcomes include the following:

- Reduction of the outstanding SNAP application backlog from 166,000 to 90,000. Achieving this reduction is primarily a result of automation enhancements and implementing waiver policies approved by FNS.
- Issuance of expedited service SNAP benefits to an average of 87 percent of applications within the federal timeliness standard of seven days. This issuance of expedited service reduces the stress this population would otherwise place on emergency food distribution by local pantries.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

Eligibility for SNAP includes the following financial and non-financial requirements, which must be verified:

- Residency: Texas resident

- Citizenship: United States citizen or eligible alien status
- Income: Percentage of Federal Poverty Level (FPL): 165 percent
- Assets: \$5,000 asset limit
- Information Regarding Income and Allowable Deductions and Costs: Gross income includes a household's total, non-excluded income, before any deductions have been made. Net income equals gross income minus allowable deductions^c and costs^d.
- Additional Information: Identity of the person interviewed.

F. Administration and key processes:

AES administers SNAP policy development, training, quality control, quality business, and the EBT system.

The eligibility system improves and streamlines eligibility services to include the use of electronic imaging technologies and automated systems to electronically manage documents, assemble cases, manage workflow, and to determine eligibility and benefits in the integrated eligibility and enrollment systems.

Households submit applications for benefits through a variety of access channels including in-person, mail, telephone, fax, and internet. AES manages and assembles applications and required documentation into cases, and routes cases through the workflow systems to process eligibility functions and then to eligibility workers to determine eligibility and enrollment into appropriate programs.

AES state office staff manage the staff who determine eligibility. Eligibility staff are in call centers and local offices throughout the state. AES uses some contract staff to provide application assistance and to image documents needed to support eligibility decisions.

Based on state statutes and federal regulations, AES reviews client eligibility reviewed and recertifies clients at specified time intervals, and regularly processes

^c Allowable deductions include a 20 percent earned income deduction, a standard deduction based on household size, a dependent care deduction when needed for work, training, or education; medical expenses for household members who are elderly or have a disability that exceeds \$35 for the month and are not paid by insurance or someone else; legally owed child support payments, a set deduction for homeless households; and excess shelter costs that are more than half of the household's income after the other deductions.

^d Allowable costs include the cost of fuel to heat and cook, electricity, water, the basic fee for one telephone, rent or mortgage payments, and taxes on the home.

changes in household circumstances (e.g., marital or employment status) to ensure households receive the benefits for which they are eligible.

AES issues SNAP benefits via EBT, an electronic system that allows a recipient to authorize transfer of their government benefits from a federal or state account to a retailer account in exchange for products received.

HHSC monitors and recovers overpayments to clients. HHSC emphasizes the prevention, detection, and prosecution of fraud and abuse throughout the service delivery and monitoring process.

Finally, AES provides field and regional services through contracts with Community Based Organizations (CBOs) that provide application assistance and outreach to clients. AES contracts, trainings, and provides informational materials and media to CBOs.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

HHSC works with FNS in administering SNAP. FNS is the federal agency with oversight of SNAP, administered by states.

J. Barriers and challenges:

Technology-related barriers have presented challenges. System outages and performance issues within key eligibility systems – such as TIERS and YTB – have periodically disrupted casework, application processing, and client communication.

Technology is significantly outdated and requires substantial knowledge and understanding by staff to work through the inefficiency of the system. It is difficult to capture the extent of that knowledge in a short period of training time. Delays in system enhancements, integration with partner platforms, and usability concerns have further limited operation efficiency.

K-M. Additional information, regulatory and complaint information:

Not applicable

Temporary Assistance for Needy Families

A. Division or program information:

Name of division or program: TANF

Location/Division: CPSO

Contact Name: Aisha Crawford, Director of SNAP and TANF

Statutory Citation for Program: Texas Human Resources Code, Chapter 31 and 34

B. Objective and major activities:

AES uses an integrated and streamlined approach to connect millions of Texans to services and supports, including TANF. TANF offers financial assistance to low-income dependent children and their foster or guardian relatives. The use of TANF funds for cash payments constitutes a small portion of the program. TANF is a federal block grant to states and local governments offering flexibility to address specific needs. Its four goals are the following:

- Assist needy families to care for children at home or with relatives;
- Reduce parental reliance on benefits by promoting work, job preparation and marriage;
- Prevent out-of-wedlock pregnancies; and
- Support two-parent family stability.

States must submit plans and reports to ensure grant compliance. TANF Cash Assistance includes monthly grants based on household size and composition and one-time \$1,000 grants for eligible households and relative caretakers. In 2005, due to low caseloads, Texas shifted the two-parent monthly TANF program to a state-funded version called TANF State Program (SP). TANF is federally time limited to a five-year cap per household, with extensions granted based on circumstances such as disability, caregiving, or domestic violence. States may set shorter limits. In Texas, limits for adults are 12-, 24- or 36-months plus a five-year freeze, based on work and education. Children can continue receiving benefits if income eligible after the adult benefits end. Federal and state limits run concurrently.

Parent and caretaker relatives applying for TANF must attend a Workforce Orientation for Applicants (WOA) conducted by TWC, which covers available

workforce services, local labor market resources, the importance of timely employment and personal responsibility and support services like childcare and transportation. Households must meet financial and non-financial criteria, sign a Personal Responsibility Agreement (PRA) and complete an application and interview. TANF households do not have a formal certification period; households receive TANF until denied, with a six-month periodic review to confirm circumstances have not changed, a functionality similar to SNAP certification.

C. Effectiveness and efficiency information:

AES tracks performance goal metrics through:

- Timeliness of application processing, as measured by federal 45-day standards;
- Work participation rates (WPRs) tracked in accordance with 45 CFR sections 261.31 and 261.40;
- Client engagement and outcome tracking, such as the number of clients entering employment, job retention rates, and average wage at placement; and
- Caseload trends, including active cases and case closures due to increased earnings or non-compliance.

Primary data sources used for performance tracking include:

- TIERS for application processing and eligibility determination; and
- The Workforce Information System of Texas (TWIST) for work activity monitoring of program outcomes.

These metrics are used to guide continuous improvement efforts. Enhancements are targeted between fiscal years 2026-27 to strengthen interagency coordination, increase data integration between TIERS and TWIST, and improve both service delivery and program impact.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

Eligibility for TANF includes the following financial and non-financial requirements, which must be verified:

- Residency: Texas resident.
- Citizenship: United States citizen or eligible alien status.
- Income: Budgetary and Recognizable Need tests.
- Assets: \$1,000 asset limit.
- Additional Eligibility Information: TANF is for families with children 18 years of age and younger. Families who may be eligible for this assistance have little to no money or do not have a way to obtain money. A family can be parents and their children or relatives caring for related children. To receive TANF, a family must be below the established income and resource limits.

TANF eligibility criteria include residence, citizenship, age, relationship and domicile, resources and income, and social security number verification. Adults with a felony drug conviction on or after April 1, 2002, are ineligible for TANF cash assistance.

States set their own income eligibility guidelines for TANF. To determine eligibility, HHSC reviews a family's income and compares it with the amount the family pays for basic needs such as childcare and work-related expenses. There are two income eligibility tests used to determine TANF financial eligibility:

- Budgetary Needs Test: Gross income minus allowable deductions (dependent care, work related expenses, and child support paid) as compared to the budgetary needs standard for the household size and type; and
- Recognizable Needs Test: Net income derived from the budgetary needs test minus an additional 1/3 or 90 percent earned income deduction as compared to the recognizable needs standard for household size and type.

The household must first pass the Budgetary Needs Test and then pass the Recognizable Needs Test to be eligible for TANF. The income limits for both tests are based on household size and household composition.

In addition, states also set their own resource eligibility guidelines for TANF. Texas' asset limit is \$1,000. Resources such as cash on hand, money in the bank, and vehicle values are considered when determining the countable amount of available resources. HHSC excludes \$4,650 from the vehicle's fair market value when determining the countable amount towards the resource limit.

F. Administration and key processes:

AES manages TANF policy, training, quality control, and quality management. TANF policy is in the [Texas Works Handbook](#).

AES manages staff who determine benefit eligibility and employes contract staff to assist with applications and document imaging.

Clients can apply for benefits in-person, by mail, phone, fax, or internet. AES assembles applications and documents into cases and routes cases through workflow systems for eligibility determination.

YTB allows clients to create accounts, apply and renew benefits, check the status of their case, report changes, and print Medicaid cards. The mobile app enables case management and verification uploads for faster services.

AES regularly reviews and re-certifies eligibility, with status changes processed when reported to prevent ineligible recipients from receiving benefits.

HHSC collaborates with TWC to promote client self-sufficiency and facilitate transitions from welfare to work. HHSC issues TANF benefits via EBT, enabling recipients to transfer funds from a federal account to retailer accounts for cash and goods.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts:

HHSC has an MOU with TWC and OAG.

TWC offers employment assistance and training programs for mandatory TANF adults and minor parents who are heads of households. Parents on TANF must cooperate with OAG to identify noncustodial parents, establish paternity, set and modify child support, and enforcement payments. HHSC collaborates with both OAG and TWC through an automated interface to facilitate referrals and coordinate case management for TANF recipients.

I. Relationship with other governmental entities:

The U.S. DHHS, Administration for Children and Families funds state agencies to deliver programs related to family assistance, child support, child welfare, and other services supporting children and families.

J-M. Barriers and challenges, additional information, regulatory and complaint information: Not applicable

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VII. Guide to Agency Divisions and Programs

Chief Program and Services Officer

Family Health Services

Family Health Services (FHS) is creating a stronger Texas by serving Texas women, children, and families and offers health and social services to meet the needs of Texans in all stages of life.

Division Support

FHS Operations and FHS Strategy provide support to all FHS programs and staff. FHS Operations provides contract oversight and support, budget maintenance, and project management assistance. FHS Strategy provides communications oversight, strategic planning, research, and evaluation, and serves as advisors to the FHS division. In addition, FHS Strategy administers two programs.

Maternal Mental Health and Substance Use Disorder

A. Division or program information:

Name of division or program: Maternal Mental Health and Substance Use Disorder (MMHSUD)

Location within the agency: CPSO

Contact name: Hannah Vardy, Associate Commissioner for Family Health Strategy

Statutory citation: None

B. Objective and major activities:

MMHSUD supports administration of a federal grant to improve maternal outcomes by enhancing access to services for pregnant and postpartum women. MMHSUD provides outreach, training, tele-mentoring, and technical assistance to perinatal providers. In addition, the program establishes and maintains quality consultative services through:

- MMHSUD psychiatric telehealth consultations;
- Increasing access to community-based, trauma-informed, MMHSUD treatment and recovery support services; and
- Developing and distributing to practitioners a directory of MMHSUD referral resources for pregnant and postpartum women in need of mental health and/or substance use care.

MMHSUD enhances the state's ability to detect maternal mental health and substance use disorders and provides fully integrated on-demand access to evidence-based MMHSUD treatment and recovery support. The program leverages existing substance use service networks funded by the Texas Health and Human Services Commission (HHSC) to provide telehealth consultation and liaison services, recovery support services, substance use disorder (SUD) treatment access, and training and tele-mentoring.

MMHSUD aims to serve perinatal providers in Texas to improve their ability to detect, diagnose, and treat maternal mental health and substance use disorders.

C. Effectiveness and efficiency information:

Metrics to determine the effectiveness of the program are listed below. The contract with the grantee stipulates targets for these metrics, as applicable:

- Number of providers trained;
- Number of providers receiving technical assistance;
- Number of providers provided outreach;
- Track and report outcomes associated with rural and non-rural perinatal provider delivery of evidence-based screening, connections to treatment, and recovery support services to pregnant and postpartum Texans;
- Report outcomes associated with availability of real-time psychiatric consultations and support in delivering or acquiring evidence-based SUD screening, referral, and treatment practices. Outcomes should track the reduction in existing gaps in care and identify access barriers for underserved women;
- Review of UT Health Houston's Center for Health Care Data to access All Payer Claims Data to establish a baseline of maternal mental health and substance use disorder services claims data and a subsequent uptake of treatment of mild to moderate MMHSUD in primary settings; and

- Increase the number of women enrolled in site-based mental health or SUD treatment.

D. History: Not applicable

E. Qualifications or eligibility requirements:

Texas perinatal providers are eligible to participate in the program. The number of providers impacted is not currently available since the grant is in the initial stages of implementation.

F. Administration and key processes:

FHS administers the program through a contract with UT Health San Antonio's Be Well Texas and in partnership with the Perinatal Psychiatry Access Network (PeriPAN).

G. Funding: See "Agency Program Information" spreadsheet.

The United States (U.S.) Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA) awards funding and the grantee provides a 10 percent match.

H. MOUs and interagency agreements or contracts:

MMHSUD program enhances the existing PeriPAN program. The MOU in place is between UT Health San Antonio's Be Well Texas and PeriPAN.

I. Relationship with other government entities:

HRSA awards the funds which flow through HHSC and then through a contract with UT Health San Antonio's Be Well Texas. Resources developed from the program may flow to local units of government that may provide perinatal services.

J. Barriers and challenges:

Contracting delays resulted in \$750,000 in unobligated funds in year one of the grant. HHSC received approval from HRSA to carryover these funds into year two.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Child Disability Prevention

A. Division or program information:

Name of division or program: Child Disability Prevention

Location within the agency: CPSO

Contact name: Hannah Vardy, Associate Commissioner for Family Health Strategy

Statutory citation: Texas Human Resources Code, Chapter 112

B. Objective and major activities:

Child Disability Prevention works to reduce the prevalence and incidence of developmental disability among children. The business area seeks to reduce silos between areas working on the prevention of developmental disabilities and leverage the state's resources toward achieving reductions in child developmental disability incidence and prevalence.

C. Effectiveness and efficiency information:

There are no metrics captured by this program since it is educational and coordinates with other programs and does not provide direct client services.

D. History:

Senate Bill (S.B.) 1527, 71st Legislature, Regular Session, 1989, added Texas Human Resources Code, Sections 112.041-112.051, and created a private-public initiative called the Office for the Prevention of Developmental Disabilities (OPDD), governed by a governor-appointed executive committee. OPDD's primary focus was teenage pregnancies, teenage drinking, and teenage brain injuries. In 1999, House Bill (H.B.) 1151, 76th Legislature, Regular Session, 1999, directed the administrative attachment of OPDD to the Texas Department of Mental Health and Mental Retardation.

S.B. 200 and S.B. 219, 84th Legislature, Regular Session, 2015, updated the Texas Human Resources Code to reflect a transfer of OPDD responsibilities to HHSC. These bills suspended provisions related to the executive committee. Upon transformation, the Health, Developmental and Independence Services division (HDIS) administered statutory requirements until 2022. After CPSO realignment,

CPSO housed Child Disability Prevention (formerly the Office of Disability Prevention for Children (ODPC)) within FHS as part of the Strategy program. During realignment, Child Disability Prevention chose to focus on the following priorities:

- Prevention of disabilities caused by maternal health issues during pregnancy;
- Prevention of disabilities caused by childhood injuries;
- Early identification and diagnosis of disabilities to ensure early intervention and services; and
- Promotion of mental health wellness for children with intellectual or developmental disabilities.

To avoid duplication of service delivery, FHS Strategy reviewed Child Disability Prevention's focus, program administration, and alignment with HHSC's strategic plan. To reduce duplication of efforts and redundancy with other HHS programs, FHS Strategy made the prevention of disabilities caused by maternal health issues during pregnancy the top priority.

E. Qualifications and eligibility requirements: Not applicable

F. Administration and key processes:

Child Disability Prevention raises awareness and disseminates information regarding the prevention of disabilities caused by maternal health issues during pregnancy.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

Child Disability Prevention supports other state program initiatives, collaborates on conference exhibits, and presents at relevant state government and stakeholder conferences. Child Disability Prevention collaborates with the Department of State Health Services (DSHS) and University of Texas at Austin to raise awareness and disseminate information regarding the prevention of disabilities caused by maternal health issues during pregnancy.

J. Barriers and challenges:

Child Disability Prevention's authorizing statute (Texas Human Resources Code, Section 112.041) is over 35 years old. Since its inception, the HHS system has undergone two major transformations; created the Offices of Disability Services and Mental Health Coordination; and established multiple plans and reports concerning improving birth outcomes for children. Additionally, DSHS and the Department of Family and Protective Services (DFPS) established child injury prevention initiatives. The result of these changes is a duplication of effort with some of the previous activities of Child Disability Prevention. FHS recommends updating the statute to reflect the current activities of the program.

K. Additional information:

The Child Disability Prevention program specialist supports the Governor-appointed Pediatric Acute-Onset Neuropsychiatric Syndrome (PANS) Advisory Council. Responsibilities include coordinating council meetings, acting as a primary point of contact between the PANS council and external stakeholders, and managing the development of the PANS council's legislative report.

L-M. Regulatory and Complaint information: Not applicable.

Early Family Nutrition and Development

The Early Family Nutrition and Development (EFND) includes the Early Childhood Intervention (ECI) program and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The EFND Associate Commissioner oversees the EFND department and ensures programs are effective, efficient, and high quality.

Early Childhood Intervention

A. Division or program information:

Name of division or program: ECI

Location within the agency: CPSO

Contact name: Faith Sandberg-Rodriguez, EFND Associate Commissioner

Statutory citation: Texas Human Resources Code, Chapter 73; Texas Government Code, Section 531.0011

B. Objective and major activities:

ECI is a statewide program supporting families with children from birth up to 36 months of age with developmental delays, disabilities, or certain medical diagnoses, authorized under Texas Human Resources Code, Chapter 73 and the federal Individuals with Disabilities Education Act (IDEA) Part C. There are 40 ECI contractors across Texas delivering ECI services. ECI services are available in every Texas county. ECI provides early intervention services designed to enhance the child's development and improve the capacity of families to meet their child's needs. Family-centered services focus on incorporating intervention activities into daily routines in the child's natural environment, or where the child lives, learns, and plays. ECI offers an array of services, such as case management, physical therapy, speech-language therapy, nutrition services, occupational therapy, specialized skills training, specialized services for children who are deaf or hard of hearing or have visual impairment and coaching on infant and toddler development and behavior.

C. Effectiveness and efficiency information:

The 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023, includes five Legislative Budget Board (LBB) performance measures for ECI. The Output measures are the following: average monthly number of children served, average monthly number of referrals, and average monthly number of eligibility determinations. The Efficiency measure is average monthly cost per child. The Explanatory measure is average monthly number of hours of service delivered per child per month.

Research has found early childhood education programs save taxpayer dollars in public education, criminal justice, health care, and other social services. Research also shows ECI programs have a positive impact on children and their families and are often vital for later success in school and the community. Texas' child outcomes, as measured by trained ECI personnel, consistently exceed the national average in federal reporting, with more than two-thirds of the children served through the ECI program significantly increasing their rate of growth in key areas such as social-emotional skills, acquisition and use of knowledge and skills, and use of appropriate behavior to meet their needs as a result of their participation in ECI.

ECI provides excellent customer service to ensure families of young children with developmental delays or disabilities have the resources and support needed to reach their goals. ECI implements strategies to increase the response rate of the Family Outcomes Survey, designed to assist in measuring family outcomes and identify areas for increased family engagement and program improvement. In this

annual survey, listed in attachment 30, most families (87.7 percent in fiscal year 2024) consistently report that ECI helped their child develop and learn.

D. History: Not applicable

E. Qualifications or eligibility requirements:

ECI served 67,413 children in fiscal year 2024.

Below are the ECI eligibility requirements:

- Residency: Texas resident.
- Age requirement: Zero months to 35 months of age.
- Program eligibility specific medical condition: To be eligible for ECI services, a child must have one of the following:
 - ▶ Medical diagnosis that is likely to cause a developmental delay and demonstrates a need for services.
 - ▶ Developmental delay of 25 percent (percentage of developmental delay is determined using an HHSC-approved standardized tool) in one or more areas of development (social-emotional, self-help, communication, motor functions, or cognitive skills).
 - ▶ Developmental delay of 33 percent (percentage of developmental delay is determined using an HHSC-approved standardized tool) if the delay occurs only in the area of expressive communication.
 - ▶ Deaf/hard of hearing or visual impairment as defined by the Texas Education Agency.

The [ECI Qualifying Diagnosis Search](#) webpage enables users to search for automatically qualifying diagnoses for ECI services. At the request of ECI, a panel of physicians periodically reviews and updates medically diagnosed conditions when ECI contractors and other stakeholders recommend specific diagnoses.

F. Administration and key processes:

HHSC administers ECI by contracting with contractors across the state. Contractors are contractually required to provide the full scope of IDEA Part C services to all eligible children in compliance with state and federal law and regulations.

Children and families access services directly through ECI contractors. Any person concerned about a specific child's development, including knowledge of a child's medically diagnosed condition that may result in a developmental delay, may make a referral to an ECI contractors. Referrals may come from parents, teachers, other caregivers, nurses, physicians, etc. For children who do not have automatically qualifying diagnoses, are not deaf or hard of hearing (DHH), or do not have a visual impairment, ECI contractor staff, with parental consent and participation, administer the HHSC-approved, standardized, norm-referenced tool to establish the child's percentage of delay. If documentation of a qualifying diagnosis, DHH or visual impairment, or a qualifying developmental delay establishes eligibility, the ECI team develops the child's individualized family service plan which documents the child and family's needs, goals, and the family's concerns and priorities. ECI contractors redetermine eligibility annually.

Transition planning occurs when the child is two years old to help families decide what services their child might need after exiting the ECI program, such as transitioning into the public school system. Figure One below summarizes key ECI processes.

Figure 1. ECI administration and key process summary.



G. Funding: See "Agency Program Information" spreadsheet.

ECI receives the following state funding each fiscal year:

- General revenue for ECI;
- Foundation School Funds;
- General revenue funds specifically designated as match for Medicaid for specialized skills training (SST) and targeted case management (TCM);
- General revenue certified as match for Medicaid Administrative Claiming; and
- Respite services funding.

Federal funding includes IDEA Part B and C, Temporary Assistance for Needy Families funds (TANF), Medicaid Administrative Claiming, and Medicaid matching funds for SST and TCM.

Table 1. ECI funding types.

Funding Type	State	Federal
General Revenue	X	
Medicaid – TCM and SST	X	X
Medicaid Administrative Claiming	X	X
IDEA Part C		X
IDEA Part B		X
Foundation School Funds	X	
TANF		X
Respite Services	X	

The federal Office of Special Education Programs (OSEP) allocates IDEA funding based on a formula that considers state population growth. The maintenance of effort provision requires states to budget in the current fiscal year at least the same aggregate amount of state and local public funds spent in the most recent preceding fiscal year for which the information is available. The basis for federal matching funds is the applicable Medicaid Administrative Claiming match rate or Federal Medical Assistance Percentage (FMAP).

H. MOUs and interagency agreements or contracts:

ECI has an MOU with the Texas Education Agency (TEA) to coordinate services delivered by local education agencies to children enrolled in ECI who are deaf or hard of hearing and who are visually impaired; and coordinate activities, roles, and responsibilities, for children who are aging out of ECI and transitioning to early childhood special education. In addition, ECI has a joint interagency contract (IAC) with TEA, Texas Workforce Commission (TWC), and HHSC Family Support Services (FSS), through which ECI contributes to a shared employee who resides at TEA and facilitates an interagency workgroup to ensure appropriate coordination and collaboration among ECI, FSS, TEA, and TWC's Childcare division.

I. Relationship with other governmental entities:

ECI collaborates with other state agencies and private organizations providing services for children and families in Texas, including TEA, DFPS, DSHS, TWC, Head Start, universities, and various professional and parent organizations to ensure

children and families are connected to the resources and supports they need. The ECI Advisory Committee, which serves as the Interagency Coordination Council required by Part C of IDEA, represents multiple disciplines with members appointed by the governor. The committee advises ECI program staff on development and implementation of policies that constitute the statewide ECI system.

J. Barriers and challenges:

Federal regulations require HHSC to ensure all eligible infants and toddlers receive appropriate ECI services with no waiting lists or service caps allowed. As a result, the ECI program largely functions as an entitlement program without a corresponding entitlement budget. Growth in the number of children served has outpaced state population growth historically, including an increasing number of children served with more complex conditions requiring more intensive services. However, federal funding has not increased comparably, creating program sustainability challenges.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

A. Division or program information:

Name of division or program: WIC

Location within the agency: CPSO

Contact name: Faith Sandberg-Rodriguez, EFND Associate Commissioner

Statutory citation: Child Nutrition Act of 1966, as amended (42 United States Code, Section 1786); Title 7, Code of Federal Regulations, Part 246, Subpart G, Section 246

B. Objective and major activities:

WIC is a nutrition program that helps low-income pregnant, postpartum, and breastfeeding women, infants, and young children up to the age of five receive tailored nutrition education, breastfeeding support, referrals to essential health and community resources, and supplemental nutritious foods. WIC significantly improves short- and long-term health outcomes of Texans by providing families the

education, support, training, and supplemental foods needed during key stages of child development. WIC foods are tailored to the specific nutritional needs of each client and are rich in protein, vitamins C and A, iron, and calcium. These nutrients are vital to healthy development during pregnancy and early childhood.

C. Effectiveness and efficiency information:

WIC reports quarterly on LBB Performance Measure 5.1.2: Number of WIC participants provided nutritious supplemental foods. WIC tracks this metric monthly to assess the effectiveness of the WIC program and outreach efforts.

Since 2019, WIC has collected customer satisfaction data (listed in Attachment 30) via a real-time survey issued to all clients the business day following WIC benefit issuance. When clients express lower satisfaction ratings, local agencies (LAs) are automatically assigned a ticket to follow up with clients and implement necessary changes as needed in their clinics. This data has been pivotal to LAs' ability to continually improve their client service by giving clinic supervisors access to real-time feedback. Overall, WIC has a 96 percent customer satisfaction rate and has seen consistent year-over-year improvements in customer satisfaction scores. Ninety-one percent of WIC clients would recommend their WIC clinic to a friend or colleague.

Additionally, WIC conducts a shopping survey that captures client satisfaction at each WIC-authorized grocery store within 48 hours after the client uses their WIC card to purchase supplemental foods. The WIC Vendor Management and Operations team shares this client feedback with the grocery stores, highlighting areas of opportunity and giving the grocery stores specific feedback to improve the WIC shopping experience. The current statewide satisfaction with shopping score is 4.5 out of 5.0.

D. History: Not applicable

E. Qualifications or eligibility requirements:

Below are the WIC eligibility requirements:

- Residency: Texas resident.
- Percentage of federal poverty level (FPL): At or below 185 percent.
- Program eligibility specific medical condition: Medical or nutrition risk as defined in Title 7, Code of Federal Regulations, Chapter 246.

- Categorical eligibility: Must be a pregnant woman, breastfeeding woman, postpartum woman, infant, or child under the age of 5. Must have a medical or nutritional risk (e.g., history of poor pregnancy outcome, underweight, iron-deficiency anemia, poor eating habits, etc.) that leads to poor nutrition or health status.
- Additional eligibility information: Adjunctive income eligibility through Supplemental Nutrition Assistance Program (SNAP), TANF, or Medicaid.

Table 2. Fiscal year 2024 WIC participation by client type.

Client Type	Number and Percent of Clients
Women	2,505,652 (26.6%)
Infants	2,243,610 (23.9%)
Children	4,652,839 (49.5%)
Total	9,402,101

F. Administration and key processes:

Administering WIC occurs through 62 contracted service providers (LAs). LAs provide services in all 254 Texas counties and deliver services directly to WIC clients through certification and enrollment in the program, issuance of benefits on an electronic benefit transfer (EBT) card, nutrition education, and breastfeeding support. WIC uses a funding formula based on the number of clients each LA serves to distribute funds.

When a client enrolls in the WIC program, the client can redeem food benefits at any of the 2,200 WIC-authorized grocery stores located across the state.

G. Funding: See “Agency Program Information” spreadsheet.

WIC receives most funding from the United States (U.S.) Department of Agriculture, Food and Nutrition Services (USDA-FNS). Other funds include revenue-generating rebate contracts with infant formula manufacturers. Title 7, Code of Federal Regulation, Section 246.16, requires rebate contracts, and those funds must be spent on food benefits.

Additional federal funding for WIC includes:

- American Rescue Plan Act: Offline to Online EBT Grant used for transitioning Texas from an offline EBT smartcard system to an online system called eWIC; and

- American Rescue Plan Act: WIC Modernization funds will be used for adding enhancements to the WIC management information system, vendor and client portals and the myWIC mobile application.

During the 2024-25 biennium, WIC-appropriated funds also included two USDA-FNS grant awards for SNAP-Education (SNAP-Ed) and Breastfeeding Peer Counseling.

H. MOUs and interagency agreements or contracts:

WIC shares an intra-agency transfer of federal funds with the HHSC's SNAP-Ed Program. WIC receives SNAP-Ed funding to provide behaviorally focused, evidence-based nutrition education and obesity prevention interventions to the SNAP-Ed target audience through WIC local agencies.

I. Relationship with other governmental entities:

WIC works with multiple levels of government to administer the program. At the federal level, USDA-FNS provides funding for WIC services and monitors WIC for compliance with federal regulations.

At the regional and local level, 45 of the 62 contracted service providers are local city and county governments, state institutions of higher education, or other political subdivisions, and deliver WIC services in their jurisdictions. The remaining 17 entities are non-profit organizations. Many LAs operate multiple clinic sites to support local access by clients.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint information: Not applicable.

Family and Youth Services and Supports

Family and Youth Services and Supports (FYSS) oversees the administration and operations of client service and educational programs that address family violence and human trafficking; improve child, youth, and family well-being; and promote healthy birth outcomes. This business area provides general support services to FYSS programs and staff, including strategic, operational, and procedural support and technical guidance to internal and external stakeholders.

Child Advocacy Centers and Court Appointed Special Advocates

A. Division or program information:

Name of division or program: Child Advocacy Centers (CAC) and Court Appointed Special Advocates (CASA). The same contract administration manager administers the CAC and CASA programs. Internally, FHS collectively refers to the CAC and CASA programs as the "Child Advocacy Program."

Location within the agency: CPSO

Contact Name: Joy Borjes, FYSS Associate Commissioner

Statutory citation: CAC - Texas Family Code, Chapter 264, Subchapter E; CASA - Texas Family Code, Chapter 264, Subchapter G

B. Objective and major activities:

HHSC's Children's Advocacy Program provides critical advocacy services for children who have experienced abuse, witnessed violence, or are in the custody of DFPS. HHSC contracts with one statewide organization to administer services for children's advocacy services and one statewide organization for children's court appointed advocacy services.

The CAC and CASA program area includes oversight of funds management, contract administration, contract monitoring, oversight of program operations, and provision of technical assistance to the contracted providers, CAC of Texas, and Texas CASA (TXCASA).

C. Effectiveness and efficiency information:

For CACs, HHSC collects data, including the number of new children served, the total number of children served, the number of forensic interviews conducted on-site, the number of child abuse cases reviewed by multidisciplinary teams, and the number of local programs.

In fiscal year 2024, HHSC added new required performance outcomes to the contract with TXCASA. There are three outcome measures to increase child safety, improve children's connections to community, and improve advocacy and support for children's overall well-being. HHSC collects quantitative data to measure each of these outcomes.

D. History:

The current Texas CASA contract executed in fiscal year 2022 is the first volunteer advocate program contract procured by HHSC. The contract was previously administered by the Office of the Attorney General (OAG). Responsibility for CASA was transferred to HHSC in fiscal year 2016.

E. Qualifications or eligibility requirements:

For CAC, eligible clients include child victims of physical and sexual abuse as referred by law enforcement to DFPS, and their families. After they reach adulthood, survivors of abuse may continue to receive services.

For CASA, the maximum age requirement is 21 years of age. Children are eligible if they are involved with the dependency court system due to abuse, neglect, or abandonment and are in the care of the DFPS.

Table 3. Fiscal year 2024 Texas CASA data.

	Counts
Total Children Served	17,864
New Children Served	6,098
Active CASA Volunteers	7,401
Inactive CASA Volunteers	1,444
New CASA Volunteers	2,247
Local Programs	73
Counties Served	217

Table 4. Fiscal year 2024 CACTX data.

	Counts
Total Children Served	60,328
New Children Served	48,861
Families Receiving Advocacy Services	53,050
Forensics Interviews Conducted On-Site	40,539
Child Abuse Cases Reviewed by Multidisciplinary Team	34,117
Children Receiving Mental Health Services	73
Children Receiving Medical Services	7,386
Children Receiving Sex Trafficking Care Coordination	815
Training Sessions Provided to Local Advocacy Centers	304
Local Programs	70
Counties Receiving Full Services	209

Table 5. Child Advocacy Programs demographic data for new children for fiscal year 2024.

	CACTX	CASA
Sex of New Children:		
Male	17,518	8,902
Female	31,236	8,864
Unknown	107	98
Age Groups of New Children:		
Ages 0-5	9,757	8,645
Ages 6-12	22,014	5,423
Ages 13-17	16,741	3,485
Ages 18+	349	310
Age Unknown	0	1
Ethnicity of New Children:		
American Indian or Alaskan Native	N/A	101
Asian	328	46
Black	7,179	4,342
Hispanic	21,708	N/A
Native American/Other Pacific Islander	105	14
White	15,920	11,060
Multi-Racial	1,512	1,541
Other	466	366
Ethnicity Unknown	1,643	394

F. Administration and key processes:

HHSC administers CAC and CASA as grants. HHSC selected the grantees following a competitive procurement. HHSC and each grantee meet monthly, with ongoing provision of technical assistance and support. HHSC also conducts quarterly enhanced monitoring.

G. Funding: See “Agency Program Information” spreadsheet.

The fiscal year 2024 funding for CACs includes general revenue, general revenue – Dedicated Sexual Assault Program Account No. 5010, and Social Services Block Grant to Title XX. The funding sources for CASA are general revenue and donations.

Fiscal year 2024 grant amount for CASA also includes funds from License Plate Trust Fund Account No. 0802.

H. MOUS and interagency agreements or contracts: Not applicable

I. Relationship with other governmental entities:

For CAC, this question is not applicable.

For CASA, HHSC coordinates with DFPS for children in conservatorship. Additionally, HHSC is currently working with the Texas Department of Public Safety (DPS) on the Federal Bureau of Investigations (FBI) audit and fingerprinting agreement.

J. Barriers and challenges:

According to grantee and subgrantees, some regions' law enforcement agencies are experiencing an increase in caseload and a decrease in available investigators, which puts a strain on all partners. There continue to be issues with the lack of access to qualified mental health providers for children and families, especially in rural areas of Texas.

K. Additional information:

As a result of an FBI audit finding for DPS, HHSC now must manage TXCASA's access to criminal history record information of CASA volunteers via the FBI Criminal Justice Information Services (CJIS) database system. HHSC is working to implement an outsourcing agreement with TXCASA to grant TXCASA the oversight of the local CASAs and their access to CJIS.

L-M. Regulatory and Complaint information: Not applicable.

Family Violence Program

A. Division or program information:

Name of division or program: Family Violence Program (FVP)

Location within the agency: CPSO

Contact name: Joy Borjes, FYSS Associate Commissioner

Statutory citation: Texas Human Resources Code, Chapter 51

B. Objective and major activities:

FVP promotes safety, self-sufficiency, and long-term independence for adult and child survivors of family violence and survivors of dating violence. Through a network of trauma-informed service providers, FVP provides emergency shelter and supportive services to survivors and their children, educates the public, provides training, and offers prevention support to various organizations across Texas.

Funding enables FVP grantees to offer a wide array of emergency support and prevention services to help people escape the cycle of family violence. Since the program's inception in 1981, FVP has grown from an original partnership with six local shelters to a service network of nearly 100 grantees.

FVP's responsibilities include oversight of funds management, contract administration, contract monitoring, oversight of program operations, and provision of technical assistance to contracted entities.

C. Effectiveness and efficiency information:

To assess effectiveness and efficiency of this program, HHSC collects information on the number of adults and children served, services provided, and the number of people denied shelter, along with the reason for denial. The program also collects and analyzes client survey responses regarding safety and resources.

D. History:

S.B. 1841, 88th Legislature, Regular Session, 2023, made significant changes to the FVP authorizing statute, Texas Human Resources Code, Chapter 51. Statute now requires all FVP centers to develop and use a trauma-informed service model and requires access to counseling and peer support services. Title 26, Texas Administrative Code, Chapter 356, operationalizes the trauma-informed service model, counseling, and peer support services changes.

E. Qualifications or eligibility requirements:

The sole eligibility basis for FVP services is the individual's status as a victim of family violence. Below is a breakdown of FVP clients by age and by race/ethnicity. Clients under 18 enter services with a parent. Additionally, the breakdown by sex of all clients served is 79.3 percent female, 19.8 percent male, and less than 1 percent refused.

Table 6. Unduplicated FVP client ages for fiscal year 2024.

	Count
Zero – 12:	18,181
13 – 17	4,814
18 – 24	5,583
25 – 59	35,967
Over age 60	1,930
Refused	55
Unknown Adult	75
Unknown Child	52
Unknown	172
Total	66,829

Table 7. Unduplicated FVP client ethnicity for fiscal year 2024.

	Count
American Indian/Alaskan Native	288
Asian	1,395
Black or African American	14,810
Hispanic or Latino	27,929
Multi-racial	2,681
Native Hawaiian/other Pacific Islander	130
White	16,784
Other	1,485
Refused	180
Unknown	1,147
Total	66,829

F. Administration and key processes:

All states and US territories receive Family Violence Prevention and Services Act (FVPSA) funds to provide shelter and supportive services. FVP administers these dollars, along with any additional state funding, to shelters and nonresidential service providers. FVP makes funding decisions based on an allocations plan, developed in consultation with the statewide domestic violence coalition, as required by federal law.

FVP processes include monthly and quarterly expenditure reporting, and monthly performance data review. FVP investigates complaints and performs financial or programmatic monitoring to ensure grantees are providing good customer service. Additionally, FVP contracts with the statewide domestic violence coalition to provide technical assistance and training to FVP grantees.

G. Funding: See “Agency Program Information” spreadsheet.

Table 8. FVP funding sources.

Funding Source	Method of Finance
General Revenue	State
Temporary Aid to Needy Families to Title XX	Federal
Social Services Block Grant (SSBG)	Federal
Family Violence Prevention and Services Act	Federal
American Rescue Plan Grants (expires 9/30/2025)	Federal
Appropriation Receipts (donations)	Other

Because of the complicated funding structure, shelters and nonresidential centers receive payment from a blended department ID. The blended department ID includes general revenue, TANF, SSBG, and FVPSA funds. FVP refers to this blended department ID as a “factor.”

H. MOUs and interagency agreements or contracts: Not applicable

I. Relationship with other governmental entities:

FVP coordinates with the U.S. Department of Health and Human Services (DHHS) Administration of Children and Families, Office of Family Violence Prevention and Services (OFVPS). OFVPS provides FVP formula grant funding, training, and technical assistance. In addition, FVP works closely with the Office of the Governor and OAG to coordinate FVPSA funding with Violence Against Women Act and Victims of Crime Act funding.

J. Barriers and challenges:

- Challenge 1: Limited shelter capacity results in the denial of approximately half of all requests for shelter due to unavailable space.
- Challenge 2: Grantees have consistently reported there is a lack of affordable housing, childcare, and transportation across the state.
- Challenge 3: Mental health services have been identified by grantees and by research as an unmet need.
- Challenge 4: FVP grantees report barriers and challenges at the local level, which can interfere with a survivor’s ability to establish self-sufficiency.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Human Trafficking Support

A. Division or program information:

Name of division or program: Human Trafficking Support

Location within the agency: CPSO

Contact Name: Joy Borjes, FYSS Associate Commissioner

Statutory citation: Texas Occupations Code, Chapters 116 and 301; Texas Health and Safety Code, Chapter 50

B. Objective and major activities:

Human Trafficking Support provides oversight of the statutorily required human trafficking prevention training program for licensed health care practitioners statewide in Texas. Program staff approve curriculum for instruction and provide technical assistance to health care practitioners who are required to take an HHSC-approved human trafficking prevention course.

Program staff developed and maintain a human trafficking course, HEART, available free of charge as required by Texas Occupations Code, Section 116.002(b)(1).

In some cases, survivors of human trafficking may contact program staff regarding resources and obtaining support directly. Program staff provide links to resources and relevant services through trauma-informed interactions with survivors by phone or by email. Most often, survivors are referred to the National Human Trafficking Hotline for more comprehensive support.

C. Effectiveness and efficiency information:

HHSC collects information about HEART utilization. On average, more than 10,000 health care practitioners per month complete HEART training to identify and assist potential victims of trafficking who seek medical and mental health care in Texas. Based on course evaluations, more than 95 percent of respondents strongly agreed the course is effective.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

All licensed health care practitioners in Texas are required to complete an HHSC-approved course to renew their license. Since 2021, over 300,000 licensed health care practitioners have completed the HHSC-developed HEART training.

Any individual or entity may submit a course to be reviewed and approved by HHSC.

H.B. 472, 89th Legislature, Regular Session, 2025 expanded the required training program to include first responders, H.B. 754, 89th Legislature, Regular Session, 2025 expanded the training to medical assistants, and H.B. 1778, 89th Legislature, Regular Session, 2025 expanded the training to tattoo artists.

F. Administration and key processes:

HHSC staff receive courses for approval via email and conduct a thorough review to ensure courses meet designated standards such as offering a certificate of completion, defining trafficking, and providing best practices for identifying and responding to survivors. Staff work with trainers or training organizations to address deficiencies. Once approved, staff maintain a list of approved courses online. Individual licensees are responsible for taking training and submitting proof of attendance to their respective licensing boards. HHSC works with licensing boards as needed to assist with confirming approved courses.

G. Funding: See “Agency Program Information” spreadsheet.

There is no dedicated appropriation for this work. HHSC uses FVP funds to support staff. In addition to the health care practitioner training requirements, the Texas Health and Safety Code, Chapter 50, requires HHSC to establish a program to improve the quality and accessibility of care for victims of child sex trafficking and a matching grant program for municipalities for the development of a trafficking prevention needs assessment.

Texas Health and Safety Code, Section 50.0102, states that HHSC may use donations in addition to appropriated funds for the matching grant program. However, HHSC does not receive sufficient donations to establish these programs.

H. MOUs and interagency agreements: Not applicable

I. Relationship with other governmental entities:

Human Trafficking program staff works with OAG and the Human Trafficking Prevention Task Force and Coordinating Council on general anti-trafficking efforts. As mentioned above, staff will also work with licensing boards when confirming approved courses.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint information: Not applicable.

SMART Innovation Grant

A. Division or program information:

Name of division or program: Supporting Mental Health and Resiliency in Texans (SMART) Innovation Grant

Location within the agency: CPSO

Contact name: Joy Borjes, FYSS Associate Commissioner

Statutory citation: Texas Government Code, Section 531.09915

B. Objective and major activities:

SMART Innovation is a state-funded grant program to provide community-based initiatives that improve access to early mental health intervention and treatment for children and families. The SMART Innovation business area supports the procurement and management of grant-funded services.

C. Effectiveness and efficiency information:

SMART Innovation measures outcomes with client pre and post-test evaluations. Grantees report these measures to HHSC on a quarterly basis. Performance measures include the following:

- Resiliency;
- Coping and social skills;
- Healthy social and familial relationships;
- Parenting skills and behaviors;
- Improved relationship skills;

- Improved self-esteem;
- Deferred from JJ;
- Relinquishment/CPS prevention; and
- Emergency room use prevention.

D. History: Not applicable.

E. Qualification or eligibility requirements:

Below are the SMART Innovation grant eligibility requirements:

- Age Requirement: Zero to 17 years of age.
- Additional Eligibility Information: Eligible population to be served is children demonstrating atypical social or emotional development or other challenging behaviors.

As this program was launched in the final two months of fiscal year 2024, reliable client information will not be available until the end of fiscal year 2025.

F. Administration and key processes:

FYSS administers the program through a competitive Request for Applications. One program specialist and two contract managers provide training and technical assistance to SMART Innovation grantees. The program completes regular grantee monitoring to ensure financial and programmatic compliance and high-quality service delivery to clients.

G. Funding: See “Agency Program Information” spreadsheet.

H-J. MOUs and interagency agreements, relationships, and barriers and challenges: Not applicable

K. Additional information:

SMART Innovation staff work closely with Behavioral Health Services (BHS) and FSS within HHSC, to ensure services are complementary and not duplicative. The programs hold collaborative workgroup meetings and inventory of prevention programs.

HHSC saw a slight decrease in funding for the 2026-27 biennium, which may impact program performance. SMART Innovation was appropriated \$14,762,133 per year for fiscal years 2026-27.

L-M. Regulatory and Complaint information: Not applicable.

Community Services Grant Houston

A. Division or program information:

Name of division or program: Community Services Grant (CSG) Houston

Location within the agency: CPSO

Contact Name: Joy Borjes, FYSS Associate Commissioner

Statutory citation: 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article IX, General Provisions, Section 17.32)

B. Objective and major activities:

CSG connects individuals in need with community crisis pregnancy services, foster care outreach, and community services in the greater Houston area, including adjacent counties of Austin, Brazoria, Chambers, Fort Bend, Galveston, Harris, and Liberty. CSG grantees ensure individuals in need connect to the requested resources and develop partnerships with organizations which provide relevant services including housing, food, safety, and behavioral health.

C. Effectiveness and efficiency information:

Client metrics are reported on a monthly basis and stem from outreach activity attendance. CSG reports statistics on the number of individuals who were connected to services from these events. This monthly data submission is paired with a narrative workbook detailing and describing each communication and outreach activity from the month. This gives in-depth analysis behind each event and how effective the outreach was at reaching the target population. From the number of individuals connected, to reaching the target population, and then to expanding partnerships with crisis pregnancy services, foster care services, and other relevant community services, the narrative workbook provides the necessary feedback for effectiveness and efficiency.

Performance measures include:

- Number of individuals to be connected to services;
- Number of greater Houston areas to be targeted; and
- Impact of outreach and communication efforts.

D. History: Not applicable

E. Qualifications or eligibility requirements:

Texas residents and any individual in need of community crisis pregnancy services, foster care services, and any other community services in the greater Houston area are eligible.

F. Administration and key processes:

FYSS administers CSG through two grant agreements, procured competitively. These grants provide community crisis pregnancy services, foster care outreach services and referrals, and community services in the greater Houston area. Processes include contract management and performance data oversight, quarterly performance meetings, and a fiscal expenditure review process.

HHSC supports CSG grantees to develop financial workbooks to ensure financial integrity and data workbooks to ensure deliverables are focused and beneficial. CSG grantees receive guidance and technical assistance from HHSC staff.

G. Funding: See “Agency Program Information” spreadsheet.

H-M. MOUs and interagency agreements, relationships, barriers and challenges, additional information, regulatory and complaint information: Not applicable

Abstinence Education

A. Division or program information:

Name of division or program: Abstinence Education Program (AEP)

Location within the agency: CPSO

Contact Name: Joy Borjes, FYSS Associate Commissioner

Statutory citation: 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 58)

B. Objective and major activities:

Direct service grantees implement medically accurate, evidence-based abstinence education programs. The programs teach personal responsibility, self-regulation, goal setting, and healthy decision-making with a focus on the future and the prevention of youth risk behaviors such as drug and alcohol use. AEP highlights a positive youth development approach to reduce teen pregnancy rates and the spread of sexually transmitted infections. In fiscal year 2024, AEP began providing direct services to Texas independent school districts whose schools were unable to receive assistance from program service providers. This initiative supports schools by coordinating teacher training, providing curriculum materials, and offering technical assistance to ensure compliance with grant requirements.

C. Effectiveness and efficiency information:

HHSC measures the program's effectiveness using analysis of individual surveys administered by the University of Texas Health Science Center at Houston and internal dashboards. Youth scores specify outcome measures related to sexual risk avoidance and associated knowledge, attitudes, and behaviors. Scores are reported to reflect the average performance of youth participants on these measures, providing a quantifiable assessment of the program's impact. HHSC also reports to the LBB the number of persons served by AEP.

D. History: Not applicable

E. Qualifications or eligibility requirements:

In fiscal year 2024, AEP served 33,579 Youth, including 17,106 males and 16,473 females.

Below are the AEP eligibility requirements:

- Residency: Texas resident.
- Age Requirement: 10 to 19 years of age.

F. Administration and key processes:

Refer to the response to Question B and [Section 7 Chief AEP Program Requirement](#) attachment.

In addition to the Program Requirement attachment, the program tracks monthly clients served and ensures only one grantee is providing services per school location.

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements:

HHSC and grantees must establish MOUs with the participating school districts. An interagency agreement with the University of Texas Health Science Center at Houston facilitates the administration and analysis of survey data while also monitoring previously served locations.

I-M. Relationships, barriers and challenges, additional information, regulatory and complaint information: Not applicable

Healthy Marriage Program

A. Division or program information:

Name of division or program: Healthy Marriage Program (HMP)

Location within the agency: CPSO

Contact name: Joy Borjes, FYSS Associate Commissioner

Statutory citation: Texas Family Code, Section 2.013; Texas Human Resources Code, Sections 31.015 and 31.018.

B. Objective and major activities:

HMP connects couples to marriage education providers on the HHSC-funded Twogether in Texas website. The website allows couples to locate pre-marital service providers who conduct marriage education classes. Additionally, completion of a Twogether in Texas pre-marital course allows participants to receive a discount on their marriage license and a waiver to the 72-hour waiting period.

C. Effectiveness and efficiency information:

HMP tracks the number of providers, participants, and certificates issued monthly.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

No eligibility criteria exist for use of the Twogether in Texas website; however, only Texas residents are eligible to receive a discount on their marriage license.

Providers must meet certain eligibility criteria to be listed on the website directory. Providers may include marriage educators; clergy or their designees; licensed mental health professionals; faith-based organizations; or community-based organizations in accordance with the Texas Family Code, Section 2.013(c).

The HMP Twogether in Texas website maintains the records of how many participants successfully complete the program and the number of providers and certificates issued. In fiscal year 2024 HMP had 307 providers, 26,602 participants, and issued 13,306 certificates.

F. Administration and key processes:

HMP maintains the Twogether in Texas portal with a directory of pre-marital education providers who meet certain criteria and provide technical guidance to vendors for the program. HMP staff review and approve curricula to ensure the curricula align with Texas Family Code, Section 2.013, before a course can be certified. Providers must teach a minimum of 8-hours curriculum to reflect conflict management, communication skills, and the key components of a successful marriage. Once participants have completed a course, they will receive a certificate of completion.

HMP uses a curriculum review tool to document quality assurance reviews of pre-marital curriculum to ensure that each provider presents a curriculum in accordance with the Texas Family Code, Section 2.013.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUS and interagency agreements: Not applicable

I. Relationship with other governmental entities:

HMP may work with local counties to assist with marriage license questions; however, there is limited interaction with any government unit.

J-M. Barriers and challenges, additional information, regulatory and complaint information: Not applicable

Judicial Bypass

A. Division or program information

Name of division or program: Judicial Bypass

Location within the agency: CPSO

Contact Name: Joy Borjes, FYSS Associate Commissioner

Statutory Citation for Program: Texas Family Code, Chapter 33

Since Texas Health and Safety Code, Section 170A.001, took effect in July 2021, the program has not been active. The remainder of the questions are not applicable.

Thriving Texas Families

A. Division or program information:

Name of division or program: Thriving Texas Families and Support

Location within the agency: CPSO

Contact Name: Joy Borjes, FYSS Associate Commissioner

Statutory citation: Texas Health and Safety Code, Chapter 54; 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 65)

Thriving Texas Families is excluded from sunset review under Texas Government Code, Section 531.0045. The remainder of the questions are not applicable. Additional information may be made available upon request. Sections B-J and L-M not applicable to TTF program.

Family Clinical Services

The Family Clinical Services (FCS) department administers a range of primary and preventive health programs and initiatives, mainly serving women and children. Health care providers across the state deliver these services to eligible Texas residents through grant agreements FCS oversees. This business area provides general support services to FCS programs and staff, including strategic, operational, and procedural support and training and technical assistance to grantees.

FCS coordinates efforts to improve the health and well-being of Texas women and their families. Efforts include statewide planning of strategic initiatives with internal and external stakeholders; training and education initiatives; and performing complex consultative services and technical assistance work.

FCS programs provide similar primary and preventive services to low-income populations. Attachment [S7 CPSO FCS Programs](#) illustrates the populations served by FCS programs and their FPL eligibility.

Family Planning Program

A. Division or program information:

Name of division or program: Family Planning Program (FPP)

Location within the agency: CPSO

Contact name: Marissa Acosta, FCS Associate Commissioner

Statutory citation: Texas Government Code, Section 531.0025; Texas Family Code, Chapter 32; 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Riders 61, 64(c), 66, 69, and 70)

B. Objective and major activities:

FPP helps fund clinic sites across the state to provide high-quality, comprehensive, low-cost, and accessible family planning and reproductive health care services to Texans. Family planning and reproductive health services help people plan the number and spacing of their children, reduce unintended pregnancies, improve future pregnancy and birth outcomes, and improve general health.

FPP services include family planning counseling, contraception, including insertion and removal of long-acting reversible contraceptives (LARCs), pregnancy testing

and counseling, permanent sterilization, preconception health screenings, sexually transmitted infection (STI) services, screening and treatment for high cholesterol, diabetes, hypertension and postpartum depression, breast and cervical cancer screening services, clinical breast exams, immunizations, and limited prenatal benefits. Postpartum depression providers also screen for postpartum depression if a client was pregnant in the past year.

While funding for client services is on a fee-for-service (FFS) basis, some providers also receive cost reimbursement funds to help support the provision of FPP services. Allowable cost reimbursement categories include, but are not limited to, administrative personnel, supplies, and equipment.

C. Effectiveness and efficiency information:

Texas Women's Health Programs Report measures include the following:

- Total number of FPP providers;
- Total unduplicated FPP clients served;
- Average number of FPP clients per provider;
- Median number of FPP clients per provider;
- Number of women receiving a LARC; and
- Service utilization by procedure code.

Data source(s) for the Texas Women's Health Programs Report for FPP are HHSC Data, Analytics, and Performance, HHSC Forecasting, and Texas Medicaid and Healthcare Partnership (TMHP). FCS does not determine the methodology for these performance measures.

- FCS monitors LBB measures to assess effectiveness and efficiency. LBB measures include the average monthly number of Family Planning clients receiving services, and the average monthly cost per Family Planning client receiving services.

Starting in fiscal year 2026, HHSC will require grantees to provide quarterly reports on their choice of HHSC-approved performance measures related to improving health outcomes and/or reducing healthcare costs. In addition, funded patient navigators (PNs) at FPP clinic sites will report quarterly on associated outcomes.

D. History: Not applicable

E. Qualifications or eligibility requirements:

TMHP collects and manages limited FPP client demographic data. In fiscal year 2024, FPP served 146,689 clients.

To qualify for FPP, applicants must first be screened to determine eligibility for the following programs that provide family planning services in this order: Medicaid, Healthy Texas Women (HTW), and FPP. Below are the FPP eligibility requirements:

- Residency: Texas resident
- Age Requirement: 0 to 64 years of age
- Sex: Male, Female
- Medicaid: Not Medicaid enrolled
- Medicare: Not Medicare enrolled
- Children's Health Insurance Plan (CHIP): Not CHIP enrolled
- Income: Percentage of Federal Poverty Level: 250 percent
- Additional Eligibility Information: Applicants with insurance may be eligible for services provided by FPP when the applicant's confidentiality is a concern or if the applicant's insurance deductible is five percent or greater than their income.

F. Administration and key processes:

FCS administers the program through the grants awarded by a competitive procurement process. There are currently 49 grantees.

Billing of FPP services to TMHP occurs on a FFS basis. FPP providers may opt to add cost reimbursement funding to their grant agreement when they apply for initial funding awards. The cost reimbursement portion of FPP funding is to develop and support grantee infrastructure for the provision of family planning services, such as personnel, fringe benefits, staff travel, contractual services, equipment, supplies, and other direct and indirect costs per state and federal requirements. Grantees may spend up to 25 percent of their award on cost reimbursement. HHSC processes and reimburses cost reimbursement funds through an internal invoice process outside of TMHP.

G. Funding: See "Agency Program Information" spreadsheet

H-M. MOUs and interagency agreements, relationships, barriers and challenges, additional information, regulatory and complaint information: Not applicable

Healthy Texas Women-Cost Reimbursement

A. Division or program information:

Name of division or program: Healthy Texas Women - Cost Reimbursement (HTW-CR)

Location within the agency: CPSO

Contact name: Marissa Acosta, FCS Associate Commissioner

Statutory Citation: 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Riders 63 and 69)

B. Objective and major activities:

In 2015, the Sunset Commission directed HHSC and DSHS to consolidate the Texas Women's Health Program with another state-funded program that provided family planning services. In 2016, HHSC implemented the HTW program through a combined FFS and CR model. The FFS component of HTW provides no cost family planning and women's health services. The CR component was launched to fund provider infrastructure and support the overall outcomes for HTW clients. Medicaid and CHIP Services (MCS) administers the FFS component of HTW. FCS administers the CR component of HTW and provides reimbursement to a limited number of HTW-enrolled providers for operational infrastructure to support the delivery of HTW direct care services.

The 88th Legislature appropriated funds to facilitate and expedite access to HTW (2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 63)). The funding supports the hiring of on-site practical nurses at clinic sites operated by HTW-CR grantees to facilitate enrollment into women's health programs.

C. Effectiveness and efficiency information:

HTW-CR grantees who also receive HTW-CR PN funding must submit quarterly reports to monitor client service levels. To increase effectiveness of the program,

HHSC hosts monthly calls with HTW-CR grantees with dedicated PNs. Several grantees requested this collaborative effort and the monthly calls serve as a community of practice for women's health service coordination best practices.

HTW-CR PN performance measures include the following:

- Number of new unduplicated individuals who are screened for services;
- Number of new unduplicated clients served by HTW-CR PN funded patient navigator(s);
- Number of new unduplicated clients served successfully navigated to existing women's and preventive health care service programs; and
- Number of non-medical service needs identified through initial assessment (ex. food, transportation, housing, childcare, and employment).

The data source for the HTW-CR PN performance measures are grantee reports. The methodologies used are the actual count of unduplicated clients served and actual count of non-medical service needs, which are self-reported by clients.

D. History: Not applicable

E. Qualifications or eligibility requirements:

To be eligible for HTW-CR funding, the grantee must be an HTW FFS provider. HTW-CR awards may be used to fund personnel, fringe benefits, staff travel, contractual services, equipment, supplies, other direct costs, and indirect costs per state and federal requirements and must be reasonable, allowable, and already allocated. No more than five percent of the payments received under an HTW-CR contract may be used for expenses related to performing administrative functions derived from subcontracting the terms of the contract.

FCS collects limited clients served data related to PN services. In fiscal year 2024, HTW-CR PNs screened 6,868 clients for non-medical service needs.

F. Administration and key processes:

FCS administers the program through the grants awarded by a competitive procurement process. There are currently 32 grantees.

Billing for HTW-CR occurs on a cost reimbursement basis. HHSC processes billing and reimbursement using an internal invoice process. Grantees submit monthly invoices to HHSC for processing.

G. Funding: See “Agency Program Information” spreadsheet.

H-I. MOUs and interagency agreements and Relationships with others: Not applicable

J. Barriers and challenges:

2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 69), required HHSC to give PNs appropriate access to TIERS to facilitate client HTW enrollment. Due to confidentiality concerns and the need for intensive technology changes to TIERS to facilitate such access, HHSC could not give external stakeholders access to TIERS. Instead, HHSC required grantees to enroll in the Community Partner Program (CPP) as Level 3 providers, which means having an on-site computer for clients to manage benefits, trained staff to help with applications, and case assistance navigators available for specialized support. This requirement necessitated each grantee entering an MOU with CPP. That process took several months or more per grantee. In addition, Level 3 accesses did not provide the information necessary for grantees to fully provide application assistance to clients. As a result, most grantees are not using the Level 3 access resource. As a result, FCS removed this requirement in the next request for applications (RFA) and plans to continue providing training and technical support to grantees to fulfill this requirement.

K-M. Additional information, regulatory and complaint information:
Not applicable

Women’s Preventive Mobile Health Units

A. Division or program information:

Name of division or program: Women's Preventive Mobile Health Units (MHU)

Location within the agency: CPSO

Contact name: Marissa Acosta, FCS Associate Commissioner

Statutory citation: 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 67)

B. Objective and major activities:

The MHU program provides funding to health care providers for purchase and operation of MHUs to help expand service capacity to areas of the state where access to women's preventive health services is not readily available. MHUs provide preventive healthcare services and screen women for and may help them enroll in existing women's health programs such as Medicaid, HTW, FPP, and Breast and Cervical Cancer Services (BCCS). Attachment [S7 CPSO Women's MHU Map](#) shows the counties covered by the seven MHUs.

C. Effectiveness and efficiency information:

MHU grantees must report quarterly on performance measures, including mobile unit site activities, client service delivery and referrals to existing women's health programs, and health outcomes as specified in the grantee's proposal.

The data source for the Women's Preventive MHU are grantee reports. The methodology for mobile unit activities is calculated mileage to and from site activities, the number of days the unit performed services, the zip code of the clients served, and actual count of types of services provided. Health outcome methodologies vary depending on the grantee's proposal; however, grantees determine baseline and target performance goals, and report on these throughout the grant period. For example, each MHU chose to improve patient health outcomes by increasing screening rates for STIs, cervical cancer, or hypertension and diabetes and set target goals for screening rates. One MHU chose to improve health outcomes by managing chronic disease and set a target goal to reduce the A1C (a person's average blood sugar levels over the past 2-3 months) or body mass index (BMI) of each patient diagnosed with diabetes by the end of the grant period.

D. History: Not applicable

E. Qualifications and eligibility requirements:

Below are the MHU eligibility requirements:

- Residency: Texas resident
- Age Requirement: 0 to 64 years of age

- Sex: Female
- Medicaid: Not Medicaid enrolled
- Medicare: Not Medicare enrolled
- CHIP: Not CHIP enrolled
- Insurance: No state or federal health care program coverage
- Income: Percentage of FPL: 250 percent
- Additional Eligibility Information: Applicants with insurance may be eligible for services provided by Women's Preventive MHUs, when the applicant's confidentiality is a concern or if the applicant's insurance deductible is five percent or greater than their income.

FCS does not collect demographic data for MHU clients. In fiscal year 2024, Women's Preventive MHUs served 524 clients.

F. Administration and key processes:

FCS administers the program through the grants awarded by a competitive procurement process. There are currently seven grantees.

Billing for MHU services occurs on a cost reimbursement basis. HHSC processes billing and reimbursement using an internal invoice process. Grantees submit monthly invoices to HHSC for processing.

G. Funding: See "Agency Program Information" spreadsheet.

H-M. MOUs and interagency agreements, relationships, barriers and challenges, additional information, regulatory and complaint information: Not applicable

Breast and Cervical Cancer Screening

A. Division or program information:

Name of division or program: BCCS

Location within the agency: CPSO

Contact name: Marissa Acosta, FCS Associate Commissioner

Statutory Citation: Texas Government Code, Chapter 531; Texas Human Resources Code, Chapter 32; 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Riders 61 and 66)

B. Objective and major activities:

BCCS is a state and federally funded program that funds clinics across the state to provide quality and accessible cancer screening and diagnostic services to eligible women. BCCS services include clinical breast exams, mammograms, pelvic exams and pap tests, diagnostic services including ultrasounds and biopsies, cervical dysplasia management and treatment, patient navigation, and application assistance for Medicaid for Breast and Cervical Cancer (MBCC).

BCCS is a grantee of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) administered by the U.S. Centers for Disease Control and Prevention (CDC). The goal of NBCCEDP is to decrease cancer incidence, morbidity, and mortality by focusing on underserved populations, who have increased cancer risk due to gaps in timely screening and care. Eligible clients receive these services free of charge. Regular screening tests can find precancerous tissue or cancer early when treatment is likely to work best.

C. Effectiveness and efficiency information:

Texas Women's Health Programs Report measures include the following:

- Total number of BCCS providers;
- Total unduplicated BCCS clients served;
- Average number of BCCS clients per provider;
- Median number of BCCS clients per provider; and
- Service utilization by procedure code.

The data source for the Texas Women's Health Programs Report for BCCS is Med-IT®, the BCCS client data and claims processing database, operated by a third-party vendor. The methodology used for Texas Women's Health Program Report client service delivery is the unduplicated clients served and actual count of BCCS providers. The Med-IT® query calculates the average and median number of BCCS clients per provider.

BCCS providers must meet NBCCEDP performance measures. Table 9 contains performance measures used to assess, in part, the grantee's effectiveness in providing BCCS services.

The data source for NBCCEDP performance measures is Med-IT®. The methodology used is based on NBCCEDP algorithms, designed to calculate key indicators such as the number of women served. Key metrics include the date last screened, patient risk-level, and the percentage of patients within the total patient population served who meet each clinical benchmark.

Table 9. NBCCEDP performance indicators.

Description	Goal
Percentage of women aged 30 and older receiving their first cervical cancer screening through the program who have never been screened or not screened within the last 10 years	Greater than or equal to 35%
Percentage of cervical cancer screening records with planned and completed diagnostic follow-up	Greater than or equal to 90%
Percentage of cervical cancer screening records with planned and completed diagnostic follow-up and time between screening and final diagnosis less than 60 days	Greater than or equal to 75%
Percentage of cervical cancer records with a final diagnosis of High-Grade Squamous Intraepithelial Lesion (HSIL), CIN2, CIN3/CIS, or invasive cervical cancer that have treatment started	Greater than or equal to 90%
Percentage of cervical cancer records with a final diagnosis of HSIL, CIN2, CIN3/CIS, or invasive cervical cancer with time between final diagnosis and treatment less than 60 days	Greater than or equal to 80%
Percentage of breast cancer screening records with abnormal results and completed diagnostic follow-up	Greater than or equal to 90%
Percentage of breast cancer screening records with completed follow-up and time between abnormal screening and final diagnosis less than 60 days	Greater than or equal to 75%
Percentage of breast cancer records with a final diagnosis of 'CIS, other,' DCIS, or invasive breast cancer that have treatment started	Greater than or equal to 90%
Percentage of breast cancer records with a final diagnosis of 'CIS, other,' DCIS, or invasive breast cancer with time between final diagnosis and treatment less than 60 days	Greater than or equal to 80%

D. History: Not applicable

E. Qualifications or eligibility requirements:

Below are the BCSS eligibility requirements:

- Residency: Texas resident
- Age Requirement: 18 to 64 years of age
- Sex: Female
- Medicaid: Not Medicaid enrolled
- Medicare: Not Medicare enrolled
- CHIP: Not CHIP enrolled
- Income: Percentage of FPL: 200 percent
- Additional Eligibility Information: Applicants whose health insurance does not fully cover screening and diagnostic services are considered underinsured and may be eligible for services. Women over age 64 years who are not eligible for Medicare may be eligible for services.

FCS collects client demographic data according to NBCCEDP service delivery and reporting requirements. In recent years, CDC also required grantees to track and report clients served by rurality. See Table 10 below for the number of fiscal year 2024 BCCS clients served by rurality.

Table 10. Fiscal year 2024 BCCS clients served by rurality.

Rurality¹	Clients Served for all Services²
Metro	19,770
Rural	126
Urban	2,852

F. Administration and key processes:

FCS administers the program through the grants awarded by a competitive procurement process. There are currently 32 grantees.

¹ Rurality based on [USDA Economic Research Service Rural-Urban Continuum Codes](#)

² Data as of 5/1/2025, Source: Med-IT®

Billing of BCCS services is through the Med-IT® database on an FFS basis and reimbursement for services is through Centralized Accounting and Payroll/Personnel System (CAPPS) Financials.

BCCS clinics are the only entry point for access to MBCC. MBCC pays for treatment for breast and cervical cancer. Women diagnosed with breast or cervical cancer by any provider across the state may receive application assistance from a BCCS provider. MBCC eligibility is overseen by HHSC Access and Eligibility Services (AES). Although state statute does not codify BCCS, MBCC is created by statute.

HHSC is responsible for the administration of the federal Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations (Cancer Grant) funded by CDC, which includes NBCCEDP, National Program of Cancer Registries (NPCR), and National Comprehensive Cancer Control Programs (NCCCP).

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts:

BCCS has an MOU with the University of Texas Health Sciences Center (UTHSC) at Houston to facilitate the sharing of all Salud En Mis Manos Dissemination and Implementation Assistance (SEMM DIA) data between BCCS and UTHSC.

BCCS has a contract with a third-party vendor, Oxbow, to manage the BCCS database, Med-IT® and provides technical assistance and training to BCCS data and billing staff.

BCCS has an IAC with Angelina County due to the previous service areas provider terminating their contract early. The IAC ensures Angelina County provides BCCS services to women in the Angelina, Polk, and San Augustine counties.

HHSC and DSHS have an interagency agreement to provide funds to the DSHS Texas Cancer Registry (TCR) and the Texas Comprehensive Cancer Control Program (TCCCP) program.

I. Relationship with other governmental entities:

BCCS has received federal funding through the NBCCEDP administered by CDC since 1991. CDC provides programmatic technical assistance and training to HHSC and DSHS staff to administer the BCCS, TCR, and TCCCP programs.

BCCS partners with UTHSC to increase breast and cervical cancer screening rates among eligible populations.

J. Barriers and challenges:

Since the last re-procurement of BCCS, five providers have requested to terminate their grant agreement with HHSC, most often citing onerous compliance activities not reimbursable under the FFS model of the program. In fiscal years 2022-23, these terminations translated to a decrease in 2,729 potential women served. To help address this issue and ensure access to care is not lost, the current re-procurement adds a cost-reimbursement component to the contracts to help cover categories such as administrative personnel, personnel travel, supplies, and equipment.

K. Additional information:

Since 2017, CDC has been prompting states to provide more in-depth support to providers by conducting promotion and outreach activities (e.g., creating, and maintaining partnerships at the local state level, developing paid media, etc.) for grantees in local communities across the state. While this model is feasible for smaller states, the population and geographic size of Texas makes adopting this model challenging and cost prohibitive. In lieu of fully adopting the model, FCS repurposed a vacant full-time equivalent position into a Training and Outreach Coordinator who will support BCCS grantees (along with other FCS grantees) with training and technical assistance.

L-M. Regulatory and complaint information: Not applicable

Title V Maternal and Child Health Services

A. Division or program information:

Name of division or program: Title V Maternal and Child Health Fee-for-Service (TV MCH FFS)

Location within the agency: CPSO

Contact name: Marissa Acosta, FCS Associate Commissioner

Statutory citation: Texas Health and Safety Code, Chapter 32; Texas Government Code, Section 531.0011

B. Objective and major activities:

The TV MCH FFS program provides a comprehensive range of preventive and primary care for children and adolescents, including dental. Pregnant women receive prenatal care services and dental care. TV MCH FFS recently added the full array of syphilis testing and treatment codes to better support public health efforts to address the rise in congenital syphilis prevalence throughout the state.

Applicants must be screened for Medicaid, CHIP, CHIP-P, and any other benefit programs. TV MCH FFS is considered a payor of last resort, except for coverage for pregnant women awaiting a Medicaid or CHIP Perinatal (CHIP-P) eligibility determination.

C. Effectiveness and efficiency information:

FCS conducts readiness assessments for new grantees to ensure providers are prepared to begin providing services.

FCS monitors TV MCH FFS LBB measures to assess effectiveness and efficiency. TV MCH FFS LBB measures are the following:

- Number of infants less than 1 year of age and children 1-21 years of age provided dental and child health services by the maternal and child health program; and
- Number of women over 21 years of age provided services by the maternal and child health program (Title V).

The data source for TV MCH FFS LBB measures is the monthly report grantees submit along with their invoice. The methodology is the count of actual number of services performed, number of clients served, and the age of client seen. In addition, data in the monthly report includes number and type of services provided to TV MCH FFS clients.

D. History: Not applicable

E. Qualifications or eligibility requirements:

The TV MCH FFS program is available to low-income children, adolescents, and pregnant women who are not eligible for Medicaid, CHIP, CHIP-P, or other sources that cover the same services.

Below are the TV MCH FFS requirements:

- Residency: Texas resident
- Age Requirement: 0 to 64 years of age
- Sex: Male, Female
- Post-partum: 12 months
- Income: Percentage of FPL: 185 percent
- Medicaid: Not Medicaid enrolled
- Medicare: Not Medicare enrolled
- CHIP: Not CHIP enrolled
- Insurance: No state or federal health care program coverage
- Medical Status: Pregnant; post-partum
- Additional Eligibility Information: Clients may receive services for up to 60 days while they wait for Medicaid and/or CHIP-P determination. A maximum of two clinical prenatal care visits is allowed for women in the process of applying for and enrolling in the CHIP-P and Medicaid for Pregnant Women programs. Clients not eligible for these or other programs may continue to receive TV MCH FFS services. If determined eligible, qualified clients may be able to receive services the same day.

FCS does not collect demographic data for TV MCH FFS clients. In fiscal year 2024, TV MCH FFS served 38,893 clients.

F. Administration and key processes:

FCS administers the program through the grants awarded by a competitive procurement process. There are currently 16 prenatal and medical grantees and 28 child health and dental grantees.

Billing for TV MCH services occurs on an FFS basis. HHSC processes billing and reimbursement using an internal invoice process. Grantees submit monthly invoices to HHSC for processing.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts:

DSHS and HHSC have an interagency agreement that provides for DSHS to fund direct services administered by HHSC, including federal TV MCH Block Grant funds and state maintenance of effort funding as general revenue. DSHS develops and submits any federally required plans. The TV MCH Block Grant includes performance metrics for an array of programs and initiatives overseen by DSHS. TV MCH FFS program does not have any specific TV MCH Block Grant performance metrics.

I-M. Relationships, barriers and challenges, additional information, regulatory and complaint information: Not applicable

Primary Health Care

A. Division or program information:

Name of division or program: Primary Health Care (PHC)

Location within the agency: CPSO

Contact name: Marissa Acosta, FCS Associate Commissioner

Statutory Citation: Texas Health and Safety Code, Chapter 31; 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 76)

B. Objective and major activities:

PHC provides funding to clinic sites across Texas to ensure eligible Texas residents receive comprehensive primary health care services. PHC serves men, women, and children of any age. PHC services include family planning services, preventive health services, diagnosis and treatment, emergency medical services, diagnostic laboratory, radiological and other diagnostic services, and health education.

C. Effectiveness and efficiency information:

PHC's legislatively mandated (Chapter 31, Texas Health and Safety Code) annual report measures include the following:

- The number of individuals receiving care in the PHC program;

- The total cost of the program, including a delineation of the total administrative costs and the total cost for each service authorized under Health and Safety Code, Section 31.003(e);
- The average cost per recipient of services; and
- The number of individuals who received services in each public health region.

The data source for the PHC annual report is the monthly report grantees submit along with their invoice. The methodologies used are the unduplicated count of clients served and the total number of individuals who received services divided by the total amount spent on the provision of medical services.

D. History: Not applicable

E. Qualifications or eligibility requirements:

Below are the PHC eligibility requirements:

- Residency: Texas resident
- Age Requirement: 0 to 99 years of age
- Sex: Female, Male
- Medicaid: Not Medicaid enrolled
- Medicare: Not Medicare enrolled
- CHIP: Not CHIP enrolled
- Insurance: No state or federal health care program coverage
- Income: Percentage of FPL: 200 percent
- Additional Eligibility Information: Applicants with insurance may be eligible for services provided by PHC when the applicant's confidentiality is a concern or if the applicant's insurance deductible is five percent or greater than their income.

FCS does not collect demographic data for PHC clients. In fiscal year 2024, PHC served 83,071 clients.

F. Administration and key processes:

FCS administers the program through the grants awarded by a competitive procurement process. There are currently 50 grantees.

Billing for PHC services occurs on a cost reimbursement basis. HHSC processes billing and reimbursement using an internal invoice process. Grantees submit monthly invoices to HHSC for processing.

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUS and interagency agreements:

The 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 76), appropriated funds for the Parkland Senior Care Project to provide primary health care services to underserved Texas seniors in Dallas County. FCS has a separate contractual agreement with Dallas County Hospital District/Parkland to implement the Parkland Senior Care Project as this initiative is separate from PHC.

I. Relationship with other governmental entities: Not Applicable

J. Barriers and challenges:

Programmatic challenges exist when trying to track client-specific services and the average cost-per-client since funding is allocated using a cost reimbursement model, where funds support administrative costs to run the program and funding is not allocated using a unit-based (FFS) model, where client services are connected to individual service codes. However, FCS is in the process of developing a more detailed data collection tool to help improve legislative reporting, where feasible.

K-M. Additional information, regulatory and complaint information:
Not applicable

Houston Preventive and Primary Health Services Grant

A. Division or program information:

Name of division or program: Houston Preventive and Primary Health (HPPH) Services Grant

Location within the agency: CPSO

Contact name: Marissa Acosta, FCS Associate Commissioner

Statutory Citation: S.B. 30, 88th Legislature, Regular Session, 2023

B. Objective and major activities:

HPPH funds services to expand access to no- or low-cost preventive and primary medical, dental, diagnostic, specialty, and children's health services to improve the health of low-income adults and children in specific zip codes within the Houston area.

HPPH services include family planning services, lab tests and counseling; preventive health services, including screening for chronic and acute conditions, immunizations, and cancer screenings; medically necessary diagnostic and radiological services; dental services, including exams, x-rays, consults, and preventive dental procedures; and comprehensive well-child/adolescent exams, health education, and referrals to social services.

C. Effectiveness and efficiency information:

HPPH performance measures include the number of new unduplicated clients, and the number and type of each service or referral provided.

The data source for HPPH measures is the monthly report grantees submit along with their invoice. The metric used is the unduplicated count of clients served, and the number of services performed.

D. History: Not applicable

E. Qualifications or eligibility requirements:

Below are the HPPH eligibility requirements:

- Residency: Texas resident
- Age Requirement: 0 to 99 years of age
- Sex: Female, Male
- Medicaid: Not Medicaid enrolled
- Medicare: Not Medicare enrolled
- CHIP: Not CHIP enrolled
- Insurance: No state or federal health care program coverage
- Income: Percentage of FPL: 200 percent
- Assets: Family resource limit

- Additional Eligibility Information: Clients must live in a city of Houston or Harris County zip code

F. Administration and key processes:

FCS administers the program through the grants awarded by a competitive procurement process. There is currently one grantee.

Billing for HPPH occurs on a cost reimbursement basis. HHSC processes billing and reimbursement using an internal invoice process. Grantees submit monthly invoices to HHSC for processing.

G. Funding: See "Agency Program Information" spreadsheet.

H-M. MOUs and interagency agreements, relationships, barriers and challenges, additional information, regulatory and complaint information: Not applicable

County Indigent Health Care Program

A. Division or program information:

Name of division or program: County Indigent Health Care Program (CIHCP)

Location within the agency: CPSO

Contact name: Marissa Acosta, FCS Associate Commissioner

Statutory Citation: Texas Health and Safety Code, Chapter 61; Texas Human Resources Code, Chapter 32

B. Objective and major activities:

The Indigent Health Care and Treatment Act (Chapter 61, Texas Health and Safety Code) requires all 254 counties to administer CIHCP through their county, a public hospital, or a hospital district. Each CIHCP entity uses their county's general revenue tax levy to provide health care services to indigent men, women, and children residing within their service areas.

CIHCP services include health care services including but not limited to immunizations, medical screening services, annual physical examinations, inpatient and outpatient hospital visits, laboratory and radiology, family planning services,

and skilled nursing facility services. In addition to providing basic health care services, CIHCP entities may provide other health care services that the county determines to be cost effective. Optional services include, but are not limited to, ambulatory surgical center services, counseling, occupational therapy, dental and vision services, and durable medical equipment.

HHSC administers state assistance funding only for counties not fully served by a public hospital or hospital district that spends more than eight percent of their general revenue tax levy on indigent health care services.

Additionally, FCS provides limited technical assistance to CIHCP entities, such as assisting counties by filing claims for retroactive Supplemental Security Income/Medicaid reimbursement for CIHCP-eligible individuals and reimbursement for up to three pharmacy claims per month.

C. Effectiveness and efficiency information:

FCS receives monthly total expenditure amounts from CIHCP entities to monitor whether the entity is eligible for state assistance funding. However, HHSC does not contract with or provide grant funding to CIHCP entities for the provision of indigent health care services and therefore does not have statutory authority to require performance measures of counties, public hospitals, and hospital districts.

D. History: Not applicable

E. Qualifications and eligibility requirements:

Below are the CIHCP eligibility requirements:

- Residency: Texas resident
- Requirement: 0 to 99 years of age
- Sex: Female, male
- Medicaid: Not Medicaid enrolled
- Medicare: Not Medicare enrolled
- CHIP: Not CHIP enrolled
- Insurance: No state or federal health care program coverage
- Income: Percentage of FPL: 21 percent
- Assets: Family resource limit

FCS does not collect clients served data for CIHCP.

F. Administration and key processes:

As required by the 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 135), HHSC has a contract with the University of Texas Medical Branch-Galveston (UTMB Galveston). The contract ensures HHSC provides funds to UTMB Galveston for the provision CIHCP services to clients of all counties, with the exception that funds may only be used for indigent patients from Galveston, Brazoria, Harris, Montgomery, Fort Bend, and Jefferson counties if those counties' CIHCP income eligibility levels, or those counties' hospital district income eligibility levels, exceed the statutory minimum set for CIHCP.

If an eligible county spends eight percent of their general revenue tax levy on indigent health care services, HHSC distributes state assistance funds to cover at least 90 percent of the amount the county spent on those services to ensure the county can continue serving eligible clients.

If state assistance funds are depleted at the time of request, a county is not liable for payments for indigent health care services. HHSC does not have unexpended balance authority for state assistance funds. Lapsed funding is returned to the Comptroller.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements, relationships, and barriers and challenges Not applicable

K. Additional information:

Requests from counties for state assistance funds have declined every year as counties have created other avenues for support. As a result, reimbursement funds significantly lapse each fiscal year.

L-M. Regulatory and complaint information: Not applicable

Family Support Services

FSS, formerly known as DFPS Prevention and Early Intervention, provides key services to at-risk populations. Per Texas Government Code, Section 531.0045, FSS is exempt from sunset review. However, below is an overview for these programs.

FSS contracts with community-based programs to assist families in achieving self-sufficiency and stability; promote healthy outcomes and strengthen support systems for children and families; prevent or reduce at-risk behaviors in children; and support workforce participation.

FSS At-Risk service programs include the following:

- Healthy Outcomes through Prevention and Early Support (HOPES);
- Texas Service Members;
- Veterans, and Families (SMVF);
- Statewide Youth Services Network (SYSN); and
- Safe Babies.

VII. Guide to Agency Divisions and Programs

Chief Program and Services Officer

Community Services

The Health and Human Services Commission (HHSC) created the Community Services (CS) Division in 2022 as part of an organizational realignment of the agency's Chief Program and Services Office (CPSO), bringing together multiple programs from three legacy divisions to create a single division focused on services and supports for older adults and people with disabilities and special health care needs. Co-locating these congruent programs has provided HHSC with opportunities to improve services for these populations, creating internal agency efficiencies in the administration of these programs, and enhancing the agency's strategic goal and objectives related to the administration of programs paramount to the health and success of older adults and people with disabilities and special health care needs.

The CS Deputy Executive Commissioner (DEC) and the Operations Support (Operations) department provide division-wide, state-level leadership and support for management, administrative, program, policy, communication, and operations functions. Operations includes financial and business management support and coordination, as well as division-wide contract oversight and support. Operations support efforts include risk review of CS contracts for client services, support for budget efficiency, and policy guidance that focuses on the effective use of program dollars for optimal client services.

Policy and Strategy

In addition to overseeing three service coordination offices and a special projects office, the Policy and Strategy division manages CS legislative coordination strategies. Highlighted below are the functions of each of the coordination and special projects offices.

Office of Aging Service Coordination

A. Division or program information:

Name of division or program: Office of Aging Services Coordination (OASC)

Location within the agency: CPSO

Contact name: Lana Estevilla, Associate Commissioner, Policy & Strategy

Statutory citation: Texas Government Code, Chapter 531, Subchapter M-2, Section 532. 491-499.

B. Objective and major activities:

OASC's mission is to support older Texans to age and live well by assessing the state's readiness to respond to the needs of older adults, raising awareness of aging-related issues and available resources, connecting the community to aging supports and innovative initiatives, and engaging with partners to strengthen and expand the aging network.

OASC is responsible for implementing strategic planning initiatives and efforts including:

- Aging Texas Well (ATW): Identifies policy issues, guides state government readiness, and promotes increased community preparedness for Texas' growing older adult population;
- Age Well Live Well: An awareness campaign offering practical ways to address the issues identified by ATW and meet the needs of the community;
- Texas Talks: An annual campaign that helps people talk to older adult family members and friends about aging and needs that may arise;
- Know Your Neighbor: A campaign that encourages Texans to form and maintain new connections with older neighbors to help reduce the risks of isolation and loneliness; and
- Texercise: A health promotion initiative to educate and engage older Texans in healthy aging behaviors and provides individuals and communities with resources.

OASC also oversees two major projects.

- No Wrong Door: A systematic and coordinated agency approach to long-term services and supports which formalizes governance structures, coordinates system efforts, collaborates with stakeholders, and identifies resource needs; and

- Texas Family Caregiver Roadmap: A strategic guide with goals and tactics to support the over three million Texas family caregivers.

C. Effectiveness and efficiency information:

OASC measures of effectiveness:

- *HHSC Strategic Plan for Fiscal Years 2025-2029, Part I, Action Item 1.2.1:* Grow social engagement opportunities for older adults by expanding program options by 10 percent;
- Community Engagement: Number of presentations or exhibits and number of attendees. In fiscal year 2024, OASC conducted 14 educational presentations including an Older Americans Month Webinar with 176 attendees and Family Caregiver Series with 261 attendees;
- Disaster Preparedness: Increase engagement in the Know Your Neighbor campaign by 5 percent across all platforms by the end of fiscal year 2025; and
- Marketing and Outreach: Raise awareness of aging issues: GovDelivery distribution of Aging Newsletter increased by 120 percent; monthly and annual website views to reach 141,018 views; resources downloaded to 1,610 (242 from Texas Talks).

D. History: Not applicable.

E. Qualifications or eligibility requirements:

OASC initiatives are available to all Texans.

F. Administration and key processes:

OASC coordinates and promotes aging services and programs through cross-division coordination, community and stakeholder engagement, research and data capturing, state readiness and preparedness to support an aging population, and marketing and outreach. OASC supports the ATW advisory committee (ATWAC) and the Statewide Interagency Aging Services Coordinating Council (SIASCC) ensuring compliance with state and agency policies, and regulations. OASC's team includes one director, four program specialists, one researcher, and one project manager.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

OASC communicates with:

- The United States Administration for Community Living (ACL) for grant opportunities and dissemination of best practices;
- National Association of Councils on Developmental Disabilities (NACDD) on the Aging and Disability Grant;
- State governments as part of the Centers for Health Care Strategies multisector plans on aging (MPA) learning collaborative;
- Area Agencies on Aging (AAA); and
- As part of SIASCC: Office of the Governor (OOG), Office of the Attorney General (OAG), Texas Department of Family and Protective Services (DFPS), Texas Department of State Health Services (DSHS), Texas Department of Agriculture, Texas Veterans Commission (TVC), Texas Workforce Commission (TWC), University of Texas Health Science Center at San Antonio, University of Texas at Austin, and Texas A&M University System.

J. Barriers and challenges:

Executive Order RP-42 established the Aging Texas Well initiative and requires a biennial strategic plan to identify and discuss aging policy issues, guide state government readiness, and promote increased community preparedness for an aging Texas. This plan acts as the state's MPA. National standards for MPAs are to develop a 10-year plan; however, the ATW Strategic Plan is currently a six-year visioning plan with two two-year progress updates. Additionally, the SIASCC enabling statute requires a five-year recurring strategic plan outlining a coordinated interagency approach to the state's aging services. Because the purpose of these plans overlaps significantly, coordinating plan development would improve efficiency.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Office of Disability Services Coordination

A. Division or program information:

Name of division or program: Office of Disability Services Coordination (ODSC)

Location within the agency: CPSO

Contact name: Lana Estevilla, Associate Commissioner, Policy & Strategy

Statutory citation: Not applicable

B. Objective and major activities:

ODSC aims to improve outcomes for Texans with disabilities by enhancing HHSC's service delivery for people with disabilities. ODSC focuses on long-term solutions; coordinating and communicating with other state agencies and organizations to ensure high-quality programs that are easy to navigate; seeking stakeholder engagement, support, and feedback; and ensuring HHS disability services and supports align with agency strategic goals.

ODSC is responsible for:

- Promoting Independence Plan (PIP): Illustrates Texas' commitment toward community living and includes a summary of ongoing efforts, actionable pursuits toward continuous progress, and transparency of collective efforts;
- Person Centered Practices Initiative: Provides technical assistance, training, and policy consultation to promote person centered practices in primary access points;
- Direct Service Capacity Building Initiative: A five-year project outlined in the Community Attendant Workforce Development Strategic Plan required by the 2020-21 General Appropriations Act, House Bill (H.B.) 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 157); and
- Serves as the CS Intellectual and Developmental Disability (IDD) contact on HHSC IDD efforts and facilitates stakeholder inquiries and concerns.

C. Effectiveness and efficiency information:

ODSC measures of effectiveness:

- *HHSC Strategic Plan for Fiscal Years 2025-2029*, Part I, Action Item 1.1.2: promote the community attendant role by expanding workforce development opportunities for attendant-like positions, including at the regional and local level;

- Oversight: Designs and implements oversight process for the biennial PIP report. This process allowed HHSC to achieve 89 percent benchmark completion in the 2022-2024 report. ODSC completed six separate benchmark activities assigned to them and partnered on two additional activities with other coordination offices;
- Education and Outreach: Authored four quarterly Ex-Officio reports to the Governors Committee for People with Disabilities (GCPD) and assisted with over 50 requests to resolve GCPD and stakeholder inquiries; received two federal grant awards and one dedicated spot to a national learning collaborative at a state cost savings; and trained over two hundred state and local office staff on person-centered practices.

ODSC also supports the development and maintenance of Enhanced Direct Care Careers, a web-based job matching and resource center to support candidates and employers within HCBS. This effort was stakeholder-informed and aligned via 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019, (Article II, HHSC, Rider 157), and *HHSC Strategic Plan 2025-2029, Action Item 1.1.2*.

D-E. History and Qualifications: Not applicable.

F. Administration and key processes:

ODSC team includes a director, a strategic initiatives team, and a person-centered practices training lead. ODSC operates by proactively seeking and leveraging collaboration within and outside HHSC to promote its mission, many times through partnerships and grant awards to:

- Focus on long term solutions through ad hoc opportunities such as implementing grants to effect system improvements;
- Coordinate and communicate with other state agencies and organizations to ensure high-quality programs that are easy to navigate through a no wrong door approach and as HHSC's Ex-Officio role for GCPD;
- Ensure HHS disability services and supports align with agency strategic goals through the maintenance of long-term initiatives; and
- Seek stakeholder engagement, support, and feedback by acting as the IDD point of contact to inform and guide action within IDD polices.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

ODSC leverages partnerships and collaborations within entities that have a disability focus including federal partners, other state agencies, and community-based organizations (e.g., Area Councils of Government).

J-M. Barriers, Additional, Regulatory, and Complaint Information: Not applicable.

Office of Veteran Services Coordination

A. Division or program information:

Name of division or program: Office of Veteran Services Coordination (OVSC)

Location within the agency: CPSO

Contact name: Lana Estevilla, Associate Commissioner, Policy & Strategy

Statutory citation: Texas Government Code, Sections. 434.212 and 434.214; Texas Government Code 531.093; Texas Health and Safety Code, Section 161.551; Texas Human Resources Code, Section 137.202

B. Objective and major activities:

OVSC enables HHSC to serve the needs of Texas service members and their families by:

- Facilitating awareness of, and access to, HHSC programs and services which meet their needs, including maintaining a database of applicable HHSC programs;
- Providing policy expertise for HHSC programs and services and leveraging data to improve services related to their needs;
- Representing HHSC on advisory councils, workgroups, and other external stakeholder groups; and
- Providing guidance on agency initiatives.

By statute, Texas Government Code 526.0601, service member includes all current and former members of the United States Armed Forces, Texas National Guard, and Texas State Guard.

C. Effectiveness and efficiency information:

OVSC oversees and monitors the implementation of *HHSC Strategic Plan for 2025-2029, Part I*, Action Item 2.4.2 – service member support. Implement universal screening for service member status to allow for aggregate reporting and planning to improve person-centered referrals and service member outcomes.

Milestone activities in support of this action item in fiscal year 2024 included:

- Facilitated development of continuity of crisis care agreements between HHSC Certified Community Behavioral Health Centers and Veterans Health Administration facilities throughout Texas;
- Policy development to help HHS identify service members and make appropriate referrals beyond the agency;
- Assisted TVC in updating its Model Language for State Agencies; and
- Developed and delivered an HHS information and awareness campaign to enhance the HHS team members' understanding of the unique challenges of military service and the military life cycle.

D. History:

In 2015, HHSC established the Office of Veteran Services under CPSO. It was renamed to OVSC and moved under CS as part of HHSC's realignment in 2022.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

OVSC includes a director, a senior policy advisor, and two program and policy analysts. They accomplish their functions by:

- Reviewing policy and program activities and providing technical assistance and guidance to program areas;
- Receiving and responding to requests for information related to agency programs and enhancing the awareness of and access to such programs; and

- Monitoring implementation of policy, rules, regulations, and laws related to how HHSC serves service members and their families.

G. Funding: See “Agency Program Information Spreadsheet.”

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

At the federal level, OVSC coordinates with the United States Departments of Defense and Veterans Affairs, and the United States Health and Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA) on suicide prevention efforts specific to service members, veterans, and their families (SMVF) subpopulation of Texas.

At the state level, OVSC works with TVC, TWC, Veterans Land Board, OAG, the Texas Military Department, and DFPS.

At the local level, OVSC engages with and refers to County Veteran Service Officers and Local Mental Health Authorities (LMHAs) and Local Behavioral Health Authorities (LBHAs) while also receiving referrals from those organizations and routing to HHSC programs and external state-level agencies, as appropriate.

J. Barriers and challenges:

HHSC, like many state agencies, struggles to identify service members who are HHSC service recipients and lacks a common data system to store service member identification that would enable the agency to leverage data to improve service delivery to the state’s service member population. OVSC works across the agency to help identify veterans using HHSC services; however, this, along with the collection of data, remains a challenge.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Special Projects

A. Division or program information:

Name of division or program: Special Projects Unit

Location within the agency: CPSO

Contact name: Lana Estevilla, Associate Commissioner, Policy & Strategy

Statutory citation: Texas Employment First Policy, Texas Government Code, Section 531.02447

B. Objective and major activities:

Special Projects is a team that implements projects and assignments that promote HHSC programs, initiatives, and strategic goals, and identifies funding opportunities and grants to facilitate program improvements, including:

- Projects and initiatives that focus primarily on individuals receiving long-term services and supports through one of HHSC's Medicaid waiver programs and other populations as well;
- Employment-based projects for people with disabilities in line with the state's employment first policy;
- Training and education on topics relevant to employment services for people with disabilities; and
- Operational support to all areas of Policy and Strategy, including contract management and procurement activities, requisitions, and grant development.

C. Effectiveness and efficiency information:

In fiscal year 2024, Special Projects provided 12 in-person trainings and 16 webinars to over 3,000 participants.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

All webinars and conferences are open to the public, but the primary audience is consumers, service providers, Local IDD Authorities (LIDDAs), caregivers, or others interested in up-to-date information on home and community-based services.

F. Administration and key processes:

Special Projects initiates projects and initiatives resulting from legislation (e.g., pilots, studies, and reports) or direction from CS leadership. Special Projects has three staff primarily assigned to work on employment-focused initiatives and programs, including the Employment Recruitment coordinator and two MFP-funded Employment First coordinators. Other staff responsibilities include identifying grant-funding opportunities; implementing and overseeing projects, assignments, and initiatives; and providing operational support and contract management.

G. Funding: See “Agency Program Information Spreadsheet.”

H. MOUs and interagency agreements or contracts:

HHSC has an MOU with TWC facilitating data sharing necessary to ensure HHSC’s compliance with the programmatic and reporting requirements mandated in Texas Government Code, Section 531.02448, as amended by Senate Bill (S.B.) 50, 87th Legislature, Regular Session, 2021, which required HHSC to coordinate the provision of service for individuals receiving services who may be eligible for or are receiving Vocational Rehabilitation (VR) in accordance with 34 C.F.R. Section 361.53(d).

I. Relationship with other governmental entities:

Special Projects works closely with LIDDAs, contracting with several on a variety of projects and initiatives including employment and Preadmission Screening and Resident Review (PASRR)-related assignments. Special Projects, TWC, and Texas Education Agency (TEA) collaborate on employment initiatives.

J. Barriers and challenges:

Programs have time-limited grants which can make consistency in programming a challenge.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Local Access and Support

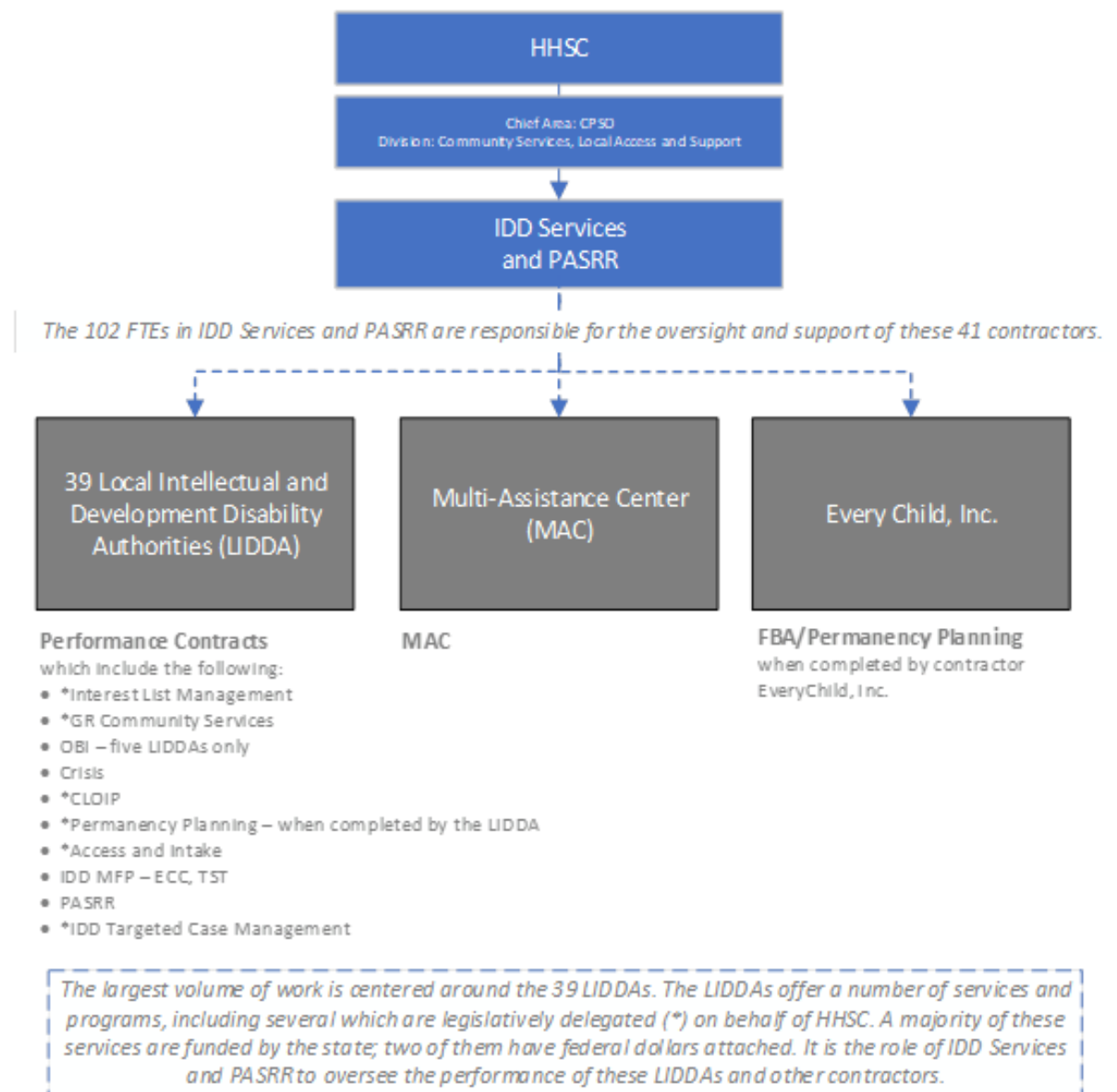
The CS Local Access and Support department is responsible for oversight of community-based programs and services that help older adults and individuals with disabilities access individualized supports within their community. Local Access and Support includes four areas: IDD Services and PASRR, Aging and Disability

Resource Centers (ADRCs), Office of Area Agencies on Aging (OAAA), and Independent Living Services.

IDD Services and PASRR

IDD Services and PASRR is responsible for the oversight and support of 41 contracted entities, including 39 LIDDAs, the Multi-Assistance Center (MAC), and the family-based alternative (FBA) contract with Every Child, Inc. Oversight by IDD Services and PASRR includes developing policies, rules, and handbooks; creating trainings; conducting quality assurance and fiscal monitoring; providing technical assistance; and managing contracts.

Figure 1. IDD service delivery structure.



Note: The contractor boxes are in gray, not blue, as they are not part of the HHS system.

Oversight and Support

A. Division or program information:

Name of division or program: IDD Services and PASRR

Location within the agency: CPSO

Contact name: Dana McGrath, Associate Commissioner; Anne McGonigle, Deputy Associate Commissioner of IDD Services and PASRR

Statutory citation: Texas Health and Safety Code, Chapters 533A, 534, 591, and 531; Texas Health and Safety Code, Title 7, Subtitle D

B. Objective and major activities:

To understand the impact of IDD Services and PASRR's oversight and support, the different contractors and their services are explained below.

LIDDAs: LIDDAs are statutorily authorized and required to administer certain programs and services on behalf of HHSC. As part of their duty, LIDDAs:

- Serve as the single point of access to publicly funded services and supports for people with IDD residing within a LIDDA service area;
- Receive legislative delegation to provide the following services:
 - ▶ General revenue funded services;
 - ▶ Permanency planning for people under the age of 22 in certain settings;
 - ▶ Enrollment into home and community-based services (HCS) and Texas home living (TxHmL), and intermediate care facilities for individuals with an intellectual disability or related condition (ICF/IID); and
 - ▶ Community living options information process (CLOIP) for people in a state supported living center (SSLC);
- Are contracted to provide the following services:
 - ▶ Crisis services; and
 - ▶ Outpatient Biopsychosocial Intervention (OBI); and
- Operate state and federally funded programs including:
 - ▶ IDD Money Follows the Person Demonstration; and
- PASRR.

Additionally, IDD Services and PASRR contracts with 39 LIDDAs for targeted case management and PASRR's habilitation coordination through the Medicaid Provider Agreement. Because these are separate contracts with their own budgets, this totals 82 contracts for the LIDDAs.

FBA: Every Child, Inc. provides family-based alternative services and permanency planning for people under the age of 22 in a nursing facility.

MAC: MAC is a program authorized by 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Article IX, Rider 150). It required HHSC to contract the support for a one-stop shop model of providing services on-site to adults and children with special needs in Bexar County and counties within Texas Public Health's regions 8 and 11.

C. Effectiveness and efficiency information:

Performance measures for the IDD Services and PASRR Program are described under the relevant subsections.

D-E. History and Qualifications: Not applicable.

F. Administration and key processes:

The IDD Services and PASRR section is made up of 10 units:

Deputy Associate Commissioner's Office: Provides support to the nine IDD Services and PASRR units, acts as liaison with internal and external stakeholders, ensures effective and timely implementation of key IDD Services and PASRR activities, including legislative initiatives and special projects.

- Contract Accountability and Oversight: Includes contract monitors who conduct reviews and monitor corrective action when required;
- Contracts Management: Manages the 84 contracts, including development and implementation of contracts and amendments;
- Fiscal and Systems Support: Includes two fiscal monitors along with budget and IT support for the section;
- Local Procedure Development and Support: Oversees the Interest List Management and enrollment activities including slot allocation;
- IDD MFP: Oversees two federally funded programs (Enhanced Community Coordination and Transition Support Teams) carried out by the LIDDAs;
- PASRR: Provides oversight and performs administrative tasks related to the federally funded PASRR program;
- Program Improvement: Provides support and technical assistance to the LIDDAs on a wide range of topics including performance contract

requirements and LBB targets. Also supports the MAC and Every Child, Inc. contractors;

- Program Services: Develops policies, procedures, rules, and handbooks related to IDD, PASRR, and MFP programs; and
- Training and Curriculum Development: Creates and provides training for LIDDAs, nursing facilities, and other relevant stakeholders involved in IDD services or PASRR programs.

G. Funding: See “Agency Program Information Spreadsheet.”

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

All 39 contracted LIDDAs are local units of government.

J. Barriers and challenges:

The various HHSC departments that handle case management for individuals with IDD lack a case management system that all parties can use. Having a universal case management system would allow other applicable departments and agencies to easily pick up an individual’s record and know the key information for the person, including their Medicaid status, enrollment updates, and date of last service coordination visit.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Access & Intake

A. Division or program information:

Name of division or program: IDD Access and Intake

Location within the agency: CPSO

Contact name: Dana McGrath, Associate Commissioner; Anne McGonigle, Deputy Associate Commissioner of IDD Services and PASRR

Statutory citation: Texas Health and Safety Code, Chapters 534 and 593

B. Objective and major activities:

As a front door for IDD services, LIDDAs must provide screening and eligibility determinations, conduct financial assessments, and explain options for IDD services and supports. When conducting intake activities, a LIDDA must determine whether an individual seeking services and supports is a member of the LIDDA priority population and is eligible for service coordination.

The LIDDA priority population is defined in rule (26 Texas Administrative Code Section 304.102(19)) as a group comprised of persons who meet one or more of the following:

- A person with an intellectual disability;
- A person with autism spectrum disorder;
- A person with a related condition on the current HHSC-approved list of related conditions who is eligible for and enrolling in services in the ICF/IID, HCS, Texas Home Living (TxHmL) or other HHSC-approved programs;
- A nursing facility resident who is eligible for specialized services for an intellectual disability or related condition;
- A child who is eligible for Early Childhood Intervention (ECI) services through HHSC; or
- A person diagnosed by an authorized provider as having a pervasive developmental disorder (PDD) or Asperger disorder through a diagnostic assessment completed before 2013.

C. Effectiveness and efficiency information:

Fiscal year 2024 Number of Clients Served: 22,314. Data for the number of clients served comes from Mental and Behavioral Health Outpatient Warehouse (MBOW), which is a system the LIDDAs input data into and IDD Services and PASRR can export or run reports through.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

There are no access and intake service qualifications as any person may inquire about LIDDA services and supports or other community services and supports. The

LIDDA must receive legally adequate consent before they provide IDD services to a person, including a determination of intellectual disability. In some cases, the LIDDA may provide services without consent if they have made all reasonable efforts to obtain consent.

F. Administration and key processes:

IDD Services and PASRR support the LIDDA's role in assessing and identifying individuals who are part of the priority population. This process ensures an interested person meets eligibility requirements and prevents inappropriate use of state funds dedicated to serving a specific population.

IDD Services and PASRR publishes the Determination of Intellectual Disability (DID) best practice guidelines and revises them to align with clinical best practices and recommendations in determining whether someone has an intellectual disability, with the last revision in 2025. This document remains a critical resource for LIDDAs, and ensures they make decisions based on clinical expertise and judgment, reducing unnecessary, costly testing when a valid DID already exists. IDD Services and PASRR also updated the Community First Choice Non-Waiver referral process to reduce the amount of time a person must wait to access this entitlement service. LIDDAs support people through their front door activities to access services in the least restrictive and least costly setting to safely meet the presenting person's needs and achieve the highest quality of life. If through the screening and intake process a person is determined ineligible for LIDDA services, LIDDAs continue to assist in submitting referrals to other community services for which they may be eligible.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

HHSC contracts with 39 LIDDAs, which are local units of government, to implement and provide access and intake activities.

J. Barriers and challenges:

Challenge 1: Many LIDDAs are facing a backlog of people waiting for a DID to access IDD services and supports. Funding issues impact the LIDDA's ability to hire and retain individuals with the appropriate credentials to conduct the DID.

Challenge 2: There are different interpretations around when the age of onset of substantial limitations in functioning must occur for “related condition” eligibility. The federal and state definitions are not clear if the limitations must have been present before age 22 or could show up later in the person’s life, resulting in inconsistent application of the rule and regulation by different waiver programs and different LIDDAs. These discrepancies mean an individual that is determined ineligible for services in one local service area could have been found eligible in another.

Challenge 3: There are some concerns about consent and who can consent on behalf of the person receiving the DID. Texas Health Safety Code, Section 593.004, regarding application for DID, restricts who can request a DID and how they make a request. HHSC can recommend revising this section to minimize restrictions or repealing the section altogether so that those acting in the individual’s best interest may request a DID on the individual’s behalf. Alternatively, HHSC may recommend repealing or revising these requirements to allow a person to request a DID orally or in writing, and not through an HHSC form. Either of these changes in statute would reduce barriers and increase access for individuals who may be eligible for IDD services to receive a diagnostic assessment.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Interest List Management

A. Division or program information:

Name of division or program: Interest List Management

Location within the agency: CPSO

Contact name: Dana McGrath, Associate Commissioner; Anne McGonigle, Deputy Associate Commissioner of IDD Services and PASRR

Statutory citation: Texas Health and Safety Code, Chapters 533A, Section 533A.0355; Texas Government Code, Sections. 546.0213, 546.0454, and 546.0455

B. Objective and major activities:

IDD Services and PASRR’s Local Procedure Development and Support (LPDS) coordinates implementation of HCS and TxHmL waiver program interest lists, also

known as Interest List Management. As required by the Performance Contract, LIDDAs must add people to the interest lists upon request, perform enrollment activities, and perform biennial contacts to update information. To ensure LIDDAs follow required processes and procedures, LPDS closely monitors the enrollment process from the time it releases a slot to HHSC's final eligibility determination.

Interest List Management is the only program IDD Services and PASRR directly implements and manages. All other services or programs are operated by a contractor the IDD Services and PASRR section oversees.

C. Effectiveness and efficiency information:

The effectiveness of Interest List Management is measured, in large part, by the performance of LIDDAs on the following activities listed in the Performance Contract:

- Completion of enrollment process into HCS by the 90th calendar day after receiving notice of the slot release, or have an HHSC approved extension for 95 percent of the enrollments due each quarter;
- Completion of enrollment process into TxHmL by the 90th calendar day after receiving notice of the slot release or have a HHSC approved extension for 95 percent of the enrollments due each quarter; and
- Completion of 50 percent of their biennial contacts by the end of fiscal year 2024 and 100 percent by the end of fiscal year 2025.

In accordance with the Performance Contract, the LIDDA is assessed a mandatory financial sanction if they fail to meet the performance measure outcomes.

D. History:

In fiscal year 2018, LPDS created the Attrition Slot Allocation Committee (ASAC) to maximize the use of attrition slots to meet the needs of people with IDD in crisis situations, aging out of DFPS' Child Protective Services (CPS), or diverting or transitioning from nursing facilities and SSLCs.

In fiscal year 2022, HHSC migrated the HCS and TxHmL interest list and enrollment data from the Client Assignment and Registration (CARE) system to the Slot Tracking and Community Services Interest List (CSIL) application in the Long-term Care (LTC) Online Portal.

E. Qualifications or eligibility requirements:

There are no program eligibility requirements to be on the HCS and TxHmL interest lists. However, to receive program services, a person must meet eligibility requirements as specified in Texas Administrative Code, Title 26, Chapter 263, Subchapter B or Chapter 262, Subchapter B.

F. Administration and key processes:

In each legislative session, HHSC receives direction to enroll a specific number of new people in the HCS and TxHmL waiver programs during the biennium. LPDS works closely with HHSC Budget and Forecasting to determine the number of slots to release to meet the legislative targets and will release the slot offers to LIDDAs.

Once LPDS notifies a LIDDA of a person's HCS or TxHmL slot offer, the LIDDA is responsible for presenting the offer, and if accepted, completing required activities for HHSC to make an eligibility determination.

LPDS oversight and management activities include:

- Processing requests and extensions for slot offers, releasing HCS and TxHmL slot offers, and monitoring slot offers from time of release to final determination;
- Ensuring nursing facility and ICF/IID residents under age 22 are added to the HCS interest list;
- Performing interest list corrections as needed, monitoring biennial contact performance, and mailing interest list letters to people added to the interest lists;
- Providing technical assistance to LIDDAs regarding interest lists; and
- Monitoring performance measures, reporting for interest lists and enrollments, conducting quality assurance on system functionality, and developing related policy, procedures, and trainings on interest list activities.

In compliance with Texas Government Code, Section 546.0454, LPDS ensures LIDDAs update interest list questionnaires when informed of a change and during each biennial contact.

System Support: LPDS also houses a sub-unit responsible for system support due to the large number of IT systems involved in enrollment. This team troubleshoots

system issues and provides technical assistance to LIDDAs and HHSC staff. The team works with HHSC information technology and other system business analysts and developers to identify and resolve defects and make improvements.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not Applicable.

I. Relationship with other governmental entities:

LPDS works closely with the 39 LIDDAs to provide interest list technical assistance.

J. Barriers and challenges:

Multiple Data Systems: The transition from a single data application (CARE) to multiple applications has resulted in a number of communication issues between the systems. IT systems and applications do not process information the same way or the same frequency and results in interruptions to services and delays in validating data. It is also cumbersome and inefficient for users to log into multiple systems to conduct activities for the same process, (e.g., from interest list to slot offer to enrollment determination).

K. Additional information:

As a result of H.B. 3720, 87th Legislature, Regular Session, 2021, and 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Article II, HHSC, Rider 41), LPDS participated in a project to enhance the YourTexasBenefits.com (YTB) HHSC application website to improve system-to-system communication with the CSIL application so individuals on the HCS and TxHmL interest lists could view and update their contact information. Other related projects resolved defects and implemented an additional enhancement to allow individuals to add themselves or another person to the HCS and TxHmL interest lists using the YTB website. LIDDAs continue to add people to the interest lists for those who are unable to use the website.

L-M. Regulatory and Complaint Information: Not applicable.

General Revenue Community Services

A. Division or program information:

Name of division or program: General Revenue (GR) Community Services

Location within the agency: CPSO

Contact name: Dana McGrath, Associate Commissioner; Anne McGonigle, Deputy Associate Commissioner of IDD Services and PASRR

Statutory citation: Texas Health and Safety Code, Chapters. 533A, 534, 591, and 531; Texas Health and Safety Code, Title 7, Subtitle D

B. Objective and major activities:

HHSC contracts with 39 LIDDAs to provide GR services, which are a range of services for individuals with IDD with the goal of helping them remain in their own homes or their family's home, particularly if they are waiting or ineligible for another IDD program, such as a Medicaid waiver. Per their Performance Contract, LIDDAs must provide respite and service coordination but can also offer an additional, optional array of services, including behavioral support, nursing, and day habilitation.

C. Effectiveness and efficiency information:

GR services have two Legislative Budget Board (LBB) performance measures:

- Average number of people receiving non-Medicaid IDD services (target: 4,942); and
- Cost per person (target: \$560.24).

In the fourth quarter of fiscal year 2024, the average number of people receiving non-Medicaid IDD services was 5,164 with a cost per person of \$676.04.

To monitor these measures, LIDDAs must enter data regarding service provision into MBOW, which is then exported and reviewed by IDD Services and PASRR quarterly to ensure compliance with LBB measures.

D. History: Not Applicable.

E. Qualifications or eligibility requirements:

Eligibility requires designation of an intellectual disability, developmental disability or related condition, developmental delay, or functional limitation.

It is important to note that a person enrolled in a waiver program is not eligible for most GR services. LIDDA GR services often are accessed by people who are not yet enrolled in a waiver but who may be waiting on an interest list. Additionally, if a person declines an offer of enrollment into HCS or TxHmL, the LIDDA must discontinue any GR services the person was receiving that are like services they could have accessed in the waiver.

F. Administration and key processes:

The oversight from IDD Services and PASRR includes contract development and monitoring, creating, and updating rules and policy, providing technical assistance, training for LIDDA employees, and fiscal and programmatic reviews of the LIDDAs.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

HHSC contracts with 39 LIDDAs to implement and provide GR services.

J. Barriers and challenges:

Many LIDDAs have reduced the array and/or amount of GR services they provide due to funding constraints, with some now only offering the required services of respite and service coordination.

K. Additional information:

GR services are like those of community-based waiver programs such as TxHmL and HCS.

Table 1. GR and waiver program services similarities and differences.

Similarities	GR	Waiver
Population Served	Serve individuals with IDD. Aim to improve access to services and quality of life for people with IDD.	Serve individuals with IDD. Aim to improve access to services and quality of life for people with IDD.

Similarities	GR	Waiver
Service Coordination	Offers or supports service coordination/case management. Focus on helping individuals navigate systems of care.	Offers or supports service coordination/case management. Focus on helping individuals navigate systems of care.
Community-Based Focus	Emphasizes community-based services rather than institutional care. Work with a network of providers and resources in the community.	Emphasizes community-based services rather than institutional care. Work with a network of providers and resources in the community.
Differences	GR	Waiver
Structure	Operated and maintained by LIDDA.	Operated and maintained by HHSC contracted community providers.
Geographic Scope	Not all GR funded services described are available in all areas of the state.	All services are available to an enrolled person.
Funding	State funded.	Medicaid funded (i.e., state/federal match).

L-M. Regulatory and Complaint Information: Not applicable.

IDD Money Follows the Person

A. Division or program information:

Name of division or program: IDD Money Follows the Person

Location within the agency: CPSO

Contact name: Dana McGrath, Associate Commissioner; Anne McGonigle, Deputy Associate Commissioner of IDD Services and PASRR

Statutory citation: P.L. 109-171, Section 6071 of the Deficit Reduction Act of 2005; P.L. 117-328, 2023 Consolidated Appropriations Act, H.R. 2617; Texas Health and Safety Code, Chapters 534 and 546

B. Objective and major activities:

The MFP Demonstration is a federal initiative sponsored by the Centers for Medicare & Medicaid Services (CMS) and supported by the Olmstead decision (1999). It is a

settlement agreement between Texas and the U.S. Department of Justice to support state efforts to increase the use of community-based settings rather than institutional settings for providing long-term services and supports under the Medicaid program. There are two programs under MFP that IDD Services and PASRR directs: Enhanced Community Coordination (ECC) and Transition Support Teams (TSTs).

- ECC coordinators provide enhanced monitoring and flexible supports to aid in the successful community experience of individuals with IDD who are diverting from or leaving SSLCs, nursing facilities, and medium or large ICF/IIDs and enrolling in community-based programs for one year.
- TSTs support community service providers who, in turn, support people with IDD who are transitioning from a facility to the community, or individuals who need more support to remain living in the community. The focus of the support is on individuals who have complex medical, psychiatric, and behavioral needs, and TST provides support via technical assistance, education, and multidisciplinary case consultations.

MFP funded programs strengthen the services and supports through enhanced Federal Medical Assistance Percentage (FMAP), intensive monitoring, flexible supports, and increased access to clinical specialists, particularly in less resourced areas of the state. The federal MFP Demonstration grant has fully funded these programs since 2014.

C. Effectiveness and efficiency information:

ECC and TST programs submit quarterly reports on program activity, barrier, and outcome data directly to the IDD MFP Unit. They also submit quarterly expenditure reports monthly to ensure grant compliance. Monthly, LIDDAs submit SSLC transition monitoring reports to track compliance, Potentially Disrupted Community Transition (PDCT) events, resource utilization, and transition outcomes, including readmission and program completion rates. The unit tracks all potential threat notifications and contract program provider closures (both voluntary and involuntary) to monitor LIDDA compliance and identify trends. It also tracks all case consultations with LIDDAs, units within the agency (e.g., Health and Specialty Care System (HSCS), Behavioral Health Services (BHS)), and other state agencies (e.g., DFPS, Texas Juvenile Justice Department (TJJD)) to identify trends and monitor outcomes and resource allocation.

Table 2. Fiscal year 2024 MFTP program statistics.

	Total
Clients Served	25,919
ECC	949
TST	23,871
SSLC Transitions	223
Potential Threats	445
Provider Closures	369
Case Consults	62
Clients who re-entered and institutional setting	102

D. History: Not applicable.

E. Qualifications or eligibility requirements:

- Medicaid eligible.
- Program Eligibility Specific Medical Condition: Intellectual disability, developmental disability or related condition, developmental delay, functional limitation.
- Additional Eligibility Information: For ECC, an individual must meet an institutional level of care, want to divert, or transition to the community, require an array of long-term services and supports to be successful in the community, and be enrolling or already enrolled in the HCS or TxHmL waiver program.

F. Administration and key processes:

The IDD MFP unit is responsible for overseeing LIDDAs' implementation of these programs and funds spent by LIDDAs to ensure grant compliance, providing technical and clinical support for complex cases, and assisting LIDDAs when HHSC Long Term Care Regulatory identifies potential threats to a person's health and safety during contract closures. The unit also monitors all SSLC transitions to community-based programs for five years and all other types of institutional transitions and diversions for one year. The unit ensures that policies and procedures are followed, resources used, PDCT events are monitored, and technical assistance is provided when problems occur to avoid re-institutionalization. Annually, on average, the IDD MFP unit touches an estimated 7,680 records via

reviews, case monitoring, and assisting the field, which does not account for the multiple meetings and communications that often occur for each individual's case.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

HHSC contracts with LIDDAs, which are government entities, to deliver ECC and TST services. MFP projects are approved by CMS.

J. Barriers and challenges:

CMS typically does not provide an approved Notice of Award (NoA) until many months into the calendar year, resulting in HHSC fronting the grant money through General Revenue. The administrative costs budget load with the fronted General Revenue is based on the prior year's award; thus, it creates budgetary constraints if the grant budget had an increase/decrease to the request. The ability to access funding for end-of-fiscal year expenses can therefore be problematic.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Crisis Services

A. Division or program information:

Name of division or program: Crisis Services

Location within the agency: CPSO

Contact name: Dana McGrath, Associate Commissioner; Anne McGonigle, Deputy Associated Commissioner of IDD Services and PASRR

Statutory citation: Texas Health and Safety Code, Chapters 533A and 534; Texas Human Resources Code, Chapter 161

B. Objective and major activities:

HHSC contracts with LIDDAs to offer crisis services to people with IDD. Crisis services vary in availability but may be available up to 24 hours, 7 days a week,

and include identifying people in need of crisis assistance, prompt face-to-face crisis assessment, crisis respite services, and crisis follow-up and relapse prevention services. The crisis intervention specialist also provides consultation to Mobile Crisis Outreach Teams (MCOTs) and develops criteria for people being referred to crisis respite. Out-of-Home Crisis Respite includes therapeutic support in a safe and secure environment with staff on-site providing 24-hour supervision to people in crisis who cannot be stabilized in a less intensive setting. In-home Crisis Respite provides therapeutic support to people in crisis in their home when deemed clinically appropriate for the person to remain in their natural environment, and it is anticipated the crisis can be stabilized within a 72-hour period.

IDD Services and PASRR oversee LIDDAs' performance related to crisis services, offers support and technical assistance, and conducts quality assurance reviews.

C. Effectiveness and efficiency information:

Fiscal year 2024 Number of Clients Served: 2,722.

This data comes from MBOW, which is a system that LIDDAs use to input their encounters, and IDD Services and PASRR can run various reports. IDD Services uses contract monitoring functions to ensure effectiveness of programs.

D. History:

In 2015, the 84th Legislature allocated funding for the first time to the LIDDAs for the development of crisis services to support people with IDD who have significant behavioral and psychiatric challenges.

E. Qualifications or eligibility requirements:

To be eligible, there must be a person with IDD in a crisis. IDD Services and PASRR defines crisis as a situation in which:

- The person presents an immediate danger to self or others;
- The person's mental or physical health is at risk of serious deterioration;
- A person believes he or she presents an immediate danger to self or others; and
- A person believes that his or her mental or physical health is at risk of serious deterioration.

Minimum Age Requirement: 3 years old

F. Administration and key processes:

IDD Services and PASRR provide oversight and technical assistance to LIDDAs. Staff assist in developing program guidance, monitoring performance and outcomes via quarterly deliverables and data reports, ensuring compliance with federal and state regulations, and coordination with partner agencies, contractors, and other stakeholders. IDD Services and PASRR staff conduct monthly and quarterly internal/external meetings to ensure ongoing oversight and accountability.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

IDD Services and PASRR contracts with 39 LIDDAs, which are governmental entities, to carry out responsibilities related to crisis services.

J. Barriers and challenges:

There continues to be a need at the local level for outpatient psychiatric services for people with IDD. Oftentimes, LIDDAs report feeling underqualified to help individuals who are experiencing behavioral or psychiatric episodes that require medication, and individuals may be refused certain programs or services due to their IDD diagnosis.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Outpatient Biopsychosocial Intervention

A. Division or program information:

Name of division or program: Outpatient Biopsychosocial Intervention Services

Location within the agency: CPSO

Contact name: Dana McGrath, Associate Commissioner; Anne McGonigle, Deputy Associate Commissioner of IDD Services and PASRR

Statutory citation: 2020-21 General Appropriations Act, S.B. 1, 86th Legislature, Regular Session, 2019

B. Objective and major activities:

OBI services deliver outpatient mental health services tailored to people with IDD and mental health, substance use disorder, or behavioral needs. OBI providers complete biopsychosocial assessments, which include a person-centered and trauma-informed treatment plan along with support for the person's support system, and training and education with community partners. The biopsychosocial approach, implemented by LIDDAs, offers a holistic perspective that shifts focus from the person's diagnosis to a comprehensive understanding of the various aspects of an individual's life that influence mental well-being.

This service provides another resource for people with IDD who might end up incarcerated, in an emergency room, or at a psychiatric hospital. All three of these settings are costly and short-term. OBI services can help keep the individual in their current residence with support.

C. Effectiveness and efficiency information:

In fiscal year 2022, HHSC implemented OBI at five LIDDAs to provide these services in their designated service area. As of February 21, 2024, 184 people were enrolled and served in the OBI services program. In addition, since the inception of the program, 365 people have been served.

In fiscal year 2023, people receiving services showed a 37 percent decrease in the number of days spent in a hospital setting and a 62 percent decrease in the number of days spent incarcerated. The program has seen additional successes including individuals showing a decrease in both aggressive behaviors as well as a decrease in the number of emergency crisis calls and situations.

In fiscal year 2024, the OBI sites provided an average of two encounters every month per person served, making a total of 5,920 touch points people in crises received.

HHSC also tracks additional performance measures through the LIDDA's performance contract to ensure effectiveness of the program.

D. History:

In 2019, the 86th Legislature allocated \$3 million for IDD outpatient mental health clinics to enhance the services available for people with IDD and mental health needs. This funding established IDD community outpatient mental health services now known as OBI.

HHSC used a two-phase approach to implementing OBI services in Texas. Phase I, funded within fiscal year 2020, established a learning collaborative to advise HHSC on best practice models of services and associated outcome measures with demonstrated success providing outpatient mental health services for persons with IDD. Phase II, funded within fiscal year 2021, was the point of further planning of the best practice models of services and provision of services to recipients of the sites.

On November 1, 2020, HHSC implemented a pilot with eligible providers required to be designated as a LIDDA in accordance with Texas Health and Safety Code, Sections 533A.035(a) and 534.105, to provide outpatient mental health services as directed by the legislature.

E. Qualifications or eligibility requirements:

To be eligible, a person must reside in Texas and have IDD, or be presumed to have IDD, and must have a co-occurring mental health condition, substance use disorder or behavior support needs.

F. Administration and key processes:

The five OBI sites operate based on requirements in the LIDDA performance contract. IDD Services and PASRR provide contract and program oversight of each LIDDA through the assessment of performance measures as well as monthly and quarterly submission of data. IDD Services and PASRR staff also connect with the five sites to regularly discuss program progress and improvement functions and receive status updates.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

IDD Services and PASRR contracts with five LIDDAs, which are governmental entities, to carry out responsibilities related to the OBI program.

J. Barriers and challenges:

As previously mentioned, there continues to be a need at the local level for outpatient psychiatric services for people with IDD. However, proven success with the current sites offering the OBI program indicates expanding OBI to other LIDDA sites could save even more in institutionalization costs and help a larger number of individuals remain in the community successfully. HHSC received \$5.28 million in the 89th Legislative Session to expand OBI services to eight additional sites around the state.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Preadmission Screening and Resident Review

A. Division or program information:

Name of division or program: Preadmission Screening and Resident Review

Location within the agency: CPSO

Contact name: Dana McGrath, Associate Commissioner; Anne McGonigle, Deputy Associate Commissioner of IDD Services and PASRR

Statutory citation: 42 CFR Part 483, Subpart C, Sections 483.100 – 483.138; Texas Health and Safety Code, Title 2, Subtitle B, Chapter 242, Subchapter A, Section 242.158

B. Objective and major activities:

PASRR is a federally mandated program that requires states to pre-screen all people, regardless of payer source or age, seeking admission to a Medicaid-certified nursing facility. PASRR has three goals:

- Identify adults and children with serious mental illness (MI), intellectual disability (ID), or developmental disability (DD);
- Ensure appropriate placement, whether in the community or in a nursing facility; and
- Ensure people in nursing facilities with MI and/or an ID or DD receive the necessary specialized services.

C. Effectiveness and efficiency information:

The effectiveness of PASRR is measured, in large part, by the performance of the local authorities (LAs), which includes the LIDDAs and the LMHA or LBHA. The PASRR unit gathers information to evaluate performance by LAs through measures in their contracts, some of which are statutorily required, including:

- Completion and timeliness rates for PASRR evaluations and resident reviews entered into the Long-term Care Online Portal (LTCOP);
- Compliance percentage for assigning a habilitation coordinator within required timeframes;
- Completion percentage of PEs or resident reviews completed in referral section, if individual has noted interest in living somewhere other than a nursing facility;
- Completion of required follow-up visits for persons or their Legally Authorized Representative (LAR) who have refused MI specialized services in the initial Interdisciplinary Team (IDT) meeting; and
- Compliance with providing MI specialized services within 20 business days after MI specialized services were agreed upon in the initial IDT meeting as statutorily required.

D. History:

In July 2019, a new Medicaid-funded service called habilitation coordination rolled out as part of the implementation of a state plan amendment. HHSC created new rules, handbooks, and forms as part of this major project, which involved collaboration among units across HHSC.

In 2020, IDD Services and PASRR updated the PASRR rule in 26 Texas Administrative Code Chapter 303, to include a new section related to MI PASRR services. Benefits included increased access and utilization for MI PASRR services, which resulted in improved health outcomes for nursing facility residents, and improved contract management and oversight of LMHA and LBHA providers. IDD Services and PASRR also developed new handbooks and forms to support MI PASRR services in 2020.

E. Qualifications or eligibility requirements:

Program eligibility: Medicaid enrolled

Minimum Age Requirement: 18 for MI services and 21 for IDD

Nursing Facility Requirement: Medical Status is LOC VIII (Medical Necessity)

To be eligible for PASRR, an individual must have a confirmed developmental disability that meets the criteria described in the definition of "persons with related conditions" in 42 Code of Federal Regulations (CFR) Section 435.1010; ID as defined in 42 CFR Section 483.102(b)(3)(i); or serious MI, as defined in 42 CFR Section 483.102(b)(1). Diagnostic eligibility is confirmed through the PASRR Level II Evaluation.

F. Administration and key processes:

The PASRR unit collaborates and implements Texas Administrative Code rules related to the PASRR program/services; authorizing Nursing Facility Specialized Services (occupational, physical and speech therapy, customized manual wheelchair, and durable medical equipment) for PASRR positive IDD nursing facility residents; performing quality monitoring of PASRR requirements.; performing quality assurance for certain nursing facility residents; and providing technical assistance to nursing facilities and LAs on PASRR program requirements.

The PASRR unit also develops Business User Requirements and assists in functional design of enhancements for the Texas Medicaid & Healthcare Partnership (TMHP) LTCOP and trains nursing facilities and LAs on PASRR portal enhancements.

The PASRR Training team offers a combination of instructor-led virtual training as well as computer-based training for LA staff who work in the PASRR program. The Training Team also offers Person-Centered Thinking training each month.

Additional Compliance Monitoring: HHSC Long-Term Care Regulatory monitors nursing facility compliance with PASRR requirements. IDD Services and PASRR's Contract Accountability and Oversight team reviews LIDDA compliance, and Behavioral Health Services Operations Quality Monitoring Unit oversees compliance for LMHAs and LBHAs.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

LIDDAs, LMHAs, and LBHAs are quasi-governmental entities. Their responsibilities related to PASRR are outlined above.

J. Barriers and challenges:

Change of Ownership with nursing facilities presents a challenge with delaying services as the PASRR Level 1 screening forms and PASRR Evaluation must be reentered, and the whole PASRR process starts over again. This is a burden to the nursing facilities, local authorities, and state as HHSC is paying for unnecessary evaluations to be resubmitted. The cost to the state is more than \$500,000 each year.

K. Additional information:

HHSC conducted a pilot from November 1, 2024, through March 31, 2025, to preauthorize PASRR specialized services for individuals with IDD to help the agency track and monitor utilization of services.

Regulatory and Complaint Information: Not applicable.

Community Living Options Information Process

A. Division or program information:

Name of division or program: Community Living Options Information Process

Location within the agency: CPSO

Contact name: Dana McGrath, Associate Commissioner; Anne McGonigle, Deputy Associate Commissioner of IDD Services and PASRR

Statutory citation: Texas Health and Safety Code, Chapters 534 and 591

B. Objective and major activities:

HHSC contracts with 13 LIDDAs to provide information and education to residents of SSLCs about the options available to live in a community setting. CLOIP aims to provide residents of SSLCs with an opportunity to receive services in a less restrictive, more cost-effective community setting. LIDDAs provide community options for individuals in institutional settings on an annual basis.

Major activities include:

- Providing community living options information to people living in the assigned SSLC and their LAR at least one time per year;
- Completing the CLOIP instrument and providing a written report to the SSLC and designated LIDDA no later than 14 calendar days prior to the person's SSLC annual planning meeting;
- Attending the SSLC annual planning meeting in person or by teleconference, unless the resident or their LAR has specifically requested the LIDDA not participate; and
- Submitting information from the CLOIP instrument through the CARE system and encounter data related to the provision of CLOIP to the MBOW.

C. Effectiveness and efficiency information:

IDD Services tracks three performance measures related to CLOIP through the LIDDA's performance contracts:

- Provide CLOIP services a minimum of one time per year (99.5 percent in fiscal year 24);
- Completion of CLOIP instrument and written report to the SSLC no later than 14 calendar days prior to annual planning meeting (99.25 percent in fiscal year 24); and
- Attend the annual meeting 100 percent of the time unless requested not to by the resident or their LAR (99 percent in fiscal year 24).

In fiscal year 24, CLOIP served an estimated 1,989 clients. The data for this number as well as performance measure compliance comes from CARE. LIDDAs enter the data for CLOIP in CARE so that IDD Services and PASRR can then take raw data and determine numbers served and compliance.

D. History:

S.B. 27, 80th Legislature, Regular Session, 2008, required the former Department of Aging and Disability Services (DADS) to develop a community living options information process, create uniform procedures for the implementation of the process, and minimize related potential conflicts of interest between an SSLC and an adult resident, an adult resident's legal representative, or a local authority.

E. Qualifications or eligibility requirements:

Eligibility for CLOIP:

- Minimum Age Requirement: 22
- Program Eligibility Specific Medical Condition: Intellectual disability, Developmental disability, or related condition.
- Additional Eligibility Information: Resides at an SSLC.

F. Administration and key processes:

HHSC provides oversight by tracking performance measures related to the provision of CLOIP. IDD Services and PASRR staff run CLOIP reports at the end of each quarter to identify any LIDDA showing out of compliance for the three CLOIP performance measures. HHSC contacts LIDDAs with compliance below 95 percent to alert them of the non-compliance and coordinates a meeting for them to present information and justification for the non-compliance. HHSC reviews all information, sends the final report to the Contracts Management Unit, and presents data at the quarterly performance review meeting. Staff also run monthly CLOIP reports to determine if anyone is past due for CLOIP and contact LIDDAs to discuss past due contacts. HHSC also provides guidance and technical assistance regarding the CLOIP process.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

IDD Services and PASRR contracts with 13 LIDDAs, which are governmental entities, to carry out CLOIP responsibilities. The LIDDAs work closely with SSLCs.

J. Barriers and challenges:

CLOIP currently uses an IT system called CARE, which is an obsolete IT system first implemented in 1986 and serves as a means for the LIDDAs to submit information to HHSC.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Family Based Alternatives/Permanency Planning

A. Division or program information:

Name of division or program: Family-based Alternatives/Permanency Planning

Location within the agency: CPSO

Contact name: Dana McGrath, Associate Commissioner; Anne McGonigle, Deputy Associate Commissioner of IDD Services and PASRR

Statutory citation: S.B. 368, 77th Legislature, Regular Session, 2001; Government Code, Chapter 546

B. Objective and major activities:

The program's goal is to help children with disabilities who live in institutions transition into family-based settings, such as foster care, adoptive homes, or permanent family homes.

Major Activities include:

- Recruitment and Training: Identifying and preparing support families to care for children with disabilities;
- Comprehensive Assessments: Evaluating the needs of each child and the capabilities of potential support families to ensure appropriate placements;
- Parental Engagement: Providing information to parents about family-based alternatives and involving them in the decision-making process;
- Identification and Support: Recognizing children in institutional settings and offering services to facilitate their return to family environments;
- Permanency Planning: Individuals with IDD in Texas who are under the age of 22 and living in non-familial settings must have a permanency plan. Permanency planning involves three major activities: obtaining background information to understand the person, their history, and their family and other significant relationships; setting goals regarding family life by engaging the family and LAR and the person in the discussion of options; and identifying action plans to achieve goals and reviewing and revising plans as needed;

- ▶ Each plan must include permanency planning goals that are ongoing and reviewed at least semiannually; and
- ▶ There are two permanency planning goals to choose from: return home with access to needed services or move to a family-based alternative setting with access to needed services.

IDD Services and PASRR contracts with EveryChild, Inc. to provide family-based alternative services and to conduct permanency planning children living in a nursing facility while LIDDAs conduct permanency planning for those living in SSLCs, ICF/IIDs, and HCS group homes.

C. Effectiveness and efficiency information:

For Family Based Alternative, IDD Services, and PASRR contracts with EveryChild, Inc. to assist Texas children to receive family support in a permanent living arrangement. Since its inception in 2002, the program has identified and tracked 2,349 children, and 904 children moved to families with EveryChild, Inc.'s assistance.

Table 3. The number of activities EveryChild, Inc. (fiscal year 2024).

Activity	Number*
Children moved or diverted from facilities to families	58
Children worked with in 2024	304
Number of Families and Guardians Assisted	268
Number of Permanency Plans Completed	189
Number of Support Families we worked with	346
Number of Newly Identified Support Families	105
Number of Providers EveryChild, Inc. provided outreach and technical assistance to (HCS and CPS)	430
Number of LIDDAs worked with on behalf of a child	33
Number of LIDDA staff that completed the on-line Permanency Planning Training	389

The program collects data for the number of children transitioned and the types of placements and measures reduction in institutionalization by comparing historical and current data on institutional populations. EveryChild, Inc. establishes its metrics and reports data to IDD Services and PASRR.

Gathering data for completing permanency plans by the LIDDAs is a hybrid process. LIDDAs must enter permanency plans into CARE. IDD Services and PASRR runs a

weekly XPTR report, which also allows the team to calculate compliance. For fiscal year 24, LIDDAs had a 98.7 overall compliance percentage.

Additionally, IDD Services and PASRR monitor performance through contract performance measures. HHSC created these performance measures to meet legislative requirements. Annually, IDD Services and PASRR must deliver the Permanency Planning and Family Based Alternatives report to the Legislature regarding all children entering and exiting an institution. The report must also contain data on families the program is providing options to move from institutional settings.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

To be eligible for family-based alternatives services, you must be a child defined as person younger than 22 years of age, who is Medicaid eligible, and have one or more of the following:

- A physical disability;
- An intellectual disability;
- A developmental disability; and/or
- A medically fragile condition.

Additional eligibility information for permanency planning: children with IDD in Texas living in non-familial settings must have a permanency plan.

For children in an ICF/IID or HCS group home setting, the LIDDA is responsible for developing and reviewing the permanency plan. Individuals must reside in an institutional setting as defined in Texas Government Code, Section 531.151.

F. Administration and key processes:

EveryChild, Inc. operates based on the requirements in the family-based alternatives contract. IDD Services and PASRR provide oversight and policy direction for family-based alternatives. Staff roles include developing program guidelines, monitoring performance metrics and outcomes, ensuring compliance with federal and state regulations, and coordination with partner agencies and stakeholders.

IDD Services and PASRR oversee and provide support to the 39 LIDDAs and Every Child, Inc. IDD Services and PASRR staff run reports with permanency plans that are out of compliance and send those to LIDDAs. Staff also review and respond to requests for technical assistance.

The active contract for family-based alternatives undergoes both programmatic and financial monitoring to ensure ongoing oversight and accountability. HHSC does this through the assessment of performance measures and through meetings which review monthly and quarterly programmatic and financial data. These meetings help facilitate proactive communication, address potential concerns, and support the contractor's performance.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

EveryChild, Inc. works alongside LIDDAs to find family-based placements and provides training and technical assistance to LIDDAs. LIDDAs are governmental or quasi-governmental entities designated by the state. DFPS also provides permanency planning activities for children in their care and residing in General Residential Operations.

J-M. Barriers, Additional, Regulatory, and Complaint Information: Not applicable.

Multi Assistance Center

A. Division or program information:

Name of division or program: Multi Assistance Center

Location within the agency: CPSO

Contact name: Dana McGrath, Associate Commissioner; Anne McGonigle, Deputy Associate Commissioner of IDD Services and PASRR

Statutory citation: 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Article IX, Section 17.31); 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 85)

B. Objective and major activities:

H.B. 1, 88th Legislature, Regular Session, 2023, HHSC Rider 85, directed HHSC to contract for the support of a demonstration project using a one-stop shop model that provides on-site services to adults and children with special needs in Bexar County and South Texas counties in Texas Public Health Regions 8 and 11. As a result, HHSC created the MAC Demonstration Project.

MAC aims to provide a centralized, coordinated care model for individuals with disabilities and special needs. Its primary goal is addressing both medical and non-medical services, such as transportation, housing, and employment, through a person-centered approach. IDD Services and PASRR contracts with Morgan's Wonderland to provide the Multi-Assistance Center Demonstration Project activities.

Major Activities include:

- Providing single point of contact by assigning coordinators to assist individuals and families in navigating available resources;
- Promoting self-determination by supporting individuals in making informed life decisions and exercising autonomy;
- Providing advocacy and community integration support for individuals and assisting them in engaging with their local community;
- Helping individuals build informal support systems and meaningful relationships;
- Assisting individuals in accessing on-site medical care, dental care and therapy services including speech, occupational, physical, and individual/family therapy services;
- Helping individuals obtain services such as transportation and other community resources; and
- Conducting outreach to ensure individuals and families are aware of and connected to MAC services.

C. Effectiveness and efficiency information:

MAC served 3,500 individuals in fiscal year 2023 and 4,797 in fiscal year 2024.

Table 4. Activities Morgan's Wonderland completed (fiscal year 2025 to date).

Area	Metrics	Fiscal Year 2025 Year to Date
Single POC Coordinators	Total number of unique individuals served (MAC Intake completed)	2,545
Single POC Coordinators	The total number of unique individuals served	4,797
Single POC Coordinators	The number of unique individuals successfully referred by SPOCC to Medical Services	1,846
Single POC Coordinators	The number of individuals successfully referred by SPOCC to Dental Services	1,069
Single POC Coordinators	The number of individuals successfully referred by SPOCC to Therapy Services	355
Single POC Coordinators	The total number and type of service encounters that the SPOCC provided	83,110
Single POC Coordinators	The number and type of assessments conducted	3,745
Single POC Coordinators	The total number of outside referrals for services not provided at the MAC	2,136
Single POC Coordinators	The total number of referrals made to the Local Intellectual and Developmental Disabilities Authorities	716
Medical Services	The number of unique individuals who received on-site medical services	15,644
Medical Services	The total number of on-site medical services encounters	20,445
Medical Services	The total number of medical referrals made by physicians	7,598
Medical Services	The number of unique individuals who received on-site dental services	1,666
Medical Services	The total number of dental services encounters	1,666
Medical Services	The total number of outside referrals made by dentists	28
Therapy Services	The number of unique individuals who received speech on-site therapy services	1,543
Therapy Services	The total number of on-site speech therapy services encounters	16,957
Therapy Services	The total number of therapy referrals made by a therapist	55
Non-medical Services	The number of unique individuals who received transportation services	573
Non-medical Services	The number of instances in which an individual received transportation assistance to attend on-site services at the Multi-Assistance Center OR to services an individual is referred to by the Multi-Assistance Center	1,341

MAC staff gather data through the MAC system, which tracks individual care plans, service utilization, and outcomes, and reports to IDD Services and PASRR.

Performance contracts include additional measures that the MAC tracks through the contract monitoring process.

D. History:

MAC was originally allocated \$3,750,000 per fiscal year. The continuation of the project occurred through the 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 85), and increased allocated funding to \$7,500,000 per fiscal year beginning in fiscal year 2024.

While initially focused on individuals with IDD, the MAC model began serving a broader range of individuals with complex medical, behavioral, and social needs. This shift allowed the center to impact more families while still prioritizing people with disabilities.

MAC, originally envisioned as a standalone hub, deepened partnerships with LIDDAs, schools, Medicaid managed care organizations, and hospitals, creating referral pathways and co-managed care plans. This marked a shift from working parallel to existing systems to becoming integrated with them.

E. Qualifications or eligibility requirements:

Residential requirements: reside in Bexar County or another county in Texas Public Health Region 8 or 11.

People who meet one of the following criteria are eligible for navigation services:

- People with intellectual disabilities;
- People with autism spectrum disorder;
- People with a related condition on the current HHSC-approved list of related conditions;
- People diagnosed with pervasive developmental disorder (PDD) or Asperger disorder through a diagnostic assessment completed before 2013;
- People of any age with long-term impairment of cognitive, sensory, motor, or communication function(s), either congenital or acquired, that is not readily rehabilitated;

- People who qualify for ECI; and
- People who reside in a nursing facility who are eligible for specialized services.

F. Administration and key processes:

IDD Services and PASRR provide oversight and policy direction for MAC as part of its mission to improve access to coordinated, person-centered services for Texans with IDD and other complex needs. Staff roles include developing program guidelines, monitoring performance metrics and outcomes, ensuring compliance with federal and state regulations, and coordination with partner agencies and stakeholders.

The active contract for MAC undergoes both programmatic and financial monitoring at least once per contract term, with the most recent quality assurance review completed in March 2024.

G. Funding: See “Agency Program Information Spreadsheet.”

H. MOUs and interagency agreements or contracts:

MAC does not replace LIDDAs but complements them. IDD Services and PASRR ensure responsibilities between these services are clearly delineated, so they do not overlap. IDD Services and PASRR manage this coordination between MAC and LIDDAs by establishing formal contracts with both entities. These agreements clearly define roles and responsibilities to avoid duplication of services and establish performance standards for accountability.

I-J. Relationships with others, and Barriers: Not applicable.

K. Additional information:

MAC is looking to grow its client base by serving individuals outside of Bexar County. Initially, MAC focused heavily on serving individuals in Bexar County while they started operations. Now in its third full fiscal year of operation, the MAC can reach individuals who may live in more rural areas or who are not as close to the MAC headquarters. MAC must serve Texas Public Health regions 8 and 11 – a total of 11 counties.

L-M. Regulatory and Complaint Information: Not applicable.

Aging and Disability Resource Centers

A. Division or program information:

Name of division or program: Office of Aging and Disability Resource Centers (OADRC)

Location within the agency: CPSO

Contact name: Dana McGrath, Associate Commissioner; Keely Lee, Director of Aging and Disability Resource Centers

Statutory citation: Older Americans Act (OAA) of 1965, Public Law 89-73, as amended through Public Law 116-131, enacted on March 25, 2020; 42 US Code, Chapter 35

B. Objective and major activities:

OADRC provides contract oversight for the 28 Aging and Disability Resource Centers (ADRCs) that provide services statewide. These providers, including government and nonprofit organizations, serve as key access points for person-centered long-term services and supports. They provide one-stop access to resources for individuals seeking community options, both private and public and offer specialized information, referrals, and assistance.

Under the oversight of OADRC, ADRCs administer programs including the following:

- The Medicare Improvement for Patients and Providers Act (MIPPA): Helps Medicare beneficiaries with limited income and assets learn about programs that may reduce their Medicare costs. Through MIPPA, ACL provides grants to states and tribes to support targeted outreach and education to eligible Medicare beneficiaries, especially those who are low-income with limited resources or residents of rural areas.
- The Texas Lifespan Respite Care Program (TLRCP), also known as Take Time Texas: Increases access to available respite services for family members caring for individuals of any age with chronic health conditions or disabilities. TLRCP offers short-term respite care services to provide a brief period of relief or rest. These services are tailored to the needs of each caregiver and can be provided in the form of in-home or out-of-home respite care.

C. Effectiveness and efficiency information:

OADRC staff monitor contract deliverables related to ADRC programs by reviewing data provided from quarterly performance reports as the program does not have a statewide information management system. To measure effectiveness and efficiency, the program uses the contract measures outlined below.

Table 5. ADRC client interactions (fiscal year 2024).

	Total
Toll-Free Line Calls	99,262
Call on Other Lines	73,085
Walk-ins	2,584
Fax/Email/Other referral sources	9,710
Application Assistance	4,754
Complaints	8
AAA Referrals	22,338
LTSS Outreach	1,503
Respite Outreach	584
Unduplicated Caregivers Served	289
Total respite hours	17,960

D. History: Not applicable.

E. Qualifications or eligibility requirements:

ADRCs serve any individual planning for long-term services and support, and their caregivers, without regard to age or income. They provide person-centered services to individuals and caregivers in the following populations:

- Individuals who are older;
- Individuals with intellectual, developmental, and/or physical disabilities;
- Individuals with chronic diseases;
- Informal, unpaid caregivers, such as family caregivers;
- Families with children who have special needs; and
- Veterans.

MIPPA serves the following populations:

- Low-income with limited resources;
- Reside in rural areas;

- Members of American Indian, Alaskan Native, Native Hawaiian communities;
- Individuals aged 65 and older;
- Individuals with disabilities under age 65; and
- Speakers of English as a secondary language.

TLRCP serves family members or caregivers, who care for a person of any age with any chronic health condition or disability.

F. Administration and key processes:

OADRC administers the ADRC program through performance-based contracts with regional organizations. These contracted providers are responsible for delivering ADRC core services, including information and referral and streamlined access to long-term services and supports. To the extent allowed by federal law and state funding, HHSC issues a Request for Applications (RFA) every five years for ADRC grantees. This process enables community-based providers to apply for funding to deliver ADRC services in designated areas.

HHSC oversees contract compliance and data reporting to ensure each ADRC meets defined performance metrics, adheres to state and federal guidelines, and effectively supports individuals navigating LTSS services.

ADRC grantees receive technical assistance through various methods, including webinars, peer learning exchanges, written guidance, and on-site training and support.

OADRC closely monitors budgets and expenditures to ensure accurate payments. This involves monthly verification of billing documents, biannual budget reviews and assessments, and implementing an annual monitoring plan. Additionally, the OADRC team uses program data to ensure quality metrics for target populations and to track performance indicators.

G. Funding: See “Agency Program Information Spreadsheet.”

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

HHSC contracts with the 28 ADRCs, 19 of whom are local councils of government. The City of Houston also contracts for one local ADRC.

J. Barriers and challenges:

OADRC and its providers must manage program and fiscal data manually; staff enter data from paper applications, postal mail, faxes, and in-person interviews into files or spreadsheets. This limits their ability to track important client information locally and at the state level. A statewide information management system would allow for a more comprehensive tracking process and improve data collection.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Office of Area Agencies on Aging

A. Division or program information:

Name of division or program: Office of Area Agencies on Aging (OAAA)

Location within the agency: CPSO

Contact name: Dana McGrath, Associate Commissioner; Katlyn Le, Director of Office of Area Agencies on Aging

Statutory citation: Human Resources Code, Title 6, Chapter 101A; Texas Government Code, Title 4, Subtitle I, Chapter 531; Texas Government Code, Title 12, Chapter 394, Section 394.902

B. Objective and major activities:

As the designated State Unit on Aging (SUA), OAAA is responsible for administering Older Americans Act (OAA) services and programs federally funded through Title III and Title VII of OAA. Title III includes supportive services, nutrition services, family caregiver supports, legal services, and preventive services. Title VII authorizes the Long-Term Care Ombudsman program, as well as elder abuse, neglect, and exploitation prevention programs. OAAA contracts with 28 local AAAs representing all 254 Texas counties to provide services to people aged 60 and older, their family members, and caregivers.

C. Effectiveness and efficiency information:

OAAA contracts with a Software as a Solution (SaaS) vendor, WellSky Corporation, to provide an aging and disability application called the SUA Programs Uniform Reporting System (SPURS). Serving as the data source for the annual report and

performance measures listed below, this system is tailored to assist states with OAA performance reporting and includes the State Health Insurance Assistance Program (SHIP) and MIPPA. SPURS serves as the data source for key information collected to report to ACL through their OAA Performance System (OAAPS), which collects participant, service, and expenditure data from SUAs across the country. ACL defines the methodology for each information item listed below. Performance measures include:

SHIP:

- Percentage of total client contacts per Medicare beneficiaries in the state;
- Percentage of persons reached through presentations, booths/exhibits, and enrollment events per Medicare beneficiaries in the state;
- Percentage of contacts with Medicare beneficiaries under the age of 65 per Medicare beneficiaries under 65 in the state;
- Percentage of low-income, rural, and non-native English contacts per total “hard-to-reach” Medicare beneficiaries in the state; and
- Percentage of unduplicated enrollment contacts discussed per Medicare beneficiary in the state (i.e., contacts with beneficiary on one or more qualifying enrollment topics).

MIPPA (fiscal year 2024):

- Total number of MIPPA contact activities: 18,751
- Total number of persons reached: 60,344
- MIPPA target population contacts: 8,300
- Contacts with applications submitted: 2,829

D. History: Not applicable.

E. Qualifications or eligibility requirements:

To be eligible to receive services under OAA, an individual must be 60 years of age or older; there are no income or resource limits.

Additional eligibility requirements for caregiver services and home-delivered meals are outlined in the OAAA Policy and Procedure Manual.

SHIP and MIPPA services support people with limited incomes, Medicare beneficiaries under the age of 65 with disabilities, and individuals who are dually eligible for Medicare and Medicaid.

Total number of people reached in federal fiscal year 2024 was 13,290,561.

F. Administration and key processes:

OAAA contracts with 28 local AAAs that deliver the OAA programs, services, and activities locally in all 254 Texas counties. OAAA key functions include oversight, guidance, and fund distribution for AAAs. AAAs provide services directly or through subcontracts with local service providers to deliver cost-effective, non-clinical, long-term services and support in the homes and communities of older adults and family caregivers.

The following divisional units collaboratively practice quality management and improvement activities in support of the funded partners.

- **Finance and Contracts:** Manages and monitors contracts to ensure compliance with state and federal requirements. These functions include all activities related to the life cycle for every contract, including on-site or desk monitoring, corrective action plans, the risk assessment process, and payments to providers. In addition, OAAA provides technical assistance and training to AAAs about contract management and monitoring.
- **Data and Reporting:** Manages annual performance reporting and submission of the State Performance Report (SPR), which includes information on the activities carried out under OAA. Data and Reporting supports the SPURS Information Management System (IMS), which includes SUA, and the State Long-Term Care Ombudsman Program (SLTCOP) consumer data, service delivery information, client intake assessments and service activities to directly satisfy all applicable state and federal requirements, including automated grant reporting for OAAPS, the National Ombudsman Reporting and the SHIP Tracking and Reporting System database. In addition, OAAA provides technical assistance and system application training to end users.
- **Program and Policy:** Ensures AAA policies and procedures are consistent with state and federal requirements. Staff assist in programmatic performance reviews and provide technical assistance to local AAAs as needed. Program and Policy staff also monitor SHIP and MIPPA data to ensure program compliance and identify areas that require further guidance and support.

G. Funding: See "Agency Program Information Spreadsheet."

OAAA uses a funding formula to distribute funds to a AAA in accordance with the Older Americans Act Section 305(a)(2)(C) and Texas Administrative Code, Section 213.301.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

Local partnerships include the 28 AAAs, most of which are councils of government. Regional partnerships include the ACL Center for Regional Operations (CRO), which serves as a liaison to states, territories, and tribes conducting day-to-day program management operations regarding OAA.

OAAA established a relationship with Federal Region VI (Arkansas, Louisiana, Oklahoma, New Mexico, and Texas), which serves as a resource and consultant regarding daily operations, deadlines, and new initiatives (e.g., State Plan on Aging, federal regulatory clarification, and training opportunities).

J. Barriers and challenges: Not applicable.

K. Additional information:

In February 2024, ACL released a final rule to update regulations for implementing its OAA programs. This was the first substantial update to OAA program regulations since 1988. Effective on March 15, 2024, the rule aligned regulations to current statute and clarified policies and expectations; regulated entities have until October 1, 2025, to comply or submit a corrective action plan to come into compliance. OAAA is in the process of updating outdated Texas Administrative Code rules and associated policy and procedures to comply with the new regulations.

L-M. Regulatory and Complaint Information: Not applicable.

Independent Living Services

A. Division or program information:

Name of division or program: Independent Living Services (ILS)

Location within the agency: CPSO

Contact name: Dana McGrath, Associate Commissioner; Cecilia Berrios, Director of Independent Living Services

Statutory citation: Texas Human Resources Code, Section 117.080

B. Objective and major activities:

ILS contracts with 11 Centers for Independent Living (CIL) for purchased services and 14 CILs to provide the base grant direct services, as required by Texas Human Resources Code, Section 117.080. Purchased services are for the procurement of goods and services needed for people with disabilities to live more independently, such as hearing aids, home and vehicle modifications, power wheelchairs and scooters, prosthetics and orthotics and durable medical equipment. Base grant services include information and referral services, independent living skills training, advocacy, peer counseling, and transition services.

HHSC provides a pass-through grant to the State Independent Living Council (SILC), whose key role is to develop the three-year State Plan for Independent Living (SPIL) and implement various independent living projects across Texas. The CILs carry out these projects separately from their contracts with HHSC. At least 51 percent of all CILs in the state and HHSC must sign the SPIL.

The ILS Program also works closely with the Texas Workforce Commission-Vocational Rehabilitation (TWC-VR). TWC-VR and ILS serve similar populations, with the primary difference being whether consumers are interested or able to work. As such, an information-sharing MOU is in place with TWC to ensure continuity of services between consumers of the two programs.

C. Effectiveness and efficiency information:

HHSC reports to LBB on two key performance measures for ILS:

- 6-2-1-OP-1: number of people receiving services from CILs: 4,768 in fiscal year 2024; and
- 6-2-1-OP-2: number of people receiving HHSC contracted ILS: 2,782 in fiscal year 2024.

Total fiscal year 2024 number of clients served: 7,550

Purchased Services contracts (for fiscal year 2023-24):

- Average wait time reduced from 619 days to 558 days;
- Successful case closures (cases where independent living goals are met) increased from 667 to 733; and
- Referrals increased from 1,597 to 1,727.

Base Grant contracts (from fiscal year 2023-24):

- Increase in independent living skills training from 192 to 319;
- Increased advocacy services from 381 to 415; and
- Implemented a new initiative to conduct quarterly training sessions to enhance grantee staff capacity.

Sources: ILS Data Reporting System and Form 3161, Consumer Demographics Report

D. History:

On September 1, 2016, HHSC outsourced the purchased services grant to CILs as required by H.B. 2463, 84th Legislature, Regular Session, 2015.

E. Qualifications or eligibility requirements:

To be eligible for services, a person must have a significant disability and reside in Texas. The program serves all disabilities regardless of income level.

According to the Governor’s Committee for [People with Disabilities: A Texas Profile](#), approximately 3.5 million Texans, or 12.1 percent, have a disability. The tables below show demographics information for the purchased services grant. Demographics data for the base grant is not reported to HHSC.

Table 6. Purchased Services Grant percent of people served by age (fiscal year 2024).

Age	Percent of People Served
Under 18	2.8%
18-54	24.4%
Over 55	72.8%

Table 7. Purchased Services Grant percent of people served by race (fiscal year 2024).

Race	Percent of People Served
Black or African American	19.1%
Hispanic or Latino	38.9%
White	39.9%
All other races	2.1%

Table 8. Purchased Services Grant percent of people served by primary disability (fiscal year 2024).

Primary Disability Type	Percent of People Served
Hearing	24.4%
Vision	5.3%
Physical	66.8%
DeafBlind	0.4%
Cognitive	1.8%
Mental/Emotional	0.4%
Other	0.9%

F. Administration and key processes:

The ILS program supports CILs through technical assistance and live webinars. The program supports the SILC through technical assistance, providing feedback on the SPIL, and sharing information with SILC on CIL progress towards spending funds and highlighting ILS program activities.

G. Funding: See “Agency Program Information Spreadsheet.”

H. MOUs and interagency agreements or contracts:

TWC and HHSC have an MOU that describes the information sharing process between the two agencies. TWC provides vocational rehabilitation services, which can include similar services to ILS purchased services but are specific to people seeking or maintaining employment. The TWC Older Individuals who are Blind Program offers some of the same vision services provided in ILS purchased services but are specific to people 55 years of age or older. TWC also offers services to help youth with disabilities transfer out of high school into adulthood, but this is more vocationally focused than that of ILS.

I. Relationship with other governmental entities:

ACL works with HHSC to provide guidance related to federal reporting and answers any questions about the laws governing CILs.

J. Barriers and challenges:

HHSC serves as the designated state entity for ACL Part B funds. The Texas SILC determines the funding distribution for CILs and operates autonomously from HHSC. There is significant variation in the contract awards for each CIL. Some CILs receive more than they are capable of spending while others consistently spend the entire amount. This allows for limited authority by HHSC to influence substantial program changes, such as methods to address lapsed funding.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Health and Independence

Health and Independence includes four sections:

- Children's Autism and Blindness Services;
- Deaf and Hard of Hearing Services (DHHS);
- Brain Injury Programs; and
- Specialty Health.

Children's Autism and Blindness Services

Autism

A. Division or program information:

Name of division or program: Children's Autism Program

Location within the agency: CPSO

Contact name: Keisha Rowe, Associate Commissioner of Health and Independence

Statutory citation: Texas Human Resources Code, Chapters 114 and 117, Section 117.082

B. Objective and major activities:

The Children's Autism Program provides focused applied behavior analysis (ABA) treatment services to children ages 3-15 with a diagnosis on the autism spectrum. ABA is a treatment that uses behavioral principles to evaluate and teach socially relevant behaviors and skills, while also increasing desired behaviors through positive reinforcement.

The Children's Autism Program is a contracted service, a payor of last resort, and implements cost sharing for families participating in services based on a sliding scale and the availability of insurance coverage. The Texas Autism Resource and Research Center (TARRC) is part of the Children's Autism Program. TARRC is a centralized virtual resource for research and support for Texans on the autism spectrum and their families. The Children's Autism Program and TARRC provide ongoing communication with autism service providers and experts to ensure program services are maximized within available resources and to ensure efforts are identified to advance training and professional development through dialogue with stakeholders.

C. Effectiveness and efficiency information:

HHSC reports to LBB on three key performance measures for the Autism Program (with fiscal year 2024 metrics):

- Average monthly number of children receiving autism services: 352
- Average monthly cost per child receiving autism services: \$729.07
- Year-end total number of children receiving services: 802

The program conducts a Children's Autism Program customer survey during each participant's exit interview through an online survey in English and Spanish. The Children's Autism Program last administered the survey in 2024. Thirty-six surveys were collected during this period with all respondents reporting as satisfied or very satisfied on areas of service location, parent training, and transition planning. Children's Autism also collects data on operationally defined target behaviors identified in the child's treatment plan and collects baseline data, includes all subsequent data in the treatment data, and enters all data into the Autism Data Reporting System.

D. History:

In 2007, the Governor and LBB submitted a letter to HHSC directing the transfer of \$5 million in appropriated funds to the Department of Assistive and Rehabilitative

Services (DARS) to provide services to children ages 3-8 with autism, initially establishing the program. By March 2008, DARS conducted a competitive procurement and awarded contracts to four community-based organizations in Dallas, Fort Worth, Houston, and Rosenberg to provide autism treatment services.

The 2010-11 General Appropriations Act, S.B. 1, 81st Legislature, Regular Session, 2009, increased appropriations for the DARS Autism Program to \$6.6 million for the biennium. DARS awarded contracts to two additional community-based organizations in Austin and San Antonio, for a total of six contractors statewide.

Through the 2014-15 General Appropriations Act, H.B. 1, 83rd Legislature, Regular Session, 2013, the Legislature increased appropriations for the program to \$8.6 million for the biennium. Legislation required DARS to develop a plan to increase the number of children receiving autism services. DARS promulgated initial rules for the Autism Program, effective March 2013, and included two types of ABA services for children: Comprehensive ABA services for children aged 3-5 years and Focused ABA services for children aged 3- through 15 years. Additionally, DARS implemented a web-based data system for the Autism Program to allow contractors to enter client demographic and service data and to submit contract billing electronically, effective June 24, 2013.

In addition to transferring the program to HHSC, the 84th Legislature (2015) codified the Children's Autism Program, to Texas Human Resources Code, Section 117.082. The legislature also appropriated \$14 million dollars to the program and required DARS to phase out the comprehensive ABA services by August 31, 2017.

E. Qualifications or eligibility requirements:

- Residency: Texas resident;
- Age Requirement: 3 to 15 years of age;
- Medical Status: Developmental disability or related condition; and
- Program Eligibility Specific Medical Condition: Diagnosed on the autism spectrum.

Table 9. Children's Autism Program demographics by percent served.

Demographics	Percent Served
Race/Ethnicity	
American Indian/Alaskan Native	1%
Asian	6%

Demographics	Percent Served
Black or African American	18%
Hispanic or Latino	50%
Native Hawaiian/other Pacific Islander	<1%
White	40%
Primary Language	
English	90%
Spanish	9%
Other	1%
Sex	
Male	80%
Female	20%
Age at Entry to Services	
3-5 years	37%
6-9 years	39%
10-12 years	17%
Gross Family Income	
\$0 - \$21,000	40%
\$21,001 - \$51,000	35%
\$51,001 - \$71,000	11%
\$71,001 - \$101,000	8%
Over \$101,000	6%

F. Administration and key processes:

HHSC administers the Children's Autism Program through 21 competitively procured, fee-for-service contracts with community-based agencies and organizations. The program rules, in addition to the contract terms and conditions, govern the operations of the HHSC Children's Autism Program.

The team is responsible for developing program rules and operating procedures, providing oversight of the contracted services, including contract monitoring, and managing TARRC and its associated activities.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

The Children's Autism Program works with TWC's VR, HHSC's ECI, TEA, Educational Service Centers (ESCs), and Local Education Agencies (LEAs). TWC VR serves transition-age students and adults, with a focus on employment. The Children's Autism Program may refer a child to the VR program for eligibility determination with parental consent. TEA, ESCs, and LEAs focus on community-based educational programs for students with autism. The Children's Autism program contractors offer the child and family support and collaboration with other service providers.

J. Barriers and challenges:

The need for ABA services exceeds the capacity of the program. The program does not maintain a centralized interest list, but the statewide number reported by the contractors is 1,088. A considerable number of the children served have intense behavioral needs that require more than one staff person to provide treatment, and more children are in rural areas with less community resources.

K. Additional information:

In 2025, the Children's Autism Program held a virtual 2025 Texas Autism Conference: Collaborative Pathways in Autism on April 14-17, 2025, and had over 1,000 attendees.

In addition, the program is exploring options for re-establishing the TARRC as an ongoing stakeholder group or other ways to gain continual feedback from stakeholders. TARRC currently only exists as a website for resources.

L-M. Regulatory and Complaint Information: Not applicable.

Blind Children's Vocational Discovery and Development Program

A. Division or program information:

Name of division or program: Blind Children's Vocational Discovery and Development Program (BCP)

Location within the agency: CPSO

Contact name: Keisha Rowe, Associate Commissioner of Health and Independence

Statutory citation: Texas Human Resources Code, Chapter 91, Section 91.028

B. Objective and major activities:

BCP provides opportunities for Texas children between the ages of birth to 22 years old who are blind or severely visually impaired to learn the skills required for personal independence, potential employment, and integration into their community. The following services provided directly by BCP staff enhance children's ability to develop skills comparable to those of their sighted peers and help children achieve financial self-sufficiency and increase independence as adults:

- **Comprehensive Needs Assessment:** All enrolled children receive an initial, comprehensive needs assessment that is updated annually which includes assessing the child and family's proficiency in developmental and core skill areas; arranging for routine eye exams and specialty eye exams; arranging for medical or non-medical diagnostic services; and helping the family understand the results of diagnostic examinations.
- **Family Service Plan:** Based on the assessment, a team that includes the family, the child, and the Blind Children's Specialist, at a minimum, agrees on a plan which meets an individual's needs.
- **Direct Service and Case Management:** Blind Children's Specialists serve a dual role as case managers and direct service providers. They may provide direct services to children and families such as skills training and parent education.

For children who meet the program's eligibility criteria and have a hearing loss, the program provides specialized DeafBlind services in addition to the other services above to address the unique needs of children with a combined vision and hearing loss and their families.

Additionally, BCP contracts to provide future planning training to families through an innovative five-session model that covers topics important to children moving from high school to community-based services: guardianship, vocational discovery, and person-centered decision making.

There are no income requirements to be eligible for services, but a cost share applies to the purchase of goods and services. BCP is a payor of last resort and cannot use funds to provide services that are the responsibility of a Local Education Agencies (LEAs) LEA regardless of the child's educational setting (e.g., home school program, public, charter, or private schools).

C. Effectiveness and efficiency information:

The program monitors:

- Staff performance, quality service delivery, and expenditures through reports from the case management system, ReHabWorks. For fiscal year 2024, this included 556 referrals to the program, 402 eligibility determinations, and 3,166 children served;
- Service contracts ensure families receive contact at least once a quarter to address identified needs. The program made 16,434 contacts in fiscal year 2024;
- Provision of direct skills training which resulted in a 42 percent increase in the number of trainings provided to families from fiscal year 2023-24; and
- Purchases, service delivery, and payments. The program monitors monthly payments of purchase orders to ensure timelines are followed, and payments are made according to prompt payment guidelines.

Annually, program leadership completes case reviews on 10 percent or more of cases enrolled in program services from the previous fiscal year to ensure quality services to children and families.

The program conducts a customer service survey every two years. The most recent survey from July to September 2023, was provided to all BCP families in active services for longer than six months and who had an active email address on file.

The survey results indicated that 69 percent of families were satisfied or highly satisfied with the BCP. Families indicated that they agreed or strongly agreed that their blind children's specialist:

- Provided the services, resources, and referrals they need (76 percent);
- Involved them in making decisions about their child's needs (79 percent);
- Was knowledgeable about program services and visual impairments (78 percent); and
- Contacted them enough for them to make progress (65 percent).

The program is focusing on increasing the frequency of contact with families to increase satisfaction.

D. History:

In 2016, BCP implemented Sunset Commission recommendations to ensure consistent oversight of expenditures and case review across all staff including establishing a management structure for needed support and realigning caseloads to an appropriate size.

In 2019, BCP revised policy to remove barriers to service delivery. Children exit from services once they meet individual goals and can return to services when needed instead of remaining enrolled in services indefinitely, ensuring children have access to services when needed and program can focus its services on those currently enrolled.

Since 2022, the program has continued to assess and make changes through continuous improvement efforts. BCP implemented an intensive nonvisual skills training to staff to increase direct skills training to children and families; migrated the case management system from Informix to MS SQL allowing for needed changes to the system to meet program needs; and realigned reporting structures to ensure workload equity and remove geographic lines of supervision to create efficiencies.

Most recently, BCP streamlined the referral process, which has dramatically reduced the time for children to access services and implemented a plan to increase referrals through outreach and public awareness.

E. Qualifications or eligibility requirements:

- Age Requirement: 0 to 22 years of age;
- Medical status: Visual impairment;
- Program eligibility specific medical condition: Documented visual impairment or blindness; and
- Additional eligibility information: If older than 18, the child must be enrolled in a secondary school through the LEA.

Table 10. BCP demographics by percent served and expenditures by age.

Demographics	Percent Served
Sex	
Male	50%
Female	42%
Age at Initial Contact	
0-9 years	82%
10-13 years	12%

Demographics	Percent Served
14-17 years	5%
18-21 years	1%
Age at Closure	
0-9 years	39%
10-13 years	27%
14-17 years	24%
18-21 years	11%
Expenditures and Age at time of Purchases	
0-9 years	\$338,154.41
10-13 years	\$202,093.36
14-17 years	\$184,134.83
18-21 years	\$62,403.26

F. Administration and key processes:

All Blind Children's specialists report to one of four program managers. BCP provides services in a four-step process (intake, plan development, active services, and closure) that helps manage case flow and tracks planned and delivered services for each consumer.

During the COVID-19 Public Health Emergency, BCP adjusted to a virtual service delivery model to ensure children and families would have access to needed services. The program provided services via phone, video call, or Microsoft Teams, but then moved to a hybrid model of service delivery that was driven by parent needs in the last quarter of the year. Program also expanded DeafBlind services and provided the first virtual family camp weekend for children who are DeafBlind.

BCP communicates and works closely with ECI, TWC, and TEA on the state and local levels to ensure quality services. Within HHSC, BCP collaborates with ECI to provide training to staff to share expertise on visual impairments; collaborate on outreach and public awareness plans; and work in partnership with ECI contractors to provide children with in-depth blindness expertise.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts:

BCP is part of an HHSC MOU with TWC to ensure continued collaboration on services for several programs. The program participates in the DeafBlind Taskforce quarterly meetings that includes members of the following agencies: Texas School for the Blind Visually Impaired, Texas DeafBlind Project, TWC, Texas School for the

Deaf and HHSC. The taskforce is run by DeafBlind individuals and the families of DeafBlind individuals.

I. Relationship with other governmental entities:

BCP participates on the Texas Advisory Committee for the Education of Students with Visual Impairments and meets quarterly.

Blind Children specialists work closely across the state with ESCs and LEAs to coordinate services and provide training to children and families. Education Service Centers are regional organizations that provide support services and resources to school districts and charter schools within a specific geographic area that are designed to help improve student performance, enhance operational efficiency, and implement educational initiatives.

J. Barriers and challenges:

As mentioned, during the Public Health Emergency the program adjusted to a hybrid (virtual and in-person) service delivery model that allows for parent choice. Families have requested more services be provided virtually. While the program does continue to provide hybrid services, the need to work hands-on with children is essential. The program will update rules to reflect all service delivery options to allow for parental choice of a combination of virtual and in-person services.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Deaf and Hard of Hearing Services

A. Division or program information:

Name of division or program: Deaf and Hard of Hearing Services

Location within the agency: CPSO

Contact name: Keisha Rowe, Associate Commissioner of Health and Independence

Statutory citation: Texas Human Resources Code, Chapter 81

B. Objective and major activities:

DHHS provides communication access services for individuals who are deaf, DeafBlind, or hard of hearing. These services assist in removing communication barriers, promoting independence, and promoting equal access and equal opportunity in all aspects of life. The programs include:

- **Resource Specialist Program:** Resource specialists are trained experts in what services are available in their coverage area for persons who are deaf, DeafBlind, or hard of hearing. They connect clients to those services offered by state and local government, service organizations, and private entities to promote independence. Private entities are not always aware of their accessibility requirements. Access specialists and technology specialists provide specialized training and support services to businesses and employers.
- **Last Resort Communication Services (LRCS):** Provides sign language interpreting and communication access real-time translation (CART) services for individuals who are deaf, DeafBlind, or hard of hearing as a last resort when the Americans with Disabilities Act (ADA) or other access mandates do not apply. These services help facilitate access to essential services and community participation.
- **Senior Citizens Program (SCP):** Provides basic life skills training and life enrichment activities to clients to help reduce social isolation. Activities may include independent living services, coping skills training, and field trips to local attractions.
- **Certificate of Deafness for Tuition Waiver:** Staff process and approve applications from qualified students to have their tuition and tuition-based fees waived at state-supported post-secondary schools in Texas. With the tuition waiver, the program provides students opportunities to access higher education and experience self-sufficiency, independence, increased employability, and effective participation in the community. The waiver does not cover room, board, or books.
- **Driver Identification Visor Card:** Staff receive and process applications and send the driver a visor card for their personal use. Each visor card identifies the driver's communication needs and offers various communication tips and strategies to assist when interacting with law enforcement or first responders.

C. Effectiveness and efficiency information:

Program staff track the number of driver identification cards issues and number of certificates of deafness issued for tuition waivers to ensure timely processing. Program is working to establish measures for program improvement.

D. History:

In 1998, the Texas Rehabilitation Commission, in cooperation with the Texas Commission for the Deaf and Hard of Hearing, conducted a pilot project that successfully demonstrated the resource specialist concept is effective and beneficial to people who are deaf or hard of hearing. The following year, the 76th Legislature appropriated funding to the Texas Commission for the Deaf and Hard of Hearing for a resource specialist project in each of the 11 HHSC Regions through contracts with 20 of the state's largest agencies that interact with the public.

In 2005, the DARS' Office for Deaf and Hard of Hearing Services merged with the Division for Rehabilitation Services. During transformation, in 2016, the legislature abolishes DARS and transfers the Office of DHHS to HHSC.

E. Qualifications or eligibility requirements:

Table 11. Program eligibility requirements.

Program	Minimum Age Requirement	Specific Medical Condition
Resource Specialist	N/A	Deaf or hard of hearing with no requirement on degree of hearing loss.
Last Resort Communication Services	N/A	Deaf or hard of hearing
Senior Citizens Program	60	Deaf, DeafBlind, or hard of hearing.
Certificate of Deafness for Tuition Waiver	17 or, if younger provide proof of being in 12th grade, have a high school diploma or equivalent	Sense of hearing is nonfunctional
Driver ID Visor Program	N/A	Deaf or hard of hearing and hold a valid, state-issued driver's license

F. Administration and key processes:

The Resource Specialist, Last Resort Communication Services, and Senior Citizens Programs operate through contracts. DHHS contract staff provide oversight and ongoing technical assistance to contracted service providers.

In the Certificate of Deafness for Tuition Waiver program and the Driver Identification Visor Card Program, DHHS staff review and approve applications based on established eligibility criteria shown above.

G. Funding: See "Agency Program Information Spreadsheet."

H-I. MOUs and relationships with others: Not applicable.

J. Barriers and challenges:

For the Certificate of Deafness for Tuition Waiver and Driver Identification Visor Card programs clients submit applications via mail or email, and staff manually enters applicant data into a database to populate a system-generated waiver or identification card for eligible applicants. Staff then mail waivers and cards to eligible applicants. The manual processes delay access to programs which ensure independence and self-sufficiency.

Research indicates that the population in Texas with some hearing loss is approximately 1,000,000 people. Resource specialists have not been able to keep pace with the demand and are unable to serve all clients. Because of this, we have seen a 30 percent decrease in services provided statewide. This is particularly an issue in heavily populated areas. Additionally, several regions of the state do not have coverage at all. This creates barriers to assistance based on where a client lives.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Specialized Telecommunications Assistance Program

A. Division or program information:

Name of division or program: Specialized Telecommunications Assistance Program (STAP)

Location within the agency: CPSO

Contact name: Keisha Rowe, Associate Commissioner of Health and Independence

Statutory citation: Texas Utilities Code, Chapter 56, Section 56.151

B. Objective and major activities:

STAP is a voucher program that provides financial assistance for assistive technology to individuals who have a disability that interferes with access to the telephone. Equipment includes amplified telephones, two-way texting devices, big button telephones, and voice dialers.

HHSC administers the program, and the Public Utility Commission (PUC) of Texas provides funding through the Universal Service Fund.

C. Effectiveness and efficiency information:

STAP reports the number of equipment and service vouchers issued to LBB. In fiscal year 2024, HHSC issued 21,937 equipment and service vouchers.

STAP has made significant improvements to modernize its processes by implementing a digital process that scans and stores paper applications electronically. This has allowed staff to access documentation more quickly and efficiently. As a result, application processing time has reduced from 9 months to around 30 days.

STAP also implemented a quality assurance process where the program audits 10 percent of all processed applications for accuracy every week. The overall application accuracy rate is 97 percent across all STAP technicians.

STAP surveys applicants and certifiers to assess quality of services, satisfaction, knowledge about the program and processes, training needs, and areas for improvement.

D. History:

S.B. 667, 75th Legislature, Regular Session, 1997, required PUC and the Texas Commission for the Deaf and Hard of Hearing to establish STAP for eligible individuals who are deaf, hard of hearing or speech impaired. The required application fee and proof of landline services deterred many people from applying for services. Clients complained about the requirement to have phone service prior to receiving equipment needed to use the service.

S.B. 1441, 76th Legislature, Regular Session, 1999, removed the application fee and landline requirements. Additionally, the bill expands STAP to include all individuals with a disability that impairs the ability to effectively access telephone networks.

S.B. 512, 83rd Legislature, Regular Session, 2013 transferred from PUC to DARS the responsibility to register and reimburse STAP vendors.

E. Qualifications or eligibility requirements:

- Minimum Age Requirement: 5 years of age;
- Medical Status: Physical disability and/or functional limitation; and
- Specific Medical Condition: A person with a disability that impairs their ability to effectively access the telephone network. The application must be certified by one of the types of professionals and must include an attestation that due to a disability the applicant requires a specialized telecommunications device to access the phone network, and that the device selected will enable the applicant to access the phone network.

F. Administration and key processes:

STAP is responsible for determining voucher categories and values for the purchase of specific devices, processing client applications, and issuing vouchers. Staff process applications using a database system that prints a voucher or a letter to the applicant, when necessary. Staff also update client information on incomplete applications to process vouchers.

STAP contracts with local service providers across the state for outreach activities that help individuals complete the application and determine the equipment most appropriate for their needs.

PUC administers the Universal Service Fund, the funding source for STAP, by charging taxable telecommunications services to telecommunications providers. Telecommunication providers may pass the charge to residential and commercial customers.

See attachments below for flowcharts and illustrations

- [S7 CPSO CS Att 01 STAP Master FlowChart](#)
- [S7 CPSO CS Att 02 STAP Application](#)
- [S7 CPSO CS Att 03 STAP Financial](#)
- [S7 CPSO CS Att 04 STAP Follow Up Letters](#)

- [S7 CPSO CS Att 05 STAP Returns](#)
- [S7 CPSO CS Att 06 STAP Info Requests](#)

G. Funding: See “Agency Program Information Spreadsheet.”

H-I. MOUs and relationships with others: Not applicable.

J. Barriers and challenges:

Challenge 1: Reliance on paper applications requires program staff to manually enter data into our case management system, affecting accuracy and efficiency.

Challenge 2: The Texas Utilities Code, Section 56.153, includes a financial independence requirement before allowing a second individual with the same type of disability within one household to be eligible for STAP equipment. This financial independence bar, as written, unintentionally hinders access to some applicants.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Board for Evaluation of Interpreters

A. Division or program information:

Name of division or program: Education, Training and Certification

Location within the agency: CPSO

Contact name: Keisha Rowe, Associate Commissioner of Health and Independence

Statutory citation: Texas Human Resources Code, Chapters 81 and 82; Texas Government Code, Chapters 57 and 2001; Civil Practice and Remedies Code, Chapter 21; Code of Criminal Procedures, Chapter 38, Section 38.31; Occupations Code, Chapter 53; 2024-45 General Appropriation Act, H.B. 1, 88th Legislature, 2023 (Article II, HHSC, Riders 118 and 126)

B. Objective and major activities:

Education, Training, and Certification is the central area for awareness and education on deaf and hard of hearing issues and services in Texas. The goal is to help connect people to resources and services, raise awareness, and improve

communication access. Education, Training, and Certification achieves these goals through the following programs:

- Consumer Education and Interpreter Training: Provides training to persons who are deaf or hard of hearing and raises awareness about hearing loss, effective communication, and access to services. This program also provides training opportunities for sign language interpreters to enhance their skills;
- Camp Sign: A week-long summer youth enrichment training program that provides an accessible environment free of communication barriers for children between the ages of eight and 17 who are deaf or hard of hearing;
- Communication Services for State Agencies (CSSA): Contracts with interpreter and Communication Access Realtime Translation (CART) referral organizations to provide state agencies via contract with communication access services for persons who are deaf or hard of hearing. By doing so, state agencies have access to the service rates HHSC has negotiated with referral agencies statewide. This contract eliminates the need for participating state agencies to continually issue individual purchase orders for services. In addition, DHHS helps ensure appropriate and qualified services are provided and resolves any complaints that may be filed against the service provider or referral agency; and
- Board for Evaluation of Interpreters (BEI) Certification Program: Tests and evaluates American Sign Language (ASL) and oral interpreter candidates to determine their skill level and award certification; administers certification maintenance; resolves consumer complaints against certified interpreters (and against non-certified interpreters for court-related settings); and maintains a registry of certified interpreters by skill level and specialty, such as trilingual certification and certification for court and medical settings. BEI improves the quality of interpreter services and protects the interests of people who use interpreters by regulating the conduct of interpreters certified by the program.

C. Effectiveness and efficiency information:

Staff track data such as number of test applications processed, number of certificates issued, number of tests administered, and pass and fail rates. In fiscal year 2024, BEI issued 1,927 certifications and administered 928 tests.

The BEI data system allows applicants to upload their own required Continuing Education Unit (CEU) documentation, process online payments for their applications and renewals, and apply for tests online. These features yield a more efficient workflow and less reliance on manual data entry. Staff collects statistics related to how many applications have been processed online, how many online payments are received, and how many CEU documents are uploaded by interpreters.

BEI is working to establish measures for Consumer Education and Interpreter Training, Camp Sign, and CSSA.

D. History:

S.B. 1157, 66th Legislature, Regular Session, 1979, established the BEI program. The bill required the testing and certification of interpreters and the development of a registry of certified interpreters. Between 1993 and 2005, the legislature passed various bills authorizing changes to the program that included:

- S.B. 1118, 73rd Legislature, Regular Session, 1993, required testing to also occur outside of Austin at no cost to the state and payment to contracted test raters to evaluate videotaped test performance;
- S.B. 1401, 76th Legislature, Regular Session, 1999, required development of a certification for trilingual interpreters;
- H.B. 2735, 77th Legislature, Regular Session, 2001, authorized a court interpreter certification program. The bill mandated the establishment of requirements for interpreting in a court setting and the regulation and certification of sign language interpreters for this purpose; and
- H.B. 2200, 79th Legislature, Regular Session, 2005, required certification for individuals to be allowed to interpret in a legal setting. Prior to this legislation, HHSC did not have the legal authority to restrict non-certified interpreters from interpreting in court.

E. Qualifications or eligibility requirements:

To be eligible for Camp Sign, a person must be between the ages of 8 and 17 who is deaf or hard of hearing.

Table 12. Eligibility criteria for BEI certification type.

Type of Certification	Requirements
BEI Test of English Proficiency (written)	• Valid photo ID • Official transcript showing the completion of at least 30 credit hours from an accredited college or university. • Application fee
BEI Performance Test	• Pass the BEI written test of English proficiency. • Valid photo ID • Official transcript showing the completion of at least 60 credit hours from an accredited college or university. • Application fee
Beyond a Basic Certification	• Must also hold the prerequisite certification level

While not an eligibility requirement, background checks are performed on applicants and results may bar final certification. There are no eligibility requirements for Consumer Education and Interpreter Training and CSSA.

F. Administration and key processes:

Consumer Education and Interpreter Training: Clients, interpreters, and other attendees complete an online registration to sign up for training. Most trainings are online webinars conducted by DHHS staff or outside experts with specialized skills. The program determines training content based on stakeholder feedback, community needs, and training proposals received from community providers.

Camp Sign: DHHS arranges the summer youth training program through a contract with a campground facility equipped to serve youth with different abilities. DHHS staff provide subject matter expertise related to the needs of campers who are deaf or hard of hearing.

Communication Access Services to State Agencies: DHHS contracts with several organizations that provide sign language and/or real-time captioning services. Contracts outline provider credentials, sign language interpreter certification requirements, standard practices, and negotiated service rates. DHHS makes these available to other state agencies via Interagency Agreements (IACs). When a contracted state agency needs communication access for their client, they submit a

service request. After they submit invoice for services rendered, DHHS staff reconcile and validate the invoice, and processes payment. DHHS then invoices the state agency for reimbursement.

BEI Certification Program: Eligible individuals seeking to obtain or advance their sign language certification can apply to take a test. Written tests can be taken at contracted sites located throughout Texas. However, performance tests must be taken in Austin, Texas. Certified interpreters must submit annual renewal documentation, pay annual dues, and meet continuing education requirements to maintain certification.

BEI contracts with certified interpreters to rate interpreter test candidates, an organization to run background checks on applicants (interpreters), entities to maintain or develop interpreter tests, and with the University of Texas to provide testing sites across Texas for the required written test.

BEI works with an advisory committee established by statute to assist with the administration of the program. The advisory committee makes recommendations regarding complaints resolution, test development, policy or rule changes, and other administrative matters.

G. Funding: See "Agency Program Information Spreadsheet."

H-I. MOUs and relationships with others: Not applicable.

J. Barriers and challenges:

BEI is using an 18-year-old, outdated test instrument. Some stakeholders in the interpreting profession are requesting new tests, such as a new Deaf Interpreter test. There is no national test for the profession and test development is costly. New tests would enable program to keep pace with evolving methods to evaluate interpreting expertise and knowledge.

K. Additional information:

HHSC leases BEI testing instruments and materials to four states. As BEI continues to become nationally recognized as a leading certifying body for sign language interpreters, there is growing interest from other states.

L. Regulatory program information:

Court or medical interpreters are certified by BEI. Without regulations to require certification for all interpreters, the standards for interpreter skill levels and ethical behavior cannot be enforced. Interpreters often communicate information that is personal and confidential. In addition, clients do not know an interpreter’s level of skill or whether the interpreter is qualified for an assignment prior to hiring them.

DHHS obtains criminal conviction record checks when a person applies to take a BEI examination; an interpreter applies for a five-year recertification; and a member of the public informs BEI that an applicant or certified interpreter has or is alleged to have a criminal conviction record. BEI rules, policies, and procedures address standards of conduct; grounds for denying, revoking, or suspending a certificate; prohibited acts; and disciplinary actions that may be taken against a certified interpreter. Actions include revocation, suspension, probation, and/or denial; or, with respect to certified court interpreters only, assessment of an administrative penalty under the law.

DHHS investigates allegations of the violation of interpreter standards of conduct. DHHS may also refer these allegations to another appropriate enforcement or regulatory authority, such as DFPS’ Adult Protective Services (APS) or CPS. Allegations concerning violations are forwarded to the director of DHHS. A certified interpreter who is found to be non-compliant or in violation of the established code of ethics is given the opportunity to respond, may be given the opportunity for a hearing, or may be given an opportunity for resolution through HHSC.

Health and Human Services Commission

Exhibit 14: Information on Regulated Population: Complaints Against Regulated Persons, Businesses, or other Entities; and Disciplinary Actions Fiscal Years 2020 to 2024

Table 13. Number of Sign Language Interpreters holding an active BEI Certificate.

	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Number of Sign Language Interpreters Holding an Active Texas BEI Certificate	1814	1795	1812	1846	1888

Table 14. BEI complaints received by source.

Complaints Received by Source	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Complaints Received	6	2	6	2	3
Complaints Initiated by Agency (originating from criminal history checks)*	N/A	N/A	N/A	N/A	N/A
Complaints Initiated by Agency (not originating from criminal history check)	0	0	0	0	0
Complaints Originating from Public (including other regulated persons or entities)	6	2	6	2	3
Complaints Originating from Other Agencies	0	0	0	0	0

Table 15. BEI disposition of complaints received.

Complaints Resolved	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023*	Fiscal Year 2024*
Total Complaints Resolved After Investigation	6	2	6	Data Not Available	Data Not Available
Complaints Dismissed for Lack of Evidence Found in Investigation	2	1	0	Data Not Available	Data Not Available
Complaints Dismissed Due to No Violation Found in Investigation	0	1	3	Data Not Available	Data Not Available
Total Complaints Resolved Through Informal Action	4	0	3	Data Not Available	Data Not Available
Total Complaints Resolved Through Formal Action	0	0	0	Data Not Available	Data Not Available

* The status of complaints for fiscal year 2023 and fiscal year 2024 in the charts above are unknown due to program complaint process issues, which have since been resolved.

Table 16. BEI enforcement action timelines.*

Timelines for Enforcement Actions	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023**	Fiscal Year 2024**
Average Days from Complaint Received to Final Resolution (includes dismissed/unfounded)	55	90	112	Data Not Available	Data Not Available
Percentage of Complaints Resolved within Six Months	100	100	100	Data Not Available	Data Not Available

* Final Resolution = complaint dismissed, or final order entered; does not include time in appeals to district court.

** The status of complaints for fiscal year 2023 and fiscal year 2024 in the charts above are unknown due to program complaint process issues, which have since been resolved.

Brain Injury Programs

Comprehensive Rehabilitation Services

A. Division or program information:

Name of division or program: Comprehensive Rehabilitation Services (CRS)

Location within the agency: CPSO

Contact name: Keisha Rowe, Associate Commissioner of Health and Independence

Statutory citation: Texas Human Resources Code, Sections 111.052, 111.059, and 111.060

B. Objective and major activities:

CRS provides intensive services needed to help individuals who have experienced a traumatic brain injury (TBI), or traumatic spinal cord injury (TSCI) live independently in their home and community. The program focuses on three primary areas that affect both function and quality of life: mobility, self-care, and communication skills. Services are provided in the person's home, a hospital, a residential facility, an outpatient clinic, or a combination of these settings to encourage maximum flexibility in service and make strides toward independence.

Services include inpatient comprehensive medical rehabilitation services (ICMRS), post-acute brain injury (PABI) rehabilitation services, and outpatient therapies.

- ICMRS: Provides medical services in a hospital for individuals who require 24-hour nursing rehabilitation services or day-treatment nursing rehabilitation services to address their physical, psychological, and rehabilitation needs. The program provides education and training for individuals and their family/support system.
- Post-Acute Rehabilitation Services:
 - ▶ PABI Services: May be provided in a residential or non-residential setting. Providers of PABI rehabilitation services use an interdisciplinary team to deliver services aimed at improving cognitive deficits. The goal of treatment is to achieve functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity, or compensatory strategies.
 - ▶ Post-acute Spinal Cord Injury (PASCI) Services: Address deficits in functional skills such as transferring from wheelchair or bed and other activities related to daily living. The services are provided in the home and in non-residential community settings.
- Outpatient Therapy: Includes physical, occupational, cognitive, and speech therapy to improve individuals' ability to function at home and in the community. Therapists work with individuals in a variety of settings, including clinical or home, to address the individual's specific needs and to teach others in the household how to help the individual.

C. Effectiveness and efficiency information:

HHSC reports one LBB measure for the CRS program: average monthly number of people receiving CRS (550 in fiscal year 2024).

Additionally, CRS monitors staff performance, reviews quality of service delivery, and tracks expenditures. CRS also measures program effectiveness by running weekly and quarterly performance reports, as well as tracking data that reports the number of active cases, number of contacts made, and number of applicants waitlisted. The average length of time a client is enrolled in CRS services is two years.

D. History:

1986-87 General Appropriations Act, H.B. 20, 69th Legislature Regular Session, 1985, created a Comprehensive Medical Rehabilitation program to provide inpatient medical rehabilitation.

S.B. 195, 72nd Legislature, Regular Session, 1991, created the Comprehensive Rehabilitation Fund (CRF) 107 Account (a special fund for CRS using driver's license fees) and expanding the types of services allowed for people with TBI or TSCI under the now named CRS program. Between 1997 and 2013, the legislature passed bills establishing and modifying the source of CRS funds, adjusting the amount of CRS funds DARS can carry forward, and appropriating additional funding for the CRS waitlist.

In 2017, the Texas Court of Criminal Appeals rendered a decision in *Salinas v. State* (No. PD-0170-16), which eliminated certain court costs allocated to CRS through Local Government Code, Section 133.102. This change impacted program funding; however, 2018-19 General Appropriations Act, S.B. 1, 85th Legislature, Regular Session, 2017, restored funding to CRS.

E. Qualifications or eligibility requirements:

Eligibility for CRS services:

- Have a TBI and/or TSCI that results in a substantial impediment to functioning independently in the home and the community in terms of mobility, self-care, and/or communication;
- Be at least 15 years of age;
- Be a resident of Texas for at least six months or have a family member living in the state for at least six months who is, or will become, the individual's primary caregiver;
- Be medically stable to participate actively in the program; and
- Not be in either the eligibility, plan initiated, or post-closure services phase of another rehabilitation services program.

CRS is the payor of last resort after the exhaustion of comparable benefits.

If an individual's household annual income is over 200 percent of the federal poverty level (FPL) guidelines they must contribute towards the cost of their care.

Table 17. CRS demographics by percent served, injury, and age.

Demographic	Percent Served
Sex	
Male	75%
Female	25%
Most Treated Condition	
Traumatic Brain Injury	66%
Traumatic Spinal Cord Injury	29%
Both TBI and TSCI	5%
Average Age	
All served population	37 years

F. Administration and key processes:

Hospitals, social workers, physicians, and other medical professionals refer applicants to CRS, who are then placed on the CRS Interest List. If eligible, the case manager transfers the applicant to a CRS social worker who assists the individual and their support system to match the needs and choices of the individual with CRS service providers. The individual is moved to the CRS Wait List once staff complete an Individualized Written Rehabilitation Plan (IWRP). CRS moves individuals into active service as funds are available.

CRS social workers work closely with the family to ensure services are implemented according to IWRP or if the plan needs to be supplemented with changes to ensure services are meeting goals.

CRS closes a case successfully when the individual and the social worker agree that all planned services were provided, and the individual has maximized their abilities to achieve their goals for independence at home and in the community. CRS then makes referrals to support services such as medical services, support groups, independent living resources, and waiver services.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

CRS collaborates with the CMS and the Social Security Administration by encouraging clients to prioritize other state and federally funded programs as needed.

J. Barriers and challenges:

CRS social workers provide person-centered planning via counseling and guidance, case management services, wraparound supports, and other services intended to address the needs of the individual as they progress through the rehabilitation process. The intensity and complexity of the services, including the expense of services and coordination with treatment teams, insurance companies, and other community resources, create challenges as social workers manage all aspects of the individual's care.

K. Additional information:

CRS demonstrates effectiveness through a decrease in the number of individuals who needed nursing home care by living independently. For those who lived at home, the program creates a significant decrease in the burden on the family because the individual learned to care for themselves or direct their own care.

L-M. Regulatory and Complaint Information: Not applicable.

Office of Acquired Brain Injury

A. Division or program information:

Name of division or program: Office of Acquired Brain Injury (OABI)

Location within the agency: CPSO

Contact name: Keisha Rowe, Associate Commissioner of Health and Independence

Statutory citation: 2008-09 General Appropriations Act, H.B. 1, 80th Legislature, Regular Session, 2007 (Article II, HHSC, Rider 51)

B. Objective and major activities:

OABI connects people with acquired brain injury, including veterans, to resources and services, raises awareness, and through educational events and community engagement, strives to prevent brain injuries.

OABI activities include:

- Providing brain injury education, awareness, and prevention;

- Providing service referrals and help to individuals with a brain injury, families, and caregivers as they navigate services and supports in Texas; and
- Providing administrative support to the Texas Brain Injury Advisory Council (TBIAC), whose purpose is to support education, awareness, and advocacy for the brain injury community.

C. Effectiveness and efficiency information:

OABI maintains a resource list of support groups by location on an interactive map. The program tracks the number of calls received for assistance and resolution.

There are no associated LBB performance measures for OABI.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

There are no eligibility requirements to access OABI resources and supports.

F. Administration and key processes:

OABI provides administrative and logistical support to the TBIAC.

Staff conduct outreach activities include providing training on brain injury; developing awareness materials including educational videos and a guide to help Texans find and get the right support; hosting an annual Brain Injury Awareness Celebration and Conference during Brain Injury Awareness Month in March; and maintaining a program website for visitors where they can download or order education materials and access support group information.

G. Funding: See “Agency Program Information Spreadsheet.”

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

OABI collaborates with the following organizations when referring community members to services and when data requests or reporting information is needed for TBIAC’s recommendations process:

- TWC;

- DSHS: Injury Prevention Unit, EMS, and Trauma Registries;
- Texas Cardiovascular and Stroke Council; and
- Texas Department of Insurance - Accident and Health Department.

J-M. Barriers, Additional, Regulatory, and Complaint Information: Not applicable.

Specialty Health

Blindness Education, Screening, and Treatment Program

A. Division or program information:

Name of division or program: Blindness Education, Screening and Treatment (BEST) Program

Location within the agency: CPSO

Contact name: Keisha Rowe, Associate Commissioner of Health and Independence

Statutory citation: Human Resources Code, Section 91.027; Transportation Code, Section 521.008 and 522.029; 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 118); 2026-27 General Appropriations Act, S.B. 1, 89th Regular Session, 2025 (Article II, HHSC, Rider 97)

B. Objective and major activities:

BEST aims to reduce the overall number of Texans who lose their sight by providing two major services.

- Funds Urgently Needed Medical Treatment: Access to medically urgent eye treatment for Texans who are uninsured and are referred by an ophthalmologist. Common eye conditions referred are Diabetic Retinopathy, Retinal Detachment, Glaucoma, Vitreous hemorrhage, and Vein Occlusion.
- Provides Adult Vision Screening Services: Blindness prevention education and resources that spread awareness of prominent eye conditions and the importance of healthy eye care. As part of this effort, BEST offers free vision screenings across the state through a contract with the National Society to Prevent Blindness dba Prevent Blindness Texas.

C. Effectiveness and efficiency information:

BEST tracks effectiveness, efficiency, and impact through the number of persons receiving screening (3,056 in fiscal year 2024) and treatment services (74 in fiscal year 2024). Contractors provide the count of individuals receiving eye screenings, and healthcare partners provide the count of individuals receiving eye treatment services using application data of those seeking approval for treatment.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

To be eligible for urgent medical eye treatment and vision screenings the individual must be an adult 18 years of age or older and:

- Physician or optometrist referral;
- Their physician or optometrist certifies that they do not have health insurance or other available resources with which to pay for prescribed treatment to prevent blindness; and
- Their physician or optometrist certifies the individual has a medically urgent eye condition that poses an imminent risk of permanent and significant visual loss.

Program staff review applications for medical treatment to confirm client eligibility before providers serve the clients, and all information on clients served is entered into the program database, ReHabWorks.

Table 18. Percent of BEST client demographics (fiscal year 2024).

Demographic	Percent Served
Race/Ethnicity	
Hispanic	78%
White	16%
African American	5%
Asian	1%
Sex	
Male	42%
Female	58%

Demographic	Percent Served
Eye Condition	
Diabetic retinopathy	63%
Detached retina	23%
Glaucoma	4%
Other	10%

F. Administration and key processes:

- **Medical Treatment Services:** An ophthalmologist or optometrist across the state can enroll as BEST program providers. Enrolled providers can then submit applications for an individual's treatment services to the BEST program.

The BEST program specialist processes eligibility, prior authorization for all services. Payment is based on the established HHSC Maximum Affordable Payment Schedule rates.

- **Vision Screening Services:** The contracted provider administers vision screenings and eye health risk assessments at locations across the state. The contracted provider submits a monthly schedule of planned screening locations for approval by the BEST program prior to service provision. Staff lead the procurement and contract oversight for the vision screening provider.
- **Education and Outreach:** Staff develop materials related to eye health and treatment and exhibit at public health fairs and conferences. BEST also coordinates with medical providers to host educational webinars focused on vision and eye health.

G. Funding: See "Agency Program Information Spreadsheet."

H-I. MOUs and relationships with others: Not applicable.

J. Barriers and challenges:

Ophthalmologist engagement in the program is low. After conducting mailed outreach to 426 providers in fiscal year 2024, two providers responded, but only one initiated the enrollment process. Program staff are working to understand what barriers prevent ophthalmologists from referring patients, and once clearly identified, will work to address those barriers.

K. Additional information:

BEST's sole source of funding is voluntary donations when Texans apply for or renew their Texas driver's license or DPS-issued identification card. This is a cost-effective resource for the state, providing access to medical care that prevents Texans from losing vision, and needing more costly disability resources.

Children with Special Health Care Needs

A. Division or program information:

Name of division or program: Children with Special Health Care Needs (CSHCN)

Location within the agency: CPSO

Contact name: Keisha Rowe, Associate Commissioner of Health and Independence; Lianna Burton, Director of Specialty Health

Statutory citation: Texas Health and Safety Code, Chapter 35; 2024-25 General Appropriation Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Riders 75 and 114).

B. Objective and major activities:

CSHCN helps children 20 years of age and younger who have special health care needs and people of any age with cystic fibrosis (CF) to improve their health, well-being, and quality of life. CSHCN provides medically necessary services through enrolled Texas providers. These services include medical, mental health, dental, vision, special medical equipment, and supplies. Additional services include family services such as respite, minor home or vehicle modifications, community services, medical transportation, and case management. CSHCN consistently has an interest list for CSHCN services.

Program service delivery relies on close collaboration with DSHS' Specialized Health and Social Services regional staff, who serve as eligibility workers and case managers for CSHCN clients. Program staff maintain communication with DSHS regional teams.

C. Effectiveness and efficiency information:

HHSC reports two LBB key performance measures for CSHCN (with fiscal year 2024 metrics).

- The monthly average number of CSHCN clients receiving services: 585;
 - ▶ Calculated by totaling the number of clients with paid claims for services in a month and averaging such across the reporting period. Estimates may be used for quarters in which claims data is incomplete; and
- The average monthly cost per CHSCN client receiving services: \$2,573.01;
 - ▶ Calculated by dividing the amount paid for receiving services by the number of CSHCN Services Program clients who received services and averaging across the reporting period.

In fiscal year 2024, 1,184 clients received services, and CSHCN spent \$21,880,844 on client services. Data is collected and maintained in CAPPS Reporting and Integrated Business Information System (IBIS).

An important indicator of CSHCN effectiveness and efficiency is managing the waiting list and cost projections. CSHCN staff work with CS Operations and a third-party actuary to project client expenditures and overall program spending. CSHCN has removed clients from the waiting list for four consecutive quarters and continues to monitor the budget for future waiting list removals.

D. History:

CSHCN is the oldest governmentally administered continuous medical assistance program in Texas for low-income children with special health care needs and people of any age with cystic fibrosis. In 1933, state legislative action initiated funding two years in advance of the first federal initiative, Title V of the Social Security Act.

S.B. 374, 76th Legislature, Regular Session, 1999, expanded program medical eligibility criteria from diagnosis-specific to a broader, functional definition of a child with special health care needs and made the program's health care benefits comprehensive. As a result of transformation, the program functions split between DSHS and HHSC, with the health care benefits program transitioning to HHSC, and the population- and community-based efforts for children and youth with special health care needs remaining with DSHS Maternal and Child Health as the Children and Youth with Special Health Care Needs (CYSHCN) Systems Development Group.

In 2022, CSHCN paused new individuals from entering the program in response to high-cost medical expenses. However, in April of 2024 the program began removing clients from the waiting list again. The program implemented a more comprehensive system to support quarterly waiting list removals throughout fiscal

year 2024 and has continued this throughout fiscal year 2025, gradually reducing the number of clients on the waiting list.

E. Qualifications or eligibility requirements:

- Percentage of FPL: 200 percent;
- Age Requirement: 0 to 20 years of age and people of any age with CF;
- Program Eligibility Specific Medical Condition: 20 years and younger who have a chronic physical or developmental condition that is expected to last at least 12 months, will limit one or more major life activity, requires more health care than what children usually need, and has physical symptoms. Persons diagnosed with CF of any age can access the program; and
- Additional Eligibility Information: Applicants with a household income that exceeds 200 percent of FPL may also meet program financial eligibility if their cumulative medical expenses within the prior 12 months exceed the difference between the household income and 200 percent FPL. Clients are required to renew their eligibility annually.

F. Administration and key processes:

Applicants submit a completed application packet with the support of DSHS' Specialized Health and Social Services (SHSS) regional staff. HHSC provides oversight of program policy and procedures, and reviews submitted applications to ensure eligibility, and clients are then added to the CSHCN waiting list. As funding allows, new clients are added to the program. Clients access services through enrolled providers and can receive services in the home, clinic, hospital, or community setting. Eligible clients receive case management services through a statewide network of regionally based social service program consultants including SHSS and contracted staff.

CSHCN providers must be enrolled in Texas Medicaid and are reimbursed through claims.

G. Funding: See "Agency Program Information Spreadsheet."

H-I. MOUs and relationships with others: Not applicable.

J. Barriers and challenges:

The program continues to have a waiting list due to the unpredictability of health care needs and rising prices of health care and pharmaceutical drugs.

K. Additional information:

Adults and children share the same state GR funds in the CSHCN program which also receives dedicated state Medicaid and Child Health funds and federal Title V funds for clients under 21. GR is available for adults with CF but can also be used to support the under 21 population should the dedicated funds be exhausted. Since eligible clients with CF may remain in active benefits over 21 years old, a significant percentage of GR funds are dedicated to serving this client population as compared to other eligible clients.

L-M. Regulatory and Complaint Information: Not applicable.

Epilepsy Program

A. Division or program information:

Name of division or program: Epilepsy Program

Location within the agency: CPSO

Contact name: Keisha Rowe, Associate Commissioner of Health and Independence;
Lianna Burton, Director of Specialty Health

Statutory citation: Texas Health and Safety Code, Chapter 40

B. Objective and major activities:

Through statewide contracts with nonprofit entities, the Epilepsy program provides outpatient care, including medical and non-medical services to persons who have epilepsy or seizure-like symptoms. The program also provides information and referral to providers for services such as transportation, mental health, dental, patient assistance, and prescription medication programs.

C. Effectiveness and efficiency information:

The Epilepsy program tracks effectiveness, efficiency, and impact with data from required epilepsy contractor monthly reports including the count of individuals receiving medical services. There were 3,532 clients served in fiscal year 2024. Program data is collected through CAPPS Reporting.

The program also collects monthly and quarterly data from contractors on the unduplicated number of clients served, as well as a breakdown of clinical case management, social services, and outreach efforts. This data informs program staff of the service need in the various geographic areas covered by the grantees.

D. History:

The Epilepsy program was enacted through H.B. 1685, 67th Legislature, Regular Session, 1981.

E. Qualifications or eligibility requirements:

Program eligibility requires all program clients:

- Have a diagnosis of epilepsy or a statement by a licensed physician that they suspect the applicant has epilepsy;
- Have income at or below 200 percent of FPL;
- Are determined not eligible for CSHCN benefits if younger than 21 years of age. If a child under 21 is on the CSHCN waiting list, the Epilepsy program can provide services until the child is removed from the waiting list;
- All clients who receive services must undergo annual eligibility recertification; and
- The Epilepsy program serves people of all ages. Of the 3,532 clients served in fiscal year 2024, 3.4 percent were under age 18 and 96.6 percent were 18 years of age or older.

F. Administration and key processes:

HHSC contracts with providers that serve 233 counties across Texas, covering all health service regions. Grantees are contracted to administer all services, including eligibility determination, copay assessment, and the full array of services provided. The Epilepsy program monitors provider services through contract management and reimbursement procedures. Contract providers must follow Epilepsy policy manual and rules, including eligibility determination, services, data collection and reimbursement.

Adherence to policy is monitored through:

- Monthly invoicing that requires financial supporting documentation for each line-item cost;
- Monthly and quarterly data reporting on unduplicated clients and a breakdown of the types of services delivered; and
- On site and desk monitoring reviews to audit grantee specific policies, procedures, and service delivery.

Contractors may subcontract with neurologists and epileptologists to provide clinical services such as diagnostic tests, including electroencephalograms (EEGs) and magnetic resonance imaging (MRIs), prescription medications, and medication management of the patient. Contractors provide outpatient care, including non-clinical services such as case management, counseling, health education, referral services, and community outreach.

G. Funding: See “Agency Program Information Spreadsheet.”

H-I. MOUs and relationships with others: Not applicable.

J. Barriers and challenges:

Some grantees have difficulty meeting their unduplicated targets due to lack of specialty providers in rural communities and staff turnover. To address this challenge, the contracts were amended to allow for more telehealth services. This aligns with shifts occurring across other clinical service programs.

Grantees report only being able to serve a small number of clients under the age of 18 due to a shortage of pediatric neurologists.

On average, while the Epilepsy program providers spend most of their grant funding (97 percent total expenditures in fiscal year 2024), they do not meet client served targets across the board. Throughout the last contract cycle, providers reported challenges with overall increasing cost of healthcare; difficulty securing medical specialists in the needed regions; and challenges negotiating affordable rates for necessary medical testing with subcontractors.

K. Additional information:

Because of the nature of the disease, individuals diagnosed with epilepsy need time and resources to identify the most effective treatment to address their seizures. Therefore, the program is designed with flexibility of providing individualized

services, and prioritizes clinical, case management, vocational support and social supports, and education about the disease.

L-M. Regulatory and Complaint Information: Not applicable.

Hemophilia

A. Division or program information:

Name of division or program: Hemophilia Assistance Program (HAP)

Location within the agency: CPSO

Contact name: Keisha Rowe, Associate Commissioner of Health and Independence;
Lianna Burton, Director of Specialty Health

Statutory citation: Texas Health and Safety Code, Chapter 41

B. Objective and major activities:

HAP helps Texans with hemophilia by providing financial support for their treatment expenses such as blood factor replacement products or by providing insurance premium assistance.

HAP provides benefits for blood factor replacement products on a first-come, first-serve basis. HAP is a payor of last resort.

HAP staff engage in stakeholder outreach efforts by attending community events, connecting with hemophilia treatment centers, conducting quarterly stakeholder meetings with bleeding disorder foundations.

C. Effectiveness and efficiency information:

The program tracks effectiveness, efficiency, and impact through the number of clients that received services (seven in fiscal year 2024). This count is received and verified through Centralized Accounting and Payroll/Personnel System (CAPPS) Financials reporting.

D. History:

S.B. 120, 65th Legislature, Regular Session, 1977, established HAP to assist persons who have hemophilia and require continuing treatment with blood factor replacement products but are unable to pay the entire cost of treatment.

H.B. 1038, 87th Legislature, Regular Session, 2015, added an option for eligible clients to receive financial assistance with paying insurance premiums.

E. Qualifications or eligibility requirements:

- Not Medicaid enrolled;
- Children's Health Insurance Plan: Not CHIP enrolled;
- Income: 200 percent of FPL;
- Minimum Age Requirement: 18 years of age;
- Medical Status: Medical diagnosis; and
- Program Eligibility Specific Medical Condition: Must have physician certified diagnosis of hemophilia.

Clients with drug coverage through private insurance, group insurance, or Medicare are ineligible for drug benefits until that coverage has been exhausted.

F. Administration and key processes:

Potential HAP clients apply directly to HHSC via web, fax, or email..

Enrolled clients provide proof of premium payment for their eligible insurance coverage to the program reimbursement officer. Program processes on average seven claims per year through HHSC Accounts Payable, following agency policy, to allow reimbursement directly to the client.

To facilitate financial assistance for blood factor products, providers, including hemophilia treatment centers and home care agencies, receive prior authorization to ship blood factor as prescribed by the physician to the client. The program provides benefits for blood products to approved HAP recipients on a first-come, first-served basis, if funds are available. A specialty health pharmacist reviews program formulary annually. The program reviews rates biennially with the support of HHSC Provider Finance, with consideration of established Medicaid drug rates for allowable products.

G. Funding: See "Agency Program Information Spreadsheet."

H-I. MOUs and relationships with others: Not applicable.

J. Barriers and challenges:

HAP statute limits who the program assists and how it helps. Due to the statute's specific diagnosis and the low-income eligibility limit in the Texas Administrative Code (200 percent of the FPL), the program budget is often not fully expended. The program has initiated a needs assessment and performed outreach to community stakeholders, foundations, families, and individuals diagnosed with bleeding disorders, to understand where needs and gaps in services exist. HAP is examining options to improve benefits and services and how adjusting eligibility criteria may impact program population and projected expenditures.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Kidney Health

A. Division or program information:

Name of division or program: Kidney Health Care (KHC) Program

Location within the agency: CPSO

Contact name: Keisha Rowe, Associate Commissioner of Health and Independence; Lianna Burton, Director of Specialty Health

Statutory citation: Texas Health and Safety Code, Chapters 42 and 83, Section 83.002; 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 114)

B. Objective and major activities:

KHC helps eligible Texans diagnosed with End-Stage Renal Disease (ESRD) who are receiving kidney dialysis or have had a kidney transplant. The program offsets medical expenses and transportation costs and is a payor of last resort. KHC is a State Pharmaceutical Assistance Program (SPAP), which allows KHC to coordinate prescription drug payments with Medicare.

The program helps eligible Texans pay for dialysis treatments, access surgery, prescription drugs, travel to medical services through mileage reimbursement, and

Medicare premiums. Enrolled providers offer covered services at a client's home, in hospitals, dialysis facilities, and pharmacies.

C. Effectiveness and efficiency information:

HHSC reports two key performance measures to the LBB.

- The average monthly number of KHC clients served (13,562 in fiscal year 2024);
 - This measure is the total average number of unduplicated clients for whom KHC made payment or reimbursed for chronic disease services received during the fiscal year month. Data are non-cumulative; and
- The average annual cost per KHC client (\$630.67 in fiscal year 2024).

KHC submits an annual report to the Governor and the Legislature by February 1 (as directed by Texas Health and Safety Code, Section 42.016) describing the program's findings, progress, activities, and the state's total need in the field of kidney health care. In fiscal year 2024, 13,891 clients received one or more program benefits, for an average annual cost per client of \$665 pre-rebate and \$427 post-rebate.

To ensure continuous program effectiveness and efficiency, KHC hosts ongoing engagement opportunities with stakeholders throughout the year during public facing webinars and gov delivery announcements; maintains continuous evaluation of the program drug formulary to ensure it remains therapeutically relevant and effective; and recently updated and enhanced customer service logistics by updating and modernizing the KHC call center for improved monitoring and assessment of customer calls for quality assurance.

D. History:

S.B. 386, 63rd Legislature, Regular Session, 1973, established KHC to address gaps in the federal Medicare ESRD program. The Medicare ESRD program was designed to reduce costs associated with renal replacement therapy; however, ESRD patients faced significant out-of-pocket costs for treatment, prescription drugs, transportation, and related expenses.

E. Qualifications or eligibility requirements:

- Program Eligibility includes Medicaid: Not Medicaid or CHIP eligible;

- Medicare: Enrolled in Medicare because of ESRD;
- Income: Household income of \$60,000 or less per year;
- Medical Status: Medical diagnosis;
- Program Eligibility Specific Medical Condition: Persons with ESRD (kidney failure) or who have had a kidney transplant; and
- Additional Eligibility Information: Must apply to and maintain Medicare coverage. If enrolled in another insurance plan, Qualified Medicare Beneficiaries, or Specified Low-Income Medicare Beneficiaries, then the client must also maintain coverage.

In fiscal year 2024, KHC had 19,310 enrolled clients. Most clients are 55-64 years old, male, Hispanic and have a gross annual income below \$20,000.

F. Administration and key processes:

Potential KHC clients must first visit a KHC participating facility, such as an outpatient dialysis facility. The provider sends application materials to HHSC for review. KHC determines eligibility, processes client information updates, and supports clients and facility social workers. Staff provide oversight of program policy, procedures, forms, and handbooks, and provide guidance to stakeholders.

Program providers includes dialysis facilities, hospitals, pharmacies, and Texas Medicare Prescription Drug Plans. Stand-alone Texas Medicare Prescription Drug Plans (PDPs) may also enroll with KHC to offset premium costs for clients. Staff provides oversight of provider enrollment through TMHP, engages with new providers for the final steps of enrollment into IBIS, and participates in troubleshooting and quality assurance reviews.

Additionally, all program drug benefits are supported by the rebates generated through agreements between KHC and drug makers for covered drugs.

HHSC's pharmacy claims vendor processes all KHC member drug claims. KHC program staff process claims for all other benefit types, including medical, travel and Medicare premiums through IBIS.

Travel benefits are also covered by KHC.

G. Funding: See "Agency Program Information Spreadsheet."

H-I. MOUs and relationships with others: Not applicable.

J. Barriers and challenges:

Challenge 1, Current technical solutions: Although KHC has a data management system (IBIS), the system lacks features that would assist in eliminating many of the manual processes that are problematic for staff.

Challenge 2, Outdated rules: Internal review of Texas Administrative Code rules identified needed changes including outdated references to DSHS, clearly outlining coordination roles with Medicare, and considering income eligibility guidelines. Specifically, current rules outline a static income eligibility limit of \$60,000. Program is collecting data to assess the impact of an adjustment to the income-eligibility requirement to be in line with other specialty health programs.

K. Additional information:

KHC also maintains regular, quarterly calls with social workers at enrolled facilities across the state to gather client impact, feedback about procedures, ensure appropriate and current program information is shared, and maintain relationships with stakeholders to sustain the health of the program.

L-M. Regulatory and Complaint Information: Not applicable.

Texas Cares Rx Program

A. Division or program information:

Name of division or program: Texas Cares Rx Program (TCRx)

Location within the agency: CPSO

Contact name: Keisha Rowe, Associate Commissioner of Health and Independence;
Lianna Burton, Director of Specialty Health

Statutory citation: Texas Health and Safety Code, Chapter 65

B. Objective and major activities:

TCRx is a prescription drug savings program for uninsured Texans. TCRx assists with access to prescription medications. The program is still in implementation.

TCRx is implementing a public website, a volunteer management portal, and the acquisition of a Pharmaceutical Assistance Program (PAP) navigation system.

C. Effectiveness and efficiency information:

Once fully implemented, program will monitor metrics including:

- Representation across the state, with a program goal to have a volunteer or site in all 254 Texas counties within five years of launch;
- Number of clients assisted by volunteers;
- Number of volunteers onboarded and retained; and
- Dollars saved to clients (based on average wholesale price).

D. History:

In 2021, H.B. 18, 87th Legislature, Regular Session, created TCRx as a pharmacy benefit program.

E. Qualifications or eligibility requirements:

Eligibility criteria for potential clients to receive medications available through the PAP navigation system are set by pharmaceutical manufacturers. Anyone can apply for a PAP by working with a TCRx-approved volunteer and site. Of note, most manufacturers have eligibility criteria that range from 150 to 600 percent FPL. This is higher than most state funded programs.

To be a TCRx volunteer, a person must undergo a background check and complete required training before the program grants them access to the software solution. Volunteers will administer applications to PAPs. There is no application processing at HHSC state office.

F. Administration and key processes:

To administer the program, TCRx includes developing a statewide network of trained volunteers who will assist clients in accessing PAPs. TCRx will engage with organizations across the state such as Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), Hospital Districts, County Municipalities, and non-profit organizations to develop the volunteer network.

The two systems used for program implementation include a volunteer management portal, a system which 'Navigators,' will use to assist clients in applying for PAPs.

TCRx will shape future initiatives based on findings and feedback from data and users in the PAP navigation implementation. This includes user feedback, utilization trends, and how TCRx can continue to recruit, train, and sustain volunteers.

See "[S7 CPSO CS Att 07 Texas Cares Rx Program Design](#)."

G. Funding: See "Agency Program Information Spreadsheet."

H-M. MOUs and interagency agreements or contracts, Relationship with other governmental entities, and Barriers, Additional, Regulatory, and Complaint Information: Not applicable.

Community Care Services

Community Care Services (CCS) is responsible for eligibility determination for Community Care Services Eligibility (CCSE) programs tailored to assist people who are older or have disabilities live independently in their communities. CCS also provides income eligible adults volunteer opportunities through one-on-one mentoring and tutoring to children with exceptional needs through the Foster Grandparent Program (FGP).

CCS Associate Commissioner's (CCS AC) office, CCSE Program Support Unit, and Community Care Services Contracts (CCSC) are support areas for CCS and provide support through managing and monitoring 2,500 open enrollment contracts and three procured grants, training, quality assurance, policy support and monitoring and management of assignments serving over 120,000 Texans.

- **CCS AC Office:** Supports all the areas that make up CCS. Staff provide statewide oversight, complete reporting of CCS programs, assist with program audits, and represent CCS in meetings and workgroups with other departments or divisions.
- **CCSE Program Support:** Consists of staff that provide program policy support, conduct quality assurance reviews, and provide training that supports CCSE program and staff. CCSE Program Policy is responsible for maintaining the CCSE Handbook and coordinates the development and revision of Texas Administrative Code and forms impacting CCSE policy and operations.

- CCSE Program Support Quality Assurance unit: Conducts quality assurance reviews on CCSE case workers and services. The team reviews certifications, redeterminations, case denials and changes and prepares routine program, statistical, and special reports as needed.
- ▶ CCSE Training team: Creates, develops, and maintains the CCSE Basic Job Skills Training guide as well as various other courses and trainings. The team's trainers are responsible for conducting in-person and virtual trainings for regional case workers across the state.
- Community Care Services Contracts (CCSC): Manages and monitors client services contracts for programs in CCS. CCSC consists of three areas: Operations, Contract Enrollment, and Contract Monitoring. CCSC is responsible for over 2,500 open enrollment contracts and three procured grants that support the CCSE program and 85 MOUs and one service agreement that supports the FGP.
 - CCSC Operations: Provides statewide support for CCS by developing and maintaining quality assurance protocols, operational procedures, forms, and monitoring tools all designed to ensure effective administration of contracts. This team provides support for contract tracking, reporting, and SCOR validation for all open enrollment contracts.
 - Contract Enrollment: Manages open enrollment contracts by reviewing contract applications for accuracy and to ensure all open enrollment contract applications meet the requirements. This team also completes contract updates and amendments as required and terminates CCS open enrollment contracts. The Enrollment team processes an average of 75 open enrollment contract applications each month.
 - Contract Monitoring: Eight regional teams across the state manage and monitor over 2,500 open enrollment contracts on a two-year cycle. This includes contract and fiscal compliance monitoring to assess open enrollment contracted provider's compliance with contracting rules, program requirements, and fiscal monitoring.

Community Care Services Eligibility

A. Division or program information:

Name of division or program: Community Care Services Eligibility (CCSE)

Location within the agency: CPSO

Contact name: Evelyn Greenfield-Johnson, Associate Commissioner of Community Care Services

Statutory citation: Texas Government Code, Chapters 531 and 2105; Texas Human Resources Code, Title 2 Chapters 22 and 32, Title 6 Chapters 102 and 103, Title 4 Chapters 250 and 253, and Title 11 Chapter 161

B. Objective and major activities:

CCSE enables people who are older or living with disabilities to achieve or maintain personal self-sufficiency and to support independent living in the community as an alternative to institutional care in nursing facilities. CCSE provides services in the community and home of the person applying or receiving services, reducing state nursing home Medicaid costs.

CCSE determines eligibility for the following services:

- Primary Home Care (PHC): A nontechnical, medically related personal care service provided to adults with health problems that limit them from performing daily activities.
- Family Care (FC): A nontechnical attendant care service for eligible adults. Primary Home Care provider agencies have the option of providing these services.
- Community Attendant Services (CAS): A non-technical, medically related Title XIX (Social Security Act) community care program available to an eligible person whose health problems limit them from performing activities essential to daily self-care, including bathing, dressing, grooming, housekeeping, shopping, meal preparation, and others.
- Day Activity and Health Services (DAHS): Licensed Day Activity and Health Services facilities that provide daytime services to people who live in the community. Services address physical, mental, medical, and social needs.
- Adult Foster Care (AFC): Provides a 24-hour living arrangement with supervision in an adult foster home for people who are unable to continue living independently in their own homes because of physical, mental, or emotional limitations.

- Emergency Response Services (ERS): Provides around-the-clock emergency response service through an electronic monitoring system to functionally impaired adults who live alone or who are socially isolated in the community.
- Home Delivered Meals (HDM): Provides nutritious noontime meals delivered to people in their homes.
- Residential Care (RC): Provides a 24-hour living arrangement in a licensed facility that includes personal care, home management, social and recreational activities, transportation, and 24-hour supervision.
- Consumer Managed Personal Attendant Services (CMPAS): Provides personal assistance services to persons with physical disabilities who are mentally and emotionally competent and able to supervise their attendant or who have someone who can supervise the attendant for them.
- Special Services to Persons with Disabilities (SSPD): Helps people with disabilities achieve habilitative or rehabilitative goals according to their service plans. Participants receive services in an adult day care facility or other approved setting to help them develop the skills needed to remain in the community as independently as possible.

C. Effectiveness and efficiency information:

HHSC reports on one LBB key performance measure for CCSE. In the fourth quarter of fiscal year 2024, CCSE reported the average number of individuals served per month (non-Medicaid community care) was 39,194.

The fiscal year 2024 number of clients served was 119,741.

The CCSE Program Support Unit, which includes Quality Assurance, follows an established process to complete Quality Assurance reviews on CCSE case work. Each month, Quality Assurance reviews four case actions for each case worker for ten Quality Assurance Standards.

CCSC completes contract and fiscal compliance monitoring on over 2,500 open enrollment contracts on a 2-year cycle to assess contracted providers compliance with contracting rules, CCSE program requirements, and fiscal monitoring.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

- Program Eligibility: A person must be Title XIX Medicaid-eligible in a community setting, be Title XIX-eligible under the provisions of Social Security Act Section 1929(b)(2)(B) or be eligible under the provisions of Title XX of the Social Security Act;
- Income: \$2,901 for Individual and \$5,802 for couple. There is no income limit for Title XX HDM;
- Assets: \$5,000 for an individual and \$6,000 for a couple. There is no resource limit for Title XX HDM or CMPAS; and
- Additional Eligibility Information: People on services must meet functional and financial eligibility criteria, and certain programs require a practitioner's statement of medical need. If Social Security or another program within HHSC has already made a financial determination for the applicant, the applicant may be considered categorically eligible. The minimum age requirement for services varies by program.

F. Administration and key processes:

An intake line run by CCSE receives referrals and assigns cases to CCSE case workers. The case worker conducts an assessment to determine eligibility. Once determined eligible, a contracted agency provides services. CCSE monitors the case at 30-days, 90-days, or 6-months depending on the service provided, as well as an annual reassessment.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

CCSE case workers make referrals to DFPS APS when appropriate. APS investigates abuse, neglect, and exploitation of adults who are elderly or have disabilities and who live in the community.

J. Barriers and challenges:

CCSE staff use a combination of manual, paper-based processes and five outdated and fragmented systems to process eligibility. Case records are paper-based and require physical filing systems across the state with no online repository. Staff manually track and monitor workload using SharePoint. Staff also enter data

manually and frequently archive data as it is not automatically backed up. There is data duplication across multiple systems. Staff use faxes for inbound and outbound provider communication. These challenges in the CCSE workflow make it difficult to efficiently and accurately track and report workload volumes and caseloads.

K. Additional information:

CCSE improved access to services by expanding CMPAS program statewide on September 1, 2024. Operational efficiencies include centralizing the nursing team, restoring functionality in the eligibility system, which allows for tracking, and monitoring of these services.

CCSE developed a new cellular application called CCSE Safe designed to enhance safety and security for our CCSE staff working out in the field.

L-M. Regulatory and Complaint Information: Not applicable.

Foster Grandparent Program

A. Division or program information:

Name of division or program: Foster Grandparent Program (FGP)

Location within the agency: CPSO

Contact name: Evelyn Greenfield-Johnson, Associate Commissioner of Community Care Services; Emily Dressen, Manager of Foster Grandparent Program

Statutory citation: Texas Human Resources Code, Chapter 114 and Section 117.082

B. Objective and major activities:

FGP uses federal funds to support volunteerism that benefits communities across Texas, offering income-eligible adults, age 55 and older, meaningful volunteer opportunities providing one-on-one emotional support, mentoring, and tutoring to children with exceptional needs. FGP volunteers are eligible to receive a tax-free stipend for hours served, along with travel reimbursement. HHSC administers 10 programs in the following greater urban areas: Abilene, Austin, Corpus Christi, Denton, Fort Worth, Lubbock, Lufkin, Mexia, Richmond, and Temple.

The program's comprehensive training equips older volunteers to provide exceptional service, enhancing their sense of purpose and ensuring high retention.

Volunteers serve at volunteer stations that are public agencies, secular or faith-based private non-profit organizations, or proprietary health care organizations that accept the responsibility for assignment and supervision of FGP volunteers. Existing volunteer stations include over 200 locations, mostly Independent School Districts, child care, and head start centers.

C. Effectiveness and efficiency information:

Throughout the 2023-24 grant year, 275 FGP volunteers provided 301,472 service hours and mentored 21,300 children and youth.

The program must meet objectives tied to federal performance measures set through the FGP grant. This includes the number of hours served, children mentored, volunteers in service, and volunteer stations.

CCS conducts quarterly site visits of each FGP volunteer station to ensure compliance with program requirements, state and federal regulations, and rules.

Volunteer station staff complete data collection tools which include teacher questionnaires, developmental measurement tools, and daily contact logs. FGP uses data collection tools to measure a child's progress in identified target areas and measure the impact the FGP volunteer had on the child's progress, with a rating of "impact" or "no impact." Performance is directly tied to grant requirements and is reported to Americorp, the federal funder, on an annual basis.

D. History:

President Johnson's administration initiated FGP in 1965. The Denton HHS-FGP was one of the initial twenty-one programs in the nation and started with 93 volunteers. HHS-FGP then expanded into Austin and Mexia in 1967, followed by Abilene, Corpus Christi, and Lubbock in 1972. Lufkin followed shortly after in 1974, and Richmond/Rosenberg in 1983.

E. Qualifications or eligibility requirements for Foster Grandparent Volunteers:

- Percentage of FPL: 200 percent;
- Income: AmeriCorps distributes an annual notice with income qualifications for FGP volunteers. It is set at 200 percent of the FPL based on the number of household members;

- Minimum Age Requirement: 55 years of age; and
- Additional Eligibility Information: Applicants must complete and pass a three-part background check.

Children served by FGP must have an exceptional need as identified and must be under 21 (some exceptions are made).

F. Administration and key processes:

The FGP service areas include 42 counties in Texas.

FGP focuses on fostering high-quality matches between a volunteer station and a volunteer's skills, interests, abilities, and preferences. Each FGP service area has relationships with local school districts and a variety of nonprofit organizations that serve as volunteer stations. FGP maintains MOUs with each volunteer station. The MOU outlines responsibilities for each party and complies with federal, state, and local statutes, regulations, and applicable circulars.

Volunteers whose income qualifies are eligible to receive a tax-free stipend for hours served, along with travel reimbursement. FGP processes stipend payments bi-monthly and travel reimbursements monthly. FGP volunteers' time is submitted, approved, processed, and paid bi-weekly. Transportation methods are also tracked, and reimbursement payments are processed and paid monthly.

FGP strives to prepare a population of exemplary volunteers by equipping them with the skills and knowledge required to mentor and tutor at-risk children. Some volunteer stations provide additional training opportunities, such as including FGP volunteers in routine staff trainings, to build confidence in the volunteers' abilities to better meet the needs of children served. FGP volunteers also participate in required monthly in-service meetings intended to enhance their volunteering experience.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts:

There are 85 MOUs with FGP volunteer stations.

I. Relationship with other governmental entities:

FGP partners with the Texas Department of Juvenile Justice and DFPS to provide services to children and youth.

J-M. Barriers, Additional, Regulatory, and Complaint Information: Not applicable.

Office of Guardianship Services

A. Division or program information:

Name of division or program: Office of Guardianship Services (OGS)/Guardianship Services Program (GSP) and Surrogate Decision-Making Program (SDMP)

Location within the agency: CPSO

Contact name: Rosa Berumen, Director Office of Guardianship Services

Statutory citation: Guardianship: Texas Human Resources Code, Chapters 48 and 161; Texas Estate Code, Title 3; Surrogate Decision-Making: Texas Health and Safety Code, Chapter 597

B. Objective and major activities:

GSP serves as legal guardian for incapacitated adults, age 18 or older, who have a disability, are unable to provide for themselves, and are impacted by abuse, neglect (including self-neglect), and/or exploitation. A person must meet the Texas Estates Code definition of an incapacitated person and the eligibility requirements of the Texas Administrative Code.

SDMP educates and trains volunteers to handle treatment decisions and facilitates Surrogate Consent Committee (SCC) meetings to make certain treatment decisions for individuals with an IDD who reside in a community-based ICFs/IID. The program has an application process to request a committee meeting and receive services from the program.

C. Effectiveness and efficiency information:

GSP uses the Guardianship Online Database (GOLD) system to collect and report the LBB measure (6-1-1-OP-1) regarding the average monthly number of individuals receiving guardianship services from HHSC. In fiscal year 2024, the average number of individuals served each month was 836. GSP also collects

information related to the average monthly number of individuals receiving guardianship services from HHSC contractors, and the average monthly number of referrals received from DFPS.

Additionally, GSP's Oversight and Community Support Unit conducts quality assurance reviews and contract monitoring visits to the work of certified guardians and its guardianship service provider contractors to measure effectiveness on an annual basis. The program reviewed 100 percent of Program Units and Service Provider Contractors in fiscal years 2022-24. The Judicial Partner Survey is another measurement tool used to gather information from partnering courts with guardianship jurisdiction on the program's effectiveness in the courtroom on guardianship cases.

SDMP educates and trains volunteers to handle treatment decisions, uniquely serving individuals enrolled in community ICF/IID settings, and provides an alternative to guardianship. SDMP uses the OneDrive system to track the average number of packets processed for individuals needing consents, as well as the number of consents approved.

D. History:

S.B. 236, 73rd Legislature, Regular Session, 1993, made APS responsible for assuming guardianship of people with severe disabilities who aged out of CPS care.

H.B. 1111, 74th Legislature, Regular Session, 1995, added APS clients into the guardianship program.

S.B. 6, 79th Legislature, Regular Session, 2005, transferred the Guardianship Program from DFPS to DADS on September 1, 2005.

In 2016, the Guardianship Program moved to HHSC and established OGS comprised of GSP and SDMP.

E. Qualifications or eligibility requirements:

Individuals served by GSP must meet criteria for services detailed in the Texas Human Resources Code, Section 161.101; and Texas Administrative Code, Title 26, Part 1, Chapter 361, Subchapter B.

Eligibility criteria include:

- Having private assets or be eligible for government benefits to meet the expenses of day-to-day living;
- Availability of less restrictive alternatives;
- Having a guardian will provide an effective remedy to the person's situation; and
- Meets the legal definition of an incapacitated person under the Texas Estates Code 1002.017.

To be eligible for a SCC meeting, individuals must have a primary diagnosis of an IDD or related condition and reside in community based ICF/IID settings.

F. Administration and key processes:

Guardianship staff are employed throughout the state. GSP also contracts with five non-profit guardianship programs throughout Texas to provide guardianship services.

DFPS, both CPS and APS, make referrals to GSP when:

- DFPS validates an allegation of abuse, neglect, or exploitation of a person who needs a guardian;
- That person meets criteria for referral in the Texas Human Resource Code;
- There are no other less restrictive alternatives; and
- No alternate guardians are available.

In limited situations, courts with probate authority make requests to GSP. Guardianship supervisors process referrals received and assigned them to guardianship specialists. The guardianship specialist conducts an in-person assessment of the individual and gathers all relevant information to determine if the individual meets the criteria for guardianship services. The guardianship specialist determines whether to pursue or not to pursue the guardianship of the referred individual. When there is sufficient evidence to support the need for guardianship, GSP notifies the referring entity about the next steps to file a guardianship application. An application is completed and filed with the assistance of the regional attorney, and a hearing is scheduled with the court. The court with guardianship jurisdiction makes the final determination on the appointment of a guardian.

Once the applications are complete, SDMP staff request a hearing. During the hearings, Surrogate Consent Committees determine the individuals' best interests and consent or refuse to consent to the requested treatment.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts:

GSP has MOUs with DFPS; APS and CPS. The MOUs outline the necessary steps to process referrals for guardianship services between DFPS and GSP.

I. Relationship with other governmental entities:

GSP works with local courts with probate authority, Social Security, Veterans Affairs, along with other state agencies as needed to secure services for individuals served by the program. Local courts with probate authority have jurisdiction over probate matters such as guardianship cases. Social Security and Veterans Affairs issues benefits to individuals served by GSP.

J. Barriers and challenges:

Following the 2016 HHSC transformation, the Legislature moved the GSP program from DADS to HHSC. Several statutory references in the Texas Estates Code, Texas Health and Safety Code, and Texas Human Resources Code continue to refer to the program as the DADS Guardianship Program. The lack of correct agency references in the statutes has, on occasion, caused confusion with the Social Security Administration and courts referring to DADS, instead of HHSC.

Maintaining an adequate SCC volunteer database and recruiting new volunteers is challenging.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

VII. Guide to Agency Divisions and Programs

Chief Programs and Services Officer

Behavioral Health Services

Behavioral Health Services (BHS) strives to ensure Texans have statewide access to community-based behavioral health services. BHS directs the provision of outpatient mental health services, community-based hospital services, substance use disorder services, and crisis services, including crisis hotlines and mobile crisis outreach teams. Additionally, BHS oversees the delivery of peer support and recovery services, veteran's mental health, rural mental health, disaster behavioral health, and programs to prevent justice involvement.

BHS ensures access and quality of behavioral health services (mental health and substance use disorder) by providing oversight and support of contracted providers, performance improvement and evaluation, technical assistance, and IT systems support.

Office of Mental Health Coordination

The Office of Mental Health Coordination (OMHC) engages with stakeholders at local, state, and federal levels to improve access to and the quality of mental health and substance use services. The legislatively authorized Statewide Behavioral Health Coordinating Council guides much of OMHC's work. OMHC also implements demonstration projects:

- **Managed Care Organization Transition Specialist Pilot:** Transitions adults with serious mental illness (SMI) and physical health needs or conditions from nursing facilities to STAR+PLUS Home and Community-based Services.
- **Bridge to STAR+PLUS Pilot:** Transitions adults with SMI and a nursing home level of need from state hospitals to the community using Local Mental Health Authority (LMHA) teams to provide transition support for up to six months before and one year after transition.
- **Housing Access Coordinator and Supportive Housing Specialists:** BHS employs a Housing Access Coordinator and contracts with an LMHA to provide on-site supportive housing staff at two high-volume Section 811 properties in Travis County.

Mental Health Programs

Mental Health Programs (MHPs) oversee community-based mental health services for children and adults. Program areas include the following:

- Children's Mental Health (CMH);
- Adult Crisis and Forensic Mental Health Services;
- Behavioral Health Medicaid Programs; and
- Disaster Behavioral Health Coordination.

Children's Mental Health

CMH provides programmatic support and oversight of child-focused programs and initiatives.

While not a separate division under CMH, a current division-wide effort is to help children in Department of Family and Protective Services (DFPS) conservatorship, including focusing on children lacking placement and children at risk of placement disruption. Specifically, CMH leads the Residential Treatment Center (RTC) Project which:

- Ensures access to intensive support for families who are at-risk of relinquishment to DFPS due to a child or youth's mental health needs; and
- Provides state-funded residential placement to meet the child or youth's mental health needs when families do not have the resources to access residential placement.

Children's Mental Health Services

A. Division or program information:

Name of division or program: CMH

Location within the agency: CPSO

Contact name: Reilly Webb, Associate Commissioner

Statutory citation: Texas Health and Safety Code, Chapters 531, 533, and 534

B. Objective and major activities:

CMH oversees contracts with 37 LMHAs and two local behavioral health authorities (LBHA) that serve children and youth and their families. The Health and Human Services Commission (HHSC) requires each authority to plan, develop policy, coordinate, and allocate resources for mental health services in their respective local service areas. CMH also provides clinical and health systems expertise to partners, stakeholders, and contractors.

Core Services - HHSC's Texas Resilience and Recovery (TRR): LMHAs and LBHAs are required to implement (TRR) Utilization Management Guidelines for the delivery of core community mental health services within the TRR system.

The TRR model establishes levels of care (LOC) and is designed to provide an appropriate array of evidenced-based services (crisis, outpatient mental health, and residential) based on the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment for young children. Children served are primarily diagnosed with a serious emotional disturbance. Core TRR services for children are determined by level of care as listed in Table 1.

Table 1. TRR Model for children and youth.

LOC	Services
LOC-0	Crisis Services
LOC-1	Medication Management
LOC-2	Targeted Services
LOC-3	Complex Services
LOC-4	Intensive Family Services
LOC-YES	Youth Empowerment Services
LOC-RTC	Residential Treatment Center Services
LOC-5	Transitional Services
LOC-YC	Young Child Services (Under age 6)
LOC-EO	Early Onset
LOC-TAY	Transition Age Youth

It is important to note that providing children and youth services often involves providing family supports, including assistance with accessing and coordinating necessary care and services, and peer support and training for primary caregivers of children and youth who are receiving services and experiencing emotional disturbances.

Additional Services (not available at each LMHA and LBHA):

- Behavioral Health Partnership Program (BHPP): HHSC contracts with 20 LMHAs and LBHAs to employ a BHPP liaison. When school districts identify a need, they can directly contact the BHPP liaison assigned to their regional service area or initiate the request through the LMHA, LBHA, or education service center (ESC). Training and resources include trauma and grief for people with an intellectual or developmental disability (IDD) and substance use prevention and intervention.
- The Children's Mental Health System Navigator Program: HHSC contracts with six LMHAs and LBHAs to deliver two types of system navigation in their local communities: System Navigators (SN) who support efforts to divert children from entering DFPS conservatorship; and System Navigators Plus (SN-Plus) who provide services and supports to children in DFPS conservatorship or children at risk of parental relinquishment. In fiscal year 2024, all SN-Plus and SNs received over 450 referrals to connect children and families to behavioral health services in the least restrictive environment.
- Multisystemic Therapy (MST®): A treatment model provided by some LMHAs developed to treat youth with serious antisocial behavior and justice-involvement. MST® engages family and support systems. MST® is short-term (three to five months) and intensive (available 24 hours a day).
- Youth Crisis Outreach Team Services (YCOT): YCOT is a specialized resource provided at eight LMHAs and LBHAs, working alongside other crisis programs to collectively provide support 24 hours a day, seven days a week. During designated hours, YCOT provides a developmentally appropriate, in-person response with specially trained staff, when any person contacts the crisis system. YCOT seeks to keep people in their local community. Targeted populations include children and youth experiencing academic challenges, truancy, family issues, exposure to violence and trauma, and suspected mental health concerns who are on the inquiry list for Youth Empowerment Services (YES) waiver services, have multiple or extended stay inpatient psychiatric hospitalizations, or have current or previous DFPS or Juvenile Justice involvement.
- Children's crisis respite (CCR): CCR serves children with a serious emotional disturbance (SED) diagnosis (or co-occurring IDD) between the ages of 3 and 17 who have low risk of harm to self or others and require direct supervision and care but do not require hospitalization. CCR provides access to short-

term, safe, and clinically appropriate residential services and provides transition planning services to the child’s family, adult caregiver, or legally authorized representative (LAR) prior to the child exiting the crisis respite facility.

C. Effectiveness and efficiency information:

HHSC monitors LMHA and LBHA utilization management by reviewing data to assess program effectiveness and progress toward goals. LMHAs and LBHAs enter data into Clinical Management for Behavioral Health Services (CMBHS), and Mental and Behavioral Health Outpatient Warehouse (MBOW). Available data includes healthcare encounters, registrations, assessments, authorizations, diagnoses, service assignments, hospital episodes, Medicaid eligibility, and jail match information. BHS tailors performance measures to each program and includes the measures in the performance contracts.

Table 2. TRR LBB performance measures, fiscal year 2024.

Measure Title	Actual Amount
Average monthly number of children receiving community mental health services	26,835
Average monthly cost per child receiving community mental health services	487
Percent of children receiving community mental health services whose functional level improved	50%

Table 3. BHPP measures, fiscal year 2024.

Measure	Results
Number of times evidence-based practices are shared with school districts	498
Number of times mental health and substance use and misuse resources are shared with school districts	52,165
Number of times a behavioral health partner assisted with implementing initiatives	319
Number of Mental Health First Aid (MHFA) trainings	464
Number trained in MHFA and Youth MHFA	7,717
Number of trainings focused on grief and trauma	600
Number trained at grief and trauma trainings	26,163

Measure	Results
Number of trainings focused on children with intellectual or developmental disabilities impacted by grief and trauma	307
Number trained at trainings focused on children with intellectual or developmental disabilities impacted by grief and trauma	8,182
Number of trainings focused on substance use and misuse prevention and intervention and number trained	495
Number trained at trainings focused on substance use and misuse prevention and intervention	14,844

Table 4. Children’s Mental Health System Navigator Pilot Program, fiscal year 2024.

Measure	Result
Number of consumers served	325
Number of trainings provided	106
Number of collaborations with community partners	570
Number of case reviews performed	325
Survey results: Training covered relevant topics	4.6
Survey results: Training was useful	4.6
Survey results: Training met its objectives	4.6

Table 5. MST measures, fiscal year 2024.

Measure	Results
Number of children served.	379
Number of children discharged.	245
Percent of children living at home.	84.9%
Percent of children in school or working.	87.1%
Percent of children with no new arrests.	89.7%
Number served with juvenile justice involvement.	224

In fiscal years 2022-24, data aggregated by the Multisystemic Therapy Institute showed approximately 90 percent of children enrolled in MST® did not acquire a new arrest, and 87 percent of children remained in school or employed, demonstrating the efficacy of this program.

D. History:

In 2022, HHSC received funding through the Budget Execution Order to contract with LMHAs and LBHAs to create an MST® team in Texas. The 2024-25 General Appropriations Act, House Bill (H.B.) 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 52), increased funding to expand MST® to 22 teams provided by 16 LMHAs.

Rider 52 also appropriated additional funding for facility-based crisis programs.

E. Qualifications or eligibility requirements:

TRR CMH Services eligibility requirements include:

- Age Requirement: 3 to 17 years of age.
- Medical Status: Children and youth who have a diagnosis of mental illness (other than a diagnosis of substance use disorder, intellectual disability, or autism spectrum disorder) and exhibit serious emotional, behavioral, or mental disorders and one of the following conditions: A serious functional impairment, at risk of disruption of a preferred living or child care environment due to psychiatric symptoms, or enrolled in special education because of serious emotional, behavioral, or mental disorders.
- Additional Eligibility Information: Children who also have a co-occurring condition, including a substance use disorder or IDD, are eligible for services.

SN and SN-Plus services eligibility requirements are:

- Age Requirement: 3 and 17
- Medical Status: A single diagnosis of SED or a primary SED and co-occurring diagnosis, including a substance use disorder or IDD and meet one of the three priority populations that need access to system navigation for behavioral health services:
 - ▶ Children in DFPS conservatorship lacking placement;
 - ▶ Children at risk of entering state conservatorship lacking placement (i.e., at risk of losing the preferred living or childcare environment due to psychiatric symptoms or enrolled in special education because of an SED); or
 - ▶ Children at risk of parental relinquishment.

MST eligibility requirements are:

- Age Requirement: youth ages 12-17. MST® providers accept referrals for youth aged 18 on a case-by-case basis.
- Youth with mental health issues who are risk of incarceration or out-of-home placement. Youth may also exhibit co-occurring needs such as trauma-related symptoms, depression, anxiety, mild or moderate intellectual disability and co-occurring diagnosis, including autism.

Table 6. MST fiscal year 2024 demographics.

	Result
Sex	
Male	209
Female	168
Prefer Not to Say	2
Age	
Children (3-12)	60
Youth (13-17)	318
18 and older	1
Total Youth Served:	379

Below are the YCOT eligibility requirements:

- Age Requirement: children and youth ages three to 17
- In need of behavioral health crisis services and intervention to prevent escalation to more acute settings.

F. Administration and key processes:

LMHAs and LBHAs must comply with applicable mental health service rules of the Texas Administrative Code as described in the performance contract, including prevention standards, case management, rehabilitative standards and client rights.

The funding methodology for core services includes population growth, brings all LMHAs and LBHAs up to an established floor, and allocates additional funds to LMHAs that have a per capita funding that is less than the statewide per capita funding rate.

HHSC staff monitors service delivery, conducts regular utilization reviews to monitor service provision and compliance with the LMHA and LBHA contract's

performance measures, updates contract documents, and provides technical assistance as needed.

CMH uses a Tableau dashboard for monitoring efficacy in addition to regional needs. The dashboard aggregates CANS scores by LMHA and LBHA, level of care, and implements sorting options to highlight needs or strengths based on statistical significance. Trends in CANS scores can be compared year over year and compared to a calculated state average on all components of the CANS assessment. The data is also used to inform requests HHSC receives regarding needs that are focused on youth in a specific geographic area, such as youth and families that present as walk ins to state hospital facilities.

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and relationships with others:

To administer BHPP, CMH collaborates with the Mental Health First Aid (MHFA) team, ESCs, LMHAs, and LBHAs within each region to coordinate training, assess district needs, address service gaps, and prevent duplication of efforts. To formalize this collaboration HHSC has MOUs with ESCs, and LMHA or LBHAs that define their respective responsibilities in supporting the BHPP liaison and program implementation.

The Children’s Mental Health System Navigator Program develops MOUs with local independent school districts to allow on-site access to mental health service, increasing access for students to receive services in the community.

I. Relationships with other governmental entities: Not applicable.

J. Barriers and challenges:

Challenge 1: Most Texas counties are designated as provider shortage areas for mental health. Due to variance across local entities and systems, not all services are available in every county.

Challenge 2: Texans in need of mental health services are increasingly presenting with multiple, complex diagnoses, including aggressive behavioral disorders. These individuals—both adults and children—often require highly specialized, coordinated care that traditional mental health programs are not equipped to provide. The severity and complexity of their behavioral challenges make it difficult to find

appropriate treatment settings that can safely and effectively address their needs, leaving many families and providers struggling to secure the right services.

Challenge 3: HHSC receives requests from other agencies including DFPS, Texas Juvenile Justice Department (TJJD), and Texas Education Agency (TEA) for SN and other intensive youth programs that are not yet available statewide.

K. Additional Information:

Senate Bill (S.B.) 26, 88th Legislature, Regular Session, 2023, allows LMHAs and LBHAs that are unable to employ a non-physician mental health professional (NPMHP) in the liaison position as originally required by this program and defined by Texas Health and Safety Code, Section 571.003(15), to request a waiver from HHSC to employ a licensed master social worker or a licensed professional counselor associate to fulfill the duties of an NPMHP serving as the BHPP liaison.

L-M. Regulatory and Complaint Information: Not applicable

Community Resource Coordination Groups

A. Division or program information:

Name of division or program: Community Resource Coordination Groups (CRCGs)

Location within the agency: CPSO

Contact name: Reilly Webb, Associate Commissioner

Statutory citation: Texas Government Code, Sections 522.0151 to 522.0157

B. Objective and major activities:

CRCGs are county-based groups that connect individuals and families with complex needs to various health and social services. These groups are comprised of local partners and community members who work together to identify and coordinate resources, including behavioral health, basic needs, and caregiver support. CRCGs are particularly helpful when a person's needs cannot be met by a single agency. Types of CRCG partners include juvenile probation officers, independent school districts, family representatives, LMHAs, LBHAs, DFPS, Department of State Health Services (DSHS), and others.

The most commonly recommended services and supports include mental health services, family therapy, parent supports, school-based behavioral interventions, special education services, state benefits, mentoring, basic needs, autism services, homelessness prevention, and IDD services.

C. Effectiveness and efficiency information:

HHSC analyzes data provided by local CRCGs monthly and uses the information to examine program effectiveness and progress toward program goals. This data informs CRCG training materials for local CRCGs and focuses HHSC efforts on action steps that help CRCGs serve people of all ages statewide.

Table 7. CRCG measures, fiscal year 2024.

Measure	Result
Number of CRCGs	140
Number of counties served	245
Number of staffings (meetings with person, family or caregiver referred) conducted to make recommendations for services and supports	1,504
Number of people served	1,504

D. History:

S.B. 298, 70th Legislature, Regular Session, 1987, established CRCGs to help bridge the gap for children with complex needs and to ensure agencies were coordinating with each other.

S.B. 1468, 77th Legislature, Regular Session, 2001, expanded CRCGs to serve adults.

E. Qualifications or eligibility requirements:

While CRCGs do not have formal eligibility requirements, the population served by CRCGs includes children (ages 0 to 12 years), youth (ages 13 to 17 years), and adults whose needs cannot be met by one agency and who would benefit from interagency coordination.

Table 8. CDCG demographics.

	First Time	Follow Up	Total
Age Range			

	First Time	Follow Up	Total
0-10	140	53	193
11-20	677	184	861
21-30	27	2	29
31-40	33	0	33
41-50	34	2	36
51-60	37	5	42
61+	51	5	56
No Data Collected	10	8	18
Sex			
Male	540	146	686
Female	460	105	565

F. Administration and key processes:

While HHSC does not provide funding to local CRCGs, it has six CRCG Regional Coordinators assigned to each of the 140 CRCGs.

The State CRCG office, in collaboration with the State CRCG workgroup, provides information, guidance, training, and technical assistance to local CRCGs. The State CRCG office also ensures adherence to the program model, develops and monitors budget and policies, and collects and analyzes program data.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts:

Eight state agencies collaborate on CRCG implementation through an MOU. State agency partners support CRCGs at both a local and state level, and include the Texas Workforce Commission (TWC), TEA, TJJD, Texas Department of Housing and Community Affairs (TDHCA), Texas Department of Criminal Justice (TDCJ), and DFPS.

I-J. Relationships with others, and Barriers: Not applicable.

K. Additional information:

Between February 2017 and August 2024, the Uvalde CRCG struggled to maintain a presence in the county. Because the program is based on volunteers, Uvalde County went through many periods where volunteers were not available or could not commit to long periods of time in the role. However, the HHSC CRCG Regional Coordinator provided targeted outreach and engagement in fall 2024 and winter 2025 to assist Uvalde and Real Counties. In spring 2025, the CRCG for Uvalde and Real Counties officially relaunched, marking a significant step forward in restoring interagency coordination in an underserved region.

L-M. Regulatory and Complaint Information: Not applicable.

Texas System of Care

A. Division or program information:

Division or program information: Texas System of Care (TxSOC)

Location within the agency: CPSO

Contact name: Reilly Webb, Associate Commissioner

Statutory citation: Texas Government Code, Section 547.0052

B. Objective and major activities:

TxSOC aims to establish a network of community-based services and supports to help children, youth, and young adults with or at risk for mental health challenges, along with their families. TxSOC supports the Texas System of Care Consortium and the Children and Youth Behavioral Health Subcommittee (CYBHS) to the Behavioral Health Advisory Committee (BHAC) that advises the TxSOC. What began with pilot projects, is now a statewide initiative promoting local systems of care and the system of care approach.

The TxSOC model includes wraparound planning and family partners (family-to-family peer support) offered to children and families with complex needs to promote positive outcomes and prevent out-of-home placements. TxSOC models are offered across all 254 counties and embedded in the Texas YES Medicaid Waiver. Communities in all regions of the state have established community collaborations committed to improving the systems of care. From 2021 to 2025, the grant expanded to strengthen school-based mental health supports. Public schools

work with mental health entities to develop and implement capacity-building strategies to provide sustained service delivery to children, youth and their families.

The United States (U.S.) Substance Abuse and Mental Health Services Administration (SAMHSA) funded state-led TxSOC efforts through a four-year grant.

C. Effectiveness and efficiency information:

HHSC CMH analyzes evaluation data provided by the University of Texas Institute for Excellence in Mental Health and quarterly reports from contracted LMHAs to assess program effectiveness and progress toward local system of care implementation.

HHSC uses National Outcome Measures data, as required by SAMHSA, to determine the number of people served through the federal grant. TxSOC served 172 children and families in fiscal year 2024.

D. History:

During the 1992-93 biennium, the Texas Children's Mental Health Plan (TCMHP) appropriated funds for an interagency initiative (1992-93 General Appropriations Act, H.B. 1, 72nd Legislature, Regular Session, 1991 (Article II, Health Welfare, and Rehabilitation Agencies)). HHSC received designation as the agency responsible for implementing a state system of care and used TxSOC and other SAMHSA grant funds to develop the system.

E. Qualifications or eligibility requirements:

TxSOC serves children and youth who have or are at risk of developing a serious emotional disturbance, and who are receiving residential or inpatient mental health services or are at risk of being removed from their home and placed in a more restrictive treatment setting.

F. Administration and key processes:

The governance body with decision-making authority for implementing the TxSOC framework across the TxSOC MOU partner agencies is CYBHS.

HHSC contracts with three LMHAs to increase access to school-based mental health services and supports for children, youth, and their families, including peer supports provided by youth and family partner supports. To implement the grant,

contracted LMHAs develop MOUs with local independent school districts to provide school and community-based services.

CMH submits annual reports to SAMHSA evaluating progress toward the grant goals. Grantees submit data via quarterly programmatic reports to HHSC. When CMH staff identify gaps or challenges, they develop training and identify resources to ensure program success.

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts:

In alignment with state statute, HHSC has a joint MOU with DSHS, DFPS, TEA, TJJD, and TDCJ – Texas Correctional Office on Offenders with Medical or Mental Impairments to collaboratively implement the TxSOC framework. The MOU prevents duplication of services as state agencies collaborate to provide a comprehensive array of children’s mental health services with access for all families.

I. Relationship with other governmental entities:

SAMHSA provides oversight and approval for grant activities.

J-M. Barriers, Additional, Regulatory, and Complaint Information: Not applicable.

Adult, Crisis and Forensic Mental Health Services

Adult, Crisis, and Forensic Mental Health Services provides programmatic direction and oversight of a statewide mental health system. LMHAs, LBHAs, and other HHSC-funded community mental health providers deliver direct services.

Adult Mental Health Services

A. Division or program information:

Name of division or program: Adult Mental Health (AMH) Services

Location/Division: Chief Program and Services Officer (CPSO)

Contact Name: Reilly Webb, Associate Commissioner

Statutory citation: Texas Health and Safety Code, Chapters 531, 533, and 534

B. Objective and major activities:

AMH oversees the provision of mental health services through contracts with 37 LMHAs and two LBHAs. HHSC requires each authority to plan, develop policy, coordinate, and allocate resources for mental health services in their respective local service areas.

LMHAs and LBHAs primarily serve adults with a SMI diagnosis of schizophrenia, bipolar disorder, or major depressive disorder.

Core Services - HHSC's TRR

Similar to children's health, LMHAs and LBHAs are required to implement HHSC's TRR Utilization Management Guidelines for the delivery of adult community mental health services. The TRR model establishes levels of care and individualized services are determined by based on strengths and needs assessed through the Adult Needs and Strengths Assessment (ANSA).

Core TRR services are listed by level of care in Table 9.

Table 9. TTR model for adults.

LOC	Services
LOC-0	Crisis Services
LOC-1M	Basic Services – Medication Management
LOC-1S	Basic Services – Skills Training
LOC-2	Basic Services – Counseling
LOC-3	Intensive Services with Team Approach
LOC-4	Assertive Community Treatment
LOC-5	Transitional Services
LOC-EO	Early Onset

Additional Core Services (available at all LMHAs and LBHAs)

- **Crisis Hotline Services:** The hotline provides callers with information, screening and intervention, support, and referrals. The crisis hotline is available to callers toll free, 24 hours per day, seven days a week.
- **Mobile Crisis Outreach Team Services (MCOT):** MCOT services provide quality psychiatric emergency care in all community settings designed to prevent further decompensation of people experiencing, or at risk of developing, a

psychiatric emergency. MCOT services are available 24 hours a day, seven days a week.

- **Inpatient Psychiatric Beds:** Inpatient psychiatric services are available to people of any age who after assessment, the LMHA or LBHA determines is a danger to self, a danger to others, or in danger of serious behavioral or physical deterioration. HHSC allocates funding to LMHAs and LBHAs using a data-driven methodology ensuring every service area has access to an equal number of beds per 100,000 people. Funds are allocated quarterly; each LMHA and LBHA subcontracts with private psychiatric hospitals to deliver intensive inpatient services for the target populations.

Additional Services (not available at each LMHA and LBHA)

- **High Fidelity and Job Developer Supported Employment Services (SES) Programs:** SES intensive services are designed to help people seeking mental health recovery supports with employment stability and individualized assistance in choosing and obtaining employment in integrated settings.
- **Mental Health Housing-Related Services:** Housing services are administered through three different programs - Projects for Assistance in Transition from Homelessness (PATH) grant, State Hospital Step-Down Program (SHSDP), and Supportive Housing Rental Assistance (SHRA). From its inception in 2021, SHSDP discharged 69 participants, with a success rate of 87 percent for people who transitioned into their community of choice.
- **Facility-based Crisis Programs:** Facility-based crisis services are provided at four levels of care. Crisis stabilization units (CSUs) are designed to reduce a person's acute symptoms of mental illness; crisis respite units provide short-term (up to seven days) crisis stabilization care to people who pose low risk of harm to self or others; extended observation units (EOUs) provide emergency stabilization and transition to a higher or lower intensity crisis option; and crisis residential units (CRUs) provide short-term, community-based residential crisis stabilization treatment and services for one to 14 days. The program provides services in Community Mental Health Hospitals (CMHHs), Private Psychiatric Bed (PBH) facilities, and Contracted Psychiatric Bed facilities (CPB).
- **Competency Restoration Services:** Delivered in different settings, court-ordered competency restoration services are provided for those found incompetent to stand trial. The goal of these services is to ensure that individuals meaningfully participate in their legal proceedings. Depending on

the local service areas, competency restoration services may be provided in an outpatient, jail-based, or inpatient setting.

- Jail Diversion Centers (JDCs): JDCs serve as an alternative location for law enforcement to drop off an adult 18 years of age or older with mental illness or a co-occurring disorder who is at risk of arrest and does not meet criteria for acute crisis.

C. Effectiveness and efficiency information:

Detailed information pertaining to performance measures, and outcomes calculations, and data sources can be found in "Information Item C" on the [Community Mental Health Contracts](#) webpage. Below is a summary of the AMH programs Legislative Budget Board (LBB) performance measures and internal program data.

Table 10. TRR measures, fiscal year 2024.

Measure Title	Actual Amount
Average monthly number of adults receiving community mental health services	96,748
Average monthly cost per adult receiving community mental health services	543

Table 11. Crisis services measures, fiscal year 2024.

Measure	Actual Amounts
The average general revenue spent per person for crisis outpatient services	\$490
The number of people receiving crisis outpatient services per year funded by general revenue	83,846

Table 12. Crisis hotline services measures, fiscal year 2024.

Measure	Actual Amounts
Total calls	110,227
Number served	58,603
Percent of crisis hotline calls resulting in a face-to-face encounter	61.3%

Table 13. MCOT services measures, fiscal year 2024.

Measure	Actual Amounts
Number of people receiving crisis intervention services in the community	48,015
Number served by using MCOT identifier	18,951
Effective Crisis Response Measure: Percent of crisis episodes during the measurement period shall not be followed by admission to a System Agency Inpatient Bed within 30 days of the first day of the crisis episode	87%
Community Linkage Measure: Percent of adults, children, and youth authorized into LOC-0 shall be authorized into a FLOC or LOC-5 within 14 days of closure from LOC-0.	23%
Crisis Follow-up Measure: Percent of adults, children, and youth authorized into LOC-5 shall receive a crisis follow-up service encounter within 30 days of the authorization into LOC-5	97%

Table 14. Inpatient Psychiatric Beds program measures, fiscal year 2024.

Measure	Actual Amounts
The average daily number of occupied mental health community hospital beds	794
The average daily cost per occupied mental health community hospital bed	562
The percentage of clients receiving crises services who avoid psychiatric hospitalization within 30 days	98

Table 15. Inpatient Psychiatric Beds program (CMHH, PPB, CPB) measures, fiscal year 2024.

Measure	CMHH Amount	PPB Amount	CPB Amount
Number served	2,544	16,388	1,745
Number of episodes	2,998	19,962	1,935
Average length of stay in days	13.07	9.28	8.54
Percent of people in a Texas Resilience and Recovery full level of care admitted to an HHSC-funded bed three or more times within 80 days	.11%	.11%	N/A

Measure	CMHH Amount	PPB Amount	CPB Amount
Frequent Hospital Admission Measure: No more than 0.3% of children and adults in a Texas Resilience and Recovery full level of care shall be admitted to a System Agency Inpatient Bed three or more times within 180 days	.11%	.11%	N/A
Number of HHSC-funded inpatient psychiatric hospitalizations before receiving services in a CPB/PPB	N/A	11,614	245
Number of HHSC-funded inpatient psychiatric hospitalizations after receiving services in a CPB/PPB	N/A	2,628	257

Table 16. PATH housing program measures, fiscal year 2024.

Measure	Actual Amounts
Number of people contacted by PATH funded staff	10,276
Number of people contacted who became enrolled in PATH	4,129
Number enrolled PATH clients who received community mental health services	5,126

Table 17. SHDSP housing program measures, fiscal year 2024.

Measure	Actual Amounts
Number of people discharged from a state hospital to a step-down home	26
Number of people transitioning from a step-down home to the community	16
Average length of stay	338 days
Percent of people working	35%
State hospital readmission and jail booking prevention	96%

Table 18. SHRA housing program measures, fiscal year 2024.

Measure	Actual Amounts
Number of people receiving SHRA	1,575
Total encounters	5,121

Table 19. Facility based crisis services measures, fiscal year 2024.

Measure	Actual Amounts
Number of persons receiving crisis residential services per year funded by general revenue	9,189
Average general revenue spent per person for crisis residential services	\$3,425

Table 20. Facility based crisis services measures, fiscal year 2024.

Measure	CSUs Result	EOUs Result	CRUs Result	Respite: Adults Result	CCR Result
Number served	1,149	5,027	4,598	2,087	145
Number of episodes	1,291	5,737	5,824	2,746	N/A
Average age of the child served	N/A	N/A	N/A	N/A	14.74
Average length of stay in days	4.9	.97	7.23	9.19 days	7.05
Average hours of mental health services received daily	N/A	N/A	24	N/A	N/A
Number of HHSC-funded inpatient psychiatric hospitalizations before receiving crisis residential services	127	478	459	280	46
Number of HHSC-funded inpatient psychiatric hospitalizations after receiving crisis residential services	98	485	410	188	56

Table 21. Jail Diversion Center measures, fiscal year 2024.

Measure	Results
Output: Unduplicated number of people served at the Judge Emmet Mental Health Diversion Center	1,833
Output: Unduplicated number served through post-booking/jail in-reach	100
Output: Unduplicated number served through post-diversion case management services	688

Measure	Results
Outcome: Percentage of unique individuals connected to treatment through short encounter-based services from the post-booking/jail-in-reach program	89%
Outcome: Percentage of unique individuals not arrested due to receiving services from the jail diversion center	99%
Outcome: Percentage of unique participants with the goal of housing stability who obtained stable housing through the aftercare case management services	33%

Note: These measures are from the Harris County pilot program only.

D. History:

OCR programs were created by S.B. 867, 80th Legislature, Regular Session, 2007. Jail-Based Competency Restoration (JBCR) began as a pilot program through S.B. 1475, 83rd Legislature, Regular Session, 2013. JBCR programs were expanded beyond the pilot program through S.B. 1326, 85th Legislature, Regular Session, 2017. JBCR is no longer considered a pilot program, and JBCR programs have expanded to 19 LMHAs and LBHAs.

Jail diversion began as a three-year pilot program established by S.B. 1185, 83rd Legislature, Regular Session, 2013, requiring HHSC to fund a grant program in the most populous county (Harris County) aimed at reducing recidivism rates, arrest rates, incarceration periods, and the wait for forensic inpatient admissions among people with mental illness. S.B. 292, 85th Legislature, Regular Session, 2017, continued the mandate beyond the initial pilot period. HHSC allocates funds annually to Harris County Jail Diversion (HCJD), with a funding match required by Harris County.

The 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, DSHS, Rider 90), allocated funds to address the housing needs of people diagnosed with mental illness. In 2019, HHSC began using funds from the federal Community Mental Health Block Grant to expand SHRA from 20 LMHAs and LBHAs to 36.

The 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013, appropriated approximately \$25 million for the enhancement or expansion of community-based crisis alternatives in underserved communities.

The following session, the 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015, appropriated approximately \$30 million to further enhance or expand community-based crisis alternatives in underserved communities.

The 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 52), appropriated funds to expand SHSDP, resulting in the addition of two new providers and increasing capacity of existing providers. The program is on track to increase its bed capacity by the end of fiscal year 2025. BHS also received \$14 million to fund up to five additional Facility Based Competency Programs (FBCPs) to reduce acute symptoms of mental illness.

In fiscal year 2024, HHSC awarded funding to five JDC projects with a funding match requirement under the Mental Health Program for Justice Involved Individuals grant (MHGJII). HHSC awarded funding to four JDC projects through mental health funding appropriated through the 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 52).

E. Qualifications or eligibility requirements:

Unless otherwise noted below, AMH services provided by LMHAs and LBHAs are available to all individuals in the priority population:

- Adults with a SMI diagnosis of schizophrenia, bipolar disorder, or major depressive disorder; and
- Adults with a mental health diagnosis and significant functional impairment.

Table 22. AMH demographics.

Demographic	Percent Served
Sex	
Female	52%
Male	48%
Age	
18-20 years	5%
21-30 years	22%
31-40 years	24%
41-50 years	19%
51-60 years	17%

Demographic	Percent Served
61+ years	12%

Below are the priority population for High Fidelity SES and Job Developer SES:

- Adults with a SMI diagnosis of schizophrenia, major depression, bipolar disorder, post-traumatic stress disorder, obsessive compulsive disorder, anxiety disorder, attention deficit/hyperactivity disorder, delusional disorder, bulimia nervosa, anorexia nervosa or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment; and significant functional impairment.

Below are the housing program eligibility requirements:

- PATH: An eligible person must be 18 years of age or older, be experiencing homelessness, and have an SMI.
- SHSDP: An eligible person must be 18 years of age or older; have a history of SMI and a minimum of three hospitalizations or long-term care stay within the last five years; not be a danger to themselves, others, or property; be able to physically evacuate without assistance in the event of an emergency; voluntarily consent or, if the person has a legally authorized representative (LAR), then the LAR must consent to the SHSDP home; and have an Intensive Treatment Plan and HHSC approval prior to admission.
- SHRA: An eligible person must be 18 years of age or older, have a diagnosis of mental illness; be experiencing homelessness or at imminent risk of experiencing homelessness; and have been assessed by an LMHA or LBHA for a full level of care. To remain in SHRA, a participant must continue receiving mental health services through the LMHA or LBHA and attempt to apply for federally subsidized housing. Program participants must develop a self-sufficiency plan outlining the steps they will take to increase personal income and secure housing without SHRA assistance.

Below are the JDC participant eligibility requirements:

- Minimum Age Requirement: 18 years of age.
- Medical Status: Mental illness or co-occurring disorder.
- Additional Information: Person must be at risk of arrest, experience a behavioral health crisis in a county with a diversion center, and not meet criteria for acute crisis.

F. Administration and key processes:

HHSC contracts with LMHAs and LBHAs to deliver AMH Services across Texas. [The Texas Administrative Code](#) requires LMHAs and LBHAs to comply with HHSC [TRR Utilization Management \(UM\) Guidelines](#) for the delivery of community mental health services within the TRR system. The funding for core services in the performance contracts use a methodology based on population growth. A second component of the methodology brings all LMHAs and LBHAs up to an established floor and a third allocates additional funds to LMHAs that have a per capita funding that is less than the statewide per capita funding rate.

AMH Services monitors delivery of services to ensure compliance, conducts regular utilization reviews to monitor service provision and compliance with contract performance measures, and updates contract documents as needed. LMHAs and LBHAs collect and report data on delivered services to HHSC at intervals determined by program requirements.

For inpatient hospital beds, HHSC allocates funding to LMHAs who subcontract with private hospitals. For inpatient competency restoration (ICR) services, BHS monitors use of allocated funds and utilization of ICR beds as well as ongoing technical assistance to support adherence to program standards.

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

OCR, JBCR, and JDC programs require significant collaboration between LMHAs and LBHAs, local county officials, court personnel, and law enforcement agencies.

J. Barriers and challenges:

Challenge 1: Most Texas counties are designated as provider shortage areas for mental health. Due to variance across local entities and systems, not all services are available in every county.

Challenge 2: Texans in need of mental health services are increasingly presenting with multiple, complex diagnoses, including aggressive behavioral disorders. These individuals—both adults and children—often require highly specialized, coordinated care that traditional mental health programs are not equipped to provide. The

severity and complexity of their behavioral challenges make it difficult to find appropriate treatment settings that can safely and effectively address their needs, leaving many families and providers struggling to secure the right services.

Challenge 3: Providers report that navigating available resources for supported employment services is challenging due to variance across local communities and systems impacting some programs performance due to communication gaps across entities and general employment opportunities, which varies by community.

Challenge 4: The lack of affordable housing and housing resources limit PATH providers' ability to link homeless individuals to appropriate housing solutions. Similarly, SHSDP programs are designed to be provided in a home-like setting with community living and outdoor activity areas. Rented property may not allow LMHAs and LBHAs to make the necessary renovations to accommodate participants' Americans with Disabilities Act (ADA) needs.

Challenge 5: HHSC state-funded grants to establish jail diversion centers are legislatively required to include matching dollars which can be a challenge for potential applicants. Additionally, JDCs experience challenges collecting effective and efficient data across stakeholders to strengthen funding applications.

Challenge 6: Several programs including Jail diversion centers require a lengthy implementation timeline due to acquiring a facility, hiring staff, establishing policies and procedures. This ramp-up time affects the ability to spend funds within the biennium to serve clients, reach peak contractor performance and achieve required deliverables.

K. Additional information:

The Inpatient Psychiatric Bed program is in the process of developing a new reporting system for LMHAs and LBHAs. This user-friendly system will enable LMHAs and LBHAs to effectively document critical information regarding a person's admission and discharge, treatment, progress, and connection to ongoing mental health services.

L-M. Regulatory, and Complaint Information: Not applicable.

Mental Health First Aid

A. Division or program information:

Name of division or program: MHFA

Location within the agency: CPSO

Contact name: Reilly Webb, Associate Commissioner

Statutory citation: Texas Health and Safety Code, Sections 1001.201-1001.20;
Texas Education Code, Sections 8.151-8.157

B. Objective and major activities:

HHSC contracts with 39 LMHAs and LBHAs to provide MHFA training in their communities. MHFA is a training program that equips individuals with the skills to recognize and respond to signs of mental health or substance use challenges. MHFA curriculum consists of three separate courses: Adults to support adults, adults to support children and youth, and teens to support other teens.

C. Effectiveness and efficiency information:

MHFA includes the following measures through contract deliverables reviewed monthly.

Table 23. MHFA measures, fiscal year 2024.

Measure	Results
Number of active MHFA trainings	519
Number of trainings who left the MHFA program	154
Average number of active MHFA trainers	12.81
Number of service members, veterans, and their family members training in an MHFA curriculum and the veterans' module of MHFA	8,613
Number of people trained in MHFA curriculum	40,325

Each quarter, LMHAs and LBHAs send a survey to participants from youth and adult MHFA trainings to collect information on the following:

- How often participants use MHFA and with whom. In fiscal year 2024, within three months of taking the training:
 - ▶ 53 percent used the training with a coworker;
 - ▶ 63 percent used the training with a friend;

- ▶ 56 percent used the training to help a student; and
- ▶ 25 percent used the training to help a student who was thinking of suicide.
- If participants would recommend MHFA training to others. In fiscal year 2024, 97 percent of respondents would recommend the training to others.
- How confident participants feel helping someone after the training. In fiscal year 2024, 96 percent of respondents reported MHFA increased their confidence to approach someone who may need help or was in a crisis.

D. History:

LMHAs and LBHAs have provided HHSC-funded MHFA training since 2014. Following the passage of H.B. 3 and H.B. 2059, 88th Legislature, Regular Session, 2023, 6,979 additional people received MHFA training in fiscal year 2024 compared to fiscal year 2023. H.B. 2059 expanded the groups of people that could be trained in MHFA for which the LMHAs/LBHAs could seek reimbursement, H.B. 3 requires public school staff who regularly interact with students to take evidenced-based mental health training.

E. Qualifications or eligibility requirements:

Community members can access MHFA training through their LMHAs and LBHAs. Targeted populations include school district employees or those with contact with students, youth under 21 years old, first responders, veterans, and those working in the criminal justice system.

Of the 40,325 people trained in fiscal year 2024, 21,607 participants were public school district, charter, and private school employees, contractors, volunteers, or school resource officers.

Table 24. MHFA participants, fiscal year 2024.

Category	Aggregate Number Trained
Instructors	128
Public School District (including Charter School) Employees, Contractors, Volunteers and School Resource Officers	21,249
Private School Employees, Contractors, Volunteers and School Resource Officers	358

Category	Aggregate Number Trained
Individuals with Direct and Recurring Contact with Students	2,335
Higher Education Employees	1,994
Community Members	10,151
Teenagers Trained in teen MHFA	1,043
Youth Trained in Youth or Adult MHFA	417
Employees of Child-Care Facilities	380
First Responders	1,235
Judges	16
Attorneys	18
SMVF (not included in any other groups)	1,001

F. Administration and key processes:

SAMHSA allocates Community Mental Health Block Grant funding to HHSC. This funding allows each LMHA and LBHA to hire a full-time MHFA outreach worker who implements the MHFA program in the LMHA's and LBHA's area.

Contracts are on a two-year basis and are monitored monthly. HHSC program and contract staff collect and review data from submitted deliverables to inform technical assistance.

LMHAs and LBHAs organize training in their local service area and handle the scheduling and program needs (including ordering materials, answering participant questions, etc.). LMHAs and LBHAs submit relevant documentation, data, and invoices to HHSC once trainings are completed for BHS oversight and monitoring.

LMHAs and LBHAs offer MHFA training in-person, virtually, or in a hybrid format.

G. Funding: See "Agency Program Information" spreadsheet.

H-M. MOUs, Relationship with others, Barriers, Additional, Regulatory and Complaint Information: Not applicable.

State Matching Grants

A. Division or program information:

Name of division or program: State Matching Grants

Location within the agency: CPSO

Contact name: Reilly Webb, Associate Commissioner

Statutory citation: Texas Government Code, Chapters 531, 547, and 547A

B. Objective and major activities:

This area administers four grants for specific purposes and populations:

- Community Mental Health Grant (CMHG): Strengthens local mental health systems by fostering community collaboration, reducing duplication of services, and improving continuity of care. CMHG addresses critical gaps in prevention, early intervention, treatment, recovery, education, screening, care coordination, and integrated services. The program also supports strategies that help individuals access, transition between, and stay engaged in mental health care and coordinate service delivery through effective case management. Grantees must be an LMHA, LBHA, non-profit organization, educational institution, or governmental entity selected based on set criteria.
- Healthy Community Collaboratives (HCC): Supports a person's transition from homelessness to the community by assisting participants in securing housing, obtaining work, and achieving sustained recovery from medical, mental, or substance use disorders. HCC brings together public, private, and community service providers and stakeholders to assist people with a mental illness or substance use disorder experiencing homelessness. Grantees must be an LMHA, LBHA, non-profit organization, educational institution, or governmental entity selected based on set criteria.
- Mental Health for Justice Involved Individuals Grant (MHGJII): Aims to reduce recidivism, arrests, and incarceration among individuals with mental illness, while also decreasing wait times for those under forensic commitments. MHGJII promotes local cross-agency coordination of behavioral health, physical health, and jail diversion services. Grantees must be an LMHA or LBHA representing a community collaborative. Community collaboratives must include the county, and each hospital district located in the county, if any. Community collaboratives may include other local entities.
- Texas Veterans and Family Alliance Grant: Improves access to mental health services and supports for Texas veterans and their families.

C. Effectiveness and efficiency information:

CMHG: Depending on the grantees' program design, some expected outcomes for CMHG participants may include the following:

- Decreased justice involvement and hospital admission;
- Reduced emergency room use;
- Improved academic progress, symptoms, activities of daily living, resiliency, and quality of life; and
- Increased employment skills, housing stability, and social supports.

Information on outputs and outcomes in fiscal year 2024 can be found in the [Community Mental Health Grant Program Fiscal Year 2024 Report Card](#).

HCC: Statute authorizes HHSC to require each HCC to select and meet at least four outcome measures per Texas Government Code, Section 547A.004. Information on outputs and outcomes in fiscal year 2024 can be found in the [Healthy Community Collaborative Grant Program Fiscal Year 2024 Report Card](#).

MHGJII: Expected outcomes may include the following:

- Decreased justice involvement and hospital admissions;
- Reduced emergency room use;
- Increased connection to treatment, resiliency, and social supports; and
- Improved symptoms, activities of daily living, and quality of life.

Information on outputs and outcomes in fiscal year 2024 can be found in the [Mental Health Grant for Just-Involved Individuals Program Fiscal Year 2024 Report Card](#).

D. History: Not applicable.

E. Qualifications or eligibility requirements:

See below for eligibility requirements for each State Matching Grant program.

CMHG: Program participants must have a mental health diagnosis.

Table 25. Sex and age breakdown of fiscal year 2024 CMHG Participants.

Demographic	Percent Served
Sex	

Demographic	Percent Served
Female	42%
Male	39%
Unknown or refused to answer or did not ask	19%
Age	
17 or younger	25%
18-20 years	4%
21-29 years	11%
30-39 years	13%
40-49 years	10%
50-59 years	8%
60 or older	8%
Unknown or refused to answer or did not ask	21%

HCC: Program participants are persons experiencing homelessness with unmet behavioral health needs.

Table 26. Sex and age breakdown of fiscal year 2024 HCC Participants.

Demographic	Percent Served
Sex	
Female	61%
Male	37%
Unknown or refused to answer or did not ask	2%
Age	
17 or younger	9%
18-20 years	2%
21-29 years	12%
30-39 years	22%
40-49 years	21%
50-59 years	19%
60 or older	14%
Unknown or refused to answer or did not ask	1%

MHGJII: Program participants are people identified with a mental illness or co-occurring psychiatric and substance use disorder with the following circumstances:

- At risk of involvement with the criminal justice system;
- Arrested and incarcerated for an alleged crime;
- Adjudicated of a crime; and
- Experiencing a mental or behavioral health crisis resulting in the involvement of law enforcement or other emergency services.

Table 27. Sex and age breakdown of fiscal year 2024 MHGJII Participants.

Demographic	Percent Served
Sex	
Female	45%
Male	40%
Unknown or refused to answer or did not ask	15%
Age	
17 or younger	14%
18-20 years	5%
21-29 years	21%
30-39 years	25%
40-49 years	14%
50-59 years	11%
60 or older	9%
Unknown or refused to answer or did not ask	1%

F. Administration and key processes:

Program staff overseeing the State Matching Grant Programs use data-driven program performance measurement and reporting processes as part of program oversight. Staff monitor expenditures and provide targeted technical assistance as needed. HHSC facilitates monthly statewide technical assistance calls to promote evidence-based, quality services and programming.

Funding for grantees is through a cost-reimbursement process, and program specialists and contract managers review invoices to ensure responsible and allowable spending.

Each behavioral health state-funded matching grant awardee must dedicate matching funds equal to a certain percentage of the state award. The match requirement is aimed at encouraging community investment in the program to achieve program sustainability. The basis for the match requirement is county population. When a grantee serves a combination of both urban and rural counties, the match requirement defaults to the urban match requirement.

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

In fiscal year 2024, CMHG contracted with local government agencies including Harris County, City of Laredo Public Health Department, Amarillo Public Health, and Hale County.

J. Barriers and challenges: Not applicable.

K-M. Additional, Regulatory and Complaint Information: Not applicable.

988 Suicide and Crisis Lifeline

A. Division or program information:

Name of division or program: 988 Suicide and Crisis Lifeline (988)

Location within the agency: CPSO

Contact Name: Reilly Webb, Associate Commissioner

Statutory citation: Not applicable

B. Objective and major activities:

HHSC is responsible for overseeing the Texas 988 network and contracts with five LMHAs to provide 988 services throughout the state. The goal of 988 is to work with the person in crisis to determine the least intrusive intervention and keep the person safe.

988 operates as a national network of local crisis centers that provide free and confidential support for anyone experiencing a mental health-related or emotional

crisis, including thoughts of suicide. People can call, text, or chat 988 to reach a trained crisis counselor 24 hours a day, seven days a week.

C. Effectiveness and efficiency information:

Since its inception in July 2022, the Texas 988 centers have answered 429,813 calls, chats, and texts. Texas monthly in-state answer rate (the percentage of calls routed to Texas answered locally rather than flowing to a national backup center) increased from 37 percent in fiscal year 2022 to 85 percent in fiscal year 2024. Moreover, the Texas 988 centers answered 136 percent more calls in fiscal year 2024 (173,828) than in fiscal year 2022 (73,699).

D. History:

The National Suicide Hotline Improvement Act (House Resolution 2345, 115th Congress, 2017-18) directed the Federal Communications Commission (FCC) to study the feasibility of designating a three-digit dialing code for the National Suicide Prevention Lifeline (NSPL). FCC designated 988 as the three-digit code and changed the name from the NSPL to the 988 Suicide and Crisis Lifeline. FCC launched 988 nationwide on July 16, 2022.

In April 2022, SAMHSA awarded HHSC the 988 State and Territory Cooperative Agreement Grant. The purpose of this funding was to improve state response to 988 contacts (including calls, chats, and texts) originating in Texas through:

- Recruiting, hiring, and training behavioral health workforce to staff local 988 centers to respond, intervene, and provide follow-up to people experiencing a behavioral health crisis;
- Engaging 988 centers to unify 988 responses across states and territories; and
- Expanding the crisis center staffing and response structure needed for the successful implementation of 988.

Additionally, in October 2024, FCC adopted rules requiring telecommunications providers to transition from routing 988 calls based on callers' telephone area codes to routing calls based on their location.

E. Qualifications or eligibility requirements:

Anyone can access the 988 Suicide and Crisis Lifeline.

Table 28. 988 fiscal year 2024 demographic data.

Demographic	Number Served
Sex	
Female	26,442
Male	27,042
Unknown or refused to answer or did not ask	120,344
Age	
12 or younger	1,242
13-24 years	14,943
25-34 years	12,257
35-44 years	6,758
45-64 years	8,413
65 or older	3,207
Unknown or refused to answer or did not ask	127,008
Total	173,828

F. Administration and key processes:

HHSC contracts with five LMHAs to provide 988 services to the entire state. Additionally, HHSC is responsible for developing and executing a comprehensive statewide 988 communication strategy to raise awareness about the service.

Texas 988 centers route contacts according to their physical location, and counselors can easily connect people in crisis with additional local resources if necessary. In fiscal year 2024, the program expanded coverage to all 254 Texas counties to ensure all 988 calls have in-state primary and backup coverage.

HHSC provides technical assistance and support to the 988 centers to address capacity challenges. HHSC collects and reports center performance metrics, and various indicators related to infrastructure, prevention, and promotion.

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts:

Texas 988 centers have established MOUs with 911 Public Safety Answering Points.

I-J. Relationship and Barrier Information: Not applicable.

K. Additional Information:

In July 2023, Integral Care, a Texas 988 center, began a pilot program to improve services and added 988 chat and text messages. Since expanding the local 988 services to include chat and text, Texas has answered over 6,440 chat and text messages.

L-M. Regulatory and Complaint Information: Not applicable.

Behavioral Health Medicaid Programs

Behavioral Health Medicaid Programs oversees program implementation, contract monitoring and quality management for the HCBS-AMH and YES waiver programs.

Home and Community-Based Services Adult - Mental Health

A. Division or program information:

Name of division or program: HCBS-AMH Waiver Program

Location within the agency: CPSO

Contact Name: Reilly Webb, Associate Commissioner

Statutory citation: Not applicable

B. Objective and major activities:

HCBS-AMH is a 1915(i) Medicaid waiver program that provides specialized supports through the provision of home and community-based services to adults diagnosed with an SMI and extended stays in psychiatric hospitals, frequent arrests, or emergency department visits. The goal of the program is to enable people to live and experience successful integration in their community of choice.

C. Effectiveness and efficiency information:

HHSC reports to LBB two key performance measures for HCBS-AMH:

- Average monthly cost per client served in HCBS-AMH program: \$6,734 in fiscal year 2024; and
- Average monthly number of clients served in HCBS-AMH program: 390 in fiscal year 2024.

BHS also monitors efficiency through contract measures and Centers for Medicare & Medicaid Services (CMS) performance measures as listed below.

Table 29. HCBS-AMH fiscal year 2024 program data.

Measure	Results
Number served	867
New enrollment	144
Number of crisis intervention service encounters before receiving HCBS-AMH services	1,460
Number of crisis intervention service encounters after receiving HCBS-AMH services ^a	610
Number of HHSC-funded inpatient psychiatric hospitalizations before receiving HCBS-AMH services	119
Number of HHSC-funded inpatient psychiatric hospitalizations after receiving HCBS-AMH services	75
Number of arrests before receiving HCBS-AMH services	76
Number of arrests after receiving HCBS-AMH services	57
Must ensure processes and instruments described in the approved 1915(i) SPA are applied appropriately and according to the approved description to determine if the needs-based criteria were met. • The number and percent of individuals that were determined to meet needs- based criteria requirements prior to receiving 1915(i) services. • The number and percent of individuals' initial needs-based criteria determination forms/instruments that were completed, as required in the approved SPA. • The number and percent of individuals' initial determinations, where level of need criteria was applied correctly.	100%
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers. • Number and percent of participants with current individual recovery plans (IRPs) updated annually • Number and percent of participants with IRPs which document the individual's choice among and between	98.7%

^a Includes only unduplicated participants served for fiscal year 2024, six months before and up to six months after enrollment. Includes only persons in emergency department or jail diversion populations. Excludes long-term hospitalization population.

Measure	Results
HCBS-AMH services. - Number and percent of participants with IRPs which document providers and individual goals consistent with their individual assessments. - Number and percent of participants with IRPs that address all members' assessed needs (including health and safety risk factors) and personal goals, either by the provision of HCBS services or through other means.	
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers. - Number and percent of participants with current individual recovery plans (IRPs) updated annually. - Number and percent of participants with IRPs which document the individual's choice among and between HCBS-AMH services. - Number and percent of participants with IRPs which document providers and individual goals consistent with their individual assessments. - Number and percent of participants with IRPs that address all members' assessed needs (including health and safety risk factors) and personal goals, either by the provision of HCBS services or through other means.	98.7%

D. History:

As required by the 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, DSHS, Rider 81), HHSC established the HCBS-AMH program for adults with SMI and a history of extended inpatient psychiatric hospital stays. Rider 81 further directed HHSC to seek a Medicaid state plan amendment under Section 1915(i) of the Social Security Act. Texas received federal approval from CMS on October 13, 2015.

In addition, the 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, DSHS, Rider 61), required the agency to expand HCBS to divert populations with SMI from jails and emergency departments into community treatment programs. HHSC is currently seeking renewal for another five-year period effective Sept 1, 2025, through August 31, 2030.

E. Qualifications or eligibility requirements:

Below are HCBS-AMH eligibility requirements.

- Minimum Age Requirement: Must be 18 years of age.
- Medical Status: SMI diagnosis and meet clinical criteria determined by the ANSA assessment on HCBS-AMH application.
- Insurance: Have active Medicaid if in the community or be Medicaid-eligible if currently in an inpatient psychiatric hospital.
- Additional Eligibility Information: Not be dually enrolled in Medicare or receiving home and community-based services by any other means.

Furthermore, individuals must meet one of the following needs-based criteria:

- Long-term psychiatric hospitalization;
- Jail diversion: Two or more psychiatric crises and four or more discharges from correctional facilities during the three years prior to the referral; or
- Emergency department diversion: Two or more psychiatric crises and 15 or more total emergency department visits during the three years prior to the referral.

Table 30. HCBS-AMH fiscal year 2024 demographic data.

Demographic	Percent Served
Sex	
Female	36%
Male	64%
Age	
18-20 years	2%
21-30 years	18%
31-40 years	30%
41-50 years	22%
51-60 years	19%
61+ years	9%

F. Administration and key processes:

HCBS-AMH is supported by seven functional teams that ensure effective service delivery, oversight, and quality. These teams provide technical assistance to providers and recovery managers, oversee billing and utilization, conduct site

inspections and contract monitoring, track and respond to critical incidents, and review service quality through regular evaluations to ensure participants receive high-quality care in compliant settings.

Two types of contractors provide HSBS-AMH services:

- Recovery Management Entities are responsible for coordination and planning of recovery management services.
- Provider Agencies are responsible for the provision of HCBS-AMH services either directly or via subcontracts

G. Funding: See "Agency Program Information" spreadsheet.

H-I. MOUs and Relationships with others: Not applicable.

J. Barriers and challenges:

Complex reporting and documentation requirements for compliance with federal regulations create challenges for provider recruitment and retention.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Youth Empowerment Services Waiver

A. Division or program information:

Name of program or division: YES Waiver Program

Location within the agency: CPSO

Contact name: Reilly Webb, Associate Commissioner

Statutory citation: Not applicable

B. Objective and major activities:

The YES Waiver is a 1915(c) Medicaid waiver program that serves youth with serious mental, emotional, and behavioral difficulties. The YES Waiver provides intensive services delivered within a strengths-based team planning process called Wraparound. Wraparound builds on family and community support and uses YES Waiver services such as specialized therapies, family supports, respite, and

community living supports to help build a family's natural support network and connection with their community.

The goal of the YES Waiver is to reduce out of home placements for youth with SED by using community-based services and supports.

C. Effectiveness and efficiency information:

BHS reports to LBB on two key performance measures related to the YES Waiver program:

- Average monthly cost per client served in YES Waiver: \$740 in fiscal year 2024; and
- Average monthly number of clients served in YES Waiver: 673 fiscal year 2024.

In fiscal year 2024, data showed a 43 percent decrease in crisis intervention service encounters after receiving YES services. Engagement supports enhanced school performance with participants achieving higher attendance and better grades and improved emotional and behavioral functioning. See Table 31 for fiscal year 2024 program measures and results gathered from CMBHS, MBOW and other provider reporting.

Table 31. YES Waiver fiscal year 2024 data.

Measure	Result
Number receiving services in level of care YES	2,389
Average hours of services received per person monthly	6.5
Number of crisis intervention service encounters before receiving YES services	1,832
Number of crisis intervention service encounters after receiving YES services	1,044
Number of hours of provider technical assistance and training	468
Preferred inquiry list templates submitted on time	90%
Percent of people who inquire about YES services that receive a return call within the required timeframe	94%
Percent of critical incidents submitted on time	72%
Percent of people aging out, transitioning to another level of care, or graduating that have a transition plan	96%

Measure	Result
Wraparound staff and subcontractor files are compliant with employment checks and training requirements	70%

D. History

The 2004-05 General Appropriations Act, H.B. 1, 78th Legislature, Regular Session, 2003, and the 2006-07 General Appropriations Act, S.B. 1, 79th Legislature, Regular Session, 2005, authorized HHSC and DSHS to develop the 1915(c) YES Waiver program. CMS approved the YES Waiver in February 2009. S.B. 1, 83rd Legislature, Regular Session, 2013, directed the YES Waiver to expand statewide, which CMS approved effective September 2015.

Additionally, since the statewide expansion in 2015, all 39 LMHAs and LBHAs have implemented a YES Waiver program.

E. Qualifications or eligibility requirements:

To participate in the YES Waiver program, a youth must meet both demographic and clinical eligibility criteria. Below are the YES Waiver eligibility requirements:

- Age Requirement: 3 to 18 years of age.
- Insurance: Eligible for Medicaid (parents' income does not apply).
- Medical Status: Qualifying mental health diagnosis and be reasonably expected to qualify for inpatient care.
- Additional Eligibility Information: Serious mental, emotional, and behavioral difficulties; at risk of being placed outside of their home, because of their mental health needs; and live in a home setting with a legal guardian or on their own, if legally emancipated.

Table 32. YES fiscal year 2024 demographic data.

Demographics	Percent Served
Sex	
Female	50%
Male	50%
Age	
0-12 years	28%

Demographics	Percent Served
13-17 years	65%
18-20 years	7%

F. Administration and key processes:

HHSC contracts with two private Comprehensive Waiver Providers (CWPs) and some LMHAs to administer the YES Waiver services. Those entities may choose to subcontract out the specialized service array or deliver those services directly. LMHAs and LBHAs administer the wraparound, or intensive case management, component of the program.

HHSC oversees LMHAs, LBHAs, and CWPs through regular quality reviews and contracts with the National Wraparound Implementation Center to train providers in high-fidelity wraparound. Key functions include processing participant eligibility, improving YES Waiver services through planning and stakeholder collaboration, delivering targeted training, resolving billing and compliance issues, monitoring inquiries and manual processes, and auditing providers to ensure performance standards are met.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

BHS and Medicaid and CHIP Services (MCS) coordinate with CMS for waiver renewals every five years and for annual report submissions.

J. Barriers and challenges:

Complex reporting and documentation requirements for compliance with federal regulations create challenges for provider recruitment and retention. Some resistance from families due to stigma or lack of understanding of mental health services and program requirements contributes to low engagement as well.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Disaster Behavioral Health Coordination

Disaster Behavioral Health Coordination (DBHC) oversees disaster behavioral health preparedness, response, and recovery activities for Texas before, during and after state- and federally-declared emergencies, including natural disasters and incidents of mass violence. DBHC services address the psychological, emotional, cognitive, developmental, and social impacts that disasters, emergencies or incidents have on survivors and first responders as they respond and recover.

DBHC has a core team and uses the network of 39 LMHA and LBHAs to deliver community-based services, ensuring assistance is accessible and tailored to the unique needs of those affected.

A. Division or program information:

Name of division or program: DBHC

Location within the agency: CPSO

Contact name: Reilly Webb, Associate Commissioner

Statutory citation: Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act; Texas Health and Safety Code, Chapter 571

B. Objective and major activities:

DBHC maintains readiness to respond to local, state, or federally declared disasters 24 hours a day, 7 days a week, 365 days a year. Staff provide timely response to requests for assistance from local emergency management, public health, and first responder entities. One of the primary services activated during a disaster is the:

- Crisis Counseling Assistance and Training Program (CCATP): Coordinates community-based outreach to address behavioral health needs and works closely with LMHAs and LBHAs to promote and deliver CCATP services and build resiliency. There are two types of CCATPs – immediate (short-term disaster relief for up to 60 days after a federally declared disaster) and the regular service program provides short-term behavioral health services for up to nine months after the date of the Presidential disaster.

DBHC staff also collaborate with internal agency groups and external community organizations to support ongoing planning efforts and ensure maximum efficacy of disaster response efforts. These programs include:

- **Mass Violence Readiness Program:** DBHC provides LMHAs and LBHAs with the necessary tools to enhance mental health preparedness for mass violence incidents by providing training and technical assistance through a phased, community-driven approach.
- **Bipartisan Safer Communities Act (BSCA):** Provides supplemental Community Mental Health Services Block Grant funds to enable states to expand access to mental health care. BSCA focuses on developing and implementing mass violence readiness, response, and resiliency toolkits; and provides LMHAs and LBHAs with a set of guidelines to initiate the establishment of a multidisciplinary community action plan.
- **Sustainable, Technical Assistance, Training, and Engagement Program (STATE):** Uses a multiphased strategy to engage community leaders and organizations providing mental health services in and around Uvalde, as well as across Texas. STATE promotes trauma-informed practices and culturally relevant services to the affected communities through advanced consultative services, program-specific training options, and direct customer interaction with stakeholders in the Uvalde community. HHSC expects this program will conclude at the end of fiscal year 2027.

C. Effectiveness and efficiency information:

For BSCA, efficiency and effectiveness of the workshops were evaluated using pre- and post-session self-assessments and participant feedback surveys. In addition to BSCA’s internal evaluations, University of Texas San Antonio (UTSA), a key partner in delivering the workshops, conducted a separate and independent analysis of participant feedback.

The DBHC team conducts both ongoing and annual reviews of internal processes to ensure response protocols are as effective as possible and tracks the number of incident responses, number of resource requests, information on recovery grant applications (if applicable), and detailed information about development of additional educational materials.

Table 33. CCATP measures, fiscal year 2024.

Measure	CCATP: Severe Storms/East TX Result	CCATP: Hurricane Beryl Result
Number of primary and secondary services conducted	101,882	30,687

Measure	CCATP: Severe Storms/East TX Result	CCATP: Hurricane Beryl Result
Number of marketing materials created	22	12
Number of invoices reviewed	9	6

Table 34. DBHC measures, fiscal year 2024.

Measure	Result
Number of disaster responses	10
Number of resource inquiries received	29

Table 35. STATE measures, fiscal year 2024.

Measure	Result
Number of disaster response	0
Number of resource inquiries received	0
Number of technical assistance site visits planning and preparedness	16
Number of trainings administered	165
Number of people trained	3,693

D. History: Not applicable.

E. Qualifications or eligibility requirements:

Below are the eligibility requirements for each of the DBHC programs.

- BSCA: Eligibility requirements are disaster response personnel and emergency points of contact at LMHAs and LBHAs.
- CCATP: Eligibility requirements are non-profit organization and government entities representing a community collaborative. Disaster behavioral health services are for people and families living or traveling through a presidentially declared disaster county or state.
- DBHC: Eligibility requirements are LMHAs and LBHAs contracted with HHSC. LMHAs and LBHAs provide the services to Texas residents.
- STATE: Eligibility requirements are the community of Uvalde and other regions impacted by mass violence incidents in Texas.

F. Administration and key processes:

BHS contracts with 39 LMHAs and LBHAs to provide immediate response and ongoing recovery crisis counseling services. Impacted LMHAs and LBHAs hire dedicated teams to support their communities following a disaster.

Upon federal declaration of a disaster, DBHC collaborates with federal partners, specifically Federal Emergency Management Agency (FEMA) and SAMHSA. DBHC maintains a presence on-site of a disaster to conduct monitoring and communication and manages the federal grant programs' budget and performance.

For ongoing grants, staff use data-driven program performance measurement and reporting processes as part of program oversight. Staff work to ensure the statements of work for each program remain up to date and relevant through each contracting cycle. Staff monitor expenditures and provide targeted technical assistance as needed to improve the quality and access to services and ensure grantees are supported throughout the grant period.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

DBHC communicates with FEMA, SAMHSA, and Texas Division of Emergency Management (TDEM) for planning efforts. DBHC works closely with TDEM to ensure the policy and procedures meet federal guidelines and conducted audits at the end of the Immediate Service Program period.

The crisis counseling services program makes referrals to programs such as the Texas Law Enforcement Management Institute, Texas A&M Engineering and Extension Services, and Texas Law Enforcement Peer Network for first responder mental health peer support.

J. Barriers, Additional, Regulatory and Complaint Information: Not applicable.

Substance Use Programs

Substance Use Programs (SUP) oversees the provision of a continuum of evidence-based services that support wellness and recovery for individuals affected by substance use, misuse and substance use disorders.

SUP consists of four program areas:

- Prevention and Behavioral Health Promotion;
- Substance Use Intervention and Treatment Programs;
- Texas Targeted Opioid Response; and
- Peer Support and Recovery.

SUP also includes a substance use medical director (SUMD) that provides expertise, guidance and support to the SUP department and BHS division.

Prevention and Behavioral Health Promotion

BHS strategically designed PBHP programs to provide trauma-informed, evidence-based services throughout the lifespan to prevent suicide in Texas and address the state's substance use priority goals: reducing underage alcohol use, commercial tobacco and nicotine products use, marijuana and other cannabinoid use, prescription drug misuse, and the use and misuse of other substances.

Prevention Resources and Training

A. Division or program information:

Name of division or program: Prevention and Behavioral Health Promotion (PBHP)

Location within the agency: CPSO

Contact name: Christine Laguna, Associate Commissioner

Statutory citation: Texas Health and Safety Code, Chapters 416A and 1001

B. Objective and major activities:

PBHP comprises the following program or functions.

- Community Coalition Partnerships (CCP): Engages and mobilizes the community to change policies, address environmental barriers to wellness, and influence social norms related to substance use prevention and behavioral health promotion. Coalitions focus on the general community with an emphasis on youth and young adults 18-25 years of age in colleges and universities.

- **Prevention Resource Centers (PRC):** Serve as the central hub for their health region's data, behavioral health promotion, and prevention training. PRCs write an annual report on surveillance data; complete compliance checks annually to strengthen compliance with commercial tobacco and nicotine laws; and host trainings and keeping HHSC abreast of regional needs.
- **Prevention Training Services (TPT):** Provides annual training to enhance behavioral health workforce development; hosts an annual meeting of prevention providers to promote collaboration and assist providers in maintaining certifications; and develops new trainings based on up-to-date prevention science and public health approaches.
- **Prevention Statewide Media Campaign:** An annual statewide campaign that aims at reducing substance use by using health messages on different media platforms. The focus of this campaign reflects state and program priorities. The "Turn To" campaign messages are for all Texans, with a focus on parents and caregivers, community stakeholders, and young adults.

C. Effectiveness and efficiency information:

BHS calculates measures using monthly data submitted by contractors to the CMBHS system. BHS measures outcomes on a larger scale by reviewing substance use prevalence data and other data regarding substance use risk factors at the county and state level. See Tables 36-39 for fiscal year 2024 measures and results.

Table 36. CCP measures, fiscal year 2024.

Measure	Results
Number of youth attending community-based processes focused on prevention and behavioral health promotion	147,436
Number of adults attending community-based processes focused on prevention and behavioral health promotion	140,0205
Total number attending community-based processes focused on prevention and behavioral health promotion	287,461
Number of media awareness activities (not including social media) focused on prevention and behavioral health promotion	672
Number of social media messages focused on prevention and behavioral health promotion	5,762
Number of changed policies and social norms to prevention and behavioral health promotion	106

Measure	Results
Number of community-based processes focused on prevention and behavioral health promotion	8,693

Table 37. PRC measures, fiscal year 2024.

Measure	Results
Number of adults attending trainings coordinated or hosted in the regions	3,276
Number of messages delivered through social media related to the prevention priorities of the statewide media campaign	3,152
Number of prevention and behavioral health promotion media placements (including those from the statewide media campaign) delivered through traditional media	162
Number of times that local, county, or regional data is shared	1,756
Number of trainings coordinated or hosted in the region within the month	135
Number of schools contracted to provide the Texas School Survey	890
Number of compliance checks, including follow-up visits for non-compliance, conducted onsite with tobacco retailers	19,578

Table 38. Prevention Training Services measures, fiscal year 2024.

Measure	Result
Number of registrants at the fiscal year 2024 prevention provider's meeting	590
Number of registrants at the fiscal year 2024 prevention directors meeting	132
Number of core certification trainings conducted	97
Number of people trained in core certifications	2,019
Number of prevention curriculum trainings	37
Number of people trained in prevention curriculum	447
Number of prevention competency trainings	24
Number of people trained in prevention competencies	505

Table 39. Prevention Statewide Media Campaigns measures, fiscal year 2024.

Measure	Result
Number of impressions served during the Turn To Check-In campaign media buy duration (January 2024 through July 2024)	262,912,702

Measure	Result
Number of website clicks to the Turn To Check-In	1,181,218
Number of People Who've Interacted with Turn To Check-In (for self)	54,931
Number of People Who've Interacted with Turn To Check-In (for someone else)	3,547
Number of impressions served across all media efforts for Turn To	1,239,377,241
Number of website clicks to the Turn To campaign web pages	718,676

D. History: Not applicable.

E. Qualifications or eligibility requirements:

Below are the Prevention Resource and Training programs eligibility requirements.

- CCP: Eligibility includes youth 12-17 years of age and young adults 18-25 years of age.
- PRC: Eligibility includes HHSC-funded prevention contractors and local community stakeholders.
- TPT: Eligibility includes HHSC-funded prevention providers, PRCs community contacts, and CCP members.

Data for these programs are aggregated and HHSC does receive individual information for demographic tracking.

F. Administration and key processes:

Prevention programs are administered through contractual agreements procured by a request for applications (CCP and PRC) or request for proposals (media campaigns and prevention training services). BHS has established processes for contracting with service providers and overseeing contract performance.

SAMHSA funds PBHP programs through the Substance Use Prevention, Intervention, and Treatment Services Block Grant, as well as competitive discretionary grants that support evidence-based strategies, community engagement, and policy or social-norm changes.

G. Funding: See "Agency Program Information" spreadsheet.

H-M. MOUs, Relationship, Barriers, Additional, Regulatory and Complaint Information: Not applicable.

Youth Prevention Programs

A. Division or program information:

Name of division or program: Youth Prevention Programs

Location within the agency: CPSO

Contact Name: Christine Laguna, Associate Commissioner

Statutory citation: Health and Safety Code, Chapters 461A and 1001

B. Objective and major activities:

Based on the National Academy of Medicine's universal, selective, and indicated prevention framework, Youth Prevention programs address four state prevention priorities: underage alcohol use, tobacco and nicotine product use, marijuana and other cannabinoid use, and prescription drug misuse. Youth Prevention programs implement the following SAMHSA Center for Substance Abuse Prevention strategies:

- Prevention education delivered to youth (and their families for family-focused programs) using evidence-based curricula;
- Information dissemination through presentations on the state's four prevention priorities;
- Providing positive alternatives; and
- Identification of problems and referral to services for participants in need of services beyond the scope of primary prevention.

C. Effectiveness and efficiency information:

HHSC reports to LBB two key performance measures related to youth prevention programs noted in the table below.

Table 40. Youth Prevention Programs LBB performance measures.

Measure	Target	2024
Average Monthly Number of Youth Served in Substance Abuse Prevention Programs	117,000	99,328
Average Monthly Cost Per Youth for Substance Abuse Prevention Services	\$ 28	\$ 25

HHSC also monitors the following performance measures submitted by contractors monthly to the CMBHS system. HHSC ensures contractors submit Curriculum Outcome Measures in CMBHS after each prevention education curriculum cycle, and develop the next fall, spring, and summer implementation plans.

Table 41. Youth Prevention Program fiscal year 2024 data.

Measure	Result
Number of unduplicated youth receiving prevention education (approved evidence-based curriculum)	136,720
Number of unduplicated adults receiving prevention education (for programs implementing approved evidenced-based family-focused curriculum only)	1,378
Number of youths participating in alternatives	396,579
Number of adults participating in alternatives	177,153
Number of youths attending prevention and behavioral health promotion presentations	497,824
Number of adults attending prevention and behavioral health promotion presentations	127,294

D. History:

The Youth Prevention Programs (Youth Prevention Universal, Youth Prevention Selective, and Youth Prevention Indicated) have evolved significantly over time. Historically centered on substance use prevention through direct education focused on drugs and alcohol, the programs have expanded to incorporate a broader behavioral health promotion approach. This approach includes wellness activities, stress reduction, and life skills development, guided by the Strategic Prevention Framework and the six Center for Substance Abuse Prevention strategies.

In fiscal year 2022, the programs adopted new service delivery methods, including virtual platforms, social media campaigns, and partnerships with other youth-serving organizations. In fiscal year 2025, the programs further enhanced their

impact by integrating new evidence-based curricula focused on stress reduction, building coping skills, increasing protective factors, and family engagement to address both substance use and behavioral health.

E. Qualifications or eligibility requirements:

The primary populations served by Youth Prevention Programs are youth in pre-kindergarten to 12th grade and their families. The secondary populations include community members and other priority populations. Below are the three types of Youth Prevention Program eligibility.

- Youth Prevention Universal: Targets a universal population of youth without consideration of individual risk for substance use or misuse.
- Youth Prevention Selective: Targets a selective population of youth who are known to be at increased risk for substance use or misuse due to factors affecting subpopulations to which they belong.
- Youth Prevention Indicated: Targets an indicated population of youth who are individually known to be at increased risk for substance use or misuse as determined by a screening tool.

F. Administration and key processes:

HHSC contracts with providers across the 11 HHS Health Regions to deliver the youth prevention programs. Contractors deliver services regionally to support responsiveness to local needs while maintaining alignment with state goals. Implementation uses evidence-based curricula and SAMHSA-endorsed strategies, including prevention education, information dissemination, positive alternatives, and referral to additional services.

HHSC provides oversight and technical assistance to ensure fidelity to evidence-based practices and effective program delivery. Contractors must submit seasonal implementation plans and report monthly performance measures through the CMBHS system.

G. Funding: See “Agency Program Information” spreadsheet.

H-M. MOUs, Relationships with others, Barriers, Additional, Regulatory, and Complaint Information: Not applicable.

Suicide Prevention

A. Division or program information:

Name of division or program: Suicide Prevention

Location within the agency: CPSO

Contact name: Christine Laguna, Associate Commissioner

Statutory citation: Not Applicable

B. Objective and major activities:

SAMHSA awarded a new youth suicide prevention grant to implement postvention programs in areas of Texas with the highest youth suicide rates. The suicide prevention team offers training and technical assistance to community stakeholders to enhance skills on the spectrum of suicide care including prevention, intervention, treatment, and postvention.

C. Effectiveness and efficiency information:

The SAMHSA grant from the previous five-year period, Resilient Youth Safer Environments, ended in fiscal year 2024. Results at the end of the five-year period include the following: 8,827 people trained in suicide prevention and 4,333 youth ages 10-24 screened for suicide risk.

Additionally, in fiscal year 2024, the suicide prevention team trained Texans in evidence-based best practice suicide prevention training.

Table 42. Suicide Prevention measures, fiscal year 2024.

Measure	Result
Number of people trained in Ask About Suicide to Save a Life (AS+K)	1,421
Number of people trained in Applied Suicide Intervention Skills Training	648
Number of people trained in Safety Planning Intervention	375
Total Suicide prevention team time (hours) spent conducting suicide prevention/intervention/postvention trainings	598

D. History: Not applicable.

E. Qualifications or eligibility requirements:

Eligibility for the Suicide Prevention Program does not depend on a specific mental health condition. HHSC encourages any individual or organization to contact the suicide prevention team for further support, training, or technical assistance.

F. Administration and key processes:

The suicide prevention team provides information about available trainings, links interested parties with the people who provide the trainings, and in some instances, provide trainings in person and via Teams.

The SAMHSA Suicide Care Initiative and the Garrett Lee Smith grant have established contracts with project partners to ensure each partner is meeting project goals and guidelines. Each program also has dedicated specialist oversight to support implementation and accountability. These program specialists hold monthly meetings to provide technical assistance to the project partners. Grants are funded by SAMHSA through a competitive process.

G. Funding: See "Agency Program Information" spreadsheet.

H-M. MOUs, Relationships with others, Barriers, Additional, Regulatory, and Complaint Information: Not applicable.

Project Advancing Wellness and Resilience in Education

A. Division or program information:

Name of division or program: Project Advancing Wellness and Resilience in Education (Project AWARE)

Location within the agency: CPSO

Contact Name: Christine Laguna, Associate Commissioner

Statutory citation: Not Applicable

B. Objectives and major activities:

Project AWARE increases mental health awareness, and access to mental health screenings, assessments, services, and supports. Grantees funded by SAMHSA partner with HHSC, independent evaluators, independent school districts (ISDs),

ESCs, and LMHAs to provide evidence-based mental health resources in community schools.

As the state mental health authority, HHSC staff provides training and technical assistance to all AWARE grantees per SAMHSA requirements.

C. Effectiveness and efficiency information:

Examples of Project AWARE reach includes:

- In Laredo, the Project AWARE grantee trained over 300 cafeteria workers and bus drivers in AS+K About Suicide to Save a Life community helper training. These workers are often the first to notice distress in youth.
- The Harris County AWARE grantee implemented universal screening in two school districts, resulting in 450 youth being screened.
- San Marcos AWARE grantee coordinated MHFA training for all San Marcos ISD staff in one day resulting in over 650 people trained.

Table 43. Project AWARE measures, fiscal year 2024.

Measure	Result
Number of schools receiving services through Project AWARE	125
Number of students screened for general mental health concerns	7,050
Number of students who received targeted screening for mental health concerns	1,000
Number of students referred to a mental health professional	802
Percent of students referred to a MH professional who received MH services because of the referral	56%

D. History: Not applicable.

E. Qualifications or eligibility requirements:

Project AWARE services are available to school aged children in 15 communities in Texas.

F. Administration and key processes:

SAMHSA awards federal AWARE grant funding to TEA who leads the project AWARE consortium, and includes multiple state agencies, including HHSC, as one of the state management team partners. HHSC oversees daily operations in accordance

with the interagency agreement and serves on the advisory board consulting with grantees on project goals and sustainability planning.

G. Funding: See “Agency Program Information” spreadsheet.

H-M. MOUs, Relationships with others, Barriers, Additional, Regulatory, and Complaint Information: Not applicable.

Substance Intervention and Treatment Program

The Substance Intervention and Treatment Program (SITP) oversees the provision of programs for individuals who are at risk of or diagnosed with a substance use disorder.

Substance Use Intervention Programs

A. Division or program information:

Name of program or division: SITP

Location within the agency: CPSO

Contact name: Christine Laguna, Associate Commissioner

Statutory citation: 2022-23 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019, (Article II, HHSC, Rider 64); Texas Health and Safety Code, Section 1001.087

B. Objective and major activities:

Intervention programs provide access to information, case management, and community linkage services to reduce the impact of substance use. The following programs provide intervention services in both community and home-based settings:

- Community Health Workers: Increase access to services for communities by addressing housing, food security, transportation and other issues impacting health at the individual and community levels.
- Comprehensive Continuum of Care: Provides pre-admission service coordination to reduce barriers to treatment, enhance motivation, stabilize life situations, and facilitate engagement in long-term recovery for pregnant

and parenting women with children. This program will discontinue at the end of fiscal year 2025; however, the population it serves will remain eligible for continued services through a newly established program beginning in fiscal year 2026.

- Outreach, Screening, Assessment and Referral (OSAR): Provides screenings and assessments, education, information dissemination, risk reduction education, case management coordination, and referral to treatment.
- Parenting Awareness and Drug Risk Education Services (PADRES): Provides community-based intervention services and education to people who are parents or expectant parents to decrease the impact of substance use.
- Pregnant and Parenting Intervention: Provides intervention services aimed at reducing the impact, severity, and cost associated with a substance-exposed pregnancy to the mother and child and their families.
- Rural Border Initiative: Provides access to a continuum of behavioral health services (substance use services, mental health promotion, and SUD and mental health treatment and recovery) to members of the rural border communities who have or are at high risk of developing a SUD.

C. Effectiveness and efficiency information:

The estimated number of people served in fiscal year 2024 is 101,729.

Table 44. Number of people served by Substance Use Intervention Program, fiscal year 2024.

Program	Number of People Served
Community Health Workers	55,055
Comprehensive Continuum of Care	3,043
Outreach, Screening, Assessment and Referral	31,399
Parenting Awareness and Drug Risk Education Services	3,558
Pregnant and Parenting Intervention	2,174
Rural Border Initiative	6,500

Table 45. Substance Use Intervention LBB performance measures, fiscal year 2024.

Measure	Actual Amount
Average Monthly Cost Per Adult for Substance Abuse Intervention Services	\$112
Average Monthly Cost Per Youth for Substance Abuse Intervention Services.	\$168
Average Monthly Number of Adults Served in Substance Abuse Intervention Programs	7,790
Average Monthly Number of Youth Served in Substance Abuse Intervention Programs	173

Table 46. Community Health Workers measures, fiscal year 2024.

Measure	Actual Amount
Number of contacts with people eligible for program services	55,055
Number of substance use referrals, linkages, and supports provided to people eligible for program services	13,709
Number of mental health referrals, linkages, and supports provided to people eligible for program services	9,561
Number of medical services referrals, linkage, and supports provided to people eligible for program services	3,610
Number of referrals, linkage, and support provided to other services and community resources to people eligible for program services	11,875
Number of overdose referral kits distributed to eligible people	9,020

Table 47. Comprehensive Continuum of Care measures, fiscal year 2024.

Measure	Actual Amount
Number of new participants enrolled in pre-entry treatment services	580
Number of ongoing participants who enrolled in treatment services	1,097
Number of participants enrolled in post-treatment services	1,346
Percent of participants enrolled in pre-entry treatment services who successfully enter treatment services	50.5%
Percent of participants enrolled in post-treatment services	16.96%
Percent of participants who completed treatment successfully	98.81%

Measure	Actual Amount
Percent of participants with active DFPS or Drug Court case who received case management services	60.58%

Table 48. OSAR measures, fiscal year 2024.

Measure	Actual Amount
Number of youth and number of adults screened for substance use	31,399
Number of adults screened and self-reporting opioid use in the last 30 days	2,201
Number of priority population adults, and those recently released from a secured environment, screened and self-reporting opioid use in the last 30 days	1,624
Percent of referrals to substance use disorder treatment	43.32%
Percent of referrals to recovery support services	31.69%
Percent of referrals to mental health services	14.40%
Percent of referrals to SUD, recovery support services, and mental health services that have a Referral Outcome within 10 business days	35.54%
Percent of adults self-reporting opioid use in the last 30 days referred to treatment with medications for opioid use disorder	36.62%
Percent of priority population adults, and those recently released from a secured environment, self-reporting opioid use in the last 30 days referred to treatment with medications for opioid use disorder	35.76%
Percent of adults self-reporting opioid use in the last 30 days that require a referral follow-up and have a documented CMBHS Referral Outcome	53.52%

Table 49. PADRES measures, fiscal year 2024.

Measure	Actual Amount
Number of community level events or presentations	447
Number of activities that are peer led	457
Number of alternative activities hosted by program	83
Number of open cases each month by female	5,037
Number of open cases each month by male	2,409
Percent not arrested – youth	100%

Measure	Actual Amount
Percent not arrested – adults	98.2%
Percent report abstinence – youth.	100%
Percent report abstinence – adults	96.99%
Percent reporting stable housing – youth	100%
Percent reporting stable housing – adults	65.94%
Percent reporting active employment and/or enrolled in education – youth	46.24%
Percent reporting active employment and/or enrolled in education – adults	57.14%

Table 50. Pregnant and Parenting Intervention measures, fiscal year 2024.

Measure	Actual Amount
Number of alternative activities and/or support groups which are peer-led	367
Number of coordination with community partners, presentations, street outreach efforts, health fairs, tours of facilities and similar which may serve participants	548
Number of eligible participants in targeted outreach encounters	2,174
Number of linkages, referral, support, and retention activities with participants	3,558
Number of open, unduplicated families on caseload each month	2,344
Number of participants receiving certificate of completion for education groups and/or coursework	829
Number of psychoeducational support groups	568
Percent delivering full-term – youth	90.91%
Percent delivering full-term – adults	83.06%
Percent of pregnant youth delivering healthy weight baby – youth	90.91%
Percent of pregnant youth delivering healthy weight baby – adults	88.71%
Percent of pregnant youth reporting abstinence from date of open case to delivery – youth	55.56%
Percent of pregnant youth reporting abstinence from date of open case to delivery – adults	46.86%
Percent of all youth participants receiving reproductive health visit (prenatal visit, postpartum visit, inter-conception visit) – youth	66.67%

Measure	Actual Amount
Percent of all youth participants receiving reproductive health visit (prenatal visit, postpartum visit, inter-conception visit) – adults	59.83%
Percent of all youth participants whose children received all recommended well-child visits during the time the participants case was open – youth	50%
Percent of all youth participants whose children received all recommended well-child visits during the time the participants case was open – adults	52.30%

Table 51. Rural Border Initiative measures, fiscal year 2024.

Measure	Actual Amount
Number of contacts with participants eligible for program services	6,500
Number of medical service referrals, linkage, and support with eligible participants	320
Number of mental health referrals, linkage, and support with eligible participants	816
Number of other referrals, linkage, and support with eligible participants	315
Number of participants receiving case management services	630
Number of substance use services, including intervention and treatment, referrals, linkage, and support with eligible participants	1,115

D. History: Not applicable.

E. Qualifications or eligibility requirements:

Below are eligibility requirements for each of the Substance Use Intervention programs.

- Community Health Workers: People who are experiencing stigma, housing instability or homelessness, injecting substances, living with or are at risk of hepatitis C virus or human immunodeficiency virus, and are experiencing barriers to entering treatment or recovery services.
- Comprehensive Continuum of Care: Pregnant and parenting women who meet clinical and financial eligibility requirements for substance use treatment. Eligible women can enroll directly with, or be referred to, the program from different community sites, including county health

departments, prenatal clinics, SUD treatment services, hospital systems, DFPS, family or domestic violence shelters, and jails.

- OSAR: Adults and youth residing in Texas.
- PADRES: Parents who reside in Texas and have a child who is younger than age six; and expectant parents who have one or more risk factors for a SUD.
- Pregnant and Parenting Intervention: Pregnant women who are Texas residents with a past or present substance use disorder and their family members; or parenting women who are Texas residents with a past or present substance use disorder and a child under age seven; and their family members.
- Rural Border Initiative: People in Texas who live in rural counties within 62 miles of the Texas-Mexico Border.

F. Administration and key processes:

SAMHSA funds intervention programs through the Substance Use Prevention, Intervention, and Treatment Services Block Grant. HHSC applies formulaic methodologies to determine funding allocations across the state through a combination of direct contracts and competitive procurement awards. SITP has developed key processes around technical assistance and deliverable reviews and approves monthly performance measures and monthly, quarterly, and annual reports.

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts:

HHSC and DFPS have a MOU which defines roles and responsibilities for providing DFPS client referrals to HHSC-funded SUD treatment and intervention services.

I. Relationship with other governmental entities: Not applicable.

J. Barriers and challenges:

Intervention programs generally face operational barriers related to limited access to safe housing, transportation, and local services available in specific regions. These challenges are particularly acute for people with criminal records.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Recovery Housing

A. Division or program information:

Name of division or program: Recovery Housing

Location within the agency: CPSO

Contact name: Christine Laguna, Associate Commissioner

Statutory citation: Texas Health and Safety Code, Chapters 469 and 531; Texas Government Code, Section 531.0999

B. Objective and major activities:

HHSC contracts with Oxford Houses of Texas to provide Texas Group Home Level 1 Recovery Housing. With access to loan funds, Oxford House locates a home for rent in a location where the need for a recovery house has been identified. Oxford House negotiates a lease agreement with a homeowner. Oxford House outreach workers establish a bank account and utilities in the name of the house and furnish the house using donations from the community and monies from the state start-up loan.

C. Effectiveness and efficiency information:

Oxford House Inc.'s (OHI) model is recognized nationally as an effective and low-cost approach for preventing relapse. Under the HHSC contract, in fiscal year 2024, OHI opened 20 new Oxford Houses, providing 164 new beds for individuals in recovery, and expanded into three new cities. As of August 31, 2024, Texas had a total of 326 Oxford Houses with 2,603 beds. Texas maintained an average occupancy rate of 83.4 percent each month, with over half of the existing residents having come directly from an HHSC-connected treatment center and over 80 percent of all residents having at least one visit to an HHSC treatment center in their lifetime.

Table 52. Recovery Housing Program measures, fiscal year 2024.

Measure	Results
Number of people served	7,724

Measure	Results
Average length of stay in days	328.4
Number of new Oxford Houses established	20
Number of active homes	326
Number of homes in repayment ^b	10

From May 2024 to June 2024, every member in every Oxford House located in Texas was asked to take a confidential, anonymous survey. 2,234 members were presented with the survey, and 2,234 members participated, resulting in a report of 100 percent of the total membership in Texas. The results are listed in the following tables.

Table 53. Oxford House members primary substance use prior to Oxford House.

Substance	Results
Alcohol	35.2%
Methamphetamine	35.8%
Opioids (Heroin)	12.4%
Cocaine	6.2%
Opioids (Prescription)	3.7%
Cannabis	4.0%
Prescription Medication	2.0%
Hallucinogen	0.5%
Inhalant	0.2%

Table 54. Oxford House Members incarceration status prior to Oxford House.

Incarceration	Results
Reported Prior Incarceration	63.7%
Members Under State Supervision	31.2%
Average Arrests Related to Addiction	4.3
Average Total Months Incarcerated	21.7

^b Peer-run recovery houses are established through a Revolving Loan fund which requires repayment within 24 months after the date on which the loan is made.

Table 55. Oxford House Members homelessness status prior to Oxford House.

Homelessness	Results
Reported Prior Homelessness	72.7%
Average Times Homeless	3
Average Longest Period Homeless (months)	9.8
Residency Prior to Oxford House	
With Family	22.4%
Homeless	17.2%
Rented Home	14.3%
Apartment	13.6%
Half-way House	10.1%
Jail/Prison	9.5%
Owned Home	5.5%
Hotel/Motel	6.4%
Hospital	1.0%

Table 56. Oxford House Member recovery results.

Recovery	Results
Average Length of Sobriety (days)	567
Opioid Misuse	45.5%
Used Medically Assisted Treatment	21.5%
Stimulant Misuse	81.6%
Average Attempts to Get Clean	6.5
Average Detox Without Treatment	1.8
Average 12-Step Meetings per Week	3.8
Counseling and 12-Step Meetings	31.2%
Self-Reported Health (1–5)	3.9

D. History:

H.B. 299, 88th Legislature, Regular Session, 2023, required HHSC to adopt minimum standards for accreditation as a recovery house that are consistent with the quality standards established by the National Alliance for Recovery Residences (NARR) and OHI. NARR designates state affiliate organizations that are responsible for accrediting recovery houses. The Texas affiliate for NARR is the Texas Recovery

Oriented Housing Network. Accreditation establishes recovery housing standards and certifies a recovery house meets those standards. This accreditation is voluntary; however, H.B. 299 makes accreditation a requirement for receipt of state funding.

E. Qualifications or eligibility requirements:

To be eligible to reside in an Oxford House, a person must be 18 years of age or older and meet one of the following eligibility requirements:

- Recent completion of a SUD residential treatment program;
- Current enrollment in an outpatient substance use treatment service (e.g., medications for opioid use disorders or recovery support services); or
- Require a place to live to support recovery from substance use.

F. Administration and key processes:

BHS administers the program through a contract awarded by competitive procurement. The program has developed key processes around technical assistance and deliverable reviews. The program subject matter expert conducts a monthly technical assistance call with the contractor to review challenges and successes, outcomes, and deliverables, and answer any questions regarding programmatic implementation.

G. Funding: See "Agency Program Information" spreadsheet.

H-M. MOUs, Relationships with others, Barriers, Additional, Regulatory, and Complaint Information: Not applicable.

Substance Use Treatment Services

A. Division or program information:

Name of division or program: Substance Use Treatment Services

Location within the agency: CPSO

Contact name: Christine Laguna, Associate Commissioner

Statutory citation: Texas Health and Safety Code, Sections 461A.052 and 1001.073

B. Objective and major activities:

Substance use disorder treatment services oversees the provision of services in the community; providing case management, counseling, education, and recovery support; and offering individualized care.

The levels of care offered by HHSC contracted providers span a broad treatment continuum of outpatient services, residential treatment, medically monitored withdrawal management, and opioid treatment services. Substance Use Treatment Services include three programs:

- Adult Substance Use Treatment;
- Specialized Female Substance Use Treatment; and
- Youth Substance Use Treatment.

Co-Occurring Psychiatric and Substance Use Disorder Services provides adjunct services to adults and youth with co-occurring psychiatric and substance use needs, emphasizing integrated treatment for both mental health and substance use disorders.

C. Effectiveness and efficiency information:

The number of people served in fiscal year 2024 is 48,211.

Table 57. Substance Use Disorder Services measures, fiscal year 2024.

Program	Number of People Served
Adult Substance Use Treatment	36,543
Specialized Female Substance Use Treatment	4,992
Youth Substance Use Treatment	2,813
Co-Occurring Psychiatric and Substance Use Disorder Services	3,863

Table 58. Substance Use Disorder Services treatment measures, fiscal year 2024.

Measure Title	Actual Amount
Average Monthly Cost Per Adult for Substance Use Treatment Services	\$804
Average Monthly Cost Per Youth for Substance Use Treatment Services	\$810

Measure Title	Actual Amount
Average Monthly Number of Adults Served in Substance Use Treatment Programs	11,436
Average Monthly Number of Youth Served in Substance Use Treatment Programs	701

Table 59. Adult substance use treatment measures, fiscal year 2024.

Measure	Results
Residential Withdrawal Management: Percent of people completed a withdrawal management episode	79%
Ambulatory Withdrawal Management: Percent of people completed acute withdrawal management services	86%
Ambulatory Withdrawal Management: Percent of people received concurrent admission to outpatient treatment services	100%
Intensive Residential: Percent of people discharged to stable housing	87%
Intensive Residential: Percent of people admitted to or involved in ongoing treatment and recovery support services	98%
Intensive Residential: Percent of people had no arrest since admission	100%
Supportive Residential: Percent of people discharged to stable housing	80%
Supportive Residential: Percent of people admitted to or involved in ongoing treatment and recovery support services	98%
Supportive Residential: Percent of people had no arrest since admission	100%
Outpatient: Percent of people discharged to stable housing	99%
Outpatient: Percent of people admitted to or involved in ongoing treatment and recovery support services	68%
Outpatient: Percent of people had no arrest since admission	99%

Table 60. Specialized female substance use treatment measures, fiscal year 2024.

Measure	Results
Residential Withdrawal Management: Percent of people completed a withdrawal management episode	75%
Ambulatory Withdrawal Management: Percent of people completed acute withdrawal management services	93%
Ambulatory Withdrawal Management: Percent of people received concurrent admission to outpatient treatment services	100%

Measure	Results
Intensive Residential: Percent of people discharged to stable housing	94%
Intensive Residential: Percent of people admitted to or involved in ongoing treatment and recovery support services	97%
Intensive Residential: Percent of people had no arrest since admission	100%
Supportive Residential: Percent of people discharged to stable housing	99%
Supportive Residential: Percent of people admitted to or involved in ongoing treatment and recovery support services	99%
Supportive Residential: Percent of people had no arrest since admission	100%
Outpatient: Percent of people discharged to stable housing	98%
Outpatient: Percent of people admitted to or involved in ongoing treatment and recovery support services	79%
Outpatient: Percent of people had no arrest since admission	98%

Table 61. Youth substance use treatment measures, fiscal year 2024.

Measure	Results
Intensive Residential: Percent of people admitted to or involved in ongoing treatment and recovery support services	96%
Intensive Residential: Percent of people had no arrest since admission	99%
Supportive Residential: Percent of people admitted to or involved in ongoing treatment and recovery support services	96%
Supportive Residential: Percent of people had no arrest since admission	100%
Outpatient: Percent of people admitted to or involved in ongoing treatment and recovery support services	58%
Outpatient: Percent of people had no arrest since admission	98%

Table 62. Co-occurring psychiatric and substance use disorder measures, fiscal year 2024.

Measure	Results
Client engagement	56.82%
Substance use disorder at discharge	92.96%
Mental health treatment status at discharge	47.91%
Percent discharging to stable housing	91.18%

D. History: Not applicable.

E. Qualifications or eligibility requirements:

HHSC established priority populations for treatment in accordance with Substance Use prevention, Treatment, and Recovery Services Block Grant requirements. When space is not available in a contractor's program service area, the contractor guarantees referral to another suitable state-funded contractor, or to HHSC's Waiting List and Capacity Management Coordinator if a placement is not possible.

Treatment contractors shall give preference for treatment services in the following order of priority:

Federal Priority Population Designations:

- Pregnant women who report injecting substances will be admitted within 48 hours.
- Pregnant women who report using substances will be admitted within 48 hours.
- People who report injecting substances will be admitted within 14 days.

State Priority Population Designations:

- People identified as being at high risk for overdose will be admitted to requested services within 72 hours.
- People referred by DFPS will be admitted to requested services within 72 hours.
- People experiencing housing instability or homelessness will receive admission to requested services within 72 hours.
- All other populations (must be admitted within 120 days of request for treatment).

Eligibility Requirements:

- Texas residency, financial eligibility (below 200 percent of the federal poverty level), and clinical eligibility must be performed prior to billing HHSC for SUD treatment services.

See below for the other eligibility requirements for each Substance Use Treatment Services program.

- Adult Substance Use Treatment: Adults 18 years of age or older who reside in Texas and are persons with a SUD and meet financial eligibility requirements based on income.
- Specialized Female Substance Use Treatment: Women who meet clinical and financial eligibility for state funded substance use treatment and are pregnant or have a dependent child or children (this includes women whose children are in custody of the state).
- Youth Substance Use Treatment: Youth who are 13 to 17 years of age and have been diagnosed with a SUD and meet eligibility for state financial support based on income, expenses, and other resources.
- Co-Occurring Psychiatric and Substance Use Disorder Services: People who reside in Texas, are identified as having a mental health and substance use issue or disorder and meet clinical and financial eligibility.

Table 63. Client demographics.

Demographic	TRA Percent Served	TRF Percent Served	TRY Percent Served	COPSD Percent Served
Sex				
Female	27.44%	100%	24.50%	50.42%
Male	72.56%	N/A	75.50%	49.58%
Age				
0-12 years			0.07%	0.02%
13-17 years		0.03%	99.93%	7.08%
18-24 years	10.50%	9.47%		7.98%
25-44 years	62.24%	82.89%		62.44%
45-64 years	25.74%	7.47%		21.13%
65+ years	1.52%	0.14%		1.35%

F. Administration and key processes:

HHSC contracts for SUD treatment services for Texans through a combination of direct contracts and competitive procurement awards with governmental entities in accordance with state and agency requirements. HHSC may directly award governmental entities based on formula-driven funding, federal grant requirements, urgent service needs, and existing infrastructure, in compliance with state and

federal regulations. SAMHSA funds intervention programs through the Substance Use Prevention, Intervention, and Treatment Services Block Grant.

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts:

HHSC and DFPS have a MOU to define roles and responsibilities for providing DFPS client referrals to HHSC-funded SUD treatment and intervention services.

I. Relationship with other governmental entities:

Funding of substance use treatment services is generally through competitive procurement, but there are some direct contracts with the two LBHAs in Region 3, TDCJ, and TJJD.

J-M. Barriers, Additional, Regulatory, and Complaint Information: Not applicable.

Neonatal Abstinence Syndrome Services

A. Division or program information:

Name of division or program: Neonatal Abstinence Syndrome Services

Location within the agency: CPSO

Contact name: Christine Laguna, Associate Commissioner

Statutory citation for program: Texas Health and Safety Code, Sections 461A.052 and 1001.073

B. Objective and major activities:

HHSC funds providers to operate four Neonatal Abstinence Syndrome (NAS) programs:

NAS Medication for Opioid Use Disorders (NAS-MOUD) provides access to Federal Drug Administration approved medication assisted treatment (MAT) medications (methadone, extended-release naltrexone, and buprenorphine). Clients are also offered immunizations, screenings, communicable disease testing for chronic disease prevention; and addressing comorbid psychiatric disorders.

Additional programs address medical, behavioral, and social needs, helping participants engage in treatment, sustain recovery, and improve overall health and family stability. These services include access to a statewide, unified treatment program (NAS-PPW), recovery housing with integrated care coordination (NAS-RRH), and personalized recovery support services (NAS-RSS).

C. Effectiveness and efficiency information:

HHSC monitors the performance measures contained in the tables below.

Table 64. NAS-MOUD measures, fiscal year 2024.

Measure	Results
Number of participants served	100
Percent of participants whose length of stay is at least one year	23.81%
Percent of participants with absence of drug use or misuse, including alcohol this year	51.90%
Percent of participants with no arrests reported on the most recent substance use disorder assessment	60.76%
Percent of participants reporting stable housing on the most recent substance use disorder assessment	56.96%
Percent of participants reporting as employed or enrolled in school on most recent substance use assessment	21.10%

Table 65. NAS-PPW measures, fiscal year 2024.

Measure	Results
Number of participants served	32
Percent of participants whose length of stay is at least one year	14.29%
Percent of participants with absence of drug use or misuse, including alcohol this year	100%
Percent of participants with no arrests reported on the most recent substance use disorder assessment	100%
Percent of people discharged and/or actively engaged in stable housing or recovery housing	100%
Percent of people employed at discharge and/or receiving supportive employment services	25%
Percent of people admitted to/involvement in ongoing treatment/recovery support services	100%

Table 66. NAS-RRH measures, fiscal year 2024.

Measure	Results
Total number of beds in the recovery residence	266
Total number of participants in the recovery residence	211
Number of new participants in the recovery residence in the reporting month	49
Number of new participants with dependent children	35
Number of participants who have secure housing at the time of discharge from recovery residence	25
Number of participants who have secure employment at the time of discharge from the recovery residence (full or part-time work)	15
Number of participants reporting abstinence at time of discharge from recovery residence	42
Number of participants who were not arrested during their stay at the recovery residence	146
Total number of participants discharged during the reporting month	44
Residents not arrested during residency at the time of discharge	69.19%
Residents reporting abstinence at the time of discharge	19.91%
Average annual occupancy rate in the recovery house	79.32%

Table 67. NAS-RSS measures, fiscal year 2024.

Measure	Results
Number of participants who receive any type of recovery services	399
Number of new participants who receive any type of recovery services	122

D. History:

Originally, HHSC designed NAS programs to only serve women who have an opioid use disorder. However, HHSC identified the need to expand program eligibility by including other diagnoses. As a result, some eligibility diagnoses expanded to allow the program to serve a greater number of women with varying substance use needs.

E. Qualifications or eligibility requirements:

Eligible participants are pregnant women and women with dependent children with a history of substance use disorder who are in or seeking recovery. See below for the other eligibility requirements for each NAS program.

- NAS-MOUD: Pregnant or postpartum women, diagnosed with an opioid use disorder (OUD).
- NAS-PPW: Pregnant and postpartum women, who have a moderate or severe OUD, stimulant use disorder, or both.
- NAS-RRH: Pregnant and parenting women, diagnosed with a SUD and currently enrolled or have completed a substance use treatment program.
- NAS-RSS: Pregnant and parenting women, diagnosed with a SUD and currently enrolled or have completed a substance use treatment program.

Table 68. Client demographics.

Age	NAS-MOUD Percent Served	NAS-PPW Percent Served
13-17 years		
18-24 years	9.09%	6.45%
25-44 years	90.91%	93.55%

F. Administration and key processes:

BHS administers NAS programs through direct contracts and competitive awards. In fiscal year 2020, HHSC awarded contracts to an LMHA and a university to provide a continuum of care—including intervention, treatment, and recovery—for pregnant, postpartum, or parenting women with opioid or substance use disorders. NAS-MOUD services were awarded competitively. These five-year contracts end after fiscal year 2025.

BHS also provides technical assistance by hosting monthly calls with contractors to discuss implementation, challenges, outcomes, and deliverables and reviewing and approving contractors' monthly, quarterly, and annual performance reports.

G. Funding: See "Agency Program Information" spreadsheet.

H-J. MOUs, Relationships with others, and Barriers: Not applicable.

K. Additional information:

Although dedicated Neonatal Abstinence Syndrome funding will conclude at the end of state fiscal year 2025, essential services for women with opioid use disorder will continue through the specialized female treatment programs.

L-M. Regulatory and Complaint Information: Not applicable.

Texas Targeted Opioid Response

A. Division or program information:

Name of division or program: Texas Targeted Opioid Response (TTOR)

Location within the agency: CPSO

Contact name: Christine Laguna, Associate Commissioner

Statutory citation: 21st Century Cures Act, Public Law 114-255, Section 1003, 130 Stat. 1033, 1044 (2016) and Further Consolidated Appropriations Act, 2024, Division D, Title II, [Public Law 118-47] and Section 1003 of the 21st Century Cures Act [Public Law 114-255] (42 USC 290ee-3 note), as amended.

B. Objective and major activities:

TTOR is a public health initiative with a mission to save lives and provide life-long support to Texans with opioid and stimulant use disorders by expanding access to prevention, integrated treatment, and recovery support services. HHSC established TTOR in May 2017 with funding from SAMHSA and contracts out a significant portion of the program's services and activities. See below for a description of each TTOR program.

- **Integrated:** Projects work with organizations that provide rapid, short-term services to people with OUD and then arrange longer-term care through other, more specialized providers. There are seven TTOR Integrated programs including Criminal Justice Opioid Response Re-entry Support, HEROES Helpline, Integrated Community Opioid Network, Overdose Prevention Drop-In Centers, Priority Admissions Counselors, Support Hospital Opioid Use Disorder Treatment Texas, and Texas Opioid Training Initiative.
- **Prevention:** Projects connect communities to resources throughout Texas, raising awareness about prescription opioid misuse, distributing life-saving naloxone, and stopping substance use disorder before it starts. There are six TTOR prevention programs: Education and Awareness Campaign, Fentanyl

Awareness Campaign, Opioid Surveillance Dashboards, Overdose Prevention Education and Naloxone, PAX Good Behavior Game, Safe Drug Disposal and Education Projects.

- **Recovery:** Programs expand access to the organizations that provide medication for OUD, ensuring people can choose from a variety of treatment options. There are four TTOR Recovery programs: Housing for Opioid Medication-Assisted Recovery Expanded Services and Evaluation, Medication-Assisted Recovery Support Training, Peer Recovery Support Services, and Recovery-Oriented Systems of Care Training and Technical Assistance.
- **Treatment:** Programs expand access to the organizations that provide medication for OUD, ensuring people can choose from a variety of treatment options. There are four TTOR Treatment programs: Contingency Management, MOUD Clinic Services, MOUD Office Services, and Project Extension for Community Healthcare Outcomes.

C. Effectiveness and efficiency information:

The number of people served in fiscal year 2024 is 3,321,499.

Table 69. Number of people served by TTOR, fiscal year 2024.

Program	Number of People Served
TTOR – Integrated	83,436
TTOR – Prevention	3,216,754
TTOR – Recovery	8,004
TTOR – Treatment	13,305

BHS reports one key performance measure to the LBB related to TTOR: the percent of adults with OUD receiving medication-assisted treatment (74 percent in fiscal year 2024).

Table 70. TTOR measures, fiscal year 2024.

Measure	Result
Number of opioid overdose reversals reported by TTOR program	3,881
Percent of people receiving medication-assisted treatment (LBB measure)	74%

D. History: Not applicable.

E. Qualifications or eligibility requirements:

See below for eligibility requirements for each TTOR program.

- Integrated: Program eligibility is for people at risk for opioid overdose and their support systems.
- Prevention: Program eligibility is for the general public.
- Recovery: Program eligibility is for people with a history of opioid use.
- Treatment: Program eligibility is for people with OUD who meet the financial and clinical eligibility requirements.

Table 71. Client demographics.

Demographic	Integrated	Prevention	Recovery	Treatment
Sex				
Female	25.06%	0.61%	9.97%	31.91%
Male	12.70%	0.30%	13.39%	37.97%
Unknown	62.23%	99.09%	76.64%	30.12%
Age				
Under age 20	0.24%	0.01%	0.59%	0.77%
21-30 years	1.00%	0.07%	5.11%	12.30%
31-40 years	1.33%	0.16%	8.50%	28.97%
41-50 years	0.70%	0.13%	5.16%	16.77%
51-60 years	0.24%	0.09%	2.26%	8.20%
61-70 years	0.10%	0.04%	0.74%	2.65%
70+ years	0.01%	0.01%	0.02%	0.15%
Unknown*	96.38%	99.49%	77.62%	30.18%

*Unknown includes numbers served from programs that do not collect demographic information.

F. Administration and key processes:

TTOR identifies funding opportunities that align with its goals and applies for those opportunities. Once awarded, TTOR implements programs in accordance with the approved grant application and budget. TTOR follows contract development and oversight policies and procedures established by HHSC, BHS, and SUP.

In addition, TTOR also established standard operating procedures and process flow charts to support consistent and compliant grant management and program implementation.

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

TTOR contracts with Houston Recovery Center, a local government corporation that provides care to people affected by substance use through early intervention and community care coordination, to operate the Drop-In Center Program in Houston.

TTOR contracts with ESC Region 13 to operate the PAX Good Behavior Game program.

J. Barriers and challenges:

Stigma related to substance use, particularly regarding the use of medication for opioid use disorder, remains a significant barrier, most notably within criminal justice settings.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Peer Support and Recovery

Peer Support and Recovery (PSR) supports, strengthens, and enhances the recovery peer workforce. Comprising staff who have personally experienced mental health disorders (lived experience), the team provides expertise on the role, function, and implementation of peer support services.

Peer support occurs when someone with lived experience gives encouragement and assistance to help someone overcome a challenge in life. Peer workers can be people who experience the challenges themselves, or family members with loved ones who experienced such challenges. The PSR peers are part of an integrated approach to peer-supported recovery.

Mental Health Peer Support and Recovery Programs

A. Division or program information:

Name of division or program: Mental Health PSR Programs

Location/Division: CPSO

Contact Name: Christine Laguna, Associate Commissioner

Statutory citation: Texas Health and Safety Code, Chapter 531 and Chapter 534; 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019, (Article II, HHSC, Rider 57); 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021, (Article II, HHSC, Rider 49); 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session 2023, (Article II, HHSC, Rider 44)

B. Objective and major activities:

Within PSR, there are four dedicated programs focused on mental health support, as described below.

- Consumer Operated Service Provider: Consists of peer-run organizations that have a sub-recipient relationship with LMHAs and LBHAs. These entities provide a broad range of peer support and recovery services to people seeking assistance for mental health challenges.
- Recovery-Focused Clubhouse: Encourages members to participate in the operation of the Recovery Focused Clubhouse by helping with various tasks, such as administrative duties, reception, food service, transportation, and financial services. The program also encourages members to participate in activities to promote outside employment, education, housing, and community interaction.
- Mental Health Peer Support Re-entry Program: A partnership with three LMHAs and county sheriffs. Certified peer support specialists provide reach-in services to people with mental health diagnoses that are incarcerated to successfully transition them from the county jail into clinically appropriate community-based care.
- Peer Run Youth Crisis Respite Program (PRYCRP): Includes community-based, non-residential peer services and connection to resources for youth and their caregivers. Transition age youth (13-17 years of age) can access one-on-one and group peer support provided by certified peer specialists as well as participate in social events and leadership development opportunities.

- Peer Specialists and Certified Family Partners: Peer specialists and family partners with lived experience deliver services that promote recovery, resilience, and active family participation in care. Both peer specialists and family partners receive formal training and certification.

C. Effective and efficiency information:

HHSC monitors the performance measures for Mental Health PSR programs contained in the tables below.

Table 72. COSP measures, fiscal year 2024.

Measure	Results
Number of contacts	945
Number of people receiving peer support (individual)	6,567
Number of people receiving peer support (group)	10,213
Number of people receiving skills training (individual)	7,216
Number of people receiving skills training (group)	13,305

Table 73. Mental Health Peer Support Re-entry measures, fiscal year 2024.

Measure	Results
Number of people served	284
Number of people showing improvement as measured by specific Adult Needs and Strengths Assessment domains	27
Number of crisis encounters before receiving mental health peer support reentry services	36
Number of crisis encounters after receiving mental health peer support reentry services	61
Percent change in crisis encounters	69.44% increase
Number of HHSC-funded hospitalizations before receiving mental health peer support reentry services	3
Number of HHSC-funded hospitalizations before and after receiving mental health peer support reentry services	2
Percent change in HHSC-funded hospitalizations	33.33% decrease
Number of jail admissions before receiving mental health peer reentry services	24
Number of jail admissions after receiving mental health peer reentry services	20

Measure	Results
Percent change in jail admissions	16.67% decrease

Table 74. Recovery-Focused Clubhouse measures, fiscal year 2024.

Measure	Results
Average daily attendance	408
Number of members attending clubhouse activities	3,514
Number of members who worked and attended clubhouse activities	1,112
Number of members receiving employment services	985

Table 75. Family Partner Services measures, fiscal year 2024.

Measure	Results
Number of children receiving family partner services through LMHAs and LBHAs	7,334
Percentage of children in a full level of care receiving any family partner support who have acceptable or improved functioning in one or more of the Child and Adolescent Needs and Strengths Assessment caregiver needs domains (Family Stress, Involvement with Care, and Knowledge)	65.2%

PRYCRP began in fiscal year 2025 so no performance measure data is available.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

Below are the eligibility requirements for each Mental Health PSR program.

- Consumer Operated Service Provider (COSP): Adult currently receiving mental health services from any community provider or at a significant risk of needing them.
- Recovery-Focused Clubhouse: Adult living with mental health challenges.
- Mental Health Peer Support Re-entry Program: Must meet one of the following criteria:
 - Scheduled for release from a county jail for “time served” and therefore not eligible for benefits through the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI).

- ▶ Scheduled for release from a county jail setting, placed on probation, and therefore potentially TCOOMMI-eligible, but unable to receive services through TCOOMMI due to a lack of program capacity.
- ▶ Scheduled for release from a county jail setting and placed on pre-trial probation with conditions of release.
- ▶ Have at least 30 days of incarceration remaining before release.
- Peer Run Youth Crisis Respite Program: Youth or young adult as well as their caregiver(s) or chosen support person who can access the program. Individuals do not need to be formally enrolled in LMHA services.
- Peer Specialists and Certified Family Partners: Parents or legally authorized representatives of children eligible to receive services through the LMHA or LBHA.

F. Administration and key processes:

BHS administers COSP, Mental Health Peer Support Re-entry programs, and PRYCRP through direct contracts with LMHAs who may subcontract for some services. LMHAs hire or subcontract peer staff that work in the communities.

BHS administers the Recovery Focused Clubhouse program through a competitive procurement process. The programs must be accredited by Clubhouse International to be eligible for the funding.

BHS staff use performance tracking to ensure quality, compliance, and effective support for individuals in recovery. Staff provide program oversight, technical assistance, and manage performance measure data.

G. Funding: See “Agency Program Information” spreadsheet.

H-I. MOUs and relationships with others: Not applicable.

J. Barriers and challenges:

Challenge 1: COSP and Recovery Focused Clubhouses receive federal funds which will end in fiscal year 2025.

Challenge 2: The Mental Health Peer Re-entry Program has not been expanded statewide. While expanding eligibility to include community-based organizations (CBOs) and non-LMHA partners could significantly enhance the program’s reach and

effectiveness, current statutory language constrains this flexibility. The 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, HHSC, Rider 49), requires HHSC to administer the program in partnership with LMHAs and county sheriffs. As written, the rider limits HHSC's contracting authority to LMHAs, thereby precluding partnerships with other types of organizations.

K. Additional information:

In 2019, HHSC took a significant step by adding peer services to the list of covered Medicaid benefits. HHSC adopted rules that define responsibilities of peer specialists, describe training requirements, authorize the establishment of a supervisory position for experienced and qualified peer specialists, and actively promote adherence to best practices in peer support through ongoing education and peer supervision.

L-M. Regulatory and Complaint Information: Not applicable.

Substance Use Peer Support and Recovery Programs

A. Division or program information:

Name of division or program: Substance Use Peer Support and Recovery

Location within the agency: CPSO

Contact name: Christine Laguna, Associate Commissioner

Statutory citation: Texas Health and Safety Code, Chapters 531 and 533

B. Objective and major activities:

PSR oversees and coordinates various peer support and recovery programs and initiatives to promote long-term recovery and improve quality of life for people with substance use disorders. The program also supports the development and sustainability of a certified peer workforce across Texas. Within PSR, there are two programs dedicated to substance use recovery support services:

- RSS: For people 18 years of age or older in long-term recovery from substance use challenges, including co-occurring mental health challenges. Certified peer specialists provide nonclinical services and supports.

- Youth Recovery Communities (YRC): Provides RSS to youth 13-21 years of age who may have a substance use disorder or want a substance-free environment. YRCs establish effective connections between recovery support organizations, substance use treatment programs, and other community resources.

C. Effectiveness and efficiency information:

HHSC monitors the performance measures for Substance Use Peer Support and Recovery programs contained in the tables below.

Table 76. RSS measures, fiscal year 2024.

Measure	Results
Number enrolled in long-term recovery coaching (12+ months)	490
Number of new participants receiving any type of direct recovery services	3,426
Number of new participants receiving any type of indirect recovery services	3,708
Number of new participants receiving any type of education services	3,539
Number of participants with reduced or maintained abstinence at 12-month follow-up interview	173
Number of participants involved in recovery activities during the past 30 days at 12-month follow-up interview	162
Number of participants demonstrating increased assessment of recovery capital scores at 12-month follow-up interview	156

Table 77. YRC measures, fiscal year 2024.

Measure	Results
Number of participants with a case opened during the reporting month	561
Number of participants whose case has been open for six months	6,561
Number of participants reporting improvement at school whose case has been open for six months	1,978
Number of participants with family and support network involvement	3,249
Number of participants reporting abstinence whose case has been open for six months	2,397

Measure	Results
Number of participants employed and not in school whose case has been open for six months	1, 439

D. History: Not applicable.

E. Qualifications or eligibility requirements:

Below are the eligibility requirements for each Substance Use Peer Support and Recovery program.

- RSS: Adults at least 18 years of age who have a history of, or are at risk of having, a SUD and co-occurring mental health challenge; or a family member, significant other, or supportive ally of the RSS participant.
- YRC: Youth 13-21 years of age who have a history, or are at risk, of a SUD and co-occurring mental health challenges. The youth along with their family members and supportive allies are eligible for services through YRCs. This population includes youth who seek recovery without the benefit of other SUD treatments.

F. Administration and key processes:

BHS administers RSS and YRC through a combination of direct contracts and competitive procurement awards. The awardees are a combination of LMHAs, LBHAs, treatment providers, and community-based organizations. PSR staff provide technical assistance and program oversight. PSR contracts with the Addiction Research Institute at The University of Texas at Austin for additional technical assistance and evaluation.

G. Funding: See "Agency Program Information" spreadsheet.

H-I. MOUs and relationships with others: Not applicable.

J. Barriers and challenges:

Many participants face barriers such as lack of access to transportation, housing instability, and limited childcare options, which hinder their ability to fully engage with the services.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

VII. Guide to Agency Divisions and Programs

Chief Program and Services Officer

Health and Specialty Care System

The Texas Health and Human Services Commission (HHSC) Health and Specialty Care System (HSCS) provides inpatient and residential care to Texans with mental illness and with intellectual and developmental disabilities (IDD). HSCS consists of 13 state supported living centers (SSLCs), 10 state hospitals owned and operated by HHSC, one state hospital owned by HHSC and operated by UTHealth Houston, one youth residential treatment facility, one outpatient clinic on the Rio Grande Campus, and two bond homes. At the end of fiscal year 2024, there were over 18,000 staff across HSCS' state-operated facilities and within division offices providing facility program support.

HSCS also has two departments that provide operational support across all HSCS departments – Business Operations and Strategy, Policy, and Communications. These departments provide executive-level oversight of finances and business operations, strategic planning, training, legislative correspondence, policy and communication and collaboration with internal and external HHSC partners. The teams within this area are dedicated to ensuring those served are provided with the highest-level of care possible, while also leveraging resources to identify and implement cost-savings solutions.

Business Operations consists of Facility Operations Support, Staff Support Services, Maintenance and Construction, and Financial Services.

- Facility Operations Support: Provides an array of facility support including workforce operations, supplies, laundry and environmental services, nutrition and food services, and risk management.
- Staff Support Services: Focuses on workforce development providing support for recruitment and retention and staff training and development.
- Maintenance and Construction: Provides oversight and execution of repairs, ensures all buildings are operating effectively, and coordinates or leads facility renovations and construction of new facilities.
- Financial Services: Provides financial reporting, and contracts.

Contracts procured through Business Operations are for the benefit of all HSCS, both state office and facilities. The purpose of these contracts ranges from administrative contracts (recruitment; affiliation agreements for interns, residents, and students; training; and employee onboarding) to client services contracts (food, drugs, laundry, environmental services, video surveillance, and staffing agreements for contracted full-time employees (FTEs)). In addition, Facility Program Support manages compliance for all HSCS contracts.

Strategy, Policy, and Communication coordinates division-wide strategic, policy, and communication functions, as well as serves as the primary point of contact for legislative coordination and stakeholder relations.

State Supported Living Centers

A. Division or program information:

Name of division or program: SSLC State Office; SSLCs

Location within the agency: CPSO

Contact Name: Laura Cazabon, Associate Commissioner of State Supported Living Centers

Statutory Citation for Program: Texas Health and Safety Code, Chapters 532A and 555

B. Objective and major activities:

SSLCs are one part of a broader continuum of services for individuals living with IDD and related conditions. SSLCs are responsible for providing compassionate, innovative, and individualized 24-hour residential care with a goal of assisting center residents in leading meaningful, healthy, and independent lives. In addition, SSLCs provide comprehensive behavioral health and health care services, including physician, psychiatry, nursing, pharmacy, and dental services for individuals with IDD.

SSLCs strive to empower and support residents in realizing personal goals by offering a variety of additional services, including but not limited to the following:

- A comprehensive review of available living options;
- A person-centered, interdisciplinary team (IDT) approach and supports;

- Vocational and employment services, skills training, and habilitation services;
- Customized adaptive aids, including seating and positioning devices;
- Religious services for different faiths;
- Helping residents maintain connections with their families and support systems by providing transportation and staff to accompany residents off campus; and
- Planned activities in the community, such as participating in sporting activities, visiting museums, shopping, and attending local events to provide leisure, recreation, and learning opportunities for residents.

The SSLC State Office provides oversight and support to all SSLCs. This oversight and support include oversight of policies, procedures, quality of care, training, and coordination with executive leadership. Thirteen SSLCs serve clients statewide (see Figure 1). In fiscal year 2024, the 13 SSLCs served 2,765 individuals.

Figure 1. SSLC Locations.



C. Effectiveness and efficiency information:

The United States (U.S.) Department of Health and Human Services (DHHS), Centers for Medicare & Medicaid Services (CMS) certifies each SSLC as an intermediate care facility for individuals with intellectual disabilities (ICF/IID). To operate as a certified facility and receive Medicaid reimbursement, SSLCs must be in compliance with applicable laws and rules. SSLCs must also be in compliance with Life Safety Code requirements that provide safety to residents from fire, smoke, and panic. Each facility undergoes an annual regulatory recertification survey and must comply with the Conditions of Participation (Code of Federal Regulation, Sections 483.400 – 480) to become recertified. Surveyors assess whether the facility provides needed services and interventions; the facility ensures residents are free from abuse, mistreatment, or neglect; residents, families and guardians participate in identifying and selecting services; the facility promotes greater independence, choice, integration and productivity; how competently and effectively the staff interact with residents; and whether all health needs are being met. As of September 1, 2024, each SSLC obtained certification to participate as a Medicaid provider in the ICF/IID program.

SSLCs provide direct care to those needing the level of care offered within the SSLC. The team is dedicated to ensuring those served receive the highest level of care possible, while also leveraging resources to identify and implement cost-savings solutions. See below for information about SSLC admissions, staffing, and resident employment.

- There were 177 new admissions in fiscal year 2024, an increase from 133 new admissions in fiscal year 2023 and the highest number of new admissions since fiscal year 2015 which had 178.
- There were 259 inquiries for possible admission in fiscal year 2024, an increase from 177 total inquiries in fiscal year 2023.
- Staff turnover rate decreased from 31 percent in fiscal year 2023 to 27 percent in fiscal year 2024.
- In the past year, the number of SSLC residents participating in off-campus employment rose by 37 percent. Potential contributors to this increase include offering increased on-campus employment opportunities which build resident skills that can transfer to future community employment.
- In the past two years, SSLCs have undertaken multiple center initiatives to grow their training and on-campus vocational programs, allowing for

increased employment opportunities for campus residents. These opportunities include jobs at an on-campus t-shirt making shop, jobs at new word-working shops, and employment at several centers who have on-campus cafes. Due to these efforts, 68 percent of center individuals between the ages of 18-65 currently maintain on-campus employment.

- From these new employment opportunities, residents have gained skills transferable to jobs in the community such as learning how to operate a cash register, how to engage and communicate with customers, and how to process payments for goods by credit card, cash, and cash applications. The success of these initiatives along with the increased scheduling opportunities for residents employed on campus has resulted in an additional 6,000 work hours being performed by residents between the months of January 2024 through July 2024.
- By the end of August 2024, HHSC SSLCs achieved compliance with 43.7 percent of the Department of Justice (DOJ) settlement agreement, or a total of 773 provisions for all SSLCs statewide.

D. History: Not Applicable

E. Qualifications or eligibility requirements:

SSLCs provide a residential setting, serving people with severe and profound disabilities. Additionally, many individuals with intellectual disability (regardless of the severity) are served at SSLCs if they also meet one of the following criteria: (1) they have complex medical needs, (2) they have one or more co-existing psychiatric diagnoses, or (3) they experience behavioral health challenges.

As of September 1, 2024:

- 2,610 individuals were receiving services or supports at a SSLC.
- 39 percent of the individuals receiving services or supports at an SSLC were medically fragile (e.g., diagnosed with chronic health conditions, such as uncontrolled seizures or heart ailments that require professional intervention less than daily; whose health status is unstable; or who have multiple, serious health problems that may be life-threatening and require professional intervention daily).
- 67 percent of the individuals receiving services or supports at an SSLC had an intellectual disability and psychiatric diagnosis.

Local Intellectual and Developmental Disability Authorities (LIDDAs) generally serve as the point of entry for SSLCs by determining an individual's eligibility for admission to an SSLC or other publicly funded service. While most admissions continue to be facilitated by the LIDDA, in 2023, the Texas Legislature passed Senate Bill (S.B.) 944, 88th Legislative Session, Regular Session, 2023, requiring HHSC to create a pathway for civil commitment without a recommendation for placement by a LIDDA interdisciplinary team. HHSC implemented this framework allowing for the first civil court commitment completed under this new statute.

F. Administration and key processes:

All SSLCs employ a director, assistant director of programs, and assistant director of administration, to oversee the services and supports provided to residents. The workforce includes the following positions: direct support professionals, physicians, nurses, dentists, physical therapists, occupational therapists and speech-language pathologists, psychiatrists, psychologists, certified behavior analysts, pharmacists, vocational counselors, and many other support personnel who work to ensure delivery of services and supports are consistent with state and federal regulations, laws, and rules. SSLC state office staff provide management support and oversight of the thirteen SSLCs. Under the direction of an associate commissioner, state office staff provide support through policies, procedures, and training to the SSLCs in the following areas:

- General administration and management;
- Clinical oversight for medical, nursing, psychological, and habilitation therapies services;
- Habilitation therapy;
- Active treatment and vocational services;
- U.S. DOJ Settlement Agreement compliance;
- Incident management;
- Legislative, stakeholder, and media information coordination;
- Staffing;
- Quality assurance and quality improvement, including development of statewide policy and rules and the maintenance of system-wide data;
- Admissions and placement support; and
- Administrative coordination and contracts oversight.

G. Funding: See “Agency Program Information” spreadsheet.

ICF/IIDs are a Medicaid-funded federal/state service with SSLC operating funds coming from the federal government, state general revenue, and third-party revenue sources (other forms of insurance such as Medicaid, Medicare, or private insurance).

H. MOUs and interagency agreements or contracts:

Each individual (or the individual’s legally authorized representative) decides where they will receive services and supports to meet his or her unique needs. Most services and supports are provided by HSCS staff at the SSLCs. When an individual’s care plan includes a service or support that is not provided at the SSLC, HSCS seeks services in the community for the resident.

HSCS uses MOUs and interagency agreements between SSLCs and other governmental entities for a variety of services. General categories of MOUs and interagency agreements include the following:

- Colleges or universities (clinical rotations by students);
- Hospitals (services provided to residents of SSLCs);
- School districts (educational services for residents); and
- Client protections such as providing advocacy, safeguarding individual rights, promoting individual choice and independence, and protection from mistreatment (Office of the Inspector General, Office of the Independent Ombudsmen, Disability Rights Texas).

I. Relationship with other governmental entities:

SSLCs work with a multitude of local, regional, state, and federal agencies to provide services and supports for residents. The level of involvement with these governmental agencies may vary from center to center.

J. Barriers and challenges:

Challenge 1: For individuals residing in SSLCs, approximately 75 percent have behavioral management needs requiring the use of additional strategies and supports to address and improve challenging behaviors. These behaviors can include conduct such as aggression towards others, self-harming conduct, and destroying property. Regulation, statute, and staffing constraints limit HSCS’ ability

to operate specialized behavioral health homes. Without the ability to better serve these residents in specialized behavioral homes the potential risk to the residents is increased.

Additionally, at present, psychoactive medication orders for individuals transferring from a state hospital to an SSLC are not transportable. The lack of transportability of psychoactive medication increases the likelihood of a potential delay in providing needed psychotropic medications for these individuals upon their transfer.

To address both issues, House Bill (H.B.) 1824, 87th Legislature, Regular Session, 2021, approved development of an SSLC pilot program offering homes with enhanced behavioral supports. The bill further allowed for the transportability of orders for psychoactive medications between the state hospitals and the SSLCs. This proposal did not become law. Enacting the proposal would benefit individual transfers and treatment programming to this day.

Challenge 2: The number individuals transitioning from SSLCs into the community has consistently decreased each fiscal year. The highest number of community transitions occurred in fiscal year 2013 at 287. In fiscal year 2024, there were only 46 community transitions. While finding a community placement capable of successfully meeting the complex needs of SSLC residents is one factor that impacts the ability to transition residents into the community, guardians may be hesitant to move their loved ones out of an SSLC due to the high quality of care the resident has received and fear the resident will not receive the same quality of care in the community.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

State Hospitals

A. Division or program information:

Name of division or program: State Hospitals Oversight; State Hospitals

Location within the agency: CPSO

Contact Name: Kristy Carr, Associate Commissioner of State Hospitals

Statutory Citation for Program: Texas Health and Safety Code, Chapters 532 and 552

B. Objective and major activities:

State hospitals serve as places of assessment, stabilization, and treatment for individuals experiencing acute psychiatric crises or chronic mental health conditions. The primary goal of state hospitals is to provide quality inpatient mental health care and support to improve the well-being and functioning of their patients.

The State Hospital Oversight area provides support and oversight to 10 state hospitals, one youth psychiatric residential treatment center, one outpatient clinic, and contracted beds authorized to provide inpatient mental health care on behalf of HHSC. These functions include oversight of policies, procedures, quality of care, training, and coordination with executive leadership.

Funding provided through S.B. 30, 88th Legislature, Regular Session, 2023, increased inpatient capacity statewide with an additional 102 state-operated inpatient beds, 166 contracted inpatient beds, and construction grants for up to 332 beds in non-state-owned facilities. The need for inpatient mental health services has increased as the population of Texas continues to grow. Expanded statewide capacity is needed to ensure Texans, in both rural and urban communities, can access high-quality inpatient care in a timely manner.

In fiscal year 2024, there were 5,394 patients served within the state-owned and operated state hospitals.

Major state hospital achievements within the last couple fiscal years include:

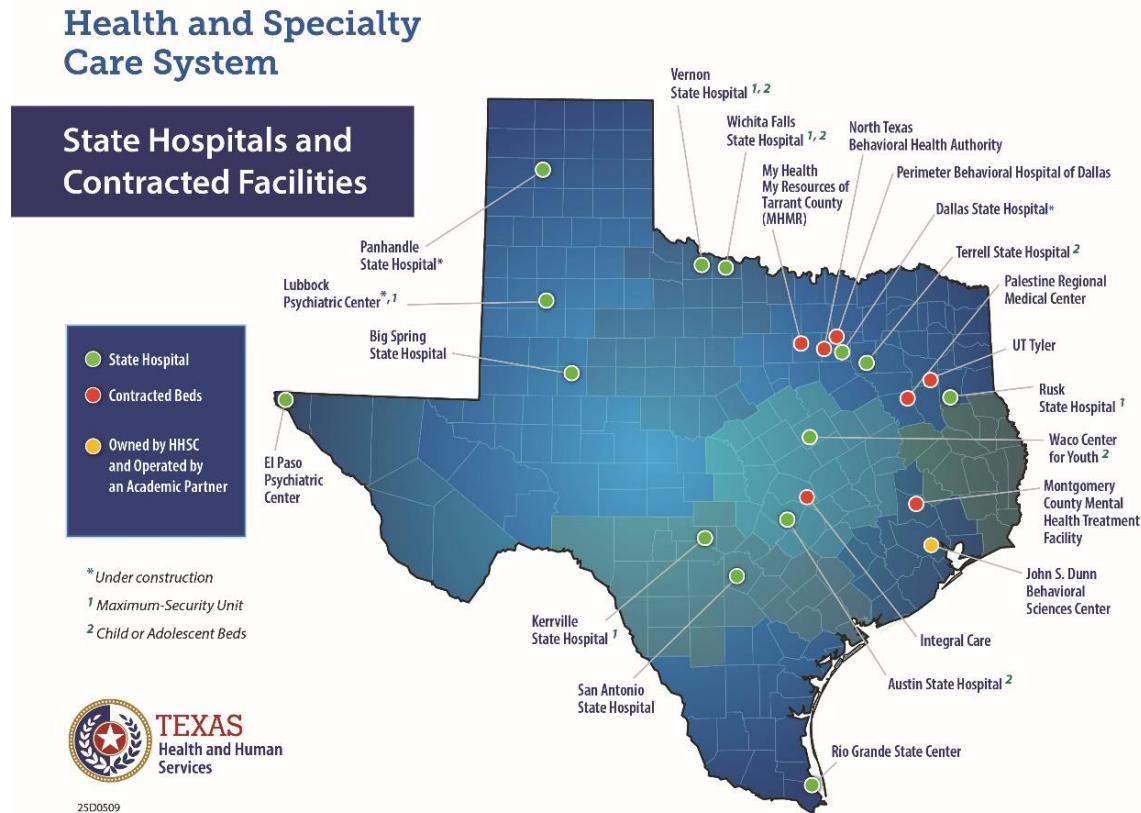
- Completion of Kerrville State Hospital renovations, adding 70 maximum-security beds, in April 2023.
- Construction completed for the replacement of Rusk State Hospital in May 2023. The replacement hospital added a new maximum-security unit with 100 beds, a new non-maximum-security unit with 100 beds, and a replacement administration building. The complex increased the number of maximum-security beds from 40 to 100.

Construction completed for the replacement of San Antonio State Hospital in January 2024 and Austin State Hospital in July 2024. S.B. 30 allocated funding for the construction and expansion of the following state hospitals:

- Terrell State Hospital replacement hospital with 250 beds, expected completion is 2027.

- North Texas State Hospital Wichita Falls replacement hospital with 250 beds, expected completion is 2027.
- A new Lubbock Psychiatric Center will be a 50-bed maximum-security unit, expected completion is 2027.
- A new 75 bed non-maximum-security hospital in Amarillo, construction is expected begin on the Panhandle State Hospital in 2025.
- Expansion of existing Rio Grande State Center with the construction of 50 maximum-security beds, construction is expected to begin in 2025.
- Conversion of 40 beds to a maximum-security unit at the existing San Antonio State Hospital, not the replacement hospital. This maximum-security unit will serve people 65 and older and others whose medical and physical conditions require additional care, construction is expected to begin in 2025.
- Additional construction funding for the 200-bed adult unit of the new state hospital in the Dallas-Fort Worth area, with at least 75 percent of the beds to be used for forensic purposes. HHSC received a monetary gift from Children's Health to fund 92 pediatric beds at the Dallas State Hospital.

Figure 2. State hospital and contracted facilities locations.



C. Effectiveness and efficiency information:

State hospitals provide direct care to those needing the level of care offered within a state hospital. The state hospital team is dedicated to ensuring those served receive the highest level of care possible, while also leveraging resources to identify and implement cost-savings solutions. See below for information about state hospital staffing and construction.

- Staff turnover rate decreased from 27 percent in fiscal year 2023 to 21 percent in fiscal year 2024.
- In fiscal year 2023 there were 548 beds offline due to factors such as construction and staffing. At the end of fiscal year 2024, the number of beds offline was 325.

The 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023, appropriated funds to implement transition support teams across the state

hospital system. The primary goal of the transition support teams is to implement strategies that promote successful transitions from state hospitals into the community. In calendar year 2024, discharge specialists facilitated a total of 83 discharges across various state hospital facilities.

In the summer of 2024, state hospitals launched the Culture of Engagement initiative to improve patient care and staff support. This effort focuses on expanding programming, enhancing staff training, improving retention efforts, and refining care strategies. By prioritizing engagement at all levels, the initiative strengthens hospital operations and ensures better outcomes for both patients and staff.

D. History: Not Applicable

E. Qualifications or eligibility requirements:

General Admission Criteria for a State Mental Health Facility (SMHF) or Facility with a Contracted Psychiatric Bed (CPB):

- With the exception of specialized units (like Waco Center for Youth or maximum-security/adolescent forensic units), state hospitals or facilities with a Crisis Psychiatric Bed may admit individuals referred by a Local Mental Health Authority (LMHA) or Local Behavioral Health Authority (LBHA) if they have a mental illness and pose a serious risk of harm or deterioration.
- Admissions are not allowed if the individual needs medical care that the facility can't provide or has an unstable physical condition.
- If someone arrives without an LMHA/LBHA referral, the facility must notify the appropriate authority, assess for emergency needs, and follow Emergency Medical Treatment and Active Labor Act requirements—either admitting the person if capable or stabilizing and arranging transfer if not.
- If the person is referred but doesn't meet criteria for inpatient care, the facility must coordinate with the LMHA/LBHA for follow-up services within 24 hours. (Based on Title 26, Texas Administrative Code, Section 306.171)

State Hospital Forensic Admission/Eligibility:

- If a judge rules that a defendant is incompetent to stand trial, the judge issues an order for inpatient competency-restoration. The court mails a copy of the commitment order to the state hospital system's forensic mailbox to add the person to the waitlist for admission to a state hospital.

- Individuals forensically committed to a state hospital may be ordered, based on the alleged crime and the patient's needs, to receive inpatient care on a state hospital maximum-security unit (MSU). Four HHSC state hospitals currently have MSUs: Rusk State Hospital, Kerrville State Hospital, North Texas State Hospital Wichita Falls, and North Texas State Hospital Vernon. While MSUs provide a higher level of security and safety for these patients, those committed to an MSU still have access to high-quality psychiatric treatment. Heightened MSU security features include:
 - Sallyports that create controlled entry and exits to the unit.
 - Extended height perimeter fences.
 - Secure courtyards that allow the patients to safely be outside.
 - Video surveillance, alarm systems, electronic monitors, metal detectors, and x-ray scanners.
 - Specialized training for staff.

MSU patients remain on the unit until they are found competent to stand trial and discharged to the court or determined to be Not Manifestly Dangerous and transition to a less secure state hospital inpatient unit.

Waco Center for Youth (WCY): WCY admits children and youth aged 13 to 17 with a psychiatric diagnosis of emotional or behavioral disability and history of behavior problems in at least two settings who do not fall within one of the areas outlined below:

- An individual who is younger than 13 years of age or an adolescent whose age at admission does not allow adequate time for treatment programming based on individual case review before reaching 18 years of age;
- An adolescent who has been found to have engaged in delinquent conduct or conduct indicating a need for supervision under Texas Family Code, Title 3;
- An adolescent who is acutely psychotic, suicidal, homicidal, or seriously violent; or
- An adolescent who is determined to have an intellectual disability.

F. Administration and key processes:

See file "[S7 CPSO HSCS Att 01 SH Admission, Discharge, and Transition.](#)"

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts:

HHSC contracts with private psychiatric hospitals to provide competency restoration services. These contracts are funded by the legislature to help reduce waitlists and increase access for individuals found “incompetent to stand trial” (IST).

I. Relationship with other governmental entities:

State hospitals have collaborated with academic institutions in the following ways:

- Physician residency programs that offer clinical training experiences within state hospitals. The unique populations served in state hospitals provide physicians with distinctive treatment opportunities, including psychiatric and physical pathologies. Resident physicians supplement the care provided by regular medical staff and increase the facility’s capacity and time spent with patients.
- HHSC partners with the University of Texas Health Science Center at Houston to design, construct, and operate the John S. Dunn Behavioral Health Science Center.
- HHSC works with Dell Medical School at The University of Texas at Austin in designing and planning Austin State Hospital’s replacement facility.

J. Barriers and challenges: Not applicable.

K. Additional information:

As mentioned under question B, operational planning for new and rebuilt state hospital facilities are underway. As state hospitals expand their capacity and footprint across the state, they are evaluating operational needs across the system to maximize capacity and people served.

L-M. Regulatory and Complaint Information: Not applicable.

Office of Forensic Services and Coordination

A. Division or program information:

Name of division or program: Office of Forensic Services and Coordination

Location within the agency: CPSO

Contact Name: Dr. Jennie Simpson, Associate Commissioner and State Forensic Director

Statutory Citation for Program: S.B. 1507, 84th Legislature, Regular Session, 2015; Texas Health and Safety Code, Section 532.013

B. Objective and major activities:

Statute tasks the state forensic director with the statewide coordination and oversight of forensic services, coordination of agency programs related to forensic patients, and addressing issues with the delivery of forensic services in the state including significant increases in populations with serious mental illness and justice system involvement. The major areas of work under the Office of Forensic Services and Coordination (OFSC) are Clinical Services and Programming; Planning, Research, and Coordination; and Policy. Each area of work consists of multiple activities.

C. Effectiveness and efficiency information:

OFSC maintains multiple effectiveness and efficiency metrics for its programs and activities. These metrics include the number of patients and residents, staff, facilities, and external entities served through OFSC programs; assessments of clinical and programming effectiveness; data related to forensic admissions management; and evaluations and studies of agency forensic programs and services. The sources of data below have been helpful in establishing baseline measures as the OFSC team transitions from their previous structure in Behavioral Health Services (BHS) to the current HSCS structure.

Sources include:

- Admissions Management Worksheet: Tracks all current Maximum Security Unit waivers, expedited admissions, alternate dispositions for inpatient forensic commitments, and Not Guilty by Reason of Insanity commitment requirements completed by OFSC clinicians.
- Standardized Clinically Based Competency Screen (SCCS) Worksheet: Tracks all OFSC-completed SCCSs of people on the forensic admission waitlist that are requested by counties.
- MSU Spreadsheet: Tracks outputs of Clinical Security Reviews completed by OFSC staff (MSU waiver process).

- Jail In Reach Referrals Spreadsheet: Tracks all county referrals the Jail In-Reach Program.
- Forensic Support Team Program Contract Performance Measures.
- Forensic Support Team (FST) Spreadsheet: Tracks all referrals for services by participating FST counties.
- Facility and Community Service Support Spreadsheet: Tracks all OFSC support activities to facilities, counties, and external legal and mental professionals.
- Trial Competency Evaluation Timelines: Tracks Texas state hospital (TSH) timeline requirements for forensic commitment at each TSH facility to guide provision of OFSC clinical and technical supports.
- Electronic Health Record and HHSC databases for raw data extraction and analysis.

D. History:

OFSC moved from BHS to HSCS and merged with the TSH's Chief of Forensic Medicine team in October 2024. The reorganization of OFSC better aligned the functions and scope of the office with the intent of the statutory authority. In addition, the reorganization centralized forensic services and programming.

E. Qualifications or eligibility requirements: Not Applicable

F. Administration and key processes:

OFSC coordinates forensic clinical services and programming (CSP), promotes evidence-based practices, ensures fidelity of forensic evaluations and assessments, and develops standardized forensic programming across state operated facilities. These functions are direct support services that are provided by OFSC's State Forensic Director, forensic psychiatrist, forensic psychologists, forensic social workers, and forensic research and policy experts to HSCS facilities. Contracts for direct services related to forensic admissions are also overseen and administered by OFSC staff.

The Planning, Research, and Coordination area focuses on activities that promote continuous improvement and data-informed decision-making across forensic programs and services. The area oversees and directs the coordination infrastructure for cross-agency forensic programs and services and continuously

plans for future forensic services in concert with BHS and the Chief Program and Services Office (CPSO). The area also provides staff liaison duties for the Joint Committee on Access and Forensic Services (JCAFS) and oversees contracted research and evaluation activities.

OFSC supports forensic policy development and coordinates legislative implementation and litigation activities across HSCS and BHS through policy analysis and implementation, working with internal and external stakeholders, and serving as liaisons with the Complex Litigation area when necessary.

G. Funding: See "Agency Program Information" spreadsheet.

The Mental Health Block Grant funds the North Texas Behavioral Health Authority, and Integral Care contracts managed by the Forensic Support Teams. In addition, HHSC contracts with the Texas Institute for Excellence in Mental Health at the University of Texas at Austin for evaluation of HHSC-funded Outpatient and Jail-Based Competency Restoration programs. Funding for the State Hospital Length of Stay Study includes funding from the Mental Health Block Grant and general revenue.

H. MOUs and interagency agreements or contracts: Not Applicable.

I. Relationship with other governmental entities:

OFSC works with behavioral health and justice stakeholders, representing local and regional units of government, including:

- LMHA and LBHAs;
- LIDDAs;
- State universities;
- Judges, court personnel, and attorneys;
- Jails;
- Law enforcement; and
- JCAFS.

J. Barriers and challenges:

The Texas Code of Criminal Procedures and the Texas Health and Safety Code, as well as administrative rules under the Texas Administrative Code, are the primary

statutes governing competency restoration programs. Statutes and rules can become outdated and conflict with the growing use of community-based competency restoration programs and current needs such as individualized treatment, and consideration of how to serve the growing forensic IDD population. Further, statutes and rules may not allow for standardization of service provisions and guidelines across community and inpatient settings.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

VII. Guide to Agency Divisions and Programs

Chief Medicaid and CHIP Services Officer

Medicaid and CHIP Services Division

The Medicaid and CHIP Services (MCS) division oversees delivery of health care and long-term services and supports to individuals that are determined eligible for the Medicaid program or Children's Health Insurance Program (CHIP).

For the 2024–25 biennium, the appropriation for Medicaid and CHIP is approximately \$77.2 billion in all funds, including \$29.8 billion from General Revenue. Less than 5 percent of this amount is allocated to administrative costs, with the vast majority directed toward client services.

Program Introductions

Medicaid

Medicaid is a joint federal-state entitlement program, enacted in 1965 under Title XIX of the Social Security Act, that pays for medical care for certain groups of low-income persons who have limited or no medical insurance. Federal and state laws define the Medicaid client population, with the overall objective to improve the health of people who might otherwise go without medical care. Medicaid provides health care and long-term services and supports (LTSS) to low-income children and their families, pregnant and postpartum women, current and former foster care youth, people with disabilities, and people aged 65 and older.

Medicaid caseload is approximately 4.1 million.

CHIP

The Balanced Budget Act of 1997 established a new state children's health insurance program under Title XXI of the Social Security Act. The program's objective is to provide health insurance to low-income, uninsured children in families with incomes too high to qualify for Medicaid but too low to afford private health insurance. CHIP perinatal services are also available for the unborn child of pregnant women. Texans who apply for benefits and do not qualify for Medicaid are automatically tested for CHIP eligibility.

Some families in CHIP pay an annual enrollment fee and copayments (also referred to as cost-sharing) for services to cover all children in the family. CHIP annual enrollment fee amounts and copayments vary and have total out-of-pocket caps based on family income. In fiscal year 2024, total CHIP enrollment fees collected were \$3,762,853.68.

CHIP caseload is approximately 165,000.

For the most recent Medicaid and CHIP caseload data visit the [HHS Data and Statistics - Healthcare](#) page of the Texas HHS website.

Federal Oversight

Texas maintains a state plan for both Medicaid and CHIP that serves as the contract between the State and United States (U.S.) Department of Health and Human Services' (DHHS) Centers for Medicare & Medicaid Services (CMS). These state plans describe the nature and scope of the Medicaid program and CHIP — including administration, client eligibility, benefits, and provider reimbursement.

The state plans give the Health and Human Services Commission (HHSC) sole authority to administer Medicaid and CHIP in Texas. HHSC's responsibilities include:

- Serving as the primary point of contact with the federal government;
- Coordinating initiatives to maximize federal funding and administering the Medical Care Advisory Committee (mandated by federal Medicaid law to advise the Medicaid agency about health and medical care services);
- Establishing policy direction for Medicaid and CHIP, administering the state plans, and coordinating with other HHSC departments and state agencies to carry out operations;
- Determining program eligibility for Medicaid and CHIP; and
- Establishing Medicaid policies (including medical and dental benefits policies), rules, reimbursement rates and oversight of Medicaid program operations, including managed care organization (MCO) contract compliance.

Significant changes to a state's Medicaid or CHIP program require the state to submit a state plan amendment (SPA) for CMS approval. Additionally, federal law allows states to apply to CMS for permission to depart from certain Medicaid requirements through waiver programs. Waivers allow states to operate their Medicaid programs under three exclusions: exceptions to Medicaid's basic

principles, required array of benefits, mandated eligibility and income groups, or combinations of these.

For more details on the governing framework of Texas Medicaid and CHIP see Chapter 5 of the [Texas Medicaid and CHIP Reference Guide \(15th edition\)](#).

Funding

Both programs are funded through a combination of state and federal funds. Federal funds are matched with state funds at a certain percentage — this is known as the Federal Medical Assistance Percentage (FMAP). CMS updates rates annually based on the state's per capita personal income.

Medicaid is an entitlement program, meaning it guarantees healthcare benefits to individuals who meet specific eligibility requirements, regardless of program spending limits. Federal match is lower than CHIP but there is no funding cap. CHIP is not an entitlement program, which means funds are capped. When a state's CHIP funds are spent, no more are available.

The fiscal year 2025 FMAP is 60.01 percent for Medicaid and the enhanced FMAP is 72.01 percent for CHIP.

For more information on the funding structure for Texas Medicaid and CHIP see:

- Chapter 5 of the [Texas Medicaid and CHIP Reference Guide \(15th edition\)](#)
- Client Services chapter of the [CFO Reference Guide: An Overview of Key Financial Topics](#)

Services

Federal law requires state Medicaid programs to provide acute care, behavioral health services, and LTSS. Children and youth also receive comprehensive dental services. States may choose to provide optional services.

States with a separate CHIP, like Texas, have flexibility in determining benefits. The Texas CHIP benefit package focuses on acute care services, but also includes some behavioral health services and dental benefits.

Below is a summary of services available:

- Acute care services: Preventative care, diagnostics and medical treatments – all clients enrolled in Medicaid are eligible;

- ▶ *Examples: Doctor and clinic visits, inpatient and outpatient hospital services, laboratory, and x-ray services.*
- LTSS: Support with ongoing, daily activities for individuals with disabilities and older adults – may be provided in a facility or community-based setting; client must meet functional eligibility requirements;
 - ▶ *Examples: Community-based care, personal assistance with activities of daily living (cleaning, cooking), and nursing facility services.*
- Behavioral health services: Screening and treatment for mental health conditions and substance use disorders (SUD) – included in all Medicaid programs;
 - ▶ *Examples: Mental health rehabilitation, medication assisted therapy for SUD, and psychological and neuropsychological testing.*
- Hospice services: Care for terminally ill people for whom curative treatment is no longer desired and who have a physician’s prognosis of six months or less to live;
 - ▶ *Examples: Physician services, nursing, personal attendant services, therapies, prescription drugs, respite care, and counseling.*
- Medical transportation services: Non-emergency medical transportation for clients who need help getting to appointments; and
- Pharmacy services: Coverage for prescription drugs.

Texas Medicaid and CHIP cover telehealth, telemedicine, and home telemonitoring (referred to as teleservices) for certain conditions when demonstrated to be clinically appropriate and cost effective.

For more details on Texas Medicaid and CHIP Services see Chapter 2 and Appendix B of the [Texas Medicaid and CHIP Reference Guide \(15th edition\)](#).

Service Delivery

Over the past two decades, Texas Medicaid has transitioned from a traditional fee-for-service (FFS) model to a predominantly managed care system, aiming to improve cost efficiency and care coordination. The state continues to operate under a dual service delivery structure, maintaining both FFS and managed care models.

About 97 percent of Medicaid and CHIP beneficiaries receive services through the managed care model. HHSC contracts with 16 MCOs and three dental maintenance

organizations (DMOs) for service delivery. The remaining three percent in FFS are mostly clients who will be but are not yet enrolled with an MCO and certain clients in our intellectual and developmental disabilities (IDD) waiver programs.

Table 1. Primary differences between the managed care and FFS service delivery models.

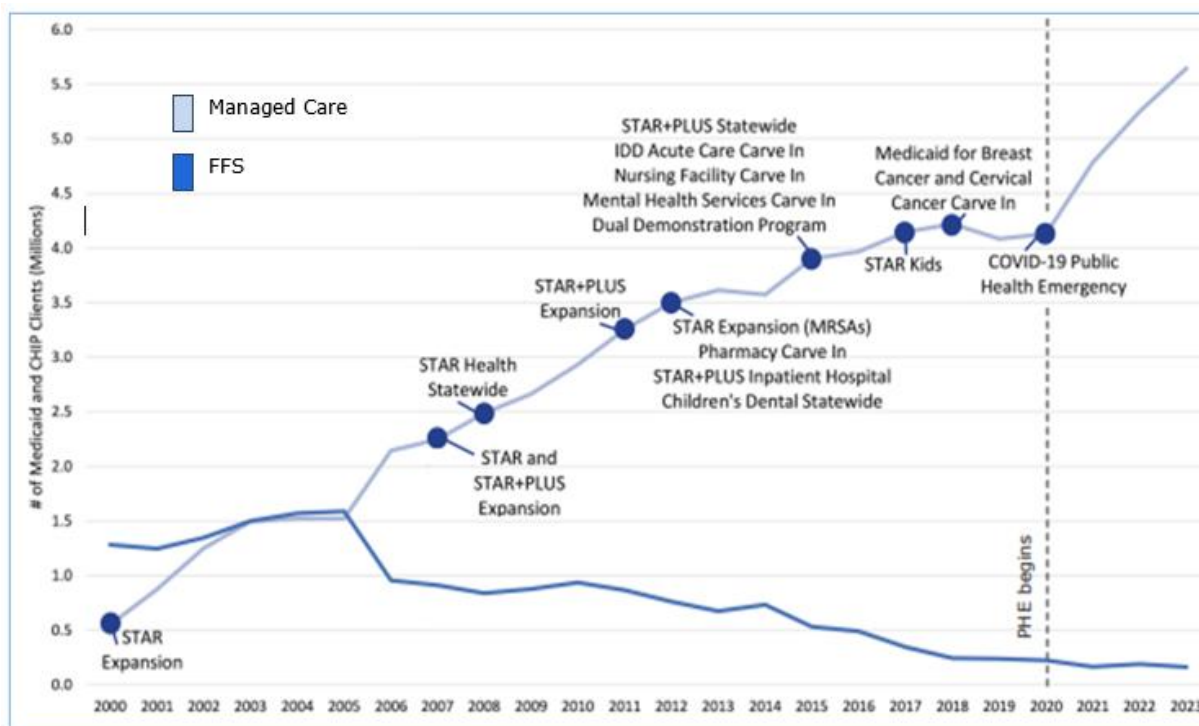
Key Features	Managed Care	FFS
Finance Model	Risk-based: MCO is paid a capitation rate for each member enrolled.	Non-risk: Providers submit claims directly to HHSC's administrative services contractor for payment.
Contracting	State contracts with MCOs. Providers enroll in Texas Medicaid and contract with MCOs.	Providers enroll in Texas Medicaid and contract with the state.
Access to Services	Members choose an MCO and receive services through their chosen medical and dental home and other providers in the plan's network – the MCO must authorize any providers that are out of network. Referrals are required for certain types of specialists.	Clients go to any Medicaid provider, but they must find their own health care providers.
Service Coordination	Provided for certain programs and on request.	Limited to persons in waiver programs.
Benefits	Value-added services. Unlimited prescriptions. Unlimited hospital stays for most adults.	Basic Medicaid benefits. 3-prescription limit for adults. 30-day hospital stay limit for adults.

The reduction in FFS caseload does not reflect HHSC scaling back on overall Medicaid operations. Operating this dual service delivery model requires maintaining parallel infrastructure, including separate administrative processes, payment systems, and oversight mechanisms to support both models effectively.

Summary of Major Programs and Who They Serve

The gradual 'carve in' of populations and services into managed care has been a deliberate process in Texas, directed by the legislature, for over two decades (see Figure 1). In the last 10 years, the number of members receiving services through managed care has grown by over 37 percent.

Figure 1. Texas managed care key milestones of expansions and carve-ins.



For major legislation that has shaped Medicaid and CHIP programs see Appendix A of the [Texas Medicaid and CHIP Reference Guide \(15th edition\)](#).

Managed Care Product Lines

- State of Texas Access Reform (STAR): Children, newborns, pregnant and post-partum women, and some Temporary Assistance for Needy Families (TANF)-level families;
- CHIP: Children in families that earn too much money to qualify for Medicaid but cannot afford to buy private health insurance (includes CHIP perinatal);
- STAR+PLUS: Adults with a disability, people aged 65 or older (including those dually eligible for Medicare and Medicaid), and women with breast or cervical cancer;
- Dual Demonstration (Medicare-Medicaid Plans – ‘MMP’): Provides a fully integrated managed care model in six counties for people who are dually eligible for Medicare and Medicaid. Both Medicare and Medicaid services are provided under a single MMP. Note that per federal regulation, HHSC is winding down Dual Demonstration by the end of 2025.

- STAR+PLUS Home and Community-based Services (STAR+PLUS HCBS): Medicaid 1115 Waiver program that provides a cost-effective alternative to living in a nursing facility for adults aged 21 and older who have disabilities or who are elderly;
- STAR Kids: Children and youth with disabilities;
- STAR Health: Children who receive Medicaid benefits because they are in conservatorship of the Department of Family and Protective Services (DFPS) and young adults previously in foster care;
- Medically Dependent Children's Program (MDCP): Medicaid waiver program that provides home and community-based services to children and youth age 20 and younger as a cost-effective alternative to a nursing facility;
 - People enrolled in MDCP receive all services through a STAR Kids or STAR Health MCO; and
- Dental: Children and adults 20 or younger enrolled in Medicaid or CHIP.

FFS Programs

Medicaid 1915(c) waiver programs

These programs are designed to provide home and community-based services to people with IDD or related conditions as an alternative to placement in an intermediate care facility (ICF) for individuals with an intellectual disability or related condition (ICF/IID).

The four waiver programs for people with IDD are described below. Demand for waiver programs exceeds capacity. These programs, as well as STAR+PLUS HCBS and MDCP mentioned above, maintain interest lists that people can join at any time.

- Community Living Assistance and Support Services (CLASS): Provides home and community-based services to people of all ages who have a related condition qualifying them for placement in an ICF/IID.
- Deaf Blind with Multiple Disabilities (DBMD): Provides home and community-based services (as an alternative to residing in an ICF/IID) to people of all ages who have deaf blindness or have a condition that will result in deaf blindness and who have an additional disability.
- Home and Community-based Services (HCS): Provides individualized services to people of all ages who qualify for ICF/IID level of care.

- Texas Home Living (TxHmL): Provides selected services and supports for people of all ages with IDD.

Healthy Texas Women

Healthy Texas Women (HTW) is a Medicaid 1115 demonstration waiver program that provides no-cost health and family planning services to low-income women aged 15 through 44 who qualify.

HTW Plus provides enhanced and targeted postpartum care services to HTW clients whose pregnancies ended within the 12 months preceding their enrollment in HTW. Enhanced postpartum benefits include services that address:

- Postpartum depression and other mental health conditions;
- Cardiovascular and coronary conditions; and
- Substance use disorders, including drug, alcohol, and tobacco use.

HHSC has legislative direction to carve HTW into managed care (House Bill (H.B.) 133, 87th Legislature, Regular Session, 2023) and the carve-in is planned to coincide with the implementation of the new STAR and CHIP managed care contracts.

For more details on Texas Medicaid and CHIP programs see Chapter 2 of the [Texas Medicaid and CHIP Reference Guide \(15th edition\)](#)

Program Effectiveness and Efficiency Measures

In addition to Legislative Budget Board (LBB) measures outlined in Section II, Exhibit 2, MCS uses the below metrics as core measures of program effectiveness and efficiency.

Table 2. MCS core measures of program effectiveness.

Measures Reporting	Description
Performance Indicator Dashboard on the Texas Healthcare Learning Collaborative (THLC) Portal	The Performance Indicator Dashboard measures are the foundation for other managed care quality related initiatives such as MCO report cards and an input in Value-based Enrollment (VBE), described below. All individual measures for the dashboard are available on the THLC portal which shows performance relative to national benchmarks. The measures can also be broken out at the state, program, service area, and MCO level as well as trends over time. Some of the dashboard measures are also CMS Core Measures which are reported on a CMS Scorecard that compares state performance.
External Quality Review Organization (EQRO) Annual Technical Report	The Annual Technical Report evaluates Texas’ progress toward the goals in its Managed Care Quality Strategy and makes recommendations for further progress – see pages 21-23 of the most current report. The Companion has MCO-specific performance evaluations. The THLC portal has source data for EQRO’s Annual Technical Report, including survey results. Quality measures are calculated by EQRO using measure steward specifications. Data sources include administrative data (such as claims, eligibility) and, depending on the measure, health record data.
CMS 1915(c) Waiver CMS-372 Report <i>(not available online, sample reports available upon request)</i>	The CMS-372 report demonstrates compliance with quality assurances, cost-neutrality, and provides details on the type, amount, and cost of services. Reporting is required annually for all 1915(c) Medicaid waiver programs. Aggregate program level data subject to submission include level of care assessments, provider qualifications, service planning, critical incidents, substantiated instances of abuse, neglect, and exploitation, and data related to financial accountability.

Measures Reporting	Description
CMS Request for Evidentiary Information (REI) and HCBS 1115 Quality Assurance Report <i>(not available online, sample reports available upon request)</i>	For each 1915(c) waiver, HHSC is required to submit an evidentiary-based quality review report in response to 'CMS Request for Evidentiary Information (REI)' approximately 21 months prior to the expiration of the waiver. The results of the review serve to inform HHSC and CMS of the state's compliance with waiver assurances in anticipation of the waiver renewal. REI reviews the first three years of the waiver renewal. The 1115 Special Term and Condition (STC) 28 and 75 requires HHSC to report annually on the STAR+PLUS HCBS performance measures. CMS requires measures falling below 86 percent compliance to be reported along with remediation details and for abuse, neglect or exploitation measures that are less than 100 percent compliant to be reported and remediated. Performance measures fall into five categories: administrative authority, qualified providers, service plans, health and welfare, and financial accountability.
Quarterly and Annual 1115 Waiver Monitoring Reports: Texas Healthcare Transformation and Quality Improvement Program	Multiple data sets sent to CMS such as managed care organization enrollment data, provider enrollment data, utilization data, MCO performance and compliance data, network adequacy data, MCO complaints data, and claims data. Section 17, pages 57-58, of the report includes a list of all attachments prepared by HHSC and submitted to CMS. Details on the type of data are also included. CMS publishes the reports and corresponding data attachments at: https://www.medicaid.gov/. Note that CMS is moving to annual reporting, including a new template, which may require new measures and exclude measures noted above.
Quarterly and Annual 1115 Waiver Monitoring Reports: HTW	HHSC collects a comprehensive array of information for reporting on HTW. This data generally falls into several key categories: enrollment and demographics, service utilization, provider network, program operations and policy changes, budget neutrality and cost savings, demonstration evaluation, program outreach and education, and program integrity, grievances, and appeals. Note that CMS is moving to annual reporting, including a new template, which may require new measures and exclude measures noted above.

Measures Reporting	Description
MCO and DMO: Financial Statistical Reports (FSRs)	FSRs are self-reported financial data prepared by MCOs and DMOs under the terms and conditions of the Uniformed Managed Care Contract and the Uniform Managed Care Manual. Financial data is validated by HHSC financial analysts and independent auditors. FSRs are used to determine experience rebate amounts (i.e. profit sharing) and are a source for establishing capitation rates in futures years.
VBE: Cost Effective Measures	Plans that perform better on key risk-adjusted cost and quality measures and have higher member satisfaction, receive a greater share of default enrollments (i.e. when a member does not select a health plan). VBE is calculated for each program, MCO, and service delivery area based on a composite value score built from measures sourced from the Performance Dashboard Indicator Dashboard and cost effectiveness measures. The cost effectiveness measures are based on a spending ratio sourced from the Chronic Illness and Disability Payment System (CDPS) – the leading method used by state Medicaid programs to risk adjust costs across health plans.
Directed Payment Program Evaluation: Annual evaluation for: CHIRP, TIPPS, DPP-BHS, and RAPPS QIPP	HHSC is federally required to annually evaluate whether the directed payment programs' payment arrangements are advancing the goals of the Texas Managed Care Quality Strategy. <i>Comprehensive Hospital Increase Reimbursement Program (CHIRP), Texas Incentives for Physicians and Professional Services (TIPPS), Directed Payment Programs (DPP)-Behavioral Health Services (BHS), and Rural Access to Primary and Preventive Services (RAPPS)</i> Data sources – page 4, data measures – page 21-27 <i>Quality Incentive Payment Program (QIPP)</i> Data measures – pages 7-8, Data sources - pages 9 - 12

Each Section 7, Question C, below outlines distinct measures of effectiveness and efficiency across the division's functional areas. While program-level measures are generally standardized and consistent from year to year, the functions within Medicaid are more varied, and their associated performance measures reflect those differences. Depending on the specific area, measures may include qualitative improvements—such as streamlined processes—or quantitative indicators like workload volume or processing times.

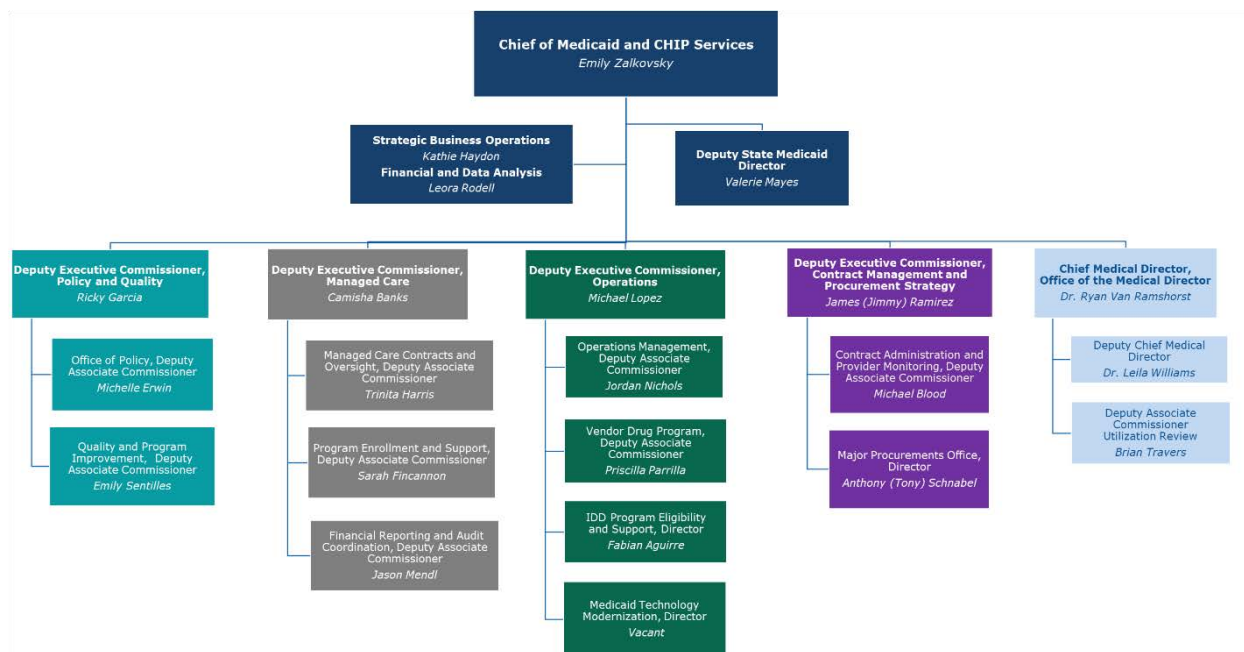
MCS Organizational Structure

Over time MCS has adapted functions and organizational structure to reflect the growing complexity of the managed care environment and its increasing administrative demands, while also maintaining the FFS infrastructure.

The managed care model improves access and quality, while reducing costs. This expectation requires more and specialized talent to execute. To effectively manage the MCO contract requirements, HHSC must mirror MCO staff expertise in every major category of MCO function.

MCS' organizational structure and functional groupings ensure the division can effectively oversee MCOs and DMOs in an increasingly intricate landscape, while also ensuring the division can support both the managed care and FFS delivery models (see Figure 2). This requires a variety of functions, including managing a high volume of contracts and driving continuous technology improvements to evolve along with the Medicaid and CHIP programs.

Figure 2. MCS organizational structure and functional groupings.



Major MCS Division Contracts

MCS manages more than 6,000 contracts across its programs and operational areas. While many of these contracts are specific to functional areas or pertain directly to provider services, several major contracts have a broad impact and

support multiple core functions. These high-impact contracts play a critical role in ensuring the delivery of services, operational efficiency, and program compliance.

- **Manage Care Contracts:** Over 40 contracts are in place with 16 MCOs and three DMOs for all the products lines, including dental for 13 service delivery areas.
- **Enrollment Broker:** The enrollment broker, Maximus, is responsible for enrolling individuals into Medicaid and CHIP managed care programs. Maximus provides enrollment materials and counseling services to help individuals understand their options and select an MCO. If an individual does not select an MCO, Maximus operates a default enrollment process that assigns the individual to an MCO based on historical enrollment data and geographic proximity.

Other enrollment broker activities include:

- ▶ Operating a call center to support inquiries from clients and providers. The call center offers multiple access channels to provide information about benefits, services, enrollment procedures, and rules;
- ▶ Managing the system that generates managed care enrollment packets and both inbound and outbound correspondence and document processing functions, including electronic imaging, auto-linking, and auto-routing;
- ▶ Providing outreach and informing services for Texas Health Steps (THSteps), the state's Medicaid preventive care program for children and youth under age 21. These services educate eligible recipients and their families about program benefits and how to access regular medical and dental checkups, immunizations, and other preventive services;
- ▶ Conducting interest list management activities for the STAR+PLUS HCBS program, which includes contacting individuals to verify continued interest and mailing applications when appropriate; and
- ▶ Providing fund management services for CHIP, Medicaid Buy-In, and Medicaid Buy-In for Children's program. This includes collecting enrollment fees and premiums for these programs.

Maximus is also responsible for maintaining accurate and updated enrollment files for Medicaid and CHIP recipients in managed care. MCOs rely on these files to reflect member changes and new enrollments.

Texas Medicaid & Healthcare Partnership (TMHP) contracts*

- Claims Contract: HHSC contracts with Accenture State Healthcare Services, LLC (Accenture) to provide claims processing and fiscal agent services for FFS Medicaid claims. Accenture is responsible for managing, enhancing, and maintaining two claims processing systems, Compass 21 for acute care, and Long-Term Care (LTC) Claims Management System. Accenture serves as HHSC's fiscal agent for acute care claims, making payments to providers on behalf of HHSC for approved service claims.
- Application Maintenance and Development (AMD) Contract: Deloitte Consulting, LLP (Deloitte), performs system maintenance and development activities for state-owned information technology systems such as, but not limited to: Provider Enrollment and Management System (PEMS), LTC Online Portal, Medicaid Client Portal, etc. This contract provides HHSC with dedicated system enhancement capacity (i.e. staffing to write software code) and HHSC directs and prioritizes the capacity. This contract also provides for ongoing maintenance of software applications.

This is a Medicaid funded contract, but the management of the contract is overseen by HHSC Information Technology (IT).

- Business Operations (Bus Ops) Contract: Accenture acts as the "front door" to TMHP. They provide call center services, provider training on systems and processes, provider relations services, prior authorization services, provider enrollment services, and other business services for HHSC.

**TMHP Contracts also include Electronic Visit Verification (EVV) which is described in detail in the Operations Management section.*

Chief of Medicaid and CHIP Services Office

A. Division or program information:

Name of division or program: Chief of Medicaid and CHIP Services Office (CMCSO)

Location within the agency: CMCSO

Contact Name: Emily Zalkovsky, Chief Medicaid and CHIP Services Officer

Statutory Citation: See Self-Evaluation Report Section 8 for a detailed list of statutory citations.

B. Objective and major activities:

The staff in this office support the CMCSO and division in strategic, operational, and administrative functions. In addition to an executive assistant, there are four units that provide these functions.

Chief Advisory Team (CAT): Supports the State Medicaid Director and Deputy CMCSO through strategic coordination, staff guidance, and leadership advisement.

Key Functions:

- Acts as liaison for leadership direction;
- Manages legislative, media, and legal inquiries;
- Coordinates litigation and legislative report processes;
- Supports memo development and executive preparation; and
- Leads high-profile special projects.

Provider Relations: A senior advisor role focused on high-profile provider issues across MCS.

Key Functions:

- Advises on complex provider challenges;
- Collaborates with MCS areas on strategic provider communication; and
- Coordinates resolutions and supports provider-related initiatives.

Financial and Data Analysis: Advises on and coordinates large scale and high profile MCS-related data or financial-related requests and assignments with Chief Financial Officer (CFO) Budget, Provider Finance, and Forecasting; Chief Policy and Regulatory Officer (CPRO) Data, Analytics, and Performance (DAP); and IT.

Key functions:

- Supports biennial budget development including projects related to strategic planning (e.g., budget structure, performance measures, and riders) and exceptional item requests;
- Develops and reviews cost estimates and fiscal impacts, including those related to proposed legislation;
- Reviews external data requests to use Medicaid or CHIP data and consults on internal use of Medicaid and CHIP data; and

- Responds to financial and data-related inquiries, including open records and legislative requests.

Strategic Business Operations (SBO): Provides planning, coordination, and operational infrastructure. SBO is composed of five units with key functions outlined below.

- Project Advisory and Coordination Team (PACT):
 - Manages the MCS Projects Portfolio and executive governance;
 - Provides certified project managers for major initiatives;
 - Develops project management tools; and
 - Oversees hurricane disaster planning and response.
- Resource Management:
 - Oversees MCS administrative budget and purchasing;
 - Tracks spending and manages Department IDs and financial forecasting; and
 - Supports staffing, Human Resources (HR) reviews, and contract negotiations.
- Internal Operations:
 - Coordinates cross-division operations and provides reporting including vacancy dashboards, CMS rules implementation, etc.;
 - Manages open records requests (ORR), records retention, MCS Continuity of Operations Plan, the MCS intranet, space planning, training compliance, and wireless device oversight;
 - Manages winter season disaster response; and
 - Leads implementation for large administrative and operational changes.
- Innovation and Process Improvement:
 - Manages audits and corrective action planning;
 - Facilitates audit governance and documentation; and
 - Leads process improvement and risk reduction efforts.
- Change Management Team:

- ▶ Drives the overall vision for internal staff engagement and oversees the new hire orientation, fellowship program, and targeted professional development;
- ▶ Advises on external communications strategy as part of the project planning process and supports development of various communication artifacts;
- ▶ Oversees the official MCO notice process and coordinates the bi-monthly MCO leadership meetings;
- ▶ Serves as quality reviewer for provider notices issued by agency contractor to ensure set guidelines are followed; and
- ▶ Acts as the Health and Human Services (HHS) Communication liaison, including streamlining requests for HHS Web Services team to ensure plain language and accessibility requirements are met.

C. Effectiveness and efficiency information:

For Program Effective Measures see Exhibit 2.

CMCSO demonstrates efficiency and effectiveness by driving ongoing process improvements and optimizing existing resources to manage increasing workloads. This includes streamlining workflows, eliminating inefficiencies, and leveraging technology to enable the team and overall division to do more with the same resources. Examples of these process improvement efforts include:

Example of volume increase year over year:

- Internal Operations: Increase of 40.3 percent ORRs with zero FTE growth

Examples of workload vs. resources:

- MCO Communications: One FTE reviews, processes, and publishes an average of 669 MCO Notices annually.

Effectiveness of staff engagement efforts:

- Per Survey of Employee Engagement (SEE) results, employee engagement increased by 17 percent between 2020 and 2024.

Example of process improvements:

- *ORRs:* Several process improvements to support the ORR process within MCS to allow for handling the increase in volume have been developed. This includes: 1) A quarterly dashboard to MCS leadership for the awareness of the volume of requests, the number of assignments their teams are receiving, and a summary of complex high-profile inquiries 2) Meetings with MCS ORR points of contact twice a year to provide refresher training for our staff, guidance on process changes, and discuss emerging issues 3) Standardizing the process for informing MCS leadership of high-profile requests prior to a response being issued; and
- *Technology:* Innovation and Process Improvement team partnered with Contract Administration and Provider Monitoring (CAPM) to develop a new system and process that transitions our HCBS waiver provider contracting from paper and makes the work process more efficient for providers and staff.

D. History:

2024: HHSC began receiving inquiries from the federal Civil Rights Office (CRO). Due to the complexity of these cases and the communications with federal Civil Rights, these cases typically take around six months to resolve.

2024: CMS Manage Care and Access Rules (see Section 2G for more details) compliance requires recurring, quarterly assessment of the existing 300 MCS webpages to identify updates necessary to adhere to federal rules. Updates include standardizing naming conventions, ensuring header consistency and operable links, validating content is current, and consolidating information to meet click requirements.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

Each area in CMCSO maintains various process and procedure documents. The functions vary considerably.

- CAT has major processes related to chief mailbox procedures, executive memo guides, and legislative reporting.
- Financial and Data Analysis has procedures for:

- ▶ Cost-related items that include reviewing MCS cost estimates for proposed legislation, developing internal proposals, and developing MCS exceptional item requests.
- ▶ Data related items that include reviewing responses to data use requests, ORRs, and other analysis produced by DAP or CFO Forecasting. All data projects for MCS go through a formal project proposal submission process for Data Governance and Performance Management (DGPM).
- PACT ensures projects are aligned with MCS strategic objectives through various forums that support the MCS Projects Portfolio which include:
 - ▶ Critical Projects (meets monthly). Reviews high priority projects that have significant impact to health care providers and members and fall in the category of high-profile projects as determined by leadership.
 - ▶ Readiness (meets bi-weekly). Reviews high priority projects approaching operational go live dates to evaluate whether teams are ready to operationalize on schedule.
 - ▶ Legislatively Mandated and Other Projects (meets quarterly). Reviews other projects that are important but generally have a lower risk profile.

Through these forums, PACT provides quarterly performance metrics to leadership and facilitates project updates to cover headlines, risks and issues, decisions needed, and stakeholder communications. All projects overseen by PACT follows the Project Management Institute (PMI) methodology for project management with Smartsheet as the technology leverage for tracking and reporting.

- Resource Management maintains HHSC processes related to Certified Accounting and Payroll Personnel System (CAPPS) Financials entry and HR policies. Internal processes are largely related to salary offer approvals, central mailbox management, and MCS reporting (admin budget, workforce, etc.).
- Innovation and Process Improvement maintains an MCS Audit Management Policy and Procedure Manual and tracking. Process improvement approaches follow a lean six-sigma method.
- While some of the Internal Operations functions involve ad hoc, special project-type work, there is a considerable amount that relies heavily on established processes. Most notably, the ORR process which involves coordination with ORR within the Office of the Chief Counsel (OCC), other HHS Chief areas, and internal MCS staff. Dependent upon the request, it may also involve MCS leadership review.

- Change Management maintains process documents related to submitting MCO notices, management of the MCS Communication Mailbox, external communication planning, and a variety of reoccurring project-based documents (i.e. development of the Texas Medicaid and CHIP Reference Guide).

Detailed process documents are available upon request.

G. Funding: See “Agency Program Information” spreadsheet.

H-I. MOUs and relationships with others: Not applicable.

J. Barriers and challenges:

Despite efforts to consolidate legislative reports, including submitting statutory initiatives, the volume of legislative reports remains high.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Medical Director’s Office

The Medical Director’s Office includes the clinical consultation and utilization review functions for the MCS division.

Office of the Medical Director and Utilization Review

A. Division or program information:

Name of division or program: MCS Office of the Medical Director & Utilization Review

Location within the agency: CMCSO

Contact Name: Dr. Ryan D. Van Ramshorst, Chief Medical Director

Statutory Citation: Texas Government Code, Chapter 533

B. Objective and major activities:

The Office of the Medical Director (OMD) is comprised of physicians, dentists, nurses, therapists, psychologists, and support staff who provide clinical consultation and oversee service utilization in both Medicaid managed care and FFS programs.

OMD works to align Medicaid and CHIP policy development with clinical best practices, standards of care, and population health initiatives. This is achieved through partnership with other state agencies (e.g. Department of State Health Services (DSHS) and external stakeholders, including provider associations.

Within OMD, service utilization oversight and clinical determinations are carried out through three primary areas:

1. Utilization Review (UR) – Conducts reviews to ensure services are medically necessary, appropriate, and delivered in accordance with program requirements. The UR area is further divided into:
 - Managed Care Utilization Review (MCUR): Includes the LTSS UR, Acute Care Utilization Review (ACUR), and Operations teams.
 - IDD/Hospice Utilization Review (IDD UR): Includes Waiver and Community Services (Field UR), IDD Waivers (Desk UR), Hospice UR, and Operations and Quality Assurance.

Core functions of the UR teams include:

- ▶ Ensures that individuals receive the appropriate type and amount of service and mitigates overutilization through utilization reviews;
- ▶ Ensures medically fragile individuals receive care coordination, transition support and, if appropriate, state-funded services needed to remain in the least restrictive setting;
- ▶ Determines eligibility for hospice payments to ensure providers comply with document requirements and rules;
- ▶ Provides clinical oversight of LTSS waiver programs delivered through Medicaid managed care to ensure contractual requirements are met with a focus on conducting assessments, service planning, service coordination and timely service delivery. LTSS UR conducts targeted reviews, as needed, based on feedback from internal and external stakeholders;
- ▶ Provides oversight of the IDD waiver and Community Attendant Services (CAS) programs to ensure services are timely and appropriately delivered and individual's health and safety concerns are being met;
- ▶ Monitors the member-level Prior Authorization Data Mart to ensure compliance with weekly submission and quality of MCO service authorization data; and

- ▶ Conducts the medical necessity and level of care (MN/LOC) assessments for STAR members applying for or currently receiving Community First Choice (CFC) services.
- 2. Medical and Utilization Review Appeals – Independently reviews provider appeals of claim denials based on medical necessity and adverse determinations from UR, audits by the Office of Inspector General (OIG) and other entities including the Recovery Audit Contractor.
- 3. Waiver Functional Eligibility Determination – Reviews assessments and determines functional eligibility for MDCP, ensuring members meet required medical necessity criteria for participation. Represents the agency for MDCP-related fair hearings.

Staff working in OMD and UR must have specialized knowledge including:

- Knowledge of medical, dental, and nursing practices and procedures, medical diagnosis procedures, and accepted medical treatment patterns;
- Knowledge of evidence-based guidelines and application to medical services;
- Knowledge of program population unique needs and the benefits available under each program; and
- Qualification as a Qualified Intellectual Disability Professional (QIDP) as defined in 42 CFR 483.430(a).

OMD also provides consultation to multiple agency councils and committees that are not solely Medicaid focused, including the Texas Diabetes Council and Sickle Cell Task Force. In addition, OMD provides clinical support to HHS areas inside and outside of MCS including Family Health Services, CFO Provider Finance, Regulatory Services Division, Appeals/Fair/Fraud Hearings, OIG, DFPS, Office of the Attorney General (OAG), and the U.S. Attorney's Office.

C. Effectiveness and efficiency information:

For Program Effective Measures see Exhibit 2.

OMD and UR show effectiveness and efficiency through the following:

Process and Program Improvement Examples:

- Designing and supporting the development of provider and hospice portals and enhancing existing applications. The hospice portal allows hospice

providers to submit information to Hospice Utilization Review electronically. This reduces the cost and administrative burden on both providers and the state for the mailing or faxing (and archiving) of packets that can be as large as thousands of pages; and

- Led a quality improvement project that increased the rate of well child visits for beneficiaries aged 0-15 months, the results of which were published in an online journal focused on Medicaid projects and research.

Cost Efficiencies:

- Estimated cost savings for IDD Desk and Field UR in fiscal year 2024: \$15,634,087.83.
- Estimated cost savings for IDD Hospice UR in fiscal year 2024: \$1,108,300.

D. History:

2004: CMS initiated a structured and transparent quality oversight process with states related to 1915(c) waiver programs. IDD UR was created to ensure the individual plan of care (IPC) services listed on the IPC plan are based on the individual's person-directed plan (PDP) and are the appropriate type and amount to ensure health and safety and ongoing community integration for the person receiving services. Hospice Utilization Review was also created and added in 2004.

2014: LTSS UR was established based on Senate Bill (S.B.) 348, 83rd Legislature, Regular Session, 2013. The legislative mandate established an UR process to determine whether a member's enrollment in the STAR+PLUS HCBS program is justified and supported.

2016: The ACUR team was established based on S.B. 8, 83rd Legislature, Regular Session, 2013. The legislative mandate ensures the provision of medically necessary clinical services and safeguards against overutilization as well.

2019: The MCUR Operations team was formed to centrally locate project management for all teams in MCUR. In 2021, the team expanded to include data analysts to capture review data, create database dashboards, and generate reports of review findings.

2020: LTSS UR expanded their annual reviews to include MDCP operated within the STAR Kids and STAR Health programs.

2021: LTSS UR incorporated targeted reviews in addition to the two annual waiver program reviews. These targeted reviews focused on personal attendant services, the Comprehensive Health Homes for Integrated Care (CHIC) Kids pilot program and STAR Kids members transitioning to adult programs.

2024: As a result of a CMS directive, OMD began conducting oversight of the functional eligibility determinations for the MDCP waiver program. The function was previously carried out by TMHP. This oversight includes clinical review, determination of medical necessity (MN), and issuing necessary communications to beneficiaries. OMD leaders and staff represent the Waiver Eligibility Unit in fair hearings. OMD clinical staff participating in the MN determination process include nurses, physicians, and administrative staff.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

Medical & UR Appeals:

- Reviews appeals submitted in response to adverse determinations made by several other entities. These determinations primarily are from the HHSC OIG Surveillance Utilization Review (SUR) and OIG's Recovery Audit Contractor (RAC) based on retrospective utilization reviews of FFS (mostly inpatient) claims paid to Medicaid providers. These appeal reviews consist of identifying medical necessity, coding accuracy, and quality of care issues. Less frequently, appeals are received for payment denials by TMHP for not meeting medical necessity criteria; and
- Communicates with providers for education about its appeal processes and common Medicaid policies used in determining final resolutions. Clinical staff also provide clinical consultations to support other areas of OMD and MCS, including MCUR, Managed Care Contract Oversight (MCCO), and Office of Policy. The unit provides clinical input to the Medical and Dental Benefits Policy (MDBP) unit to inform the policy development process.

OMD Waiver Unit:

- Conducts functional eligibility determinations for the MDCP waiver including clinical review, determination of MN, and issuing necessary communications to beneficiaries. Beneficiaries have the right to appeal the decision via the fair hearing process. OMD leaders and staff represent the OMD Waiver Unit in fair hearings.

Utilization Reviews:

For MCUR, the process of conducting URs across teams involves a planning period that includes creating a project charter and timeline; creating review tools, performance measures and system requirements specific to the review; training; and determining a sample methodology. UR meets with the MCOs to provide information about the review and request documentation and the following these meetings the review commences. At the conclusion of the review, preliminary reports of findings are sent to each reviewed MCO and the MCOs are allowed a rebuttal period to submit additional information for consideration before final reporting is completed. The reviews conclude with meetings with each MCO to walk through any concerns and to provide feedback and technical assistance. Finally, remedies, including corrective action plans (CAPs) and/or liquidated damages (LDs), are recommended for areas of non-compliance.

LTSS UR has 42 registered nurses who conduct desk reviews and member interviews. Many of the interviews are conducted in the member's home but may also be done audio-visually or telephonically. ACUR has 12 nurses, four therapists, and four behavioral health specialists who conduct desk reviews.

In IDD UR, Desk and Field UR teams complete level of need reviews and are tied to reimbursement rates for certain services in the HCS and TxHmL waiver programs. The Desk UR team reviews submissions where a change in Level of Need (LON) is being requested, or to ensure that a previously assigned level of need is still appropriate for the individual (especially for LON 9 individuals with life-threatening behaviors and enhanced supervision requirements). For submissions reviewed by the Desk UR team for LON, staff review information submitted in TMHP to support and justify the requested LON. For Field UR, the LON information is requested by support staff and then reviewed by an MCS psychologist. The review for Field UR includes both desk and in-person reviews. Providers can submit additional information for reconsideration prior to the initial decision and determination being implemented. If UR sustains the decision to reduce or not authorize the requested LON, the provider can submit a request for an administrative hearing.

Service proposals reviewed by the Desk UR team are made through TMHP or through the IDD Operations Portal and assigned to program specialist staff and nurses for review. Individual plans of care reviewed by Desk UR can be approved, denied, or reduced, while for DBMD, eligibility for the waiver can be approved or denied. For Field UR, submissions are requested by support staff and submitted to UR for review and can result in no change to service, reduction and denial of services, adding a service, or increasing a service. For all adverse action taken by

UR, the individual or legally authorized representative is offered appeal rights and can request a fair hearing and administrative hearing.

The Field UR team has 56 registered nurses and three program specialists who are assigned regionally across the state to conduct desk reviews and in-person interviews. Most of the interviews are conducted in the individual's residence but may also be done audio-visually or telephonically. Sample size is determined at a statewide random sample statistical calculation containing the size of the total statewide program population, the desired error level, and the desired level of confidence. The exception to this random sample is DBMD, which is a static random sample where the same number of individuals are pulled as part of the sample each year.

Hospice UR conducts retrospective desk reviews to determine a provider's eligibility for Medicaid payments based on compliance with state and federal documentation requirements. Outcomes from these reviews may result in recoupment of hospice payments. Appeal requests are handled by SOAH.

Table 3. Relevant processes provided in attachments.

File Name	Document Description
S7_CMSCO_OMD&UR_Att_01_ACUR_Clinical_Process_Maps	ACUR Clinical Process Maps
S7_CMSCO_OMD&UR_Att_02_LTSS_Review_Process_Map	LTSS Review Process Map
S7_CMSCO_OMD&UR_Att_03_Medically_Fragile_Process_Flow_Chart_3_2024	Medically Fragile Process Flow Chart 3_2024

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

Federal: OMD partners with federal agencies (CMS) to design and implement quality improvement projects focused on improving outcomes for Medicaid beneficiaries.

OIG: UR makes referrals to the OIG for any concerns related to fraud, waste or abuse.

DFPS: The Managed Care High Needs and Quality Assurance team coordinates with DFPS for individuals who receive private duty nursing and are transitioning to the STAR+PLUS or HCS program.

J. Barriers and challenges:

OMD has encountered the following operational challenges over the last two years:

- Challenge 1: Significant increase in fair hearing requests since fiscal year 2023 (+56 percent) and limited staff to manage the increased volume.
- Challenge 2: Limited technological and financial resources to address system inefficiencies. Technologies or systems needing enhancement include Salesforce applications (IDD Ops Portal, UMR, and Field UR), Hospice Power Platform applications (Provider Portal, Workload Management System), and Quality Assurance application (needs to be able to pull information quickly and accurately from all IT systems).
- Challenge 3: Challenges recruiting and retaining high quality clinical professionals due to limitations in salary, increased cost of living, and disparity in pay between current staff and newly hired staff. Limited compensation for staff in UR positions that require more experience and/or education than other positions with the same title in the agency (ex: IDD Field and Desk UR requires that program specialists, psychologist and nurses be QIDPs).

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Policy and Quality

The Policy and Quality DEC oversees the MCS Office of Policy and the Quality and Program Improvement units.

Office of Policy

A. Division or program information:

Name of division or program: Office of Policy

Location within the agency: CMCSO

Contact Name: Michelle Erwin, Deputy Associate Commissioner

Statutory Citation: Code of Federal Regulations Title 42, Texas Government Code Chapters 531 and 533, Texas Health and Safety Code Chapter 62

B. Objective and major activities:

Office of Policy develops and implements policies and procedures for Medicaid and CHIP programs and services in accordance with federal and state laws and regulations.

Key functions:

- Researches and analyzes state and federal requirements for Medicaid and CHIP and determines impacts to programs and services;
- Coordinates activities related to the Medicaid and CHIP state plans, Medicaid waivers, all MCS Texas Administrative Code rules, advisory committees, and federally recognized Indian tribes;
- Develops and manages the program policies for the 1915(c) and 1115 Medicaid waivers;
- Serves as the primary liaison with CMS for MCS;
- Develops and implements Medicaid FFS medical and dental benefit policies. This includes working with the FFS claims vendor to ensure policies are implemented in the system in accordance with the policy; and
- Manages program policy for Medicaid and CHIP acute services, LTSS services, and managed care programs. This includes amending MCO and DMO contracts to ensure MCOs are operationalizing requirements in accordance with the policy.

Other functions of this area include:

- Leads legislative coordination for MCS and conducts bill analysis during the Texas legislative session. During the interim, staff work on legislative reports and implementing legislation;
- Provides guidance and technical assistance to MCOs and DMOs, providers, FFS claims vendor, provider enrollment vendor, and other HHS areas when Medicaid and CHIP policies change in response to state and federal requirements, to align with medical or dental standards, and to make policy and program improvements;
- Responds to legislative and stakeholder information requests related to Medicaid and CHIP;

- Coordinates updates to interagency contracts (IACs) with DSHS for Medicaid and CHIP newborn screening testing, CHIP vaccines, Case Management for Children and Pregnant Women (CPW) services, and FFS Personal Care Services and CFC services;
- Manages the online provider education vendor and related website that provides educational opportunities for providers, including continuing education credits;
- Provides direction to DSHS regional staff who provide FFS Personal Care Services and CFC services to Medicaid FFS clients and who conduct THSteps provider relations activities on behalf of MCS;
- Manages federal Money Follows the Person (MFP) grant. This includes managing the overall budget, working with Behavioral Health Services and Community Services to allocate funding for projects in these departments, getting approval from CMS, and providing grant oversight for multiple non-Medicaid specific projects; and
- Provides staff support and serves as subject matter liaison for advisory committees and their subcommittees: State Medicaid Managed Care Advisory Committee (SMMCAC), IDD System Redesign Advisory Committee (IDD SRAC), and Medical Care Advisory Committee (MCAC).

While not specific to Medicaid or CHIP, Office of Policy also conducts other major activities:

- Manages policy for Title XX services including CAS, day activity and health services, and primary home care;
- Develops policy for non-Medicaid programs that help persons remain in their own home or their family's home, including Consumer Managed Personal Attendant Services (CMPAS) and Special Services to Persons with Disabilities (SSPD);
- Maintains sections in TAC that are not Medicaid-specific including sections on Day Activity and Health Services (DAHS), Adult Foster Care (AFC), and Home-Delivered Meals; and
- Responsible for policy sections in multiple provider handbooks that are not Medicaid-specific including DAHS and Emergency Response Services (ERS).

C. Effectiveness and efficiency information:

For Program Effective Measures see Exhibit 2.

Process Improvement Examples:

Office of Policy continuously improves the Medicaid benefit implementation process to ensure policies are medically appropriate, patient-centered, transparent, and based on the best available evidence. In 2015, MDBP unit implemented a [public Medicaid topic nomination process](#). In 2016, MDBP implemented an internal governance process to review potential new Medicaid benefits. Office of Policy continues to refine this process.

Effectiveness Statistics (fiscal year 2024):

- Conducted research to update or implement approximately 80 medical and dental benefit policies;
- Began the consideration process for approximately 30 topic nominations for changes to medical and dental benefit policies;
- Coordinated and held 52 advisory committee meetings;
- Developed, coordinated, and submitted approximately 210 SPAs, waiver amendments, and related deliverables to CMS;
- Oversaw the development for approximately 25 rule projects, completed 27 rules review, and 12 administrative rule transfers;
- Held approximately 73 standing policy meetings with Medicaid and CHIP MCOs and DMOs;
- Coordinated responses to over approximately 5,000 external emails from entities such as individual providers, provider associations, and MCOs; and
- During the 89th legislative session, completed over 870 bill analyses.

D. History:

Office of Policy manages program policy for all Medicaid and CHIP managed care programs. The transition of programs and services into managed care expanded and added complexities to the scope of work for this unit. For example, staff engage MCOs (15 CHIP MCOs and 16 Medicaid MCOs), DMOs (three DMOs), and SMMCAC when HHSC implements major Medicaid and CHIP policy changes. Engagement includes hosting transition calls with MCOs and DMOs, collaborating with MCOs and DMOs on new solutions and processes, drafting notices and communication materials, responding to MCO and DMO questions, and maintaining question and answer logs.

2016: Office of Policy experienced major organizational changes since the last Sunset review including incorporating new staff and functions related to 1) THSteps and Medicaid carved-out services formerly administered by DSHS; and 2) Medicaid waiver programs and LTSS services formerly administered by the Department of Aging and Disability Services (DADS). With these changes, the Office of Policy:

- Coordinates with DSHS THSteps provider relations state office and regional staff;
- Manages policy for CPW services, FFS THSteps Personal Care Services, and CFC services;
- Analyzes THSteps policy, including serving as THSteps clinical policy experts;
- Manages policy for Medicaid waiver programs: MDCP, TxHmL, DBMD, CLASS, and HCS;
- Manages Medicaid policy for community-based ICFs and nursing facilities;
- Manages policy for managed care aspects of the Medicaid delivery system;
- Manages policy for Medicaid Title XX services: CAS, DAHS, and primary home care;
- Manages policy for additional services such as hospice services and Consumer Directed Services; and
- Manages the MFP program.

Future changes that will impact functions include activities to comply with CMS final rules “Ensuring Access to Medicaid Services” and “Medicaid and CHIP Managed Care Access, Finance, and Quality” that became effective on July 9, 2024 (see Section 2G for more details). These rules require changes that will impact MCS, including, but not limited to, new reporting, new technology systems, advisory committee changes, and CHIP alignment with certain Medicaid rules. Updates to the Medicaid state plan, Medicaid waivers and program policy documents, including MCO contracts, will need to be made to reflect new rule requirements.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

Attachment 19 includes processes for creating new medical and dental benefit.

Other key Office of Policy processes include determining evidence of sufficiency, updating existing policies, developing or updating policies, and other core processes

related to program policy updates and changes for Medicaid and CHIP programs – largely with the outcome of contract amendments or handbook updates.

Legislative operations processes are designed to support Government and Stakeholder Relations (GSR) processes while ensuring a central standardized method to managing the division’s bill analysis.

Table 4. Office of Policy processes.

File Name	Document Description
S7 CMCSO Policy Att 01 Contract Amend. Process	Annual Contract Amendment Process
S7 CMCSO Policy Att 02 STAR Kids Handbook Process	STAR Kids Handbook Revision & Routing Process Document
S7 CMCSO Policy Att 03 STAR +PLUS Handbook Process	STAR+PLUS Handbook Routing Process Document
S7 CMCSO Policy Att 04 Determining Evidence Sufficiency	Determining Evidence Sufficiency – Guiding Questions
S7 CMCSO Policy Att 05 Medical Benefits Policy Development	Medical Benefits Policy Development Guidelines
S7 CMCSO Policy Att 06 New Benefit Creation Process Map	Medical/Dental Benefit Policy Development Work
S7 CMCSO Policy Att 07 Bill Analysis Checklist	Bill Analysis Process
S7 CMCSO Policy Att 08 Cost Estimate Checklist	Cost Estimate Process
S7 CMCSO Policy Att 10 SPA Workflow	Process and timeline for submitting a SPA to CMS
S7 CMCSO Policy Att 11 Medicaid Waiver Amendment Workflow	Process and timeline for submitting a Waiver Amendment to CMS

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

Federal: Communicates and coordinates with CMS on items such as:

- Medicaid and CHIP SPA submissions, CMS requests for additional information, and HHSC’s responses;

- Medicaid waiver amendment submissions, and CMS formal and informal questions and HHSC's responses;
- Clarifications requested by HHSC of new federal requirements;
- Updates from CMS of new federal requirements or upcoming activities;
- CMS reports like the CHIP annual report and 1115 Medicaid Demonstration waiver monitoring reports; and
- Regular and ad-hoc meetings with CMS.

Other State Agencies:

- Collaborates with DSHS Regional and Local Health Operations (RLHO) to provide program and policy guidance to DSHS regional staff about THSteps services, CPW services, FFS Personal Care Services, and CFC services. DSHS RLHO also informs Office of Policy of any concerns or issues from the DSHS regional offices and THSteps providers;
- Regularly coordinates with DSHS Laboratory staff and DSHS RLHO on amendments to IACs, including negotiating budgets, for Medicaid and CHIP newborn screening testing, CHIP vaccines, CPW provider training, and FFS Personal Care Services and CFC services;
- Meets with DSHS leadership and staff to provide major Medicaid and CHIP policy and program changes;
- Coordinates with DFPS to assess for any DFPS impacts when there are major policy and program changes impacting STAR Health members in state conservatorship;
- Regularly attends quarterly meetings for the Texas Department of Criminal Justice's (TDCJ) Correctional Managed Care Healthcare Committee. Policy staff participate as an ex-officio member;
- Shares program oversight functions of School Health and Related Services (SHARS) with Texas Education Agency (TEA). MDBP regularly communicates SHARS policy updates with TEA and education service centers; and
- Holds a monthly meeting with OIG to coordinate major policy changes and to provide policy guidance to OIG staff.

Regional: Regularly works with federally recognized tribes and tribal organizations located in Texas and Oklahoma to ensure they are informed of Medicaid and CHIP program updates impacting the tribes. Federal Coordination, Rules, and

Committees (FCRC) holds quarterly meetings with Texas' federally recognized tribes and tribal organizations and bi-monthly calls with Oklahoma and Texas federally recognized tribes in conjunction with CMS.

Local: Provides policy guidance about Medicaid and CHIP services, including behavioral health services, to local mental health authorities, local behavioral health authorities, local IDD authorities, and local health departments.

J. Barriers and challenges:

Over the last year, CMS issued multiple federal regulations and subsequent sub-regulatory guidance that require additional resources and attention to implement. At times, the implementation of federal regulations requires SPAs or waiver amendments that take several years for CMS to approve, which poses an administrative burden.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Quality and Program Improvement

A. Division or program information:

Name of division or program: Quality and Program Improvement

Location within the agency: CMCSO

Contact Name: Emily Sentilles, Deputy Associate Commissioner

Statutory Citation: Texas Government Code Chapter 543A; Texas Health and Safety Code Chapter 255

B. Objective and major activities:

Quality and Program Improvement (Q&PI) implements and manages programs to enhance quality in Medicaid and CHIP programs. This unit also drives the continued transformation from a volume-based system to a value-based system of care. The Q&PI team manages quality assurance tools, quality monitoring programs, incentive payment programs, and other performance improvement and value-based initiatives and consists of four teams:

Quality Assurance (QA) Team: The QA team evaluates and reports on Medicaid managed care health plan performance and oversees the state's EQRO contract and

deliverables. QA regularly engages managed care stakeholders, particularly MCOs, DMOs, and provider groups. QA oversees the following key initiatives:

- **Administrative Interviews:** EQRO conducts administrative interviews with each Medicaid and CHIP health plan at least every three years. The interviews help to assess MCO and DMO compliance with state standards for access to care, structure, and operations and gives QA a chance to have in-depth, one-on-one conversations with MCOs about quality improvement opportunities.
- **Appointment Availability Studies:** On behalf of HHSC, EQRO conducts direct monitoring of MCO provider networks including the length of time a recipient must wait between scheduling an appointment and receiving treatment from the provider. EQRO uses a mystery shopper method to assess the availability of appointments and responsiveness of provider office staff. The study includes four reports in the areas of behavioral health, prenatal, primary care, and vision. MCOs that do not meet minimum performance thresholds are subject to contract remedies, including CAPs and LDs.
- **Core Measure Reporting:** Each year Texas reports metrics for CMS Child and Adult Health Care Quality Core Measure Sets.
- **MCO Report Cards:** HHSC provides information on outcome and process measures to Medicaid and CHIP members regarding MCO performance during the enrollment process. To comply with state statute and the quality rating system required under federal rule, QA works with the EQRO to develop and publish report cards for each program service area. These report cards assist potential enrollees in selecting an MCO based on quality metrics. Report cards are updated annually, posted on the HHSC website, and included in Medicaid enrollment packets.
- **Pay-for-Quality (P4Q):** MCS' P4Q programs create financial incentives and disincentives based on MCO and DMO performance on priority quality measures. Currently, under P4Q, health plans can gain or lose up to 3 percent and dental plans up to 1.5 percent of capitation dependent on how they perform on these measures.
- **Performance Improvement Projects (PIPs):** EQRO evaluates PIPs from each MCO and DMO in accordance with state and federal regulations. Projects are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction.
- **Performance Indicator Dashboards:** Performance Indicator Dashboards include a series of measures for each Medicaid program that give a

comprehensive view of performance to support MCO accountability. Dashboard measures are benchmarked with high and minimum standards. MCOs falling below the minimum performance standard of 33.3 percent or more of the dashboard measures are subject to CAPs.

- Quality Assessment and Performance Improvement Programs (QAPI): Medicaid MCOs are required to operate QAPI programs that use objective quality standards, foster data-driven decision-making, and support programmatic improvements. MCOs report on QAPI programs each year, and these reports are evaluated by the EQRO.
- Quality Forum: HHSC hosts an Annual Quality Forum that brings agency, EQRO, MCO, DMO, and provider staff together to discuss opportunities for improving the quality of care for Medicaid and CHIP members. Past topics have included: maternal health, integration of behavioral health, alternative payment models and value-based payment, and best practices.
- Texas Managed Care Quality Strategy: HHSC is required to review and submit the Texas Managed Care Quality Strategy to CMS at least every three years.
- THLC: The [THLC portal](#) is a secure web portal developed for use by HHSC and Medicaid contractors to track performance data on key quality of care measures, including potentially preventable events (PPEs), Healthcare Effectiveness Data and Information Set (HEDIS) metrics, survey data, and other quality of care information. The portal provides results for the Performance Indicator Dashboards, P4Q Dashboard, CMS Core Measures, and hospital PPEs.

Quality Data Analytics and Reporting (QDAR) Team: QDAR is responsible for programs incentivizing quality improvement and alternative payment models, improving data exchange between Medicaid stakeholders, and navigating data systems for purposes of health care quality analysis and reporting. QDAR engages stakeholders from across healthcare fields to identify and address quality improvement opportunities in the Medicaid and CHIP programs. Below outlines QDAR functions and initiatives under their oversight:

- Advisory Committees: QDAR supports four advisory committees working to improve the quality and efficiency of Medicaid health care services and, in some cases, broader systems of care that are not Medicaid specific.

Medicaid-Specific

- ▶ The Value-Based Payment and Quality Improvement Advisory Committee promotes multi-stakeholder collaboration for quality improvement and value-based payment initiatives in Medicaid.

Not Medicaid-Specific

- ▶ The Palliative Care Interdisciplinary Advisory Council raises awareness and provides education and recommendations related to palliative care services available to people of any age and at any stage of a serious illness.
- ▶ The Perinatal Advisory Council recommends criteria for hospital neonatal and maternal care designations.
- ▶ The Policy Council for Children and Families works to improve Medicaid and other services for children and families with children who have a disability.
- Aligning Technology by Linking Interoperable Systems (ATLIS): ATLIS incentivizes MCOs to partner with hospitals and other providers, regional Health Information Exchanges (HIEs), and the Texas Health Services Authority's state-level shared services platform (HIETexas) to increase the interoperable exchange of electronic health information to advance quality and value in Medicaid.
- Alternative Payment Models (APMs): HHSC requires MCOs to link 50 percent of their provider payments to performance measures. MCOs must report on their APMs annually and demonstrate progress supporting and engaging providers to implement value-based payment approaches to address quality improvement priorities.
- Annual Report on Quality Measures and Value-Based Payments: HHSC must report annually on efforts to develop quality measurement and quality-based, or value-based, payment initiatives. The comprehensive report includes information on managed care value-based programs, quality improvement programs, trends in key quality measures, maternal health care improvement initiatives, and the state's early warning system for long-term care facilities.
- Cross-Agency Coordination on Healthcare Strategies and Measures: The 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session 2021, and 2024-25 General Appropriations Acts, H.B. 1, 88th Legislature, Regular Session 2023, requires five state agencies responsible for the health care of millions of Texans (DSHS, Employee Retirement System of Texas, HHSC, Teacher Retirement System of Texas (TRS), and

TDCJ) to coordinate data analyses to identify potential efficiencies and quality improvements.

- Federal Waiver Monitoring Reports: QDAR's Quality Reporting Unit (QRU) oversees detailed federally required reporting for the 1115 Transformation Waiver and six 1915(c) HCBS waiver programs. Reporting is quarterly and annual for both the 1115 waiver and the 1915(c) programs. As part of these responsibilities, the unit is implementing the new, federally required HCBS Quality Measure Set. Waiver quality measures are comprehensive and compiled or calculated from a variety of sources across DSHS, DFPS, and HHSC. QRU tracks and reports on approximately 200 waiver metrics in total.
- HIE Connectivity Project and Biennial HIE Legislative Report: The HIE Connectivity Project aims to improve care coordination and health outcomes for Medicaid beneficiaries by increasing interoperability and the meaningful use of electronic health information. Every biennium, the HIE team releases a comprehensive legislative report assessing progress toward ensuring the interoperability of HHS information systems.
- Hospital Quality-Based Payment Program (HQBPP): HQBPP incentivizes hospitals and MCOs to improve rates of potentially preventable readmissions (PPR) and potentially preventable complications. Hospitals that perform poorly on one or both measures relative to the state norm are subject to a payment rate reduction. For FFS, HHSC makes reimbursement adjustments directly to inpatient hospital payments. For managed care programs, HHSC builds the adjustments into MCO capitation payments. MCOs typically pass rate reductions to hospitals as part of their APMs.
- Pediatric Therapy Monitoring: QDAR collects and reports data from providers and MCOs and publishes a required semi-annual report assessing member access to pediatric acute care therapy services (including physical, occupational, and speech therapies).
- VBE: VBE incorporates quality and value-based metrics into Medicaid's auto enrollment process so that higher performing MCOs receive a greater share of enrollment among individuals who do not self-select a health plan.

For more details on Texas Medicaid and CHIP quality programs see Chapter 3 (pages 65 – 71) of the [Texas Medicaid and CHIP Reference Guide \(15th edition\)](#)

The Quality Monitoring Program (QMP) Team: QMP helps improve conditions in Texas nursing facilities that could be detrimental to the health, safety, and welfare

of residents. QMP is not a regulatory program, and quality monitors (QM) do not cite deficient practices.

QMP's work to improve nursing facility quality benefits for both Medicaid and non-Medicaid residents. However, over 95 percent of nursing facilities visited or otherwise supported by QMP are Medicaid-certified, and two important QMP functions are Medicaid specific: the Minimum Performance Standards (MPS) program and QMP's nursing facility Preadmission Screening and Resident Review (PASRR) team as (described below).

The functions performed by QMP require specialized education and extensive experience in long-term care. QMP requires the following:

- Registered Nurses with a current Texas Registered Nurse license;
- Registered Dietitian with a current Texas Dietitian License;
- QIDP; and
- Registered Pharmacist with a Texas Registered Pharmacist license.

QMP has two units:

Program Development and Innovation Unit (PDIU): Serves largely as the operations unit of QMP by overseeing legislative reporting, facilitating grant-funded interventional projects, collaborating on nursing facility rules projects, managing the QMP shared mailbox and webpage, representing QMP on various workgroups, and conducting contract management.

Another core function of PDIU is developing evidence-based best practices (EBBP) focus areas for QMP field staff. Below is a summary of related initiatives.

- Clinical Focus Area Development: PDIU clinical staff improve nursing facility quality of care by developing clinical focus area resources using EBBP data and general best practice frameworks. The purpose of clinical focus area development is to create and update resources and guidance for use by quality monitoring staff and nursing facility providers.
- Center of Excellence in Long-Term Care (COE): PDIU manages the COE contract with the University of Texas at Austin School of Nursing (UTSON). COE is a web-based continuing education platform, which has been developed and hosted with UTSON since 2016. COE training modules provide best practices to nurses, LTC administrators, and nurse aides who serve older adults and people with disabilities.

- Annual Quality in Long-Term Care Conference (QLTCC): PDIU hosts this two-day conference in collaboration with the University of Texas at Austin's Office of Professional Development, Steve Hicks School of Social Work. The QLTCC focuses on advancing quality in LTC by providing clinical and social information related to the care of older adults and those with dementia-related conditions in nursing communities.
- MPS: PDIU oversees the STAR+PLUS nursing facility MPS. HHSC worked with stakeholders to select Minimum Data Set measures and performance thresholds for nursing facilities for the MPS program. Nursing facilities that do not meet the minimum performance over time may be required to initiate certain corrective actions and could be subject to non-renewal of managed care contracts. HHSC published the MPS measures and HHSC-established benchmarks on the HHSC website.

Quality Monitoring Unit (QMU): The second unit with QMP is comprised of nurses, dietitians and pharmacists, and is responsible for PASRR. Core functions are to conduct NF system reviews, including mandated federal and state PASRR regulations, provide technical assistance on evidence-based best practices, and offer in-service and training opportunities. QMU collaborates with PDIU on focus area development and priorities. Below is a summary various types of nursing facility visits and related initiatives.

- Early Warning System (EWS): The EWS model uses information from multiple sources to predict the risk that a nursing facility will perform poorly during an HHS Long-Term Care Regulatory Inspection and Survey. Nursing facilities with EWS scores that indicate the highest risk will generally be scheduled for a Rapid Response Team (RRT) visit, while nursing facilities at moderate to high risk receive quality monitoring visits, conducted by a single QM.

Quality monitoring visits are conducted by individual QMs to evaluate a facility's system of care in specific clinical areas and provide technical assistance to assist the facility in the improvement of those systems. QMP staff are prohibited from helping prepare a regulatory services survey or participating as part of a plan of correction.

- RRT Visits: QMP conducts RRT visits based on high risk identified through EWS scores and violations of the three-strike rule. The three-strike rule occurs when a facility receives three citations in a 24-month period, and those citations are determined to constitute an immediate threat to the health and safety of a resident(s), related to abuse and/or neglect.

RRT visits are conducted in an atmosphere that encourages learning and team building; however, facilities are required by statute to cooperate with the RRT to improve the quality of care provided to residents. RRT visits can also be completed at the request of the provider or HHSC Regulatory Services department.

- Technical Assistance and In-service Visits: QMs provide technical assistance and in-service educational presentations to nursing facility staff, offering evidence-based information interactively. The information provided is used to stimulate collaboration for quality improvement.
- PASRR Visits: Ensure all nursing facility residents are thoroughly evaluated, are placed in nursing facilities only when it is appropriate and ensure persons with IDD and severe mental illness (MI) have been appropriately screened and evaluated. PASRR monitors also ensure persons with IDD and MI are placed in the least restrictive residential setting to meet their overall physical, mental, and psychosocial needs, and that they receive the specialized services needed to maximize their potential.

4. Delivery System Quality & Innovation (DSQI) Team: DSQI works on a wide spectrum of quality-related initiatives. DSQI staff must be familiar with healthcare quality measurement and evaluation.

- DPP: DPPs are designed to help Medicaid managed care programs achieve delivery system and payment reform and performance improvement.

The programs are approved by CMS annually or every three years, depending on the program. DSQI manages the quality aspects of the DPPs, which includes developing quality program requirements, selecting measures appropriate and meaningful for the respective providers, and reviewing all reported performance. The financial aspects are managed by CFO Provider Finance.

DPPs allow states to set parameters for Medicaid managed care spending to help achieve their overall goal of delivery system and payment reform and improved performance. Specifically, a state is permitted to direct Medicaid MCOs to make certain payments to healthcare providers, either through an adjustment to the monthly base capitation rates or through a separate payment term.

The current DPPs are:

- ▶ CHIRP for hospitals;

- DPP-BHS for community mental health centers and local behavioral health authorities;
- RAPPS for rural health clinics;
- TIPPS for physician groups; and
- QIPP for nursing facilities.

For more details on Texas Medicaid DPP programs see:

- Chapter 4 (pages 102-103) of the [Texas Medicaid and CHIP Reference Guide \(15th edition\)](#)
- Pages 39-46 of the [CFO Reference Guide: An Overview of Key Financial Topics](#)

Non-Medical Drivers of Health (NMDOH) Action Plan: NMDOH are the conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. The action plan was published on the [HHSC NMDOH webpage](#) in February 2023.

Non-medical Needs Screening of Pregnant Women: As directed by the legislature, HHSC adopted standardized screening questions that Medicaid MCOs and Thriving Texas Families service providers and subcontractors must use to screen all consenting pregnant women for non-medical needs, coordinate services and referrals, and report the results to HHSC.

DSQI is now program lead in the operational phase of this project. This includes working with HHSC's data analytics team and MCCO teams in reviewing the screening reports submitted by MCOs. DSQI leads development of the [required reporting](#).

Reducing Preventable Emergency Department Utilization: DSQI reports data on potentially preventable emergency department visits (PPVs), and HHSC initiatives to reduce PPVs, improve health outcomes, and engage stakeholders and providers that receive uncompensated care compensation.

Maternal Opioid Misuse Model (MOM): In 2019, the Texas Legislature, through S.B. 750, 86th Legislature, Regular Session, directed HHSC to apply for Center for Medicare and Medicaid Innovation (CMMI) funding to address the state's high rate of maternal morbidity and mortality. Funding for the MOM model was awarded in 2020. The MOM model is a service delivery model that aims to improve the quality of care and reduce costs for pregnant and postpartum Medicaid beneficiaries with opioid use disorder.

HHSC partners with the Harris Health System, Baylor College of Medicine, Santa Maria Hostel, and the Patient Care Intervention Center to implement the MOM model at a centralized clinic in Harris Health System's Ben Taub Hospital to serve beneficiaries from the greater Houston area. In addition to the traditional package of prenatal and postpartum services provided by Medicaid, women receive intensive care coordination, engagement, and treatment referral services.

As of September 2024, 107 Medicaid beneficiaries have received services through this model.

C. Effectiveness and efficiency information:

For Program Effective Measures see Exhibit 2.

Staff oversee the \$14 million annual EQRO contract, reviewing more than 250 deliverables each fiscal year. Staff saved \$397,152.51 in general revenue in fiscal year 2024 identifying opportunities to obtain more federal match by reclassifying deliverables. Staff also oversee more than 100 MCO and DMO performance improvement projects and have responded to 65 technical assistance requests on PIPs alone in fiscal year 2024.

These efforts have made a difference in advancing managed care quality. In the 2024 Annual Technical Report, Texas' EQRO concluded, "Several quality indicators for fiscal year 2024 exceeded national benchmarks, including well-childcare and access to care for adults enrolled in STAR+PLUS. Additionally, Texas Medicaid performed near national averages in mental health quality measures, with increasing utilization of telehealth and telemedicine for behavioral health, improved rates of follow-up care, and higher compliance with appointment availability standards. Maternal health outcomes also saw improvement, with significant reductions in maternal morbidity rates. Improvements in return rates of records used to validate the completeness and accuracy of encounter data facilitated more comprehensive program evaluation. Beyond these specific areas, several MCOs achieved statistically significant improvements in targeted PIPs, particularly within the STAR+PLUS and STAR Kids programs."

In medical P4Q, \$51 million was recouped and redistributed in fiscal year 2022. In fiscal years 2022-23 improvements were made on the following P4Q measures:

- CHIP on Weight Assessment and Counseling for Nutrition and Physical Activity (WCC);

- STAR on Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD_ Medication (ADD) – Initiation Phase and Prenatal and Postpartum Care – Postpartum;
- STAR+PLUS on Hemoglobin A1c Control for Patients with Diabetes- HbA1C <8 percent (HBD) and PPRs; and
- STAR Kids on Help with Care Coordination.

Q&PI also helped catalyze the Medicaid program's transformation to value. The state's APM initiative, encouraging MCOs to push incentives to the provider level, launched at about the same time Q&PI was formed. Initially, MCO use of APMs that connect a portion of provider reimbursement to performance was limited. But, as of fiscal year 2022, every MCO has adopted a full portfolio of APMs, and the percentage of provider payments connected to value for Medicaid stands near the state's goal of 50 percent.

Q&PI further engages providers through five DPPs. To gain CMS approval, DPPs must advance Texas Medicaid quality goals. Thus, quality measure reporting and now, even some emerging pay for performance in DPPs has allowed Texas providers to draw down billions in federal funds each year (including approximately \$5.5 billion for fiscal year 2025) that are critical for Medicaid provider financial stability and member access to care.

The most recent evaluation of CHIRP, TIPPS, RAPPS, and DPP-BHS indicates these DPPs are impacting provider quality in a positive direction as well, finding:

- The state is making clear progress in meeting four (of five) evaluated quality strategy goals of the Texas Managed Care Quality Strategy (note, the Quality Strategy has since been revised to include a total of four strategies);
- Many key measures are showing progress, as 15 of the 24 provider-reported program-specific evaluation measures have improved; and
- Many providers are now engaging in NMDOH screening and follow-up planning for food, housing, and transportation needs. There were also increases in care coordination planning, health information exchange, and integrated physical and behavioral health.

Among the DPP success stories is nursing facility quality, as measured through the QIPP program. For the most recent year of the QIPP evaluation, seven measures reported through QIPP had already met or exceeded the goals of DPP, four other measures were improving, and two had declined.

Q&PI's QMP program supports nursing facility quality improvement by identifying facilities at risk for low performance, conducting site visits to these at-risk facilities, and offering educational opportunities to professionals who work in nursing and other LTC facilities. During fiscal year 2024, QMP conducted 1,231 QM visits and 359 rapid response visits to at risk facilities.

Between calendar years 2014 and 2020, QMP also led initiatives to support reducing the use of antipsychotics in nursing homes. According to National Partnership Data, in the 3rd quarter of 2014, Texas was 50th in the nation for antipsychotic use in nursing homes (prevalence of prescribed antipsychotics 24.56 percent). By the 4th Quarter of 2023, Texas was 2nd in the nation (prevalence of prescribed antipsychotics 8.9 percent).

D. History:

2014-2015: Q&PI was formed during the agency transformation resulting from the last Sunset review. That transformation process consolidated quality improvement and value-based work having a significant impact on Medicaid. Prior to transformation, the four distinct offices that now comprise Q&PI operated in a somewhat siloed environment, each with different executive level leadership. Over time, these teams, in their new structure, have integrated, and Q&PI (and thus Quality), under the leadership of its deputy associate commissioner, has gained a distinct and recognizable identity within the Medicaid program.

In the last five years, HHSC secured a new 1115 Medicaid Waiver, which ended the Delivery System Reform Incentive Payment program, and those dollars and certain quality aspects were transitioned into DPP programs. Q&PI has also made significant changes to DPPs to incorporate more pay-for-performance with providers and received approval from CMS for a 3-year value-based DPP program (QIPP). The team launched a new MCO incentive program, ATLIS, to drive health information exchange; updated MCO APM contractual requirements; and launched the NMDOH Action Plan, among other ongoing work to oversee quality improvement.

2021: H.B. 2658, 87th Legislature, Regular Session, 2021, directed HHSC to adopt rules establishing MPS for nursing facility providers participating in the STAR+PLUS Medicaid managed care program; monitor provider performance in accordance with the standards; and require corrective action, as HHSC determines necessary. The bill also required HHSC to share program data with STAR+PLUS Medicaid MCOs, and MCOs may act on that data as appropriate.

2024: Significant changes in federal rules governing many quality programs were finalized. The team analyzed the rules for impact on Q&PI programs and is working through required changes and implementation timelines. The rules add reporting of new federal home and community-based services' measures and create an MCO Quality Rating System to communicate health plan performance to members (similar to current MCO report cards), among other requirements. See Section 2G for more details.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

All areas of QPI maintain written standard operating procedures or similar documentation for major projects.

Table 5. QPI processes.

File Name	Document Description
S7_CMCSO_Q&PI_Att_01_HEDIS & Quality of Care Process	HEDIS/Quality of Care Process and Timeline
S7_CMCSO_Q&PI_Att_02_1115 Monitoring Report Process	1115 Monitoring Report Development Process
S7_CMCSO_Q&PI_Att_03_National Core Indicator Timelines	National Core Indicators (NCI) Survey Activities
S7_CMCSO_Q&PI_Att_04_Min. Perf. Standards Processes	HHSC Internal Minimum Performance Standards Operational Plan
S7_CMCSO_Q&PI_Att_05_Quality Monitoring Focus Area Processes	QM Focus Area Development, Review and Revisions
S7_CMCSO_Q&PI_Att_06_Quality Monitoring Visits Processes	Quality Monitoring Overview and Visit Process
S7_CMCSO_Q&PI_Att_07_Rapid Response Team Procedure	Rapid Response Team Policy and Procedure

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

CMS: Reviews programs and deliverables for key Q&PI functions, including DPPs, the HIE Connectivity Project, and the state's Medicaid Managed Care Quality Strategy. Q&PI routinely submits quality measure results and reports to CMS.

CMS innovation center, CMMI, DFPS, and Harris Health: Operate the MOM model demonstration in Texas. Q&PI maintains a contract to administer the MOM model with Harris Health, a governmental entity that owns and operates three hospitals and numerous clinics throughout Harris County. Q&PI also has a cooperative agreement with CMMI.

Agency for Healthcare Research and Quality: Second federal agency that serves as a measure steward for Consumer Assessment of Healthcare Providers and Systems surveys.

Texas Health Services Authority: A quasi-governmental entity established by the Texas Legislature to support statewide health information exchange, holds contracts with HHSC and works with Q&PI's HIE team, with additional collaboration from regional HIEs, to advance Medicaid HIE connectivity strategies.

The Center for Health Care Data at the University of Texas Health Science Center at Houston (Center): Facilitates HHSC's Cross Agency Coordination on Healthcare Strategies and Measures project involving four other agencies, DSHS, ERS, TRS, and TDCJ. Staff from the five agencies meet regularly with the Center and publish a biennial legislative report. The program operates under a contract with the Center. The Center also maintains the state's All Payor Claims Database (APCD). Q&PI currently represents Medicaid on the APCD stakeholder advisory group.

DSHS: Q&PI staff collaborate on projects involving the exchange of data and subject matter expertise on the Medicaid program, general health care quality, patient safety, and to advance the state's public health goals. Q&PI staff also represent Medicaid on the Texas Statewide Health Coordinating Council administered by DSHS.

J. Barriers and challenges:

- Challenge 1, Data Access: Though Texas, like the nation, has made progress with provider adoption of electronic health records' systems, standards-based exchange and meaningful use of electronic data, particularly through the state's federated system of regional HIEs and HIETexas, remains fragmented, impeding the state health systems and Medicaid's potential to conduct quality improvement initiatives and implement more advanced APMs. Currently, data available to calculate quality and value-based metrics are often 18-24 months old, limiting timely feedback on performance to providers and MCOs. Greater access to data through HIEs could reduce the length of quality improvement cycles. Clinical data needed to measure

outcomes, rather than processes, also remains difficult to obtain. Texas is not positioned for full industry transition to digital quality measurement by 2030, as expected by CMS and the National Committee for Quality Assurance, the measure steward for HEDIS, the backbone for many of the state's managed care quality initiatives. Each year the state's EQRO provides recommendations to make advances in this space. The ability to implement these recommendations is dependent on system capabilities, associated resources and existing authority.

- Challenge 2, 'Hard to Fill' Positions: Q&PI performs specialized functions, and positions can be difficult to fill, especially those with clinical or advanced data analysis requirements. For example, Q&PI has been forced to reduce QMP nursing positions to raise salaries for the remaining positions to a competitive level. QMP also experiences shortages of dietician and pharmacy positions. Fewer clinical staff ultimately translates into a reduction in QM visits and technical assistance to nursing facilities.
- Challenge 3, Non-Medicaid Activities: One legacy of past reorganizations is that Medicaid staff lead and manage non-Medicaid projects and reports. Q&PI invests significant staff resources to support three non-Medicaid advisory committees, the Perinatal Advisory Council, the Palliative Care Interdisciplinary Advisory Council and the Policy Council, originally managed outside of MCS. These committees perform essential functions for HHS and the state but may be more effective if housed with better aligned HHS areas with MCS collaboration as needed. Likewise, at least one comprehensive legislative report developed by Q&PI, "Interoperability for Texas: Powering Health," deals more with broader IT systems and projects than with the exchange of health information among Texas Medicaid stakeholders.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Operations

The Operations DEC area within MCS includes the following units: IDD Program Eligibility and Support (IDD PES), Operations Management, Medicaid Technology Modernization (MTM), and the Vendor Drug Program (VDP).

IDD Program Eligibility and Support

A. Division or program information:

Name of division or program: IDD PES

Location within the agency: CMCSO

Contact Name: Fabian Aguirre, Director

Statutory Citation: Not applicable

B. Objective and major activities:

IDD PES includes a licensed psychologist, QIDPs, and support staff who authorize diagnostic and functional eligibility and oversees enrollment of individuals in certain FFS programs. IDD PES:

- Provides programmatic eligibility, including LOC authorization, and enrollment of individuals into the following FFS 1915(c) Medicaid waiver programs:
 - HCS
 - TxHmL
 - CLASS
- Authorizes LOC for the following FFS non-waiver programs:
 - ICF/IIDs
 - State Support Living Centers (SSLCs)
 - CFC non-waiver
- Processes the transfer of HCS, TxHmL, and CLASS program services between contracted providers;
- Authorizes the termination of HCS, TxHmL, and CLASS program services; and
- Monitors suspension of HCS, TxHmL, and CLASS program services.

C. Effectiveness and efficiency information:

For Program Effective Measures see Exhibit 2.

In April 2019, in collaboration with IDD Utilization Review, IDD PES successfully launched the IDD Operations Portal. This application allowed external users to electronically submit and receive documents from internal users, significantly enhancing the tracking and processing of forms.

Between May 2022 and August 2023, IDD PES led a project focused on system enhancements for HCS and TxHmL. These enhancements, related to the Client Assignment and Registration (CARE) system to TMHP system migration, significantly improved form submission and system functionality. Pending forms for the waiver programs reduced 50 percent because of the enhancements. IDD PES continues to efficiently process forms in this system as the total population across the waivers increases. From fiscal year 2020 to fiscal year 2024, the HCS and CLASS waiver programs have experienced a 17 percent increase in the number of individuals served.

D. History:

2016: Consolidating DADS led to the division of Program Enrollment and UR into two distinct areas within MCS. IDD PES is primarily responsible for verifying eligibility, processing enrollments, and providing support for transfers, suspensions, and terminations.

2022: IDD PES functions expand in scope and complexity due to the HCS/TxHmL Forms and Claims Migration project. This project involved the transfer of eight forms and claims processing from CARE to the TMHP Long Term Care Online Portal (LTCOP).

2025: IDD PES incorporated DBMD form processing into its scope of work. This additional scope promotes consistency in forms processing across IDD waiver programs.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

IDD PES core processes center around:

- Workflow of Activities: The process for which IDD PES reviews and processes forms waiver programs;
- TMHP LTCOP: LTCOP is an online platform for both external and internal users to efficiently complete necessary forms for HCS and TxHmL programs. Additionally, LTCOP facilitates the processing of forms for the ICF/IID program. IDD PES maintains comprehensive instructions for processing all forms associated with HCS and TxHmL, and it is comparable to the user guide for the ICF/IID program; and
- IDD Operations Portal: The IDD Operations Portal is an online application in the Salesforce platform used by external and internal users to efficiently

transmit forms and supporting documentation for CLASS, DBMD, HCS, TxHmL, ICF/IID, and CFC Non-Waiver. IDD PES maintains comprehensive instructions for transmitting forms and supporting documentation associated with various programs.

Table 6. IDD PES processes.

File Name	Document Description
S7_CMCSO_IDD_PES_Att_01_CLASS_Enrollment	CLASS Enrollment Workflow

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

Local intellectual and developmental disability authorities (LIDDAs): LIDDAs are quasi-governmental entities designated by HHSC to serve as the primary point of contact for individuals with IDD. LIDDAs provide, or contract to provide, an array of services and supports for individuals with IDD. There are 39 LIDDAs in Texas. LIDDAs are responsible for:

- Enrolling eligible individuals into the following Medicaid programs: ICF/IID (including SSLCs), HCS, and TxHmL; and
- Permanency Planning for individuals under 22 years of age who live in an ICF/IID, SSLC, or a residential setting of the HCS Program.

J. Barriers and challenges:

- Challenge 1: A significant portion of IDD PES activities relies on the compliance of external partners adhering to the Texas Administrative Code and the guidelines outlined in HHSC Handbooks. IDD PES cannot process enrollments, transfers, or terminations until the necessary forms and documentation have been submitted for review. Upon receipt of these forms and documents, IDD PES verifies all required information is complete and accurate prior to processing. If any documents contain inaccuracies, they will be returned to the submitter for correction and delay the processing of forms.
- Challenge 2: For individuals with IDD to access Medicaid services, they must also be financially eligible for Medicaid. Delays in determining eligibility, as

well as the potential loss of Medicaid, create significant obstacles in the processing of forms and delivery of services to clients.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Medicaid Technology Modernization

A. Division or program information:

Name of division or program: MTM

Location within the agency: CMCSO

Contact Name: Michael Lopez, Deputy Executive Commissioner, Operations

Statutory Citation: Not applicable

B. Objective and major activities:

The MTM team is focused on strategies that align with CMS direction to replace the older, inflexible, monolithic single-system MMIS (Medicaid Management Information System) with MES (Medicaid Enterprise Systems)—a modern, modular, and interoperable approach. These efforts also support state and agency goals to deliver cost-effective technology and business process innovations that improve customer service.

The major functions:

- Modernizing by replacing or upgrading over 30 legacy applications including those used for provider management, data integration, and claims management;
- Implementing modernization efforts in compliance with the CMS Medicaid Information Technology Architecture framework, as required by Seven Conditions and Standards for Enhanced Funding; and
- Enhancing staff productivity via a high degree of automation to improve operational efficiency and user experience.

In addition to Medicaid and CHIP, several other non-Medicaid programs and state agencies rely on MES, which requires ongoing coordination. They include:

Non-Medicaid Programs

- Children with Special Health Care Needs (CSHCN)
- Family Planning Program (FPP)
- Medical Assistance Only (MAO) State Paid
- Former Foster Care in Higher Education (FFCHE)
- Foster Care, State Paid
- Permanency Care Assistance (PCA)
- Adoptive Assistance
- State Paid Adoption Subsidy
- Rehab Services Substance Use
- County Indigent Health Care Program (CIHCP)
- Kidney Health Care (KHC)
- Behavioral Health (BH)
- Primary Health Care (PHC) Program
- Expanded Primary Health Care (EPHC) Program
- Breast and Cervical Cancer Services Program
- Title XX Family Care
- Guardianship

Other State Agencies

- Comptroller of Public Accounts (CPA) – to pay long term care FFS claims that have been processed by TMHP
 - HHSC’s Accounting Department and systems interface with Comptroller of Public Accounts (CPA) to make payments based on claims approved by TMHP
- OIG and OAG - to investigate fraud, waste and abuse

The various modernization efforts are led by the agency MES Modernization Workgroup under the guidance and supervision of the agency MES Modernization Executive Steering Committee (ESC).

C. Effectiveness and efficiency information:

For Program Effective Measures see Exhibit 2.

HHSC transitioned away from a single MES vendor in September 2023 to include AMD and Business Operations and Business Integration (Bus Ops). The AMD and Bus Ops contracts are now in the operations phase. HHSC also transitioned most state-owned MES applications into state-owned data centers operated by the Texas Department of Information Resources.

D. History:

2009: In compliance with the Health Information Technology for Economic and Clinical Health Act, HHSC developed strategies to incentivize the adoption and use of health information technology and promote the establishment of HIE in Texas. MTM led the implementation of the HIE Connectivity Project and Patient Unified Lookup System for Emergencies (PULSE) through partnerships with the Texas Health Services Authority and local HIE organizations.

Ongoing management and operation of the HIE Connectivity and PULSE capabilities is now transitioned to the Q&PI area in MCS.

2016: CMS directed states to modernize their Medicaid Management Information Systems (MMIS). In response, HHSC developed a strategy to procure three separate contracts to three different vendors to transition Texas' single, vendor supported MMIS into modular contracts, with each contract established for different base contract durations.

2022:

- Bus Ops contract was awarded to Accenture State Healthcare Services, LLC and executed on December 2, 2022.
- AMD contract was awarded to Deloitte Consulting, LLP and executed on November 29, 2022.
- Claims Processing and Adjudication and Financial Services (Claims) contract was awarded to Conduent State Healthcare, LLC and executed on December 5, 2022.

2024: HHSC terminated its claims contract with Conduent State Healthcare, LLC for convenience. Since the 2015 merger of DADS and Department of Assistive and Rehabilitative Services (DARS) into HHSC, Texas has been using two separate, inherited sets of business processes to handle claims adjudication — one for acute care and another for long-term care. Moving to an outsourced "claims-as-a-service" platform requires replacing those separate processes with a single, unified system that can handle both types of care.

Like many other states, Texas still uses an outdated legacy system for processing claims. These systems were built in the late 1990s and early 2000s and rely on custom, state-specific code to reflect program policies and rules. The new outsourced platform, however, needs to use standardized national code sets instead.

During planning and implementation sessions, HHSC realized that updating and aligning all business processes and codes was more complex than expected. Neither HHSC nor its vendors could complete this work in the short timeline needed to meet the planned transition date.

Current efforts to address these issues include:

- Replacing local Texas-specific codes with national standard codes; and
- Separating non-claims-related functions from the existing claims system.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

MTM uses an established governance process to review and approve various modernization efforts. The governance process includes a cross-functional MES Modernization Leadership Team and reports to the MES Modernization ESC. These efforts are monitored by the MES Modernization ESC. The status and progress made are also reported to the Texas Quality Assurance Team (QAT) as well as to CMS.

MTM uses a roadmap of the proposed and in-progress modernization efforts to plan, schedule, and execute the efforts. Each of the modernization efforts is executed by an appropriate software lifecycle development cycle (SDLC) methodology. In most instances, the projects are executed using the Scaled Agile Framework methodology. The processes for the identification, monitoring, and response to risks and issues are built into the SDLC methodologies. Quality of the project is ensured via numerous checks and balances by the various stakeholders involved in the workgroup; reporting and monitoring by the steering committees aforementioned; and Procurement and Contracting Services (PCS) and legal reviews and participation.

Table 7. MTM processes.

File Name	Document Description
S7_CMSCO_MTM_Att_01_MES_Modernization-Governance Charter v1.1	MES Modernization-Governance Charter v1.1

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

The modernization efforts initiated by the MTM team are supported by federal financial participation from CMS and monitored by Texas QAT.

Texas QAT is comprised of LBB, DIR, SAO, and CPA. MTM collaborates with IT to report on project status to QAT under the requirements of Rider 6, 2024-25 General Appropriations Acts, H.B. 1, 88th Legislature, Regular Session 2023.

J. Barriers and challenges:

- Challenge 1, Complexity of Transition: During the transition into the Claims Adjudication and Financial Services contract scheduled for completion by November 30, 2024, HHSC discovered the need to implement a system-wide business process re-alignment and certain technology components to ensure a successful transition into a more modular MES ecosystem and has initiated efforts to ensure a successful future claims procurement. Accomplishing this is a complex effort that requires substantial resources and participation across HHSC, including from non-Medicaid programs.
- Challenge 2, CMS Rules: Compliance with CMS direction requires two technology initiatives: advancing Medicaid technology modernization goals and complying with new federal interoperability rules related to prior authorizations.
- Challenge 3, System Capacity: HHSC's current internal and contracted systems modification capacity is inadequate, and must be augmented, to implement the required modernization efforts in a timely fashion while simultaneously implementing the systems modifications to comply with federal and state legislative mandates.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Operations Management

A. Division or program information:

Name of division or program: Operations Management

Location within the agency: CMCSO

Contact Name: Jordan Nichols, Deputy Associate Commissioner

Statutory Citation: Texas Government Code, Chapter 532, Subchapter F; Texas Government Code, Section 532.0151; Texas Government Code, Section 532.0152

B. Objective and major activities:

The Operations Management team supports the accurate and timely payment of FFS provider claims by ensuring valid provider, client, and service data. Several non-Medicaid programs leverage the administrative and technical structures provided by Operations Management, including Title XX family care, CSHCN program, KHC program, and others. For example, some non-Medicaid programs are required to enroll through the Provider Enrollment and Management System, and some non-Medicaid claims are processed by TMHP. The department is divided into three major areas:

1. Provider Services: Supports daily Medicaid provider operations across several specialized teams. Key functions:

- Provider Recoupments and Holds (PRH): Analyzes and recoups overpayments, manages vendor payment holds, interfaces with LTC FFS providers to explain recoupments and payment options.
- Provider Claims Services: Resolves payment issues and ensures proper documentation for claims, supports LTC FFS providers and processes claim reconsideration requests, and offers direct provider support via a hotline.
- Provider Resolution and Administrative Appeals (PRAA): Oversees Medicaid provider enrollment and monitors related TMHP vendors, coordinates with numerous teams across HHSC to manage and improve the provider enrollment processes, oversees acute care FFS claims and associated second-level provider appeals (after appealing to TMHP), processes override requests for acute care FFS claims that were not filed timely.

- EVV: Ensures accurate tracking of personal care services and home health care services in the member's home or community, manages vendor contracts, policy compliance, and stakeholder engagement.

2. Business Automation Support (BAS): Manages Medicaid IT projects and system operations. This area acts as a liaison with HHSC IT and the TMHP AMD vendor on behalf of MCS and across HHSC. BAS serves as the intake point for TMHP automation projects, assists stakeholders with completing project request forms, works with HHSC and vendor technical staff to define requirements and estimate the project effort, prioritizes work efforts for the TMHP AMD vendor, and provides product owners to implement the efforts. The three teams and their major functions within BAS include:

- LTC Products Team: Oversees LTC systems and resolves authorization and payment issues, manages reference data (such as provider rates determined by CFO Provider Finance) to ensure accurate payment processing, and leads technology-related projects affecting LTC FFS payment and authorization processes.
- Acute Care Products and Governance Team: Manages system change requests and enhancements for acute care, oversees vendor performance and applies agile project management.
- Encounters, File Support, and Coordination (EFSC): Encounters represent the details of a service claim that was submitted by a provider to an MCO or DMO for healthcare services rendered to a Medicaid member. EFSC oversees MCO and DMO encounter data processing and quality, uses accepted encounter data to calculate and make federally qualified health center (FQHC) payments, manages the MCOHub file-sharing system, and leads regular MCO and DMO engagement.

3. Centralized Support: Provides cross-departmental support for Operations Management through:

- Audit and Legislative Coordination: Manages audits, legislative responses, and associated reports.
- Business Continuity: Handles emergency planning and disaster response for Operations Management.
- Communications: Develops provider and stakeholder communications for Operations Management related work.

- Policies and Training: Creates internal policies, training, and procedures. Also, provides technical writing support for areas within Operations Management to ensure accurate and effective procedures and training.
- Health Insurance Premium Payment (HIPP) Program Oversight: Oversees the HIPP program operations and vendor compliance. The HIPP program helps families with at least one eligible Medicaid recipient in the household maintain private health insurance coverage by reimbursing the employee's employer-sponsored monthly insurance premiums in lieu of providing a Medicaid health plan for the eligible person.

C. Effectiveness and efficiency information:

For Program Effective Measures see Exhibit 2.

Since 2018, Operations Management has held regular stakeholder engagement meetings, especially in the EVV space, allowing vendors operating the program to provide valuable feedback.

In 2021 and 2024, Operations Management has led two successful initiatives to expand the use of EVV to additional populations to comply with federal law. By completing these implementations, HHSC successfully avoided federal penalties. Both projects required system changes, coordination with new teams, development of new policies, and significant stakeholder engagement.

In 2025, Operations Management expanded efforts to engage providers on the provider enrollment function.

In 2020, Operations Management worked with HHSC IT to quickly develop and implement a Non-Risk Payment System to reimburse MCOs for services that had not yet been factored into MCO capitation rates. This system was used to pay for COVID-19 services at a time when these services could not be accurately factored into capitation rates. HHSC still uses this system to reimburse MCOs in other atypical scenarios, such as disasters.

In 2024, Operations Management established a new project intake and prioritization process. This process accounts for the fact that the TMHP contract has been split into multiple contracts and provides a framework for evaluating the priority of each TMHP project requested throughout the agency.

Operations Management made significant improvements to the EVV proprietary system onboarding process in 2023, which greatly increased the ability to bring on proprietary system operators with existing state resources. This change also

resulted in a small contract cost reduction for the TMHP EVV contract. Proprietary system vendors increased from 3 in 2020 to 11 in 2024. Proprietary system operators (providers who choose to use their own system) increased from three in 2020 to 880 in 2024.

Operations Management works with HHSC IT and the TMHP AMD vendor to implement technology changes through the scaled agile framework (SAFe) methodology. One benefit to this methodology is the ability to quickly pivot to high priority work. In 2024 and 2025, Operations Management implemented several initiatives that were able to be completed quickly such as changes to reduce provider abrasion in the enrollment process.

Effectiveness statistics (fiscal year 2024):

- 29,124,814 LTC FFS claims processed.
- \$5,280,440,430 in LTC FFS payments processed.
- 66,721 calls handled by Provider Claims Services.
- \$5,241,995 in LTC FFS overpayments collected.
- \$3,034,803 in LTC FFS claim recoupments entered.
- \$4,161,991 in cost avoidance for LTC FFS claims.
- 4,607 EVV mailbox cases worked.
- 58 TMHP project high-level estimate requests completed.
- 1,682 TMHP complaints processed.
- 2,044 acute care FFS administrative appeals completed.
- \$98,955,567 in non-risk payments processed.
- 161,962,524 managed care encounters processed.

D. History:

2016: To comply with federal mandates related to provider enrollment, HHSC required Operations Management to manually enroll LTSS providers who were not previously enrolled. A new LTSS provider enrollment file was created as part of this process and is still maintained today.

2017: Operations Management absorbed the EVV program and associated three FTEs. The EVV program was understaffed and required a significant reallocation of staff over the following three years to stabilize the program and meet new federal mandates.

2019: S.B. 1991, 86th Legislature, Regular Session, 2019, required HHSC to establish a new proprietary system operator model for EVV. This new model allows providers to use their own purchased or developed EVV system rather than the state EVV system.

2019: OIG began conducting recovery audit contractor (RAC) audits resulting in appeals from audited providers. Per the Texas Administrative Code, HHSC is responsible for adjudicating the appeals. HHSC did not receive any additional staff to manage the increased volume and workload associated with these RAC appeals.

2021: HHSC transitioned platforms for key administrative activities performed by providers for the 1915(c) HCBS and TxHML programs from the Client Assignment Registration system to the LTC Online Portal and LTC Claims Management System managed by TMHP.

2021: HHSC implemented PEMS as required by S.B. 200, 84th Legislature, Regular Session, 2015. PEMS consolidated enrollment processes previously distributed throughout the agency into one integrated system. HHSC also implemented enhanced requirements to align with federal mandates increasing the complexity of provider enrollment. Operations Management is now responsible for oversight of this system and the various enrollment processes.

2023: HHSC transitioned from one TMHP contract to four contracts with separate vendors. Operations Management's scope and responsibilities changed with this transition. The complexity of managing multiple vendors has added significant administrative overhead and additional project management responsibilities to this team. Operations Management provides full-time product owners for 12 agile sprint teams.

Generally, the increasing complexity of Medicaid and healthcare administration has resulted in an ongoing cycle of major technology projects. Operations Management has had to evolve to support these major projects. Operations Management typically receives one-time funding to pay for software enhancements and hire staff augmentation contractors to manage the project but has never received additional staffing to oversee and manage the enhanced systems. Continuously adding more functionality to existing systems increases the complexity of those systems and the operations they support.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

- The PRH team researches and analyzes LTC FFS Medicaid claims to identify, verify, and recoup Medicaid overpayments and prevent invalid provider recoupments Claims Payment and Encounters.
- Provider Claims Services is responsible for ensuring proper and accurate service authorizations and supporting records are available for the reimbursement of nursing facility and hospice services, approving services and billing authorizations for multiple LTC FFS waiver programs, rehabilitation and specialized services, assisting facility-based LTC FFS providers (including ICF/IDD and SSLCs) with supporting records so that Medicaid authorizations are available, and providing direct assistance to providers via a phone hotline.
- The PRAA team oversees Medicaid provider enrollment, oversees acute care FFS claims processing, and performs second-level claims payment administrative appeals. PRAA coordinates with numerous teams across HHSC to implement, oversee, and improve the provider enrollment process.
- The EVV team administers the implementation, operation, and effective use of EVV by setting policies, designing operational procedures, monitoring compliance with policies, and engaging stakeholders to operate the program.
- The BAS area manages information technology-related projects, operations, and maintenance, with a focus on how the technology supports Medicaid business operations. The team acts as a liaison to HHSC Information Technology and the TMHP AMD vendor on behalf of customers within MCS and across HHSC. BAS serves as the intake point for TMHP automation projects and assists stakeholders with completing project request forms, works with HHSC and vendor technical staff to define requirements and estimate the project effort, prioritizes work efforts for the TMHP AMD vendor, and provides product owners to implement the efforts.
- Centralized support team has a variety of processes that align with MCS and HHSC related to audits, legislative coordination, business continuity, etc. The team also uses standard contract oversight practices for the HIPPP program.

Table 8. Operations Management processes.

File Name	Document Description
S7 CMSCO Operations Management Att 01 Credit Collections 2020 01	Credit_Collections 2020_01

File Name	Document Description
S7_CMSCO_Operations_Management_Att_02_Debt_Referral_2023_01	Debt Referral 2023_01
S7_CMSCO_Operations_Management_Att_03_High_Level_Process_Flow_Provider_TMHP_HHSAS_USAS	High Level Process Flow Provider/TMHP/HHSAS/USAS
S7_CMSCO_Operations_Management_Att_04_LBC_Intake_Process_V1.00	LBC Intake Process V1.00
S7_CMSCO_Operations_Management_Att_05_Managed_Care_Medicaid_Encounter_Flows_2025	Managed Care Medicaid Encounter Flows 2025
S7_CMSCO_Operations_Management_Att_06_Texas_EVV_Open_Model_January_2024	Texas EVV Open Model January 2024
S7_CMSCO_Operations_Management_Att_07_Vendor_Hold_Inbox_2023_01	Vendor Hold Inbox 2023_01
S7_CMSCO_Operations_Management_Att_08_Nursing_Facility_Forms	Nursing Facility Forms

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

CMS: For policy guidance, system certification, system funding, and technical assistance.

OAG: When Operations Management is unsuccessful in collecting Medicaid overpayments from a provider.

OIG: Collaboration on provider enrollment processes.

Texas QAT: Comprised of LBB, DIR, SAO, and CPA. Operations Management collaborates with IT to report on MMIS contract and project status to QAT under the requirements of Rider 6, 2024-25 General Appropriations Acts, H.B. 1, 88th Legislature, Regular Session 2023.

J. Barriers and challenges:

- Challenge 1: Following the end of the COVID-19 Public Health Emergency, HHSC resumed the provider enrollment revalidation process. Providers are experiencing difficulty with the revalidation process. The volume of revalidations that were delayed due to the public health emergency and the functionality of PEMS are the root cause of the challenges. While HHSC anticipated and planned for the increased volume once revalidations resumed after the public health emergency (PHE), the actual volume once revalidations resumed was much larger. Operations Management is examining whether any enrollment requirements can be relaxed or changed to simplify the enrollment process.
- Challenge 2: EVV statutory language, Texas Government Code, Chapter 532, Subchapter F, related to proprietary system approval has created an inefficient process to review and approve proprietary systems. The law is clear that HHSC may recognize a provider's proprietary system and allow the provider to use that system. Many Medicaid providers use the same proprietary EVV systems offered by various software companies. Under current statute, HHSC is only permitted to approve a proprietary system that is purchased or developed by a Medicaid provider; HHSC cannot accept applications for system approval from entities other than a Medicaid provider. HHSC has heard from provider associations and industry stakeholders that they are displeased with HHSC's interpretation of the current law and believe reviewing each provider's implementation of the system is unnecessary. Changes to this statute were proposed in both the 88th and 89th Legislative session but did not pass.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Vendor Drug Program

A. Division or program information:

Name of division or program: Vendor Drug Program

Location within the agency: CMCSO

Contact Name: Priscilla Parrilla, Deputy Associate Commissioner

Statutory Citation: Texas Government Code, Chapters: 353 – 355, 382, 531, 533; Texas Human Resources Code, Title 2, Chapter 36; Texas Human Resources Code, Title 8; Code of Federal Regulations Title 42, Social Security Act Title XIX

B. Objective and major activities:

Vendor Drug Program (VDP) provides statewide access to covered outpatient drugs for recipients enrolled in Medicaid, CHIP, and non-Medicaid programs - the Children with Special Health Care Needs (CSHCN) Services program, and the Kidney Health Care (KHC) program. Major functions:

- Oversees the administration of drug benefits by Medicaid managed care plans and their pharmacy benefit managers;
- Manages the drug benefits for recipients who remain in the FFS delivery model;
- Administers the drug manufacturer rebate program that collects more than \$2 billion per year in revenue;
- Manages the outpatient drug formulary (list of Medicaid covered drugs) for the pharmacy benefit, the clinician-administered drugs (CAD) crosswalk for the medical benefit, and Preferred Drug List (PDL) for all Medicaid and CHIP recipients; and
- Helps ensure appropriate use of medications; monitors pharmacy provider compliance with program-related laws, regulations, and policies; directly resolves pharmacy issues; and directs and oversees the program's administrative vendor.

VDP pharmacists must possess a current license to practice pharmacy in Texas. The license must be in good standing with the Texas State Board of Pharmacy and with any other state the pharmacist is licensed in. VDP has five areas which support these functions.

1. Policy and Project Management:

- Develops and manages VDP processes for submitting managed care contract and manual amendments;
- Manages the manual for communication to external stakeholders; and
- Coordinates amendments to rules and SPAs for VDP.

2. Drug Utilization Review and Formulary Management (DURFM):

- Manages the state's Medicaid and CHIP formularies for drug coverage under the pharmacy benefit;
 - Maintains the drug formularies for CSHCN and KHC;
 - Maintains HTW and HTW+ formularies which include women's health and family planning drugs only;
 - Reviews prospective clinical prior authorizations, prospective system edits, retrospective analysis of prescribing patterns and client medical history, and retrospective provider education;
 - Initiates and develops activities of the federally required Drug Utilization Review (DUR) Board to include both retrospective and prospective drug utilization review and educational intervention strategies for physicians, pharmacists, and other health care professionals as well as PDL program analysis fall outside the normal and nationally accepted practice guidelines; and
 - Administers the PDL, oversees the PDL vendor, and supports DUR Board activities.
3. Pharmacy Claims & Business Analysis (PRBA):
- Provides change management and oversight of the FFS pharmacy benefit services vendor, Gainwell Technologies;
 - Subject matter expertise for the program's multiple drug rebate programs;
 - Ensures the quality of MCO's pharmacy claims data submitted to HHSC; and
 - Participates in the National Council for Prescription Drug Programs (a national standards development organization) meetings to help ensure industry standards meet the needs of state Medicaid pharmacy benefit systems.
4. Clinical Pharmacy and Clinician Administered Drug Operations:
- Manages the CAD outpatient benefit;
 - Performs in depth research on each new Healthcare Common Procedure Coding System (HCPCS) code creating clinical policy and prior authorization determinations and evaluating population estimates;
 - Reviews the Psychotropic Medication Utilization Review action plan and reports annually submitted to HHSC for each MCO; and

- Conducts quarterly reviews of psychotropic medication profiles for foster care children placed through the Interstate Compact on the Placement of Children agreement.

5. Cross Coordination and Pharmacy Benefit Oversight (CCPBO):

- Provides coordination and oversight over the Managed Care Contract and the FFS Pharmacy Claims and Administration vendor (Gainwell) requirements that require program subject matter expertise;
- Coordinates VDP activities for managed care Operational Reviews, Readiness Reviews, and Targeted Reviews that inspect the vendors compliance with the pharmacy services contract requirements; and
- Reviews and tests the MCOs' and PBMs' processes and procedures and samples of claims submissions for contract compliance.

VDP is also responsible for several functions for non-Medicaid programs and services.

- Serves as the lead point of contact for Specialty Health Program (KHC and CSHCN) claims processing, support of data governance, rebate invoicing, and any reporting. These programs leverage the FFS pharmacy claims processing system. VDP is the point of contact for all FFS pharmacy vendor activities;
- Provides advisory support and assistance to Specialty Health Program regarding KHC and CSHCN formulary drug addition, reports, drug files, and high dollar drug notifications;
- Assists with a nicotine replacement therapy report and coverage impact for DSHS Tobacco Prevention and Control Program;
- Advises the Family Planning Program for potential formulary and claims processing integration;
- Assists with the nursing facility drug report for CFO Provider Finance regarding the project implementing S.B. 26, 88th Legislature, Regular Session, 2023, which is a cost projection project for nursing facilities that uses relevant medication costs for individuals in state hospitals; and
- Manages Specialty Health Program content on the VDP website (manuals, forms, search function, etc.).

C. Effectiveness and efficiency information:

For Program Effective Measures see Exhibit 2.

On March 31, 2024, VDP successfully transitioned from other vendors to Gainwell Technologies. The goal of the project was to modernize drug utilization review, continue to innovate and improve healthcare services for members and providers, and lower costs through improvement of business operations and functions. This resulted in several improvements including (1) increased efficiency by moving from four vendors to one vendor to streamline processes, data exchanges, feedback, and lower costs; (2) removed duplicative and redundant processes; (3) reduced invoicing and monitoring to one vendor instead of four vendors; and (4) moved certain responsibilities from HHSC to the vendor.

Additionally, VDP continues to evaluate member services and identify areas where VDP can increase access to covered services and products. Examples include covering non-drug items such as continuous glucose monitors through the pharmacy benefit, working on a project to provide access to adult vaccines through pharmacy, and ensuring access to new and innovative cell and gene therapies in medical benefits by leading a project to make sure HHSC has a process to cover these. VDP also obtained approval from CMS on a SPA to add non-drug products to the formulary.

The DURFM unit conducts approximately eight major educational reviews each year, which retrospectively address clinical areas that may have inappropriate drug usage. In fiscal year 2023, retrospective drug utilization review (RDUR) initiatives saved approximately \$1 million, while the prospective DUR (ProDUR) program generated savings of \$4 million in FFS. For fiscal year 2024, RDUR initiatives are estimated to reflect a cost savings of approximately \$200,000, while the savings for ProDUR are estimated at \$6 million in FFS. This ProDUR program incorporates systematic checks at the point-of-sale to identify and prevent potential issues such as drug interactions, therapeutic or ingredient duplications, drug-disease contraindications, age restrictions, and maximum dosage limitations, ultimately protecting Medicaid client's well-being and optimizing medication use.

The PRBA unit effectively oversees the invoicing and collection of rebates from drug manufacturers. This includes federal, supplemental, and value-based Medicaid rebate programs. Below is a summary of some of the rebate collections in the from 2019 through 2023:

Medicaid – FFS:

- VDP collected \$75,579,235 in federal rebates and \$5,927,605 in supplemental rebates.

Medicaid – MCOs:

- VDP collected \$8,998,707,645 in federal rebates and \$812,009,316 in supplemental rebates.

CHIP Rebates:

- \$90,809,804 has been collected in rebates.

More information can be found in the Performance Reporting for the Prescription Drug Rebate Program report located online at

<https://www.hhs.texas.gov/sites/default/files/documents/annual-performance-report-prescription-drug-rebates-nov-2024.pdf>.

D. History:

S.B. 1780, 86th Legislature, Regular Session, 2019, allowed HHSC to negotiate a value-based arrangement with a prescription drug manufacturer.

H.B. 2822, 87th Legislature, Regular Session, 2021, required HHSC to automate prior authorization (PA) for drugs in the antipsychotic class and to issue specific messaging for PA denials for drugs in the antipsychotic class; and allowed adult Medicaid members to bypass preferred drug PAs in certain circumstances.

2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Article II, HHSC, Rider 22 and Exceptional Item 3), appropriated funds for HHSC to expand access to direct-acting antiviral medications for Medicaid clients with chronic Hepatitis C by entering into a cost-effective rebate agreement with a drug manufacturer.

H.B. 3286, 88th Legislature, Regular Session, 2023, made numerous changes to the formulary, preferred drug list, and DUR Board processes and resulted in eight different items requiring implementation. VDP completed implementation of seven items before the 89th Legislative Session. The final item is a requirement to create a new temporary non-preferred status for new formulary drugs.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

VDP maintains a comprehensive VDP Process Guide. The process guide details the VDP business processes and procedures to document and address specific program and functional business needs. Processes and procedures captured in the guide include the below (among others):

- Contract management;
- Invoicing;
- Claims processing and payment;
- Formulary management; and
- Drug utilization review.

Table 9. VDP Processes.

File Name	Document Description
S7 CMCSO VDP Att 01 Operational Readiness Review	Operational Readiness Reviews
S7 CMCSO VDP Att 02 Process Guide	Vendor Drug Program Process Guide

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

CMS: Provides federal regulations and guidance for many aspects of prescription drug delivery for Medicaid recipients, including formulary management, DUR, reimbursement, MCOs, and rebates.

J. Barriers and challenges:

The Gainwell contract is more robust and comes with additional requirements and standards. VDP is working on a project to evaluate all deliverables associated with the Gainwell contract (FFS and managed care) and move to a risk-based monitoring approach due to limitations with staff resources.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Managed Care

The Managed Care DEC area includes the following units: Financial Reporting and Audit Coordination (FRAC), MCCO, and Program Enrollment and Support (PES).

Financial Reporting and Audit Coordination

A. Division or program information:

Name of division or program: FRAC

Location within the agency: CMCSO

Contact Name: Jason Mendl, Deputy Associate Commissioner

Statutory Citation: Texas Government Code, Section 533.104

B. Objective and major activities:

FRAC oversees financial and audit processes for major MCS contracts, including:

- All managed care contracts;
- TMHP Claims Administrator (MMIS);
- TMHP Business Operations (MES);
- TMHP Application Maintenance and Development (MES);
- TMHP Electronic Visit Verification (MES); and
- Enrollment Broker.

In addition to contract related work, FRAC also processes delivery supplemental payments (DSPs) to MCOs and manages accounts receivables for acute care FFS claims. Below are FRAC' five specialized teams and major functions.

1. Financial Reporting Team: Handles oversight of financial deliverables submitted by MCOs, DMOs, and Medicare-Medicaid Plan (MMPs). All plans contracting with the State of Texas are responsible for submitting numerous financial deliverables, including Quarterly and Annual Financial Statistical Reports (FSRs). The submission schedule, templates and instructions, and all other requirements are dictated by the contract.

Two core aspects related to this oversight and reporting are:

- FSRs: The primary statement of financial results submitted by MCOs to HHSC. FSRs are designed, using state cost principles as well as federal regulations (48 CFR Part 31 and 2 CFR Part 200), to filter out costs that are not beneficial to Texas Medicaid members. The FSR is a detailed, multi-page modified income statement that contains both summary and detail level information on Membership, Revenue, Medical, Dental, Pharmacy and Administrative Expenses and Net Income by service area and program. Each of these reports show both quarterly and fiscal year-to-date amounts. The FSRs are prepared on a continually updated basis during a given fiscal year.
- Experience Rebates (ER): HHSC establishes a profit-sharing methodology whereby a portion of any profits in excess of 3 percent of revenue reported by the plan is recovered based on a sliding tiered schedule. The ER was put in place through Texas Government Code, Section 533.014, and Texas Administrative Code, Section 353.3, as a fiduciary safeguard for taxpayers, which helps ensure that capitation rates paid are not excessive in comparison to MCO costs.

For more information on Experience Rebates, see Chapter 3, page 76-78 of the [Texas Medicaid and CHIP Reference Guide \(15th edition\)](#)

Major functions:

- Designs financial reporting templates;
- Develops contract language pertaining to financial oversight;
- Maintains financial and accounting principles (Texas Medicaid Cost Principles) to ensure compliance with state and federal regulations;
- Validates and reconciles FSRs;
- Supports other internal and external entities with FSR data (e.g., OIG, CFO Actuarial Analysis);
- Monitors MCO financial performance, including the financial aspects of subcontracts and affiliate relationships;
- Recommend strategies to address issues;
- Calculates quarterly financial benchmarks and analyze trends;
- Administers the recovery of excess profits through the ER process; and

- Provides financial expertise for Request for Proposals (RFPs) and contract amendments, CMS reporting, and quality programs.

2. Financial Compliance Team: Primary role is to support external and internal financial related audits of the MCO and DMOs. These audits may be conducted by any state or federal agency. Major functions:

- Manages agreed-upon procedures audits of the MCO and DMO FSRs and implement CAPs;
- Remedies issues identified and ensures accurate financial reporting post-audit;
- Adjusts reporting, recalculates the ER, if warranted, and tracks final ER payments and refunds;
- Conducts FSR-to-encounter reconciliations for Non-Emergency Medical Transportation; and
- Reviews MCO and DMO incentive and bonus plans and fair market value analyses to ensure contract compliance then oversee correction of reporting errors.

3. Contract Finance Oversight Team: Monitors pricing and costs for TMHP contracts and Enrollment Broker contracts. The TMHP contracts support both Medicaid and non-Medicaid programs such as the Family Planning Program and CSHCN. Major functions:

- Reviews Pricing Schedules and Basis of Estimate (BOE) to establish reasonable Fixed Pricing schedules for the HHSC programs the contracts support;
- Prepares fiscal year projections for CFO Budget Office, and MCS SBO Resource Management;
- Analyzes Change Order Requests (CORs) to ensure fees and requirements in the COR and cost model are reasonable, accurate and meet HHSC business needs;
- Reviews contract changes including reviewing CORs, administrative changes and contract amendments, to determine and track financial impacts;
- Approves and rejects contract fees; and
- Ensures timely and accurate contractor invoicing.

4. Delivery Supplemental Payments (DSPs) and Encounter Reconciliation Team: Focuses on DSPs and quarterly encounter reconciliations.

MCOs participating in STAR, CHIP, and CHIP Perinatal submit and receive DSP claims to HHSC to cover expenses for the delivery of a child. Medicaid covers more than 50 percent of all Texas births. DSPs are intended to make costs associated with a pregnancy equitable, in particular when a pregnant MCO member transfers to a different plan toward the end of pregnancy. Major functions:

- Processes 13,000 DSP claims per month equating to about \$50 million; and
- Oversees the Quarterly Encounter Reconciliation Report, which reconciles the year-to-date paid claims reported in the FSR to the appropriate encounter paid dollars reported in the Encounters Data Warehouse.

5. Accounts Receivable (A/R) Team: Manages the recovery of outstanding Medicaid provider FFS overpayments. Major functions:

- Recovers long-standing, difficult-to-collect A/R cases;
- Works with TMHP, the vendor who ensures past due ARs are actively collected;
- Develops policies and improvements for A/R and contract monitoring;
- Escalates cases as needed to division or agency leadership;
- Coordinates provider bankruptcies and legal actions with OAG;
- Provides guidance during Claims Administrator transitions; and
- Collaborates with state and federal partners (CMS, OAG, OIG).

The nature of the work conducted in FRAC requires staff to have a specialized blend of financial, analytical, and policy interpretation skills, essential for overseeing complex Medicaid and CHIP contracts and financial operations.

C. Effectiveness and efficiency information:

For Program Effective Measures see Exhibit 2.

Efficiency 1: FRAC made temporary changes to the Experience Rebate methodology to account for significant increases in MCO profit experienced during the early stages of the COVID-19 public health emergency. MCOs share profits greater than three percent of revenue with HHSC. During the temporary change, HHSC recovers all MCO profits greater than the five percent threshold. The maximum profit that an

MCO can achieve after HHSC recoups the ER is 4.6 percent of revenue. In fiscal year 2024, HHSC reverted to the standard Experience Rebate methodology. The temporary change to Experience Rebate methodology allowed FRAC to recover more Experience Rebate during the COVID-19 public health emergency than it would have under the normal Experience Rebate methodology. FRAC estimates this change saved \$1.995 billion All Funds.

Efficiency 2: Through a combination of hiring and training staff, workflow management processes, work visualization, and continuous improvement the FSR Reporting Team achieved or surpassed FRAC benchmarks:

- Reduced Experience Rebate Calculation average cycle time (calculated from when preparer submits experience rebate calculation to secondary reviewer to when secondary reviewer signs off on calculation) from 7.67 days in fiscal year 2020 and fiscal year 2021 to 1 day in fiscal year 2024. That represents a decrease of 87 percent in the average cycle time.
- Reduced total process lead time (calculated from receipt of FSRs to finalized experience rebate calculation) from 628 days for fiscal year 2021 to 104 days in fiscal year 2023. That represents an 83 percent reduction in total process lead time. Lead time is expected to fall even further in 2024 in part due to additional process improvements.
- Reduced cycle time of ARTS suspense account reconciliation from 16 hours to 0.5 hours (97 percent reduction).
- Reduced initial review FSR cycle time from 10 business days to five business days (50 percent reduction). Initial reviews are conducted six times per year, and involve the entire eight person FSR reconciliation team, so this results in six weeks of savings annually.
- Coverage Ratio (which represents the number of FSRs reconciled within a fiscal year as a percentage of total FSRs submitted by MCOs) was 16.67 percent in fiscal year 2022, 30.00 percent in fiscal year 2023, 33.33 percent in fiscal year 2024, and on track to hit 83.33 percent in fiscal year 2025. Fiscal year 2026 is currently projected to have a coverage ratio of 100 percent, which means that all FSRs for fiscal year 2026 (six periods which includes two annual periods and four quarterly) will be reconciled.
- Initiated process to document standard workflows in more than 27 policy documents created in fiscal year 2025, in addition to standardized reconciliation templates, standardized experience rebate allocation

templates, and review checklists for experience rebate calculation and FSR reconciliation.

Process Improvement 1: In 2017, FRAC assumed responsibility for managing the DSP process and transitioned from a manual process to a web-based application in coordination with HHS-IT, resulting in significantly greater efficiency and accuracy. The procedures for validating delivery supplemental payments consist of numerous criteria and checks, including the claim having eligible diagnosis codes, existence of the child in HHSC systems under the client's case, and the client's Medicaid coverage at the time of the delivery.

Initially the rejected claim rate was around 15 percent, FRAC has reduced the reject rate to <1 percent since by eliminating acceptance of claims based on insufficient or invalid diagnosis codes by revising the list of eligible diagnosis codes and increasing the number of codes required to validate a delivery, process improvements with the DSPP app, and significant MCO training. FRAC has created and implemented user manuals, guides, and policies and procedures to ensure DSP claims are processed timely and accurately in accordance with contractual requirements.

Process Improvement 2: MCS has created a consolidated, online application for the issuance and reporting of corrective action plans. FRAC's adoption of the consolidated system has simplified the reporting process for MCOs and DMOs and aided FRAC in identifying improvements in the review of the corrective action plans which has evolved into a more thorough assessment of what each plan has stated. In turn, the complexity of the review and monitoring of MCOs and DMOs in their effort to make these corrections has grown.

Snapshot of FRAC Volume and Effectiveness: FRAC is responsible for financial oversight of 44 managed care contracts valued at over \$36 billion in fiscal year 2024. The number of contracts and their value has increased substantially since fiscal year 2010 when there were 17 contracts valued at \$5 billion.

- FRAC has collected over \$10.3 billion in Experience Rebate recoveries since 2014.
- The Financial Compliance teams agreed-upon procedures (AUP) audits have identified a net total of disallowed expenses on MCO and DMO FSRs of \$84,960,540 and \$135,856,549 over the last two audit cycles.

- ▶ These figures represent overstatements of net income from which the ER is calculated.
 - ▶ The total cost of conducting these AUPs was \$2,499,287 and \$2,521,015 respectively.
 - ▶ This is a return on investment of 3,299 percent and 5,289 percent. For every dollar invested, \$32.99 and \$52.89 was identified as an overstatement of expense in the FSR reporting.
- 1,032 MCO and DMO FSRs reviewed annually, 172:1 staff ratio.

D. History:

In recent years, with the increase in managed care services, programs, and payment methodologies (i.e. DPPs) there has been a significant expansion in scope and oversight provided by MCS. In addition, the managed care model has become more complex in terms of accounting and financial principles. FRAC is responsible for managing the oversight of the complex financial data that is submitted by MCOs and for developing, implementing, and monitoring new ways to oversee contract compliance and to ensure accuracy of financial deliverables. Along with increased focus on contract oversight activities, Experience Rebate amounts collected grew exponentially during the pandemic.

With the inclusion of non-emergency medical transportation into managed care in fiscal year 2021 and the growth of DPPs in fiscal year 2022, the complexity of the work has changed. Each of these has brought with them the need for staff's continued education on the rules regarding their administration and reporting and resulted in additional steps being added to the agreed-upon procedures.

To further illustrate the impacts of such changes, in fiscal year 2022, delays in CMS approvals of the state's DPPs resulted in implementation delays. Some of the downstream impacts to the delayed implementation were retroactive rate changes by CFO Actuarial Analysis, delay in dissemination of DPP scorecard information to the MCOs, and HHSC initiating additional reconciliation processes to true up the capitation payments to revised rates. FRAC had to request updated FSR data from MCOs and recalculate the Experience Rebate amounts based on updated revenue and net income amounts for each MCO. This was an additional step in our reconciliation process and pushed back our completion rates and timelines. FRAC anticipates annual reconciliations will continue to be the norm for subsequent FSR reporting years, especially due to DPP process impacts.

Additionally, in fiscal year 2023, the MES Modernization transition from one MMIS Claims Administrator Contract to separate MMIS Claims Extension, Business Operations, Applications Maintenance and Development, and EVV Contracts, quadrupled workload for staff, including the complexity of budget department IDs, financial requirements, and number of invoices received. The complexity of the work also increased due to Purchase Order requirements (not applicable for the MMIS Claims Administrator Contract) and tracking expenditures to the proper budget department IDs.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

- Financial Reporting: Administer defined processes to calculate and update ERs, issue Medical Loss Ratio (MLR) reports, and reconcile FSR to encounters;
- Financial Compliance Team: Develop Agreed Upon Procedures (AUP) and AUP Engagement statement of work for third party auditor. Once work is complete the team validates and processes AUP findings from AUP Engagement, which can result in changes to calculation of Experience Rebate;
- Contract Finance Oversight Team: Core process comprised of five major steps:
 - ▶ Establishes base contract and amendment Pricing Schedules to ensure they are reasonable, complete, accurate and meet the agency's needs;
 - ▶ Tracks all contract expenditures to ensure federal and state requirements are followed and within budget;
 - ▶ Performs detailed monthly analysis of actual hours worked to paid amounts. Results have led to refunds to HHSC and revised Pricing Schedules;
- Reviews, approves, and/or rejects all contractors' Monthly Invoices. Verify each invoice with appropriate HHSC program staff; and
 - ▶ Manages the annual Retrospective Cost Settlement Reviews and financial reports with potential financial impact.

DSP and Encounter Reconciliation Team:

- Follows procedures for validating delivery supplemental payments consist of numerous criteria and checks, including the claim having eligible diagnosis codes, existence of the child in HHSC systems under the client’s case, and the client’s Medicaid coverage at the time of the delivery; and
- Runs the Quarterly Encounter Reconciliation Report, which reconciles the year-to-date paid claims reported in the FSR to the appropriate encounter paid dollars reported in the Encounters Data Warehouse. The quarterly encounters-to-FSR reconciliations aim to ensure MCOs submit encounters and FSRs accurately and completely. Through these reconciliations, potential issues with either data set provided by MCOs can be identified.

Links to documents posted related to the work FRAC does: [Contracts, Manuals, and Financial Statistical Reports](#)

Table 10. FRAC processes.

File Name	Document Description
S7_CMCSO_FRAC_Att_01_Experience_Rebate_Calculation	Experience rebate calculation process
S7_CMCSO_FRAC_Att_02_Encounters_Reconciliation_Process	Encounters reconciliation process

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

CMS: From a contract finance and financial reporting perspective including work products such as APD, Advance Planning Document Update (APDU), Implementation Advanced Planning Document (IAPD), and Implementation Advance Planning Document Update (IAPDU), MLR Reporting, and general financial reporting requirements.

J. Barriers and challenges:

It has been challenging to continue to adhere to self-imposed timelines for FRAC’s completion of duties due to turnover of tenured staff and a lagging vacancy fill rate attributed to private sector competition. The growing program complexity further diminishes the ability to fill vacancies as the need for experienced FTEs capable of

performing at a higher functional level in turn has grown. As private sector benefits and compensation base have year-over-year been able to actively address rising costs of living, FRAC does not have the ability to properly incentivize qualified individuals to join or stay at HHSC.

To further illustrate, in a typical fiscal year, it takes FRAC approximately 12 to 18 months to complete the FSR reconciliation and ER process, then an additional eight months to audit each FSR. Each change or delay created in any part of the life cycle of a state fiscal year has a negative impact on the ability of FRAC to conduct its work within these timeframes. When a change in a program occurs, the action to take must be disseminated through to FRAC to appropriately alter its monitoring and audit work to address that specific change. This often interrupts the ability of FRAC to maintain its steady workflow as it must pause to ensure the most appropriate course of action is being taken.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Managed Care Contracts and Oversight

A. Division or program information:

Name of division or program: MCCO

Location within the agency: CMCSO

Contact Name: Trinita Harris, Deputy Associate Commissioner

Statutory Citation: Texas Transportation Code, Chapter 547; Texas Government Code, Chapters 531, 533 and 791; Texas Health and Safety Code, Chapter 62, 166, 462, 573, and 574; Texas Occupational Code, Sections 151 and 157; Texas Estates Code, Chapter 752; Texas Family Code, Chapter 55; Texas Code of Criminal Procedure, Chapter 46B; Texas Human Resources Code, Section 32; Rehabilitation Act of 1973, Section 504; Texas Insurance Code, Chapter 1952; Maternal and Infant Health Improvement Act, Chapter 32

B. Objective and major activities:

MCCO conducts and coordinates oversight activities for MCOs, DMOs, Independent Review Organizations (IROs), and Non-Emergency Medical Transportation (NEMT) service providers.

MCCO also manages state and federal contract activities including management of provider and pharmacy complaints related to managed care. Complex member complaints are referred to MCCO by the Office of the Ombudsman.

MCCO Contracts:

- Administers all managed care contracts and related contracts;
 - Managed care: STAR, STAR+PLUS, STAR Kids, STAR Health, CHIP, Dental, Medicare Advantage Plan and Dual Special Needs Plan Contracts, Texas Dual Demonstration Project (also known as the MMP Contracts),
 - Related contracts: Network Access Improve Program Contracts (NAIP), IRO, and Non-emergency Medical Transportation – Demand Response Transportation Services (Open Enrollment)
- Processes contract amendments, renewals, and new contracts;
- Manages Uniform Managed Care Manual (UMCM) updates;
- Develops methodologies for the scoring and reporting of vendors in the Vendor Performance Tracking System (A-F grade);
- Gathers information from monitoring team over a specific period on LDs, CAPs, and other items to determine scores; and
- Compiles and processes LDs related to MCO and DMO non-compliance.

Operational and Readiness Review:

- Facilitates readiness and operational reviews for MCOs and DMOs that ensure contractors are operationally prepared to begin providing services and go-live on a new system or major process changes in advance of the implementation date; and
- Leads cross-divisional planning, trainings, technical assistance, and systems testing for program changes and implementations.

MCO and DMO Monitoring:

- Oversees MCO and DMO compliance with contract requirements and performance standards;
- Enforces CAPs and LDs for non-compliance;

- Conducts targeted and enhanced monitoring as needed when non-compliance is recurring or significant; and
- Monitors Demand Response Transportation Services (DRTS) providers responsible for providing NEMT services for individuals in FFS Medicaid and non-Medicaid programs – CSHCN, and Transportation for Indigent Cancer Patient program (TICP).

For more information on operational and readiness reviews, see Chapter 3, (pages 55, 75) and non-compliance remedies (pages 79-80) of the [Texas Medicaid and CHIP Reference Guide \(15th edition\)](#)

MCCO Communications:

- Reviews MCO and DMO marketing, member, and provider materials for compliance;
- Investigates marketing violations and recommends corrective action;
- Participates in readiness and operational reviews; and
- Provides technical assistance across MCS regarding managed care marketing expectations.

Research and Resolution:

- Investigates and tracks managed care legislative, provider, and escalated member complaints and inquiries;
- Reviews complaint information from providers and MCO responses to determine adherence to UMCC and UMCM;
- Coordinates with other MCS areas through resolution; and
- Analyzes and reports on complaint trends.

Complex Care Services:

- Operates escalation helpline for MDCP and DBMD;
- Oversees IROs and manages the external medical review process for benefit denials or reductions that are appealed by Medicaid members;
- Coordinates immediate jeopardy cases with MCOs to ensure member needs are being met; and

- Provides notification to MCOs of facility closures (nursing facilities, assisted living facilities, and ICFs) to ensure the timely and safe transfer of members.

Medical Transportation Program Client Services:

- Coordinates with DRTS providers to arrange scheduled NEMT rides to and from appointments for individuals in Medicaid FFS and non-Medicaid programs – CSHCN and TICP;
- Arranges other transportation services that comply with federal regulations, including curb-to-curb, bus, airline, mileage reimbursement. Also processes meal and lodging requests; and
- Investigates and track complaints from clients against transportation vendors through resolution.

Special Projects and Network Adequacy:

- Responds to open records requests and completes legislative bill analysis;
- Tracks audit follow-ups and CAP implementation;
- Develops TexConnect deliverables and enhancements; and
- Ensures that MCOs and DMOs meet minimum provider access standards (distance and travel time standards) by using quarterly standard performance reports generated by DAP. A special exception process is managed by this team where allowances can be granted for noncompliance if the MCO and DMO provide adequate documentation showing their due diligence in ensuring members have access to care.

MCCO staff are required to obtain and maintain an active Certified Texas Contract Manager (CTCM) certification.

C. Effectiveness and efficiency information:

For Program Effective Measures see Exhibit 2.

Technology to Improve Business Processes: In response to 2018-19 General Appropriations Act, S.B. 1, 85th Legislature, Regular Session, 2017, MCCO, in collaboration with HHSC IT, developed TexConnect to:

- Serve as a single location hub for communicating information such as policy updates and event notifications with MCOs and DMOs. Also houses the CAP and LD processes for MCS;
- Allow MCOs and DMOs to submit many deliverables with built-in validations to ensure accuracy. The system also maintains the deliverables in a database eliminating the need to save individual reports on a shared drive; and
- Automate many MCO and DMO deliverables in a readable format, alleviating the significant manual effort previously involved in accepting and populating deliverables.

System functionality is reviewed every year for potential enhancements.

Increased Collaboration:

- Operational Review Enhancement Workgroup: The MCCO team worked with other MCS program areas to launch the Operational Review Enhancement Workgroup in 2018 for the purpose of:
 - Strengthening the operational reviews process by expanding into additional review areas;
 - Ensuring operational review tools support outcome-based performance monitoring; and
 - Facilitating participation from all MCS program areas.
- Audits and Deliverables Workgroup: MCCO hosts a monthly Audits and Deliverables workgroup meeting with MCOs and DMOs to discuss a variety of topics ranging from process implementations, policy changes, and new deliverables.

D. History:

The functions listed below increased scope of work, requiring additional staff, training, and cross collaboration with other MCS program areas.

2017: The Medical Transportation Program (MTP) was moved within MCS and placed within MCCO. This resulted in MCCO being responsible for the MTP statewide call center and complaints as well as oversight of the managed transportation organizations (MTO) for several years. In 2021, this work decreased when non-emergency medical transportation was carved in to managed care as a result of H.B. 1576, 86th Legislature, Regular Session, 2019. MCCO maintains the FFS

delivery model which includes arranging NEMT services for FFS as well as two non-Medicaid programs, CSHCN and TICP.

MCCO Research and Resolution established a Trending and Reporting team tasked with the following responsibilities:

- Tracking complaints and inquiry data on a weekly, monthly, quarterly basis, or as required;
- Analyzing data to identify and report specific trends;
- Providing data to internal stakeholders upon request; and
- Reviewing complaint and inquiry cases in the HHS Enterprise Administrative Report and Tracking (HEART) System to ensure that all complaints and inquiries are addressed and resolved in accordance with program policies and procedures, utilizing a second-level review tool.

2019: HHSC implemented TexConnect as required by the 2018-19 General Appropriations Act, S.B.1, 85th Legislature, Regular Session, 2017. MCCO serves as lead area for establishing TexConnect functionality and coordinating across MCS to provide cross-division training and technical support as changes are implemented.

2020: MDCP and DBMD escalation lines were implemented as required by S.B. 1207, 86th Legislature, Regular Session, 2019. This change resulted in MCCO standing up call center functionality and requiring staff to be available 8:00 a.m. – 8:00 p.m. and be on call at nights, weekends, and holidays.

2022: MCCO implemented contracts with an IRO to perform external medical reviews (EMR) when requested by Medicaid members for certain benefits that have been denied, reduced, or terminated by their MCO or DMO, in accordance with Texas Government Code, 531.024162, as amended by S.B. 1207, 86th Legislature, Regular Session, 2019. The staff dedicated to this process are responsible for contract oversight and management of the EMR processes involving MCOs and IROs. These functions are performed by the same staff that are responsible for the MDCP and DBMD Escalation Helpline previously mentioned.

For more information on the member complaints and external medical review process, see Chapter 3 (pages 72-74) of the [Texas Medicaid and CHIP Reference Guide \(15th edition\)](#)

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

Below are high level descriptions of processes.

Operational and Readiness Review Process:

- Readiness Reviews: Conducted prior to program implementations or system changes;
- Operational Reviews: Conducted at least every two years to assess compliance;
- Review Methods; and
 - Desk Review: Evaluates documents and systems remotely.
 - Onsite and Webinar: In-person or virtual assessments and interviews.
 - Combination: Blends both approaches.
- Issues “Go-Live” letters upon successful remediation of deficiencies.

Monitoring and Oversight Process:

- Analyzes contract deliverables to monitor MCO and DMO performance;
- Recommends CAPs and LDs for contractual non-compliance;
- Oversees provider directories, incident reports, subcontractor performance, and escalated complaints; and
- Coordinates with MCOs and DMOs and internal HHSC divisions on contract adherence.

Contract Administration and LD Process:

- Manages contract changes and updates;
- Secures legal approval and routes documents through CAPPS Financials;
- Reviews MCO submissions, calculates LDs, and coordinates payment tracking; and
- Maintains vendor scoring through the Vendor Performance Tracking System.

Complaint Resolution Process:

- Logs complaints in the HEART system and investigates with relevant stakeholders;

- Communicates with complainants throughout the resolution process;
- Sends formal resolution letters aligned with Medicaid and CHIP rules and policies; and
- Analyzes trends for reporting and performance improvement.

Demand Response Transportation Services Client Services NEMT Coordination Process:

- Handles intake and eligibility for NEMT services;
- Coordinates a variety of transportation types including curb-to-curb, bus, airline, and mileage reimbursement;
- Enters and tracks service data in the Texas Medical Transportation System; and
- Educates and redirects client inquiries based on managed care enrollment.

Table 11. MCCO processes.

File Name	Document Description
S7_CMSCO_MCCO_Att_01_Operational Review Timeline of Activities	Operational Review Timeline of Activities
S7_CMSCO_MCCO_Att_02_CAP Statuses	CAP Statuses
S7_CMSCO_MCCO_Att_03_CAP Flowchart	CAP Flowchart
S7_CMSCO_MCCO_Att_04_MCS CAP Flowchart	MCS CAP Flowchart
S7_CMSCO_MCCO_Att_05_MCO CAP Flowchart	MCO CAP Flowchart
S7_CMSCO_MCCO_Att_06_Escalated Remedies	Escalated Remedies
S7_CMSCO_MCCO_Att_07_101 Webinar Series Presentations	101 Webinar Series Presentations
S7_CMSCO_MCCO_Att_08_Managed Care Readiness Guide	MCS Managed Care Procurement Readiness Guide

G. Funding: See "Agency Program Information" spreadsheet.

H-I. MOUs and relationships with others: Not applicable.

J. Barriers and challenges:

- Challenge 1: Policy updates developed by PCS regarding Texas Government Code, Section 2262.053, requires contract managers (CMs) to maintain a variety of checklists and ensure that all contract documents to include, risk assessments, vendor screenings, monitoring documentation, deliverables, financial documents, internal and external correspondence and emails, training documents, technical assistance documents, vendor performance tracking system reports, closeout documentation, and contract checklists are uploaded to System of Contract Operation and Reporting (SCOR) or other agency approved storage location, throughout the contract life cycle and at least annually.

While the process and requirements might work for smaller contracts in the agency, staffing and technology are insufficient to manage the volume of correspondence, contract documentation and emails received MCS-wide regarding the managed care contracts specifically, but other contracts as well.

- Challenge 2: The Comptroller of Public Accounts (CPA) published rule updates in December 2023 requiring PCS to develop a new version of the PCS-147, vendor reporting document. PCS transitioned the PCS-147, PDF document, to a Power App (portal) that requires the CM to manually enter vendor information into the portal.

Previously, CMs used a methodology for grading which used specific non-compliance items based on finalized LDs and determined a letter grade for A-F. The new reporting categories are not measurable in the same way and LDs cannot be used for this purpose. With these new rules, state agencies no longer assign grades.

The new PCS-147 portal also requires CMs to select performance measures on six categories including Delivery, Administration, Product, Scope, Customer Service, and Communication (plus various subcategories). To implement this, new grading policies and procedures must be developed and additional collaboration with contract monitoring departments throughout the division must occur, which creates a significant increase in scope of work. Additionally, a methodology to summarize or average the performance measures into a single report will need to be developed for the CM to load the result into the portal. PCS staff will enter the information from the HHSC portal into the CPA portal and provide a summary that includes the grade as calculated by the CPA portal.

Similar to the challenge 1, staffing and technology are insufficient to manage this new process for larger contracts such as managed care.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Program Enrollment and Support

A. Division or program information:

Name of division or program: Program Enrollment and Support (PES)

Location within the agency: CMCSO

Contact Name: Sarah Fincannon, Deputy Associate Commissioner

Statutory Citations: Medicaid 1115 Waiver, 1915(c) of the Social Security Act, 42 CFR Part 438

B. Objective and major activities:

PES largely supports Medicaid managed care members being properly enrolled in the correct managed care programs. Related to enrollment, PES oversees the processing of capitation payments to MCOs and DMOs. This area also provides STAR+PLUS HCBS, MDCP, CLASS, and DBMD interest list management and program assistance. Major areas and functions are:

Premiums Payable System (PPS) Support:

- Provides managed care enrollment support related to capitation payments to MCOs and DMOs;
- Develops, oversees, and performs functions related to operational systems processing, data management, analysis, and reporting. An example of the reporting is the administration of the PPS Portal and Deliverables Tracking System (DTS) that captures MCO contract deliverables and assists in the collection of quality-measure data;
- Validates and oversees the MCOs' approximate \$3.0 billion monthly capitation payments for all Medicaid managed care programs, CHIP, CHIP dental, and Children's Medicaid Dental;

- Responds to inquiries related to Medicaid and CHIP managed care capitation payments from various HHSC areas in addition to MCO and DMO questions; and
- Serves as a check and balance in determining the accuracy of managed care enrollment requirements and payment rate classifications.

Enrollment Resolution Services:

- Conducts Medicaid managed care enrollment reviews using established state and federal guidelines and provides timely resolution to managed care enrollment issues related to accessing care;
- Corrects managed care enrollment errors identified and coordinates with program areas to identify procedural or systematic issues;
- Completes manual enrollment actions such as authorizing access into managed care programs for newly eligible managed care recipients;
- Processes manual disenrollments by terminating the enrollment once it is determined program requirements have not been met; and
- Identifies inefficiencies or deficiencies in agency systems, such as the Texas Integrated Eligibility System (TIERS) and makes recommendations that lead to better managing of enrollment issues and improvement of the performance of the Medicaid managed care programs.

Enrollment Broker (EB) Vendor Operations Management:

- Reviews contract deliverable for EB, maintained with CAPM, to ensure contractor is meeting contractual obligations;
- Responds to inquiries from MCOs and other entities, internal and external, via the EB Operations mailbox;
- Serves as a subject matter expert across the agency regarding EB processes;
- Conducts quality assurance reviews regarding customer service provided by EB call center representatives; and
- Participates in EB projects related to system and process updates to ensure vendor is meeting expectations.

For more information on EB See the Major MCS Contracts Section.

Interest List Management:

- Adds and updates, including interest list release activities, individuals on the MDCP, STAR+PLUS HCBS, CLASS, and DBMD interests lists through the toll-free hotline; and
- Specific to MDCP and STAR+PLUS HCBS, facilitates the eligibility determination process in coordination with the MCO, Access and Eligibility Services (AES), and the individual and/or legally authorized representative.

Product Management (PM):

- Serves as liaison with AES regarding needed TIERS changes;
- Coordinates with the various internal and external stakeholders to include AES, MCOs, HHSC Office of Ombudsman, Medicaid providers, the EB vendor, TIERS IT to resolve case-specific issues and the identification of procedural or systematic issues; and
- Serves as product owners for TIERS updates for MCS business areas.

Program Support Unit (PSU):

- Facilitates enrollment into STAR+PLUS HCBS and MDCP waivers by coordinating and ensuring all eligibility components have been met prior to enrollment into the waiver. Eligibility is determined by income and resources, as well as LOC or MN. The criteria for varies by program;
- Provides reporting for management of STAR+PLUS HCBS and MDCP interest lists; and
- Manages interest list releases statewide for the CLASS waiver and DBMD waiver.

C. Effectiveness and efficiency information:

For Program Effective Measures see Exhibit 2.

Enrollment Resolution Services: The area regularly reports systems issues found through the inquiries they receive regarding managed care access. These reports lead to projects that fix or enhance the eligibility and enrollment system functionality which benefits Texans who are utilizing Medicaid services.

PPS Support Team: The PPS capitation payments process includes a 4-point validation performed by HHSC IT to ensure there are no errors. Once payments have been validated by IT the process moves to PES where summary and voucher

data is reviewed by 1st and 2nd level approvers to ensure the amounts for each line item of the voucher are accurate and being charged to the correct funding codes.

EB Operations Management: The area regularly reviews vendor processes for efficiency and cost savings and has recently led the following initiatives. The area worked with the EB vendor to reduce overall cost to the State:

- Reduced EB vendor home visits which result in less travel costs for the state;
- Provided enhanced customer service by implementing Vietnamese speaking customer service agents in the EB call center;
- Implemented projects to reduce overall mail volume by combining enrollment packets by household and enhancing electronic communication options for Medicaid and CHIP recipients; and
- Changed key performance requirements including reducing the average speed to answer, abandonment rate, and call handling performance standards. Additional changes include extending the timeframe for processing outreach tasks, transitioning from a “temp to hire” to a direct hire staffing model, migrating to Amazon webservices, full stack automation, and downsizing the Austin, TX facility location.

Interest List Management:

- Enhanced Yourtexasbenefits.com with functionality to allow customers to place themselves on an interest list, check their status, update contact information, and update the Interest List questionnaire as directed by H.B. 3720, 87th Legislature, Regular Session, 2021; and
- Streamlined the process of generating, managing, and retrieving offer letters for the CLASS, MDCP, and DBMD programs in Community Services Interest List (CSIL).

Product Management: The PM team is responsible for the successful implementation of MCS-led TIERS initiatives. One example of an initiative is a new project to modernize how TIERS enrolls individuals into managed care through the utilization of rules engine software.

D. History:

In 2018, PPS extended system functionality to include voucher automation. The purpose was to replace manual processes used for the payment of premiums for all

managed care programs. This new functionality was needed due to the growth and expansion of existing programs and related services. PPS was automated to include a fully functional EDI transaction file to process the monthly capitation data sending the information to several HHSC areas in the CFO's office such as Medicaid Accounting, Budget, and Federal Reporting.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

PPS: Texas contracts with MCOs to facilitate the delivery of medical services to enrolled clients through provider networks. Texas makes payments directly to MCOs and DMOs on a capitated basis. The capitation rate is a fixed contractual fee paid by HHSC to MCOs and DMOs each month for each enrolled client. In exchange, MCOs arrange for or provide a defined set of covered services to clients, regardless of the services used by the enrolled client for the month.

PPS is an application that generates capitation payments for clients enrolled in multiple programs including STAR, STAR Health, STAR+PLUS, STAR Kids, CHIP, CHIP dental, Children's Medicaid Dental Services (CMDs), MMP, and Medicare Advantage.

PPS processes capitation payments by receiving client eligibility and enrollment data from the TIERS, the Service Authorization System (SAS), Clinical Management for Behavioral Health Services (CMBHS), and the EB vendor (MAXIMUS) and generating payment files. The capitation payment files are sent to departments internal to HHSC and to contractors serving the program for payment. In addition to the payment applications, PPS also supports MCOs' DTS.

Product Management: The primary role of the project management team is to serve as TIERS product owners for TIERS system changes requested by MCS business areas because of MCS-led initiatives. At receipt of project concepts, the product owner will draft an epic capturing the objective of the project and any needed system requirements. This process requires coordination with the requesting business area and any impacted stakeholders, including developing a suitable project timeline according to the business area's needs and available TIERS sprint capacity, as shared with other sections of HHSC (ex. AES).

To resolve TIERS inquiries, the team conducts research to ensure that data within the TIERS system is accurate and coordinates with other sections under PES and/or

AES to obtain the information needed to provide an accurate response to the inquiry.

EB Operations: Vendor oversight staff check deliverables for reporting inconsistencies through tracking spreadsheets, conduct quality assurance by listening to a subset of calls that come through the call center, and review case information related to CHIP enrollment fees through use of supporting systems. Regular deliverable reviews include checking policy and procedures for accuracy and compliance with federal and state law.

For inquiries, staff review all relevant systems and files transferred between trading partners to determine the root cause of the issue and provide a comprehensive plan for resolution. Sometimes this results in projects updating applicable processes and procedures. As part of project management, staff hold meetings with applicable stakeholders, review policy, write requirements, review user stories, and submit formal contract communications as needed to implement any changes or process improvements.

For procurements and readiness reviews, staff review all policy and procedures submitted by MCOs and DMOs or the vendor to determine accuracy and compliance with established standards as well as aiding in relevant systems testing to ensure data is flowing as expected.

PSU: PSUs regional staff facilitate the required waiver eligibility functions by coordinating with multiple entities within HHSC as well as with external parties that includes HHSC Community Services staff, MCOs, and applicants or members.

Waiver program members cannot be enrolled in more than one Medicaid waiver program at a time. When coordinating the eligibility determination process for MDCP and STAR+PLUS HCBS, regional PSU staff are responsible for identifying if the individual may be on the CLASS, DBMD, HCS, or TxHmL interest lists by reaching out to internal partners, HHSC IDD PES or Community Services staff to confirm enrollment. If an individual is enrolled in one of the IDD waiver programs, PSU will coordinate with internal partners on the individual's choice of waiver and determine the program enrollment or termination effective date.

PSUs are also the point of contact for the coordination and monitoring of members transitioning from nursing facilities to MDCP or STAR+PLUS HCBS in the community, and individuals aging out of children's programs no longer available to them when they reach age 21.

The STAR+PLUS and STAR Kids PSU Operational Procedures handbooks posted on the HHSC public facing website contains approved policies, procedures, and guidance for PSU staff:

- [STAR Kids Program Support Unit Operational Procedures Handbook](#)
- [STAR+PLUS Program Support Unit Operational Procedures Handbook](#)

Interest List Management (ILM): Operate the Community Services Interest List (CSIL) toll-free hotline 1-877-438-5658 to add and update individuals on the STAR Kids MDCP, STAR+PLUS HCBS, CLASS, and DBMD interest lists, to include managing interest list releases for each of the waiver programs.

ILM follows the internal approved employee guide for operational policies, procedures, and guidance.

Program Support Operations Review Team (PSORT): This team is responsible for conducting MDCP and STAR+PLUS HCBS operational, readiness, and targeted reviews. PSORT evaluates timeliness of contractual requirements, operational procedures as it relates to direct coordination points between MCOs and regional PSUs relating to the following processes:

- Interest List Releases;
- MFP and Nursing Facility Limited Stay;
- Upgrades;
- Annual Assessments; and
- Medical Necessity Denials.

Table 12. PES processes.

File Name	Document Description
S7_CMSCO_PES_Att_01_PPS_Overview	PPS Overview
S7_CMSCO_PES_Att_02_PPS_System_DataFlow	PPS System DataFlow
S7_CMSCO_PES_Att_03_PSORT_Employee_Guide	PSORT Employee Guide

G. Funding: See “Agency Program Information” spreadsheet.

H-I. MOUs and relationships with others: Not applicable.

J. Barriers and challenges:

IT system limitations, including the lack of automated processes to allow back and forth communication between TIERS, TMHP, and Service Authorization System Online (SASO) to relay corrected or updated member eligibility and enrollment data, have created challenges for the STAR+PLUS HCBS program. If these enhancements were completed, it would promote data synchronization and lessen manual entry prone to error.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Contract Management and Procurement Strategy

The Contract Management and Procurement Strategy DEC area within MCS includes the following units: CAPM and the Major Procurements Office (MPO).

Contract Administration and Provider Monitoring

A. Division or program information:

Name of division or program: CAPM

Location within the agency: CMCSO

Contact Name: Michael Blood, Deputy Associate Commissioner

Statutory Citations: 10 Texas Government Code, Subtitle F, Chapters 2261 and 2262; 2 Texas Human Resources Code, Chapter 32; 6 Texas Human Resources Code, Chapter 102; 4 Texas Health and Safety Code, Chapters 250 and 253; 4 Texas Government Code, Chapter 411; 1 Texas Administrative Code, Part 15, Chapter 354, 355, and 357; 42 Code of Federal Regulations, Chapter 4; 45 CFR, Part 96; Social Security Act 1915(c)

B. Objective and major activities:

CAPM is responsible for all non-managed care contracts within MCS and manages provider monitoring activities related to FFS waiver programs.

CAPM administers the enrollment and award contracting processes, contract management activities, and oversight activities for over 6,000 contracts including for community-based programs, facility-based programs, waiver programs, various

procured contracts, and complex high dollar, high risk contracts. In addition, CAPM contract staff:

- Serve as the initial point of contact for applicants, contractors, and stakeholders;
- Complete contract activities and provide technical assistance;
- Manage the contract enrollment and development process; and
- Monitor contracts for contract, programmatic, and fiscal compliance.

This is accomplished via three core areas with multiple teams.

1. Provider Monitoring (PM): Monitors four types of waiver programs and the FFS Financial Management Services Agencies (FMSAs). PM also has a support unit that is responsible for tracking, reporting, and quality assurance activities of the monitoring teams. Three teams within PM:

- Provider Fiscal Compliance team: HCS and TxHmL providers.
- CLASS/DBMD monitoring team: CLASS, including Direct Service Agencies (DSAs) and Case Management Agencies (CMAs), and DBMD providers.
- FMSA monitoring team: FMSAs who provide financial management services to individuals that have opted to self-direct their service delivery in the CLASS, DBMD, HCS, and TxHmL waivers programs, and Primary Home Care (PHC) program.

The monitoring scope and frequency for the waiver contracts is mandated by CMS. Major functions:

- Conducts monitoring and reviews activities of a provider's or agency's financial, personnel, and individual service records to determine compliance with program requirements; and
- Uses monitoring teams to provide billing and program oversight, training, and technical assistance through the process of formal and routine monitoring reviews and complaint investigations.

Provider monitoring staff handling contract monitoring activities are CTCM. This certification is usually obtained within one year of employment with CAPM.

While PM performs monitoring activities for the FFS waiver programs and FFS FMSAs, the Open Enrollment Contracts and Operations unit's Waiver Program

Enrollment team is responsible for performing contract management activities for those contracts.

2. Procured Contract Administration: Includes the Claims Administrator Contract Oversight (CACO) and Contract Administrative Services (CAS) teams. Major functions:

- Manages the contract, monitoring and oversight of contractor performance on various types of procured contracts for Medicaid and CHIP including TMHP, EVV, Business Operations, EB, Vendor Drug, and EQRO contracts;
- Facilitates the development and solicitation of smaller procured contracts including the audit pool contract and drug rebate contracts;
- Provides technical assistance to contractors and program staff;
- Completes desk reviews on contractors regarding fiscal, programmatic, administrative, standard, and enhanced monitoring;
- Creates and amends contracts to add or delete work and services, add, increase, or decrease funds;
- Creates requisitions for purchase orders to encumber funding for services;
- Meets regularly with program staff and contractor to resolve disputes regarding contract requirements, discuss new services, discuss current work items, etc.;
- Assists in procurements for Medicaid and CHIP supporting contracts;
- Assists in solicitations with Compliance and Quality Control (CQC) reviewers, evaluations, legal reviews, and finances;
- Assists with new contract transition phases to operational phase;
- Reviews deliverables for accuracy and assure, once accepted, they are properly recorded in relevant repositories; and
- Uses SCOR and CAPPS Financials systems to maintain relevant and required contract documentation.

CAPM monitors key performance requirements (KPM) in several large contracts critical to Medicaid and CHIP operations. This requires continuous monitoring and interaction with contractors and other HHSC staff to ensure contractors are performing accordingly. If KPMs are missed, LDs associated with these KPMs may be imposed for damages incurred. Direct harm to clients or providers is also monitored and appropriate remedies are pursued. CAPM oversight on these

contracts for KPMs is valuable to ensure that contractors are adhering to the contract requirements and services are delivered as contracted for.

3. Open Enrollment Contracts and Operations (OECO): Includes the Program for All-Inclusive Care for the Elderly (PACE)/nursing facilities/ICF, Waiver Provider Enrollment, and Operations teams.

Major function is performing contract administration, management, and oversight for the below contracts. Scope of this work includes:

- Contract enrollment;
- Contract maintenance, invoice processing, and technical assistance;
- Contract renewal, amendment, extensions, and termination;
- Contract monitoring and oversight;
- Review and analysis of contract performance and deliverables; and
- Determination and monitoring of compliance with contract terms and federal and state policies, rules, and regulations.

In addition, the OECO is responsible for CAPM audit coordination, ORR management for the unit, Provider Computer based Training and Testing, CAPM Reporting, and CAPM Travel facilitation and expense reconciliation.

C. Effectiveness and efficiency information:

For Program Effective Measures see Exhibit 2.

- CAPM has implemented a web-based monitoring tool that allows staff to update standards and measures as new rules and requirements are implemented, eliminating the need for procurement and cost of a vendor to update monitoring tools. CAPM staff report quarterly and annually on performance measures. Trend analysis is conducted on the performance measures to develop and update technical assistance and training for contracted providers monitored by CAPM. Since 2019, when trend analysis was standardized in provider monitoring, performance measure compliance scores have improved steadily.
- Launched on February 21, 2025, the Contract Application and Management for Providers (CAMP) portal, a provider-facing, web-based portal that allows Medicaid waiver and Hospice program applicants and contractors to submit

contract applications and contract management requests to streamline the process and drive efficiencies. This facilitates and tracks applications and contract management requests to both CAPM contract specialists and applicants and providers and provides real-time status updates of the application or contract management request. Prior to the launch of this system, processing of these contracts was exclusively paper based.

- CAPM assisted PACE contractors to implement the CMS published “PACE Final Rule (CMS-4168-F)” including ensuring contractors were familiar with the changes to regulations including grounds for denying PACE applications, immunization requirements for staff, deadlines for reviewing recommendations and scheduling services, and altering their grievance resolution processes.
- CAPM executed 125 waiver contracts in fiscal year 2023, 440 in fiscal year 2024, and 329 in fiscal year 2025 year to date. Fiscal year 2025 is projected to exceed fiscal year 2024 by over 32 percent. Additionally, CAPM remediated 1,200 contract packets that had deficiencies including required missing documentation.
- CAPM digitized and stored over 300,000 legacy contract documents in HHSC systems, transitioned HCS and TxHmL Provider Applicant Training to a new learning management system format, facilitated travel for over 140 travelers annually, and provided unit support and coordination for multiple agency and federal audits including Payment Error Rate Measurement by CMS and Audit of Select Contracts by Internal Audit.

D. History:

The work CAPM has historically done has changed dramatically, as many responsibilities once handled by PCS—or newly required by PCS—have transitioned to the program areas. As a result, the role of the program area contract manager has grown significantly, along with the increasing size and complexity of contracts. While contract managers have always been responsible for contract oversight, their role in contract administration has expanded substantially. In addition to monitoring performance and compliance, they now manage more of the administrative lifecycle—drafting contracts, initiating procurements, and coordinating directly with legal and policy teams. This shift reflects a more comprehensive and hands-on role that demands deeper involvement in planning, execution, and ongoing contract management.

Following transformation, DADS contracting functions for facility-based programs, waiver programs, and community-based programs were consolidated into CAPM. The underlying support functions for these contract types, like Contract Oversight and Support, were dissolved entirely or absorbed into other areas of the agency. The bulk of new contract functions were those previously managed by Long Term Care Regulatory (LTCR) – Licensing which transitioned to CAPM without FTE support. The following is a timeline of the movement of contracting responsibilities into CAPM without sufficient corresponding FTE or contractor support:

- September 1, 2017: HCS and TXHML contracting team combined with the Provider Monitoring team to form Contract Compliance and Provider Monitoring, the predecessor to CAPM.
- September 1, 2018: Nursing facilities (transferred from LTCR – Licensing), CLASS, DBMD, FMSA, and Transition Assistance Services (TAS) contracts were transferred without dedicated FTEs.
- February 1, 2019: One FTE was added to manage nursing facility contracts.
- June 2019: ICF/IID and Hospice contracts were transferred from LTCR - Licensing, also with no FTEs.
- August 2019: An additional FTE was added for ICF/IID contracts. Approximately 500 Medicaid Administrative Claiming (MAC) contracts transitioned from HHSC Regulatory to CAPM with no additional FTEs.
- September 1, 2019: Six FTEs were added to the nursing facility and ICF/IID contract team. Simultaneously, four positions were reassigned from managing HCS, TxHmL, CLASS, DBMD, TAS, and MAC contracts to manage major procured contracts which saw an increase in monitoring requirements.
- June 2020: An additional FTE was added to manage approximately 3,000 contracts for HCS, TxHmL, CLASS, DBMD, TAS, and MAC.
- February 2022: One more FTE and five contractor positions were added for managing HCS, TxHmL, CLASS, DBMD, TAS, and MAC. The five contractors are responsible for application processing.

The unsupported, patchwork-style of contract movement into CAPM, while prior support systems and teams dissolved, absorbed, or were reassigned resulted in a breakdown in the HHSC contract enrollment and management process creating long delays in application processing and in contract changes or updates. During this time, PCS made several revisions to the Procurement and Contract Management Handbook that impacted contract oversight including moving responsibilities

directly to CAPM contract managers like attestations, liability provisions, and other changes mandated by statute or rule for the agency to comply with and which is more properly a PCS agency-wide function.

These changes, developed to apply to the broadest number of contracts by often using the simplest contract example, did not consider the unique challenges they would pose to CAPMs FFS, zero-dollar value contracts like HCS and TXHML which have oversight functions spread throughout the agency, or complex procured contracts. The team has experienced higher than average turnover annually because of these challenges, including at the managerial level.

The 89th Legislature, 2025, appropriated MCS funding to fill approximately 28 previously unfunded FTEs to support this work.

Beginning fiscal year 2025, CAPM began implementing an improved and retooled approach to processing applications and working through the backlog of pending contract actions. Preliminary numbers indicate that CAPM will execute 32 percent more contracts in fiscal year 2025 than those executed in fiscal year 2024.

Another area of historical change is in provider monitoring. The workload for CAPM has significantly increased and now incorporates new functions. As part of remediation for CMS waiver performance measures, trainings and new forms were identified as process improvements and these tasks were transitioned to CAPM. For example, staff are now developing forms, training materials, and webinars designed to assist providers in meeting documentation requirements related to service delivery. Originally, provider monitoring function was to assess compliance with policies and rules established by federal and state regulations. However, the scope has extended to include provider education and training to ensure providers understand and can effectively implement service requirements while ensuring client safety.

Additionally, the team has been tasked with outreach efforts to encourage individuals and entities to apply to become HHSC contractors, with a focus on underrepresented provider types such as CLASS and DBMD.

The transition of claims administration for LTC claims to TMHP in May 2022 has altered the responsibilities of the team that oversees HCS and TxHmL reviews. The team is now responsible for collecting recoupments and overpayments because there is no longer any active billing in the Client Assignment and Registration (CARE) system to offset the recoupments. As a result, there are recoupments in

CARE that must be collected manually, and the reconciliation process for these claims has been absorbed by the provider monitoring team. Responsibilities now include collecting manual payments from providers, identifying appropriate funding codes, determining federal match eligibility and amounts (including enhanced match rates under the COVID-19 PHE), and following up with providers who fail to remit payment according to the repayment agreement.

The transition to CARE from TMHP disrupted upstream and downstream data retention processes. CAPM is now tasked with reviewing over 20,000 rows of data monthly to determine the accurate number of active group homes, host homes, and companion care residences. This data is critical not only for oversight but also for verifying children in DFPS conservatorship are placed with providers that meet performance standards. In addition to cleaning and validating the data manually, staff must also manually match provider numbers with associated national provider identifiers (NPIs) before submitting information to TMHP for use in PEMS.

Provider monitoring staff are currently maintaining the CLASS Case Management Agencies, CLASS Direct Services Agencies, and DBMD provider choice lists. This function falls outside the intended scope of CAPM responsibilities and was added five years ago when the AES Contract Oversight and Support (COS) unit was disbanded. The team updates these lists monthly, as the information is public-facing and required for external publication.

HCBS Compliance and Heightened Scrutiny Reviews: CAPM staff are now responsible for the oversight of compliance with certain aspects of the federal HCBS settings requirements (implemented March 2023) and conducting heightened scrutiny reviews. In certain circumstances, monitoring staff perform site visits, often before the provider is fully operational or Medicaid-enrolled, to assess compliance.

During these visits, staff gather provider responses and collect evidence regarding compliance with federal settings rules. The findings are then submitted to the CMS for final determination regarding the setting's compliance status.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

CAPM has established internal contract monitoring policies and procedures that incorporate the minimum standards and outline processes for standard and enhanced contract monitoring requirements. The policies address how program and

contract areas ensure applicable staff are in compliance with requirements of Texas Administrative Code, Section 20.166.

Contract monitoring activities are documented in the designated central repository and can be planned, ongoing, periodic, or unscheduled. These may be conducted in a variety of ways, but they must remain objective and address contract complexity, value, performance, and risk. There are standard items each program area and contracting area may review across all contracts. However, monitoring activities, questions, methods, and tools must also target specific elements or issues of concern unique to a particular contract or a group of contracts with similar or like services. In determining what monitoring activities to conduct for a given contract, CAPM considers the following:

- Type of purchase;
- Contract requirements;
- Changes in the contractor's operations, personnel, or environment (e.g., shifts in population demographics or staff turnover);
- Individual risk factor scores on programmatic or fiscal risk assessment instruments. Risk factors can be scored the highest to identify weaknesses and help develop solutions for improvement;
- Prior monitoring history and past performance (e.g., problems recently resolved, recurring issues); and
- Contractor strengths in areas tested and proven to be continuously compliant, in which case it may be appropriate to omit or reduce monitoring of those areas.

OECO generally follows the "Contracts- New Applications for all Waiver Programs" and the "CAPM Waiver Contract Enrollment" manuals.

The contract actions and management functions of OECO consists of requests for information changes, contract updates, changes of ownership, and sanctions and terminations.

The CAPM team assess FFS Medicaid waiver program providers' compliance with program requirements through both programmatic and fiscal monitoring reviews. These reviews are conducted according to the federally approved monitoring frequencies. Provider monitoring reviews providers for the CLASS, DBMD, HCS, and TxHmL waivers.

Additionally, CAPM’s provider monitoring conducts separate contractor and fiscal and tax monitoring reviews for Financial Management Services Agencies (FMSAs). These agencies serve as fiscal intermediaries for individuals who choose to self-direct their services in CLASS, DBMD, HCS, TxHmL, or PHC.

Monitoring is a comprehensive process that ensures contractors comply with federal, state, and contractual requirements. Monitoring is divided into programmatic, fiscal, and contract compliance reviews, depending on the program and agency type. The goal is to ensure that services are delivered appropriately and that funds are used correctly.

Provider performance for all waiver program types and agencies is evaluated through the CMS waiver performance measures, which are reported quarterly and annually. These measures help assess the overall effectiveness of the programs.

If a performance measure falls below the 86 percent threshold, HHSC is required to submit remediation plans to CMS for review and approval. These plans outline the steps HHSC will take to address areas of underperformance and ensure continuous improvement in service delivery and program compliance. The integration of regular reviews, recoupment measures, and performance tracking ensures a high level of service quality and financial oversight.

Table 13. CAPM processes.

File Name	Document Description
S7_CMCSO_CAPM_Att_01_Contract_Expiration_Termination_Closeout	Contract Expiration, Termination, and Closeout Process doc
S7_CMCSO_CAPM_Att_02_Contract_Managers_Process	Contract Managers Process doc
S7_CMCSO_CAPM_Att03_Enrollment_Broker_Deliverables	Enrollment Broker deliverables process doc
S7_CMCSO_CAPM_Att_04_CLASS_DBMD_Provider_Review	Review process flow chart for CLASS and DBMD providers
S7_CMCSO_CAPM_Att_05_FMSA_Monitoring_Review	Flow chart of FMSA monitoring review
S7_CMCSO_CAPM_Att_06_Provider_Fiscal_Compliance_Review	Flow chart of provider fiscal compliance review
S7_CMCSO_CAPM_Att_07_Procurement_Forecast_Action_Plans	Process doc for procurement forecast and action plans

G. Funding: See “Agency Program Information” spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

DFPS: DFPS submits a prospective provider and location of group home for a child foster care placement. Provider monitoring conducts research on group home locations and providers that are considered for child foster care placement. Provider Monitoring submits the contractor’s performance as an HCBS waiver provider and provides historical monitoring results and previous contract actions and sanctions. DFPS uses this information to determine if the provider is an appropriate placement for foster care residential placement of a child.

CMS: CAPM partners with CMS to manage PACE through a three-way agreement, with CMS overseeing federal regulations, CAPM conducting readiness reviews, and PACE organizations operating the programs, all while monitoring and auditing for quality and compliance.

Texas Department of Public Safety (DPS): CAPM partners with DPS to utilize and maintain access to the TxDPS Crime Records Division Secure Website including auditing of access and record reviews.

OIG: CAPM collaborates with OIG on program development, Medicaid enrollment and renewals, and refers potential waste, fraud, or abuse in programs under its oversight.

OAG: Direct contact with OAG investigators from the Medicaid Fraud Control Unit. Discuss contract and programmatic requirements. and identify the appropriate funding stream for individuals enrolled with providers (e.g., LTC FFS, acute care, or managed care).

M. Barriers and challenges:

- Challenge 1, Contract Ecosystem: The unsupported, patchwork-style of contract movement into CAPM, while prior support systems and teams dissolved, absorbed, or were reassigned resulted in a breakdown in the contract enrollment and management process creating long delays with application processing and in contract changes or updates. These delays can exceed 36 months. Refer to Section D for history of changes.

- **Challenge 2, Complexity and Workload:** CAPM's workload continues to hover around 400 percent of comparable areas in HHSC. Marginal improvements in efficiency have been achieved, but the contract to FTE ratio remains grossly out of alignment and is not sustainable. CAPM has a backlog of thousands of contract applications and contract actions for waiver, nursing facility, and hospice service providers that results in provider abrasion and escalations. The volume of requests for changes in ownership in both hospice and nursing facilities continues to be very challenging with the current team size.

An emerging challenge has been the entry of private equity firms into the long-term care space such as hospice and nursing facilities. The complexity and frequency of changes of ownerships has overwhelmed the team, and the legal structures of these organizations are difficult to identify.

The agency maintaining a continuous open-enrollment process for waiver and hospice contracts further exacerbates the situation. The volume of applications and contractors exceeds the actual need for many areas of the state, including major metropolitan areas like Dallas/Fort Worth and Houston. The large number of contractors in these areas presents oversight challenges and places additional demands on the agency's limited resources, particularly when striving to maintain consistent oversight for lower-dollar contracts.

The five-year terms on FFS waiver contracts have increased the workload substantially for limited to no benefit. It has increased application and contract action delays across all programs, causes breaks in service to individuals served under the contracts, threatens contractor business operations, increases employee claims with Texas Workforce Commission against these providers for not paying them, and adds an administrative burden to contractors who must already submit revalidation for Medicaid enrollment and licensing renewals.

As mentioned in Section D, the 89th Legislature, 2025, appropriated MCS funding to fill approximately 28 previously unfunded FTEs to support overcoming these challenges. CAPM is in the process of assessing resource allocation by team and initiating the hiring process.

- **Challenge 3, Contract Extensions and Procurement Timelines:** For procured contracts, HHSC must not use appropriated funds to pay for an extension to an existing contract beyond the base term and optional extensions provided for in that contract unless certain conditions are met. The duration and cost of the extension is limited to not more than one additional option period as defined in the contract to address immediate operational or service delivery

needs. If the contract does not contain a defined option period, the extension is limited to one year per the General Appropriations Act.

The procurement for these large system contracts, such as those contracts that make up Medicaid Enterprise Systems, is lengthy and can take multiple years to complete, the transition times from one vendor to another can be up to 24 months and rarely is less than six, and HHSC has a number of these contracts which are all interrelated in functions performed and the functions have to be available 365 days a year. The disconnect between procurement timelines, transition lengths, and the shortened term for contracts, keeps the agency in a perpetual procurement cycle, often forced to automatically use the optional extension years well in advance to properly plan and transition a replacement procurement because there are not resources to continuously procure, and the contracts cannot reasonably be extended year to year. The limitation of not recognizing these unique contracts drives costs upward for both vendors and HHSC. Additionally, because these systems interface with each other, reprocurring a contract "out of sequence" creates large risks for service delivery and access to care.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Major Procurement Office (MPO)

A. Division or program information:

Name of division or program: MPO

Location within the agency: CMCSO

Contact Name: Anthony Schnabel, Director of Major Procurements

Statutory Citation: Texas Government Code, Section 62.155, and Chapters 533, 540, and 2155

B. Objective and major activities:

MPO assesses, plans, prioritizes, and performs a variety of technical activities for MCS' major procurement initiatives to ensure the division's needs are effectively represented.

This includes leading the planning, development, review, and revisions of multiyear, multi-million-dollar competitive RFPs and other solicitations, including but not limited to Medicaid Enterprise System vendors for claims processing and financial reporting, business operations, enrollment broker, pharmacy benefit management for the FFS program, external quality review organization, and Medicaid and CHIP managed care contracts. MPO also supports determining the appropriate solicitation method, drafts statements of work and performance measures, creates best value factors, establishes timelines, procurement posting, and management of the procurement process within MCS, in coordination with PCS.

MPO leads the authorship and editing of procurement documents to ensure competitive procurements meet MCS, and HHSC procurement requirements, standards, and timelines.

These procurements are inherently high-risk as they directly impact Medicaid client services and providers and the administration of over \$36 billion in client services. State contracting requirements, outlined by CPA, apply to most HHSC procurements which PCS serves an important support function for HHSC. Contracts in MCS are typically never under \$10 million and contract values are frequently in the hundreds of million-dollar range. PCS' organization and practices are not designed for these types of contracts. In addition, because it is not PCS's role to be involved in program administration, they are not able to assure these types of procurements fully meet MCS needs. For example, for most procurements price is a best value criteria. Medicaid managed care contracts have the price dictated by HHSC (Actuarial Analysis), so the development of best value criteria must be based on program goals and objectives.

The ecosystem of managed care requires not just managed care contracts. Federal law requires states with a managed care model to have contracts for an independent enrollment broker, an independent external quality review organization, and requires MMIS and MES vendors be able to interface with all these contractors. MPO staff participate in day-to-day administration of the Medicaid program and CHIP, stay abreast of major programmatic changes which will impact future solicitations, understand the state and federal regulatory frameworks around procurement, contracting, and administration of the Medicaid and CHIP programs, and are current on the needs of Medicaid and CHIP programs. MPO staff have direct access to MCS leadership.

C. Effectiveness and efficiency information:

For Program Effective Measures see Exhibit 2.

Timely contract execution of highly complex administrative, technology, and professional services contracts which results in effective, efficient administration of the Medicaid program to better deliver high quality health care services to Texans.

Successful contract execution with a vendor that demonstrates best value requires significant advanced planning and development of a solicitation with clear objectives and specifications which meet evolving federal and state requirements, customized to meet the strategic goals and specific needs of the particular program within Medicaid.

D. History:

The services and functions of the MPO have not changed from original intent. There remains, and will always be, a need for a specialized procurement office to address the uniqueness of Medicaid procurement and contracting. However, the challenges faced have increased as the work has become more complex to properly administer, faces significantly more litigation risks, and requires even more specialization to effectively administer. As HHSC moves forward on Medicaid modernization (MES) efforts and reprocures existing critical Medicaid support contracts, MPO is best positioned to ensure MCS needs, such as clear contract requirements, remedies, and improved coordination among vendors is achieved in future solicitations.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

MPO uses a general operating procedure to outline roles and responsibilities in procurement. Procedures for staff include procurement commencement, solicitation development, project management, and approval procedures. MPO helps coordinate project stakeholders and subject matter experts in all of these processes. Guidance is specific to MPO. For example, guidance for evaluation tool development helps ensure the evaluation tool is tailored to the solicitation and ensures distinction amongst respondents for Medicaid procurements. Rather than a pass and fail approach, MPO develops solicitations based on specific program goals and objectives, particularly as they relate to the quality of services delivered by potential Medicaid vendors.

G. Funding: See "Agency Program Information" spreadsheet.

H-M. MOUs, Relationships with others, Barriers, Additional, Regulatory, and Complaint Information: Not applicable.

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VII. Guide to Agency Divisions and Programs

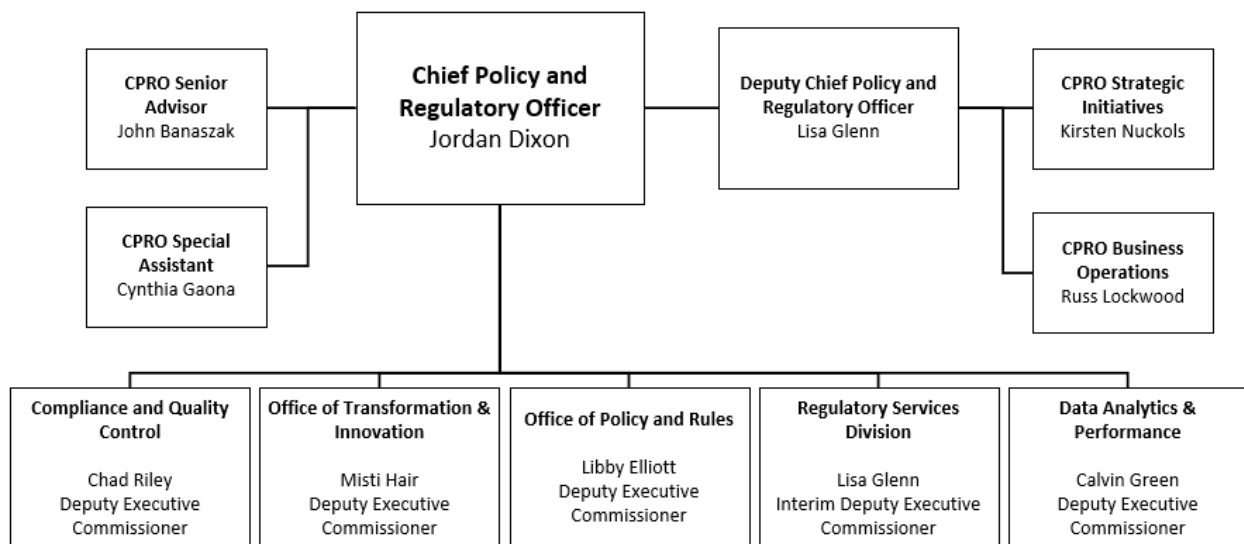
Chief Policy and Regulatory Officer

Chief Policy and Regulatory Office

Contacts:

- Jordan Dixon, Chief Policy and Regulatory Officer, jordan.dixon@hhs.texas.gov
- Lisa Glenn, Deputy Chief Policy and Regulatory Officer, lisa.glenn@hhs.texas.gov

Figure 1. CPRO organizational chart.



Overview

The Chief Policy and Regulatory Office (CPRO) is comprised of five divisions: Compliance and Quality Control (CQC), Data, Analytics, and Performance (DAP), Office of Policy and Rules (OPR), Office of Transformation and Innovation (OTI), and the Regulatory Services Division (RSD). CPRO divisions have broad responsibilities ranging from regulatory oversight of healthcare providers to quality control over procurement activities.

OPR supports the Health and Human Services (HHS) executive leadership by collaborating with and advising program areas to ensure a coordinated system-wide approach to developing and reviewing rules and policy, advisory committee appointments and meetings, and rulemaking activities.

OTI serves as a hub for process improvement throughout the HHS system, providing innovative solutions to high-impact, cross-divisional operational issues. This office is responsible for initiating projects that streamline operations, enhance service delivery, and introduce new technologies or methods to improve processes and outcomes.

DAP enhances the Health and Human Services (HHSC)'s capacity for data-driven decision-making by creating, coordinating, and maintaining an integrated system of processes, services, and solutions that serve as the framework for meeting the agency's data, analytics, and performance needs. DAP is responsible for responding to data and analytics requests from the legislature, public, and agency staff to effectively operate programs, respond timely to open records and media requests, meet litigation needs, and fulfill state and federally required reporting. Drawing from many HHSC data sources, DAP provides recurring and ad hoc reporting, visualization development and support (including Geographic Information System (GIS) and mapping tools), data quality/management, and research and evaluation services.

CQC's role is to improve oversight of HHSC procurement and contract management functions. CQC plays a central role in ensuring HHS conducts its procurement processes in accordance with relevant laws and standards. It is responsible for monitoring and maintaining the quality and integrity of contracting processes and ensuring HHS programs adhere to internal guidelines. This oversight is critical in maintaining the transparency and accountability of the procurement system.

RSD protects the health and safety of consumers of long-term care, childcare, and acute health care facilities. RSD also licenses and certifies some professionals, oversees enforcement activities, and manages the intake of complaints and incidents, which are investigated to maintain high standards of care and safety. The division's work is fundamental to protecting vulnerable populations and ensuring providers deliver care and services in a safe, effective, and compliant manner.

To support and maintain day-to-day operations, CPRO includes the deputy CPRO, senior advisor, business operations lead, and special assistant.

Office of Policy and Rules

A. Name of division or program:

Name of division or program: Office of Policy and Rules

Location within the agency: CPRO

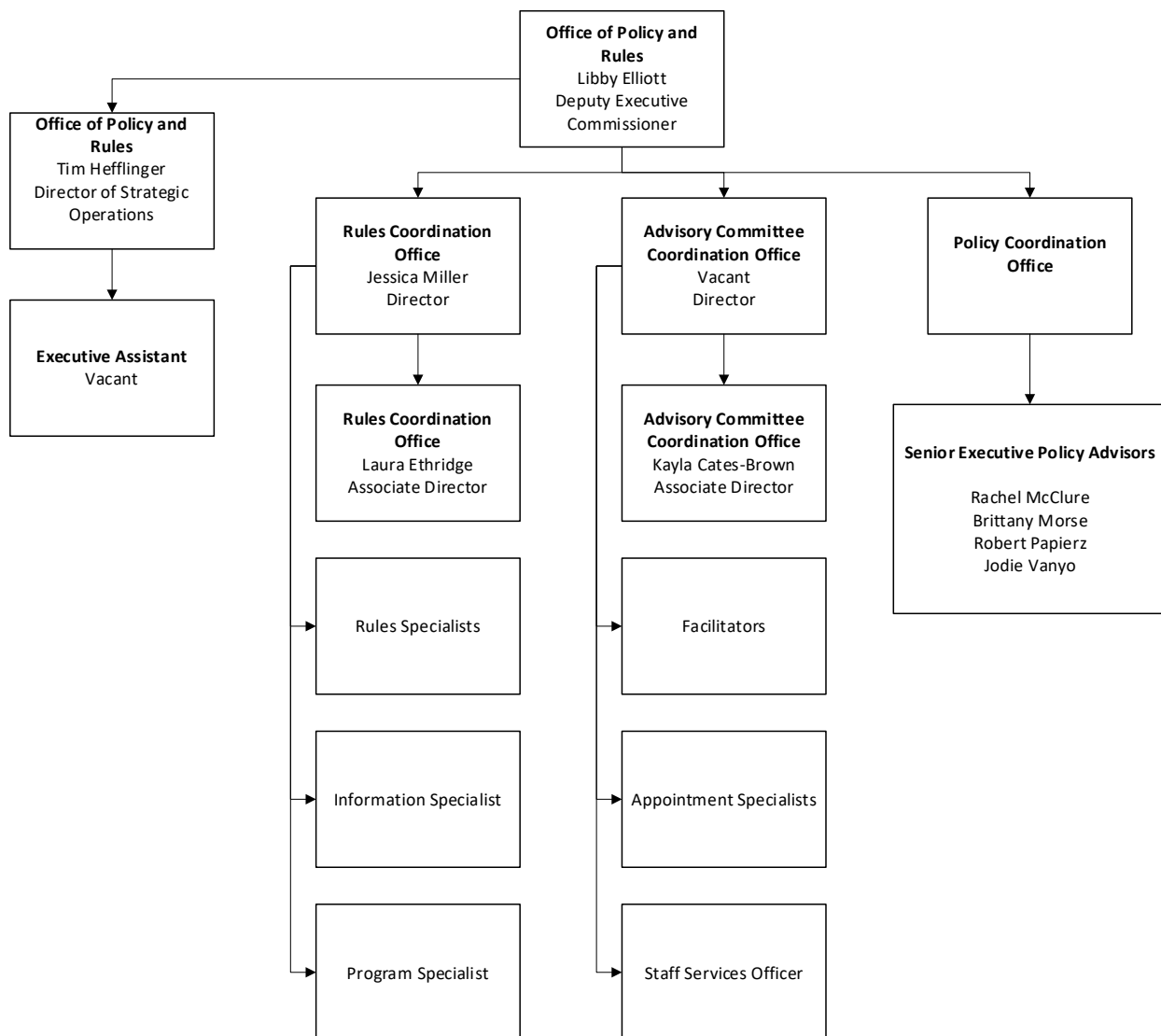
Contact name: Libby Elliott, Deputy Executive Commissioner (DEC)

Statutory citation: Texas Government Code, Chapter 524, Subchapter D, Section 524.0152; Texas Government Code, Chapter 523, Subchapter C, Section 523.0102; Texas Government Code, Chapter 523, Subchapter E, Section 523.0201; Texas Government Code, Chapter 523, Subchapter E, Section 523.0203; 2024-25 General Appropriations Act, House Bill (H.B.) 1, 88th Regular Session, 2023 (Article II, HHSC, Rider 142 and 143); Texas Government Code Section 523.0107.

B. Objective and major activities:

OPR consists of three offices which ensure a coordinated system-wide approach to developing and reviewing rules and policy, advisory committee appointments and meetings, and rulemaking activities.

Figure 2. OPR organizational chart.



Policy Coordination Office (PCO): The Senior Executive Policy Advisors (SEPA) assist agency leadership and program areas by:

- Reviewing agency policy documents such as rules and rule documents, memos, and legislative and advisory committee reports;
- Drafting operational circulars, reports, and presentations;
- Conducting in-depth research and analysis on policy issues;
- Supporting legislative implementation; and
- Managing or assisting with special projects.

Advisory Committee Coordination Office (ACCO): Manages a centralized process for tracking and coordinating executive commissioner appointments to advisory committees and provides full administrative support to the HHSC Executive Council. ACCO coordinates with program areas to facilitate their advisory committee meetings and ensure committees conduct these meetings in compliance with the Open Meetings Act. ACCO follows established procedures that promote uniformity and transparency. Since 2021, ACCO has adopted a hybrid (both virtual and in-person) meeting format for all meetings to which they lend administrative support.

Rules Coordination Office (RCO): Manages a centralized process for rulemaking in compliance with Texas Government Code, Chapters 2001 and 2002. RCO assists program areas with:

- Rule project timelines and planning; and
- Processing rulemaking proposals and adoptions, emergency rules, and statutorily required rule reviews, such as the “Four Year Rule Reviews” required by Texas Government Code, Section 2001.039.

RCO processes emphasize transparency, accuracy, and efficiency, while prioritizing rules needed to implement legislation.

C. Effectiveness and efficiency information:

OPR’s key performance measures are shown in the following tables.

Table 1. ACCO key performance measures.

Measure	Description	Data Source/ Methodology
Compliance with Open Meetings Act	Percentage of meetings supported and/or facilitated by ACCO that comply with the Open Meetings Act	Internal ACCO tracking documentation
Appointments Process Duration	Average number of business days for ACCO and program to complete the appointments process – Measures systemwide performance	Internal ACCO tracking documentation
Advisory Committee Appointment Statuses	Information on Advisory Committee membership status(es)	ACCO Member Tracker Application Reporting from Salesforce

Table 2. RCO key performance measures.

Measure	Description	Data Source/ Methodology
Compliance with Four-Year Rule Review Requirements	Percentage of required Four-Year Rule Reviews that are complete	Rule Review Tracker Data
Bills Requiring Rules Project Completion	Percent and number of rulemaking projects required by legislation complete, in progress, and on hold	Rulemaking Application Reports data from Salesforce; Internal RCO tracking documentation
Rulemaking Processing Time	The duration of the rulemaking process from start to finish	Internal RCO tracking documentation

Table 3. PCO key performance measures.

Measure	Description	Data Source/ Methodology
Volume of policy review assignments	Number of policy review assignments, including Rules, Reports, and Memos	SEPA Performance Measures Spreadsheet
Volume of Special Projects	Information on Completed Special Projects and engagements	SEPA Performance Measures Spreadsheet
Timeliness of Rule Project Reviews	The percentage of Rule packet reviews completed within the prescribed number of business days	SEPA RCO Performance Measures Spreadsheet

D. History:

In 2016, HHSC formed RCO to assist with rulemaking. Initially, RCO was part of the Office of Policy and Performance. The Office of Policy and Performance underwent significant organizational changes in November 2017, which resulted in the separation of RCO and policy advisors from the rest of the division.

In January 2018, HHSC transferred ACCO functions from Government and Stakeholder Relations (GSR) to OPR. This completed the transformations that created OPR in its current formation.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

DEC-OPR: DEC-OPR determines the strategy and direction of the office and has three direct reports in addition to the SEPAs: the director of Strategic Operations (DSO-OPR), RCO director, and ACCO director. In addition to administering the Office, DEC-OPR is responsible for the Finding of Fact process. The Finding of Fact process is required by Texas Government Code, Chapter 2254, Subchapter A, Section 2254.028, and requires state agencies, prior to entering into a major consulting services contract, to obtain a "finding of fact" from the Office of the Governor that the consulting services are necessary and cannot be performed by another state agency or institution of higher education.

Relevant Process Maps:

- [Finding of Fact Process](#)

PCO: In addition to conducting regular SEPA duties, executive leadership or an HHSC program area may request a SEPA to assist with, manage, or lead a special project or workgroup. To receive SEPA assistance, an HHSC or Department of State Health Services (DSHS) team member must fill out a SEPA Request Form. The DEC-OPR reviews the request and assigns a SEPA according to resource availability and the knowledge and abilities of each SEPA.

Relevant process maps:

- [PCO ProcessMaps](#)

Primary processes include:

- SEPA Review of Rule Projects;
- SEPA Review of executive commissioner Memos;
- SEPA Contribution to and Review of Reports;
- SEPA Review of DSHS Advisory Committee (AC) Appointment Recommendations; and
- SEPA Special Projects.

ACCO: ACCO director directs the activities of the advisory committee facilitators and the appointment specialists. The facilitators facilitate advisory committee and HHS Executive Council meetings, and the appointment specialists process advisory committee solicitations and appointments. There is cross-training between these two groups.

Relevant Process Maps:

- [AC Nominee Process](#)
- [AC Appointments Process](#)
- [ExecCouncilProcess](#)
- [MeetingFacilitationProcess](#)

Primary processes include:

- Processing AC nominations;
- Processing AC appointments;
- Facilitating HHS Executive Council meetings; and
- Facilitating AC Meetings.

RCO: RCO director, along with the associate director, leads the activities of the rules specialists, who manage and facilitate the entire rulemaking process RCO is supported administratively by an information specialist and a rules filing coordinator.

Relevant Process maps:

- [Rulemaking](#)
- [Comment Lifecycle](#)

Primary processes include:

- Rulemaking
- Four Year Rule Review

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

ACCO may interact with other levels of government while coordinating advisory committee meetings. Because ACCO's role is to coordinate advisory committees and not define their programming, ACCO's interactions with other governmental entities occur *incidentally* as a result of individual Advisory Committee members'

affiliation with a governmental entity and not because ACCO is mandated to interact with that entity. ACCO may also interact with representatives of local, regional, federal, or tribal units of government when soliciting applications or nominations for advisory committees.

J. Barriers and challenges:

- Challenge 1, RCO: The volume of rules adopted in response to legislation and federal mandates continues to rise. As of Spring 2025, the Texas Administrative Code has 44,241 rules, of which HHS rules comprise 9,892 (22 percent).
- Challenge 2, RCO: In addition to the public comment period required by the Administrative Procedures Act, Texas Government Code, Section 523.0102, adds a second requirement for HHSC by requiring the public have the opportunity to comment on proposed rules at an HHS Executive Council meeting, which must be held at least four times a year. The requirement to hear public comment at HHS Executive Council is redundant for certain types of rules that have separate hearing requirements. Currently, the agency must slow the rulemaking process to arrange for the publication of a proposed rule in the *Texas Register* to coincide with a quarterly HHS Executive Council meeting to ensure it is open for public comment when the meeting occurs. To reduce the rule-making timeline, in July 2025 HHS began holding monthly HHS Executive Council meetings. Increasing the frequency of HHS Executive Council meetings is expected to reduce the duration of rules projects by up to seven weeks.
- Challenge 3, ACCO: Each legislative session may result in legislation requiring formation of new advisory committees. Each new advisory committee increases the workload for ACCO, Office of Chief Counsel, and HHSC program areas to ensure continued compliance with agency policies and the Open Meetings Act – both of which are key to transparency for the public, regulated entities, and the Texans we serve. In addition, new advisory committees mandated by the legislature often have defined purposes that overlap significantly with existing advisory committees.
- Challenge 4, ACCO: ACCO provides support for executive commissioner appointments and meeting facilitation support/guidance. The number of advisory committees that receive either full or partial ACCO support is 45 – more than any other state agency by a significant margin.
 - Appointment Support Only: 2 DSHS Committees

- Facilitation Support Only: 8 HHSC Committees, 11 DSHS Committees
- Full Support: 21 HHSC Committees; 3 DSHS Committees

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Office of Transformation and Innovation

A. Name of division or program:

Name of division or program: Office of Transformation and Innovation

Location within the agency: CPRO

Contact name: Misti Hair, Deputy Executive Commissioner

Statutory citation: Texas Government Code, Chapter 2056, Sections 523.0155 and 2054.1264; Senate Bill (S.B.) 200, 84th Legislature, Regular Session, 2015.

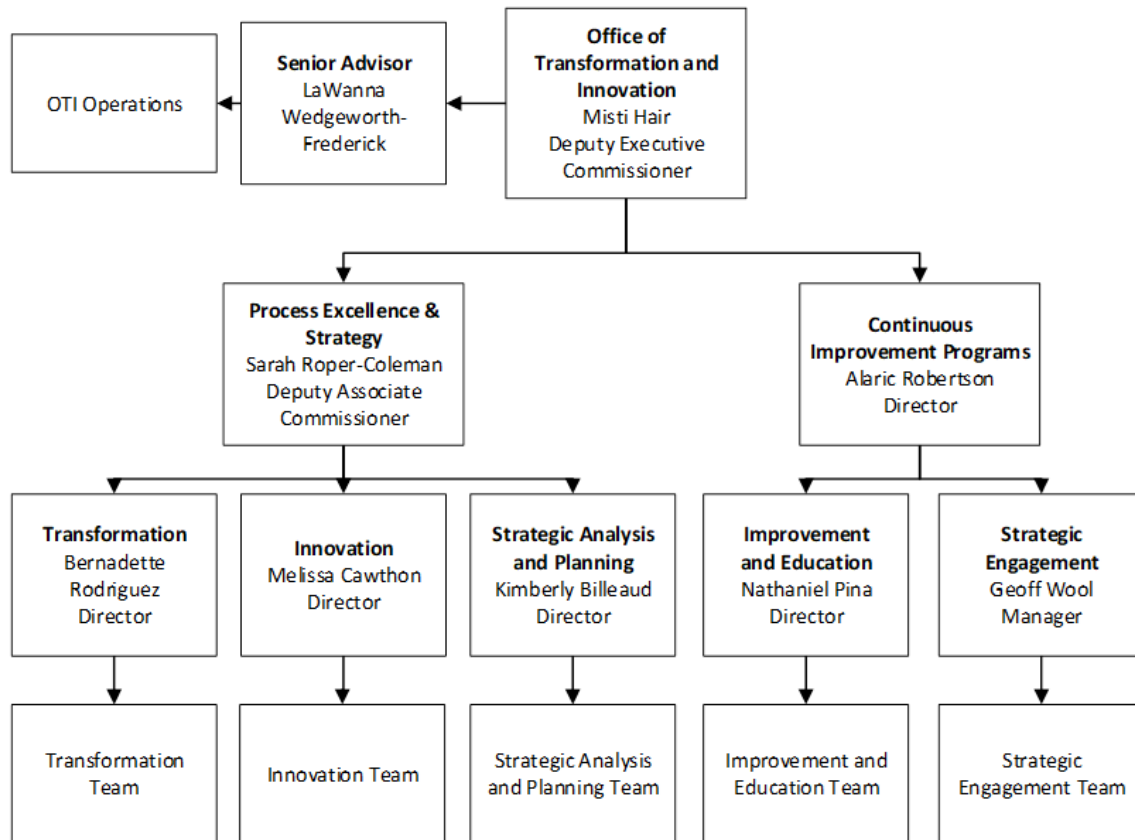
B. Objective and major activities:

OTI is the hub for continuous improvement and change management efforts that promotes and enables an efficient, accountable, and data-driven organization as envisioned by the Texas Legislature. OTI's overarching goals are to improve and strengthen communication and identify and implement actionable, tangible improvements in the daily operations of HHS employees, thereby improving service delivery outcomes and enhancing Texans' health and safety. OTI includes three divisions: OTI Operations, Process Excellence and Strategy, and Continuous Improvement Programs. OTI's divisions collaborate with all areas of HHSC and the DSHS to identify, develop, and implement transformative and improvement initiatives. OTI provides expertise in the following areas:

- Identifying, implementing, and supporting process and system improvements;
- Facilitating coordination across HHS agencies and divisions;
- Promoting a culture of continuous improvement through training, consultative services, and technical support to build process improvement expertise throughout HHS;
- Applying a structured approach to change management to promote participation and buy-in;

- Planning and facilitating ongoing transformation activities; and
- Developing and managing the HHSC strategic planning process.

Figure 3. OTI organizational chart.



C. Effectiveness and efficiency information:

OTI's key business functions are measured through internal performance metrics reported through the executive commissioner on a quarterly basis.

Table 4. OTI core business functions performance measures.

Measure	Measure Description	Methodology	Data Source	Annual Target
Continuous improvement projects and initiatives completed	Total number of activities with an actual end date within the reporting period. Includes: advisory services, initiatives, process improvement projects, rapid improvement projects, trainings, and transformation projects.	Sum of select activity types with an actual end date within the reporting period.	OTI Work List (SharePoint)	70
Business area salary cost avoidance	OTI FTE resource allocation in hours; Business area project team member average salary.	OTI = total number of hours OTI FTEs worked on the activity. Business Area = average salary (plus 32.52% for fringe) of all business area staff assigned to the project team converted to an hourly rate (FY2024 = \$39 per hour; FY2025 = \$50 per hour).	Time Allocation Form Results (SharePoint)	\$150,000
Customer Satisfaction Rating	Overall customer satisfaction with responsiveness; professionalism and courtesy; timeliness of service delivery; skills and expertise.	Average score from customer service principles.	SSA customer survey results (Excel) OTI Annual Feedback Assessment Improvement Review (FAIR) report	4.5

D. History:

In response to recommendations from the 2013-14 Sunset Advisory Commission review and resulting legislation (S.B. 200, 84th Legislature, Regular Session, 2015), HHSC was reorganized to produce a more efficient, effective, and responsive system. HHSC created OTI to assist with implementation of the extensive changes that are commonly referred to as "Transformation."

S.B. 200 required HHSC to develop a transition plan that outlined the system's reorganized structure and to submit the plan to the Transition Legislative Oversight Committee (TLOC). As required by Texas Government Code, Section 531.02041, if the executive commissioner "proposes to make a substantial organizational change to the health and human services system that was not included in the transition plan, the executive commissioner shall, before implementing the proposed change, submit a report detailing the proposed change to the Health and Human Services TLOC." OTI served as the lead for Transformation-related activities, including notification to TLOC of substantial changes, until September 1, 2023, when the subchapter expired.

S.B. 24, 88th Legislature, Regular Session, 2023, transferred programs in the Prevention and Early Intervention (PEI) division at the Department of Family and Protective Services (DFPS) to HHSC's Family Health Services (FHS) division. OTI led this transfer, and on September 1, 2024, the PEI program and staff transferred to HHSC as Family Support Services (FSS). The successful transfer of FSS ensured there was no disruption of services to programs and recipients including data collection, reporting, and budgeting. Preventing disruption of these services allows both agencies to meet all legislative and federal reporting requirements.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

OTI works to drive system-wide, performance-based improvement pursuant to the mandate of Government Code, Section 523.0155, requiring HHSC establish an executive level office to oversee and coordinate policy and performance efforts across the system. OTI's three divisions work in close collaboration with program areas to identify, develop, and implement improvement initiatives across the HHS system. These divisions include Operations, Process Excellence and Strategy, and Continuous Improvement Programs.

OTI Operations: Provides ongoing support to OTI divisions and teams. OTI Operations houses administrative and business operations functions for OTI. The division supports the development and implementation of internal initiatives and supports OTI implementation of systematic improvements across HHS. OTI Operations manages and supports the Continuous Improvement Ideas Portal process.

Process Excellence and Strategy: Includes three teams, Transformation, Innovation, and Strategic Analysis and Planning.

- The Transformation team focuses on improving the efficiency and effectiveness of HHS programs, operations, and processes. The team continues to identify, implement, monitor, and report on organizational and operational changes throughout the HHS system.
- The Innovation team focuses on identifying opportunities to research, develop, and implement forward-thinking, innovative initiatives and projects throughout HHS. The team works to break down organizational silos, strengthen collaboration across HHS departments, divisions, and agencies, and develop solutions to complex, high-impact operational issues facing HHS.
- The Strategic Analysis and Planning team oversees the HHSC strategic plan, monitors internal metrics, and coordinates OTI's contribution to the CPRO operational plan. With support from other members of OTI and HHS business areas, this team is responsible for the coordination and support of the HHSC Sunset review.

Continuous Improvement Programs: Includes two teams, Improvement and Education and Strategic Engagement.

- The Improvement and Education team supports the development of a culture of continuous improvement at HHS by developing, maintaining, and administering a system-wide training program to develop skills and expertise in process improvement techniques and tools. The team also provides consultative, mentoring, and technical assistance support to other OTI divisions and other areas of the agency conducting process improvement activities and projects.
- The Strategic Engagement team supports OTI initiatives and system-wide improvements through employee engagement efforts and strategic communication planning that help facilitate and manage change. Strategic Engagement develops internal communication plans, facilitates internal

communication with staff members going through change, and pursues stakeholder input regarding OTI projects. The team is responsible for facilitating the Cross-Division Coordination Group (CDCG)—a community of experts across HHS who review and help shape broad initiatives and policy changes with the goal of improving processes and reducing redundancy—called for in S.B. 200, 84th Legislature, Regular Session, 2015.

Baseline Services

Relevant process maps:

- Service Requests;
- Staff Time Allocation;
- Continuous Improvement Ideas Portal Submissions;
- SSA Updates;
- HHSC Strategic Planning Process; and
- CDCG Management.

Consultation: OTI provides consultative services to the executive commissioner and HHS executive or program leadership to identify, plan, and support projects for continuous improvement that benefit specific business areas or span the HHS system. As a result of this work, OTI often provides reports and deliverables that include recommendations for consideration by HHS executive leadership. OTI consultation with executive leadership includes:

- Identifying and prioritizing projects that will result in tangible benefits and improvements; and
- Ensuring coordination and alignment of similar projects or projects that impact several HHS areas.

Business Process Improvement: OTI provides business process improvement services for HHS areas, which includes analysis of business requirements and workflow, process and value stream mapping to identify constraints and inefficiencies, determination of potential process improvements and implementation support, and ongoing monitoring to determine project impact. OTI works with operational and programmatic areas to validate business process mapping and to prioritize areas for improvement.

Transformation Services: OTI provides transformation services to support initiatives that involve organizational changes; the transfer of functions between areas and/or state agencies; the consolidation of programs or functions; and the determination of new functions or activities to be carried out within HHS. This work may include analysis of positions, job duties, and funding sources.

SSAs: OTI is responsible for developing, maintaining, and publishing SSAs. OTI collaborates with all HHS administrative support areas and key HHS divisions to:

- Coordinate SSA content development and facilitate negotiations;
- Finalize SSAs for signature;
- Develop and maintain a policy and process to escalate and resolve SSA-related issues and track reported issues; and
- Update and maintain Circular C-051.

Change Management: OTI supports projects with significant agency-wide impacts by working with HHSC programs, divisions, and administrative support areas undergoing change to help those programs engage their stakeholders with the goal of securing buy-in and acceptance of the change. OTI does this by helping programs identify and engage affected stakeholders and promoting ongoing communication as the program and stakeholders go through the change. The process may involve conducting needs assessments and stakeholder analysis; identifying known risks and concerns; developing communication strategies, timelines, and ideas for effective stakeholder engagement; and developing implementation timelines.

MOU and Interagency Contracts (IAC): OTI assists in developing and updating transformation-related agreements within HHSC and with other state agencies such as DFPS. OTI provides guidance on content, may provide draft language, and support program areas with the negotiation and finalization of agreements.

CDCG Facilitation: OTI oversees and facilitates HHS system cross-division coordination by managing CDCG. Services include developing and maintaining foundational CDCG policies and documents, updating membership, facilitating meetings, and otherwise managing the CDCG process. OTI works with CDCG to identify, develop, and implement projects that cross organizational “silos” and benefit HHS. OTI obtains CDCG input and feedback on programmatic and operational issues and ensures this information is communicated within HHS and subsequently pursued.

HHSC Strategic Planning: OTI is responsible for developing, updating, and publishing the HHSC Strategic Plan.

HHS System Change, Coordination, and Notification: OTI serves as the point of contact for HHS related to the management of substantive organizational changes, including coordination with the Texas Sunset Advisory Commission, regarding HHS system transformation and improvement.

The office collaborates with HHS system programs, operational areas, and non-HHS agencies on select reports, including the Sunset self-evaluation report. These efforts include working with HHS areas to develop report content; researching policies and statutory requirements; engaging stakeholders; requesting information or data from across the system; and working with stakeholders on recommendations, if needed. OTI finalizes reports for executive approval and ensures timely submission to the Office of the Governor, Legislative Budget Board, Sunset Commission, legislative committees, or other entities.

Continuous Improvement Programs: OTI provides process improvement and change management training, consultation, and mentorship services for HHS. These services include training on the use of established methodologies such as Lean, Six Sigma, Theory of Constraints, Design Thinking, Agile Project Management, and PMI concepts, as well as best practices in change management. OTI works with operational and programmatic areas to support the planning, implementation, and sustainment of change initiatives and continuous improvement efforts through educational opportunities, targeted consultation, and ongoing mentorship.

Continuous Improvement Ideas Portal: The Continuous Improvement Ideas Portal allows employees to suggest ideas for cost savings and business process improvements throughout HHS. Each quarter, the public may vote on their favorite idea using an online form on the Process Improvement page.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts:

S.B. 200, 84th Legislature, Regular Session, 2015, directed HHS to plan and implement an efficient and effective system of administrative services while also ensuring accountability in providing these services. SSAs between DSHS, HHSC programmatic divisions, and HHSC administrative support areas outline standards and processes for delivering administrative services. The SSA for OTI outlines the

roles and responsibilities of OTI and receiving area partners. Circular C-051 (HHS Support Services Agreement Policy) establishes the policy for implementing a system of administrative services through SSAs that ensure HHSC and DSHS divisions receive adequate support.

I-M. Relationship with other governmental entities; Barriers; Additional, Regulatory, and Complaint Information: Not applicable.

Data, Analytics, and Performance

A. Name of division or program:

Name of division or program: Data, Analytics, and Performance

Location within the agency: CPRO

Contact name: Calvin Green, Deputy Executive Commissioner

Statutory citation: Not applicable

B. Objective and major activities:

DAP's vision is to enhance HHSC's capacity for data-driven decision making by creating, coordinating, and maintaining an integrated system of processes, services, and technology solutions that serve as the framework for meeting all agency data, analytics, and performance needs. DAP supports this vision via five broad functions:

- Ensuring HHSC system data is well governed, high quality, easy to locate, and ready to use;
- Directly providing some full-service analytics, performance visualization, and data reporting services;
- Automating recurring reports, including coordinating and developing self-service and semi self-service data and analytic tools and environments maintained throughout HHSC;
- Recommending agency-wide data governance, performance, and analytics strategies to executive leadership and coordinating implementation of executive direction; and
- Providing data and analytics related support and consultative services (e.g., data literacy training, visualization design support, etc.).

DAP is responsible for fulfilling data and analytics requests from the legislature, public, and agency staff to effectively operate programs, respond timely to open records requests and media requests, meet litigation needs, and to fulfill state and federally required reporting. Drawing from a wide range of HHSC data sources containing millions of data points, DAP provides recurring and ad hoc reporting, visualization development and support (including GIS and mapping tools), and research and evaluation services to internal program customers, legislative partners, and external stakeholders.

Over the past three years, DAP processed over 8,800 data requests, and these requests continue to grow in number and complexity. Leveraging state and federal investment in HHSC's Performance Management and Analytics System (PMAS) program, DAP is partnering with HHSC Information Technology (IT) in the developing programmatic and technical solutions to meet the agency's data management, data quality, and data analytics needs. The goal of PMAS is to establish a set of curated, connectible, cloud-based data marts and tools that can facilitate linkages between siloed program data sets and generate reliable, actionable information for staff and leadership to use to effectively administer a wide range of HHSC's programs and services.

Concurrently, DAP is leading implementation of cutting-edge data governance processes across HHSC data systems and working to expand those efforts to improve data quality and bolster HHSC's ability to apply advanced data analysis tools, derive data-driven insights and fulfill complex data requests in a timely manner.

C. Effectiveness and efficiency information:

To monitor its performance, DAP maintains several internal performance measures.

Table 5. DAP internal performance measures.

Measure	Measure Description	Methodology	Data Source	Annual Target
Data Dissemination and Reporting routine data reporting efficiency	Percent of routine reports delivered by established deadlines.	Quarterly calculation of number of routine reports completed on/before deadline divided by total number of reports completed.	DRROC	95%

Measure	Measure Description	Methodology	Data Source	Annual Target
Data Dissemination and Reporting ad hoc data reporting efficiency	Percent of ad hoc reports delivered by established deadlines.	Quarterly calculation of number of ad hoc reports completed on/before deadline divided by total number of reports completed.	DRROC	95%
Information & Data Management metadata acquisition	Number of acquired metadata from enterprise data systems.	Quarterly count of net new data systems that have had metadata acquisition work completed.	EIM Dashboard	N/A
PMAS Project Milestones and Deliverables	Percent of PMAS milestones and deliverables completed timely.	Quarterly calculation of number of milestones planned and number of milestones completed timely.	IRIS and PMAS project tracker	95%
PMAS Customer Satisfaction (estimated roll-out fall 2025)	Post-project customer satisfaction and ongoing needs assessment for PMAS project deliverables and tools.	Customer satisfaction survey completed by the program customer at project close-out and subsequent follow-up 3-6 months after completion as part of ongoing maintenance to assess deliverable functionality, benefits, and ongoing needs.	Survey data	90%
Signal Detection, Visualization, and Performance reporting efficiency	Percent of milestones reached, and deliverables completed, by established deadlines.	Quarterly calculation of number of milestones/deliverables completed on/before deadline divided by total number of reports milestones/deliverables completed.	DRROC (MCDA) Internal tracking system (GIS/Demo) Wrike (PA/PV)	95%

Measure	Measure Description	Methodology	Data Source	Annual Target
Performance Analysis and Performance Visualization Teams (estimated roll-out fall 2025)	Percent of dashboard views (or viewers) out of expected use.	Monthly or quarterly calculation of number of dashboard views (or viewers) by program areas out of anticipated number of views (or viewers).	Tableau Cloud	90%

D. History:

As directed by S.B. 200, 84th Legislature, Regular Session, 2015, HHSC established the Office of Performance (OP) in 2016, using existing full-time employees (FTE) to continue the full-service data fulfillment work of the previous Center for Analytics and Decision Support (CADS), and with approximately six new FTEs for the office to begin envisioning and developing a strategy and system that could support data-driven insights and accountability for HHSC performance.

DAP successfully implemented the Data Governance and Performance Management (DGPM) Council and Executive Steering Committee (ESC) organizational structure in 2019 to allow HHSC and DSHS executives to guide data-related strategy and resource prioritization for PMAS. PMAS was established to realize the vision for a comprehensive and interconnected data analytics and performance management system by making agency data visible, accessible for authorized stakeholders, understandable, trusted, governed, and useful for the development of analytical tools and cross-system connections. Established in 2018 as a limited pilot and expanded incrementally, PMAS has made steady improvements toward a transparent, strategically aligned approach to data and performance management across HHSC. Comprised of people, tools, processes, and places, PMAS is:

- An integrated, flexible system of processes, services, and solutions;
- Iterative, scalable, and driven by program needs;
- Guided and directed by the DGPM ESC and council to ensure alignment with the agency's strategic priorities; and
- Since its inception as a pilot, the PMAS program's strategy and approach have been evolving to meet the complexities of HHSC's changing data and analytic needs.

With exceptional item funding received in fiscal years 2024-25, HHSC made progress toward formalizing PMAS as the agency's coordinated strategy for data analytics and performance, establishing the PMAS Snowflake Cloud Platform as the centralized hub for HHSC analytics. Through PMAS, HHSC has developed and implemented a strategy to begin identifying high priority and frequently accessed data sets, profiling and ingesting them into the shared cloud platform. To date, PMAS has successfully ingested over two and a half billions of rows of high priority program data from HHSC program areas including Medicaid and CHIP Services (MCS), Access and Eligibility Services (AES), Procurement and Contracting Services (PCS), and FHS.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

DAP divides its functional areas into five departments:

- Business Operations Support (BOS): BOS is responsible for developing data-sharing agreements, managing DAP contract activity, and supporting business functions internal to DAP.
- Information and Data Management (I&DM): I&DM (in coordination with IT) advances data governance and master data management strategies across HHSC.
- Signal Detection, Visualization and Performance (SDVP): SDVP develops and maintains recurring data visualizations, anomaly detection tools, and performance management tools for various areas across HHSC. The Medicaid and Children's Health Insurance Program (CHIP) Data Analytics (MCDA) team supports MCS full-time, while the PMAS and Demography teams work with customers across HHSC.
- Performance and Analytics Integration (PAI): PAI serves as the single DAP customer interface for data and analytics projects requiring coordination across multiple areas of DAP, HHSC, or both. PAI provides project management, process management and coordination, research and evaluation, and advanced analytics services to HHS customers.
- Data Dissemination and Reporting (DD&R): DD&R is responsible for providing full-service data, reporting, and analytic services requested by programs, government relations, open records, and other internal and external stakeholders.

Relevant process documents:

- PMAS process descriptions; and
- DGPM program and process descriptions.

Circular C-049 describes HHSC divisions' roles as they relate to data management to demonstrate alignment with the Texas Data Management Framework.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts:

DAP develops and oversees data sharing agreement MOUs with external stakeholders (universities, state agencies, non-profits, etc.) for the use of HHSC program data. External requesters use HHSC program data to conduct research studies and prepare reports required by federal and state law. The data sharing MOUs HHSC enters are zero-dollar contracts.

I. Relationship with other governmental entities: Not applicable.

J. Barriers and challenges:

DAP has experienced an increasing demand for reporting and analytics over the past several years, and the technical and analytic complexity of analytic requests has also grown. This increase could jeopardize HHSC's ability to meet data, research, and analytic timelines as well as mandates associated with legislative and federal requirements that are connected to Medicaid funding.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Compliance and Quality Control

A. Name of division or program:

Name of division or program: Compliance and Quality Control

Location within the agency: CPRO

Contact name: Chad Riley, Deputy Executive Commissioner

Statutory citation: Texas Government Code, Chapters 783, 2155, 2156, 2261, and 2262

B. Objective and major activities:

CQC plays a critical role in providing independent oversight of the procurement and contracting activities of HHS system agencies to help ensure compliance with all statutory, regulatory, policy, and procedural requirements, and to promote quality and effectiveness.

Solicitation Review Unit (SRU): Reviews and approves all complex solicitations at specific phases of the process, reviews and validates the evaluation tool for each solicitation, and facilitates the complex solicitation evaluation and scoring process.

Fiscal Monitoring Unit (FMU): Conducts specialized fiscal monitoring reviews of HHSC recipient and subrecipient grantees in support of certain services within the Chief Program and Services Office. The reviews promote fiscal accountability by determining financial compliance with terms and conditions of the contract and with state and federal regulations, and by providing feedback and technical assistance to prevent future non-compliance.

Single Audit Unit (SAU): Monitors HHS recipient and subrecipient grantees for compliance with the Texas Grant Management Standards (TxGMS) and federal Uniform Grant Guidance, Title 2 of the Code of Federal Regulations, Part 200 (2 CFR 200). SAU conducts desk reviews of single audit reporting packages and coordinates with program staff regarding management responses to corrective action plans.

Contract Compliance Unit (CCU): Assesses certain agency contract management practices to ensure quality outcomes, such as implementation of effective monitoring activities; supports the improvement of contracting outcomes by advising on contract documents as requested by the SRU, agency partners and leadership; and maintains data and technical solutions that support the division's oversight efforts, to include analyzing the quality of agency contracting.

C. Effectiveness and efficiency information:

CQC measures its core business functions through internal performance metrics reported through CPRO up to the executive commissioner on a quarterly basis.

Table 6. CQC core business function internal performance measures.

Measure	Measure Description	Methodology	Data Source	Target
Timeliness conducting reviews of complex solicitations and Department of Information Resources Statements of Work (SOWs)	Number of business days to complete each review period measured against the number of days allocated for CQC review in the Procurement Action Lead Time Schedule published by PCS.	Average number of business days to complete a review period for solicitations approved during the reporting period in each of the three categories: 1) No Contract Advisory Team (CAT) Review to Post; 2) Pre-CAT Review; and 3) Post-CAT Review to Post.	Solicitation Review Dashboards (SharePoint)	Less than 12 days to complete each review period
Timeliness conducting fiscal monitoring compliance reviews	Average number of business days for completing compliance reviews measured against the established target of completion within an average of 100 business days. Target is based on a recommendation by the audit firm conducting the Statewide Single Audit of HHSC in 2018.	Total average number of business days for all compliance reviews completed during the reporting period calculated from the start of each review to the completion date.	Compliance and Quality Control Monthly Productivity Report (Teams)	100 business days or less
Timeliness conducting single audit reviews	Management Decision Letters (MDLs) issued within six months of receipt of a complete Single Audit Reporting Package as required in federal Uniform Grant Guidance (2 CFR 200).	Percentage of MDLs issued within six months of receipt of a complete Single Audit Reporting Package completed during the reporting period.	Compliance and Quality Control Monthly Productivity Report (Teams)	100%

CCU is not currently tracking performance measures. The team was only recently created and is focusing on building the program and developing its foundational

components. CCU just became fully resourced during the 89th Legislature, Regular Session, 2025.

D. History:

CQC was created in April 2018 after identifying scoring and compliance deficiencies in complex solicitations and contracts awarded by HHSC as a division independent of PCS and charged with the responsibility to review PCS and other agency functions to ensure the agency was aligned with organizational resources and processes and satisfied all purchasing and contracting requirements.

The initial core functions of CQC were to:

- Review all complex procurement solicitations for compliance and quality;
- Identify and recommend corrections to issues such as deficiencies in the scope of work or potential fatal flaws;
- Review and finalize evaluation tools and score sheets;
- Assist PCS purchasers with evaluator training;
- Compile, aggregate, and validate evaluator scoring; and
- Approve the posting of solicitations for public response.

The scope of CQC's review of complex procurement solicitations eventually expanded to include review prior to third-party review (e.g., Contract Advisory Team and other external entities) as well as the review and approval of all addenda to active solicitations.

Following a PCS reorganization, HHSC transferred two additional functions – FMU and SAU – to CQC in October 2019. As both FMU and SAU are responsible for the review and compliance monitoring of HHS system recipient and subrecipient grantees pursuant to requirements of 2 CFR 200 and TxGMS, it was determined these compliance functions were better aligned with CQC than PCS.

CQC initially reported directly to the Chief Operating Officer (COO) but was transferred under the CPRO in April 2020.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

CQC is administered by an executive management team comprised of the division's DEC, associate commissioner, SRU director, FMU and SAU director, CCU director, and Policy and Operations advisor. The DEC provides strategic direction, leads the daily operations of the division, and approves initiatives such as process improvement projects undertaken by CQC. The division employs a staff of professionals, including a systems analyst, contract administration managers, financial analysts, auditors, a program specialist, and an administrative assistant to carry out the division's responsibilities. The staff is responsible for ensuring the quality control and compliance of all major complex procurement and grant solicitations administered by HHS. The staff is also responsible for ensuring compliance by programs and grantees with all fiscal monitoring and single audit requirements.

To administer responsibilities relating to complex procurements, staff review and approve all complex solicitations at specific phases of the procurement process; review and validate the evaluation tool for each solicitation; and facilitate the complex solicitation and scoring process in accordance with all applicable state and federal statutes and regulations and with agency policies and procedures related to procurements and grants. These include the Texas Comptroller of Public Accounts' (CPA) State of Texas Procurement and Contract Management Guide; the HHS System Procurement and Contract Management Handbook; Uniform Grant Guidance, 2 CFR 200; TxGMS maintained by the CPA; and all applicable HHS policies and procedures.

Relevant process maps:

- [CQC-SRU Solicitation Review and Evaluation Process Overview](#); and
- [CQC-SRU Procurement Planning Detailed Process Map](#).

To administer responsibilities relating to fiscal monitoring and single audit requirements, staff conduct specialized fiscal monitoring compliance reviews of certain HHSC recipient and subrecipient grantees. Staff also provide technical assistance to program staff and grantees on matters of financial compliance and refer suspected fraud, waste, or abuse to the HHS Office of Inspector General (OIG). Staff also monitor HHS recipient and subrecipient grantees for compliance with single audit requirements, conduct desk reviews of single audit reporting packages, and coordinate with program staff regarding management responses to audit findings and corrective actions plans. All fiscal monitoring compliance reviews and single audit reviews are conducted in accordance with and to ensure

compliance with Uniform Grant Guidance, 2 CFR 200, TxGMS, contract provisions, and all applicable HHS policies and procedures.

Relevant process maps:

- [CQC-FMU Fiscal Monitoring Review Process Flowchart](#);
- [CQC-SAU Level 1 Flowchart 2025](#); and
- [CQC-SAU Procedures Detail Flowchart 2025](#).

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

As recipient or subrecipient grantees of HHS agencies, cities, counties, school districts, local mental health authorities, education service centers, state university health science centers, and other public entities are or may be subject to federal and/or state requirements for single audits and/or fiscal monitoring compliance reviews pursuant to 2 CFR 200 or TxGMS. In such instances, SAU and FMU work with these entities to ensure compliance with all applicable requirements.

J-M. Barriers and challenges; Additional, Regulatory, and Complaint information: Not applicable.

Regulatory Services Division

RSD regulates and provides guidance to protect the health, safety, and well-being of vulnerable people in regulated facilities throughout the state. RSD also issues professional licenses, receives and investigates complaints about regulated providers, and enforces regulations to ensure operations meet requirements for health and safety. RSD includes three regulatory divisions: Long-term Care Regulation (LTCR), Child Care Regulation (CCR), and Health Care Regulation (HCR).

In the fall of 2024, CPRO launched a multi-year initiative related to regulatory reform that will have an impact on health and human regulated entities in Texas. The purpose of this project is to evaluate the current landscape of state and federal requirements for HHSC's 38 different types of long-term care (LTC), acute care, and childcare providers, and identify opportunities to eliminate or streamline rules and other requirements that are outdated, redundant, or overly burdensome. In concert, HHSC's efforts will seek to modernize the agency's regulatory framework

to be more clear, concise, and squarely focused on protecting the health and safety of the individuals served by these providers.

Regulatory DEC Office, Operations, and Complaint & Incident Intake

A. Name of division or program:

Name of division or program: Regulatory DEC Office, Operations, and Complaint & Incident Intake

Location within the agency: CPRO

Contact name: Luis Morales, Associate Deputy Executive Commissioner

Statutory citation: Texas Health and Safety Code, Chapters 142, 244, 247, 248, 248A, 252, 254, and 260A; Texas Human Resources Code, Chapter 103

B. Objective and major activities:

The RSD DEC Office provides administrative support to the DEC.

Regulatory Operations: Supports the division with data management, contracting, procurement, and workforce functions, as well as communications, project management, and legislative coordination. Operations Support provides administrative support for the Texas Medical Disclosure Panel (TMDP), including meeting coordination, email box coordination, and assistance with rule projects. Additionally, Regulatory Operations administers the federal Civil Money Penalty (CMP) grant program through the United States (U.S.) Department of Health and Human Services' (DHHS) Centers for Medicare & Medicaid Services (CMS).

Since the last Sunset Commission review, Regulatory Operations has worked to strengthen the quality of communications from the division and introduce process improvements, including developing a new document review tool to streamline departmental reviews. Regulatory Operations also took on providing administrative support for the TMDP.

Complaint & Incident Intake (CII): CII processes and routes complaint and incident intakes for most regulated providers. CII has leveraged technology to increase efficiency while providing good customer service. Examples include the addition of a feature allowing callers to receive a call from the first available agent if there are

calls in queue on the toll-free hotline; development of portals for complaint and incident submissions; redesigning phone menu and hold messages for better caller experience; and use of automated customer satisfaction surveys.

Since the last Sunset Commission review, CII has incorporated processing of acute care intakes, which has resulted in expanded consumer access to file a complaint and improved consistency of intake processing with other regulated provider types.

Technological improvements such as the hotline call-back assist feature and online complaint and incident portals have improved the consumer and provider experience while increasing efficiency.

C. Effectiveness and efficiency information:

Table 7. CII internal performance measures.

Measure	Measure Description	Methodology	Data Source	Fiscal Year 2024
Hotline average hold time	Average time callers spend holding for a live agent.	Total wait time/interactions.	Genesys, AVAYA, and Cisco	6 min 45 sec avg wait time year to date (YTD)
Percent calls answered	Percentage of calls successfully connected with an agent.	Number of answered calls divided by total number of calls presented to the Automatic Call Distribution system.	Genesys, AVAYA, and Cisco	56% calls answered YTD
Customer satisfaction overall score	Average satisfaction score on the CII customer satisfaction telephone survey for question that asks whether callers are satisfied overall.	Callers can select ratings of one to five on a Likert scale. Calculated by number of responses that select "Strongly Agree" or "Agree".	Genesys, AVAYA, and Cisco	66% overall satisfaction YTD

Other efficiency metrics for each unit are calculated by total workload divided by number of filled FTEs. Data source: HHS Enterprise Admin Reporting and Tracking System (HEART), Texas Unified Licensure Information Portal (TULIP), Outlook,

ASPEN Complaints/Incidents Tracking System (ACTS), Internet Quality Improvement and Evaluation System (iQIES), Genesys.

D-E. History, and Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

The DEC provides oversight, guidance, and strategic planning to ensure RSD performs its duties and functions in accordance with applicable statutes and federal requirements.

Operations Support supports the other RSD departments by providing assistance, guidance, and support on various administrative functions.

CII units are organized according to the functions they perform: Intake, quality assurance, program support, and records management.

- The Toll-Free Intake Processing unit processes and triages hotline calls for Regulatory Services investigation. The CII toll-free line, 1-800-458-9858, is answered 7 a.m.–7 p.m. Monday through Friday.
- Specialized Intake Processing processes and triages non-hotline contacts for Regulatory Services investigation, including voicemail, email, online web portal, fax, and mailed submissions.
- The Quality Assurance Unit (QAU) reviews CII intakes to ensure accurate content and prioritization. QAU also serves as the liaison between the Regulatory Survey Offices and CII.
- The Program Support Unit is responsible for entry of intakes into the federal complaint tracking systems as well as processing provider incident investigation reports and other program support functions.
- Records Management staff are responsible for the identification, review and release of long-term care regulatory records.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts:

DFPS Statewide Intake (SWI): SWI processes reports regarding abuse, neglect, and exploitation (ANE) of children, adults with disabilities at home, and the elderly. They also process reports of abuse of children in child-care facilities or treatment

centers and adults who live in state hospitals or supported by programs for people with mental illness/intellectual disabilities. SWI processes complaints and intakes for regulatory standards of regulated childcare operations and forwards them to HHSC Child Care Regulation for investigation. SWI assesses jurisdiction for DFPS investigation based on state law regarding ANE. DFPS does not regulate or license any providers CII is assessing jurisdiction for any person served by a licensed and/or certified long-term or acute care provider based on state regulations and federal survey/certification requirements. CII has established referral and receipt procedures with each of the above areas.

I. Relationship with other governmental entities:

CII works with CMS regarding the processing of complaints and incidents of federally certified providers, as a part of the survey and certification function of HHSC as the State Survey Agency. In addition, the Records Management unit works with CMS as needed on public information requests for long-term care federally certified providers.

J. Barriers and challenges:

Challenge 1: TMDP is an independent board administratively attached to HHSC. TMDP's purpose is to determine which risks and hazards related to medical care and surgical procedures health care providers or physicians must disclose to their patients or persons authorized to consent for their patients. It also establishes the general form and substance of such disclosure. The administrative responsibilities for the TMDP moved from DSHS to HHSC during transformation. The statutorily required duties of the TMDP may align better with the functions performed at Texas Medical Board. Having the panel administratively attached to the medical board would likely be more effective than HHSC because the panel's current functions do not correlate with the programmatic duties performed by HHSC.

Challenge 2: CII workload volume remains high due to the increased number of provider types served and expanded access and ease of filing consumer complaints, as well as incidents self-reported by providers.

Challenge 3: Regarding Civil Money Penalties Program, RSD is dependent on CMS policies and rules related to the program and must operate within those parameters. However, within the last two years CMS has become more stringent with the requirements. The changes have led to a decline in applications for the available funds.

K-L. Additional, and Regulatory information: Not applicable.

M. Complaint and regulatory actions:

A complaint is an assertion that a requirement of licensure or certification has been violated. Complaints can come directly from individuals and residents, family members, health care providers, advocates, law enforcement, other state agencies, etc. Reports may be oral or written.

Table 8. Total complaints received. (fiscal year 2020-24)

	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Complaints Received	LTC: 18,944 HCR: 3,941	LTC: 16,049 HCR: 4,675	LTC: 17,615 HCR: 4,815	LTC: 17,604 HCR: 4,922	LTC: 21,086 HCR: 5,615

* HHSC captures total complaints received for all provider types. Some of the requested specific breakdowns of complaint types, including the number of complaints originating from the public, are not collected for all programs and provider types and have been omitted from the table template.

Table 9. Disposition of complaints received. (fiscal year 2020-24)

	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Complaints Received*	LTCR: 18,944 HCR: 3,941	LTCR: 16,049 HCR: 4,675	LTCR: 17,615 HCR: 4,815	LTCR: 17,604 HCR: 4,922	LTCR: 21,086 HCR: 5,615
Complaints Found Jurisdictional	LTCR:18,589 HCR: 3,593	LTCR:15,751 HCR: 4,238	LTCR:17,328 HCR: 4,367	LTCR:17,229 HCR:4,305	LTCR:20,763 HCR:4,888
Complaints Found Non-Jurisdictional	LTCR:73 HCR: 346	LTCR: 78 HCR:438	LTCR: 52 HCR:449	LTCR:138 HCR:618	LTCR: 131 HCR:728
Total Complaints Dismissed (no investigation)	LTCR: 282 HCR:1,230	LTCR: 220 HCR:1,437	LTCR: 235 HCR:1,878	LTCR:237 HCR:1,809	LTCR:192 HCR:1,801
Total Complaints Sent for Investigation	LTCR:18,589 HCR:2,712	LTCR:15,751 HCR: 3,239	LTCR:17,328 HCR: 2,938	LTCR:17,229 HCR: 3,144	LTCR:20,763 HCR: 3,815

* Since complaints may not be processed within a single fiscal year, rows below may not equal the total.

Long-Term Care Regulation

A. Name of division or program:

Name of division or program: Long-Term Care Regulation

Location within the agency: CPRO

Contact name: Michelle Dionne-Vahalik, Associate Commissioner

Statutory citation: Texas Health and Safety Code, Chapters 142, 222, 242, 247, 248A, 250, 252, 260A, and 533A; Texas Human Resources Code, Chapters 32, 48, 103, and 161; Texas Occupations Code, Chapter 55

B. Objective and major activities:

LTCR inspects, investigates, and surveys facilities, agencies, programs, and individual providers of long-term care services. LTCR licenses or certifies long-term care providers to ensure compliance with licensure rules or federal certification requirements. LTCR conducts investigations of ANE and forwards perpetrators to RSD Enforcement for placement on the Employee Misconduct Registry (EMR). LTCR administers licensing and certification programs for certain professional licenses. LTCR provides the following core services:

- License and/or certify (state, federal, or Alzheimer's) including surveying and investigating providers of Long-Term Care services;
- Allocate Medicaid beds to applicable providers;
- License, certify, or permit professionals and other related staff of providers of Long-Term Care services; and
- Perform support tasks related to regulating Long-Term Care providers, including creation of policy and rules, training, and performing quality assurance.

LTCR regulates providers based on various requirements such as licensed, certified (Medicare or Medicaid), Alzheimer's certified, and state requirements. Each provider can fall under one or more of the requirements. The providers LTCR regulates fall under the following facility types.

Nursing facilities:

- Licensed, required except for hospital-based nursing facilities

- Certified (Medicare and/or Medicaid) – optional
- Alzheimer’s Certified – optional

Day Activity Health Services Facilities (DAHS):

- Licensed only

Assisted Living Facilities (ALF):

- Licensed
- Alzheimer’s Certified – optional

Intermediated Care Facility for Individuals with an Intellectual Disability (ICF/IID):

- Licensed, required except for state owned or operated facilities such as the State Supported Living Centers (SSLCs)
- Certified (Medicaid) – required

Prescribed Pediatric Extended Care Centers (PPECC):

- Licensed Only

Home and Community Support Services Agencies (HCSSA):

- Licensed
- Certified (Medicare) – optional

Home and Community-based Services (HCS):

- Certified (Medicaid)
- Texas Home Living (TxHmL)
- Not licensed, contracted through MCS

C. Effectiveness and efficiency information:

Legislative Budget Board (LBB) Performance Measures:

- Average daily caseload per worker – provider investigations.
 - Data Sources: IMPACT and Chief Financial Officer (CFO)-Monthly Active Status Position Reports

- Number of LTC Licenses issued.
 - Data Source: TULIP
- Number of LTC contacts.
 - Data Sources: ASPEN and iQIES
- Number of licenses/credentials issued.
 - Data Source: TULIP

Quality Assurance (QA) staff metrics:

- The number of average cases read monthly, resubmittal rate, error rate, efficiency in reading cases, data turnover rate, number of data errors, timeliness of citation review turnaround, number of case review approvals, and number of quality feedback on case review approvals.
 - Data source: Internal database

Workload Metrics:

- CMS State Performance Standards System: CMS uses this system to measure performance for all the states. For federal fiscal year 2025 ([CMS Admin Info: 25-03-ALL](#)), there are three domains: 1) survey and intake process, 2) survey and intake quality, and 3) noncompliance resolution. LTCR meets quarterly with CMS to cover the status of performance for each of the 13 measures within the three domains.
 - Data sources: ASPEN, iQIES, ACTS
- CMS Mission and Priority Document (MPD)/Budget: CMS directs workload priorities via MPD and the budget. For federal fiscal year 2025 ([CMS Admin Info: 25-05-All](#)), the tiered work is described by program type and lists the requirements for each. For example, certified nursing facilities must have a recertification survey with no more than 15.9 months elapsed between completed surveys. If CMS decides they are not going to fully fund the workload, the states provide the projected percent of completion for the tiered priorities.
 - Data sources: ASPEN, iQIES, ACTS
- Licensed only workload: Metrics are extracted from statute and/or rule by program type. Workload is monitored for survey and investigation timeframes as well as other scopes of work, such as the issuance of reports

of finding to providers. Quality assurance metrics are shared with leadership and regional units monthly. These include results of temporary and ongoing audits for certain data elements (i.e. zero deficiency surveys), meeting principles of documentation requirements for citation writing, timeline for issuance of reports to providers, etc.

- ▶ Data sources: ASPEN, iQIES, ACTS, TULIP

Licensing and Credentialing:

- Licensing and Credentialing has a quality assurance program that for provider licensure and certification measures the timeliness of application assignment and initial review, pending and approved applications by specialist, and timeliness of certification processing. Audits are also completed for compliance with aspects of the application review process. For Medicaid bed allocation, data is maintained on the applications received and processed. For credentialing, measures include timeliness of issuance of the credential or training program approval. For each call center within Licensing and Credentialing, statistics are maintained.

- ▶ Data source: TULIP and Genesis (call center).

Curriculum and Training:

- Data is maintained on staff training completion and provider training attendance.
- ▶ Data source: Learning Management System and internal tracking

Policy and Rules:

- Data is maintained on the number of policy assignments, rules promulgated, handbook updates, inquiries received, and presentations created and/or presented.
- ▶ Data source: Internal tracking

D. History:

H.B. 2292, 78th Legislature, Regular Session, 2003 moved LTCR from DSHS to the Texas Department of Aging and Disability Services.

S.B. 492, 83rd Legislature, Regular Session, 2013 created the PPECC program.

S.B. 200, 84th Legislature, Regular Session, 2015 consolidated LTCR and HCR into one division at HHSC and S.B. 1999, 84th Legislature, Regular Session, 2015, changed Adult Day Care to DAHS Facilities.

S.B. 219, 84th Legislature, Regular Session, 2015, reenacted the joint training program under LTCR Curriculum and Training as required by Texas Human Resource Code, Section 22.039.

H.B. 3117, 86th Legislature, Regular Session, 2019 required HHSC to develop a plan for allocation of new ICF/IID Medicaid beds.

2024-25 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 21), required HHSC to develop a plan to replace the day habilitation program based on the CMS 2014 regulations governing settings where Medicaid Home and Community Based Services (HCBS) were provided with a deadline of March 2023. The new program is Individualized Skills and Socialization (ISS) and was placed under a DAHS license.

E. Qualifications or eligibility requirements:

Licensed providers owners, controlling parties, and affiliates are screened on the following:

- Clearinghouse that includes criminal background information.
- Criminal background checks (CBC) are held to Texas Health and Safety Code, Chapter 250.
- Federal and State exclusion lists.
- EMR; and
- Enforcement Actions Review.

Facility-based providers:

- Right to the property.
- Successful Life Safety Code (LSC) survey and successful health survey.

Agency providers:

- Successful health survey.

Nursing Facility:

- Financial Review – review of the financial conditions of the applicant, including the facility and the parent company, including bankruptcy or tax liens.

Nursing Facility Administrators (NFA) (reciprocity and provisional licensing available under certain circumstances):

- Bachelor's Degree, with a minimum of 12 semester credit hours in long-term care administration or its equivalent.
- Internship hours: 1,000 hours unless requirements for a waiver are met.
- HHSC Required Training: Infection Control and Personal Protective Equipment.
- Pass state and national exams.
- United States Federal Bureau of Investigation (FBI)-based fingerprints with criminal history compared to the required criteria in Texas Health and Safety Code, Chapter 250.

Medication Aides (MA) (waivers and reciprocity available under certain circumstances):

- 18 years old.
- High school graduate or pass General Education Development (GED) exam.
- Be employed in a facility as a nurse aide or non-licensed direct care staff on the first official day of an applicant's MA training program.
- Complete an approved MA training program.
- Pass the permit exam.
- FBI-based fingerprints with criminal history compared to the required criteria in Texas Health and Safety Code, Chapter 250.

Certified Nurse Aides (CNA) (waivers and reciprocity available under certain circumstances):

- Complete an approved nurse aide training and competency evaluation program (NATCEP).
- Pass the certification exams (written and skills).

- Name-based fingerprints by training program with criminal history compared to the required criteria in Texas Health and Safety Code, Chapter 250. Pending: FBI-based fingerprinting.

Statistical Breakdown:

Table 10. Number of licenses by licensed provider type.

Licensed Providers	Number of Licenses as of 4/21/2025
Nursing Facilities	1186
ALF	2007
DAHS	1,127
ICF/IID	732
PPECC	13
HCSSA	8269

Table 11. Number of currently credentialed NFA, MA, CAN, and NATCEPs.

Credentialing	Current Active as of 4/21/2025
NFA	2,081
MA	8,709
CNA	91,582
NATCEP	762

Table 12. Number of applications approved by licensed provider type.

Program	Applications Approved 2023	Applications Approved 2024
Nursing Facilities	1,234	1,176
ALF	1,266	1,033
DAHS	987	482
ICF/IID	367	298
PPECC	13	12
HCSSA	6,569	6,321
CNA	51,707	54,778
MA	8,892	9,610
CBC	2,012	1,140

Program	Applications Approved 2023	Applications Approved 2024
NFA	1,396	1,166
NATCEP	1,271	1,316

Table 13. Number of call center calls relating to licensed providers, CNAs, MA, NFAs, and NATCEPs.

Program	Call Center Calls 2023	Call Center Calls 2024
Licensed Providers	18,309	28,381
CNA	91,802	106,589
MA	11,916	60,971
NFA	4,625	32,451
NATCEP	2,822	31,398

F. Administration and key processes:

LTCR has state office units that support and oversee the work of regional units. These units provide leadership, policy/rule development, training, quality assurance, and logistical assistance to regional units. Regional units manage the work for the surveys and investigations for licensure and certification compliance for over 15,000 providers.

LTCR has 23 handbooks available that describe the functions of LTCR. For the federal scope of work performed via the 1864 agreement with CMS, the CMS State Operations Manual provides the guidance/direction to the states for administration of these functions.

[LTCR has the following maps detailing key regulatory functions](#) (current as of 5/14/2025).

Table 14. LTCR process maps.

LTC Program	Process Maps
All programs	- Determining Allegation Findings - CII Process Map - Writing Successful Citations – Instructions for uploading Immediate Threat/Immediate Jeopardy (IT/IJ) Template
ALF	Health Maintenance Activity

LTC Program	Process Maps
	• Survey Process Map • Informal Dispute Resolution (IDR) Process Map • Orientation – Placements • Inappropriate Placements
DAHS	• Survey Process • DAHS ISS Survey Process Map
HCS/TxHmL	• HCS/TxHmL Survey Process • Residential Survey Process
HCSSA	• Survey Process Map
ICF/IID	• Survey Process • IDR Process Map • Scheduling Algorithm • ANE Investigations Process Map • Investigation Process Map • Intellectual and Developmental Disabilities (IDD) Regulation Oversight • Preventing ANE – Task Two • LSC Survey Process
Nursing Facilities	• Survey Process • NFA Referral • Referral during EMR, Nurse Aide Registry (NAR), Medication Aide Registry (MAR) • Attaching IT/IJ Templates • Intake Prioritization Flow • Responsibilities Related to Pre-Admission Screening and Resident Review (PASRR) Pre-Admissions • Responsibilities Related to PASRR Residents • Regional Offsite Review (ROR) Process • Uploading Records in NeuDocs • Care Plan Timeline • Nursing Facility Orientation (NFO) Team Coordinator Training • Medication Administration
PI	• Investigations Survey map

LTC Program	Process Maps
	• Child Protective Services (CPS) Primary Conservatorship Identification Process • Serious Injury • EMR Review Procedure Process Flowchart (PI) • Complaint Intake Process • PPECC Survey Process Map
Employee Related	• Criminal Background Check Process Map • QA Internal Investigations Map

LTCR has also provided the following process maps externally on the HHSC website for providers on licensing and credentialing processes.

Table 15. LTCR external process maps.

LTC Program	Process Maps
ALF: How to Become an ALF Provider Texas Health and Human Services	• ALF Health Maintenance Activity • ALF Survey Process Map • ALF Informal Dispute Resolution (IDR) Process Map • ALF Orientation – Placements • ALF Inappropriate Placements
DAHS Facilities: How to Become a Day Activity and Health Services (DAHS) Provider Texas Health and Human Services	• Initial (DAHS and DAHS with Individualized Skills and Socialization) • Initial (DAHS-Individualized Sills and Socialization Only) • Renewal • Change of Ownership • Relocation • Temporary Closure
PPECC: How to Become a PPECC Provider Texas Health and Human Services	• Initial • Initial – Temporary • Renewal • Change of Ownership • Relocation • Temporary Closure
HCSSA: How to Become a Licensed HCSSA Provider 	• Initial – Parent Agency • Initial – Branch or Alternate Delivery Site

LTC Program	Process Maps
Texas Health and Human Services	• Renewal • Change of Ownership • Relocation • Temporary Closure (Medicare Certified) • Temporary Closure (Non-Medicare Certified)
ICF/IID: How to Become an ICF/IID Provider Texas Health and Human Services	• Initial • Renewal • Change of Ownership • Relocation • Temporary Closure
Nursing Facilities: How to Become a Nursing Facility Provider Texas Health and Human Services	• Initial • Initial-Hospital Based • Renewal • Change of Ownership • Relocation • Temporary Closure (Medicare Certified) • Temporary Closure (Non-Medicare Certified)
Nursing Facility Medicaid Bed Allocation: Bed Allocation Rules and Policies Texas Health and Human Services	• Waivers and Replacements • Exemptions, Swing-Beds, and Co-Insurance
NFA: Become a Texas Nursing Facility Administrator Texas Health and Human Services	• Traditional Initial Route • Health Services Executive (HSE) Qualification Route • Reciprocity Route • Military Service Member of Military Spouse Stationed in Texas Route • Provisional License Route
NFA: Renew or Revise a Texas NFA License Texas Health and Human Services	• Renewal, Traditional Route • Military Renewal Waiver Application • Inactive Status • Reinstatement • Late Renewal Route

LTC Program	Process Maps
	• Name Change Application
NFA Preceptors: Become a Preceptor Texas Health and Human Services	• Initial and Renewal
CNA: Become a Certified Nurse Aide in Texas Texas Health and Human Services	• Traditional Nurse Aide Route • Reciprocity • Military Spouse Stationed in Texas Waiver • Out-of-State Training Waiver • Nurse Aide with Equivalent Military Training Waiver • RN/LVN Graduate Waiver • RN/LVN Student Waiver • Training Program Closed • Request for Waiver of Nurse Aide Training and Competency Evaluation
CNA: Renew or Make Changes to a Nurse Aide Certificate in Texas Texas Health and Human Services	• Option1: The nurse aide requests their own renewal • Option 2: The nurse aide's employer can request the renewal • Option 3: The nurse aide renews by retraining and retesting • Option 4: The nurse aide renews by retesting without retraining • Option 5: Military Renewal Waiver Application • Name Change Application
MA: Become a Medication Aide in Texas Texas Health and Human Services	• Traditional Initial Route • Nursing Students and Nursing Graduates Route • Correction MA Route • Reciprocity Route • Military Service Member or Military Spouse Stationed in Texas Route
MA: Renew or Make Changes to a Medication Aide Permit Texas Health and Human Services	• Renewal Route • Military Renewal Waiver Application • Name Change Application

LTC Program	Process Maps
NATCEP: Become a NATCEP Texas Health and Human Services	Initial Application
NATCEP: Renew or Make Changes to a NATCEP Texas Health and Human Services	- Renewal Application - Change Application

G. Funding: See "Agency Program Information" spreadsheet.

LTCR's funding consists of general revenue and federal funding from CMS. LTCR submits an annual budget to CMS for the scope of work anticipated to be performed each year for certified providers, including the number of staff required to complete the work.

Licensing fees are charged (most set by statute) for nursing facilities, DAHS, DAHS-ISS, ALF, ICF, PPECC, and HCSSA providers for the following: initial, renewal, renewal late fee, relocation, capacity increase, change of ownership, Alzheimer's certification, and updates to their administrative records on file with LTCR. The fees for these programs are deposited in Comptroller Fund 0001 – General Revenue and Dedicated Fee account 5018 - Home Health Services.

Fees are charged for credentialing nursing facility administrators, medication aides, and certified nurse aides for applications, examinations, license, late fees, fingerprint fees, and miscellaneous fees. The fees for these programs are deposited in Comptroller Fund 0001 – General Revenue. Some of these fees are paid by the credentialed individuals to the state of Texas, some are paid directly to the external entities that administer the exams, and the fingerprint fees are paid to the Texas Department of Public Safety.

H. MOUs and interagency agreements or contracts:

CMS certifies nursing facilities, ICF/IID, and home health and hospice for Texas under a HCSSA license. CMS contracts with HHSC LTCR to be the state survey agency under the 1864 agreement. Activities are defined and prioritized through the [CMS Mission and Priority Document](#).

For accrediting organizations, LTCR has an MOU with each organization (The Joint Commission, Accreditation Commission for Health Care, and Community Health Accreditation Partner) that defines the responsibilities of each. Accrediting organizations provide survey functions for a fee on behalf of the state and CMS under certain circumstances. For certified HCSSAs, CMS has approved three organizations, and Texas has MOUs with each one for state surveying.

The Office of the Long-term Care Ombudsman conducts some investigations into clients' rights and other complaints. LTCR works closely with the Long-term Care Ombudsman on any overlapping jurisdiction.

I. Relationship with other governmental entities:

CMS: CMS certifies nursing facilities, ICF/IID, and home health and hospice for Texas under a HCSSA license. CMS contracts with HHSC LTCR to be the state survey agency under the 1864 agreement.

Local Authorities: Local authorities having jurisdiction provide requirements at a local (city, county, etc.) level that the providers that LTCR regulates must comply with. LTCR expects that all regulated providers adhere to those local requirements.

DSHS: LTCR staff supports DSHS for Emergency Support Function #8 during disasters for the populations served by LTC providers. Regional LTCR employees help staff and liaise with state, county, and city entities such as the Disaster District Emergency Operations Center, the Catastrophic Medical Operations Center, and the Disaster District Councils when disasters occur.

LTCR will occasionally work with DSHS on health issues for the populations such as their epidemiology teams for outbreaks in LTCR congregate settings.

J. Barriers and challenges:

Challenge 1: H.B. 4696, 88th Legislature, Regular Session, 2023, moved jurisdiction for ANE investigations for the HCSSA, ICF/IID, HCS, and TxHmL waiver programs from DFPS to HHSC. While HHSC has implemented the move for HCSSAs for ICF/IID, the agency faces challenges with creating the support structure needed to transition HCS and TxHmL waiver programs, which have delayed implementation. Example of challenges HHSC faces include creating the complaint intake process (consolidating the types of complaints from allegations of noncompliance with regulations to ANE) and updating current systems to fully implement this process.

Challenge 2: While LTCR has undertaken multiple efforts to recruit and retain staff, it continues to face ongoing challenges in this critical area. LTCR has recovered some from staff losses suffered during the COVID-19 public health emergency, but certain positions continue to be difficult to fill, particularly front-line survey staff that includes architects, engineers, and Life Safety Code specialists. The result has been backlogs and delays in facility inspections and investigations.

Challenge 3: LTCR's licensing and credentialing team continues to address ongoing IT challenges posed by TULIP. TULIP applies to licensing facilities and providers, along with credentialing of NFAs, CNAs, MAs, and approving NATCEPs. Given the issues related to this system, LTCR staff provided significant guidance and technical assistance to those who are licensed, certified, and/or credentialed.

K. Additional information:

As of July 2023, LTCR cross-trains staff so a single surveyor can conduct both a regulatory inspection to assess a provider's compliance with health and safety rules, and an investigation into potential ANE of individuals receiving long-term care services from HCSSA agencies and ICF/IIDs to match long standing processes in nursing facilities, ALF, DAHS, and PPECC. The result is greater efficiency in the use of LTCR staff, as well as benefits to providers, who no longer have multiple LTCR staff conducting dual investigations in their facilities.

L. Regulatory program information:

Regulated providers (nursing facilities, DAHS, ALF, ICF, PPECC, HCSSA, HCS, and TxHmL):

- Why the regulation is needed: For the protection of the health and safety of individuals receiving services.
- The scope of, and procedures for, inspections or audits of regulated entities:
 - Survey for LSC requirements (where required - facility based providers or inpatient hospice).
 - Survey for health requirements.
 - Inspection for complaints and intakes, including ANE.
- Follow-up activities conducted when non-compliance is identified:
 - A plan of correction is required when non-compliance is identified.
 - Follow-up surveys completed, when necessary.

- Actions available to the agency to ensure compliance:
 - See Enforcement section for available remedies.
- Procedures for handling consumer/public complaints against regulated entities:
 - Most complaints are submitted through HHSC RSD CII section.
 - The exception involves complaints of alleged ANE in the HCS/TxHmL providers, state hospitals, and a list of various other provider scenarios under LTCR PIs' jurisdiction.

Regulated occupational licensees and training programs (NFA, CNA, MA, NATCEP, and MA training programs):

- Why the regulation is needed: provide protection to those receiving services from the occupational licensees by ensuring that the occupational licensees meet minimum requirements.
- The scope of, and procedures for, inspections or audits of regulated entities:
 - Surveys of NATCEPs.
- Follow-up activities conducted when non-compliance is identified:
 - A plan of correction is required when non-compliance is identified.
 - Follow-up surveys completed, when necessary.
- Actions available to the agency to ensure compliance.
 - See Enforcement section for available remedies.
- Procedures for handling consumer/public complaints against regulated entities:
 - Complaints are submitted through HHSC CII section.
 - Complaints are submitted to LTCR for NATCEPs.

M. Complaint and regulatory actions:

**Health and Human Services Commission
Long-Term Care Regulation**

**Exhibit 14. LTCR Information on regulated populations; Complaints against regulated persons, businesses, or other entities; and disciplinary actions*
Fiscal Years 2020 to 2024**

Table 16. LTCR Information on Complaints Against Persons or Entities

Number within Total Regulated Population (Active Credentials Only)	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Number of (License/ Certification/ Registration/ Permit Holder) – Providers	12,372	12,681	13,077	14,041	14,261
Total Number of (License/ Certification/ Registration/ Permit Holder) - Occupational	112,890	110,184	128,686	139,356	103,978

* Data for 2020-23 taken from the LTCR Annual Report. Data for 2024 is a point in time. For HCS/TxHmL, MCS Contract Administration and Provider Monitoring is the resource for the number of contracted providers.

The data provided in the tables below include the following potential limitations:

- The requested data does not directly align with LTCR’s scope of business or the multiple LTCR intake processes/systems. For example, LTCR uses the term “resolved”, to mean the provider was in compliance with applicable regulations, not necessarily the complaint was resolved to the complainant’s satisfaction.
- LTCR may track categories in one system or program and not others. LTCR notated those instances in the tables where the data excludes specific programs.
- All complaints are investigated and assigned an outcome. None are “dismissed” for lack of evidence or no violation found. Either the preponderance of evidence substantiates the allegation occurred, or it does not.

Table 17. LTCR Information on Complaints Against Persons or Entities

Complaints Received by Source*	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Complaints Received	36,264	31,169	31,762	30,545	28,695
Complaints Initiated by Agency (not originating from criminal history check)	35,909	30,871	31,434	30,041	28,220

* HHSC does not collect data on complaints initiated by agency originating from criminal history checks; complaints initiated by the public; or complaints originating from other agencies and are therefore omitted from the table template.

Table 18. LTCR Information on Complaints Against Persons or Entities

Disposition of Complaints*	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Complaints Received**	36,264	31,169	31,762	30,545	28,695
Complaints Found Jurisdictional	18,589	15,751	17,369	17,358	20,915
Complaints Found Non-Jurisdictional	73	78	52	138	131
Total Complaints Dismissed (no investigation)***	282**	220**	235**	237**	192**
Total Complaints Sent for Investigation	35,909	30,871	31,434	30,041	28,220

* HHSC does not track complaints dismissed for lack of evidence or dismissed due to no violation alleged and are therefore omitted from the table template.

** Since complaints may not be processed within a single fiscal year, rows below may not equal the total.

*** These values do not include PI ANE complaints.

Table 19. LTCR Information on Complaints Against Persons or Entities

Complaints Resolved	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Complaints Resolved After Investigation	32,933	31,144	31,199	26,912	23,546
Total Complaints Resolved Through Formal Action**	15,613*	16,024*	17,211*	14,733*	18,225*

* HHSC does not track complaints dismissed for lack of evidence found in investigation, or dismissed due to no violation found in investigation, or total complaints resolved through informal action and are therefore omitted from the table template.

** These values do not include PI ANE complaints.

Child Care Regulation

A. Name of division or program:

Name of division or program: Child Care Regulation (CCR)

Location within the agency: CPRO

Contact name: Rachel Ashworth-Mazerolle, Associate Commissioner

Statutory citation: Texas Human Resources Code, Chapters 42, 43, 44, 48, 63, and 73; Texas Government Code, Chapter 411.

B. Objective and major activities:

CCR is responsible for regulating and educating providers to protect the health, safety, and well-being of children not in the care of their families that attend daycare in facility-based settings or homes or live in 24-hour residential child-care settings such as foster homes, pre-consummated adoptive homes, and general residential operations. CCR objectives include:

- Regulating all childcare operations and child-placing agencies to protect the health, safety, and well-being of children in care.
- Permitting and monitoring operations and agencies for compliance with state licensing statutes, rules, and policies.
- Investigating complaints alleging violations of minimum standards in child care and residential childcare operations.

- Conducting background checks on individuals affiliated with regulated childcare operations in compliance with federal and state statutes, rules, and policy.
- Informing parents and the public about child care, including how specific childcare and residential childcare operations comply with minimum standards of care.
- Giving childcare providers technical assistance on meeting minimum standards, rules, and laws.
- Implementing court orders related to foster care litigation.

C. Effectiveness and efficiency information:

CCR's Performance Management Unit (PMU) is a statutorily required (Texas Human Resources Code, Section 42.0211) and is responsible for evaluating CCR compliance with applicable laws, rules, and policies during monitoring and investigative regulatory activities. PMU has a quality assurance process that involves qualitative reviews of documentation to assess efficacy of the program by conducting routine evaluations on set task areas throughout the year.

PMUs assesses CCR performance with several hundred case reading measures across 20 different surveys including background check functions. PMU also completes targeted reviews of specific task areas based on need or leadership request. CCR requires supervisors to conduct field assessments on their employees, which involve observing an employee conducting regulatory activities and asking the regulated operation for direct feedback on the employee's activities while at the regulated operation. At the conclusion of each evaluation period, PMU analyzes data using statistical software and makes recommendations to CCR leadership for program improvements. The information is also used to inform CCR staff on CCR's performance and used as guidance for management and CCR leadership.

Table 20. CCR LBB key performance indicators (KPIs).

Measure Number	Measure Title	Methodology	Data Source
8-2-1-EF-1	Average Monthly Day Care Caseload Per Monitoring Worker	Count the number of facility and investigation assignments associated with day care monitoring during the reporting period (numerator) and divide by the number of day care monitoring workers with active assignments during the reporting period (denominator). When calculating 2nd, 3rd, and 4th quarters, recalculate the year-to-date total.	Child Care Licensing Automation Support System (CLASS)
8-2-1-EF-2	Average Monthly Residential Caseload Per Monitoring Worker	Count the number of facility and investigation assignments associated with residential licensing monitoring workers during the reporting period (numerator) and divide by the number of residential monitoring workers with facility or investigation assignments during the reporting period (denominator).	CLASS
8-2-1-OP-1	Number of Child Care Facility Inspections	Add together the total number of inspections made by licensing representatives of all regulated and non-regulated childcare facilities within the reporting period. Exclude inspections conducted as part of non-abuse/neglect investigations or abuse/neglect investigations, attempted inspections, and assessments.	CLASS
8-2-1-OP-2	Number of Completed Non-Abuse/Neglect Investigations	Sum the total number of non-abuse/neglect investigations completed within the reporting period.	CLASS
8-2-1-OP-3	Number of Child Care Regulatory Permits Issued	For the reporting period, sum the number of new and renewed permits that were issued to operations and administrators.	CLASS

D. History:

CCR was formerly Child Care Licensing located within DFPS. In September 2017, CCR transitioned to HHSC and became a part of the newly created RSD.

CCR has gone through significant organizational changes over the last few years, including creating two new areas: Heightened Monitoring and Foster Care Litigation

unit on the Quality and Compliance team. These areas are tasked with supporting foster care litigation requirements and tracking compliance with remedial orders.

E. Qualifications or eligibility requirements:

CCR regulates daycare and residential facility types. CCR is also responsible for licensing childcare administrators and child-placing agency administrators who are responsible for ensuring that general residential operations and child-placing agencies operate according to CCR regulations.

Daycare facility types are Child Care Centers or In-home childcare operations that care for children 13 or younger while parents or guardians are at work or school. The care provided is less than 24 hours a day. Facility type qualifications and inspection requirements are listed below:

Licensed Child Care Center:

- Provides care and supervision to seven or more children 13 or younger;
- Provides care at least two hours, but less than 24 hours per day, for three or more days a week;
- Provides care at a location other than the license holder's home;
- Must meet minimum standards; and
- Receives at least one unannounced inspection per year.

Licensed Before or After-School Program:

- Provides care and supervision, including the supervision of recreation or skills instruction or training, to children attending pre-kindergarten through sixth grade;
- Provides care at least two hours per day, three or more days a week, before or after, or before and after the customary school day and during school holidays;
- Must meet minimum standards; and
- Receives at least one unannounced inspection per year.

Licensed School-Age Program:

- Provides care and supervision, including the supervision of recreation or skills instruction or training, to children attending pre-kindergarten through sixth grade;
- Provides care at least two hours per day, three or more days a week, before or after, or before and after the customary school day and during school holidays, the summer period, or any other time when school is not in session;
- Must meet minimum standards; and
- Receives at least one unannounced inspection per year.

Licensed Child-Care Home:

- Provides care and supervision to seven to 12 children aged 13 or younger (no more than 12 children can be in care at any time, including children related to the caregiver);
- Provides care at least two hours, but less than 24 hours per day, for three or more days a week;
- Provides care in the primary caregiver's home;
- Must meet minimum standards; and
- Receives at least one unannounced inspection per year.

Registered Child-Care Home:

- Provides care and supervision for up to six unrelated children aged 13 or younger during school hours and can also provide care and supervision for six additional school-age children after school hours (no more than 12 children can be in care at any time, including children related to the caregiver);
- Provides care at least four hours a day, three or more days a week, for three or more consecutive weeks; or four hours a day for 40 or more days in a 12-month period;
- Provides care in the primary caregiver's home;
- Must meet minimum standards; and
- Receives at least one unannounced inspection every one to two years.

Listed Family Home:

- Provides care and supervision for up to three unrelated children;
- Provides care at least four hours a day, three or more days a week, for three or more consecutive weeks; or four hours a day for 40 or more days in a 12-month period;
- Provides care in the primary caregiver's home;
- Must meet minimum standards; and
- Is not routinely inspected unless a report is received alleging child abuse or neglect, an immediate risk of danger to the health or safety of a child, or the caregiver is caring for too many children.

Temporary Shelter Care:

- Provides child care for seven or more children at a temporary shelter, such as a family violence or homeless shelter, when the parent is away from the shelter;
- Operates for at least four hours a day, three days a week;
- This type of program is issued a Compliance Certificate and CCR does not routinely inspect these shelters;
- They must comply with the standards in Texas Administrative Code, Chapter 743;
- Mostly these standards cover personnel and training requirements, including child/caregiver ratio; serious incident reporting; and safety practices; and
- CCR only inspects at application before issuing a permit and then if we receive any allegations of deficiencies with standards.

Small Employer-Based Child Care Operation:

- Is located on the employer's premises;
- Employs less than 100 full-time employees;
- Provides care and supervision for up to 12 children of the employer's employees;
- Has no minimum standards; and
- CCR does not routinely inspect these operations unless a report alleging child abuse or neglect is received.

24-hour Residential Child Care facility types provide around-the-clock child care for children 17 or younger whose parents or guardians are temporarily or permanently unable to care for them. This may include agencies providing adoption services. Facility type qualifications and inspection requirements are listed below.

General Residential Operation:

- Provides 24-hour care and supervision for seven or more children, ages 17 and under;
- May provide any of the following services:
 - Childcare services;
 - Programmatic services, including emergency short-term care services, therapeutic camp services, a transitional living program, or assessment services; or
 - Treatment services for children with an emotional disorder, an intellectual disability, an autism spectrum disorder, or a primary medical need;
- Must meet minimum standards; and
- Receives at least one unannounced inspection per year.

Child-Placing Agency:

- Is a person or entity other than a child's parent who places or plans for the placement of a child in a foster family home, adoptive home, or other residential child-care setting;
- Does not provide direct care for children;
- Evaluates the home before verifying a foster family home or approving an adoptive home;
- Is responsible for supervising and regulating foster and adoptive homes;
- Must meet minimum standards; and
- Receives at least one unannounced inspection per year.

Child-Placing Agency Foster Family Home:

- Provides care for six or fewer children (in some instances a home can provide care for up to eight children) aged 17 and younger; and

- Is issued a verification after a child-placing agency evaluates the home, including interviews with the household members, a review of the background check results and an inspection of the home to make sure the home meets minimum standards.

Child-Placing Agency Adoptive Home:

- Is issued an approval to accept adoptive placements after a child-placing agency evaluates the home, including interviews with the household members, a review of the background check results and an inspection of the home to make sure the home meets minimum standards.

F. Administration and key processes:

CCR has three functional areas:

- Regional Operations: Conducts inspections and investigations of operations, oversees operations on Heightened Monitoring, and regulates licensed administrators.
- Program Operations: Oversees Policy and Rules, Program Support, Professional Development, and Strategic Operations.
- Quality & Compliance: Monitors Foster Care Litigation (FCL) Quality and Control (Q&C), Performance Management, and the Centralized Background Checks Unit.

Regional Operations is comprised of both state office staff and field staff. Day Care (DC), Residential Care (RC), and Heightened Monitoring (HM) field staff are dispersed throughout the state in the following ways:

- DC is broken up into 11 regions and divided into four districts throughout the state. Each district comprises the following: A regional director, one program administrator, program specialists, supervisors, inspectors, and administrative assistants.
- RC is broken up into 11 regions and divided into three districts throughout the state. Each district comprises the following: A regional director, one to two program administrators, program specialists, supervisors, inspectors, and administrative assistants.

- HM is broken up into 11 regions. The team is comprised of the following: A director of field, program administrators, managers, program specialists, supervisors, inspectors, and administrative assistants.
- CCR policies and processes for regulating and licensing operations can be found on the [HHSC Child Care Regulation website](#).

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts:

CCR has nine active contracts to coordinate program activities and avoid duplication or conflict with other entities that provide similar or identical services or functions to the target population. Contract details are listed in the table below.

Table 21. CCR MOUs and interagency agreements.

Contractor/Procurement Method	Purpose	Type of Contract
Texas Workforce Commission (TWC) Child Care and Development Funds (CCDF) Non-Competitive Grant	Provides equal access to child care for children receiving childcare assistance and to ensure parental choice	Interagency
DFPS Non-Competitive IAC	Payment of Foster Care Lawsuit Court Monitoring	Interagency
TWC Navigator Non-Competitive Grant	Funding for eight CCR Navigator Positions	Interagency
Public Consulting Group, LLC. Request For Proposal	Consulting Services	Interlocal
TWC Criminal Background Check Unit Non-Competitive Grant	For reimbursement of cost associated with background checks conducted for Listed Family Homes	Interagency
Texas Department of Public Safety Exempt	Payment for access to criminal history records	Interagency
University of Texas at Arlington Exempt	UTA will administer the Child Placing Agencies and Child Care Administrator Exams for CCR	Interagency

Contractor/Procurement Method	Purpose	Type of Contract
Texas Department of Public Safety* (For all Regulatory Services including CCR) Exempt	Payment for access to criminal history records	Interagency
Pacer Exempt	To obtain court records for Federal cases	Interagency

I. Relationship with other governmental entities:

DFPS completes ANE investigations at childcare operations and works jointly with CCR for heightened monitoring activities.

RSD Child Care Enforcement (CCE) department completes administrative reviews for CCR decisions related to findings and decisions for CCR-regulated operations, manages State Office of Administrative Hearings (SOAH) hearings related to CCE decisions for CCR-regulated operations, and determines if HHSC should impose corrective or adverse actions on CCR-regulated operations.

CCR provides support to other areas who use CLASS for documenting childcare investigations, heightened monitoring activities, completing background checks, reviewing childcare operation history, etc.

CCR collaborates with the following local, regional, and federal units of government:

- OIG on joint child care operation investigations.
- Office of the Attorney General (OAG) on joint child care operation investigations and operation audits.
- Texas Network of Youth Services on obtaining stakeholder feedback on rule projects.
- Texas Alliance of Child and Family Services on obtaining stakeholder feedback on rule projects.
- Child and Adult Care Food Program on aligning CCR rules with CACFP guidelines, share resources and technical assistance with existing operations, and new applicants to assist them in becoming CACFP providers.

J. Barriers and challenges:

CCR faces challenges keeping up with technological advancements while remaining within available budgets and considering competing financial priorities. S.B. 593, 88th Legislature, Regular Session, 2023, required HHSC to conduct an independent assessment of residential childcare rules, standards, and requirements in Texas. The implementation of S.B. 593 recommendations will impact the whole of HHSC. The recommendations require substantial changes and demand careful allocation of resources and funding.

K. Additional information: Not applicable.

L. Regulatory program information:

CCR regulates all childcare operations and child-placing agencies to protect the health, safety, and well-being of children in care. CCR conducts the following types of inspections:

- **Application Inspections:** Conducted during the application phase when an operation is applying for a new permit. Application inspections are generally announced inspections and include an evaluation of all applicable subchapters.
- **Initial Inspections:** Conducted before an operation receives a full license. Within six months of issuing the initial license, CCR generally conducts at least three unannounced initial inspections while unrelated children are in care to determine whether the applicant is meeting applicable statute, administrative rules, and minimum standards on a continuing basis. If there are no unrelated children in care, the inspector may announce the inspections.
- **Monitoring Inspections:** Conducted during routine visits to the operation. Monitoring inspections must include evaluation of at least one entire subchapter of the applicable minimum standards and may include evaluation of additional individual statutes, administrative rules, or minimum standards, or any conditions or restrictions. CCR must evaluate all applicable subchapters every two years.
- **Investigation Inspections:** Conducted when CCR investigates reports of possible violations of statute, administrative rules, or minimum standards.
- **Follow-Up Inspections:** Conducted when CCR must evaluate compliance with recent deficiencies. CCR also conducts follow-up inspections to ensure that

an operation is no longer operating following a suspension, revocation, or denial.

- Random Sampling Inspections (Residential Care only): Conducted at foster homes verified by child-placing agencies to ensure the agency is complying with applicable statute, administrative rules, and minimum standards.
- Other Types of Inspections when:
 - Consulting with an operation's administrator or director;
 - Hand-delivering a corrective or adverse action notice;
 - Conducting an investigation interview; or
 - Conducting a heightened monitoring (HM) inspection, including an HM follow-up inspection (RC only).

CCR conducts the following types of follow-up activities when non-compliance is identified:

- Follow-Up Inspections: Conducted when CCR must evaluate compliance with recent deficiencies. CCR also conducts follow-up inspections to ensure that an operation is no longer operating following a suspension, revocation, or denial.
- Follow-Up emails: Received when there is a citation, a citation that can be shown as compliant via photographs, or when receiving a written plan for follow up.
- Follow-Up phone calls: Conducted when there is a citation or when further discussion is necessary.
- Discussions with the operation: When a concern with a citation or compliance history is determined, a discussion with the operation can be held.
- Warning Letter Compliance Notification: Sent when it is determined the operation has concerns with an investigation, high risk citations, investigations or one high risk investigation. This letter notifies the operation of the identified areas of concern and notifies the operation enforcement action is possible.
- Plan of Action: This is a voluntary plan offered by CCR and initiated by the operation after concerns are noted at the operation.
- Technical Assistance: Offered to the operation when suggestions and tips regarding standard compliance are available.

- Internal Staffing: Conducted when concerns with an operation is identified to discuss next steps.
- CCE Submission: Completed after internal staffing indicate the need for enforcement action.

CCR conducts the following activities to ensure compliance:

- Discussions with the operation: When a concern with a citation or compliance history is determined, a discussion with the operation can be held.
- Technical Assistance: Offered to the operation when suggestions and tips regarding standard compliance are available.
- Warning Letter Compliance Notification: Sent when it is determined the operation has concerns with an investigation, high risk citations, investigations or one high risk investigation. This letter notifies the operation of the identified areas of concern and notifies the operation enforcement action is possible.
- Plan of Action: This is a voluntary plan offered by CCR and initiated by the operation after concerns are noted at the operation.
- CCE Submission: Completed after internal staffing indicate the need for enforcement action.

CCR receives complaints via fax, mail, email, online, voicemail, regional office phones, and DFPS' SWI toll free hotline. CCR investigates complaints about regulated childcare providers per Chapter 42 of the Texas Human Resources Code and documents in CLASS, the agency's system of record. DFPS SWI investigates abuse/neglect complaints about regulated childcare providers in CLASS and IMPACT, DFPS' system of record. CCR conducts inspections as needed and required per state and federal statute. CCR addresses complaints through investigation and response documented. CCR addresses complaints through the investigation process and documents all findings.

M. Complaint and regulatory actions:

**Health and Human Services Commission
Child Care Regulation**

**Exhibit 14. CCR information on regulated populations; complaints against regulated persons, businesses, or other entities; and disciplinary actions.
Fiscal Years 2020 to 2024**

Table 22. CCR Information on Complaints Against Persons or Entities

Number within Total Regulated Population (Active Credentials Only)	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Number of (License/Certification/Registration/Permit Holder)	16,904	16,070	15,804	16,094	15,901
Total Number of (License/Certification/Registration/Permit Holder)	532	550	558	571	597

Table 23. CCR Information on Complaints Against Persons or Entities

Complaints Received by Source*	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Complaints Received	34,209	57,141	56,629	29,047	26,453
Complaints Initiated by Agency (not originating from criminal history check)**	716	2,164	1,182	1,275	1,999
Complaints Originating from Public (including other regulated persons or entities)	31,895	53,300	54,180	26,629	23,087
Complaints Originating from Other Agencies***	1,598	1,677	1,267	1,143	1,367

* HHSC does not collect data on complaints initiated by agency originating from criminal history checks and the row is therefore omitted from the table template.

** Count of intakes by source-initiated by agency provided by HHSC staff.

*** Count of intakes by source-originated from other agencies-DFPS staff and state agencies.

Table 24. CCR Information on Complaints Against Persons or Entities

Disposition of Complaints*	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Complaints (Intakes) Received**	34,209	57,141	56,629	29,047	26,453
Complaints Found Jurisdictional***	16,044	16,290	15,560	16,025	15,777
Complaints Found Non-Jurisdictional****	2,133	4,819	4,927	1,765	1,315
Total Complaints Dismissed (no investigation)*****	824	869	749	750	845
Complaints Dismissed Due to No Violation Alleged (no investigation)*****	14,938	34,862	35,074	10,114	7,810
Total Complaints Sent for Investigation	16,044	16,290	15,560	16,025	15,777

* HHSC does not track complaints dismissed for lack of evidence and the row is therefore omitted from the table template.

** Since complaints may not be processed within a single fiscal year, rows below may not equal the total.

*** Count of Non-Abuse/Neglect Intakes Received that Resulted in an Investigation.

**** Count of Non-Abuse Neglect Intakes Administratively Closed for Operations Not Subject to Regulation.

***** Count of Non-Abuse/Neglect Intakes Administratively Closed as Repeated Reports.

***** Count of Non-Abuse/Neglect Intakes Administratively Closed as Not Subject to Investigation.

Table 25. CCR Information on Complaints Against Persons or Entities

Complaints (Intakes) Resolved*	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Complaints Resolved After Investigation**	16,044	16,290	15,560	16,025	15,773

Complaints (Intakes) Resolved*	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Complaints Dismissed to No Violation found in Investigation***	12,454	12,782	11,426	11,924	11,582
Total Complaints Resolved Through Informal Action****	23,461	47,536	46,316	17,618	14,996
Total Complaints Resolved Through Formal Action*****	10,745	9,603	10,310	11,425	11,449

* HHSC does not track complaints dismissed for lack of evidence found in investigation and the row is therefore omitted from the table template.

** Count of Non-Abuse/Neglect Intakes Associated with a Completed Investigation.

*** Count of Non-Abuse/Neglect Intakes Associated with a Completed Investigation with No Deficiencies Cited.

**** Count of Non-Abuse/Neglect Intakes Administratively Closed or Associated with a Completed Priority 5 Investigation.

***** Count of Non-Abuse/Neglect Intakes Associated with a Completed Priority 1 - 4 Investigation.

Table 26. CCR Information on Complaints Against Persons or Entities

Disciplinary Actions Taken*	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Warnings (Letters)	214	255	298	317	384
Remedial Plans (if applicable) Plan of Actions**	156	153	241	209	220

* HHSC only tracks warning letters and remedial plans. All other disciplinary actions are therefore omitted from the table template.

** A plan of action is a voluntary enforcement action that is a collaborative effort between CCR and an operation. The goal of a plan of action is to develop a plan to reduce risk and help improve the operation's compliance with CCR statutes, administrative rules, and minimum standards.

Table 27. CCR Information on Complaints Against Persons or Entities

Timelines for Non-Abuse/Neglect Investigations**	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Average Days from Complaint Received to Final Resolution-Priority 1-2	21.56	21.09	21.20	21.91	22.04
Average Days from Complaint Received to Final Resolution- Priority 3-5	31.44	30.43	31.64	34.98	37.01
Maximum Days from Complaint Received to Final Resolution-Priority 1-2	163	288	204	240	169
Maximum Days from Complaint Received to Final Resolution-Priority 3-5***	717	393	230	143	320
Average Days from Complaint Received to Dismissed (no investigation)****	2.05	2.30	1.81	2.03	2.19
Average Days from Start to Finish of Investigation- Priority 1-2-	21.56	21.09	21.20	21.91	22.04
Average Days from Start to Finish of Investigation- Priority 3-5	31.44	30.43	31.64	34.98	37.01
Number of Complaints Open for More than One Year (as of August 31 st of Fiscal Year)	4	3	3	2	0
Percentage of Complaints Resolved within Six Months	14,564	14,523	13,911	14,286	14,240

* HHSC does not track average days from complaint received to dismissed or average days from complaint received to investigation finished and is therefore omitted from the table template.

** Final Resolution is when the complaint is dismissed or final ordered entered; does not include time in appeals to district court.

*** One investigation in fiscal year 2023 and one investigation in fiscal year 2024 were excluded due to incorrect completion dates entered. Both were completed timely and a data correction will need to be completed.

**** Average Number of Days to Administratively Close Non-Abuse/Neglect Intakes. There were 100 intakes that were received during FY 2020-24 that were excluded due to an

incorrect date being entered (For example, the year started with “00” instead of “20”). There are 15 intakes that were admin closed during FY20-24 that lacked a closure reason. These intakes (115) were excluded from the data.

Health Care Regulation

A. Name of division or program:

Name of division or program: Health Care Regulation

Location within the agency: CPRO

Contact name: Suling Homsy, Associate Commissioner

Statutory citation: Texas Health and Safety Code, Chapter 1001; Texas Occupations Code, Chapters 110 and 504

Governing authority: Texas Health and Safety Code chapters for regulated acute health care facilities. Abortion facilities – Texas Health and Safety Code, Chapters 171 and 245; Ambulatory surgical centers – Texas Health and Safety Code, Chapter 244; Birthing centers – Texas Health and Safety Code, Chapter 245; Chemical dependency treatment facilities – Texas Health and Safety Code, Chapter 464; End stage renal disease facilities – Texas Health and Safety Code, Chapter 251; Freestanding emergency medical care facilities – Texas Health and Safety Code, Chapter 254; General and special hospitals – Texas Health and Safety Code, Chapter 241; Limited services rural hospitals – Texas Health and Safety Code, Chapter 241 Subchapter K; Narcotic treatment programs – Texas Health and Safety Code, Chapter 466; Private psychiatric hospitals and crisis stabilization units – Texas Health and Safety Code, Chapters 571-578; Special care facilities – Texas Health and Safety Code, Chapter 248. Governing authority Occupations Code chapters for regulated professional licenses; Licensed chemical dependency counselors – Texas Occupations Code, Chapter 504; Sex offender treatment providers – Texas Occupations Code, Chapter 110, Section 110.051. When used in these chapters, “department” now refers to HHSC.

B. Objective and major activities:

HCR surveys and investigates health care facilities within its statutory authority to protect the health and safety of patients and consumers and ensure compliance with state and federal laws and rules. HCR investigates complaints received against these provider types.

HCR licenses and regulates Licensed Chemical Dependency Counselors (LCDC) and Licensed Sex Offender Treatment Providers and investigates complaints received against these two professional license types.

HCR licenses the following health care facilities: Abortion facilities, ambulatory surgical centers, birthing centers, chemical dependency treatment facilities, freestanding emergency medical care facilities, general and special hospitals, limited services rural hospitals, narcotic treatment programs, private psychiatric hospitals and crisis stabilization units. Licensing functions include application review, fee assessments, architectural and life safety code approval, and performing initial on-site surveys.

C. Effectiveness and efficiency information:

HCR processes applications received within allotted time periods. HCR has established a licensing policy to ensure timely, accurate, and consistent licensing activities including application processing steps, meeting time frames, answering inquiries, data entry, and issuing or closing licenses. HCR tracks licensing application and renewal processing times. Data and Systems Management generates an annual report that provides details for the average license process times for professional licensing and health care facility licensing. HCR facilities compliance utilizes several databases to track complaints and workloads. TULIP tracks complaints and the Architectural Review Unit uses TULIP for project and appointment tracking. Facilities compliance uses ASPEN for workload tracking, and Hyland OnBase is the Substance Use Disorder Compliance Unit (SUDCU) tracking system for inspections and investigations tracking.

As of July 2024, LCDCs can renew their license entirely online including paying online and uploading supporting documents. This same-day renewal application processing time has increased both customer satisfaction and staff productivity while decreasing the number of application status inquiries.

HCR digitized licensing records to ensure accessibility across HCR.

HCR maintains a low staff turnover rate, typically five percent or lower.

HCR worked with IT to develop and implement a new database software to manage staff workloads, prioritize work, and ensure equitable distribution of workloads. In addition, HCR worked with IT to allow facilities to upload renewal documents into the database.

RSD procured a new learning management system to modernize and streamline training by allowing the ability to build, automate, and track programs.

D. History: Not applicable.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

HCR conducts compliance and complaint investigations and conducts compliance reviews for architectural requirements for some state licensed and CMS certified facilities. One of the key processes is investigating complaints and the following illustrates the process. See HCR [Complaint Process Overview Flow Chart](#)

HCR Program Operations develops policies and rules, provides training, engages in quality assurance activities, engages in strategic operational improvement activities, and receives, processes, and issues licenses to HCR regulated providers.

G. Funding: See "Agency Program Information" spreadsheet.

HCRs funding consists of general revenue and federal funding from CMS. HCR submits an annual budget to CMS for the scope of work anticipated to be performed each year for certified providers, including the number of staff required to complete investigations and surveys.

Licensing fees are charged in accordance with statute for LCDC and Licensed Sex Offender Treatment Provider (LSOTP). There are also health care facility licensing fees for the following: initial and renewal applications, relocation, capacity increase, and change of ownership. The Fees for these programs are deposited into Comptroller Fund 0001 – General Revenue.

H. MOUs and interagency agreements or contracts:

No MOUs, interagency agreements, or interagency contracts. However, HHSC does have a contract with an external third party to enhance HCR's organizational processes and structure to ensure quality, safety, and compliance.

I. Relationship with other governmental entities:

HCR serves as CMS' State Survey Agency for certain acute care providers and suppliers. HCR must meet CMS performance measures, works closely with the CMS

Dallas office on survey and certification workload, and receives federal funding from CMS for this partnership. HCR staff are subject to random moment sampling for compliance with federal matching. HCR also serves as the State Survey Agency for the Clinical Laboratory Improvement Amendments (CLIA) program which is a self-funded federal program which requires staff to be 100 percent allocated to this federal workload. HCR may inspect and investigate CMS certified beds in the state hospitals, at the direction of CMS.

J. Barriers and challenges:

Challenge 1: HCR currently experiences challenges with technology and tools that are inefficient and cumbersome. Specifically, there are multiple systems for different units that do not interact with each other. Staff often have to complete documentation in different systems that leads to inefficient processes.

Challenge 2: HCR's Professional Licensing unit experiences challenges with software and the inability to collect applications and license application fees online. This challenge results in significant mail volume and the need for manual processing and digitizing paper applications and mailed checks. HCR also utilizes multiple data management systems that do not communicate with each other, which can create inefficiencies. Manual processing results in delays in providing licensure to applicants.

Challenge 3: The Council on Sex Offender Treatment is administratively attached to HHSC and the HCR director of Licensing is the executive director. In addition to administrative duties, HCR Professional Licensing staff review deregistration eligibility applications for registered sex offenders. However, because sex offenders must register with the Department of Public Safety (DPS), the agency that requires registration may be a better fit to review eligibility applications.

Challenge 4: HCR also faces challenges with balancing state-level and federal-level complaint investigations. CMS requirements and limited FTEs within HCR to complete state-level investigations make it difficult for HCR to prioritize state-level investigations.

K. Additional information: Not applicable.

L. Regulatory program information:

HCR is responsible for the regulatory oversight of hospitals and other acute health care facilities, chemical dependency counselors, and sex offender treatment

providers in Texas. HCR oversees 23 provider types, including those listed below. HCR also oversees hospitals operating under a Certificate of Public Advantage (COPA) under [Health and Safety Code Chapter 314A](#).

- State Licensed-Only Facilities: Abortion facilities (ABOs), birthing centers, chemical dependency treatment facilities (CDTFs), crisis stabilization units (CSUs), freestanding emergency medical care facilities (FEMCs), narcotic treatment programs (NTPs), and special care facilities (SCFs).
- Federally Certified Facilities: Federally qualified health centers (FQHCs), laboratories - Clinical Laboratory Improvement Amendments (CLIA), community mental health centers (CMHCs), comprehensive outpatient rehabilitation facilities (CORFs), outpatient physical therapy (OPT), outpatient speech therapy (OST), portable X-rays, and rural health clinics (RHCs).
- State Licensed and Certified Facilities: Ambulatory surgical centers (ASCs), end stage renal disease (ESRD) facilities, general and special hospitals, private psychiatric hospitals, and limited services rural hospitals (LSRHs).
- Registered-Only: Faith-based chemical dependency treatment programs.
- Professional Licenses: Chemical dependency counselors and sex offender treatment providers.
- Regional Operations: Conducts compliance and complaint investigations and conducts compliance reviews for architectural requirements for some state licensed and CMS certified facilities.
- Program Operations: Develops policies and rules, provides training, engages in quality assurance activities, engages in strategic operational improvement activities, and receives, processes, and issues licenses to HCR regulated providers.

M. Complaint and regulatory actions:

Health and Human Services Commission

Health Care Regulation

Exhibit 14. HCR information on regulated populations; complaints against regulated persons, businesses, or other entities; and disciplinary actions.

Fiscal Years 2020 to 2024

Table 28. HCR Information on Complaints Against Persons or Entities

Number within Total Regulated Population (Active Credentials Only)	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Number of (License / Certification / Registration / Permit Holder) Health Care Facilities	3,339	3,401	3,394	3,337	3,257
Total Number of (License / Certification / Registration / Permit Holder) Professional Licenses	11,237	11,342	11,118	10,864	10,804

Table 29. HCR Information on Complaints Against Persons or Entities

Complaints Received by Source *	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Complaints Received**	3,941	4,675	4,815	4,922	5,615

* HHSC does not collect data on complaints initiated by agency originating from criminal history checks, complaints initiated by agency not originating from criminal history checks, complaints originating from the public, or complaints originating from other agencies and therefore omitted from the table template.

** Total Complaints Received = TULIP Complaints that are RS Non LTC record type from CII.

Table 30. HCR Information on Complaints Against Persons or Entities

Disposition of Complaints*	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Complaints Received**	3,941	4,675	4,815	4,922	5,615
Complaints Found Jurisdictional***	3,593	4,238	4,367	4,305	4,888

Disposition of Complaints*	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Complaints Found Non-Jurisdictional****	346	438	449	618	728
Total Complaints Dismissed (no investigation)	1,230	1,437	1,878	1,809	1,801
Total Complaints Sent for Investigation*****	2,712	3,239	2,938	3,114	3,815

* HHSC does not track complaints dismissed for lack of evidence and complaints dismissed due to no violation alleged and the rows are therefore omitted from the table template.

** Total Complaints Received = from TULIP, added per CII.

*** Complaints Found Jurisdictional = complaints given a priority that is not NA or substance abuse priority 5.

**** Complaints Found Non-Jurisdictional = complaints with NA and substance abuse priority 5.

***** Total Complaints Sent for Investigation = complaints given a priority other than withdrawn, NA, referral or substance abuse priority 5.

Table 31. HCR Information on Complaints Against Persons or Entities

Complaints Resolved*	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Complaints Resolved After Investigation	707	763	888	1,093	1,152
Complaints Dismissed for Lack of Evidence Found in Investigation**	641	695	770	944	1,016
Complaints Dismissed to No Violation found in Investigation***	66	68	118	146	130

* HHSC does not track complaints resolved through informal or formal action and are therefore omitted from the table template.

** Complaints Dismissed for Lack of Evidence Found in Investigation are also termed Unsubstantiated.

*** Complaints Dismissed to No Violation found in Investigation are also termed as Substantiated but not cited.

Regulatory Enforcement

Regulatory Enforcement (RE) was created in 2020 and is composed of enforcement units previously housed in LTCR, CCR, and HCR. Enforcement's mission is to incorporate Fairness, Accountability, Consistency, and Transparency (FACT) in every enforcement decision to promote provider compliance with requirements that ensure quality of life, quality of care, and health and safety for Texans in long-term care, child care, and health care facilities. Enforcement staff continue to work diligently to keep up with enforcement review timelines and streamline the review processes across the various regulated entities and individuals.

A. Name of division or program:

Name of division or program: RE. In this section, RE includes information regarding Long Term Care Enforcement (LTCE), Child Care Enforcement (CCE), and Health Care Facilities Enforcement (HCFE).

Location within the agency: CPRO

Contact name: Corey Kintzer, Associate Commissioner

Statutory citation:

LTCE: Texas Health and Safety Code, Chapters 142, 242, 247, and 252; Texas Human Resources Code, Chapters 103, 161, and 248A

CCE: Texas Human Resources Code, Chapter 42

HCFE: Texas Health and Safety Code, Chapters 161, 164, 171, 222, 241, 243, 244, 245, 248, 251, 254, 311, 321, 322, 323, 462, 464, 466, 571, 572, 573, 574, 575, 576, 577, 578, and 611

B. Objective and major activities:

LTCE: Texas Human Resources Code, Chapter 32, designates HHSC as the State Medicaid Agency (SMA) to set state Medicaid standards. CMS delegated its authority as the SMA to approve, disapprove, or terminate the Medicaid participation of facilities and to impose federal enforcement actions to HHSC. LTCE promotes compliance with federal and state regulations by ensuring HHSC responds appropriately to a facility or program provider's failure to meet requirements, to prompt providers to reach and maintain compliance with the requirements and promote residents' health and safety. Regulatory Enforcement divides its LTCE work into two units:

- Long-Term Care Facility Enforcement (LTCFE) covers the following LTC facilities:
 - ALF;
 - Nursing facilities; and
 - ICF/IDD.
- Community Supports and Integration Enforcement (CSIE) covers the following LTC community programs:
 - HCS/TxHmL;
 - DAHS;
 - ISS;
 - PPECC; and
 - HCSSA.

Additionally, the Credentialing and Registry Enforcement (CARE) unit enforces rules that apply to people working in HHSC-regulated facilities and agencies to protect the health and safety of our residents, consumers, and clients. CARE takes individuals referred for enforcement actions through due process to a final disposition of the referral and imposes final actions. The CARE program includes:

- NFA Enforcement;
- Nurse Aide (NA) Enforcement;
- MA Enforcement;
- EMR;
- LCDC Enforcement;
- Council on Sex Offender Treatment (CSOT) Enforcement; and
- CCR Administrator Enforcement.

CCE: CCE is authorized to initiate enforcement actions when a childcare operation does not comply with licensing laws, administrative rules, minimum standards, or the specific terms of the license, listing, registration, or certification. CCE decides corrective actions, adverse actions, referrals for judicial actions, and administrative penalties within the residential and daycare regulatory programs. CCE conducts administrative reviews of CCR and CCE actions and decisions to include deficiencies cited, waiver and variance decisions, exemption requests, determinations of

immediate threat, corrective action, and adverse action. Additionally, the CARE unit enforces rules that apply to staff who work in HHSC-regulated facilities and agencies to protect the health and safety of residents, consumers, and clients. The CARE unit takes individuals referred for enforcement actions through due process to a final disposition of the referral and imposes final actions. The CARE program includes CCR Administrator Enforcement.

HCFE: HCFE processes disciplinary actions for HCR including their Health Facility Compliance, Licensing, and Substance Use Disorder Programs. The case review and disciplinary action process consists of reviewing and analyzing licensure, re-licensure, complaints investigations, inspections, and surveys for the following facility types: abortion facilities, ambulatory surgical centers, birthing centers, chemical dependency treatment facilities, end stage renal disease facilities, freestanding emergency medical care facilities, general/special hospitals, limited services rural hospitals, narcotic treatment programs, private psychiatric hospitals, and special care facilities to determine appropriate enforcement remedies and penalties for each case if applicable.

Additionally, HCFE reviews complaints for the Texas Department of Insurance (TDI) to determine appropriate enforcement remedies and penalties if applicable after a review of the evidence provided.

C. Effectiveness and efficiency information:

RE promotes effectiveness and efficiency through striving for:

- 90 percent of imposed administrative penalties being within 80 percent of assessed penalties;
- Conducting timely and fair enforcement activities that promote provider compliance; and
- 90 percent post informal dispute resolutions completed within the established timeframe of 15 calendar days from receiving Michigan Peer Review Organization (MPRO) recommendations and providing notification of due process.

D. History:

The purpose of creating a separate RE area was to ensure all regulatory enforcement decisions are made using an objective methodology to remove the potential for bias and to ensure the evidence collected meets the preponderance of the evidence standard.

Prior to creating RE, LTCR regional staff, in conjunction with state office staff, conducted the enforcement reviews of cases involving long-term care facilities, community service providers, and unlicensed facility/provider staff. LTCR transferred nursing facility enforcement reviews to RE effective July 1, 2021, for nursing facilities and all other long-term care provider types on September 1, 2021. On June 12, 2023, RE merged CSIE and HCSSA Enforcement into one unit.

CCE began a phased transition from CCR to RE in March 2022 and the reorganization was completed in September 2023.

HCFE has undergone significant structural and procedural enhancements since its transition from DSHS to HHSC on September 1, 2017. These changes reflect a broader shift from manual processes to standardized, technology-driven enforcement practices and data, improving transparency, consistency, and turnaround time across the program.

Recent RE improvements include:

- Implementation of administrative penalty matrices;
- Development of a centralized SharePoint system for real-time case management and referrals for CSIE and HCFE units; and
- 2023 Implementation of the Issue, Rule, Analysis, and Conclusion (IRAC) procedure for case reviews to ensure consistent and quality reviews for all proposed disciplinary actions.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

LTCE: LTCE reviews deficiencies and violations and the supporting evidence to determine appropriate penalties, remedies, and sanctions where warranted. The review process uses the IRAC methodology to ensure a strict comparison between facts gathered during investigation and the language of the rule alleged to be violated. Enforcement reviews are conducted for the following LTC programs and individuals:

- HCS;
- TxHmL;
- DAHS;

- ISS;
 - Limited to violations and deficiencies with scope and severity (S/S) D and above;
- PPECC;
- HCSSA;
 - Limited to state violations at Level B and HCSSA Medicare certified deficiencies resulting in noncompliance with Conditions of Participation;
- ALFs;
 - Limited to violations and deficiencies with S/S D and above;
- ICFs;
 - Limited to violations and deficiencies with S/S D and above; and
- Nursing facilities limited to:
 - Health violations and deficiencies resulting in Conditions of Participation (CoP) not met;
 - Health violations and deficiencies with S/S D and above; and
 - LSC violations and deficiencies with S/S of D and above.

CCE:

- Corrective and Adverse Action Referrals: HHSC's CCR division refers a childcare operation to CCE for possible enforcement action. CCE reviews the operation's compliance history and determines whether an enforcement action is needed, and which enforcement action is appropriate, in accordance with Texas Administrative Code, Subchapter L, Chapter 745, Title 26. CCE notifies CCR whether an action will be taken. If an action is appropriate, CCE notifies the childcare operation of the action and due process timeframes.
- Monetary (Administrative) Penalties: CCE uses information from CCR to identify deficiencies cited at childcare operations which are associated with administrative penalties. CCE confirms that there is sufficient evidence to support the deficiency and determines the administrative penalty amount, using Human Resources Code, Section 42.078. CCE notifies the childcare operation of the administrative penalty and due process timeframes.
- Administrative Reviews: Childcare providers submit administrative review requests to CCE when they disagree with a deficiency cited by CCR, when CCR has denied a waiver/variance or exemption, or when CCR has issued an

individual a determination of immediate threat (DIT). Providers also submit requests for administrative review when they disagree with an enforcement action taken by CCE. CCE gives the provider (or individual, in cases of DIT) an opportunity to provide documentation and meet with CCE to provide information which supports their position. CCE determines whether the decision made by CCR or action imposed by CCE is appropriate and notifies the provider or individual of the outcome.

- For each review described above, CCE staff use the IRAC methodology to ensure a strict comparison between facts gathered during an inspection or investigation and the language of the rule alleged to be violated.

HCFE: HCFE operates a centralized, structured enforcement workflow.

1. Referrals are received via SharePoint and assigned within 1–2 business days.
2. The assigned program specialist completes a review, internal case notes, drafts the Notice of Violation (NOV) and Enforcement Tracking Worksheet (ETW) within 10-15 business days depending on the number of referred citations, followed by review/approval cycles involving team leads and directors.
3. OCC consults and informal conferences (if requested) follow.
4. Orders (Agreed, Default, Revocation, etc.) are issued based on response.
5. A full case life cycle typically spans 20-25 business days.

Enforcement approved NOV's, ETW's, and orders are shared with HCR's referring party to inform them of what violations moved forward and/or what violations did not move forward.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

RE works with SOAH for the purpose of appeals of enforcement actions through formal due process. Additionally:

LTCE works with:

- CMS to coordinate the imposition of federal enforcement remedies, to include recommendations for CMP, in certified facilities when the provider fails to comply with applicable federal regulations.

- OAG. The relationship includes RE's referral of cases to OAG to seek a court order when someone operates an unlicensed facility. RE may also refer cases to OAG for collections of unpaid administrative penalties.

CCE works with:

- OAG to seek a court order for unlicensed facilities or other judicial actions. RE also refers cases to OAG for collections of unpaid administrative penalties; and
- DFPS to access IMPACT, the DFPS central registry for ANE investigation findings of individuals and operations; and notify DFPS when CCE takes adverse action on a General Residential Operation or a Child Placing Agency, so DFPS may make appropriate placement actions for children in foster care.

HCFE works with:

- TDI to handle enforcement cases related to certain insurance billing practices;
- DSHS for nursing services staffing data; and
- OAG to seek court orders for unlicensed facilities and for collections of unpaid administrative penalties.

J. Barriers and challenges:

LTCE Challenge 1, program administration: challenges include increasing workloads, staffing needs, and a lack of technology resources to automatically track RE determinations to reduce work hours associated with each deficiency or violation, the risk for error in data entry, and time spent producing and retrieving data reports regarding team performance.

LTCE Challenge 2: Some rules under each program need revisions and clarifications. For example, Texas Administrative Code Title 26, Part 1, Chapter 561, EMR, requires amendments to implement legislative mandates related to the interagency reportable conduct search engine, clarification of the HHSC process used to determine whether a person meets requirements for inclusion in EMR, and criteria for removal from EMR.

CCE: Not applicable.

HCFE: Not applicable.

K. Additional information:

LTCE: Not applicable.

CCE: Individuals and entities impacted by regulatory enforcement actions or decisions include:

- 20,299 regulated childcare providers which HHSC has issued a listing, registration, or license to provide child day care services or residential childcare services (Reference HRC Chapter 42.052);
- 3,001 unregulated childcare providers who fail to meet the Human Resource Code requirement for a permit to operate a childcare program;
- 4,878 Texas Workforce Commission/Texas Rising Stars Providers;
- Texas Department of Agriculture/Child and Adult Care Food Program;
- DFPS/Foster Care/Youth Services;
- Seven Single Source Continuum Contractor (SSCCs);
- Various accrediting agencies for Day Care and Residential Care operations; and
- Parents seeking child care and residential care.

HCFE: HCFE ensures regulatory compliance through consistent and fair enforcement, using a structured, matrix-based penalty system and detailed documentation protocols (Issue, Rule, Application, and Conclusion methodology). The program leverages tools such as VERSA, SharePoint, and ETW to monitor case progress and maintain transparency. Updates to manuals, templates, and processes are continuous, reflecting a commitment to quality improvement. HCFE communicates with the Enforcement Coordination Team to address any training needs and/or trends seen in case reviews.

L. Regulatory program information:

RE is needed to ensure the health, safety, and well-being of the individuals served by long-term care, health care facility, and child-care programs and to ensure inspection, survey, investigation findings appropriately support the enforcement action. For each HHSC-regulated program, rules outline the procedures for inspections, audits, and investigations. Follow-up activities are completed to allow these entities return to compliance and protect those they serve. The rules include enforcement actions, administrative penalties, informal reviews, administrative

appeals, revocation, suspension, and vendor holds which are necessary to promote compliance and ensure agencies, providers, and facilities provide the necessary care and services to individuals served.

M. Complaint and regulatory actions:

**Health and Human Services Commission
Regulatory Enforcement
Exhibit 14. LTCR disciplinary actions taken
Fiscal Years 2020 to 2024**

Table 32. Regulatory Enforcement Information on Complaints Against Persons or Entities

Disciplinary Actions Taken	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Complaints Resolved Through Final Orders (Formal and Informal)*, **	363	457	418	754	911
Number of Administrative Penalties Issued	1,162	838	777	675	555
Total Amount of Administrative Penalties Issued	\$7,684,650	\$4,644,225	\$4,812,700	\$5,018,505	\$5,759,245
Total Amount of Administrative Penalties Collected ***	\$1,100,483	\$2,228,895	\$2,611,969	\$1,561,908	Not Available
Average Amount of Administrative Penalties Issued	\$6,613	\$5,542	\$6,194	\$7,435	\$10,377
Average Amount of Administrative Penalties Collected ***	\$947	\$2,660	\$3,362	\$2,314	Not Available
Warnings	N/A	N/A	N/A	N/A	N/A
Reprimands	8	2	2	14	3
Suspensions	8	3	26	51	76
Probated Suspensions	4	6	13	N/A	1

Disciplinary Actions Taken	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Revocations	146	161	183	188	421
Remedial Plans (if applicable)	N/A	N/A	N/A	N/A	N/A
(Other Disciplinary Action – Specify) ****	141	137	129	149	114

* Since complaints may not be processed within a single fiscal year, rows below may not equal the total.

** Includes Nursing Facility Administrator, Nurse Aide, Medication Aide, and Employee Misconduct Registry referrals received, and Informal Dispute Resolution cases received.

*** The total amount of administrative penalties issued for fiscal year 2024 has not been determined and is not available.

**** Other Disciplinary Actions include Nurse Aides and other unlicensed staff reported to the Employee Misconduct Registry (EMR), Referrals to the Office of the Attorney General (OAG), Denial of Certification Recommendations, Vendor Hold Recommendations, and Vendor Holds.

Table 33. Regulatory Enforcement Information on Complaints Against Persons or Entities

Disciplinary Actions Appealed	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Hearings at SOAH***	331	256	205	223	183
Agency Prevailed at SOAH****, *****	294	196	174	149	151
Agency Did Not Prevail at SOAH*****	104	89	94	92	84
Total Appeals by Respondent to District Court *****	1	3	2	0	2
Agency Action Affirmed by District Court	0	0	2	1	3

Disciplinary Actions Appealed	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Agency Action Overturned by District Court	0	0	0	1	0
Total Appeals by Agency to District Court*****	0	0	0	0	0
Agency Action Affirmed by District Court	0	0	0	0	0
Agency Action Overturned or Changed by District Court	0	0	0	0	0

* By rule, HCS and TxHmL LTC appeals moved under SOAH's jurisdiction effective January 1, 2023. SOAH data prior to that date does not exist.

**HHSC's Office of the Chief Counsel (OCC) defends Provider Investigations (PI) EMR cases, which includes allegations investigated by both DFPS and HHSC Provider Investigations. These cases have historically been heard at the HHSC Appeals Division. Although these cases were not docketed at SOAH, OCC has included them in the table.

*** The data reflects all cases docketed at SOAH in each identified fiscal year. Although most cases are docketed with SOAH, only a percentage of the cases go to hearing on the merits.

****This data includes cases in which SOAH ruled in whole or in part to uphold the HHSC's action. It also includes cases in which petitioner accepted the agency's enforcement action and withdrew their appeal, settled the case, did not appear at hearing (which resulted in default judgement), and cases which SOAH granted the agency's motion for summary disposition.

*****Although the case is heard before a SOAH Administrative Law Judge (ALJ), it is OCC's Appeals Division who issues final orders that indicate whether HHSC Prevailed at hearing.

***** This data reflects the number of cases in which SOAH ruled against the agency or the agency rescinded its proposed action in the designated fiscal year.

*****This data reflects the number of cases in which SOAH ruled against the agency or the agency rescinded its proposed action in the designated fiscal year. Once a Judicial Review Request/Appeal to District Court is filed, the OCC notes the case file, but their role in the contested case process is concluded. OCC coordinates with OAG to represent HHSC in state district court.

*****The agency did not appeal SOAH outcomes to district court.

Table 34. Regulatory Enforcement Information on Complaints Against Persons or Entities

Disciplinary Actions Taken	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Complaints Resolved Through Final Orders (Formal and Informal)*	34,206	57,139	56,626	29,046	26,447
Number of Administrative Penalties Issued	1,247	1,536	2,018	1,961	1,806
Total Amount of Administrative Penalties Issued	\$161,443	\$186,413	\$439,940	\$502,340	\$553,090
Total Amount of Administrative Penalties Collected	\$150,402	\$172,384	\$391,290	\$403,305	\$403,185
Average Amount of Administrative Penalties Issued	\$129	\$121	\$218	\$256	\$306
Average Amount of Administrative Penalties Collected	\$121	\$112	\$194	\$206	\$223
Warnings	N/A	N/A	N/A	N/A	N/A
Reprimands	N/A	N/A	N/A	N/A	N/A
Suspensions**	0	1	1	3	2
Probated Suspensions***	0	0	1	0	0
Revocations	13	29	5	24	27
Remedial Plans (if applicable)	N/A	N/A	N/A	N/A	N/A
(Other Disciplinary Action – Specify) ****	49	87	88	73	43

* Since complaints may not be processed within a single fiscal year, rows below may not equal the total. This number includes CCR's complaints along with CARE's licensee referrals.

** Suspensions for CCE are involuntary suspensions and CARE's Suspension of a License.

*** Probated Suspensions include CARE's Probated Suspensions of a Licensee's License.

**** Other Disciplinary Action includes Denial, Probations, Refuse to Renew, Adverse Amendment, Judicial Actions, and CARE's Denial of an Application for a License, Denial of License Renewal, and Voluntary Surrender.

Table 35. Regulatory Enforcement Information on Complaints Against Persons or Entities

Disciplinary Actions Appealed	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Hearings at SOAH*	15	33	27	92	83
Agency Prevailed at SOAH**	46	45	19	30	82
Agency Did Not Prevail at SOAH***, ****	15	14	14	26	48
Total Appeals by Respondent to District Court	0	1	1	0	0
Agency Action Affirmed by District Court *****	0	0	0	1	1
Agency Action Overturned by District Court	0	0	0	0	0
Total Appeals by Agency to District Court	0	0	0	0	0
Agency Action Affirmed by District Court	0	0	0	0	0
Agency Action Overturned or Changed by District Court	0	0	0	0	0

*The data provided reflects all CCR cases docketed at SOAH in each identified fiscal year. These numbers do not include hearing involving DFPS Central Registry findings. In fiscal year 2025, those cases were transferred back to DFPS. Although most cases are docketed with SOAH, only a percentage of the cases go to hearing on the merits.

** This data includes cases in which SOAH ruled in whole or in part to uphold the HHSC's action. It also includes cases in which petitioner accepted the agency's enforcement action and withdrew their appeal, settled the case, did not appear at hearing (which resulted in default judgement), and cases in which SOAH granted the agency's motion for summary disposition.

*** This data reflects the number of cases in which SOAH ruled against the agency, or the agency rescinded its proposed action in the designated fiscal year.

**** Unlike Long-Term Care Enforcement and Health Care Facility Enforcement, SOAH does not issue a PFD in CCR cases. Instead, the order issued by the SOAH ALJ is the final order. Petitioners are still afforded the opportunity to file a Motion for Rehearing with SOAH before they are able to request judicial review in state district court.

***** This data reflects the number of petitioners who requested judicial review of the agency's action in the designated fiscal year. Once a Judicial Review Request/Appeal to District Court is filed, OCC notes the case file, but their role in the contested case process is concluded. OCC coordinates with OAG to represent HHSC in state district court.

Table 36. Regulatory Enforcement Information on Complaints Against Persons or Entities

Disciplinary Actions Taken	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Complaints Resolved Through Final Orders (Formal and Informal)*	155	135	111	202	238
Number of Administrative Penalties Issued	108	135	45	159	148
Total Amount of Administrative Penalties Issued	\$499,750	\$1,083,650	\$189,550	\$2,188,675	\$59,060,300
Total Amount of Administrative Penalties Collected	\$1,039,325	\$403,730	\$284,460	\$158,550	\$422,313
Average Amount of Administrative Penalties Issued	\$4,627	\$8,027	\$4,308	\$13,765	\$399,056
Average Amount of Administrative Penalties Collected	\$7,586	\$3,256	\$3,512	\$1,133	\$2,690
Warnings**	0	0	2	1	22
Reprimands***	0	1	1	3	0
Suspensions****	8	3	26	51	75
Probated Suspensions*****	4	6	1	0	0
Revocations	0	0	0	0	0

Disciplinary Actions Taken	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Remedial Plans (if applicable)	N/A	N/A	N/A	N/A	N/A
(Other Disciplinary Action – Specify) *****	4	0	1	2	3

* Since complaints may not be processed within a single fiscal year, rows below may not equal the total. Complaints resolved through order includes HCFE Facilities and CARE's licensees.

** Warnings include HCFE Facilities and CARE's Warning to a person's license.

*** Reprimands include CARE's licensees.

**** Suspensions include CARE's suspending of license.

***** Probated Suspensions include CARE's restrictions on a license.

***** Other Disciplinary Action includes HCFE Denial of Application and CARE's Denial of Application, Denial of License Renewal, and Voluntary Surrender.

Table 37. Regulatory Enforcement Information on Complaints Against Persons or Entities

Disciplinary Actions Appealed	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Total Hearings at SOAH*	4	4	2	2	14
Agency Prevailed at SOAH**, ***	1	9	4	0	1
Agency Did Not Prevail at SOAH****	0	1	0	0	0
Total Appeals by Respondent to District Court	0	1	0	0	0
Agency Action Affirmed by District Court*****	0	0	0	0	0
Agency Action Overturned by District Court	0	0	0	0	0
Total Appeals by Agency to District Court	0	0	0	0	0

Disciplinary Actions Appealed	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024
Agency Action Affirmed by District Court	0	0	0	0	0
Agency Action Overturned or Changed by District Court	0	0	0	0	0

* This data provided reflects all cases docketed at SOAH in each identified fiscal year.

Although Most cases are docketed with SOAH, only a percentage of the cases go to hearing on the merits.

** This data includes cases in which SOAH ruled in whole or in part to uphold the HHSC's action. It also includes cases in which petitioner accepted the agency's enforcement action and withdrew their appeal, settled the case, did not appear at hearing (which resulted in default judgement), and cases in which SOAH granted the agency's motion for summary disposition.

*** Although the case is heard before a SOAH ALJ, it is HHSC's Appeals Division who issues final orders that indicate whether HHSC prevails at hearing.

**** This data reflects the number of cases in which SOAH ruled against the agency, or the agency rescinded its proposed action in the designated fiscal year.

***** This data reflects the number of petitioners who requested judicial review of the agency's action in the designated fiscal year. Once a Judicial Review Request/Appeal to District Court is filed, OCC notes the case file, but their role in the contested case process is concluded. OCC coordinates with OAG to represent HHSC in state district court.

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VII. Guide to Agency Divisions and Programs

Chief Public Affairs Officer

The Chief Public Affairs Office (CPAO) was established in 2020 as one of ten Health and Human Services Commission (HHSC) chief areas. CPAO oversees internal and external communications, public complaint resolution, government and stakeholder relations, and advises the executive commissioner and executive leadership team.

CPAO oversees the Office of Communications, Office of Government and Stakeholder Relations (GSR), and Health and Human Services (HHS) Office of the Ombudsman (Ombudsman).

Communications

A. Division or program information:

Name of Program or Function: Office of Communications

Location/Division: CPAO

Contact Name: Christine Mann, Communications Director

Statutory Citation for Program: None

B. Objective and major activities:

The Office of Communications oversees public-facing materials, campaigns and media relations for HHSC, and ensures messaging is consistent with agency branding. Chief areas request editorial services, graphic design services, social media promotion, and web and video services through the Office of Communications. Additionally, the Press Office is the single point of contact for media inquiries and receives media inquiries through a dedicated press line and email address. The Office of Communications produces Spanish translation for HHSC and offers Spanish translation services to the Department of Family and Protective Services (DFPS), Department of State Health Services (DSHS), and Office of the Inspector General (OIG). Units within the Office of Communications adhere to the following objectives to guide daily operations:

- Deliver accurate, timely content to improve access to services;

- Act as the central hub for external and internal communications;
- Use media channels to provide clear, accessible messaging to reach a broad audience; and
- Keep employees connected through engaging internal communications.

C. Effectiveness and efficiency information:

While the Office of Communications does not actively maintain performance measures, it provides transparent, cost-effective and efficient services by:

- Providing timely responses to inquiries from local, state and national news media;
- Ensuring the hhs.texas.gov website is online, accessible and accurate;
- Accurately translating client-facing information into Spanish so clients can efficiently apply for benefits; and
- Distributing critical information to Texans.

D. History:

While the HHSC communications department has existed since the 1990s, the consolidation of the health and human services agencies in 2003 led to the creation of separate communication offices in DFPS and DSHS. At the time, the HHSC supported OIG communications efforts, however the OIG Policy and Publications division maintained oversight of those functions. In 2016, the OIG communications team was formally established. Today, HHS communications offices operate independently and regularly coordinate with HHSC.

E. Qualifications or eligibility requirements: Not applicable

F. Administration and key processes:

The Office of Communications provides support to program areas and oversees agencywide and public-facing materials, campaigns, and media relations.

The office consists of seven units:

- The Press Office: Manages all media relations for the agency, responds to media inquiries and monitors news coverage. The Press Office also manages open records requests from credentialed media representatives.

- The Social Media unit: Manages social media accounts, oversees organic and paid social media campaign messaging, and responds to consumer inquiries.
- The Editorial Services unit: Writes and edits content for staff and the public, including websites, reports, graphics and other print and online materials.
- The Outreach and Graphic Design Services unit: Works with staff in developing strategic communications plans to reach specific public awareness campaign objectives and target audiences. The unit also produces flyers, posters, brochures, and social media layouts.
- The Translation Services unit: Translates HHSC, DFPS, DSHS and OIG materials into Spanish for Texans with limited English proficiency, while meeting agency brand, style, and grammar standards for the agency.
- The Web Services unit: Manages the intranet and 17 various public-facing websites. The team provides guidance to chief area designees in developing content based on program goals, audience, web layout best practices, and compliance with accessibility requirements.
- The Video Services unit: Produces internal and public-facing videos about programs and services. The team also captures photos for agencywide and public use.

G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts:

Translation Services translates materials for DSHS and DFPS through interagency agreements. Translation requests for OIG are infrequent and completed on an informal, ad hoc basis.

I-M. Relationship with other governmental entities; Barriers and challenges; Additional, Regulatory, and Complaint information: Not applicable.

Government and Stakeholder Relations

A. Division or program information:

Name of Program or Function: Government and Stakeholder Relations

Location/Division: CPAO

Contact Name: Jonathan Connors, GSR Director

Statutory Citation for Program: None

B. Objective and major activities:

GSR is the HHSC contact with the Office of the Governor, elected officials, state agencies, and other external stakeholders. GSR advises executive leadership on legislative matters, coordinates meetings and hearing requests, responds to inquiries from elected officials and external stakeholders, and ensures the timely submission of all legislatively required reports.

GSR collaborates with agency staff to track and implement legislation and budget direction, as well as maintain subject matter expertise to draft timely and accurate responses to legislative communications. GSR also engages with legislators and stakeholders to build strong external and legislative relationships.

Throughout Texas legislative regular and special sessions, GSR maintains the Legislative Tracking System, which allows HHSC to efficiently coordinate legislative analysis and agency cost estimates for all pieces of legislation that may impact HHSC. During the legislative interim, GSR maintains the Legislative Reports Tracking System to monitor and coordinate reports required by statute, rider, or rule. Additionally, GSR monitors and tracks all implementation efforts resulting from new bills passed during the previous legislative session.

C. Effectiveness and efficiency information:

GSR ensures HHSC provides transparent, cost-effective, good customer service, and consistent messaging of HHSC needs and priorities.

While GSR does not actively maintain performance measures, it maintains the following core objectives:

- Provide timely and accurate information to the Office of the Governor, legislative offices, state agencies, and external stakeholders;
- Develop, coordinate, and implement legislative strategy for HHSC;
- Manage the implementation of legislation on behalf of the agency;
- Serve as the primary liaison to local, state, and federal elected officials;
- Provide timely and accurate information about legislative activity to agency leadership and program areas; and

- Oversee the timely submission of legislatively required reports and studies.

D. History:

While GSR serves as the primary point of contact for legislative affairs, the stakeholder relations function is decentralized. GSR serves as a quasi-stakeholder relations unit and acts in an advisory capacity, sometimes assisting external stakeholders with navigating the agency.

As a result of the last sunset review of Article II agencies, GSR assumed the government relations role for the programs transferred to HHSC from the Department of Aging and Disability Services (DADS) (abolished), Department of Assistive and Rehabilitative Services (abolished), DFPS, and DSHS. DFPS, DSHS, and OIG maintain their own government relations offices to support the programs that remain at those agencies.

HHSC requested an exceptional item during the 89th Legislative Session to formalize the stakeholder functions and processes within GSR to support the agency, but the item was only partially funded.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

GSR includes three teams: Government Relations, Constituent Services, and GSR Support and Coordination.

- Government Relations: Supports HHSC by providing guidance on legislative activities. They facilitate and coordinate responses to legislative offices and other elected officials throughout the year and work closely with agency leadership and legislative coordinators for each area.
- Constituent Services: Directs phone and email correspondence from legislators seeking assistance and answers on behalf of their constituents. They coordinate with chief areas to provide answers on legislation and other constituent needs.
- Support and Coordination: Manages the Legislative Tracking System, Legislative Reports Tracking System, official reports, correspondence, and makes sure GSR remains timely for all responses and assignments.

G. Funding: See " Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

GSR is the single point of contact for communicating with state legislative offices, the Office of the Governor, and other state agencies for legislative matters with local, regional, and federal units of government. GSR is responsible for coordinating with the Texas Office of State-Federal Relations and all congressional offices in conjunction with the executive commissioner's office.

J-M. Barriers and challenges; Additional, Regulatory, and Complaint information: Not applicable.

Ombudsman

A. Division or program information:

Name of Program or Function: Office of the Ombudsman

Location/Division: CPAO

Contact Name: Elisa Hendricks, Ombudsman

Statutory Citation for Program: Texas Government Code, Chapter 523, Subchapter F, Section 523.0255

B. Objective and major activities:

The Ombudsman provides dispute resolution services as an impartial party, performs consumer protection functions, and collects data on inquiries and complaints. The units within the Ombudsman are described below:

- Ombudsman Complaint Services (OCS): Answers the main Ombudsman Office toll-free line addressing inquiries and complaints about all HHS programs and services including benefits and eligibility for Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Medicaid. OCS educates consumers on the various HHS program areas while striving to resolve issues upon initial contact.

- Executive Operations and Reporting (EOR): Sets the strategic mission and goals, manages resources and ombudsman budgets, and ensures consistent customer service among all areas of practice. This business area also houses general operation and reporting functions, such as data collection, quality assurance, training, administrative support, and operating procedures.
- Foster Care Ombudsman (FCO): Assists children and youth in DFPS conservatorship with complaints regarding issues within DFPS or HHSC authority.
- Ombudsman Managed Care Assistance Team (OMCAT): Coordinates with a network of entities to provide support and information services to members who experience barriers to receiving Medicaid services.
- Ombudsman for Behavioral Health (OBH): Serves as an impartial party to help consumers and their health care providers navigate and resolve issues related to access to services, including care for mental health conditions and substance use disorders.
- Intellectual or Developmental Disabilities Ombudsman (IDDO): Reviews complaints regarding the rights of individuals with intellectual or developmental disabilities (IDD). IDDO receives complaints from individuals receiving services from Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Medicaid waiver programs, as well as local intellectual and developmental disability authorities (LIDDAs).
- Specialized Ombudsman Services (SOS): Provides support on inquiries and complaints from consumers that are not initially resolved by OCS. SOS handles escalated issues requiring a more detailed, intensive review as well as legislative inquiries and complaints.

C. Effectiveness and efficiency information:

The Ombudsman achieves efficient complaint resolution by:

- Reducing or eliminating duplicate complaint investigations by communicating and coordinating with HHS program areas involved in the complaint;
- Ensuring staff respond to, investigate, and resolve complaints in a timely and accurate manner; and
- Maintaining the HHS Enterprise Administrative Report and Tracking System (HEART), the agency contact tracking database, which allows HHS program areas to document, track, and share consumer contacts in one place.

The Ombudsman ensures the effective delivery of consumer services by:

- Restoring denied benefits, reopening cases, or achieving other positive outcomes that allow consumers to access the benefits to which they are eligible.
 - ▶ In fiscal year 2024, 17,872 or 32.5 percent of consumer complaints resulted in positive outcomes.
- Compiling HHS complaint data which is regularly reported to the executive commissioner and shared with HHS program areas to identify trends or systemic issues that may need to be addressed.
- Providing recommendations on improving policies and procedures to remove obstacles that prevent HHS consumers from accessing services.

D. History:

- In 1982, OBH was established as the consumer services and rights protection office at the former state agency, Texas Department of Mental Health and Mental Retardation, and appointed advocates at all state hospitals, state supported living centers (SSLCs), local mental health authorities (LMHAs), and LIDDAs.
- In 1995, the Medicaid Services helpline was created with the passage of Senate Bill (S.B.) 601, 74th Legislature, Regular Session, 1995.
- In 2003, House Bill (H.B.) 2292, 78th Legislature, Regular Session, 2003, created the Ombudsman.
- In 2007, OMCAT transitioned from STARLink, a private nonprofit initially contracted to provide these services, to the Ombudsman.
- In 2009, the Office of Independent Ombudsman (OIO) for SSLCs was established through S.B. 643, 81st Legislature, Regular Session, 2009, to provide oversight of SSLCs. The independent ombudsman is appointed by the Governor; however, receives operational support from HHSC and is administratively attached to the CPAO.
- S.B. 200, 84th Legislature, Regular Session, 2015, consolidated ombudsman functions from three state agencies — the DADS (abolished), DARS (abolished) — and DSHS. S.B. 830, 84th Legislature, Regular Session, 2015, created FCO for children and youth.

- In 2017, OBH transitioned from Behavioral Health Services into the Ombudsman. OBH was given additional duties to accept complaints about mental health parity with H.B. 10, 85th Legislature, Regular Session, 2017.
- In 2019, Consumer Rights-ID transitioned from the Regulatory Services Division into the Ombudsman to become IDDO.
- H.B. 3462, 88th Legislature, Regular Session, 2023, consolidated the various enabling statutes and standardized practice among all ombudsman functions.

E. Qualifications or eligibility requirements: Not Applicable

F. Administration and key processes:

The Ombudsman is commonly known as the “office of last resort.” It encourages consumers to initially resolve complaints or issues directly with the program area. When that does not occur, the consumer contacts the Ombudsman to help reach a resolution. While both the HHS program area and the Ombudsman strive to resolve the issue, the latter provides an impartial viewpoint and seeks to determine if policy and procedure were conducted properly.

The Ombudsman receives inquiries and complaints, provides dispute resolution, and consumer protection. The office is also responsible for collecting, analyzing, and reporting HHS program area complaint data. Consumers can submit questions or complaints by phone, online, mail, or fax.

OCS responds to inquiries and resolves complaints on HHS programs or services. OCS staff answer the Ombudsman’s main toll-free line and receive inquiries and complaints via the Ombudsman’s online submission form. Inquiries and complaints are entered into HEART.

Cases requiring additional coordination with other HHS staff are escalated to SOS, which facilitates and manages complex complaints, including urgent and escalated assignments via HEART. In addition to these escalations, SOS staff answer a dedicated phone line available to legislative staff and receive cases from the executive clerk’s constituent tracking system (CTS), including referrals from the Office of the Governor or GSR.

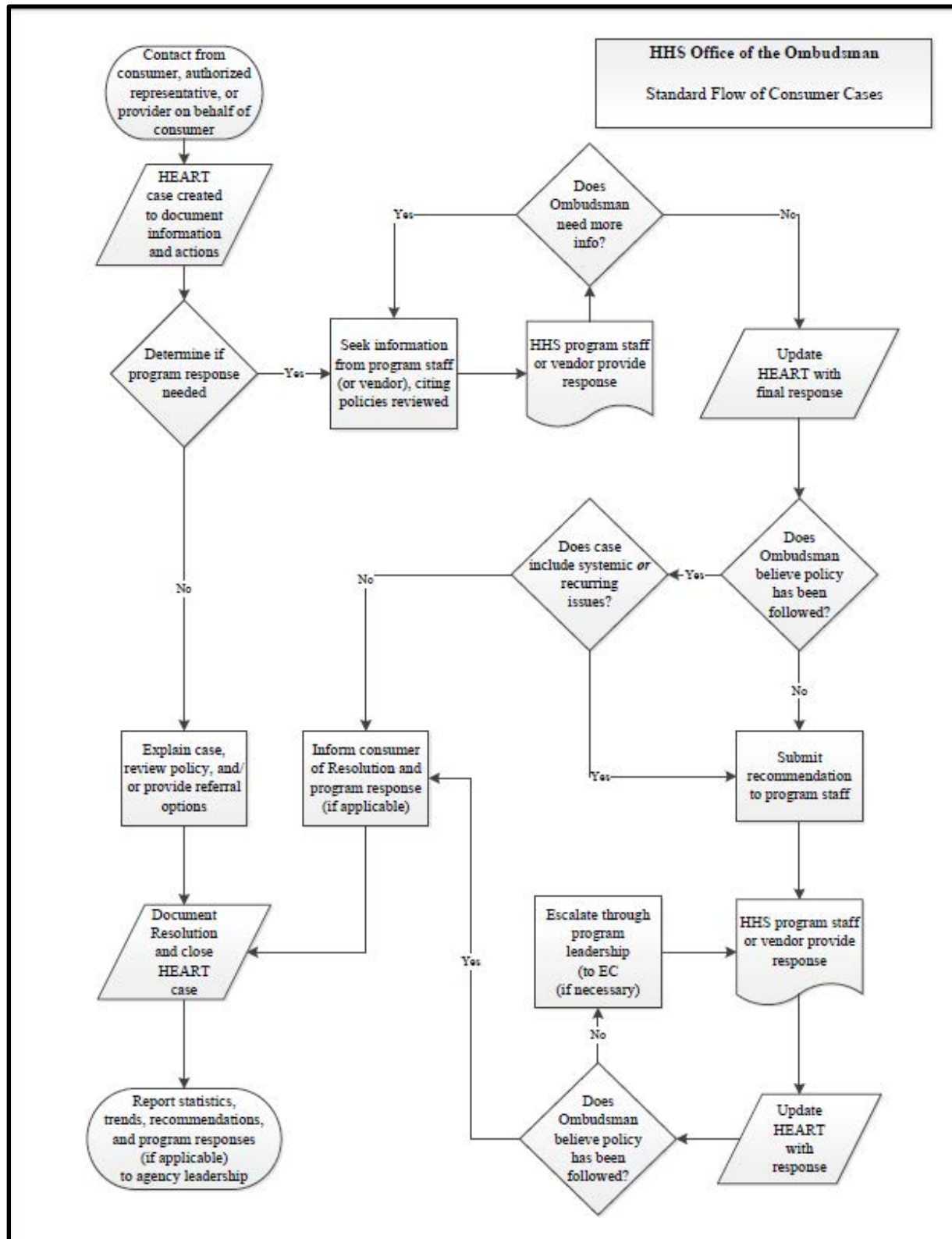
Per federal regulation, each Medicaid managed care organization (MCO) is required to offer consumers a process to resolve complaints. OMCAT assists Medicaid program staff, MCOs, and health care providers in resolving consumer complaints. OMCAT helps members navigate the Medicaid managed care system, answers

questions about their coverage, and helps consumers understand their rights and how to advocate for themselves.

The Ombudsman often provides recommendations to address issues. Additionally, the office publishes a statutorily required annual report with findings and recommendations.

The Ombudsman's complaint resolution process is demonstrated in the flowchart below.

Figure 1: Ombudsman's complaint resolution process.



G. Funding: See "Agency Program Information Spreadsheet."

H. MOUs and interagency agreements or contracts:

The Ombudsman has two memoranda of understanding (MOU).

- When DFPS became an independent agency, HHSC initiated the MOU to memorialize FCO's functions.
- H.B. 10, 85th Legislature, Regular Session, 2017, later updated by H.B. 2595, 87th Legislature, Regular Session, 2021, required both the Texas Department of Insurance and OBH to address mental health parity complaints. The MOU facilitates the interaction between the agencies.

I. Relationship with other governmental entities:

Accepting federal funds requires states to comply with federal regulations that address complaints and issues. The Ombudsman works with HHS program areas, including local and regional offices, to provide recommendations to resolve these complaints and issues.

- OBH works with state hospitals, LMHAs, and Licensed Behavioral Health Authorities (LBHAs).
- FCO works with DFPS on complaints about services, including statewide residential treatment centers (RTCs) and RTCs located in other states.
- IDDO collaborates with LIDDAs and Medicaid waiver services, such as TxHmL, that have regional locations.
- OMCAT supports consumers with complaints about Medicaid services through their health plan. Because there is frequent overlap between Medicaid and Medicare, the Ombudsman may refer consumers to the United States (U.S.) Department of Health and Human Service's (DHHS) Centers for Medicare & Medicaid Services and the U.S. Social Security Administration offices.

J-M. Barriers and challenges; Additional, Regulatory, and Complaint information: Not applicable.

Long-Term Care Ombudsman

A. Division or program information:

Name of Program or Function: Office of the State Long-Term Care Ombudsman (LTCO)

Location/Division: CPAO

Contact Name: Patty Ducayet, State LTCO

Statutory citation for program:

- Texas Human Resources Code, Chapter 101A, Section 251, Subchapter F, Office of State Long-Term Care Ombudsman.

State functions are implemented via:

- 26 Texas Administrative Code, Chapter 88, State Long-Term Care Ombudsman Program.
- 26 Texas Administrative Code, Chapter 553, Licensing Standards for Assisted Living Facilities, Subchapter E, Access to Residents and Records by the State Long-Term Care Ombudsman Program.
- 26 Texas Administrative Code, Chapter 554, Nursing Facility Requirements for Licensure and Medicaid Certification, Subchapter E, Access and Visitation Rights.

Federal authority is established in statute and regulation:

- 42 USC, Section 3058G, State Long-Term Care Ombudsman Program.
- 45 Code of Federal Regulations, Part 1324, Subpart A, State Long-Term Care Ombudsman Program.

B. Objective and major activities:

LTCO advocates for resident rights and optimal resident quality of care and life at nursing facilities and assisted living facilities. LTCO investigates and resolves complaints, supervises ombudsman representatives, and performs legislative advocacy on behalf of residents of nursing and assisted living facilities.

LTCO provides direct services to over 90,000 residents of about 1,200 nursing facilities and over 40,000 residents of about 2,000 assisted living facilities. The office helps residents exercise their rights, educates facilities about staff responsibilities, and resolves complaints such as problems of abuse, neglect, involuntary discharge, and poor care.

Without Texas' long-term care ombudsmen, residents in nursing facilities wouldn't have an advocate to make sure they receive quality services.

C. Effectiveness and efficiency information:

LTCO uses federal and Legislative Budget Board measures to determine client satisfaction when resolving complaints. In 2024, LTCO resolved 88 percent of complaints received.

D. History:

In 1978, U.S. Congress amended the Older Americans Act to establish the State LTCO program. Federal and state law mandates ombudsmen to identify, investigate, and resolve complaints made by or on behalf of residents, and to connect residents with services to protect their health, safety, welfare, and rights.

E. Qualifications or eligibility requirements:

LTCO investigates complaints and provides information on behalf of a person who resides in a nursing facility or assisted living facility. Inquiries and complaints can be made by any person, including residents, facility staff, family members and friends of residents, legislators, and an ombudsman. People seeking information about a facility can also contact an ombudsman for insight.

F. Administration and key processes:

LTCO is authorized by the state and federal government to advocate for people living in nursing and assisted living facilities. The program's mission is to improve the quality of life and care for residents of these facilities by providing prompt, informal complaint resolution, and promoting systemic change on behalf of residents' interests.

Most ombudsman services are provided within a long-term care facility and in direct communication with a resident of the facility or the necessary care staff.

LTCO who work within the 28 local ombudsman entities must comply with program training, rules, policies, and procedures. LTCO oversees programmatic functions and operations, and the housing agency oversees personnel management.

Staff and volunteer ombudsmen make regular visits to nursing and assisted living facilities to investigate and resolve complaints on behalf of residents. Most of their visits are spent talking with residents and asking about their experience at the facility. Ombudsmen also observe facility conditions, provide consultations and training to residents, family members, and facility staff.

G. Funding: See “ Agency Program Information Spreadsheet.”

Funding through the federal Older Americans Act — Title III-B Supportive Services and Title VII Ombudsman and Elder Abuse Prevention — provides 73 percent of program funding.

The state office is funded with a 2.5 percent set aside of the state’s total Title III-B Supportive Services allocation. Title VII Ombudsman funds are distributed as a pass-through to local ombudsman entities using the funding formula codified in 26 Texas Administrative Code, Chapter 88, Section 105(b).

The Title VII funding formula includes a base amount, with the remaining 75 percent distributed based on the licensed capacity of nursing facilities in the service area and the other remaining 25 percent based on the number of staff and volunteer ombudsmen serving in the local ombudsmen entity.

Each Area Agency on Aging (AAA) determines how the remaining funds are budgeted for ombudsman operations. In many cases, Title III-B contributes a significant amount of funding, and all or most of the AAA’s allocation of Title VII Elder Abuse Prevention funds is typically used for ombudsman services.

State funding is allocated to local ombudsman entities for services via a formula in the same section of TAC as above to assist in program operation costs. Funds are distributed based on the number of assisted living and nursing facilities in the service area, the number of facilities located in a rural area, and the type and licensed capacity of assisted living facilities in the service area. An AAA can also use some of its general revenue received through the HHSC Office of AAA to support ombudsman services.

Some local ombudsman entities receive small amounts of local funds raised by the AAA or subcontracted agency housing the entity. One local ombudsman entity receives municipal funding from cities’ community-based development block grant funds and other local ombudsman entities have received smaller time-limited grants for special projects.

H. MOUs and interagency agreements or contracts:

State and federal law addresses how LTCO must interact with the state survey agency to perform different and complementary functions. This distinction is illustrated in the practice of legislative complaints that are made through GSR.

A complaint made to a legislative office that relates to a nursing or assisted living facility resident is often assigned to both the HHSC Long-Term Care Regulatory and the State LTCO Program for action.

Long-Term Care Regulatory investigates whether a facility is complying with the minimum standards of its license, assesses financial penalties, and requires a written corrective action plan to address noncompliance. In contrast, LTCO focuses on how residents or other complainants want to address their problem with facility management.

LTCO takes an informal approach in making suggestions and recommendations to the resident, with an emphasis on communication and care planning. This allows for flexibility and typically involves significant communication and follow-up with all parties to achieve the desired outcome.

I. Relationship with other governmental entities:

The program works with regional councils and councils of government, which house all but one AAA that contracts with HHSC to provide services under the Older Americans Act. This includes local ombudsman services. LTCO regularly consults with the Texas Association of Regional Councils when revising policies that affect AAA services and operations.

To provide in-person services, HHSC contracts with 28 AAAs within councils of government and regional councils, and with one nonprofit organization, the United Way of Tarrant County. Among the 28 AAAs, 25 include the local ombudsman entity, which consists of staff and volunteer ombudsmen. Three AAAs subcontract with another agency to include the local ombudsman entity:

- The Senior Source, a nonprofit in Dallas County;
- The University of Texas Health Houston, a governmental entity in Harris County; and
- LIFE, Inc., a nonprofit organization in the South Plains service area.

J. Barriers and challenges:

Challenge 1: Operating LTCO through contracts with AAAs has benefits and challenges. The state office is operating well within the current structure of using local ombudsman entities to perform ombudsman services. However, the program oversight structure generates conflicts in roles and responsibilities between LTCO and AAAs.

Challenge 2: Limited human resources, use of local ombudsman entities, and need to lower costs, result in a de-centralized intake process that limits the ability of LTCO to manage and control incoming complaints.

K. Additional information:

LTCO is envisioned as a program that provides services at the bedside and home of an LTC resident. This differs from other HHSC ombudsman services. Since LTC residents are often unable to use a phone, LTCO investigations typically require in-person resident interviews and observation. This allows the LTCO to interview facility staff and review records on site.

Disability Rights Texas, a protection and advocacy agency for people with disabilities, is federally funded and has access to LTC facilities. However, it has limited resources and does not duplicate the functions of an LTC ombudsman.

Disability Rights Texas has historically served more individuals who are developmentally disabled, which is a small subset of nursing facility residents. LTC ombudsmen are permitted to refer people to Disability Rights Texas for legal case assistance, along with the Texas Legal Services Center, LIDDAs, LMHAs, and AAA services.

L-M. Regulatory and complaint information: Not applicable.

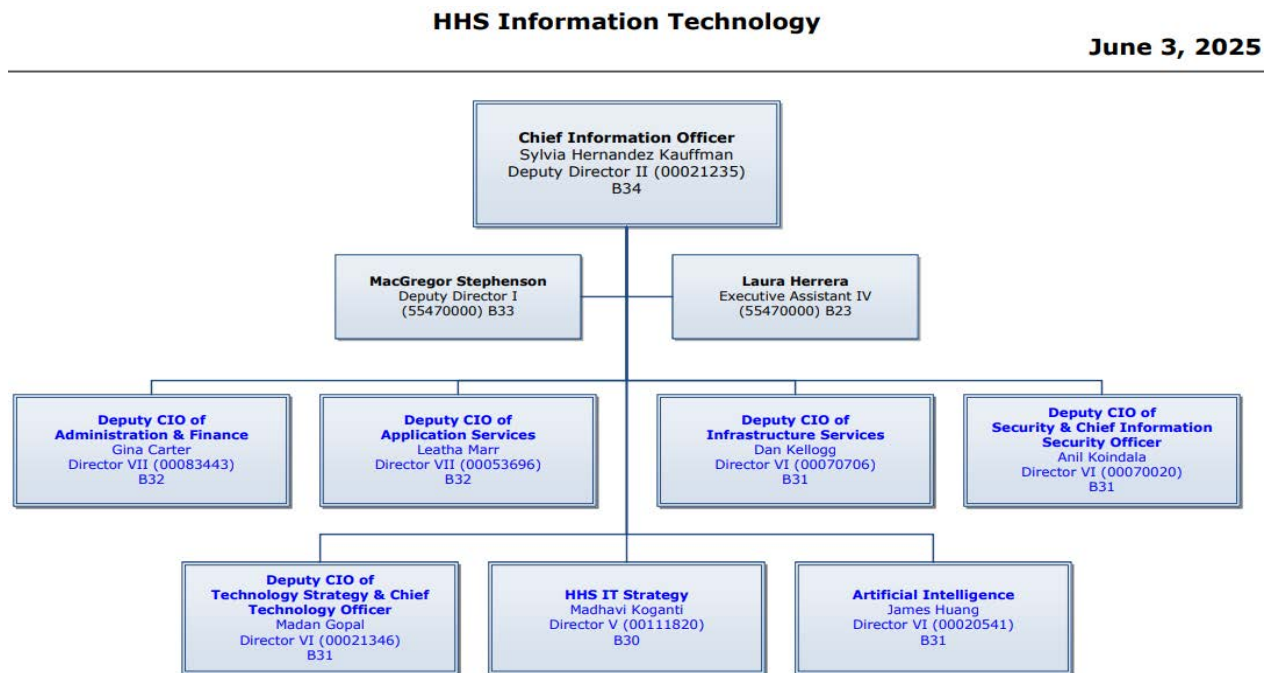
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VII. Guide to Agency Divisions and Programs

Chief Information Office

The Chief Information Office (CIO) is responsible for developing and delivering information technology (IT) services for the Health and Human Services (HHS) system which support operational needs, provide effective security for systems and data, and support long range strategic planning. CIO supports HHS IT needs through the efforts of more than 1,500 employees, over 500 staff augmentation contractors, and multiple vendors, overseeing approximately 450 production systems. The CIO has gone through significant transformation since the CIO was elevated to a Chief level officer in October 2024. This includes partially restructuring the area and reviewing position titles and job responsibilities.

Figure 1. CIO organizational chart.



Infrastructure Services

A. Name of division or program:

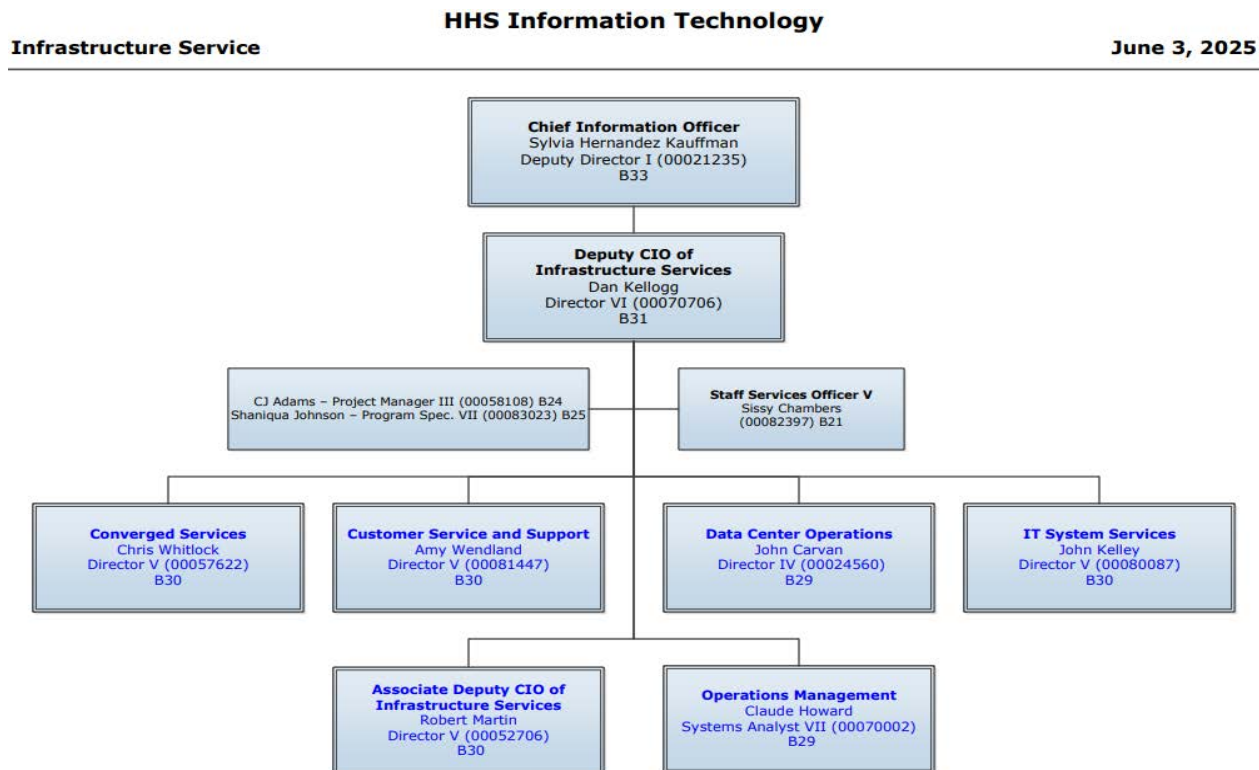
Name of division or program: Infrastructure Services (IS)

Location within the agency: CIO

Contact name: Daniel Kellogg, IS Deputy CIO

Statutory citation: Texas Government Code, Chapter 2054; 2024-25 General Appropriations Act, House Bill (H.B.) 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 2)

Figure 2. IS organizational chart.



B. Objective and major activities:

IS supports critical IT infrastructure and includes Converged Services, Customer Service and Support (CSS), Data Center Operations, System Services, and Operations Management. IS provides a variety of services to support HHS operational needs including network and data centers, Help Desk, and system access:

- Converged Services: Handles telecommunications and networking.
- CSS: Provides on-site tracking and resolution of IT issues for all HHS offices.
- Data Center Services: Ensures HHS programs receive reliable data center services.
- System Services: Manages user identities, access to systems, and Microsoft 365 services.

- Operations Management: Provides technical analysis, planning, coordination, budgeting, monitoring of the Project Portfolio Management System (PPM) for accountability as well as coordinates deliverables across all IS teams and Department of State Health Services (DSHS) Lab Informatics team.

C. Effectiveness and efficiency information:

Measures of effectiveness are included in Table 1.

Table 1. Effectiveness measures.

Current Tools	Metrics
TIERS and YourTexasBenefits performance monitoring	Average response time, number of transactions each day, and number of active concurrent users.
Network Availability	Maximum uptime/reliability across core of network services such as Internet, wide-area network (WAN), Firewall and virtual private network (VPN) remote access, consistently achieving an overall 99.9 percent availability.
Bandwidth Utilization	Monitors and manages bandwidth utilization to ensure it does not exceed 75 percent continuous utilization.
Enterprise Telephony Systems Aggregate SLA Compliance index	Percent based measurement of successful compliance with response and resolution time requirements based on contracted Service Level Agreements (SLAs). Measures the performance of the vendor management of incidents/workorders as outlined in the ETS contract.
Google CCAI Virtual Agent Dashboard Metrics	Total Calls offered: Total unique customer interactions with virtual agent in given period. Used to verify volume of calls and platform activity. Average Queries/Call: On an average, how many queries a customer is asking to the virtual agent in a single interaction. Used to measure usage of questions and interactions with virtual agent for trends.
Genesys Platform	SLA Target Percent: Service level target is a contact center performance statistic expressed as "X percent of conversations answered in Y seconds." Analytics uses this service level target to calculate whether calls are within the service level defined in the SLA.

D-E. History and Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

The primary function of IS is to provide an environment for HHS applications to function so staff can provide services to constituents.

IS is closely monitored using various technologies to ensure the highest level of uptime possible. The team responds to requests for additional services and reacts to incidents that prevent staff from accessing a system properly or services from being deliverable. These requests and incidents are closely tracked with stringent SLA's. IT environments are capital intensive and require continuous and ongoing refresh, averaging four to five-year replacement cycles. Services must be secure and highly reliable with built-in failover and redundancy. IS teams conduct research on new technologies to identify the needs for future development and to plan and budget for those improvements.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts:

Health and Human Services Commission (HHSC)/Department of Family and Protective Services (DFPS) Interagency Contract (IAC): HHSC, through its Information Technology Customer Service Help Desk (ITCSDH), provides help desk services for DFPS. ITCSDH is responsible for the operation of a Customer Service team in support of IT related incidents and service requests.

HHSC/Texas Civil Commitment Office (TCCO) MOU: HHSC provides administrative and technical support to TCCO directed by Texas Government Code, Chapter 420A.11, Administrative Attachment; Support. TCCO remains a separate agency and is not a part of the HHS system.

I. Relationship with other governmental entities: Not applicable.

J. Barriers and challenges:

- Challenge 1, Service Complexity in Specialized Healthcare Environments: Supporting 10 state hospitals, the Waco Center for Youth and 13 State Supported Living Centers (SSLCs) introduces unique challenges, as these environments require specialized IT functions such as voice and data cabling, networking, electronic health records systems, and desk-side computing. The distinction between health systems and general IT support environments has driven the need for specialized training and resources, ensuring that the team can meet the diverse needs of each area without compromising service quality.

- Challenge 2, Statewide Support for Public Health Programs: With CSS supporting public health programs like the Special Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC) and DSHS, CSS must stay responsive to changes in state or federal program requirements. This includes navigating updated guidelines, protocols, or compliance requirements, ensuring that IT support aligns with those requirements.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Applications Services

Application Services - Administration

A. Name of division or program:

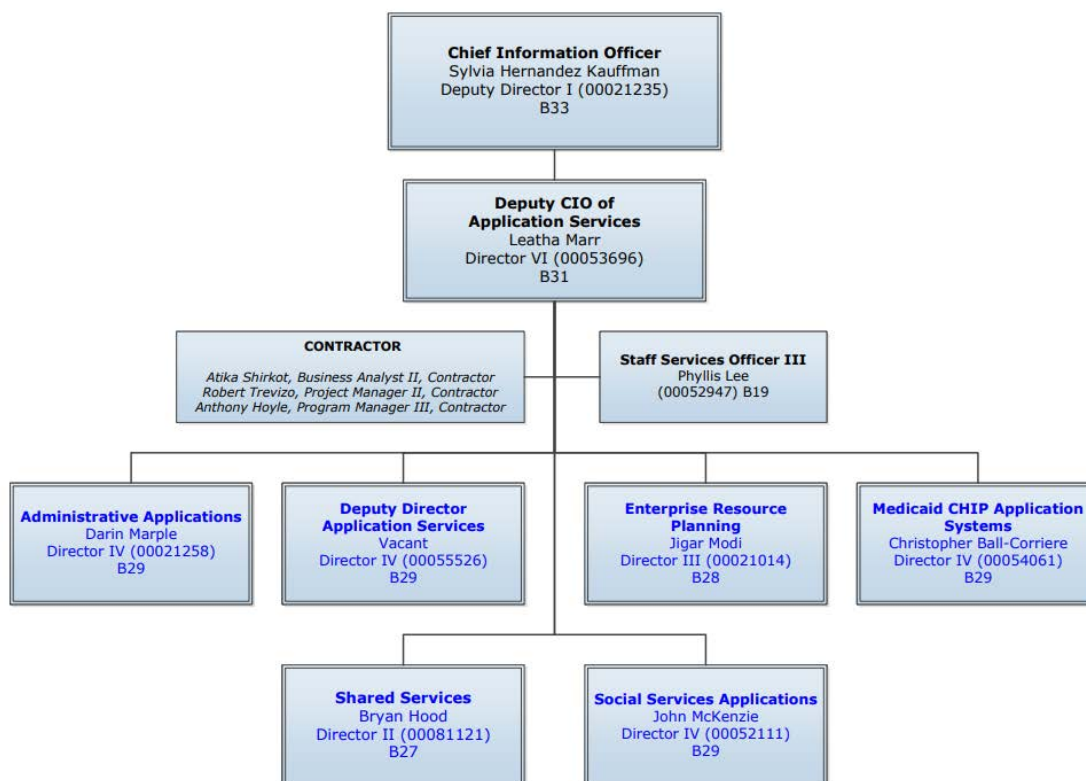
Name of division or program: Application Services - Administration

Location within the agency: CIO

Contact name: Leatha Marr, Deputy CIO of Application Services

Statutory citation: Texas Government Code, Chapter 531

Figure 3. Application Services organizational chart.



B. Objective and major activities:

Application Services oversees the entire system development lifecycle from requirements, design, development, testing, release management/deployment, and operations through system retirement or decommission. The team also supports several software-as-a-service (SaaS) solutions and platforms such as Salesforce and Microsoft Power Platform. Portfolios include Administrative Applications, Enterprise Resource Planning, Deputy Director Application Services, Medicaid and CHIP Systems Applications, Social Services Applications and Shared Services which assist the other portfolios.

C. Effectiveness and efficiency information:

IT administers over 400 applications, each of which are stable in production, a testament to the work of IT staff. As a result, IT focuses on solving tomorrow's problems rather than fixing yesterday's issues. The following metrics are tracked for all of Application Services.

- Application Services tracks system availability for critical systems with a target of 99.5 percent uptime and consistently meets or beats that target. The number of critical systems is derived from Archer data collected as part of the continuity of operations process.
- Data on security vulnerabilities and associated remediations using multiple tools including reports from the Department of Information Resources (DIR), Veracode static and dynamic code scans, and any available penetration tests is also used to verify the effectiveness and operational strength of the applications. Application code is not released into production with critical or high vulnerabilities.
- Application Services tracks metrics on assigned projects, operational work requests, and maintenance work requests using data available in the PPM tool.
- Other metrics are tracked at the application portfolio level.

Effective and proven communication channels to agency staff are in place for planned and unplanned outages.

D-E. History and Qualifications or eligibility: Not applicable.

F. Administration and key processes:

Application Services receives requests for services through different methods, depending on the size and type of request. Any request large enough to be considered a project is submitted and solutioned in accordance with Circular C-009 Information Technology Governance Policy, Circular C-010 HHS IT Project and Project Management Policy, and [IT Governance Project Intake Process](#).

Smaller requests are received through the application-specific ticketing process where the request is subject to individual change management or advisory boards that typically include information and application owner representatives, as well as information custodian representatives. If requestors need assistance with this process, they can engage with their respective Business Relationship Manager (BRM) or any Application Services Portfolio Director.

G. Funding: See "Agency Program Information" spreadsheet.

H-I. MOUs and interagency agreements or contracts and Relationship with other governmental entities: Not applicable.

J. Barriers and challenges:

Challenge 1, Technical Debt and Modernization: Applications need upgrades to support new technologies, with a focus on reducing technical debt and security vulnerabilities. This includes leveraging existing tools and strategically expanding new capabilities to leapfrog legacy systems. Examples include:

- Client Assignment and Registration (CARE) leverages out-of-support mainframe technology. CARE is an IBM Model 204 mainframe with a programming language that is similar to COBOL. People with the skillset to maintain this technology have mostly aged out of the workforce, and IT is unable to find managed services to provide this support. The technology has many security vulnerabilities that cannot be remediated due to its age, so CARE requires an approved risk acceptance that the agency is likely not to tolerate very far into the future.
- C21 is a Hewlett Packard (HP) Non-Stop Kernel (NSK) mainframe that leverages CA Gen (also known as CoolGen) to generate model-driven code. People with the skillset to support this technology are also aging out of the workforce. Further, replacement parts for the mainframe infrastructure are not guaranteed, even by HP, should the agency's system encounter hardware failure. Both of these systems require replacement but will need significant funding to achieve.

Challenge 2, Resource Management and Prioritization: Effective capacity planning and prioritization are essential to manage workload, reduce burnout, and ensure critical projects receive necessary resources. This involves balancing funding, staff resources, customer demands, technical debt, system stability, and cybersecurity.

Challenge 3, Change Management and Communication: Adopting a standard release and change management process and tools across all of Application Services is needed to ensure awareness, training, and minimal impact on service delivery. Currently, the individual portfolios are using tools and many processes that were brought over from legacy agencies.

Outsourcing the complete development of applications to external vendors can create issues. While the vendor may effectively develop the system, not having Application Services involved in the development process can cause significant downstream impacts when Application Services is then required to maintain and update a vendor-developed application. Without an understanding of the system, Application Services must quickly learn the system's requirements, functions, etc., to address issues and provide support and this is incredibly burdensome.

Outsourcing the complete application development also creates challenges when HHSC moves to replace an outdated application because the expertise to define the current system and needs for a future system reside with a vendor and not with Application Services.

K-M. Additional, regulatory, and complaint information: Not applicable.

Administrative Applications

A. Name of division or program:

Name of division or program: Administrative Applications (AA) IT Services

Location within the agency: CIO

Contact name: Leatha Marr, Deputy CIO of Application Services

Statutory citation: Not applicable.

B. Objective and major activities:

AA provides IT services to the Office of the Executive Commissioner (EC), Chief Financial Officer (CFO), Chief Operating Officer (COO), Office of the Inspector General (OIG), and Office of the Independent Ombudsman (OIO). AA Services maintains more than 50 applications as well as the SharePoint, Microsoft PowerPlatform, and Salesforce Platforms. In support of these areas, AA completes over 200 maintenance releases a year and implements projects to improve services and the security posture of the agency for critical applications including the HHS Enterprise Administrative Reporting and Tracking System (HEART), System of Contract Operation and Reporting (SCOR), and Legislative Tracking System (LTS).

In addition to completing more than 200 maintenance releases, AA implemented the Vaccine Allocation and Ordering System (VAOS) to address needs during the COVID-19 Public Health Emergency, is developing an agency-wide Grants Management System, modernizing HEART and CFO-FSS applications, and recently completed the delivery of LTS 2.0.

Application Services supports OIG's tools, applications, and infrastructure for:

- Detecting, deterring, and preventing fraud, waste, and abuse;
- Audits;
- Investigations (pursuant to generally accepted investigative policies);

- Inspections conducted under the Council of the Inspectors General on Integrity and Efficiency standards (Blue Book); and
- Reviews conducted under Principles and Standards for Offices of Inspector General developed by the Association of Inspectors General (Green Book).

Application Services conducts activities, tasks, oversight, and leadership spanning across the various groups of development, analysis, and leadership staff working to ensure the OIG is well supported and have escalation paths to ensure their needs are met.

C. Effectiveness and efficiency information:

The metrics below are part of the project closeout process which includes a retrospective Root Cause Analysis (RCA) that drives continuous improvement. The RCA identifies improvement points which are in turn tracked as deliverables.

Table 2. Metrics.

Metric	Description	Repository
Releases Completed	Number of releases approved and completed in production by application.	Jira
Defects Found in Testing	Defects found in QA testing, for applications/projects with QA teams.	Jira
Defects Found during Hypercare	Defects found after the release during the hypercare period.	Jira
Jira Items (Stories, Epics, Bugs) Completed	Jira items completed and released.	Jira
Project Burnup	Project workload delivered relative to story point measurement for the individual team.	Jira
Defects Found by Users	Defects found by User Acceptance Testing (UAT) testers.	Jira

The AA teams support OIG in its mission by providing applications that facilitate the day-to-day operations to conduct investigations, identify fraud, prosecution related activities, federal and legislative reporting and funds recovery. These goals are met through the use of data collection and interfaces with data for referrals and investigations from multiple internal and external sources which are updated on regular cycles and stored in the applications supported by AA.

- Through use of applications supported by the Application Services team, OIG is able to leverage data from partner systems such as; Texas Integrated Eligibility Redesign System (TIERS), Texas Workforce Commission (TWC), Public Assistance Reporting Information System (PARIS), Accounts Receivable Tracking System (ARTS), Electronic Disqualification Recipient System (eDRS), Electronic Benefits Transfer (EBT) Archive, Texas Department of Criminal Justice (TDCJ), and the Texas Veterans Commission (TVC).
- In full utilization of the funding provided during the 88th Legislative Session, Application Services has engaged in several projects that will be delivered to support OIG and its mission. These include the modernization of and improvements to the Automated System for the Office of Inspector General (ASOIG) applications, Waste Abuse Fraud Electronic Reporting Systems (WAFERS), SI Case Management System (SICM), and development of Robotics Process Automation (RPA) that will leverage the power of current technologies to accomplish many targeted improvements and initiatives. These are currently in development stages and in-flight, targeted for production release on or before August 31, 2025.

D-E. History and Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

Deliverables are tracked via Kanban to show the full lifecycle of requests that move from proposal to intake to implementation to closeout. Kanban setup defines the workflow between these different states. History of deliverables and commentary are housed in Jira.

Project Management Guidelines are hosted on SharePoint, and up to date documentation can be provided upon request.

G. Funding: See "Agency Program Information" spreadsheet.

H-M. MOUs and interagency agreements or contracts; Relationship with other governmental entities; Barriers and challenges; Additional, Regulatory, and Complaint information: Not applicable.

Application Services - Enterprise Resource Planning

A. Name of division or program:

Name of division or program: Enterprise Resource Planning (ERP) – Centralized Accounting and Payroll/Personnel System (CAPPS) Human Capital Management (HCM) and CAPPS Financials

Location within the agency: CIO

Contact name: Leatha Marr, Deputy CIO of Application Services

Statutory citation: Texas Government Code, Chapter 2101

B. Objective and major activities:

ERP is responsible for CAPPS HCM and CAPPS Financials applications through the software development lifecycle from requirements to ongoing maintenance. The development team creates and supports the Texas Comptroller of Public Accounts (CPA) provided CAPPS solution and agency modifications as required. Examples include:

- ERP provides customer service to both internal agency staff and external providers and uses a statewide ERP baseline.
- The CAPPS HCM team successfully managed the processing of legislative salary increases for more than 51,000 employees.
- The CAPPS HCM team efficiently processed leave awards and special salary actions for agency staff.
- The CAPPS Financials team achieved a major goal by implementing a code fix or enhancement for the "Drawdown processes (5B detail version)." This improvement aimed to enhance daily performance, particularly in the creation of the HHSC custom drawdown table, streamline processing of large datasets for agencies, and mitigate lengthy processing times, thereby reducing periodic Oracle errors.
- CAPPS Financials has provided excellent support to business in completing financial year end close in less than anticipated time.
- CAPPS Financials Disaster Assistance Payments process has been improved to make bulk payments at a faster pace.
- CAPPS HCM has made improvements to the telework module to allow for better internal reporting.

C. Effectiveness and efficiency information:

ERP tracks metrics such as maintenance and enhancement tickets worked, along with associated timeframes for response. Additionally, ERP tracks all CPA exceptions with their statuses, as well as dates when mandatory items are implemented. The agency must attest to this on a quarterly basis to CPA.

D-E. History and Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

ERP is managed by the HHSC Deputy CIO of Application Services. It employs the HHSC IT intake process for new program initiatives related to technology solutions and financial endorsement. These initiatives must receive approval from the PPM group followed by the Executive Steering Committee. When projects or enhancements are approved for implementation, project managers, developers, and support personnel are allocated as necessary. Support activities and the overall advancement of the project and service requests are monitored using HHSC's PPM tool and Jira.

State agencies are required to use CAPPS for their ERP needs. HHSC is a CAPPS hub agency, meaning it is allowed to host its own instance, but must stay in compliance with the requirements established by CPA. As an agency, HHS participates in the governance process and requests exceptions to the baseline code depending on agency needs. HHS also has a steering committee group to coordinate and align IT activities with all stakeholders and target audience to include representatives from the agencies that leverage the HHSC instance of CAPPS HCM and CAPPS Financials.

G. Funding: See "Agency Program Information" spreadsheet.

H-I. MOUs and interagency agreements or contracts and Relationship with other governmental entities: Not applicable.

J. Barriers and challenges:

All agencies are required to use CAPPS HCM and CAPPS Financials; however, there are limited human resources with the PeopleSoft skills required to support the system. All agencies that have an implementation are competing for the same pool of limited resources.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Application Services - Deputy Director AS

A. Name of division or program:

Name of division or program: Deputy Director Application Services (DDAS)

Location within the agency: CIO

Contact name: Leatha Marr, Deputy CIO of Application Services

Statutory citation: Not applicable.

B. Objective and major activities:

Deputy Director AS provides support for the Family Health Services (FHS), Community Services (CS), Health and Specialty Care System (HSCS), Behavioral Health Services (BHS), and Regulatory Services Division (RSD). DDAS supports custom-built applications, vendor managed systems, and SaaS solutions with maintenance and operations, enhancements and release management, help desk, project management, audit and security coordination, and legislative coordination. Application Services collaborates with various groups to ensure the program areas are well-supported and have escalation paths to ensure their needs are met.

- FHS: DDAS supports over 30 information systems: Early Childhood Intervention (ECI), WIC, Thriving Texas Families, and other family support services.
- CS: Blind Children's Vocational Discovery and Development Program, Children with Special Health Care Needs, Children's Autism Program, Comprehensive Rehabilitation Services, Deaf and Hard of Hearing Services, Independent Living Services (ILS), Kidney Health Care, and Texas Cares Rx.

DDAS also SSLCs and state hospitals. To provide more effective and efficient operational support, HSCS Applications will be implementing a single cloud-based, vendor-supported, electronic health records (E-HR) system for use at both SSLCs and state hospitals. Currently, these facilities use two different E HR systems: Integrated Resident Information System (IRIS) at SSLCs, and myAvatar at state hospitals, both supported by HSCS Applications.

For BHS, a limited set of applications manage the end-to-end client experience and provider experience for mental health and substance use programs, and IDD Residential Treatment Center for children and adolescents.

- Key applications include Clinical Management Behavioral Health Services (CMBHS), CARE, Behavioral Health Management System (BHSMS), and CLAIMSII. These applications are crucial for uninterrupted operations. The team employs various strategies to deliver cost-effective solutions.

DDAS supports information systems used by the RSD and is divided into two support areas: Long-Term Care (LTC) and Child Care Regulation (CCR). Major systems in this area include Texas Unified Licensure Information Portal (TULIP), Childcare Licensing Automated Support System (CLASS), and Public Provider.

- Along with daily maintenance and operations, DDAS provides Help Desk support, system enhancements, data exchange functions, and project management. Help Desk staff receive, triage, and assist in resolving requests for assistance from HHSC staff and external users. Information systems provide data used in data exchange with numerous systems including those within HHSC, other state agencies, and the federal government.

C. Effectiveness and efficiency information:

DDAS provides software solutions to streamline business processes to provide support effectively and efficiently for external clients. For example:

- Connected an application for the Deaf and Hard of Hearing Services program with the Texas.gov Transaction Payment Engine (TPE), which enables online credit card processing for certifications.
- Connected the WIC Management Information System with the Eligibility as a Service (EaaS) to verify Medicaid, Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF) data to streamline adjunct eligibility determination for WIC participants. This changed improved clients' abilities to access services.
- Enhanced the WIC Management Information System to improve WIC participants' experience and increase WIC clinic staff efficiency by enhancing the self-service participant portal and adding a self-service mobile app.
- The upcoming integration of electronic health records between SSLCs and state hospitals through a unified vendor solution will provide more effective and efficient support to state operated facilities. Currently, HSCS Applications supports two separate E-HR systems that support SSLC and state hospital operations, which is not an efficient use of resources.

In addition, the systems supported provide the following annually:

- Over 600 million benefits issued;
- Over \$183 million processed payments, invoices, and claims;
- Over 3,500 instances of credentialling and training requirements to meet compliance standards; and
- Over 800,000 systems users.

To track the effectiveness and efficiency of application releases, project delivery, requests and customer support, the following items are collected and used:

- FTEs/Contractors enter hours (timesheets) worked towards projects, operational and maintenance requests in the Project and PPM. This is part of tracking projects, level of effort and resource capacity, which also assists with estimating future projects/assignments.
- Resources utilize Azure DevOps to track assignments/tasks related to help desk ticket items, application releases, and enhancement requests. Reports are generated to view tickets opened/closed and progress of maintenance/project delivery tasks. FHS and CS Application Services completes over 130 maintenance releases, including code and scripts, a year and implements projects to improve services. In addition, over 2000 Azure DevOps help desk and maintenance tickets closed annually.
- Application/server vulnerabilities are captured and remediated to meet security standards. These are reported in the Archer system.
- For vendor managed systems and SaaS solutions, customer feedback surveys are conducted for staff and participants.

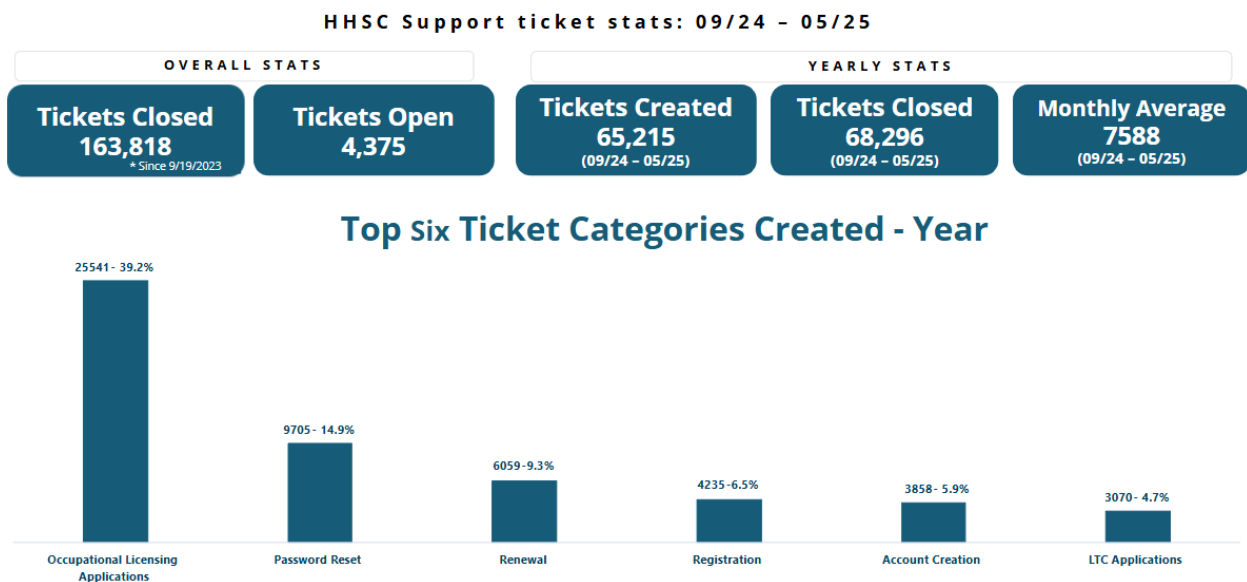
Customer satisfaction remains a core focus within DDAS, with the business area actively seeking feedback through surveys and other channels to tailor services to customer needs. Ongoing training ensures staff are responsive and professional, reflecting the agency's dedication to delivering high-quality services. By prioritizing timeliness, accuracy, and helpfulness, Regulatory Applications fosters trust with customers, resulting in heightened satisfaction levels. Regulatory Applications has an overall customer satisfaction survey score of 84 percent for the past four Major Information Resource Projects (MIRPs) that have been surveyed.

Some examples of metrics collected and measured by DDAS for LTC for TULIP are captured in the Salesforce Customer Relationship Management (CRM) dashboards and are routinely evaluated to gain insight into the number of tickets being created/handled as well as to identify the area of the application the ticket is being created for. Metrics are also captured on the number of LTC applications (e.g.,

Nurse Aide, Medication Aide, and Nursing Facility Administrator, etc.) processed. Additionally, some examples of metrics are also captured for CCR on the number of permits issued inspections and investigations completed and background checks processed annually. Remedy on Demand is utilized for CCR ticketing and provides insight into the number of tickets being created/handled as well as to identify the area of the application the ticket is being created for. These metrics identify application(s) users are having difficulty with, communicate with the supporting program area, and work with them to determine a solution to better serve both internal and external HHS customers.

Figure 4. Support ticket metrics.

FY25 Operational Report: CRM Analysis



D. History:

- Senate Bill (S.B.) 24, 88th Legislature, Regular Session, 2023, transferred the Prevention and Early Intervention (PEI) division from DFPS and established FSS within HHSC, effective September 1, 2024. This transfer involved changes to IT infrastructure, application development, and reporting and analytics within HHSC. In migrating PEI, the applications unit transitioned and integrated the following systems on-time into the HHSC application structure: Prevention and Early Intervention Reporting System (PEIRS), PEI Admin, Providers Available in Your County (PAIYC), and PEI Public Site (PEIPS).
- Per H.B. 1575, 88th Legislature, Regular Session, 2023, Application Services developed the information system for the Thriving Texas Families Program to

capture and aggregate data regarding the nonmedical health-related needs of pregnant women.

- H.B. 18, 87th Legislature, Regular Session, 2021, created the Texas Cares Program and directed HHSC to establish a prescription drug savings program for certain uninsured individuals or individuals without health benefit coverage for prescription drugs. 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023, provided funding to implement information systems for the Texas Cares Rx program, which is on target for completion in fiscal year 2025.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

DDAS receives requests through different methods, depending on the size and type of request. Requests large enough to be considered a project, follow the HHSC IT intake process for technology solutions. Projects are monitored via PPM and decisions are approved by the Executive Steering Committee. Azure DevOps is utilized to capture smaller requests for maintenance and help desk ticket items. Approvals for deployments to production environments are received from application owner representatives, as well as information custodian representatives. Information is captured in the Release Migration Documentation Form (RMDF). In addition, the deployment process is listed in the build release documentation and source code is managed in Azure DevOps/GITHub.

DDAS supports three separate E-HR systems for SSLC's and state hospitals, including IRIS, myAvatar and WORx/Medimar. These are managed and supported by Vendors respectively, Oracle/Cerner, Netsmart, and Wellsky.

The performance reports for these three applications are sent to IT, SSLCs and state hospitals, and a contract team periodically based on metrics provided by the program to the Vendor.

DDAS acts as a liaison between program and Vendor. Program puts in tickets for any issues and DDAS works with the vendor to resolve them based on SLA's and if program has any issues in getting resolution they escalate it to IT Apps leadership.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts:

The information systems provide data used in data exchange with multiple systems including those within HHSC, other state agencies, and the federal government ([https://www.ecfr.gov/current/title-7/part-246#p-246.26\(d\)](https://www.ecfr.gov/current/title-7/part-246#p-246.26(d))).

- HHSC has an MOU with DFPS for a data connection (interface) between the HHSC-run PEIRS, DFPS run the Information Management Protecting Adults and Children in Texas (IMPACT) system. IMPACT is used to establish and maintain contracts, budgets, and billing automation in CAPPS Financial. HHSC is dependent on IMPACT for the continuation of payments until HHSC can implement the new Grants Management System.
- HHSC has an MOU with DSHS Vital Statistics office to share data on individuals who have passed away matching Kidney Health Care and Children with Special Health Care Needs program participants listed in the Integrated Business Information System (IBIS).
- HHSC and DSHS have a Letter of Operation to use the Centralized Billing System (CBS). Texas WIC Information Network (TXIN) sends a request for Medicaid reimbursements for prescription infant formula issued to WIC participants and redeemed by WIC grocers to CBS. CBS aggregates this information and passes the request to the Texas Medicaid and Healthcare Partnership (TMHP). After TMHP processes this request, reconciliation files are passed back to TXIN.

I. Relationship with other governmental entities:

In addition to the relationships discussed above, DDAS provides the EHR application myAvatar managed and support services to DSHS's Texas Center for Infectious Disease (TCID) facility.

J. Barriers and challenges:

Challenge 1: Technical Debt and Modernization

Challenge 2: Resource Management and Prioritization

Challenge 3: Workforce Development and Retention

Challenge 4: The modernization initiatives established by S.B. 26, 88th Legislature, Regular Session, 2023, should continue after implementation, leading to sustained cost savings and improved data accuracy. The scope of S.B. 26 only allowed for the modernization of certain functions within the existing system, leaving other functionality behind in legacy technology. Some of the legacy technology has been

referenced in the overall Application Services section as CARE. Other legacy technology left behind is in use for CMBHS, which is a monolith that has only partially been modularized and modernized.

Challenge 5: Development teams face challenges in keeping up with evolving security requirements. As new threats and vulnerabilities emerge, security standards evolve rapidly, requiring developers to update code, frameworks, and tools regularly. Integrating these changes slows development timelines, as teams prioritize secure coding practices, conduct security audits, and apply patches to maintain compliance. Balancing security demands with the need for faster releases is challenging when faced with limited resources. Additionally, development teams need ongoing training and additional tools to stay current on best practices, making security a continuous, demanding focus that requires careful attention and adaptation.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Application Services - Medicaid/CHIP

A. Name of division or program:

Name of division or program: Medicaid and CHIP Systems

Location within the agency: CIO

Contact name: Leatha Marr, Deputy CIO of Application Services

Statutory citation: Texas Government Code, Chapter 523; 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 6).

B. Objective and major activities:

Medicaid and CHIP Systems (MCS) provides information technology support services for MCS program areas through vendor contract oversight, systems modernization, systems maintenance, and new system planning and implementation. The MCS teams work in collaboration with the Centers for Medicare & Medicaid Services (CMS), ensuring compliance with federal statutes and guidance.

C. Effectiveness and efficiency information:

IT provides accurate, effective software solutions to the business areas to perform their work in the most efficient manner allowing for a high level of support for external clients.

IT and program Leadership's desire to continuously serve the needs of Texans in an effective manner led Application Services to start an internal transformation initiative. This transformation will help to increase speed, quality, and efficiency with a core focus on a customer-centered approach using a Lean Agile mindset and a product-driven approach. In favor of this, the MCS team has adopted the Scaled Agile Framework (SAFe) as the delivery model for the Application Maintenance and Development contract.

Table 3. Performance metrics.

Metric	Source	Purpose
QAT Rider 6 Reporting	PPM Tool and MS Teams Foundation Server	Tracks progress of the AMD Contract's Scaled Agile Framework (SAFe) delivery and delivery of other modernization efforts.
Project – Timely Completion	PPM Tool	Tracks project tasks and timely completion. Perform capacity management.
Project – Completed Under Budget	PPM Tool	Tracks project costs and completion under/over budget. Perform capacity management.
System Vulnerabilities (Critical, High, Medium, Low)	Archer	Tracks vulnerabilities, analysis, risks, and remediation.
Transformed-Medicaid Statistical Information System (T-MSIS) Data Quality	CMS Outcomes-Based Assessment (OBA) Dashboard	Tracks CMS prescribed data quality metrics.
Operational and Maintenance Work Items – Progress and Status	SharePoint	Tracks resource utilization and progress using weekly reports.
Production Tickets – Progress and Status	BMC Helix	Tracks resource utilization and progress using weekly reports.

D. History: Not applicable.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

The MCS team is comprised of three sub-teams: Contract Oversight, Medicaid/Children's Health Insurance Program (CHIP) Systems Applications, and Long-Term Care Applications. Each team is led by a Manager or Director and reports directly to the MCS Director.

Contract Oversight team:

- Manages the Medicaid Management Information System (MMIS) Deloitte Application Maintenance and Development (AMD) Contract.
- Provides updates and oversight for the contract and contract staff.
- Purchases and maintains a list of all hardware and software purchases (over 150 purchases each year – more than half of total IT purchases).
- Processes contract invoices and hardware and software purchases.
- Maintains, tracks, and reviews all deliverables and key measures for the contract.
- Supports delivery of Design, Development and Implementation (DDI) work, Maintenance work, IT-centric work, and ongoing operations. Also support Vendor Drug Program (VDP) and Enrollment Broker (EB).

The Medicaid and CHIP Systems Applications (MCSA) team:

- Manages 18 custom browser-based Medicaid support applications and/or batch processing systems.
- Focuses on systems modernization, systems maintenance, and new system planning and implementation.
- Work in collaboration with the HHSC program areas and CMS, ensuring compliance with state policy, federal statutes and guidance provided by CMS.

The Long-Term Care Application team:

- Provides support and maintenance of 30 custom applications.
- Manages web services and batch processing systems supporting authorization of LTC services.
- Focuses on systems modernization, systems support and maintenance, and new system planning and implementation.

G. Funding: See "Agency Program Information" spreadsheet.

H-I. MOUs and interagency agreements or contracts and Relationship with other governmental entities: Not applicable.

J. Barriers and challenges:

The contract intended to implement a new Medicaid Claims system was cancelled because implementation was going to require significant customization of a SaaS solution, as well as significant enhancements to other agency systems that would have substantially increased the cost and timeline for implementation. The cancellation of this contract required shifting certain project priorities, identifying new solutions, and doing a full assessment to better prepare for the next implementation. The cancellation also resulted in support difficulties with the aging legacy solution requiring contingency planning to sustain until a new solution can be procured.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Application Services - Social Services

A. Name of division or program:

Name of division or program: Social Services Applications (SSA)

Location within the agency: CIO

Contact name: Leatha Marr, Deputy CIO of Application Services

B. Objectives and major activities:

SSA manages the software development and maintenance of the TIERS and other Social Services applications. SSA works closely with TIERS Operations for application hardware and infrastructure management. SSA also coordinates closely with Access and Eligibility Services (AES) and MCS to address regulatory and operational needs for the eligibility program areas.

TIERS is HHSC's eligibility system of record for CHIP, Medicaid, SNAP, and TANF. It manages delivery of ninety-seven types of assistance including food, cash, medical, and community care services to support Texans in need. Over 10,000 unique users rely on TIERS every day. TIERS automates complex rule-based processing, ensuring consistency in eligibility determination. Serving more than 8 million recipients annually, TIERS is a mission critical system for HHSC and Texas.

The TIERS suite of applications includes multiple user-facing applications, including the main TIERS module. Many other applications fully integrate with the TIERS Suite of Applications. In addition, TIERS supports over 30 partners, most of which have multiple interfaces. The TIERS applications include 11,000 business rules, over 3,000 user screens, and more than 2,000 database tables. There are two Data Centers supporting the TIERS infrastructure.

C. Effectiveness and efficiency information:

SSA continues to focus on modernizing TIERS eligibility and enrollment processes by promoting expanded self-service capabilities for Texans and enhanced automation in core eligibility functions to reduce workload for HHSC eligibility workers.

SSA employs the following desired program outcomes to advance the TIERS systems:

- Make expanded self-service capabilities available to clients.
- Improve the client self-service experience for electronic document submissions.
- Improve eligibility workforce effectiveness in delivering services to clients.
- Increase business process automation to improve the efficiency of eligibility operations and client service delivery.
- Improve the client and worker user experience with user interface improvements.
- Implement key technology transformations to ensure systems provide reliable, seamless, and secure services.
- Refresh existing out-of-date technology tools to improve system security and reliability.

Enhanced the YourTexasBenefits.com website and the Your Texas Benefits mobile app to better enable Texans to directly manage their benefit eligibility. These two applications support over 16 million customer logins per month.

The following metrics are used to assess the impacts of the desired program outcomes and help measure the value-based delivery to clients who receive the benefits.

- Expand self-service capabilities available to clients.

- Number of self-service applications submitted.
 - Number of self-service renewals submitted.
 - Number of electronic notices sent.
- Improve the client self-service experience with electronic document submissions.
 - Number of client self-service submissions received.
- Improve workforce effectiveness in delivering services to clients.
 - Worker average service time.
 - Number of worker tasks completed.
 - Percentage of workers of tasks completed.
 - Percentage worker of tasks pended.
- Number of Texas Works Path to Success (TWPS) classes.
- Increase business process automation to improve the efficiency of eligibility operations and client service delivery.
 - Number of workarounds.
 - Number of automated reports.
 - Number of on-demand interviews.
- Improve the client and worker user experience with user interface changes, including application support.
 - Number of biometric logins.
- Implement key technology transformations to ensure eligibility and enrollment users' experience is reliable, seamless, and secure.
 - Number of applications on Adobe Flex.
 - Number of browser-agnostic apps.
 - Number of documents using intelligent forms.
 - Authority to connect secured.
- Refresh existing out-of-date technology tools to support workforce and clients accessing E&E tools.
 - Number of out-of-date tools.
 - Number of completed platform upgrades.
 - Number of cloud-ready applications.

- ▶ Number of completed infrastructure upgrades.

D-E. History and Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

SSA uses defined processes and procedures to administer the TIERS Suite of Applications. These processes are support by custom configurations in the OpenText PPM and Jira tools. All HHSC resources and contractors are required to follow these procedures.

The following IT SSA processes are available upon request:

- IT SSA Agile Process Guide
- TIERS Change Management Plan
- TIERS Configuration Management Plan
- TIERS CPM Process Guide
- TIERS Governance Process
- IT SSA Jira User Guide
- TIERS Level II Help Desk Plan
- TIERS Performance and Quality Management Plan
- TIERS PPM Timekeeping Guide
- TIERS Project Management Plan
- TIERS Risk Management Plan
- TIERS RITS Process Guide
- TIERS Software Specification Standards and Guidelines
- TIERS Support and Maintenance Plan
- TIERS Test Management Plan

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts:

HHSC and CMS have security agreements in place for TIERS including:

- CMS Interconnection Exchange Agreement;

- CMS Computer Matching Agreement; and
- CMA Interconnection Security Agreement.

I. Relationship with other governmental entities: Not applicable.

CMS: HHSC must submit Advance Planning Documents and comply with CMS standards in order to receive the federal match.

J. Barriers and challenges:

Managing increased caseload: HHSC will move to address both challenges by emphasizing self-service capabilities and business process refinements. As a result of gains in business process efficiency, HHSC works to deliver timely benefit determinations for Texans, while also maintaining quality when agency resources are stretched beyond normal limits. HHSC will continue to rely on the analysis of self-service and business process data to define and deliver the highest value enhancements to further support these desired outcomes for business activities defined above. In addition, HHSC is assessing cloud, open-source, Artificial Intelligence (AI), Machine Learning (ML), bots and associated technologies to identify technologies to further improve HHSC's ability to manage the continuing increase in eligibility determination workload.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Security and Chief Information Security Officer

A. Name of division or program:

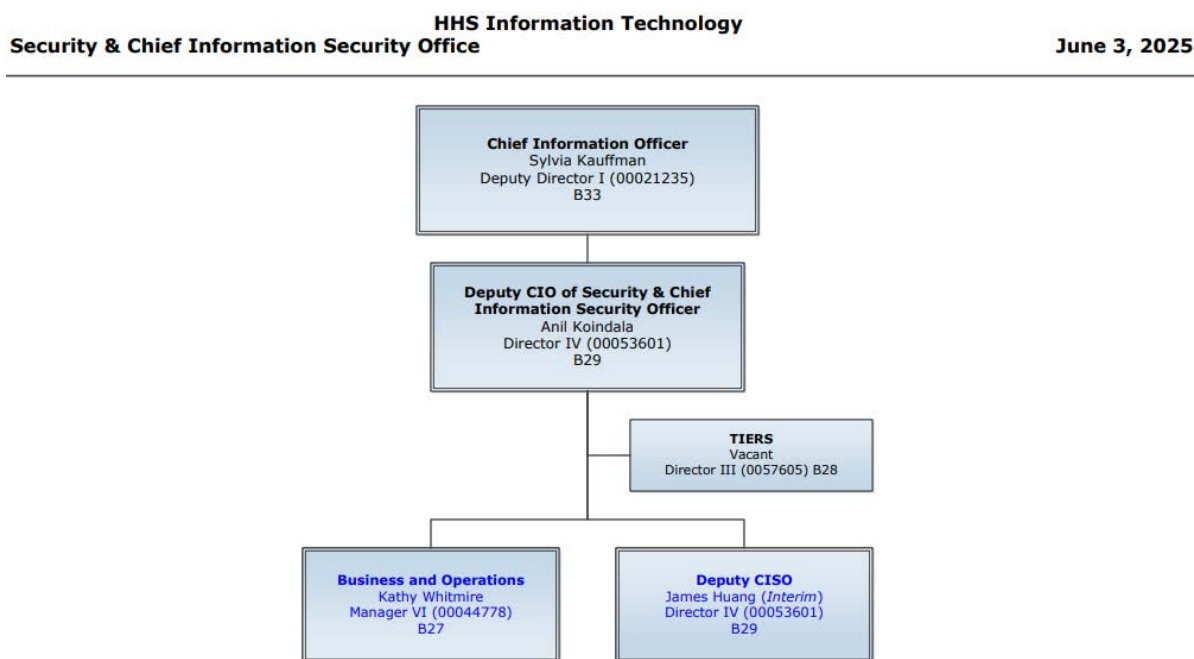
Name of division or program: Security

Location within the agency: CIO, Deputy CIO of Security and Chief Information Security Officer

Contact name: Anil Koindala, CIO of Security and Chief Information Security Officer

Statutory citation: Texas Government Code, Chapter 2054

Figure 5. Information Security organizational chart.



B. Objective and major activities:

The Chief Information Security Officer conducts independent security assessments of HHS information systems. The Office maintains and supports the overall HHS information security awareness program and required reporting. The Cybersecurity Operations Center provides network, system, and application vulnerability assessments and penetration testing for HHS information systems. The Center provides assistance with security concerns, issues, and incidents.

C. Effectiveness and efficiency information:

The Chief Information Security Office proactively secures sensitive data and systems, minimizing the risk of costly incidents and downtime. By implementing efficient threat detection, streamlined compliance processes, and ongoing security awareness training, the Office helps ensure a secure and responsive environment that safeguards public trust and optimizes service continuity. The Chief Information Security Office tracks and reports the effectiveness of security awareness training. Quarterly, the Office reports the percentage of employees that have failed the phishing simulations campaign with the standard of no more than 10 percent failure rate.

The Office employs advanced encryption and cybersecurity protocols to protect personal and health-related information from unauthorized access, ensuring the

privacy and security of all data handled by the agency. By leveraging state-of-the-art technology and efficient processes, the Office minimizes operational costs while maintaining high standards of security.

Implementing 24/7 network monitoring and incident response helps HHS detect and address cybersecurity incidents quickly, reducing the risk of significant damage, especially from attacks occurring after hours. Swift detection is crucial, as attackers can spread laterally within an hour and use persistence mechanisms like ransomware, making remediation more challenging. The Chief Information Security Office does track incident response for time resolution. The standard is incidents are resolved within five days.

Further information will be provided during the Sunset review.

D-E. History and Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

Sensitive information about administration and key processes will be shared as needed with Sunset Commission staff.

G. Funding: See "Agency Program Information" spreadsheet.

H-I. MOUs and interagency agreements or contracts and Relationship with other governmental entities: Not applicable.

J. Barriers and challenges: Not applicable.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Deputy CIO of Technology Strategy and Chief Technology Officer

A. Name of division or program:

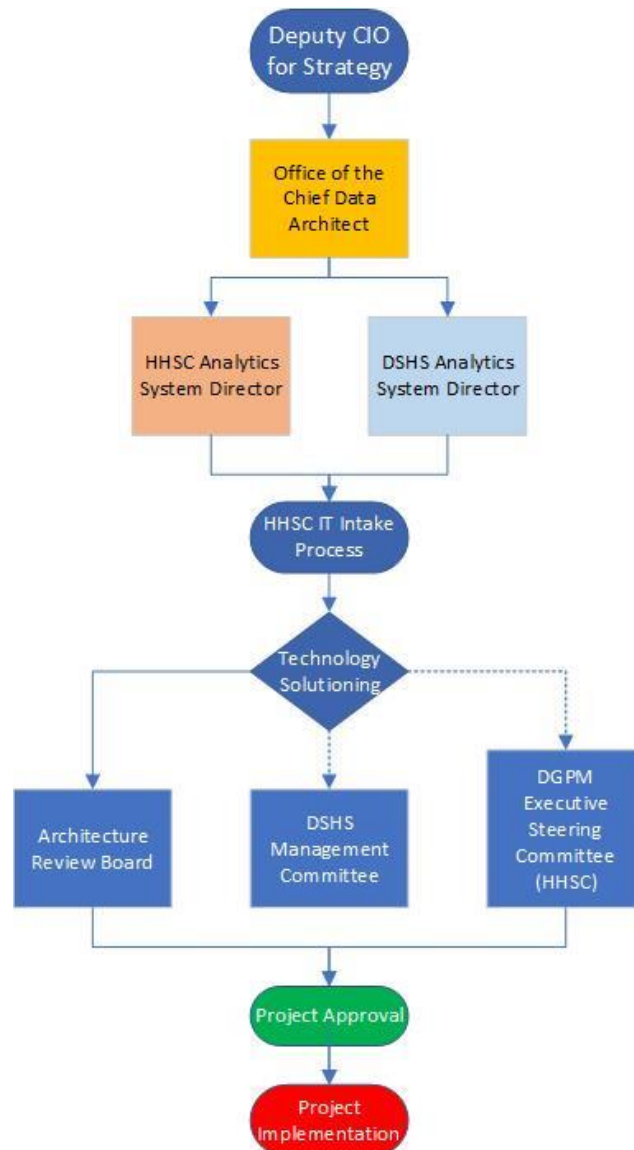
Name of division or program: Technology Strategy

Location within the agency: CIO, Chief Data Architect

Contact name: Madan Gopal, Deputy CIO of Technology Strategy and Chief Technology Officer (CTO) (Interim)

Statutory citation: Texas Government Code, Chapter 2054; S.B. 200, 84th Legislature, Regular Session, 2015; H.B. 3875, 86th Legislature, Regular Session, 2019; 2020-21 General Appropriations Act, S.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 175)

Figure 6. Deputy CIO of Technology Strategy and CTO organizational chart.



B. Objective and major activities:

The Office of the Chief Data Architect's mission is to enable HHS to positively impact Texans by using outcome-based analytics, improving HHS system performance, increasing transparency by aligning effectively with business goals, and using quality data. The Office enables the integration of disparate, siloed data to respond quickly and accurately to HHS program, administrative, and stakeholder

requests for information, leading to more appropriate and effective operational and policy decisions.

C. Effectiveness and efficiency information:

The Office of the Chief Data Architect strives to develop and implement performance measures that foster data-driven decisions to achieve the HHS mission. This includes providing broad and deep perspectives into overall system performance, increasing transparency, improving communication, and aligning program activity with HHS strategic priorities. Providing solutions, processes, and tools for data sharing, data analytics/interpretation, and transparency in measurement method:

- Ensures data quality that is holistic in nature (e.g., universal data warehouse and seamless data system interoperability);
- Fosters and expands the effective use of data, analytics, performance measures, and predictive analytics throughout the HHS System; and
- Enhances data sharing to authorized users internal and external to the agency.

The Chief Data Architect (CDA) is responsible for establishing and supporting HHS data and analytics services architecture through the oversight and utilization of the Performance Management and Analytics System (PMAS). PMAS curates data for claims producing geolocation visualizations which help monitor managed care compliance. Automated processes streamline analytics for regulatory and performance reporting, including claims data. Efforts extend to ad-hoc analytics for leadership to facilitate data-driven reporting. The PMAS team created the new AES DataMart, which ingests eligibility and enrollment data from disparate systems for real-time reporting. HHSC procurement staff utilize PMAS dashboards to monitor metrics that improve the efficiency of procurement and contracting processes.

Key projects also involve modernizing data processes, such as converting legacy systems to innovative platforms, geocoding client addresses, and automating data for regulatory services. This includes license tracking to aid in the efficient processing of Nursing Facility applications. The Mother-Child data integration performed by Enterprise Information Management (EIM) helps clarify pregnancy outcomes, improving outreach.

The CDA leads the strategic design and governance of the State Health Analytics and Reporting Platform (SHARP), enabling secure, scalable data sharing with Local Health Departments (LHDs). CDA ensures compliance with data privacy policies and

supports interoperability, analytics, and reporting. Through phased rollouts, SHARP delivers vital health data—like Immunization, Hospital Inpatient/Outpatient and Vital Events—to LHDs, enhancing public health decision-making and transparency.

DSHS data is shared with LHDs through SHARP. The first rollout allowed 17 LHDs to receive Texas Health Care Information Collection data via SHARP, and 11 LHDs receive Vital Event Data through SHARP. DSHS leadership tracks effectiveness of the data sharing using metrics such as number of LHDs taking part in the data sharing effort, number of users onboarded etc. The metrics are available as Analytic dashboards maintained by the DSHS Program Operations team.

To measure and monitor department effectiveness and efficiency, the chief data architect developed and implemented data strategies for agency programs that would be used to direct PMAS to the desired future state. DSHS progress is displayed on a SharePoint dashboard which shows percentage completion of chief data architect metrics. The data source for both HHSC and DSHS metrics is maintained in Jira cloud, a Software-as-a-Service application, and the methodology is based on the percentage of completion of Jira project tasks, goals, and/or milestones.

D-E. History and Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

The Deputy CIO for Strategy oversees the Office of the Chief Data Architect. Directors oversee operations separately for HHSC and DSHS analytics systems. The chief data architect uses the HHSC IT intake process for new program projects for technology solutioning and financial approval. These projects are then required to be approved by the Architecture Review Board (ARB) and/or the Data Governance & Performance Management (DGPM) Executive Steering Committee for HHSC. For DSHS projects, approval from ARB and the DSHS Management Committee. Once projects are ready to be implemented, project managers, developers, and support staff are assigned as needed. Tasks and overall project progress are then tracked within the PMAS Engagements Roadmap in Jira Cloud for HHSC and similar projects in Jira for DSHS projects.

The IT intake process is documented in the IT governance intake process. The ARB process is documented in the CTO ARB SharePoint site. Both the DGPM Executive Steering Committee for HHSC and the Data Executive Steering Committee for DSHS, which are program governance processes and are documented in their respective areas.

G. Funding: See "Agency Program Information" spreadsheet.

H-I. MOUs and interagency agreements or contracts and Relationship with other governmental entities: Not applicable.

J. Barriers and challenges:

HHSC program areas face challenges with implementing data sharing caused by a wide variation in the technologies used to store and access the data, access to new technology, limited support structures, and viable data structures at the time of implementation. This continues to present challenges for the chief data architect in the development of a continuum of analytics which will show the client journey across programs and services from providers.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Chief Technology Officer

A. Name of division or program:

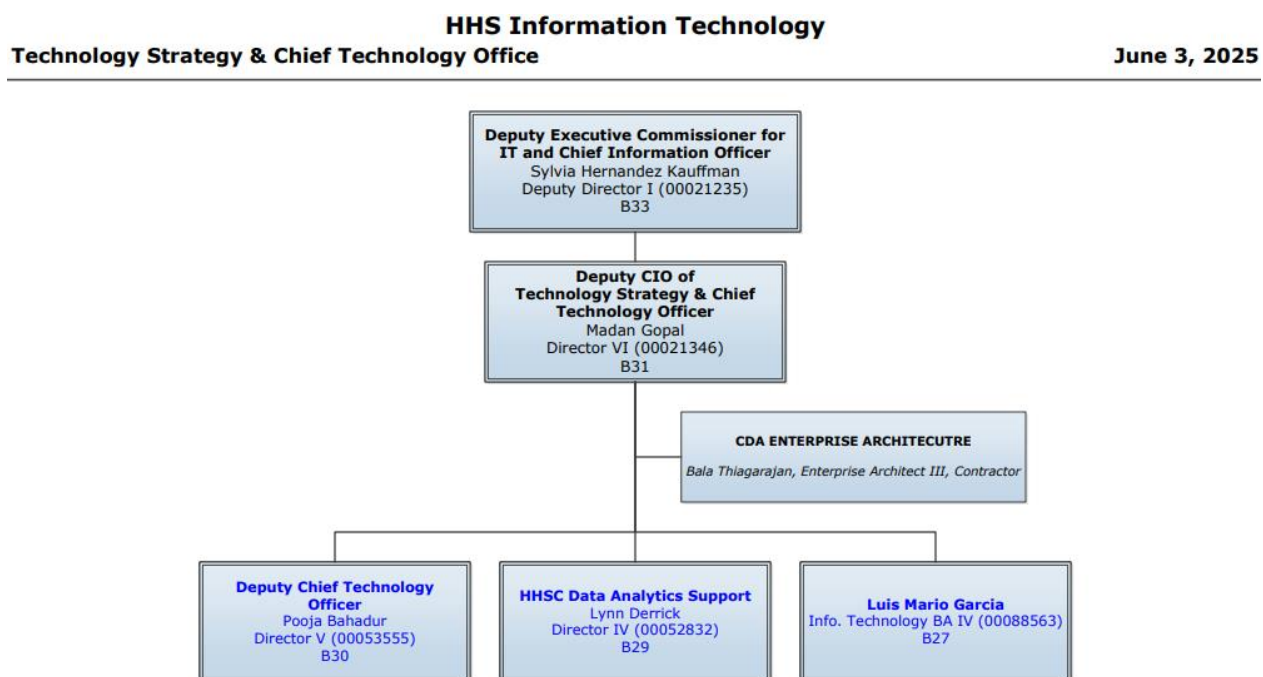
Name of division or program: Chief Technology Office

Location within the agency: CIO

Contact name: Madan Gopal, Deputy CIO of Technology Strategy and CTO (Interim)

Statutory citation: Texas Government Code, Chapter 531

Figure 7. CTO organizational chart.



B. Objective and major activities:

CTO is responsible for managing the HHSC's technology roadmap, strategies, and standards to align with the agency's vision and mission in making a positive difference in the lives of Texans. CTO provides critical support for the agency to develop policies and procedures, oversee technology resources, and research innovative technologies.

CTO is responsible for developing and updating the agency's Technical Strategy, which includes standards, best practices, reference architectures, and the evaluation of technology and tools. The CTO office supports IT and HHS programs by identifying technology transformation needs, conducting technical consultations, and determining technical solutions. CTO facilitates technical innovation through engagement with other IT areas and programs, and through the evaluation and testing of leading-edge solutions to meet business needs and enhance customer service.

Recognizing how quickly AI is becoming popular, CTO leads the groundwork to form a strategy towards safe and secure, and trustworthy use of AI.

C. Effectiveness and efficiency information:

CTO strives to develop and implement performance measures that foster data-driven decisions to achieve the HHS mission. This includes providing broad and deep perspectives into overall system performance, increasing transparency, improving communication, and aligning program activity with HHS strategic priorities.

The CTO office-maintained various metrics, such as: ARB approval/rejection metrics, Reference Architecture (RA) metrics, Software Reviewed Metrics, number of Project Controls Documents (PCDs) created per month metric, and Vendor Engagement Program (VEP).

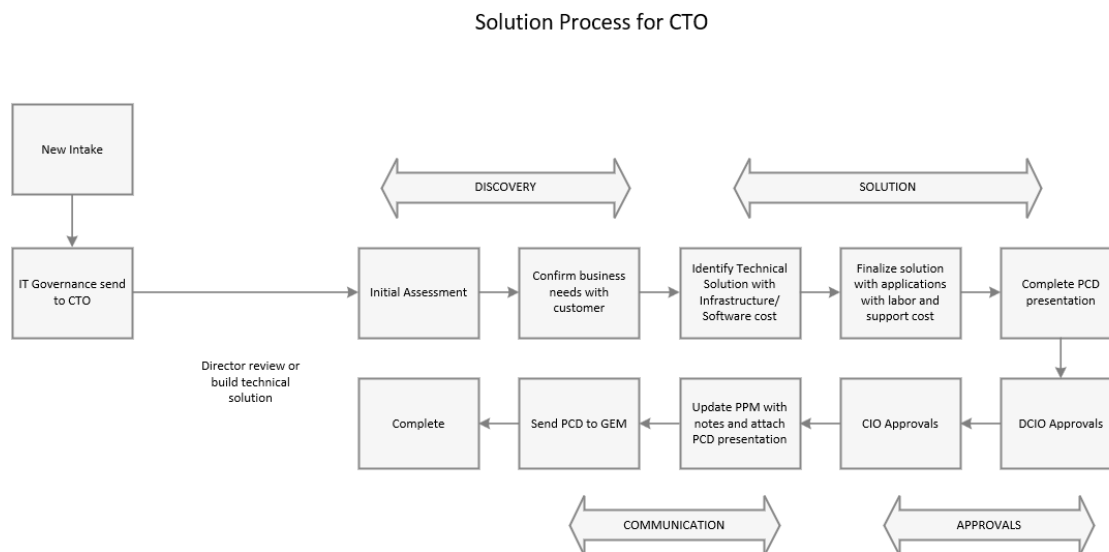
D-E. History and Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

CTO reports to CIO and is responsible for providing vision, leadership and guidance on emerging technology and its incorporation of the technology into HHS' IT ecosystem. The office is involved with planning for future technology needs, managing enterprise and agency technology risks, and ensuring the efficient and effective use of technology resources.

CTO contributes to several of the agency's processes and procedures to ensure effective technology administration. CTO's solution process is a sub-process that is documented within the IT Governance Project Intake Process, provides guidance in the Software Review Process, provides technical guidance in the AI software review process, and leads the agency's ARB, which is a governing body tasked with ensuring that all technology initiatives and projects align with the agency's strategic goals, standards and best practices. A high-level view of the CTO's solutioning process is shown below. The process details are in the documents referenced above.

Figure 8. Solution process for CTO.



G. Funding: See "Agency Program Information" spreadsheet.

H-I. MOUs and interagency agreements or contracts and Relationship with other governmental entities: Not applicable.

J. Barriers and challenges:

With the advancement and speed of technology, CTO is crucial to HHS in protecting, fostering trust, and providing services to Texans. The advancement and speed of technology hinders the CTO's ability to effectively provide the services when it's mostly dependent on program funding.

K-M. Additional, Regulatory, and Complaint information: Not applicable.

Administration and Finance

A. Name of division or program:

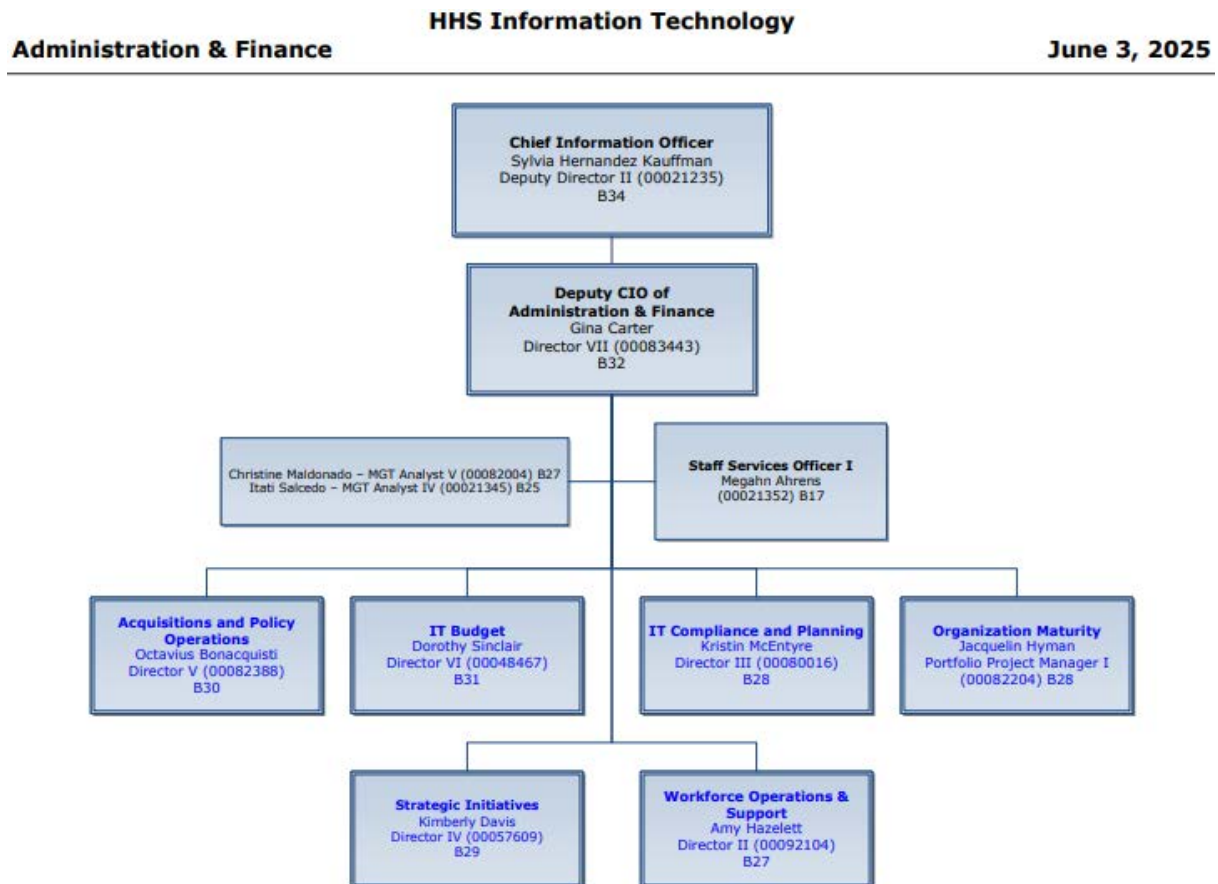
Name of division or program: Administration and Finance (IT Business Operations prior to October 2024)

Location within the agency: CIO

Contact name: Gina Carter, Deputy Chief Information Officer for Administration and Finance

Statutory citation: Texas Government Code, Section 2157.068; 45 Code of Federal Regulations (CFR) Part 95, Subpart F; 42 CFR Part 433, Subpart C; 42 CFR Part 432, Subpart C; 7 CFR 277.18; 45 CFR Part 95; Subparts A, E, F, and G

Figure 9. Administration and Finance organizational chart.



B. Objective and major activities:

Administration and Finance, formerly IT Business Operations, provides independent, objective, and innovative services that create operational efficiencies that comply with internal and external administrative policies and procedures. Administration and Finance includes Budget Management and Finance, Federal and State Reporting Coordination, IT Procurement and Contracting, Planning Policy and Performance, Workforce Operations and Support, IT Communication and outreach, and Legislative Support.

Budget Management and Finance is comprised of two teams, Budget Analysis and Time and Cost Allocation.

- **Budget Analysis:** Establishes, communicates, and manages the operating budget for IT at HHSC and DSHS and coordinates the collection and reporting of financial data, including time effort reporting results, for key projects. This team serves as the point of contact for all budget matters and coordinates between IT areas and agencies on the Legislative Appropriations Request and exceptional funding for IT related projects, mid-year review and budget development.
- **Time and Cost Allocation:** Manages time effort reporting system to capture IT work results for proper cost allocation and ensures compliance reporting for time effort reporting inputs. Early in the calendar year 2019, the team began assessing IT operations for work performed to ensure costs are allocated appropriately to established Department Identifiers (Dept IDs) and factors.

Federal/State Reporting Coordination is comprised of two teams, IT Audit Coordination and Advanced Planning Documents.

- **IT Audit Coordination:** Leads and facilitates all audits impacting IT, internally and externally. Works with auditors to facilitate field work, address finding concerns, and closures of action plans. Prepares audit reports, management response plans, implementation constraints, and measurements of success.
- **Advanced Planning Documents (APD)** are the mechanism used to request Federal Financial Participation (FFP) for the design, development, and implementation of mechanized claims processing and information retrieval systems used in federal programs as well as TIERS Eligibility and Enrollment Systems Modernization for the ongoing operation of those systems.

The APD team works with IT management, project sponsors, and program liaisons across HHSC to develop high-quality advanced planning documents requesting FFP for the costs of the planning, development, acquisition, installation, and implementation of information system equipment and services or a services acquisition.

The APD team helps develop and coordinate the documentation to be submitted on behalf of the agency to include the estimated total project cost and project funding requested from CMS at an enhanced match rate for FFP (50/50, 75/25, 90/10), United States (U.S.) Department of Agriculture (USDA) Food and Nutrition Service (FNS), and Administration for Children and Families (ACF).

Additionally, the APD team determines enhanced rate, monitors, and tracks Medicaid and non-Medicaid APD budgets to ensure spending is in allowance of federally funded approvals and provides a preemptive monitoring system

to kick off APD-updates to avoid potential disallowance of federal funding. These APDs involve technology and program costs and are frequently large so the team provides oversight to ensure the agency is accurately recording APD related costs to APD program codes to receive maximum federal funding based upon federal approval levels.

IT Procurement and Contracting includes IT Requisition Entry and Invoicing, Staff Augmentation, Procurement Projects and Support, and IT Contract Management.

The unit initiates procurements, enters requisitions and invoices for IT-related goods or services; and acquires and provides contract management services for employees of vendors (contractors) obtained through a DIR information technology staff augmentation contract (ITSAC) to perform work (assignments) for HHS.

IT Policy and Process Operations: In accordance with IT Governance Policy Circular C-009 IT coordinates with staff to develop policies for IT, including developing flowcharts and securing IT leadership approval for IT policies and processes.

Workforce Operations and Support: Reviews documents and coordinates the approval process for creation of new positions, job audits, temporary assignments and assist staff with posting positions and recruiting IT resources.

Legislative Support: Supports IT on legislative initiatives (e.g., exceptional items) and related activities (e.g., Business Operating Plans), including serving as IT's Legislative Coordinator during the Texas legislative session.

C. Effectiveness and efficiency information:

- IT Governance Policy: In accordance with IT Governance Policy Circular C-009, IT developed a governance model through which the IT division receives requests for projects and works with HHS organizational areas to approve, prioritize, and deliver them. The model ensures that IT projects align with HHS strategic priorities, and the business needs of organizational areas.

The model applies to any business need that an organizational area (as opposed to an individual workforce member) has for a technology or service that meets the definition of an IT project.

CIO approves and oversees the model used to develop and publish policies, standards, processes, and procedures for services or functions for which IT is primarily responsible.

- Performance Metrics - IT Procurement and Contracting and Planning, Policy and Performance:

- ▶ Percent of enhanced monitoring contracts compliant with requirements:
 - ◇ Definition: The percent of active HHSC and DSHS IT contracts with a current contract value equal to or greater than \$20 million dollars and \$0 contracts with expenditures equal to or greater than \$20 million dollars are required by the HHS Procurement and Contract Management Handbook (PCMH) to have an enhanced monitoring plan in the system of record, SCOR.
 - ◇ Data Source: SCOR, List of Contracts report.
 - ◇ Methodology: The numerator is the number of active HHSC and DSHS IT contracts with a current contract value equal to or greater than \$20 million and \$0 contracts with expenditures equal to or greater than \$20 million with an enhanced monitoring plan documented in SCOR. The denominator is the number of active HHSC and DSHS IT contracts with a current contract value equal to or greater than \$20 million and \$0 contracts with expenditures equal to or greater than \$20 million. Divide the numerator by the denominator and multiple by 100 to obtain the percentage of active HHSC and DSHS IT contracts requiring enhanced monitoring with an enhanced monitoring plan and enhanced monitoring vendor notification uploaded to SCOR.
- ▶ Percent of IT contracts with at least one vendor performance report completed:
 - ◇ Definition: This performance measure is the percentage of contracts valued at \$5 million or more, with more than 12 months from start date, that have at least one vendor performance report (i.e., form PCS 147) uploaded to SCOR.
 - ◇ Data Source: SCOR Contract Documentation report and the List of Contracts report.
 - ◇ Methodology: The numerator is the number of active HHSC and DSHS IT contracts with a current contract value equal to or greater than \$5 million and a begin date at least 12 months prior to the reporting month with a VPTS, Procurement and Contracting Services (PCS) 147 document uploaded to the SCOR contracts Documentation submodule within the last 12 months.

The denominator is the number of active HHSC and DSHS IT contracts with a current contract value equal to or greater than \$5 million. Intra-agency contracts and memoranda of understanding are excluded from the numerator and denominator.

Divide the numerator by the denominator and multiple by 100 to obtain the percent of active HHSC and DSHS IT contracts with a current contract value equal to or greater than \$5 million that have at least one VPTS, PCS 147 uploaded to the SCOR contracts documentation submodule.

► Average Days to Publish Policies:

- ◇ Definition: This measure reports the average days for requests for development of policies and standards from the date that the new or revised request is assigned to the date the document is published in the policy repository during the quarter.
- ◇ Data Source: IT PPP Policy Tracker
- ◇ Methodology: The development time for requests published during the quarter is measured in days from the date the request is assigned for the new/revised policy or standard until the date it is published in the IT policy repository. Average days are calculated by dividing the sum number of elapsed days for all requests by the count of requests published.

► Cybersecurity Training:

- ◇ Definition: Percentage of required Form 3834 cybersecurity training attestations uploaded to SCOR.
- ◇ Data Source: SCOR is used to collect the data.
- ◇ Methodology: The denominator is the number of active or approved contracts and contract amendments to renew or extend a contract that are required to have 3834 cybersecurity training forms in SCOR.

The numerator is the number of required 3834 cybersecurity training forms uploaded to SCOR.

D. History:

In October 2024, IT Business Operations became Administration and Finance. Two new functions were transferred to Administration and Finance, Strategic Planning and IT Outreach. The Office of E-Health Coordination and the e-Discovery moved to Administration and Finance in fiscal year 2025.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

Several IT key processes are:

- IT Governance Project Intake Process
- IT Project Management Process
- Requesting a Contract Review from the QAT Team Process

Other IT process documents are available upon request.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts:

IT has 15 MOUs and IACs. These include:

TIERS-Related MOUs and IACs

Legal Entity Name: State of Michigan/ Contract Type: Interagency / IT Area
Managing Contract: TIERS

- Purpose: Interagency agreement with the State of Michigan for the use of TIERS software. TIERS is the system for eligibility and benefit determination of Michigan's cash, medical, food, and childcare assistance programs.

Legal Entity Name: Virginia Department of Social Services/ Contract Type:
MOU/IAC / IT Area Managing Contract: TIERS

- Purpose: Interagency agreement with the Commonwealth of Virginia for the use of TIERS software. TIERS is the system for eligibility and benefit determination of Virginia's cash, medical, food, and childcare assistance programs).

Legal Entity Name: Bureau of Information Systems Department/ Contract Type:
MOU / IT Area Managing Contract: TIERS

- Purpose: Licensing of the HHSC "Your Texas Benefits" mobile application agreement with the Commonwealth of Pennsylvania for their use of the mobile application.

Legal Entity Name: State of Wisconsin / Contract Type: Interagency / IT Area
Managing Contract: TIERS

- Purpose: Licensing of "Your Texas Benefits" mobile application agreement with the State of Wisconsin Department of Health Services for their use of HHSC's mobile application.

Legal Entity Name: State of Connecticut / Contract Type: Interstate Compact / IT Area Managing Contract: TIERS

- Purpose: Licensing of "Your Texas Benefits" mobile application agreement with the State of Connecticut Department of Social Services for their use of the mobile application.

Legal Entity Name: State of Arkansas / Contract Type: Interstate Compact / IT Area Managing Contract: TIERS

- Purpose: Licensing of "Your Texas Benefits" mobile application agreement with the State of Arkansas Department of Human Services for their use of the mobile application.

Non-TIERS-Related MOUs and IACs

Legal Entity Name: DIR/ Contract Type: Interagency / IT Area Managing Contract: IT Contract Management

- Purpose: Interagency Contract with DIR for the use of their Shared Technology Services (STS) program.

Legal Entity Name: Texas Juvenile Justice Department (TJJD) / Contract Type: Interagency / IT Area Managing Contract: IT Applications

- Purpose: To allow the TJJD use of HHSC's "Client Trust Fund" tracking software, and training manual.

Legal Entity Name: Office of the Attorney General (OAG) / Contract Type: Interagency / IT Area Managing Contract: IT Infrastructure Services

- Purpose: Allows OAG to use HHSC's network hub to interface with various federal agencies. This contract provides OAG with access to data from various federal agencies including the U.S. Internal Revenue Service (IRS), Social Security Administration, and the Office of Child Support Enforcement (OCSE). This contract enables OAG to follow the federal requirements for safeguarding confidential information stipulated in 42 USC 654 (26).

Legal Entity Name: Texas Department of Public Safety / Contract Type: Interagency / IT Area Managing Contract: IT Applications

- Purpose: Licensing agreement with the Texas Department of Public Safety for SCOR developed by HHSC.

Legal Entity Name: DSHS Contract Type: Interagency / IT Area Managing Contract: IT Contract Management

- Purpose: IAC-Regulatory Automated System; The purpose of this contract is to identify the services performed and to facilitate the transfer of funds between HHSC and DSHS that support services provided by the Regulatory Automation System.

Legal Entity Name: DSHS / Contract Type: Interagency / IT Area Managing Contract: IT Contract Management

- Purpose: IAC contract between HHSC and DSHS regarding HHSC Medicaid Administrative Claim (MAC). HHSC purchases Core Grouping Software (CGS) CMS Medicare Ambulatory Payment Classification (APC) Grouper with Medicare Hospital Outpatient Department (HOPD) Reimbursement licenses ("grouper software licenses") from 3M Health Information Systems, Inc. ("3M"). DSHS reimburses HHSC for costs associated with the grouper software licenses.

Legal Entity Name: Texas Facilities Commission (TFC) / Contract Type: Interagency / IT Area Managing Contract: IT Contract Management

- Purpose: IAC for JHW Cooling Elec Infra; TFC provides professional architectural and engineering services associated with the development of programming and design, construction administration, and contracting with construction vendors to provide cooling and infrastructure services at the John H. Winters Building data center.

Legal Entity Name: DFPS / Contract Type: IAC Revenue Generating Contract / IT Area Managing Contract: IT Contract Management

- Purpose: For HHSC to provide DFPS IT Help Desk Support Services.

I. Relationship with other governmental entities:

- State of Michigan: HHSC allows the Michigan Department of Technology, Management, and Budget to use the HHSC TIERS software through interagency agreement.
- Virginia Department of Social Services: HHSC allows the governmental entity use of the HHSC TIERS software through interagency agreement.
- Pennsylvania Bureau of Information Systems Department: HHSC allows the governmental entity use of the HHSC "Your Texas Benefits" mobile application through interagency agreement.
- State of Wisconsin Department of Health Services: HHSC allows the governmental entity use of the HHSC "Your Texas Benefits" mobile application through an interagency agreement.
- Connecticut Department of Social Services: HHSC allows the governmental entity use of the HHSC "Your Texas Benefits" mobile application through interagency agreement.
- Arkansas Department of Human Services: HHSC allows the governmental entity use of the HHSC "Your Texas Benefits" mobile application through interagency agreement.
- Centers for Medicare and Medicaid Services: HHSC receives federal funding from the governmental entity for state projects, particularly those involving automated data processing or information systems. Funding is requested through Advance Planning Documents.
- Department of Information Resources: Texas Government Code, Section 2157.068, requires state agencies to procure IT commodities from cooperative contracts managed by the governmental entity, unless otherwise exempted by the governmental entity. Further, Texas Government Code, Chapter 2054, prohibits state agencies from spending appropriated money to contract or issue purchase orders for data center services or disaster recovery services outside of the statewide technology centers, unless otherwise exempted by the governmental entity.
- Texas Juvenile Justice Department: HHSC allows the governmental entity use of the HHSC Client Trust Fund tracking software and training manual through interagency agreement.
- Texas Office of the Attorney General: HHSC allows the governmental entity to use HHSC's network hub to interface with federal agencies through an interagency agreement.

- Texas Department of Public Safety: HHSC allows the governmental entity use of the HHSC SCOR license through an interagency agreement.
- Texas Facilities Commission: HHSC obtains professional architectural and engineering services from the governmental entity associated with cooling and infrastructure services at the John H. Winters Building data center through interagency agreement.
- Department of Family and Protective Services: HHSC provides IT Help Desk Support Services to the governmental entity through an interagency contract (i.e., a revenue generating contract).

J. Barriers and challenges:

See Section IX.

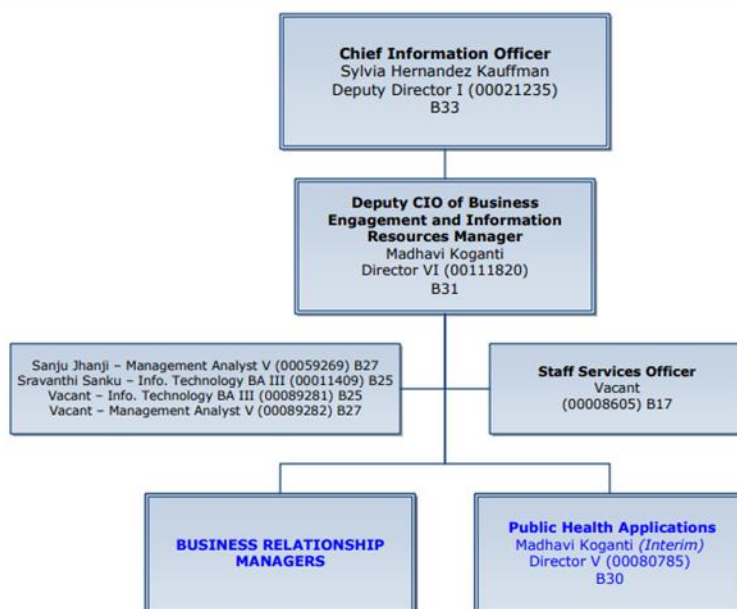
K-M. Additional, Regulatory, and Complaint information: Not applicable.

Business Engagement (previously called IT Strategy)

Public Health Applications

The Business Engagement division supports the DSHS Public Health Applications (PHA). This function includes identifying potential applications, development, testing, deployment to production, maintenance, support, updating, and replacing all applications for DSHS. Business Engagement Office supports IT governance practices and business relationship management by providing staff resources to maintain communications between all the program areas within HHSC and DSHS for the purpose of promoting a responsive and reliable collaboration between IT and the program areas. This function is critical to bring strategic alignment between IT and program areas, to identify the business needs that can be satisfied by technology components, to develop roadmaps for existing applications, to provide visibility and governance for all IT services provided to satisfy the business needs across HHSC and DSHS.

Figure 10. Business Engagement organizational chart.



A. Name of division or program:

Name of division or program: Public Health Applications

Location within the agency: Business Engagement

Contact name: Madhavi Koganti, Director of DSHS IT Strategy

Statutory citation: Texas Health and Safety Code, Chapters 171, 241, 243, 244, 248, 251, 464, and 466; Texas Occupations Code, Chapter 110 and 504

B. Objective and major activities:

PHA supports timely implementation of technology; delivers innovative solutions that enable the DSHS and HHS provide services to Texans; and develops strong partnerships and technology solutions to empower research, analysis, and decision-making. The majority of PHA resources provide support to DSHS with a few providing support to HHS.

PHA provides technology solutions to DSHS in support of:

- Public Health Laboratory;
- Community Health Improvement;

- Infectious Disease Prevention;
- DSHS financial data processing and grants tracking;
- Consumer Protection: Licensing, inspection and compliance activities with online services for Texans;
- Regional and Local health services supporting statewide patient and follow up care;
- Vital Statistics and records;
- Coordination for public health emergency preparedness and response via Health Alert Network; and
- Provide data to support data reporting, analysis, trending and GIS dashboard.

For HHS, PHA provides support for Health Care Regulation licensing of facilities and professionals and health facilities to ensure regulatory compliance.

For DSHS, PHA provided a streamlined and easy-to-use process for Texans to access approved Preventable Adverse Events and Healthcare-associated Infections through the newly developed TxHSN application. Federal funding provided the opportunity to revamp and develop state-of-the-art public health applications and functionality that has improved the lives of Texans.

C. Effectiveness and efficiency information:

Table 4. Metrics.

Metric	Description	Tool	How it's Used
Releases Completed	Number of releases approved and completed in production by application	Jira/BMC Helix	Measures ability to deliver: Percent Releases completed.
Defects Found In Testing	Defects found in QA testing, for applications/projects with QA teams	Jira/ALM/BMC Helix	Ensures high product quality: Number of defects found during testing.
Defects Found during Hypercare	Defects found after the release during the hypercare period	Jira/ALM/BMC Helix	Ensures high application performance in hypercare: Number of defects found.

Metric	Description	Tool	How it's Used
Project development artifacts (Stories, Requirements, Epics, Defects) Completed	Project development artifacts completion	Jira/ALM	Measures project effectiveness: Percent of projects delivered on-time, on-schedule and on-budget.
Project artifacts and tracking	Project workload delivered relative to project scope and specifications.	PPM	Measures project efficiency against user requirements.
Operational Activities	Post go live support maintenance and monitoring	BMC Helix	Measures resource efficiency/capacity.
Software procurement and renewals	New software purchases and annual renewals.	BMC Helix	Ensures application up-time and continuity.
Application Security and Vulnerability Management	Managing security posture for applications in production	SharePoint/Archer	Measures application security: # of outstanding vulnerabilities.

D-E. History and Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

Project Management Guidelines are hosted in SharePoint, and up to date documentation can be provided upon request. Business needs are tracked via intakes.

- Intakes are tracked in PPM tool;
- Intakes are converted to project;
- Projects are tracked and monitored in the PPM tool following the Texas Project Delivery Framework and guidelines established by HHSC Project Management Office;
- Project deliverables are tracked in PPM/Jira documenting the full lifecycle of artifacts via the Software Development Life Cycle (SDLC) process;
- Change Management process is accomplished through the Change Approval Board (CAB) for all production deployments;

- Production incidents are handled through the Information Technology Service Management (ITSM) process; and
- Software renewals and purchases are handled through processes and guidelines established by PCS.

Security and vulnerability management is performed according to the agency cybersecurity standards:

G. Funding: See "Agency Program Information" spreadsheet.

H-I. MOUs and interagency agreements or contracts and Relationship with other governmental entities: Not applicable.

J. Barriers and challenges:

Challenge 1: While additional federal funding has supported multiple new projects, this has created a significant burden on existing IT staff resources to provide operational support. The addition of new applications to the Portfolio that this team manages adds work to maintain and support the applications. Technology systems should be merged/consolidated, where appropriate, to better support them.

Several new DSHS applications were built in the last five years as COVID-19 funding was available. Most of these applications were transitioned from the implementation vendor to FTEs in Public Health Applications for maintenance and support. Providing maintenance and support to an application involves timely procurement of software, timely upgrades of hardware, resolution of defects, addition of enhancements, proactive identification and resolution of vulnerabilities, continuous monitoring, continuous improvements, consistent maintenance to avoid business interruptions and many more activities depending on the size, technology stack and complexity of the application and its environments. Each new application consumes a lot of resources. The number of FTEs in Public Health Applications team was reduced when COVID-19 funding was discontinued. For efficient utilization of resources in the long-term, the number of applications should be reduced by merging and/or consolidating them.

Challenge 2: Legacy systems and ever-increasing exposure to application security vulnerabilities requires more resources to maintain, resolve and implement preventive measures. Lengthy approval and purchasing processes make it difficult for IT to procure vendors to support the applications.

K. Additional, Regulatory, and Complaint information: Not applicable.

Business Engagement Office

A. Name of division or program:

Name of division or program: Business Engagement

Location within the agency: CIO, Business Engagement Office

Contact name: Madhavi Koganti, Director of DSHS IT Strategy

Statutory citation: Texas Government Code, Chapter 524

B. Objective and major activities:

Business Engagement Office includes Business Relationship Managers and Governance Engagement Managers who act as the primary liaisons between IT and program areas translating business objectives into technology opportunities and ensuring IT investments deliver expected business outcomes and value. These resources help build strong, trusted relationships with business leaders and decision-makers, manage stakeholder expectations, maintain ongoing engagement, serve as a voice of the business within IT and voice of IT to the business. They help to communicate IT strategies, roadmaps, and capabilities in business terms, and ensure IT and business plans are aligned and that both sides understand mutual priorities by facilitating strategic alignment meetings, portfolio reviews Management Committee meetings, and Executive Steering Committee meetings. Innovation advocacy, governance participation and continuous improvement are other functions performed by this team.

C. Effectiveness and efficiency information:

Table 5. Metrics.

Metric	Description	Tool	How it's Used
Strategic alignment	Percent of IT initiatives aligned with business goals	Portfolio Project Management (PPM) tool tracks the number of planned intakes	Measures the degree to which IT work supports business strategy.
Number of intakes/proposals processed	Business demand converted into initiatives	Portfolio Project Management (PPM) tool tracks the number of intakes processed	Measures effectiveness in identifying and shaping business demand.

Metric	Description	Tool	How it's Used
Stakeholder Engagement	Involvement of Business Stakeholders and Decision makers in Governance processes	Governance meetings	Ensures visibility, collaboration and cohesive decision-making.
Relationship Health and satisfaction of business stakeholders	Stakeholder Satisfaction Score	Customer Satisfaction Survey	Measures trust and satisfaction level of Key business partners towards IT.
Long-term value realization	Percent of demand realizing planned value post-delivery	Project Closeout reports track the business objectives achieved and benefits realized	Measures the realization of benefits due to engagement, close partnerships with business stakeholders and established governance processes.

D. History and Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

- Strategic initiatives are tracked in PPM tool as Ideas. Business needs are tracked via intakes. Intakes are tracked in PPM tool.
- Intakes are converted to projects or operational work requests based on the level of effort and cost of implementation.
- Projects are tracked and monitored in the PPM tool following the Texas Project Delivery Framework and guidelines established by HHSC Project Management Office.
- Management Committee meetings and Executive Steering Committee meetings are used for collaborating to mitigate risks and issues, and cohesive decision making.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts; Relationship with other governmental entities; Barriers and challenges; and Additional, Regulatory, and Complaint information: Not applicable.

Artificial Intelligence and Chief Artificial Intelligence Officer

Established in April 2025, the mission of the Chief Artificial Intelligence Office (CAIO) is to serve as the visionary and strategic leader for AI initiatives within HHS.

A. Name of division or program:

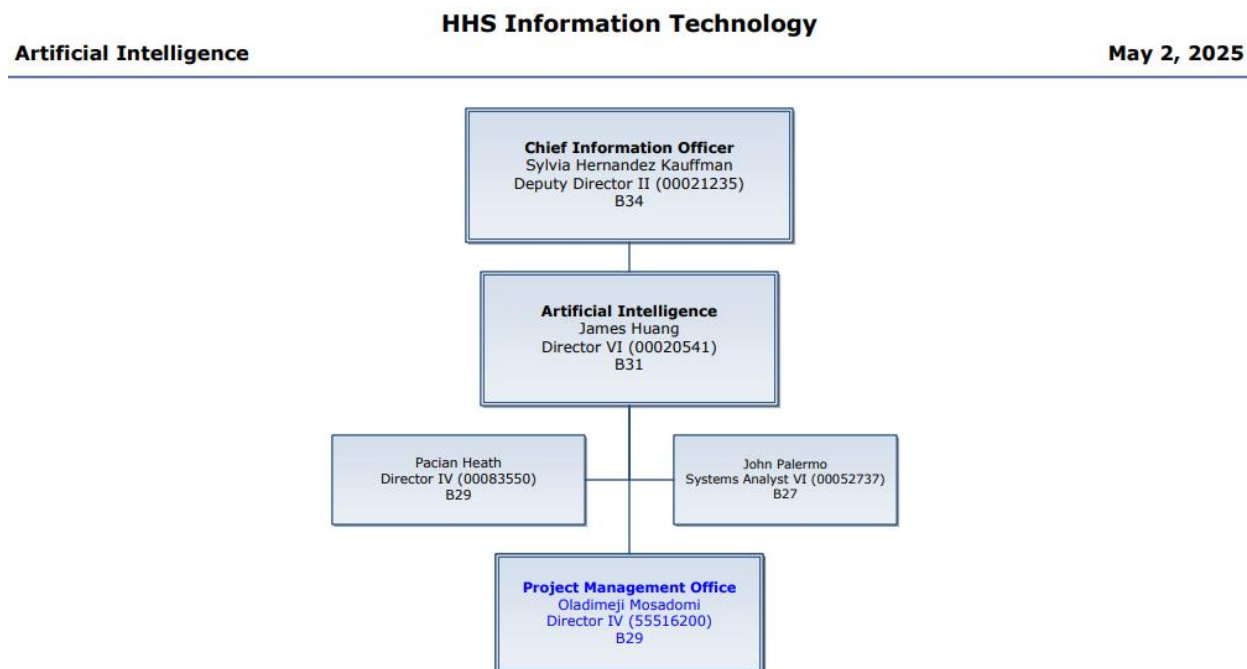
Name of division or program: Artificial Intelligence

Location within the agency: CIO

Contact name: James Huang, Deputy CIO of AI and Chief AI Officer

Statutory citation: Not applicable.

Figure 11. AI organizational chart.



B. Objective and major activities:

The AI function is pivotal in driving the adoption, development, and deployment of artificial intelligence technologies to enhance operational efficiency, deliver innovative public services, and ensure data-driven decision-making processes in an ethical and security conscious manner.

CAIO is executing this mission through:

- Development and implementation of a comprehensive AI strategy aligned with the agency's mission and goals;
- Working closely with CTO to ensure compatibility and consistency with enterprise architecture and standards;
- Identifying and prioritizing AI opportunities to optimize public service delivery and internal operations;
- Staying abreast of emerging AI technologies and industry trends to ensure the agency remains at the forefront of innovation;
- Communicating the vision, strategy, and progress of AI initiatives to stakeholders, including senior management and government officials;
- Preparing and presenting reports on AI investments, project outcomes, and future plans;
- Engaging with the agency staff, vendors, and state leadership to articulate the benefits and objectives of the agency's AI initiatives;
- Leading and mentoring a team of AI specialists, data scientists, and technologists to drive AI development, implementation and monitoring;
- Fostering a culture of innovation and collaboration across departments to integrate AI solutions seamlessly;
- Building partnerships with other state agencies, academic institutions, industry experts, and technology vendors to foster research and development;
- Fostering the design, development, and deployment of AI projects, ensuring they meet technical, ethical, and regulatory standards;
- Ensuring that AI solutions are scalable, sustainable, and deliver measurable value;
- Monitoring and evaluating the performance of AI systems to continuously improve their effectiveness and impact;
- Identifying AI models that can be applied in multiple areas to maximize development value and agency resources;
- Establishing and enforcing policies and processes for the ethical use of AI, ensuring transparency, accountability, and fairness;
- Working closely with legal and compliance teams to navigate AI-related regulatory challenges and data privacy issues; and

- Promoting responsible AI practices and public trust in HHS AI technologies.

C. Effectiveness and efficiency information:

CAIO manages the governance and risk assessments of all AI operations and projects. Through the AI Software Review process, CAIO monitors the demand for AI technology by HHS division and allocates resources to support each division's needs, thereby ensuring that the CAIO effectively addresses HHS AI requirements and mitigates risks. As the newly established CAIO progresses, it will continue to transition to and develop the following performance metrics:

Table 6. CAIO performance metrics.

Performance Metrics	How it is and will be used
AI Portfolio Management	The metrics for AI Portfolio Management facilitate the assessment of both ongoing and completed workloads. Additionally, they capture the efficacy of the AI project management process: • Number of AI projects in planning, execution, and completed • Percentage of AI projects delivered on-time and on-budget • AI project return on investment (projected vs. realized)
AI Governance and Risk Management	AI Governance and Risk metrics measure how effectively risks are minimized. • Number of AI Software Risk Assessments in progress and completed • AI Governance Tiering Coverage (percent of models classified by risk level, e.g. high-risk per statutory definition) • Number of Compliance or Ethical findings and issues resolved
AI Adoption and Engagement	The metrics for AI Adoption and Engagement monitor the demand for and the effective integration of AI technology into HHS. • Number of divisions using AI tools or products • Percentage of employees using AI tools or products • AI Training and Events Attendance Rate

Performance Metrics	How it is and will be used
AI Model Operations	The metrics for AI Model Operations are designed to monitor the efficiency of the maintenance and issue resolution processes that support the AI models actively used by HHS: • AI Model Uptime and Availability • Average Time to Detect & Resolve Model Issues • AI/Machine Learning (ML) Operations or Inference operating costs which define the expenses of running a trained AI model to generate outputs
Innovation & Value Delivery	The metrics for Innovation and Value Delivery are used to assess the effectiveness of deployed AI technology in providing demonstrable value to HHS: • Number of Business Applications developed using AI • Number of Business Processes automated or semi-automated using AI • Cost Savings Attributed to AI
Strategic Alignment	The metrics for Strategic Alignment are used to monitor the effectiveness of AI initiatives in supporting the strategic objectives of HHS and HHS programs. • Percentage of AI Initiatives Aligned to Strategic Goals • Number of AI Initiatives Supporting Priority Programs (e.g., legislative mandate, modernization, accessibility) • AI Maturity Level (based on a state established framework)
External and Cross-Agency Collaboration	The metrics for "External and Cross-Agency Collaboration" measure CAIO's effectiveness in working with external agencies. • Number of External Partnerships (e.g., academia, vendors, other agencies) • Number of Shared AI Use Cases or Reusable Components • Number of Contributions to Statewide Agency AI Governance

D-E. History and Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

CAIO operates as a cross-functional organization influencing all areas of HHS. Through the AI Governance processes, CAIO facilitates the identification,

prioritization, and funding of AI projects that are essential for the modernization, efficiency, and effectiveness of HHS programs.

CAIO manages potential AI risks using the AI Software Exception Request process and the AI Project Proposal Submission processes.

- Through the AI Software Exception Request process, HHS program areas request software with AI components. CAIO facilitates the risk identification and assessment process with Infrastructure Services, CTO, and chief information security officer to evaluate the requested software and provide approval or rejection recommendations to CIO.
- This procedure facilitates the identification of secure AI tools and the development of an approved AI software catalogue from which HHS programs may select.
- The AI Project Proposal Submission process enables HHS and CAIO to systematically capture and evaluate proposed AI projects. This process includes use case analysis, feasibility assessment, and other critical evaluations before committing resources and significant effort.

CAIO collaborates with program areas and IT departments to develop and implement policies, processes, standards, and practices for safe and effective AI technologies benefiting Texans.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

CAIO collaborates extensively with DIR and other relevant entities to acquire AI services and technologies, as well as to develop and deliver HHS-focused AI programs.

J-M. Barriers and challenges; Additional, Regulatory, and Complaint information: Not applicable.

Project Management

A. Name of division or program:

Name of Program or Function: Project Management

Location/Division: CIO

Contact Name: James Huang, Deputy CIO of AI and Chief AI Officer

Statutory Citations for Program:

Project delivery framework: Texas Government Code, Section 2054.118(d); 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Article IX, Section 9.02(a))

QAT contract reviews: 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Article IX, Section 9.01(c)).

QAT to monitor that projects are on-time and on-budget: Texas Government Code, Section 2054.1181(d)

QAT review the final results of the projects: 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Article IX, Section 9.02(h))

QAT to provide "additional oversight services" for all MIRPs within "additional monitoring warranted" agencies (as designated by the State Auditors Office (SAO)): Texas Government Code, Section 2054.1181

B. Objective and major activities:

The Project Management function is crucial in ensuring IT products and services are delivered within budget and on schedule. PMO monitors the performance of IT projects across HHS and develops policies, processes, and standard operating procedures to facilitate accurate and timely reporting on all IT projects across the enterprise. It maintains high standards for regular reporting and updates on all IT projects. The Project Management Office (PMO) escalates issues to CIO as necessary to ensure timely action across HHS program areas.

PMO uses the PPM tool to track IT time effort reporting as well as projects and maintenance efforts. The system allows IT staff to track hours planned and expended against IT projects that serve agency business needs. Data input into the tool is tracked daily, weekly, semi-monthly, and monthly through 25 reports and dashboards. Stakeholders across the agency use this data to support current and future project and resource investment decisions.

PPM houses project data for all IT project-related activities. Reporting capabilities provide users and executives with a clear understanding of project status, resource utilization, and financial performance across portfolios. Project managers rely on

the solution for day-to-day project execution, including creating work plans, assigning tasks, tracking contractor time and project progress, managing budgets, identifying and mitigating risks and issues, and providing monthly project status reports.

C. Effectiveness and efficiency information:

PMO tracks project and portfolio management health measures to measure effectiveness and efficiency of IT project management processes. These measures include:

Table 7. Performance metrics.

Performance Metrics	How it is and will be used
Portfolio Management	The Portfolio Management metric is used to track and measure the overall health of HHS IT project health. • Percent of Small, Medium, and Large Projects Reporting Green, Yellow, and Red • Portfolio and project financial breakdown by HHS divisions • Number of projects in each phase of the project management lifecycle
MIRP Management	The MIRP Management metric is used to monitor and control the health of QAT-related projects. • Percent of Major Information Resource Projects Reporting Green, Yellow, and Red • Number of projects in each phase of the QAT project management lifecycle
Project Performance Management	The Project Performance Management metric is used to ensure projects are delivered on time and on budget. • Number of Red and Yellow Projects • Number of projects entering the Initiation and Closing phase in the lifecycle • Number of projects requiring additional monitoring or project change request

Performance Metrics	How it is and will be used
QAT Project Reporting	The QAT Project Reporting metric measures the number of reports submitted to the Quality Assurance Team on or before due dates, for each of the following reporting requirements: • Business Case Package (including Statewide Impact Analysis) • Cancellation Letter • Cost Benefit Analysis (CBA) • Monthly Monitoring Report (MMR) • Post Implementation of Business Outcomes (PIRBO) • Project and Acquisition Plan • Project Change Request • Quarter Monitoring Report (QMR) • Revised Business Case

D. History:

PMO was established in December 2024, evolving from the Project Management Center of Excellence (PMCoE). Before this transformation, PMCoE aimed to promote IT project management excellence through training and standard operating procedures. Its mission was to enhance project performance by empowering IT project leaders for successful outcomes. Key areas of focus included project execution, reporting, and benefits realization.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

PMO is an essential part of the CAIO unit, ensuring projects are completed on time and within budget. It manages key IT project controls, reviews documentation, generates reports, supports data-driven decisions, and trains new IT project managers.

G. Funding: See "Agency Program Information" spreadsheet.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

PMO regularly engages with the QAT, which includes members from SAO, DIR, CPA, and Legislative Budget Board (LBB). CAIO ensures compliance with statutory

requirements related to project management, Texas Project Delivery Framework documentation, and regular project monitoring reports, while also responding to inquiries. Monthly and quarterly detailed project status reports for each Major Information Resource Project are provided. Additionally, the PMO collaborates closely with DIR as a member of the Project Delivery Advisory Board.

J-M. Barriers and challenges; Additional, Regulatory, and Complaint information: Not applicable.

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VII. Guide to Agency Divisions and Programs

Office of Audit and Compliance

The purpose of the Office of Audit and Compliance (OAC) is to strengthen Health and Human Services' (HHS) ability to create, protect, and sustain value by providing independent, risk-based, and objective assurance, insight, and foresight. OAC reports directly to the Executive Commissioner and its scope of work includes both Health and Human Services Commission (HHSC) and Department of State Health Services (DSHS). OAC conducts audit work and provides management with information and analyses to assist in initiating improvements to operations and to strengthen internal controls. As part of this work, OAC provides advice and assistance on governance, risk management, and controls and supports HHSC business areas as they continue to work toward more effective and efficient processes. OAC includes two divisions: Internal Audit and Compliance.

Internal Audit Division

A. Name of division or program:

Internal Audit Division (Internal Audit)

Location within the agency: OAC

Contact Name: Nicole Guerrero, Chief Audit Executive, and Rachelle Wood, Internal Audit Division Director

Statutory citation: Government Code, Chapter 2102

B. Objective and major activities:

Internal Audit provides independent, objective audit, assurance, and consulting services designed to add value and improve HHS operations. Audits provide an independent assessment of processes and activities based on evaluating management controls, testing transactions, and reviewing evidence. Internal Audit leadership determines the nature and scope of each audit by assessing risks on HHS processes and programs through a formal risk assessment process. Based on available staff hours, review of audit history, input from executive management, and other factors, audit develops an audit plan for the executive commissioner's

review and input. Projects conclude with written reports that provide information to management detailing the results of the audit and offer suggestions and recommendations for improvement.

C. Effectiveness and efficiency information:

Internal Audit demonstrates cost effectiveness through performance measures, including percentage of staff time spent on direct audit activities and percentage of approved projects completed. Internal Audit reports released by the Division offer recommendations to increase the efficiency of HHS system processes.

D. History: See Section III.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

Internal Audit enhances HHS governance, risk management, and control processes by providing independent and objective assurance, advice, insight, and foresight that protects and enhances HHS programs and operations.

Internal Audit completes at least 18 audits each year in addition to completing a comprehensive and continuous risk assessment of HHS programs and support functions.

G. Funding: See "Agency Program Information" spreadsheet.

H-M. MOUs, Relationships with others, Barriers, Additional, Regulatory, and Complaint Information: Not applicable.

Compliance Division

A. Division or program information

Name of division or program: Compliance Division (Compliance)

Location within the agency: OAC

Contact Name: Nicole Guerrero, Chief Audit Executive, and Jose Garcia, Compliance Division Director

Statutory Citation: Not applicable.

B. Objective and major activities:

Compliance coordinates state and federal external audits and establishes a centralized repository of audit recommendations to ensure the HHS system addresses audit recommendations in a timely manner. Compliance administers the Audit Findings Management (AFM) system, which centralizes all audit recommendations and allows for the tracking, monitoring, and verification of outstanding recommendations to gain compliance. Recommendation statuses include:

- Open (not implemented);
- Rejected (reported as implemented but found to not be implemented upon verification);
- Ready (reported as implemented but has not been verified by audit staff); and
- Closed (implemented and verified).

C. Effectiveness and efficiency information:

Compliance maintains, monitors, and validates internal and external audit recommendations within the AFM. Implementation of AFM increased the efficiency and effectiveness of monitoring audit recommendations by ensuring HHS mitigates and addresses identified audit risks. Additionally, Compliance periodically discusses all open and rejected recommendations with appropriate program management and associated executive management through enhanced coordination meetings.

Compliance validated 163 audit recommendations in fiscal year 2024 and applied an enhanced validation process to an additional 78 audit recommendations to move audit recommendations to closed status. The implementation of the enhanced validation process increased the efficiency of validating lower risk audit recommendations. Compliance continues to reduce findings and associated disallowed costs through the audit coordination process. In fiscal year 2024, Compliance closed 22 projects and continued to coordinate 22 ongoing federal projects, nine ongoing state projects, and seven federal projects in the resolution phase of the audit. Compliance facilitated the successful reduction of over \$400 million in federal audit questioned costs during fiscal year 2024. This resulted in cost savings of 78 percent of the total costs questioned in the audit report.

D. History:

See Section III.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

Compliance instituted an audit resolution process focused on addressing federal audit recommendations and reducing disallowed costs. Through coordination with federal auditors, associated federally assigned resolution officials, and HHSC staff, Compliance facilitates the gathering of additional information to reduce questioned costs.

To increase recommendation verification efficiency, Compliance uses an enhanced validation process. Staff review corrective actions taken and available information to determine whether HHS implemented audit recommendations. Risk level and complexity of the corrective action plans determines the audit recommendations reviewed using the enhanced validation process.

Compliance coordinates audits and reviews conducted by state and federal external entities. The coordination process covers all phases of the audit/review (planning/fieldwork/reporting/resolution) until project closure.

G. Funding: See "Agency Program Information" spreadsheet.

H-M. MOUs, Relationships with others, Barriers, Additional, Regulatory, and Complaint Information: Not applicable.

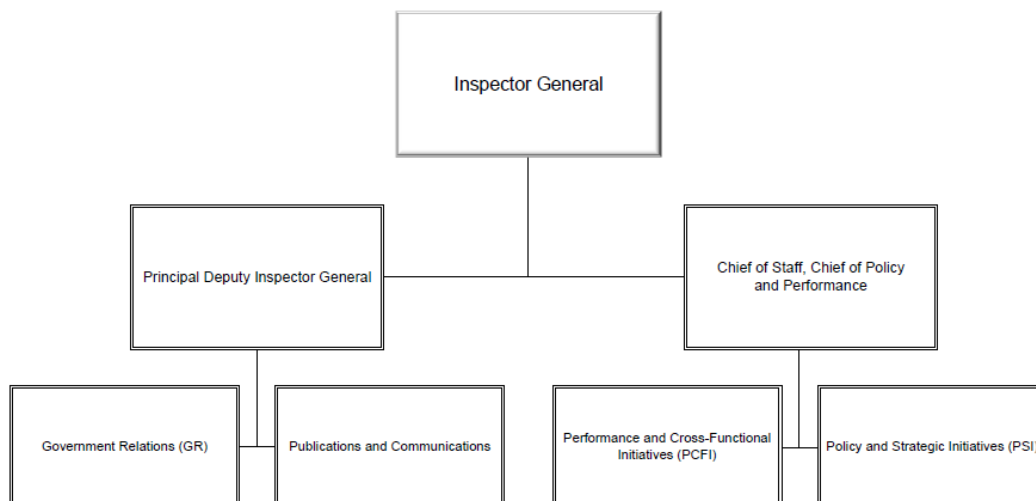
VII. Guide to Agency Divisions and Programs

Office of Inspector General

Established by the Texas Legislature in 2003, the Health and Human Services (HHS) Office of Inspector General (OIG) safeguards the integrity of the state's health and human services programs and ensures the health and welfare of program clients. The OIG achieves this by overseeing health and human services activities, providers, and clients through compliance and enforcement measures aimed at identifying and reducing fraud, waste, and abuse (FWA). Additionally, OIG recovers taxpayer dollars and strives to enhance the efficiency and effectiveness of programs across HHS. OIG also receives reports of FWA from the public, government agencies, and health and human services providers.

Administration

Figure 1. OIG organizational chart.



A. Division or program information:

Name of division or program: Administration

Location within the agency: OIG

Contact name: Susan Biles, Principal Deputy Inspector General

Statutory citation: Texas Government Code, Sections 544.0103 (duties of the office) and 544.0101 (appointment of the Inspector General)

B. Objective and major activities:

Administration is comprised of the Inspector General, the Principal Deputy Inspector General Division, and the Chief of Staff Division.

Inspector General

The Inspector General, appointed by the Governor, manages all agency functions and priorities. The Inspector General is accountable for all OIG activities, directs all OIG initiatives and budgets, and represents the OIG with policymakers and stakeholders.

Principal Deputy Inspector General Division

The Principal Deputy Inspector General supports the Inspector General in the execution of OIG priorities and OIG day-to-day operation and administration. The division includes the Communications and Government Relations (GR) teams, which focus on engaging with and ensuring timely responses to OIG critical stakeholders and coordinating OIG-wide initiatives and special projects.

Communications: Manages press relations, maintains OIG's website and social media platforms, publishes OIG's external-facing reports and work products, and facilitates communication between the Inspector General and various stakeholders.

Government Relations: Serves as the primary liaison between OIG, executive and legislative branches, and key stakeholders. GR develops legislative initiatives and budget requests in addition to monitoring and analyzing legislation with an impact on the OIG. Additionally, GR oversees implementation of new laws, assists legislative offices with constituent inquiries, and communicates with stakeholders. GR ensures executive and legislative leadership offices remain informed about key developments within the OIG.

Chief of Staff Division

The Chief of Staff supports the Inspector General by providing counsel, helping to manage OIG priorities, coordinating projects and initiatives across all OIG areas, and ensuring OIG strategic initiatives are successfully implemented. The division includes the Policy and Strategic Initiatives (PSI) team and the Performance and

Cross Functional Initiatives (PCFI) team, which provide policy and project support across OIG divisions and act as liaisons between OIG, Health and Human Services Commission (HHSC), and outside stakeholders.

PSI: Led by a deputy inspector general who oversees staff that serve as the policy team and serves as a liaison between HHSC and the OIG. The team manages the OIG's centralized risk review process to identify and evaluate potential areas of risk for OIG review, conducts policy research to support OIG functions, makes recommendations to HHSC for policy changes, contract changes, and liquidated damages or corrective action plans based on OIG work, develops and administers managed care training, and leads policy-related projects as needed.

PCFI: Led by a deputy inspector general who directs project managers and analysts in cross-divisional projects, including quality assurance, information technology project development and implementation, rules and audit coordination and consultation, facilitation, and ad hoc research.

C. Effectiveness and efficiency information:

Table 1. OIG metrics, fiscal year 2024.

Metric	Fiscal Year 2024
Principal Deputy Inspector General	
Statutorily Required Reports Published	9
Informational Articles Written for Stakeholders	12
Number of Issued OIG Update Newsletters	12
Reach of OIG Update Newsletter	20,708
Number of Media Inquiries Addressed	28
Number of Legislative Inquiries Addressed	132
Chief of Staff	
Program Integrity Topics Identified, Evaluated, and Approved	14
Policy Clarification Requests Completed	69
Policy and Managed Care Organization (MCO) Contract Changes Submitted	10
Managed Care Trainings Provided to OIG Staff	11
Implementation of Cross-Functional Projects	10
Facilitation of Rule Creation or Amendment	6

Metric	Fiscal Year 2024
Facilitation and Tracking of Responses to External Inquiries, Reviews, and Surveys	6
Initiation and Monitoring of New Information Technology Projects	7
Stakeholder Meetings Facilitated	11

D. History: Not applicable.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

Principal Deputy Inspector General: The GR team and Communications team are each managed by a director who reports to the Principal Deputy Inspector General. Formal policies and procedures exist and are reviewed annually for bill tracking, legislative inquiries, stakeholder inquiries, news media, and digital media management.

Chief of Staff: Led by the Chief of Staff, who also serves as the Chief of Policy and Performance. The two program areas, PSI and PCFI, are each led by a deputy inspector general. Policies, procedures, and job aids exist for quality control and other processes. OIG leadership directs the work of the teams and assigns projects throughout the fiscal year.

G. Funding: See "Agency Program Information" spreadsheet.

Table 2. Funding formulas.

General Revenue	Federal Funds	Other Funds
34.63%	31.78%	33.59% ¹

¹ Other Funds includes interagency contract funding with the Texas Department of Family and Protective Services (DFPS) (25 percent) and the Texas Department of State Health Services (DSHS) (8 percent).

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

Principal Deputy Inspector General: Work with other governmental entities on an ad hoc basis to address specific issues that arise or to assist OIG program areas in

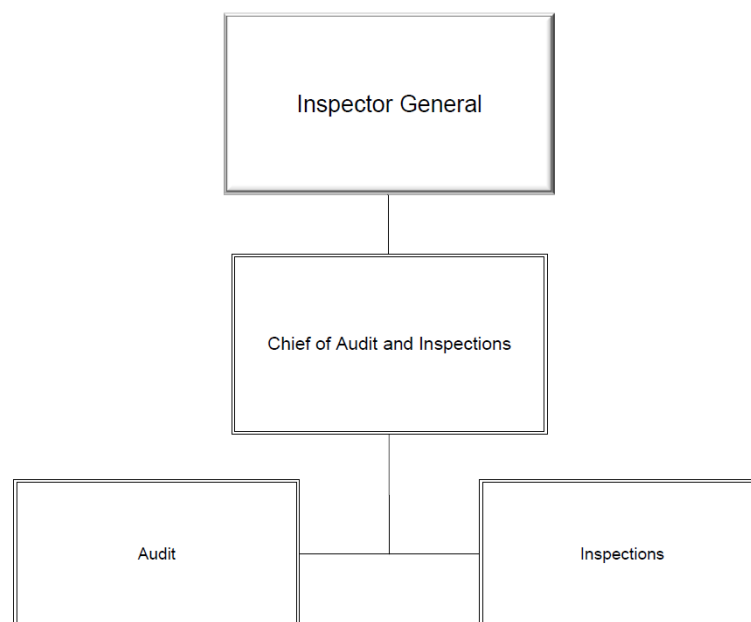
connecting with appropriate entities. This may include, but is not limited to, local law enforcement, prosecutorial entities, federal law enforcement, and regulatory entities.

Chief of Staff: The PCFI team coordinates with the HHSC Office of Audit and Compliance (OAC), OIG leadership and other OIG units to respond to audits, reviews, and other information requests from the U.S. Government Accountability Office (GAO), HHS-Office of Internal Audit, U.S. Department of Health and Human Services' (DHHS) Office of Inspector General, U.S. DHHS Centers for Medicare & Medicaid Services (CMS), U.S. Social Security Administration, auditors contracted by U.S. DHHS or Texas HHS, and other third-party auditors. The PCFI team also facilitates and coordinates meetings with other states' offices of inspectors general and program integrity offices.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Audit and Inspections

Figure 2. Audit and Inspections organizational chart.



A. Division or program information:

Name of division or program: Audit and Inspections

Location within the agency: OIG

Contact name: Kacy VerColen, Chief of Audit and Inspections

Statutory citation: Texas Government Code, Sections 544.0103, 544.0109, 544.0354(b)(1), 544.0108(b) and 544.0109(1)

B. Objective and major activities:

The Audit and Inspections Division is comprised of the following units:

Audit: To help identify and reduce FWA, the Audit team conducts risk-based performance audits related to (a) the accuracy of medical provider payments, (b) the performance of HHS agency contractors, subcontractors, and grantees, (c) programs, functions, processes, and systems within HHS, and (d) local mental and behavioral health authorities. OIG Auditors also perform risk-based follow-up assessments to determine the resolution status of prior audit issues and limited scope audits of provider claims identified as outliers through data analysis algorithms to further assess the risk identified. Audits and reviews are performed in compliance with the Generally Accepted Government Auditing Standards (Yellow Book).

Inspections: Conducts inspections of providers and MCOs that are focused on compliance with applicable statutes and contract provisions as well as FWA. Additionally, inspections evaluate HHS programs, systems, and functions for systemic issues to improve HHS. Inspectors also perform follow-up assessments of actions taken in response to previous inspections. Inspections adhere to the Quality Standards for Inspection and Evaluation (Blue Book).

C. Effectiveness and efficiency information:

Table 3. Audit and Inspections measures, fiscal year 2024.

Metric	Fiscal Year 2024
Audit	
Audits Completed ¹	34
Audit Recommendations ²	87
Inspections	
Inspections Completed ³	9

Metric	Fiscal Year 2024
Inspection Recommendations ⁴	9

¹ LBB performance measure, which includes the total number of reports issued by or on behalf of the OIG audit team.

² Includes the number of recommendations in reports completed by or on behalf of the OIG audit team.

³ Includes the number of reports issued by the inspections team.

⁴ Includes the number of recommendations in reports issued by the inspections team.

D. History:

The audit function has existed since OIG's inception in 2003. The Inspections team was developed in fiscal year 2016 and became a part of the Audit division in fiscal year 2020.

Senate Bill 26, 88th Regular Session, 2023, added the requirement that OIG audit local mental and behavioral health authorities on a revolving basis.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

The Audit and Inspections division is comprised of auditors and inspectors, with directors providing oversight and support staff for coordinating quality review, editing, and distribution of final reports. The audit and inspection process includes three phases: planning, fieldwork (testing), and reporting. Throughout these phases, auditors and inspectors maintain regular communication with the auditee or inspectee.

Planning: During planning, staff consult with program subject matter experts and HHSC policy personnel to understand program operations and identify appropriate criteria for evaluation. They also perform interviews to gain insight into the entity's processes and internal controls. In addition, data is often obtained to gain further knowledge of the entity's operations and to assist with determining the sampling and testing methodologies to be used in fieldwork.

Fieldwork: Fieldwork involves applying knowledge gained during planning to identify potential gaps or control weaknesses. Auditors and inspectors request documentation to verify practices and address discrepancies. Any discrepancies

identified are discussed with the entity, which is given the opportunity to submit additional information to resolve identified issues.

Reporting: Following fieldwork, a draft report is prepared and shared with the entity for review. The entity may submit relevant documentation to clarify or resolve identified issues, and if appropriate, the draft report is revised. Auditees and inspectees are also invited to submit management responses outlining corrective actions to address the findings and recommendations.

All documentation from the planning, fieldwork, and reporting phases is stored in Teammate software, which also guides staff through each step to ensure compliance with applicable standards and internal procedures.

G. Funding: See “Agency Program Information” spreadsheet.

Table 4. Funding formulas.

Department	General Revenue	Federal Funds	Other Funds
Executive Management	34.63%	31.78%	33.59% ¹
Audit	50.49%	42.27%	7.24% ²
Inspections	30.67%	35.74%	33.59% ³

¹ Other funds include interagency contract funding with DFPS (25 percent) and DSHS (8 percent).

² Other funds include interagency contract funding with DFPS (6 percent) and DSHS (1 percent).

³ Other funds include interagency contract funding with DFPS (25 percent) and DSHS (8 percent).

H. MOUs and interagency agreements or contracts: Not applicable.

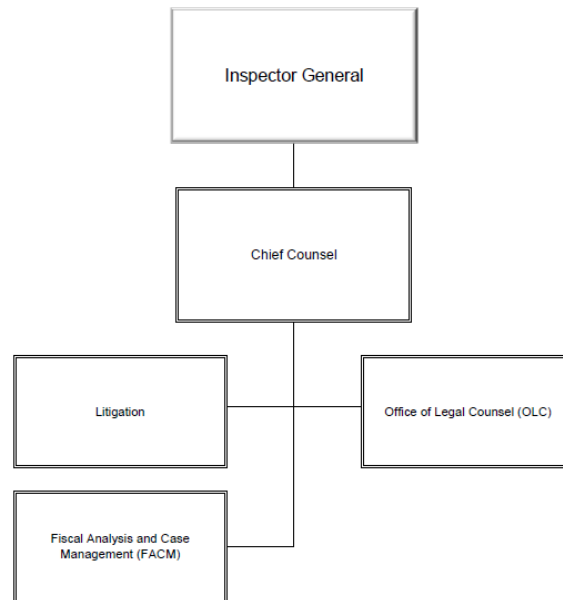
I. Relationship with other governmental entities:

Audit and Inspections work with CMS to give and receive training on Medicaid programs and to seek clarification on federal rules as needed. Additionally, Audit and Inspections works with the Texas Office of the Attorney General (OAG) by referring cases to them for further enforcement actions. Audit and Inspections also coordinate with the OAG Medicaid Fraud Control Unit (MFCU) and OAG Healthcare Program Enforcement Division (HPED) to deconflict potential concurrent audits, inspections, and investigations. Audit and Inspections collaborate with HHSC, DFPS, and the State Auditor’s Office (SAO) to avoid duplication.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Chief Counsel

Figure 3. Chief Counsel organizational chart.



A. Division or program information:

Name of division or program: Chief Counsel

Location within the agency: OIG

Contact name: Erik Cary, Chief Counsel

Statutory citation: Texas Government Code, Sections 544.0102(b)(4) and 544.0052, Texas Human Resources Code, Section 32.039

B. Objective and major activities:

The OIG Chief Counsel Division provides legal counsel and support to the Inspector General. The OIG Chief Counsel Division works collaboratively with the HHSC Office of Chief Counsel, which provides legal support for administrative functions. The OIG Chief Counsel Division is comprised of the following:

Office of Legal Counsel (OLC): Provides legal advice and support to all aspects of the OIG's operations. OLC responsibilities include the following:

- Researching issues, draft policies, procedures, and rules;
- Reviewing and researching audit, inspection, and review criteria when requested;
- Recommending legislative considerations;
- Serving as liaison to HHSC for open records requests;
- Coordinating and processing expunction petitions and orders, bankruptcy filings, and proofs of claim;
- Reviewing draft contracts;
- Ensuring appropriate measures are taken to collect unpaid final debts arising from OIG actions; and
- Managing processes for the sharing of recoveries between OIG and Managed Care Organizations (MCOs) as authorized and required by state statute.

Litigation: Initiates administrative enforcement actions and sanctions resulting from OIG oversight activities and handles any associated appeals. Actions include the following:

- Providing notice and finalizing overpayments, penalties, payment holds, and provider enrollment terminations and exclusions against Medicaid providers for certain program violations; and
- Overseeing and managing the self-disclosure process, which involves providers self-reporting potential Medicaid violations.

Financial Analysis and Case Management (FACM): Supports the OIG Chief Counsel Division in the following ways:

- Processing referrals and open cases;
- Initiating accounts receivable for OIG Chief Counsel Division and other program areas;
- Estimating federal share liability, and initiating federal share payments and reclamation requests of federal share payments;
- Managing the enforcement and allocation of assessed final debt amounts and any associated collections activities, including, but not limited to,

coordinating with OLC to ensure final debts are appropriately accounted for and addressed in bankruptcy proceedings;

- Initiating collection remedies for unpaid final debts;
- Managing the process for sharing of recoveries between OIG and MCOs as authorized and required by state statute; and
- Overseeing the Texas OIG Exclusion Database.

C. Effectiveness and efficiency information:

Table 5. Chief Counsel measures, fiscal year 2024.

Metric	Fiscal Year 2024
Total Dollars Recovered ¹	\$17,158,657
Cost Avoidance from Excluded Provider – Ordered to Pay Restitution	\$2,959,267
Cases Opened	408
Cases Closed	484
Settlements ²	119
Exclusions	219
Payment Holds	6
Education Letters Sent	3

¹ Because Chief Counsel cases largely originate in other divisions, there is overlap in the dollars recovered. These amounts are not double counted in OIG reporting; however, they are included in each area's description in the Self Evaluation Report for informational purposes.

² While there is a potential for overlap between cases closed and the number of settlements, settlements are generally paid overtime, and cases are not considered closed until paid in full.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

The OIG Chief Counsel Division is led by the Chief Counsel, who oversees deputy inspectors general and directors for each of the following:

OLC: Provides general counsel functions for OIG. Most assignments are ad hoc in nature and at the request of a specific program area or OIG administration. Assignments are given to staff attorneys based on areas of expertise and workload. Project timelines vary based on the urgency of the request, the amount of research necessary, and the desired end-product – e.g., formal memo, email response, or meeting.

Litigation: Receives case assignments from FACM. Once a case is opened, the director of litigation assigns it to a staff attorney, who directs all necessary activities under the oversight of OIG Chief Counsel leadership.

Each week, staff attorneys present cases to the OIG Litigation Review Committee for initial input on legal theories and strategic direction. Key case decisions—such as issuing subpoenas, sending notices of administrative action, conducting examinations under oath, and evaluating settlement offers—are routed through the OIG Chief Counsel chain of command.

Case resolution timelines vary based on factors such as the need for additional evidence, the provider's level of cooperation, the feasibility of settlement, and, if pursued, the duration of litigation. (See Appendix 19: Major Process Maps for OIG Enforcement Action Process Flow and OIG Appeals Flowchart.)

Financial Analysis and Case Management Section: FACM staff open cases based on referrals from OIG program areas, other state agencies (e.g., licensing boards, the OAG), provider self-reports, or self-generated matters from Litigation. Cases are then assigned, based on type and workload, to either FACM staff or Litigation attorneys, as directed by the director of litigation. FACM handles mandatory action cases, including exclusions, terminations, and contract cancellations.

In coordination with the Texas Medicaid & Healthcare Partnership (TMHP), FACM establishes accounts receivable for final debts resulting from OIG recoveries. FACM also manages collection activities for unpaid debts in collaboration with the OAG, OLC attorneys, and TMHP. FACM staff research and review federal data matches and take appropriate actions based on the results. They also coordinate bankruptcy matters, routing them to internal stakeholders and serving as the liaison with the HHSC Office of Chief Counsel Legal Services Division.

G. Funding: See "Agency Program Information" spreadsheet.

Table 6. Chief Counsel funding formulas.

Department	General Revenue	Federal Funds	Other Funds
Executive Management	34.63%	31.78%	33.59% ¹
Chief Counsel	50.11%	49.89%	0.00%

¹ Other funds include interagency contract funding with DSHS (25 percent) and DFPS (8 percent).

H. MOUs and interagency agreements or contracts:

OIG, OAG MFCU, and OAG HPED work together under a statutorily required MOU that ensures cooperation in detecting, investigating, and prosecuting Medicaid fraud. While OIG has jurisdiction over administrative matters, OAG has jurisdiction over criminal and civil fraud matters. Specifically, OAG MFCU conducts criminal investigations into allegations of fraud, physical abuse, neglect, and exploitation by health care providers in the Medicaid program. OAG's HPED is primarily responsible for civil enforcement of health care fraud. OIG refers potential fraud cases that may warrant civil or criminal enforcement action to OAG MFCU or OAG HPED.

Coordination activities include monthly meetings on cases being developed and a clear division of responsibilities. OAG HPED intervenes in privately filed *qui tam* actions and then elects to proceed in civil litigation. OIG provides investigative and supporting attorney resources to OAG HPED when requested by OAG and refers cases to OAG HPED that are more appropriately pursued in state district court. In addition to standing meetings, OAG and OIG units coordinate activities and strategies on an ad hoc basis, subject to ethical and legal restrictions on civil/criminal case coordination.

OLC maintains MOUs with licensing boards for the purpose of accessing criminal history record information obtained by the respective licensing boards. OIG uses this information during the enrollment and reenrollment of providers seeking to participate in the state's health care programs. The licensing boards include DFPS, DSHS, Texas Medical Board, Texas Board of Nursing, Texas State Board of Dental Examiners, Texas Department of Licensing and Regulation, Executive Council of Physical and Occupational Therapy Examiners, Texas Optometry Board, Texas Board of Chiropractic Examiners, Texas Behavioral Health Executive Council and Texas Board of Pharmacy.

OLC also maintains an memoranda of agreement (MOA) with the National Insurance Crime Bureau to allow the parties to share all information allowed by law to help prevent FWA.

I. Relationship with other governmental entities:

The OIG Chief Counsel Division works with federal agencies including the Department of Justice (DOJ), the Federal Bureau of Investigation (FBI), and CMS; state agencies including licensing agencies such as the Texas Department of Insurance and the Texas Department of Licensing and Regulation, as well as Texas and other states' criminal and civil Medicaid fraud control units; and local agencies including law enforcement and prosecutors to coordinate and deconflict criminal investigation and prosecution activities.

J. Barriers and challenges:

Challenge 1, Appeals: OIG due process procedures vary depending on the type of violation or dollar amount in question. These differences are driven by statute or rules and may involve varying deadlines for appealing adverse decisions, as well as different forums for dispute resolution.

Texas Government Code, Section 544.0507, governs appeals procedures for OIG investigations; however, in *Phillips v. McNeil*, 635 S.W.3d 620, 629-630 (Tex. 2021) the Texas Supreme Court held that the OIG failed to comply with this statute by not providing a hearing at the State Office of Administrative Hearings (SOAH) for an audit. The Court determined that the audit in question amounted to an "investigation of potential abuse," but the Court did not confirm whether the ruling would apply to OIG matters beyond the circumstances described in that case.

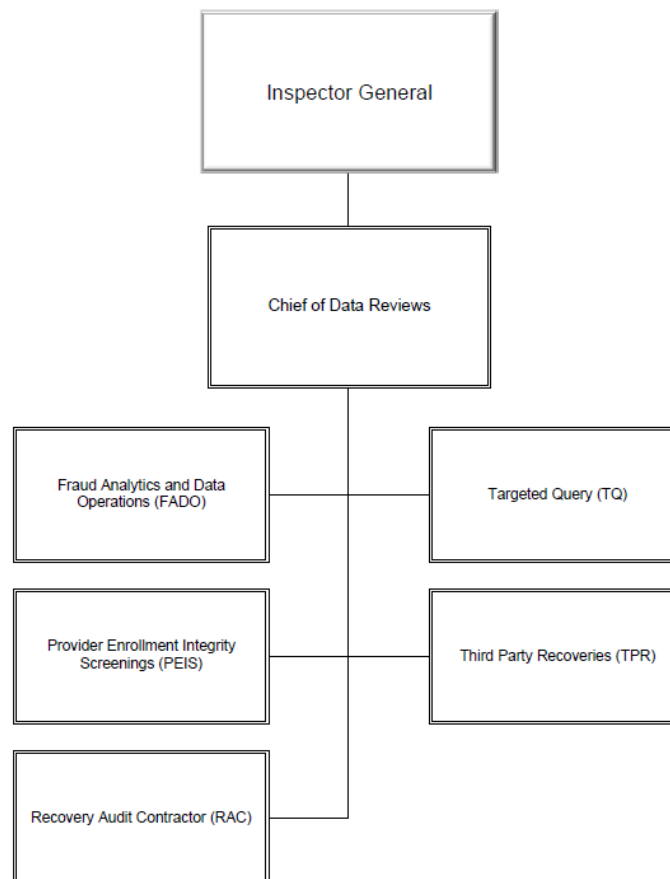
Challenge 2, CAF Holds: 42 CFR Section 455.23(a)(1) requires OIG (state Medicaid agency, etc.) to suspend all Medicaid payments to a provider if an investigation determines there is a credible allegation of fraud against that provider; this is known as a CAF (credible allegation of fraud) hold. Texas Government Code, Section 544.0303(d)(3)(B), which defines in State law when OIG may impose a payment hold requires the OIG to show that a person's CAF presents (i) a "significant risk to the State"; and (ii) a "threat to the integrity of the Medicaid" program. However, the state statute does not define any of the terms in these phrases nor does it provide assistance in interpreting this language.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Data Reviews

Data Reviews leverages data and technology to build tools and processes that effectively and efficiently prevent, detect, and deter FWA within Texas Medicaid and other health care programs, helping ensure that taxpayer funds for health and human services are spent properly.

Figure 4. Data Reviews organizational chart.



Fraud Analytics and Data Operations (FADO)

A. Division or program information:

Name of division or program: Fraud Analytics and Data Operations

Location within the agency: OAG, Data Reviews Division

Contact name: Diane Salisbury, Chief of Data Reviews

Statutory citation: Texas Government Code Sections 544.0103, 544.0451, 544.0152, and 544.0453

B. Objective and major activities:

FADO supports audits, investigations, inspections, and reviews through data analytics, data-informed research, sampling statistical models, and other support services described below. It is broken up into the following teams:

Fraud Analytics (FA): Responsible for performing advanced data analytics to proactively detect potential FWA by identifying trends and patterns that are used to self-initiate or support investigations, reviews, audits, and inspections. FA develops complex algorithms and models to analyze the behavior and billing practices of providers, clients, retailers, and MCOs.

FA also supports data initiatives projects, which focus on detecting program violations by Medicaid providers, using advanced algorithms to identify similar patterns of improper billing and reimbursement behavior across Medicaid providers that can be evidenced through data. Data initiative identified overpayments results in leads that are referred for investigation and litigation activities as appropriate.

Data Operations (DO): Oversees data management functions, conducts data-informed policy research, develops data intelligence solutions, and provides data system and application support to OIG. The team develops sampling and statistical models to support OIG investigations, reviews, audits, and inspections; designs, develops, and maintains OIG data visualization tools and operational dashboards; performs data queries and analyses; coordinates with the HHSC claims administrator and MCOs to collect and compile data to support OIG's work; and serves as the liaison with HHSC Information Technology and external vendors to enhance and maintain OIG's FWA technology systems.

C. Effectiveness and efficiency information:

Table 7. FADO measures, fiscal year 2024.

Metric	Fiscal Year 2024
Number of Data Requests Received ¹	562

Metric	Fiscal Year 2024
Number of Data Requests Completed ²	558
Number of Algorithms Executed ³	344
New Algorithms Developed ⁴	5

¹ This is the number of requests submitted to FADO. The data requests include ad hoc data pulls, data analysis and validation, provider analyses, statistical analysis and extrapolations, technical assistance with tools and systems, data research and analytical support, and special projects.

² This is the number of requests submitted by OIG divisions to FADO that have been completed. The data requests include ad hoc data pulls, data analysis and validation, provider analyses, statistical analysis and extrapolations, technical assistance with tools and systems, data research and analytical support, and special projects.

³ This measure is a count of “production” algorithms, which are algorithms that are programmed in a particular style with the intent to be replicated over time.

⁴ This measure is a count of “newly developed” algorithms. New algorithms are those that are developed in response to an identified behavior or pattern or in support of an investigation, audit, exploratory, or other ad hoc request.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

The two teams within FADO are each led by a deputy director who reports to the Chief of Data Reviews.

FA: Develops and maintains FWA detection algorithms and models, which include both rules-based approaches and the application of artificial intelligence/machine learning (AI/ML), and other statistical methods. FA delivers identified leads and risks from its algorithms and models to OIG stakeholders through its data analytics products, including dashboards and custom reports. In addition, FA is tasked with continuous monitoring and evaluation of algorithms and models to ensure sustained accuracy, effectiveness, and relevance over time. FA is responsible for maintaining documentation, metadata, and lineage information for algorithms, models, dashboards, and reports developed.

FA plays a supporting role in investigations, audits, inspections, and reviews by fulfilling ad-hoc data analytics requests, interpreting analytics outputs, providing

visual summaries, and offering consultative data and analytics expertise to OIG customers to support data-informed decision-making.

DO: Comprised of three operational teams: Data Research and Support, Statistical Analysis and Data Visualization, and Data Strategy.

The Data Research and Support team is responsible for data acquisition and validation of paid claims requests in support of OIG audits, investigations, inspections, and reviews; oversight and direction of all Medicaid Fraud Abuse Detection System (MFADS) projects; support for internal utilization review systems; coordination with external technology vendors/entities on behalf of OIG; and the development and administration of all OIG SharePoint sites.

The Statistical Analysis and Data Visualization team is responsible for the design and development of all statistically valid random samples and extrapolations for audits and investigations, provider analysis development and support, and administration of all OIG Tableau dashboards.

The Data Strategy team is responsible for assisting all OIG areas in the development of data strategy approaches (what data is available and how to structure/complete data requests) and data policy research and analysis functions.

G. Funding: See "Agency Program Information" spreadsheet.

Table 8. FADO funding formulas.

Department	General Revenue	Federal Funds	Other Funds
Executive Management	34.63%	31.78%	33.59% ¹
Data Operations	37.48%	40.54%	21.98% ²
Data and Technology	49.99%	50.01%	0.00%
MFADS Contract 50/50	50.00%	50.00%	0.00%
MFADS Contract 75/25	25.00%	75.00%	0.00%

¹ Other Funds includes interagency contract funding with DFPS (25 percent) and DSHS (8 percent).

² Other Funds includes interagency contract funding DFPS (17 percent) and DSHS (8 percent).

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

FADO provides data assistance to OAG MFCU, OAG HPED, and federal partners such as the U.S. Department of Health and Human Services Office of Inspector General, DOJ, and FBI. The data assistance provided includes data acquisition, data analysis, and summary reports to support active investigations and initiatives.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Provider Enrollment and Integrity Screenings

A. Division or program information:

Name of division or program: Provider Enrollment Integrity Screenings

Location within the agency: OIG, Data Reviews Division

Contact name: Diane Salisbury, Chief of Data Reviews

Statutory citation: Texas Government Code, Sections 544.0151, 544.0152, 544.0153, 544.0154, and 544.0155

B. Objective and major activities:

The Provider Enrollment Integrity Screenings (PEIS) unit conducts federal and state-required screening activities for providers seeking to enroll in Texas Medicaid, Children's Health Insurance Program (CHIP), and other state health care programs. This may include reviewing ownership, disclosures, licensure, criminal history, and site visits, based on the level of risk associated with the provider or provider type. The screenings prevent FWA and protect the health and safety of Texans by preventing providers who do not meet minimum standards from entering the program.

OIG screens all newly enrolling and re-enrolling providers, all high- and moderate-risk revalidating providers, and any other providers that match against federal or state databases or disclose information in their application requiring further review. On average, about 20-22 percent of all enrollment applications are routed to OIG for screening.

C. Effectiveness and efficiency information:

Table 9. PEIS Measures, fiscal year 2024.

Metric	Fiscal Year 2024
Percentage of Timely Completion (<10 days) ¹	93.83%
Provider Enrollment Applications Processed ²	26,538
Individuals Screened ³	76,086

¹ Texas Government Code, Section 544.0155 requires that the PEIS team complete all state and federally required screenings within 10 days of receiving a complete provider enrollment application. Compliance is calculated by comparing the number of applications processed within 10 days with the total number of applications processed in the reporting month.

² The total number of applications processed at the National Provider Identifier (NPI)-level.

³ Total number of individuals and entities screened by OIG as part of a provider enrollment application or informal desk review (IDR). Each provider enrollment application may contain multiple individuals (owners, managing employees, performing providers, etc.) who need to be screened.

D. History:

OIG's provider enrollment screenings have increased with the deployment of the Provider Enrollment Management System (PEMS) in December 2021, which identifies more high-risk screenings and additional provider types required to undergo OIG screening to enroll in Texas Medicaid and other HHS programs. Prior to this system change, providers were required to submit a separate application for each provider type and practice location. PEMS allows for enrollment at the National Provider Identifier (NPI) level, meaning one application may include multiple different provider types and practice locations, substantially increasing the size and complexity of the application. All associated provider types and practice locations must be screened at the highest level applicable to any part of the NPI-based enrollment application. This has contributed to extended processing times for all aspects of provider enrollment, including the required screenings completed by PEIS.

E. Qualifications or eligibility requirements:

Providers seeking to enroll, re-enroll, or revalidate their enrollment in Texas Medicaid and other state health care programs are required to meet program requirements, as defined by federal and state laws and rules. These requirements apply to individual providers, performing providers, group providers, facility providers, and their owners, partners, officers/directors, and managing employees.

F. Administration and key processes:

Providers seeking to enroll, re-enroll, or revalidate their enrollment in Texas Medicaid or other health care programs are required to be screened based on their assigned risk level as a prerequisite for participation. Categorical risk levels are assigned by CMS or, for Medicaid-only provider types, HHSC (in collaboration with OIG) based on the provider type's risk of FWA. Many of the provider enrollment requirements are prescribed by CMS rules in the Code of Federal Regulations (CFR). More detailed technical guidance is provided by CMS through the [Medicaid Provider Enrollment Compendium](#) (MPEC).

The provider enrollment process in Texas requires close collaboration between Medicaid and CHIP Services (MCS), TMHP contractors, and OIG.

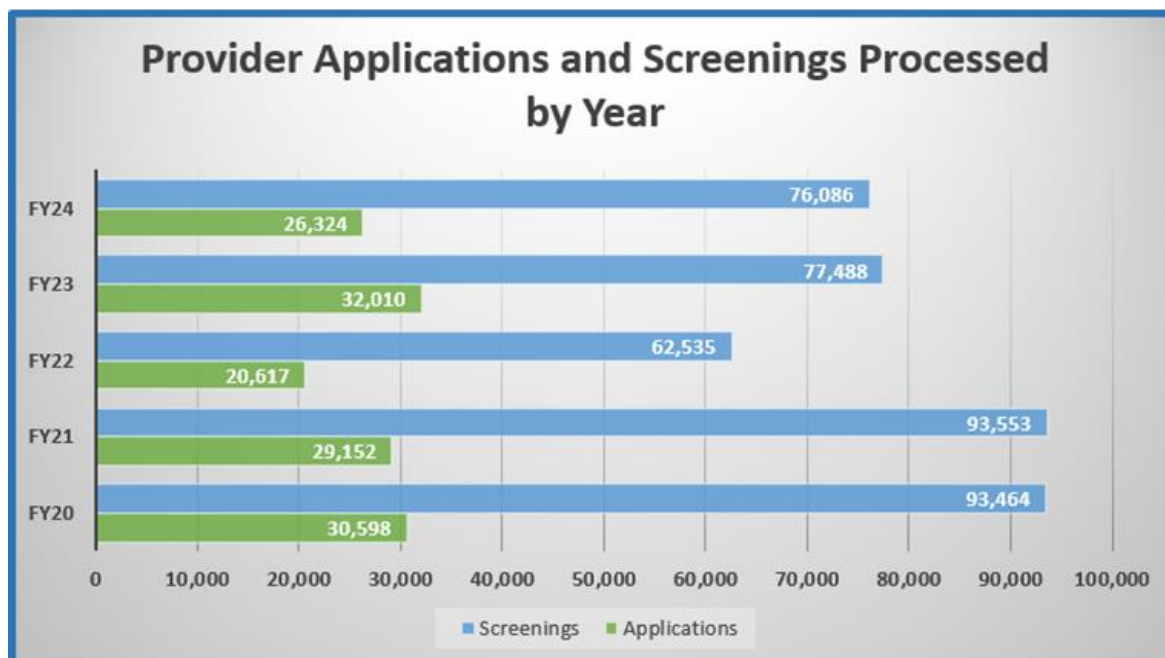
The PEIS team receives enrollment applications electronically via PEMS and conducts the following screening activities prior to making an enrollment recommendation and returning the application to TMHP. Certain activities apply only to moderate- and high-risk provider types, as assigned by CMS or, for Medicaid-only provider types, assigned by HHSC in collaboration with OIG.

- Criminal history background checks through the Texas Department of Public Safety (including FBI fingerprint checks for high-risk providers).
- License verification with the applicable licensing authority for the individual's occupation, including any actions taken against the individual's license (e.g., Texas Medical Board, Texas State Board of Dental Examiners, Texas Department of Licensing and Regulation, etc.).
- Review of any sanctions imposed (e.g., recoupments, payment holds, cancellations, debarments, suspension, exclusion, revocation, etc.).
- Medicare verification for moderate- or high-risk provider types that are required to be enrolled in Medicare prior to enrolling in Medicaid.
- Review site visit documentation for moderate- or high-risk providers.
- Review of disclosures (e.g., board orders, corporate integrity agreements, etc.).

On average, over the last five years, PEIS conducted approximately 80,625 individual screenings across 27,740 applications per year.

The following chart depicts the total number of applications processed and associated screenings completed by OIG for fiscal years 2020-24.

Figure 5. Provider applications and screenings processed, fiscal year 2020-24.



Note that the PEMS system was deployed in December 2021. Prior to PEMS, providers enrolled at the Texas Provider Identification (TPI) level (individual application per line of business/practice location). In PEMS, providers enroll at the National Provider Identification (NPI) level, meaning that applications are now more complex, including multiple programs, provider types, and locations.

G. Funding: See "Agency Program Information" spreadsheet.

Table 10. PEIS funding formulas.

Description	General Revenue	Federal Funds
PEIS	48.83%	51.17%
Fingerprint Checks	50.00%	50.00%

H. MOUs and interagency agreements or contracts:

MOUs for access to a licensing board's criminal history record information are discussed in the OIG Chief Counsel's response.

I. Relationship with other governmental entities:

CMS establishes many of the provider enrollment program integrity requirements that state enrollment processes must adhere to. Failure to appropriately screen and enroll providers in compliance with federal program integrity requirements may result in audit findings and potential loss or recoupment of federal funding.

PEIS works closely with HHSC MCS, Texas Medicaid Healthcare Partnership (TMHP) enrollment contractors, and CMS to ensure that health care professionals and medical entities are enrolled into Texas Medicaid and other state programs in accordance with state and federal requirements.

As described in previous questions, PEIS also works with professional licensing boards to validate licensure and examine board actions and orders.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Third Party Recoveries

A. Division or program information:

Name of division or program: Third Party Recoveries

Location within the agency: OIG, Data Reviews Division

Contact name: Diane Salisbury, Chief of Data Reviews

Statutory citation: Human Resources Code, Sections 32.0421-32.0424 and 32.04242; Texas Government Code, Sections 532.0059 and 546.0403; 42 United States Code, Sections 1396p(b) and 1396a(a)(25), and 42 CFR Sections 433.135-433.154

B. Objective and major activities:

Under Section 1902(a)(25) of the Social Security Act, states are required to gather information about other liable third parties to ensure that Title XIX of the Social Security Act (Medicaid) funds are used for the payment of medical services only after all available third-party resources have been exhausted. With the exception of a few waiver programs, Medicaid is required to be the payor of last resort, meaning that any other third parties liable for a payment must pay before Medicaid. A third party is any individual, entity, or program liable for medical assistance provided to a Medicaid participant. Examples include private insurance carriers, cash medical assistance from child support arrangements, and responsible party insurance coverage related to accidents or injuries.

Third Party Recoveries (TPR) works to ensure that Medicaid is the payor of last resort by preventing payments and recovering Medicaid funds spent on services

that a third party is primarily responsible for paying. TPR also oversees the Medicaid Estate Recovery Program (MERP), a federally mandated program that recovers the costs of Medicaid long-term care benefits received by certain Medicaid recipients.

Note: TPR refers to the OIG unit; TPL refers to third-party liability processes, many of which are carried out by the Texas Medicaid Business Operations contractor.

C. Effectiveness and efficiency information:

Table 11. TPR measures, fiscal year 2024.

Metric	Fiscal Year 2024
Cost Avoidance ¹	\$168,645,943
TPR Total Identified Recoveries	\$949,264,071
TPR Gross Recoveries ²	\$276,794,427
TPL Gross Recoveries	\$76,180,540
Medicaid Estate Recovery Program Recoveries ³	\$5,855,903
Cash Medical Support Payment Recoveries	\$194,757,984
Liquidated Damages Recommended	\$125,000

¹ Cost avoidance is calculated based on the Medicaid-allowed portion of a claim that was submitted to Medicaid but denied due to the identification of other health insurance that should be the primary payor. The Medicaid allowed amount, rather than the billed amount, is counted for this measure in order to identify true cost savings to the program.

² This is used in the calculation of the LBB performance measure, Total Recoveries. It includes TPL, MERP, and Cash Medical Support Payment gross recoveries.

³ Recovery of the costs paid by Medicaid for long-term care benefits received by certain people on Medicaid after their death.

D. History:

The TPR unit has transitioned between HHSC and OIG over the years. Prior to 2015, TPR was part of OIG. In 2015, the TPR unit was moved to HHSC. In 2018, TPR returned to OIG.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

TPR is led by a director who reports to the Chief of Data Reviews.

The TPR unit is comprised of components described below. Texas relies on contractors to carry out these functions on behalf of the State, and the TPR team manages and oversees the related contracts and program functions.

TPR oversees a contract with the Texas Medicaid Business Operations contractor for the following:

- Identification of Liable Third Parties: This occurs either when clients report a liable third party (e.g., commercial insurance coverage) or when the State or its contractor identifies liable third parties through data-sharing and matching agreements.
- Cost Avoidance: When a primary payor is identified either through client disclosure or automatically through claims processing, claims are denied, and the provider is instructed to bill the other insurance first.
- Cost Recovery (Pay & Chase): When Medicaid or CHIP pays a claim, but data matching activities later determine that a primary payor should have been responsible, TPR seeks reimbursement from the liable third party (e.g., a commercial insurance carrier).
- Subrogation (Tort): When a Medicaid or CHIP client is injured, TPR seeks recovery of Medicaid or CHIP expenditures related to the client's injuries from any settlement with, or judgment against, a liable third party.

Additionally, TPR oversees:

- Cash Medical Support Payments: On behalf of TPR, OAG recovers cash medical support payments that are designated in a support order for medical purposes and that a child's caretaker has assigned to the State as a condition of Medicaid or CHIP eligibility.
- MERP: Involves the repayment of Medicaid expenditures from the estate of a deceased Medicaid recipient who received certain long-term care services through Medicaid, as required by 42 CFR Section 433.36 and the Social Security Act Section 1917(b).

Finally, MCOs are also required to cost avoid and recover from liable third parties. MCOs have 120 days to recover costs for prescriptions and medical services that should have been paid for by a third party. After 120 days, the state's TPR process will attempt to recover the funds and will then retain, in full, all recoveries received.

After 365 days from adjudication of a claim, the MCO loses all rights to pursue or collect any recoveries subject to TPR.

G. Funding: See “Agency Program Information” spreadsheet.

Table 12. TPR funding formulas.

Department	General Revenue	Federal Funds	Other Funds
Third Party Recoveries	50.00%	50.00%	
Motor Vehicle Program (MVP) Contract	50.00%	50.00%	
MERP Contract ¹			100.00%

¹ MERP is funded from appropriated receipts from estimated revenues in Fund 8044, which includes Medicaid revenue collections.

H. MOUs and interagency agreements or contracts:

OIG has an interagency contract with OAG for the reporting of Title IV-D child support case referrals where other insurance has been identified and for recovery of the associated cash medical support payments.

Additionally, OIG has an MOU with the Texas Comptroller’s Office (CPA) to identify potential recoveries in the Texas Achieving a Better Life Experience (ABLE) program. The ABLE program allows certain individuals to put funds aside in a protected savings account to be used for the individual’s care without counting against Medicaid eligibility resource limits. When an individual with an ABLE account passes away, the CPA notifies both TPR and the Texas Medicaid Business Operations contractor. If the individual received any Medicaid services during the time in which the ABLE account was in effect, the state may pursue recovery from remaining funds in the account.

I. Relationship with other governmental entities:

As discussed above, TPL works with OAG and CPA.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Targeted Queries

A. Division or program information:

Name of division or program: Targeted Queries

Location within the agency: OIG, Data Reviews Division

Contact name: Diane Salisbury, Chief of Data Reviews

Statutory citation: Texas Government Code, Section 544.0102

B. Objective and major activities:

The Targeted Queries (TQ) unit uses data analytics to identify improper payments in Medicaid claims and works with providers to recover overpayments. The TQ model uses algorithms that can be replicated over time to detect ongoing patterns of waste or abuse in provider billing to recover misspent Medicaid funds for common errors or schemes. The model is also designed to identify lower-dollar overpayments that occur across a high volume of providers, such as payments made after a client's date of death or billing for home health services when a client is hospitalized.

C. Effectiveness and efficiency information:

Table 13. TQ measures, fiscal year 2024.

Metric	Fiscal Year 2024
Dollars Recovered ¹	\$5,823,615
MCO Identified Overpayments	\$2,889,055
Fee for Service Identified Overpayments	\$3,719,384
Cases Opened	1,057
Cases Closed	1,278

¹ This is included in the LBB Measure, Total Dollars Recovered.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

TQ is led by a manager who reports to the Chief of Data Reviews. The TQ unit obtains retrospective payment review targets based on algorithms that detect potential FWA evidenced purely through data. The algorithms are typically run by either OIG's FADO team or the TMHP Claims Administration contractor. The TQ unit confirms algorithm findings with applicable policy requirements, reviews the data, develops provider letters, and engages providers for potential recoveries.

G. Funding: See "Agency Program Information" spreadsheet.

Table 14. TQ funding formulas.

General Revenue	Federal Funds
50.00%	50.00%

H-M. MOUs, Relationships, Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Recovery Audit Contractor

A. Division or program information:

Name of division or program: Recovery Audit Contractor

Location within the agency: OIG, Data Reviews Division

Contact name: Diane Salisbury, Chief of Data Reviews

Statutory citation: Texas Government Code, Sections 544.0504; 42 USC Section 1396(a)(a)(42)(B); and 42 CFR Sections 455.500-518.

B. Objective and major activities:

The Medicaid Recovery Audit Contractor (RAC) program is a federally required program through which the state contracts with a vendor to identify and recover Medicaid overpayments using both data analytics and clinical reviews of medical records. The unit has historically operated in Medicaid fee-for-service only. However, House Bill (H.B.) 142, 89th Regular Session, 2025, expands the RAC program into managed care effective September 1, 2025.

C. Effectiveness and efficiency information:

Table 15. RAC measures, fiscal year 2024.

Metric	Fiscal Year 2024
Net Recoveries ¹	\$66,491,493
Identified Recoveries	\$67,801,816

¹ Net Recoveries are gross recoveries less contingency fees. This is used in the calculation of LBB Measure, Total Recoveries.

In addition to LBB performance measures, the RAC unit performs contract monitoring activities to ensure the RAC vendor's compliance with contract terms (e.g., completeness, timeliness, and accuracy of deliverables). Contract requirements that are regularly reviewed include:

- Medical record requests (MRR): Ensuring that the RAC vendor is not exceeding the mailing limitations established by OIG.
- Reducing potential redundancy: Ensuring that deconfliction takes place in accordance with OIG policies and procedures.
- Appeals success rate: Ensuring that the RAC vendor demonstrates quality work in identifying improper Medicaid payments by maintaining a 95 percent success rate.
- Scenario development: Confirming that the RAC vendor presents new scenarios for potential review in accordance with contract terms and applicable policies.

D. History:

Texas implemented the RAC program within HHSC in 2013. In 2016, oversight of RAC program activities was transitioned to OIG.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

RAC program functions are coordinated between OIG, MCS, the RAC vendor, and HHSC's TMHP claims administrator.

- OIG oversees the RAC program and manages the RAC vendor contract. OIG serves as the programmatic liaison between the RAC vendor, HHSC's TMHP claims administrator, and other HHSC areas with respect to RAC-related issues.
- The RAC vendor identifies improper payments by comparing Medicaid claims data with applicable federal and state laws, rules, and policies governing Texas Medicaid.
- The RAC vendor proposes scenarios to the OIG RAC team for review. Scenarios must be reviewed and approved by OIG RAC personnel and HHSC MCS policy staff. When a new scenario is approved, the RAC vendor will test the scenario on a limited number of claims and review the results with the OIG before full implementation (See [Attachment 19: Process Flowcharts](#), RAC Scenario Reviews).
- HHSC's TMHP claims administrator recovers RAC-identified overpayments through provider billing offsets.
- HHSC MCS' Office of the Medical Director performs complex RAC appeals, and HHSC MCS' Provider Resolution and Administrative Appeals (PRAA) team conducts automated RAC appeal reviews.

G. Funding:

Table 16. RAC funding.

Strategy	General Revenue	Federal Funds
B.1.1	\$5,425,572	\$5,425,572
K.1.1	\$54,943	\$54,943

Table 17. RAC funding formulas.

General Revenue	Federal Funds
50.00%	50.00%

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

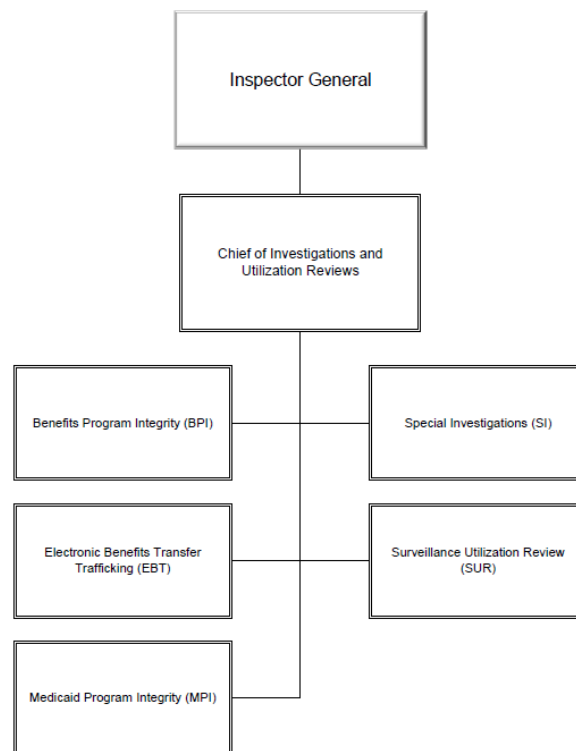
The RAC unit coordinates with MCS and OAG on deconfliction activities.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Investigations and Utilization Reviews

The Investigations and Utilization Reviews (IUR) Division protects the integrity of HHS through investigations and reviews of HHS programs and systems. This includes oversight of providers, retailers, and clients, as well as oversight of HHS employees through Internal Affairs (IA) and the State Center Investigations Team (SCIT).

Figure 6. Investigations and Utilization Reviews organizational chart.



Benefits Program Integrity

A. Division or program information:

Name of division or program: Benefits Program Integrity (BPI)

Location within the agency: OIG, IUR Division

Contact name: Steve Johnson, IUR Chief

Statutory citation: Texas Government Code, Sections 544.0103(e) and 544.0402; 7 CFR Section 273.16(a)(1); and 7 USC Sections 2014 and 2015

B. Objective and major activities:

BPI investigates allegations of overpayments to and improper enrollments of health and human services program clients in the Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF) program; Medicaid; CHIP; and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

C. Effectiveness and efficiency information:

Table 18. BPI measures, fiscal year 2024.

Metric	Fiscal Year 2024
Number of Completed Investigations ¹	16,707
Claims Established (Dollars Identified for Recovery) ²	\$86,611,879
Dollars Recovered ³	\$53,746,019
Total Number of Investigations Opened	17,103
Total Investigations Cleared in Less than 180 Days	15,295

¹ Completion is defined by either “no claim” (the equivalent of a closure), submission for criminal prosecution, submission for an administrative hearing, or by sending an overpayment demand letter for agency and client errors. This is used in the calculation of LBB performance measure, Number of Completed Provider and Recipient Investigations.

² Calculated in the Automated System for the Office of Inspector General (ASOIG) by totaling all claims submitted using the above completed investigation criteria for adjudication.

³ Calculated by HHS Fiscal Management Accounts Receivable by totaling all payments received from beneficiaries for a given timeframe. This is used in the calculation of LBB performance measure, Total Dollars Recovered.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

BPI is led by a deputy inspector general who reports to the IUR Chief. BPI is comprised of two areas: Intake and Full-Scale. BPI receives referrals concerning

beneficiary FWA from HHSC Access and Eligibility Services (AES), OIG’s public-facing website, and OIG’s public-facing telephonic hotline. BPI’s Intake Unit is responsible for reviewing all referrals from AES and from the public regarding beneficiary FWA to assess if an overpayment exists and to investigate cases with the highest potential for recovery. Once Intake has made a determination, the referral is either closed or it progresses to a full-scale investigation and is assigned to an investigator. Full-scale investigators have 180 days to gather evidence and determine whether an overpayment exists.

If an overpayment is identified the case can be resolved in one of three ways: 1) client declines a hearing and agrees to repay the amount; 2) the client is referred for an administrative disqualification hearing; or 3) in cases of criminal fraud, the client may be referred to the local prosecuting authority.

G. Funding: See “Agency Program Information” spreadsheet.

Table 19. BPI funding formulas.

Department	General Revenue	Federal Funds	Other Funds
Executive Management	34.63%	31.78%	33.59% ¹
BPI	48.89%	51.11%	0.00%
County District Attorneys – FS	0.00%	100.00%	0.00%
County District Attorneys – Medicaid	50.00%	50.00%	0.00%

¹ Other Funds includes interagency contract funding with DFPS (25 percent) and DSHS (8 percent).

H. MOUs and interagency agreements or contracts:

BPI maintains Interlocal Cooperation Contracts with individual counties and their associated judicial districts. The contracts outline OIG’s responsibilities in investigating FWA and subsequent referral to the local prosecuting authority. The contracts outline the county or district attorneys’ responsibilities in prosecuting cases referred by OIG. The contracts also outline the monetary payment that OIG will make to the local prosecuting authority to help offset the cost to prosecute and contain a data use agreement.

I. Relationship with other governmental entities:

BPI interacts with the following local and federal units of government:

- Local Prosecuting Authorities: District and county attorneys across the state that accept criminal referrals for beneficiary fraud submitted by OIG.
- Local Law Enforcement: Joint investigations with local law enforcement can occur when jurisdiction may overlap for criminal investigations.
- Federal Law Enforcement Agencies: Joint investigations with federal law enforcement when jurisdiction may overlap for criminal investigations.
- U.S. Department of Agriculture (USDA) Food and Nutrition Service (FNS): FNS provides federal oversight of the SNAP program. FNS sets federal SNAP policy, provides guidance, and offers clarification. They also conduct annual audits into the administration of the SNAP program, including program integrity.
- CMS: CMS provides federal oversight of the Medicaid and CHIP programs. CMS sets federal Medicaid and CHIP policy, provides guidance, and offers clarification.

J. Barriers and challenges:

BPI faces a key challenge in prosecuting beneficiary eligibility fraud due to a mismatch between federal and state timelines. Federal regulations require states to investigate and recover overpayments going back six years, but Texas Penal Codes commonly used for prosecution have shorter statutes of limitations, limiting potential recoveries.

Local prosecutors typically accept only three penal codes for fraud cases:

- Tampering with Governmental Record (Section 37.10) – 2-year statute
- Fraudulent Securing of Document Execution (Section 32.46) – 7-year statute
- Theft (Section 31.03) – 5-year statute

Of these, Section 37.10 is most often used due to its straightforward language and because it allows felony prosecution without a minimum dollar threshold. However, its 2-year statute of limitations often conflicts with the 6-year federal look-back, reducing potential restitution.

When local prosecuting authorities substitute Section 37.10 for charges originally recommended under Section 32.46 or Section 31.03, up to four years of

recoverable overpayments may be lost, undermining both program integrity and compliance with federal expectations.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Medicaid Provider Integrity

A. Division or program information:

Name of division or program: Medicaid Provider Integrity

Location within the agency: OIG, IUR Division

Contact name: Steve Johnson, Chief of Investigations and Utilization Reviews

Statutory citation: Texas Government Code, Sections 544.0051(b), 544.0054, 544.0103, 544.0103(e)(3) and (e)(5), 544.0104-544.0107, 544.0110, 544.0251-544.0257, and 544.0502; Social Security Act 1902(a)(3); and 42 CFR Part 455.

B. Objective and major activities:

Medicaid Provider Integrity (MPI) investigates allegations of FWA by Medicaid providers and other individuals who deliver Medicaid services to Medicaid clients. The MPI Intake Resolution Unit (IRU) conducts preliminary investigations, and the Provider Field Investigations (PFI) unit conducts full-scale investigations.

MPI is supported by the Program Integrity Development and Support team (PIDS), the Clinical Subject Matter Experts (CSMEs) team, and the Investigative Strategy Team (IST).

Clinical Subject Matter Experts: The CSME team consists of a physician, dentist, dental hygienist, and pharmacist who provide clinical expertise to OIG staff across the organization. This team also communicates with the compliance departments of MCOs and dental maintenance organizations (DMOs) to educate their staff and clarify questions regarding clinical documentation and OIG's application of program policy.

Program Integrity Development and Support and Investigative Strategy Teams: MPI is supported by PIDS and IST in the following ways:

- Develops and maintains the internal policies, procedures, and job aids;

- Develops and conducts staff training;
- Acts as a liaison between state and federal agencies and their contractors, other program areas within OIG, and MCO Special Investigative Units;
- Prepares reports related to investigative activities;
- Stores and maintains MPI evidence collected in association with investigative activity;
- Develops investigative plans and deconflicts with other programs;
- Develops high-quality deliverables;
- Researches Medicaid policies; and
- Leads special projects and performs other administrative duties as assigned.

C. Effectiveness and efficiency information:

Table 20. MPI measures, fiscal year 2024.

Metric	Fiscal Year 2024
MPI Recoveries	\$15,075,519
Intake	
Number of Referrals (Complaints) Received	2,442
Cases Opened ¹	1,652
Number of Completed Cases ²	1,639
Cases Referred to Other Entities	781
Number of Referrals to MFCU ³	272
Average days to complete a Preliminary Investigation ⁴	22.83
Full-Scale	
Number of Completed Cases ⁵	213
Referrals to Other Entities	7
Average number of days to complete a Full-Scale investigation ⁶	177.11

¹ Not all complaints become open cases due to a lack of information.

² Includes: Total number of closed cases, cases completed and transitioned to litigation, cases transferred to Acute Care Services (ACS), cases transferred to full-scale, and cases transferred to Accounts Receivable (AR).

³ Number of Intake cases with an informal Provider Notice sent to the MFCU in the period reported.

⁴ The average days between receipt of a case in Intake to case completion in the period reported.

⁵ Total number of closed cases, cases completed and transitioned to litigation, cases transferred to Medical Services (ACS), and cases transferred to (AR). Included in the LBB performance measure, Number of Completed Provider and Recipient Investigations.

⁶ The average days between receipt of a case in PFI to case completion in the month reported for cases received by PFI. A completed case is defined as a case transitioned to Litigation or Medical Services or closed.

D. History:

Senate Bill (S.B.) 207, 84th Legislature, Regular Session, 2015, required that full-scale investigations be completed within 180 days unless OIG determines more time is needed to complete the investigation.

H.B. 2379, 85th Legislature, Regular Session, 2017, amended Texas Government Code, Section 531.1131 (Section 544.0502 as of April 1, 2025) to outline the sharing of recoveries between OIG and MCOs. Specifically, MCOs are permitted to retain 50 percent of any recovery resulting from a fraud or abuse investigation and remit the remainder to OIG. OIG pays the federal share out of its 50 percent and deposits the remainder into the general revenue fund. If OIG initiates the recovery based on a referral from an MCO, it retains 50 percent and sends the other 50 percent to the MCO. Additional coordination with MCOs is required to ensure that both entities do not begin payment recovery efforts for the same case of FWA.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

MPI is led by a deputy inspector general who reports to the IUR Chief.

Investigations start with IRU receiving a referral from any source, whether it be from the public, an MCO, or another agency. IRU conducts a preliminary investigation to determine if the referral should go to a full-scale investigation. This determination occurs within 45 days of assignment.

If the preliminary investigation does not find evidence supporting the complaint, IRU closes the case. If IRU determines the complaint falls within the purview of another agency, board, or entity, IRU closes the case and refers the complaint as appropriate.

Cases approved for transfer are assigned to a full-scale investigation unit based on current caseload, and the PFI manager assigns the case to the appropriate PFI investigator. Within the first 30 days of case assignment, the PFI investigator reviews the documentation and evidence obtained by IRU and obtains encounter data to determine the highest paid codes, payors, and to assess any data-driven allegation.

The PFI investigator conducts preliminary research, data analysis, and interviews to assess whether evidence supports the initial complaint or reveals additional indicators of FWA. Investigators may collaborate with OIG units such as Surveillance Utilization Reviews (SUR), OIG Chief Counsel, FADO, PIDS, and IST to ensure thorough investigation and complaint resolution.

Following initial research, a case consultation is held to determine the sampling population and methodology. The investigator then requests client and business records for review based on the approved sample. Regional field staff may assist with record collection and staff or client interviews when needed.

If medical determinations are involved, the investigator submits a request for clinical review. Otherwise, the investigator evaluates the records to determine whether the documentation substantiates the allegations. After completing the review, the investigator prepares case disposition documents summarizing findings and recommending a case outcome. These documents are reviewed by the PFI manager and IST for accuracy and clarity.

Referrals and complaints are received from several sources, including, but not limited to, the OIG fraud hotline; OIG's online Waste, Abuse and Fraud Electronic Referral System (WAFERS); internal OIG staff; MCOs; and DMOs contracted with the State of Texas.

MPI makes referrals to OAG MFCU when a provider is suspected of fraud or abuse involving criminal conduct. MPI and OAG MFCU work together by sharing resources, training, and information that will lead to successful administrative or criminal prosecution.

G. Funding: See "Agency Program Information" spreadsheet.

Table 21. MPI funding formulas.

Dept	General Revenue	Federal Funds	Other Funds
Executive Management	34.63%	31.78%	33.59% ¹

Dept	General Revenue	Federal Funds	Other Funds
Medical and Dental Professionals (Administrative Costs)	50.00%	50.00%	0.00%
Medical and Dental Professionals (Salary)	37.28%	62.72%	0.00%
MPI	50.00%	50.00%	0.00%

¹ Other Funds includes interagency contract funding with DFPS (25 percent) and DSHS (8 percent).

H. MOUs and interagency agreements or contracts:

MOUs for access to a licensing board's criminal history record information are listed in OIG Chief Counsel's response to Question H.

I. Relationship with other governmental entities:

MPI works closely with federal health care task forces around the state and OAG MFCU. MPI provides OAG MFCU referrals at the preliminary investigation, full-scale investigation, and litigation stages, as warranted. OIG and OAG MFCU meet to discuss current cases. MPI provides investigative support, as needed.

OAG MFCU also acts as a conduit for MPI to work with FBI task forces. MPI may also serve as a liaison between OIG's FADO or SUR units to ensure the task force obtains the necessary resources.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Special Investigations

A. Division or program information:

Name of division or program: Special Investigations

Location within the agency: OIG, IUR Division

Contact name: Steve Johnson, Chief of Investigations and Utilization Reviews

Statutory citation:

- Electronic Benefits Transfer Trafficking: Texas Human Resources Code Sections 33.011 and 33.032; 7 CFR Section 273.16(a)(1)

- Internal Affairs: Texas Government Code Section 544.0102(h)
- Major Case Unit: Not applicable
- WIC Vendor Monitoring Unit: 42 USC Section 1786(f); 7 CFR Part 246
- State Centers Investigative Team: Texas Health and Safety Code, Sections 552.101 and 555.101

B. Objective and major activities:

Special Investigations is comprised of five units, including the Electronic Benefit Transfer Trafficking Unit (EBT), WIC Vendor Monitoring Unit (WIC VMU), Internal Affairs (IA), Major Case Unit (MCU), and SCIT.

EBT Trafficking: Comprised of commissioned law enforcement officers and non-commissioned investigators who conduct criminal investigations regarding SNAP benefit misuse. EBT operates in accordance with the State Law Enforcement Bureau (SLEB) Agreement with the USDA to investigate unauthorized use, possession, and trafficking of taxpayer dollars in the SNAP program.

WIC VMU: Conducts in-store reviews, compliance buys, and invoice audits to monitor vendors participating in WIC. WIC VMU operates in accordance with mandates from the USDA, safeguarding taxpayer dollars by verifying and enforcing compliance with contracts put in place by Texas WIC.

IA: Conducts criminal and administrative investigations involving allegations of employee misconduct and contract fraud for HHSC, DFPS, and DSHS. IA also supports the OIG with computer and cellular phone forensics capabilities.

MCU: Is a team of multidisciplinary experts with extensive investigative and forensic accounting experience. MCU conducts or assists in high-complexity, high-risk cases.

SCIT: Comprised of commissioned peace officers who conduct criminal investigations involving abuse, neglect, and exploitation committed by HHSC employees against clients at State Supported Living Centers (SSLCs) and state hospitals.

C. Effectiveness and efficiency information:

Table 22. Special Investigations measures, fiscal year 2024.

Metric	Fiscal Year 2024
Electronic Benefits Transfer Trafficking	
Referrals Received	2,151
Investigations Opened	345
Completed Investigations ¹	368
Dollars Recovered ²	\$754,349
Claims Established for Recovery	\$2,618,102
WIC Vendor Monitoring Unit	
Completed Inventory Audits	104
Completed Compliance Buys	301
Completed On-site Reviews	351
Number of Cases Closed (Compliance Buys & On-site Reviews)	429
Number of Cases Closed (Inventory Reviews)	104
Number of Education Letters Sent	846
Internal Affairs	
Referrals Received	483
Investigations Opened	282
Completed Investigations	166
Major Case Unit	
Completed Investigations ¹	7
State Centers Investigative Team	
Referrals Received	5,003
Investigations Opened	898
Completed Investigations	920
Investigations Referred for Prosecution	51

¹ This is included in LBB performance measure, Number of Completed Provider and Recipient Investigations.

² This is included in the calculation of LBB performance measure, Total Dollars Recovered.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

The units within Special Investigations are each led by a director who reports to the Chief of Investigations and Utilization Reviews.

EBT Trafficking: Consists of commissioned peace officers, non-commissioned investigators, management, and support staff who operate across different regions within the State. The officers and investigators perform traditional investigative activities such as surveillance, undercover buys, interviews of witnesses, and reviews of records related to the trafficking of SNAP benefits. Trafficking includes the use of SNAP benefits outside the rules and regulations established in the CFR. Investigations are conducted on retail stores (both authorized and non-authorized by USDA-FNS as SNAP retailers). EBT works in cooperation with the USDA-FNS as well as a variety of local law enforcement and district attorneys, where cases may be referred for possible criminal prosecution.

WIC VMU: Inspectors conduct compliance buys and on-site store inspections in WIC-contracted stores throughout the State of Texas. The visits involve ensuring stores are compliant with their WIC contracts. Additionally, WIC VMU monitors perform inventory reviews to verify WIC stores are correctly redeeming or charging the State for items they have purchased.

IA: Receives internal and external referrals, which are processed by an intake team that determines whether the referral falls under IA's investigative purview, whether an investigation should be opened, whether the matter should be closed without an investigation, or whether it should be referred to another entity.

If an investigation is opened, the case is assigned to an IA field investigator who gathers documentation, conducts interviews, and determines whether the investigation meets the evidentiary standard for a criminal or administrative case. Investigations are documented in investigative and final reports, which are sent to HHSC, DFPS, or DSHS. Criminal cases that document a violation of law are also submitted to a district or county attorney for prosecutorial consideration.

IA has a Forensics Research and Analysis Team (FRAT) that performs evidentiary searches on and related to electronic devices. FRAT produces forensics reports that are used by field investigators as evidence. FRAT provides support to several OIG programs and units.

MCU: Works on complex investigations from other areas of OIG, generally from IA and MPI. These investigations move through the intake process of the referring OIG area and are then referred to MCU due to the complex nature of the case. For reporting requirements, these cases remain with the referring area but are also tracked internally by MCU. If MCU identifies criminal activity in an investigation, MCU will make a referral to the proper law enforcement agency, whether that be OAG MFCU, FBI, a local district attorney, or local law enforcement. MCU assists the law enforcement agency by providing evidence from the investigation indicating potential criminal activity.

MCU supports MPI investigations when there is a need for one or all MCU members' special skill sets. Also, MCU provides OIG Chief Counsel with financial forensics, data analysis and programming, and advanced investigation skills when requested. Case referrals and requests for MCU assistance are reviewed by MCU management, and a determination is made on whether the case or request aligns with MCU's skill sets.

SCIT: Consists of commissioned peace officers who investigate employees accused of client abuse, neglect, exploitation, and other criminal offences that occur at SSLCs and State Hospitals. These officers are co-located within the regions near the facilities to conduct investigations in a timely manner.

SCIT receives referrals via an intake mailbox or directly from local law enforcement. The referral is evaluated by a captain and, if it is determined that a case should be opened, the recommendation is then sent to the lieutenant, who assigns a sergeant to conduct the investigation. Should evidence of criminal activity be identified, the case is referred to the local district attorney for prosecution. SCIT's process map can be found in Attachment 19: Major Process Maps.

G. Funding: See "Agency Program Information" spreadsheet.

Table 23. Special Investigations funding formulas.

Department	General Revenue	Federal Funds	Other Funds
Internal Affairs	34.63%	31.78%	33.59% ¹
WIC Vendor Monitoring	0.00%	100.00%	0.00%
Medicaid Fraud Law Enforcement	50.00%	50.00%	0.00%
EBT Investigations	50.00%	50.00%	0.00%
DDS CDI	0.00%	100.00%	0.00%

Department	General Revenue	Federal Funds	Other Funds
Management	32.46%	67.55%	0.00%
SCIT	58.96%	38.86%	2.18% ²

¹ Other Funds includes Interagency contract funding with DFPS (25 percent) and DSHS (eight percent).

² Other Funds includes HHSC Intellectual and Developmental Disability Appropriated Receipts.

H. MOUs and interagency agreements or contracts:

EBT Trafficking: Operates under an SLEB, which is a partnership with the USDA-FNS to address SNAP trafficking.

IA: Uses two documents to coordinate activities and avoid duplications or conflicts with HHSC, DFPS, and DSHS. Both documents outline information sharing, reporting requirements, and provide a framework for the investigative purviews of IA and the respective agency. For DFPS, there is an MOU (HHS 000334100001), and for HHSC and DSHS, there is a single interagency circular (C-027).

WIC VMU: Has an MOU with the HHSC WIC program to coordinate compliance activities on existing WIC-contracted vendors and prevent duplication of work.

SCIT: Has an MOU with HHSC to delineate the roles and responsibilities of the parties relating to the investigation of a report of alleged abuse, neglect, or exploitation in SSLCs or State Hospitals.

I. Relationship with other governmental entities:

The Special Investigations division collaborates with federal, state, and local agencies to support its mission. At the federal level, it partners with agencies such as USDA and FBI to investigate cases involving federal benefit programs and complex, high-profile matters. OIG also works with the FBI McAllen Complex Financial Crimes Task Force to identify and pursue health care fraud and financial crimes involving individuals and organized groups. At the state level, OIG coordinates with law enforcement and regulatory agencies to align efforts and share information on FWA and misconduct. Locally, Special Investigations engages with law enforcement to address cases within local jurisdiction. IA supports these efforts by coordinating with HHSC, DFPS, DSHS, and various legal entities at the local, state, and federal levels to meet investigative needs, including the review and prosecution of sustained criminal cases.

J-M. Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

Surveillance Utilization Review (SUR)

A. Division or program information:

Name of division or program: Surveillance Utilization Review

Location within the agency: OIG, IUR Division

Contact name: Steve Johnson, Chief of Investigations and Utilization Reviews

Statutory citation: Texas Government Code Section 544.0103; 42 CFR Section 456.3

- Hospital Utilization Review: 42 USC Section 1396a(a)(3) and 42 CFR Part 456, Subpart C
- Nursing Facility Utilization Review: 42 USC Section 1396r and 42 CFR Part 483, Subpart B
- Lock-In: 42 CFR Section 431.54(e) and (f)

B. Objective and major activities:

SUR is comprised of clinical (nurses) and non-clinical support staff who conduct claim and medical record reviews on various HHS programs. SUR also provides clinical consultation to other OIG divisions. It includes the following:

Hospital Utilization Review (HUR): OIG nurses perform retrospective desk utilization reviews of paid inpatient hospital claims for services provided to Medicaid recipients to assess the medical necessity for inpatient care; appropriateness of the diagnosis related group assignment, including whether diagnoses are supported by the information in the medical record and whether coding was consistent with federal coding guidelines; and quality of care provided during the inpatient stay.

Nursing Facility Utilization Review (NFUR): OIG nurses perform retrospective desk and onsite utilization reviews of nursing facility records to evaluate whether facilities correctly assessed and documented residents' needs, whether Medicaid reimbursements were appropriate for the level of care provided, and whether care provided was medically necessary. The reviews result in changes to the Resource

Utilization Group (RUG), which determines the amount Medicaid pays for the resident.

Lock-In Program: Receives referrals from MCOs and the public for identified Medicaid recipients who may require restricted access to a single designated pharmacy. This may be due to duplicative, excessive, contraindicated, or conflicting health care services, including drugs, or evidence of abuse, misuse, or fraud related to Medicaid benefits.

Acute Care Surveillance (ACS): Nurses conduct retrospective reviews of acute care provider billing to ensure compliance with Texas Medicaid policies and guidelines. ACS nurses use data queries, referrals, and special projects to identify cases for review.

SUR Support: Program specialists provide support to clinical staff through operational functions and project management, including process improvements, report and template development, and research. Regional administrative assistants support HUR and NFUR reviews by initiating and maintaining processes to request, collect, and organize records, as well as communicate with providers.

C. Effectiveness and efficiency information:

Table 24. SUR measures, fiscal year 2024.

Metric	Fiscal Year 2024
Nursing Facility Reviews Completed ¹	215
Nursing Facility Collections ²	\$2,002,532
Nursing Facility Dollars Identified for Recovery	\$3,838,792
Acute Care Cases Completed	194
Acute Care Provider Collections ³	\$1,152,520
Acute Care Dollars Identified for Recovery	\$985,250
Hospital Reviews Completed	922
Hospital Collections ⁴	\$19,539,141
Hospital Dollars Identified for Recovery	\$21,605,974
Lock-in Cost Avoidance	\$7,070,246
Average number of Lock-In Program Clients	2,734

¹ LBB performance measure.

² Included in the calculation of LBB performance measure, Total Dollars Recovered.

³ Included in the calculation of LBB performance measure, Total Dollars Recovered.

⁴ Included in the calculation of LBB performance measure, Total Dollars Recovered.

D. History: Not applicable.

E. Qualifications or eligibility requirements:

OIG does not have its own qualifications or eligibility requirements; however, it enforces program requirements as part of its oversight responsibilities.

F. Administration and key processes:

SUR is led by a deputy inspector general who reports to the IUR Chief. The deputy inspector general oversees two directors: one who oversees HUR and NFUR review staff and regional administrative assistants, and the other who oversees ACS, Lock-In, NFUR reconsiderations, and non-clinical support.

SUR conducts ongoing retrospective reviews of acute care, inpatient hospital, and nursing facility records to identify overpayments and educate providers. SUR generates cases for review based on a variety of methods, including data analytics, risk assessments, and stratification. Following preliminary research and deconfliction, SUR requests medical records from providers. Once received, the records are reviewed by a clinician and, depending on the services, may also be reviewed by a certified coder and a physician consultant. SUR sends preliminary findings to the provider outlining the errors identified and the provider's due process rights.

Once all due process is exhausted, SUR recovers overpayments from providers in HUR and ACS cases. SUR also recovers overpayments from MCOs based on RUG adjustments submitted from nursing facility review findings.

SUR administers the Lock-In program. MCOs review members' pharmacy and acute care claims history and make referrals to OIG based on utilization trends and Lock-In program criteria. Lock-In program staff conduct reviews and analyze data and incoming referrals from MCOs, medical providers, state agencies, law enforcement officials, and members of the public that identify Texas Medicaid recipients who may meet criteria for lock-in. The Lock-In program restricts an individual's access to a single designated pharmacy and designated provider for primary care if it finds that:

- A recipient received duplicative, excessive, contraindicated, or conflicting health care services, including drugs; or

- A review indicates abuse, misuse, or fraudulent actions related to Medicaid benefits and services.

G. Funding: See “Agency Program Information” spreadsheet.

Table 25. SUR funding formulas.

Department	General Revenue	Federal Funds	Other Funds
Executive Management	34.6%	31.8%	33.6% ¹
Quality Review 50/50	50.0%	50.0%	0.0%
Quality Review	39.8%	60.2%	0.0%
Acute Care Surveillance	40.6%	59.4%	0.0%
Lock In Program 50/50	50.0%	50.0%	0.0%
Lock in Program	32.1%	67.9%	0.0%

¹ Other Funds includes interagency contract funding with DFPS (25 percent) and DSHS (8 percent).

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities: Not applicable.

J. Barriers and challenges:

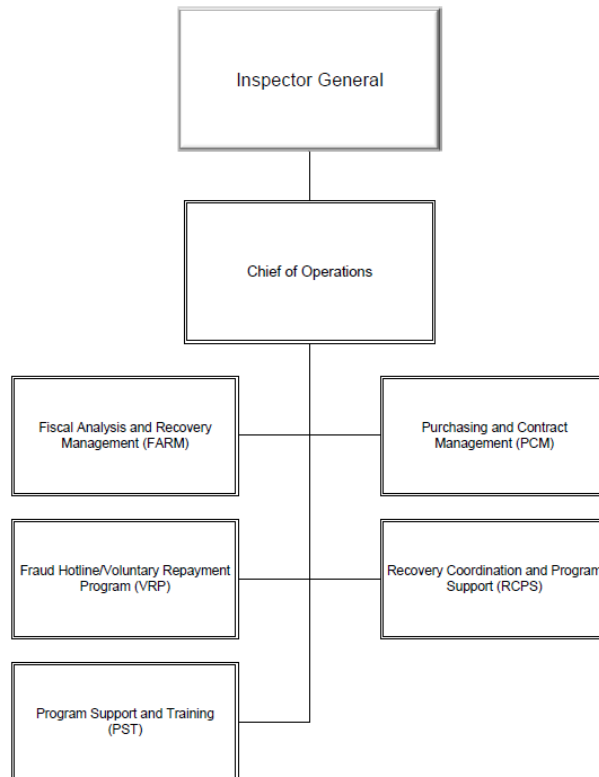
Challenge 1: The technology systems utilized by SUR to conduct reviews and track cases are outdated, inflexible, and lack integration. Developed in 2012, these applications are spread across multiple platforms and require manual workarounds to perform basic functions such as gathering information, generating notices, and calculating recoupment amounts. Requested updates are time-consuming to implement, and the systems do not support real-time inventory or case status reporting.

Challenge 2: This fragmented and manual process reduces productivity, increases the risk of errors, and limits the ability to adjust workflows to address high-risk areas. The lack of a centralized platform for tracking review-related information complicates reporting, hinders data analysis, and burdens clinical staff with repetitive tasks. These limitations collectively hamper efficient operations and obstruct efforts to modernize and streamline review processes.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

Operations

Figure 7. Operations organizational chart.



A. Division or program information:

Name of division or program: Operations

Location within the agency: OIG

Contact name: Matt Chaplin, Chief of Operations

Statutory citation: Not applicable

B. Objective and major activities:

The Operations Division supports the daily operations of OIG by providing program support, training, fiscal analysis, recovery management and coordination, purchasing, contract management, and managing the OIG Fraud Hotline and the Voluntary Repayment Program (VRP).

C. Effectiveness and efficiency information:

Table 26. Operations measures, fiscal year 2024.

Metric	Fiscal Year 2024
Number of Trainings	172
Recovery Payments Processed	4,155
Fraud Hotline Contacts Received ²	34,986
Fraud Hotline Contacts Handled ³	32,549
Fraud Hotline Handle Rate ⁴	93%
Fraud Hotline Internal Referrals	5,407
VRP Calls Handled	763
VRP Payment Letters Mailed	614
VRP Collections	\$136,841

¹ Contacts include phone calls, emails, voicemails, postal mail, and faxes.

² Contacts Handled include contacts received that the OIG Fraud Hotline handled (e.g., answered phone calls, responded to emails, postal mail, and faxes, returned voicemail messages).

³ The Handle Rate is calculated by dividing the number of contacts handled by the number of contracts received.

D. History: Not applicable.

E. Qualifications or eligibility requirements: Not applicable.

F. Administration and key processes:

The Operations Division is led by the Chief of Operations, who oversees a deputy inspector general and directors who manage each of the following:

Program Support and Training (PST): Promotes OIG training services and internal policy development. PST organizes office-wide training initiatives, assists the divisions of OIG in developing and delivering targeted training, and manages the agency's internal policies and procedures. PST reviews and updates policies on an annual basis to ensure alignment with current laws, best practices, and operational needs.

Purchasing and Contract Management (PCM): Helps ensure compliance with procurement, contracting, and other purchasing requirements by coordinating with

OIG division staff, HHSC Procurement and Contracting Services (PCS), and HHS System Contracting (Office of Chief Counsel).

Processes include supplementary activities, including records management, Centralized Accounting and Payroll/Personnel System (CAPPS) Financials, and System of Contract Operations and Reporting (SCOR) data entry and document uploads, invoice and expenditure tracking, and reporting requirements.

Fiscal Analysis and Recovery Management (FARM): Manages OIG's budget and accounts receivable. FARM identifies and addresses any budget, expenditure, or method of finance issues, and collaborates with HHSC Budget staff to ensure timely handling of OIG budget adjustments and communicates OIG's budget requests for the Legislative Appropriations Request.

FARM collaborates with OIG programs and HHSC Accounts Receivable to process payments and apply those payments against established accounts receivable. This ensures OIG programs receive credit for recoveries resulting from audits, investigations, settlements, targeted queries, and retrospective reviews.

OIG Fraud Hotline: Accepts reports of FWA within Texas health care and benefits programs through a toll-free hotline, mail, email, and fax. Once documented, complaints are referred to OIG investigative areas or referred to a more appropriate hotline, agency, or department.

VRP: Manages repayment by non-US citizens to HHSC for emergency Medicaid services, often related to childbirth. VRP staff review Medicaid claims, determine the outstanding balances, process and provide receipt of payments, and send a paid-in-full receipt after the balance has been paid.

G. Funding: See "Agency Program Information" spreadsheet.

Table 27. Operations funding formulas.

General Revenue	Federal Funds	Other Funds
34.63%	31.78%	33.59% ¹

¹ Other Funds includes Interagency contract funding with DFPS (25 percent) and DSHS (8 percent).

H-M. MOUs, Relationships, Barriers and Challenges, Additional, Regulatory, and Complaint Information: Not applicable.

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VII. Guide to Agency Divisions and Programs

Perinatal Advisory Council

Created by House Bill (H.B.) 15, 83rd Legislature, Regular Session, 2013, the Perinatal Advisory Council (PAC) advises the Health and Human Services Commission (HHSC) on matters related to perinatal care including neonatal and maternal health. See the [Perinatal Advisory Council website](#) for additional information on PAC and its activities. PAC is composed of 19 members appointed by the executive commissioner. For details on PAC's membership and statutory duties see Section IV, Policymaking Structure, Exhibit 6, Subcommittees and Advisory Committees. PAC is subject to Sunset Commission review and is abolished on September 1, 2027, unless continued by the Legislature.

Administration

A. Division or program information:

Name of division or program: Perinatal Advisory Council

Location within the agency: CMCSO

Contact name: Suja Pillai, M.D., Director of Quality Data Analytics and Reporting, Medicaid and CHIP Services (MCS) Quality & Program Improvement

Statutory citation: Texas Health and Safety Code, Section 241.187; 1 Texas Administrative Code, Section 351.813

B. Objective and major activities:

PAC is charged with:

- Developing and recommending criteria for designating levels of neonatal and maternal care, respectively, including specifying the minimum requirements to qualify for each level designation; developing and recommending a process for the assignment of levels of care to a hospital for neonatal and maternal care, respectively; making recommendations for the division of the state into neonatal and maternal care regions;
 - ▶ [Neonatal Designation](#)

‣ [Maternal Designation](#)

- Examining utilization trends relating to neonatal and maternal care; and
- Making recommendations related to improving neonatal and maternal outcomes.

The advisory council was charged with submitting a report detailing the advisory council's determinations and recommendations to the department and the executive commissioner not later than September 1, 2016. The report was delivered and published on time.

The council does not have ongoing reporting requirements; however, it does issue periodic updates to recommendations or because of legislative direction, on certain topics by letter. H.B. 1164, 87th Legislature, Regular Session, 2021, authorized PAC, with input from subject matter experts, stakeholders, and DSHS to develop considerations for patient safety practices and recommendations for maternal rules related to the diagnosis, referral, transport, and management of women with Placenta Accreta Spectrum Disorders (PASD). PAC issued corresponding recommendations to the DSHS commissioner on October 20, 2021.

H.B. 37, 89th Legislature, Regular Session, 2025, requires the PAC to provide input and collaborate with the HHSC executive commissioner on the development of a program to recognize hospitals with a maternal designation that provide perinatal bereavement care training to hospital staff and the criteria for awarding recognition to a hospital under the program.

C. Effectiveness and efficiency information:

HHSC MCS provides support to the PAC as it continues to examine utilization trends in neonatal and maternal care and recommend ways to improve neonatal and maternal outcomes. This includes an analysis of the impact of maternal level of care designations on severe maternal morbidity and a planned analysis of the impact of neonatal levels of care.

D-E. History and Qualifications: Not applicable.

F. Administration and key processes:

The HHSC MCS Council Coordinator provides logistical support to PAC, including providing staff liaison to support the operation of PAC, PAC subcommittees, and the quarterly PAC meetings. The Council Coordinator also coordinates the member

solicitation and recommendation process for PAC, which goes to the executive commissioner for final PAC appointment and reappointment decisions.

HHSC staff are responsible for following the processes in [Circular C-022: HHSC Policy for Advisory Committees](#) when providing support services to advisory committees. HHSC Advisory Committee support staff must utilize the Advisory Committee Coordination Office (ACCO) for all advisory committee meetings. ACCO provides support services to include activities that enable members to fulfill the charge of the advisory committee; logistical and process facilitation support before, during, and after meetings; soliciting nominations for member appointments; and completing annual evaluations of advisory committees.

PAC related communications are facilitated through the following email: Perinatal_Advisory_Council@hhs.texas.gov.

G. Funding:

Funding for fiscal year 2024 (staff salary and member travel): \$75,000. Additionally, one Program Specialist VI supports and dedicates ten hours/week to PAC activities as council coordinator, and one Director II provides oversight of PAC coordination and dedicates one hour/week.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

The council submitted a report with its recommendations to HHSC and DSHS in September 2016 and continues to issue periodic letters with updated recommendations as needed.

PAC has traditionally worked closely with DSHS under the DSHS commissioner to provide input on the development and management of the Hospital Designation Program, including the Neonatal and Maternal Rules that govern the program.

J. Barriers and challenges: Not applicable.

K. Additional information:

PAC is supported by MCS staff; however, the work of PAC is not limited to Medicaid or CHIP programs or providers.

L-M. Regulatory and Complaint Information: Not applicable.

VII. Guide to Agency Divisions and Programs

Statewide Interagency Aging Services Coordinating Council

Created by House Bill (H.B.) 728, 88th Legislature, Regular Session, 2023, the Statewide Interagency Aging Services Coordinating Council (SIASCC) ensures the state takes a strategic approach to providing aging services to Texans. See the [SIASCC website](#) for additional information on SIASCC and its activities. SIASCC is comprised of representatives of state agencies and institutions of higher education that receive general revenue (GR) for aging services. The committee is presided over by HHSC's Aging Texas Well Coordinator.

SIASCC has 17 members chosen by the member agencies and institutions. In 2023, the executive commissioner determined one voting member per agency or institution would be appointed and appointed six ex-officio members representing Health and Human Services Commission (HHSC) program areas. For details on SIASCC membership and statutory duties see Section IV, Policymaking Structure, Exhibit 6, Subcommittees and Advisory Committees. SIASCC is subject to Sunset Commission review when HHSC is reviewed, and is abolished on September 1, 2027, unless continued by the Legislature.

A. Division or program information:

Name of division or program: Statewide Interagency Aging Services Coordinating Council

Location within the agency: CPSO

Contact name: Lana Estevilla, Associate Commissioner, Community Services, Policy and Strategy.

Statutory citation: Texas Government Code, Chapter 526, Subchapter Q.

B. Objective and major activities:

SIASCC's objective is to ensure a strategic statewide approach to interagency aging services. Council activities include:

- Quarterly meetings (March, June, September and December) with guest presenters on a variety of aging related topics;
- Committees that focus on the research and development of the annual inventory of state-funded aging programs and services, the biennial expenditure proposal, and the five-year strategic plan;
- An implementation plan developed by each member agency outlining how the agency will implement the tactics outlined in the strategic plan; and
- Submission of each agency's implementation plan to the governor, lieutenant governor, and legislature.

C. Effectiveness and efficiency information:

SIASCC had three required deliverables in fiscal year 2025. The council met the deadlines for each of the deliverables.

- SIASCC Coordinated Expenditure Proposal due November 1, 2024.
- SIASCC Inventory of State-Funded Aging Services and Programs due December 31, 2025.
- Texas Statewide Interagency Aging Services Strategic Plan due March 1, 2025.

D-E. History and Qualifications: Not applicable.

F. Administration and key processes:

HHSC provides administrative and logistical support to SIASCC. SIASCC held public meetings two times in fiscal year 2024. The inaugural SIASCC meeting was March 20, 2024, and the second occurred on June 5, 2024.

G. Funding:

OASC supports the SIASCC in convening meetings, drafting reports, and providing any other support members need. Funding includes travel costs for the presiding officer to attend quarterly meetings in person per HHSC policies for conducting open meetings. This equals approximately \$9,236.00 per fiscal year.

H. MOUs and interagency agreements or contracts: Not applicable.

I. Relationship with other governmental entities:

SISACC is composed of member agencies and institutions that coordinate and collaborate on development of the required Texas Statewide Interagency Services Strategic Plan, other reports, and initiatives.

J. Barriers and challenges:

The SIASCC enabling statute requires a five-year recurring strategic plan outlining a coordinated interagency approach to the state's aging services. Executive Order RP-42 established the Aging Texas Well initiative and requires a biennial strategic plan to identify and discuss aging policy issues, guide state government readiness, and promote increased community preparedness for an aging Texas. This plan acts as the state's MPA. National standards for MPAs are to develop a 10-year plan; however, the ATW Strategic Plan is currently a six-year visioning plan with two two-year progress updates. Because the purpose of these plans overlaps significantly, coordinating plan development would improve efficiency.

K-M. Additional, Regulatory, and Complaint Information: Not applicable.

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VIII. Statutory Authority and Legislation

A. Fill in the following tables, listing citations for all state and federal statutes that grant authority to or otherwise significantly impact your agency. Do not include general state statutes that apply to all agencies such as the Public Information Act, the Open Meetings Act, or the Administrative Procedure Act. Provide information on Attorney General opinions from fiscal years 2020-2024 or earlier significant Attorney General opinions that affect your agency's operations.

Under section 524.0001 of the Texas Government Code, the Health and Human Services Commission (HHSC) is responsible for oversight of Health and Human Services (HHS) agencies. The Statutes tables below list the federal and state statutes granting authority to or significantly affecting HHSC and provides a brief description of each statute and its impact. In addition to statutes, HHSC is subject to a host of federal regulations, state administrative rules, and sub-regulatory guidance from other state and federal agencies not listed. The Attorney General Opinions table lists the Attorney General opinions affecting HHSC from 2020 to 2024 as well as other significant opinions outside of the reporting timeframe.

Health and Human Services Commission

Exhibit 15: Statutes / Attorney General Opinions

Table 1. Federal statutes.

Citation / Title	Authority / Impact on Agency
7 United States Code (USC) Chapter 51 / Supplemental Nutrition Assistance Program	Establishes the Supplemental Nutrition Assistance Program (SNAP), including requirements for state verification of applicant eligibility and program administration. HHSC administers SNAP.
8 USC Chapter 14 / Restricting Welfare and Public Benefits for Aliens	Establishes the Temporary Assistance for Needy Families (TANF) program, replacing the Aid to Families with Dependent Children (AFDC) program. State agencies must implement work requirements, time-limited benefits, and data reporting to receive federal block grants. Restricts eligibility for public benefits based on immigration status.
20 USC Chapter 31 / General Provisions Concerning Education	Governs federally funded education programs, including administrative procedures, family educational and privacy rights, and evaluation requirements.

Citation / Title	Authority / Impact on Agency
20 USC Chapter 31 Subchapter 3 Part 4 / General Provisions Concerning Education	Provides students and parents with rights to access and control educational records, such as educational records of those participating in an early childhood intervention (ECI) program. State health and human services agencies working with educational institutions must ensure compliance when handling student data.
20 USC Chapter 33 / Education of Individuals with Disabilities	Provides federal grants to states to support special education and related services for children with disabilities. Includes provisions for state administration of funds and authorized activities, including a specific provision making Medicaid the payor of first resort for any related services that Medicaid would otherwise be obligated to provide to a child. Texas implements this provision through the School Health and Related Services (SHARS) program.
20 USC Chapter 33 / Education of Individuals with Disabilities	Establishes a federal program to support early intervention services for infants and toddlers with disabilities and their families to enhance child development. The statute includes provisions relating to ECI program eligibility and service provision.
29 USC Chapter 16 / Vocational Rehabilitation and Other Rehabilitation Services	Subchapter V includes non-discrimination provisions. Subchapter VII provides financial support to states for the provision of independent living services, development and support of networks for centers for independent living (CILs), and coordination among State independent living rehabilitation service programs, CILs, and state-side councils. HHSC administers the Independent Living Services (ILS) program.
42 USC Chapter 6A Subchapter II / Public Health Service, Subchapter II / General Powers and Duties	Authorizes the Secretary of the United States (U.S.) Department of Health and Human Services (DHHS) to conduct and support research, investigations, and public health initiatives. Includes provisions related to federal-state cooperation, such as grant and cooperative agreements programs for comprehensive health planning and newborn hearing screening.
42 USC Chapter 6A Subchapter II Part F / Public Health Service, Subchapter II / General Powers and Duties	Establishes federal standards for laboratory testing on human specimens to ensure accuracy and reliability and federal certification standards. State health agencies must ensure laboratories conducting diagnostic testing are certified and meet quality standards.
42 USC Chapter 6A Subchapter III-A / Substance Abuse and Mental Health Services Administration	Establishes the Substance Abuse and Mental Health Services Agency (SAMHSA) to oversee national efforts in preventing and treating substance use and mental health disorders. Authorizes grants to states to fund behavioral health services.

Citation / Title	Authority / Impact on Agency
42 USC Chapter 6A Subchapter VIII / Population Research and Voluntary Family Planning Programs	Provides federal grants for voluntary family planning services to assist states in planning, establishing, maintaining, coordinating, and evaluating family planning services.
42 USC Chapter 6A Subchapter XIII / Preventive Health Measures with Respect to Breast and Cervical Cancers	Establishes a grant program for states to provide breast and cervical cancer screening and related services. Includes service and evaluation requirements as well as requirements pertaining to Medicaid state plans.
42 USC Chapter 6A Subchapter XVII / Block Grants	Provides federal block grants to states for mental health and substance use prevention, treatment, and recovery services as well as data collection and analysis. These grants support community-based programs and allow states flexibility in addressing local behavioral health needs.
42 USC Chapter 7 Sections 401-433 / Federal Old-age, Survivors, and Disability Insurance Benefits	Establishes a Social Security program to provide retirement, survivor, and disability benefits to eligible individuals and their families. Includes a provision requiring ongoing funding reviews and reporting of identified savings in Medicare and Medicaid programs. Authorizes disability determinations by either the Social Security Administration or by a state.
42 USC Chapter 7 Sections 601-687 / Grants to States for Aid and Services to Needy Families with Children and for Child-welfare Services	Provides federal block grants to states to fund TANF and child welfare services. Includes requirements for state administration of grant funds.
42 USC Chapter 7 Sections 701-710 / Maternal and Child Health Services Block Grant	Provides funding to states to improve the health of mothers and children, particularly those with low income or limited access to care. The statute establishes maternal, infant, and early childhood home visiting programs and appropriates funding to states for sexual risk avoidance education.
42 USC Chapter 7 Sections 1301-1320d-8 / General Provisions, Peer Review, and Administrative Simplification	Establishes general provisions for federal programs created by the Social Security Act, as well as mechanisms for peer review and fraud prevention in federal health programs. Includes provisions for data transparency, program integrity, and administrative efficiencies for Medicare and Medicaid. Social Security Act Section 1115 authorizes the Secretary of Health and Human Services to approve demonstration projects that may help promote the objectives of Medicaid and to waive state compliance with certain aspects of federal law. These demonstration projects, often referred to as “1115 waivers,” give states flexibility in designing and improving their own programs. HHSC currently operates a Section 1115 demonstration project entitled the “Texas Healthcare Transformation and Quality Improvement Program.”

Citation / Title	Authority / Impact on Agency
42 USC Chapter 7 Subchapter XVI / Supplemental Security Income for Aged, Blind, and Disabled	Establishes a national program to provide assistance to older adults, people who are blind, and people with disabilities with limited income and resources. The statute includes Medicaid eligibility and determination provisions related to Supplemental Security Income and state supplemental payments.
42 USC Chapter 7 Sections 1395-1395III / Health Insurance for Aged and Disabled	Establishes the Medicare program to provide health insurance for individuals aged 65 and older and certain individuals with a disability. Includes hospital insurance (Part A), supplemental medical insurance (Part B), Medicare Advantage (Part C), and prescription drug coverage (Part D), along with provisions regarding demonstration projects and the use of state agencies to determine provider compliance with Medicare conditions of participation.
42 USC Chapter 7 Sections 1396-1396v / Grants to State for Medical Assistance Programs	Establishes the program for medical assistance, commonly known as Medicaid. Medicaid is a jointly funded state–federal healthcare program that serves eligible individuals, including children, pregnant women, older adults, and people with disabilities who meet income and resource requirements. These statutes describe eligibility groups, the range of services that can be offered through the Medicaid program, and general terms and conditions for federal matching funds. HHSC is the single state Medicaid agency and administers the Texas Medicaid program in accordance with the state plan and various waiver programs, all of which are approved by the Centers for Medicare & Medicaid Services (CMS).
42 USC Chapter 7 Sections 1397-1397f / Block Grants and Programs for Social Services and Elder Justice	Provides block grants to states for social services aimed at increasing self-sufficiency, preventing abuse, and reducing institutional care. Contains programs to prevent, report, and address abuse, neglect, and exploitation of older adults. Provides community-based care, home-based care, or other forms of less intensive care and referral or admission to institutional care when other forms of care are inappropriate.
42 USC Chapter 7 Sections 1397aa-1397mm / State Children’s Health Insurance Program	Establishes the State Children’s Health Insurance Program (CHIP), a federal-state partnership to provide health insurance to uninsured children in families with incomes too high to qualify for Medicaid but too low to afford private coverage. Allows states to use funds to design their CHIP program as a separate program, an expansion to their Medicaid program, or a combination of both. HHSC administers a separate CHIP program in Texas. To be eligible for funds under the CHIP program, states must submit a state plan, which must be approved by CMS.

Citation / Title	Authority / Impact on Agency
42 USC Chapter 13A / Child Nutrition	Provides federal support for child nutrition programs, including establishing the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). WIC provides food, nutrition education, referrals, and other services to low-income women and children up to age five who are at nutritional risk. The statute includes eligibility requirements and requirements to coordinate between the WIC and Medicaid programs.
42 USC Chapter 21 / Civil Rights	Provides certain protections against employment discrimination based on race, color, religion, sex, or national origin, in certain circumstances. HHSC is subject to the Act as an employer and as a provider of federally funded programs. The HHS Civil Rights Office acts as an implementing and enforcement arm for federal and state civil rights protections.
42 USC Chapter 35 / Programs for Older Americans	Establishes the federal Administration on Aging and provides funding for services to older adults. State agencies submit plans to obtain grants for administering programs for older adults, such as nutrition, recreation, caregiver support, and elder rights protection services.
42 USC Chapter 67 / Child Abuse Prevention and Treatment and Adoption Reform	Establishes the federal Office on Child Abuse and Neglect and provides funding for child abuse prevention and treatment programs. State agencies must meet federal requirements to receive funding.
42 USC Chapter 67 - Subchapter III / Community-based Grants for the Prevention of Child Abuse and Neglect	Provides formula grants to states for developing and enhancing community-based programs that prevent child abuse and neglect. The statute includes eligibility requirements to apply for grant funding and performance reporting requirements for states receiving grants.
42 USC Chapter 68 Subchapter IV / Major Disaster Assistance Programs	Provides federal assistance for individuals and households affected by major disasters declared by the president. The statute outlines procedures for disaster declarations, authorization of aid, and states' roles and responsibilities in administering federal assistance funds.
42 USC Chapter 110 / Family Violence Prevention and Services	Establishes funding and national coordination for family violence prevention and services. State agencies are eligible for grants to support shelters, crisis intervention services, and prevention programs.
42 USC Chapter 119 / Homeless Assistance	Establishes federal programs to support individuals experiencing homelessness including education and housing services. Authorizes grants to state agencies and other entities to provide medical and supportive human services to homeless populations, particularly children and youth and veterans, through coordinated service delivery.

Citation / Title	Authority / Impact on Agency
42 USC Chapter 126 / Equal Opportunity for Individuals with Disabilities	Provides civil rights protections to individuals with disabilities in employment, public services, and public accommodations.
42 USC Chapter 144, Subchapter I / Programs for Individuals with Developmental Disabilities	Establishes federal programs to support individuals with developmental disabilities. Provides federal assistance to State Councils on Developmental Disabilities. The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act gives Disability Rights Texas (DRTx) authority to investigate allegations of abuse and neglect or rights violations of individuals with mental illness in state hospitals and other mental health programs in Texas.
Title 47, USC Chapter 5 Section 251e(4) / State Authority Over Fees	Establishes 9-8-8 as the universal number for mental health crisis and suicide prevention services. State agencies may collect fees to cover costs related to efficient routing of calls made to 9-8-8 centers to appropriate crisis centers and responding to calls made to the 9-8-8 hotline.
21st Century Cures Act, Public Law 114-255	Establishes new programs to accelerate medical product development and support state responses to the opioid crisis. The act contains provisions and funding for state opioid response programs and mental health and substance abuse block grants. Section 12006(a) mandates that states implement electronic visit verification for all Medicaid personal care services and home health services that require an in-home visit by a provider.
Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 2010, Public Law 111-80	Provides funding for United States Department of Agriculture and Food and Drug Administration programs, including food safety and nutrition initiatives. The act contains funding and provisions for SNAP and WIC programs.
Consolidated Appropriations Act, 2021, Public Law 116-260	Provides funding for federal agencies and COVID-19 relief. The act extends TANF and childcare entitlements to states and funds health programs, including Medicaid and CHIP.
Deficit Reduction Act of 2005, Public Law 109-171	Provides for Medicaid reform and cost containment through changes to eligibility, benefits, and program integrity. Requires state health agencies to implement new requirements for asset transfer verification, long-term care services, and quality reporting.
Further Consolidated Appropriations Act, 2024, Public Law 118-147	Provides fiscal year appropriations for federal departments including the U.S. DHHS. The act provides funding and provisions for health programs, including Medicaid and CHIP.

Citation / Title	Authority / Impact on Agency
<u>Healthy, Hunger-Free Kids Act of 2010, Public Law 111-296</u>	Establishes updated nutrition standards and expands access to child nutrition programs. The act encourages state licensing agencies to include nutrition and wellness standards in childcare licensing standards and provides grants for nutrition education and obesity prevention.
<u>Individuals with Disabilities Education Improvement Act of 2004, Public Law 108-446</u>	Provides federal funding and guidelines for special education services for children with disabilities. This funding includes awards for the ECI program.
<u>Patient Protection and Affordable Care Act, Public Law 111-148</u>	Establishes comprehensive health care reform including insurance marketplaces and consumer protections. When applications are submitted to the federally-facilitated marketplace (FFM) from Texas, each application is assessed for Medicaid and CHIP eligibility. Applications found to potentially meet eligibility requirements for Medicaid or CHIP are transferred from FFM to HHSC for final determination. Additionally, the law modified financial eligibility processes to use Modified Adjusted Gross Income (MAGI) methodologies and prohibited asset tests when determining eligibility for Medicaid and CHIP. Also, the act establishes maternal, infant, and early childhood home visiting (MIECHV) programs and outlines requirements for states to obtain grant funding for MIECHV programs.

Table 2. State statutes.

Citation / Title	Authority / Impact on Agency
<u>Texas Agriculture Code, Chapter 12 / Powers and Duties</u>	Section 12.041 requires HHSC to assist in the identification of children who are categorically eligible for school breakfast and lunch programs. Section 12.042 establishes the home-delivered meal grant program at the Texas Department of Agriculture to help defray the costs of providing home-delivered meals that are not fully funded by HHSC or an area agency on aging.
<u>Texas Agriculture Code, Chapter 15 / Farmers Market Nutrition Programs</u>	Requires the executive commissioner to adopt rules relating to special nutrition programs.
<u>Texas Agriculture Code, Chapter 23 / Food System Security</u>	Requires the executive commissioner to appoint a nonvoting member to the Texas Food System Security and Resiliency Planning Council to represent relevant HHSC programs.
<u>Texas Business and Commerce Code, Chapter 20 / Regulation of Consumer Credit Reporting Agencies</u>	Exempts consumer reports provided to HHSC under certain circumstances from the application of a security freeze.

Citation / Title	Authority / Impact on Agency
Texas Civil Practice and Remedies Code, Chapter 74 / Medical Liability	Subchapter C creates the Texas Medical Disclosure Panel (TMDP) to address patients' informed consent to medical treatment. Requires TMDP to determine which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their patients or persons authorized to consent for their patients and to establish the general form and substance of such disclosure. Administratively attaches TMDP to HHSC and requires HHSC employees to serve as staff for TMDP (as amended by House Bill 923, 89th Legislature, Regular Session, 2025).
Texas Civil Practice and Remedies Code, Chapter 81 / Sexual Exploitation by Mental Health Services Provider	Establishes that a mental health services provider is liable to a patient or former patient for certain sexual exploitation acts. Requires employer reporting and establishes employer liability for certain reporting failures.
Texas Code of Criminal Procedure, Chapter 42A / Community Supervision	Article 42A.4045 requires the executive commissioner to adopt rules relating to educational programs for residents of substance abuse treatment facilities.
Texas Code of Criminal Procedure, Chapter 46B / Incompetency to Stand Trial	Sets forth the process for finding someone incompetent to stand trial and committing them to competency restoration services. The chapter includes requirements for HHSC facilities providing competency restoration services, jail-based competency providers, and outpatient competency restoration providers and gives HHSC authority to oversee jail-based competency restoration programs.
Texas Code of Criminal Procedure, Chapter 46C / Insanity Defense	Sets forth the process for a criminal court judge to acquit someone found not guilty by reason of insanity (NGRI) and subsequently commit the NGRI individual to an HHSC facility or outpatient provider. The chapter sets out requirements for HHSC facilities and outpatient providers that serve individuals on NGRI commitments.
Texas Code of Criminal Procedure Chapter 49 / Inquests Upon Dead Bodies	Article 49.24 requires certain facilities where health care is provided to report certain resident deaths to the Office of Attorney General (OAG) and certain resident deaths to the Justice of the Peace.
Texas Code of Criminal Procedure, Chapter 56A / Rights of Crime Victims	Article 56A.305 authorizes HHSC to contract to provide health care providers with access to prescription drugs for the purpose of providing medical care to a victim of sexual assault.

Citation / Title	Authority / Impact on Agency
Texas Code of Criminal Procedure, Chapter 62 / Sex Offender Registration Program	Requires the executive director of the Council on Sex Offender Treatment (CSOT) to serve on the Texas Department of Criminal Justice's Risk Assessment Review Committee. Requires CSOT by rule to establish, develop, or adopt an individual risk assessment tool or group of tools that evaluates the criminal history of a person required to register as a sex offender and seeks to predict the likelihood of recidivism and the continuing danger the person poses to the community. Requires CSOT to evaluate a person with a single reportable offense using this individual risk assessment tool and provide the person a written report detailing the outcome of the evaluation for use in the person's motion for early termination of the duty to register as a sex offender.
Texas Education Code, Chapter 8 / Regional Education Service Centers	Establishes regional education service centers to support school districts with training, technical assistance, and program implementation. The statute requires local mental health authorities (LMHAs) to employ a non-physician mental health professional as a mental health and substance use resource for school districts in the region served by the regional education service center.
Texas Education Code, Chapter 19 / Schools in the Texas Department of Criminal Justice	Section 19.011 requires HHSC's cooperation in compiling certain information for individuals confined by the Texas Department of Criminal Justice.
Texas Education Code Chapter 25 / Admission, Transfer and Attendance	Section 25.041 establishes the right of school-aged children or wards of state supported living center (SSLC) employees living on-property at the SSLC to attend public school.
Texas Education Code Chapter 29 / Educational Programs	Subchapter L requires a school district to provide educational services to forensic SSLC offender residents who are under age 22, and to employ behavior support specialists to serve the residents. Requires a memorandum of understanding between HHSC and school districts.
Texas Education Code, Chapter 38 / Health and Safety	Requires HHSC to consult on and participate in certain activities of the Texas Education Agency relating to health and human services.
Texas Education Code, Chapter 51 / Provisions Generally Applicable to Higher Education	Grants the executive commissioner rulemaking authority relating to certain requirements in institutions of higher education.
Texas Education Code, Chapter 61 / Texas Higher Education Coordinating Board	Requires HHSC's participation on an advisory committee to advise on the development and administration of program to support graduate medical education. Requires HHSC's cooperation and support on certain responsibilities relating to repayment of certain physician education loans.

Citation / Title	Authority / Impact on Agency
Texas Education Code, Chapter 73 / The University of Texas at Houston	Describes funding mechanism and certain operational requirements for the Harris County Psychiatric Center. Describes transfer of lease and other obligations relating to certain research institutions.
Texas Election Code, Chapter 20 / Voter Registration Agencies	Designates HHSC and DSHS as voter registration agencies and assigns voter registration responsibilities.
Texas Family Code, Chapter 2 / The Marriage Relationship	Provides the legal framework for marriage in Texas, including license requirements, eligibility, and procedures. The chapter includes provisions related to premarital education courses and requires HHSC to maintain a website where providers of premarital education courses may register.
Texas Family Code, Chapter 33 / Notice of and Consent to Abortion	Provides requirements for parental notification and judicial bypass procedures before an abortion can be performed on a minor. Requires HHSC to produce and distribute informational materials explaining the rights of a minor, alternatives to abortion, and health risks associated with abortion.
Texas Family Code, Chapter 55 / Proceedings Concerning Children with Mental Illness or Intellectual Disability	Provides a framework for juvenile court commitments for mental health and residential intellectual disability services. Addresses commitments due to unfitness for court proceedings and lack of responsibility for alleged delinquent conduct or conduct indicating a need for supervision. Authorizes a juvenile court or jury to order a child to be placed with HHSC for a period of 90 days, if the child is found to be unfit as a result of mental illness or an intellectual disability.
Texas Family Code, Chapter 58 / Records; Juvenile Justice Information System	Designates HHSC a "juvenile service provider." Affords health and human services agencies limited access to juvenile justice information.
Texas Family Code, Chapter 154 / Child Support	Requires HHSC to be consulted by the Title IV-D agency concerning a health care program for certain children in Title IV-D cases.
Texas Family Code, Chapter 160, Section 763 / Uniform Parentage Act	Section 160.763 requires HHSC to develop and implement a confidential reporting system for health care facilities where assisted reproduction procedures are performed under gestational agreements.
Texas Family Code, Chapter 162 / Adoption	Describes HHSC's role, as the state Medicaid agency, with respect to the Interstate Compact on Adoption and Medical Assistance.
Texas Family Code, Chapter 261 / Investigation of Report of Child Abuse or Neglect	Requires a state agency that operates, licenses, certifies, registers, or lists a facility in which children are located or provides oversight of a program that serves children to make a prompt, thorough investigation of a report that a child has been or may be abused, neglected, or exploited in the facility or program.

Citation / Title	Authority / Impact on Agency
Texas Family Code, Chapter 262 / Procedures in Suit by Governmental Entity to Protect Health Safety of Child	Provides procedures to seek court orders or take emergency possession of a child to protect the child's health and safety. The statute includes provisions concerning the relinquishment avoidance program administered by HHSC.
Texas Family Code, Chapter 264 / Child Welfare Services	Provides a framework for delivering child welfare services. The chapter includes provisions related to children's advocacy centers and court-appointed volunteer advocate programs.
Texas Family Code, Chapter 266 / Medical Care and Educational Services for Children in Conservatorship of Department of Family and Protective Services	Requires HHSC to collaborate with the Department of Family and Protective Services (DFPS) on a medical services delivery model for children in DFPS conservatorship.
Texas Government Code, Chapter 57 / Court Interpreters	Requires HHSC to adopt rules relating to the certification of court interpreters.
Texas Government Code, Chapter 76 / Community Supervision and Corrections Departments	Requires HHSC's participation on a community justice task force to support the development of a community justice plan.
Texas Government Code, Chapter 155 / Duties Respecting Guardianship	Provides for consultation with HHSC in the adoption of minimum standards for the operation of guardianship programs.
Texas Government Code, Chapter 321 / State Auditor	Imposes requirements relating to audit plans and performance of audits relating to certain HHSC contracts.
Texas Government Code, Chapter 322 / Legislative Budget Board	Excepts HHSC from the definition of "state agency" for purposes of the Legislative Budget Board (LBB's) Major Contracts Database.
Texas Government Code, Chapter 402 / Attorney General	Requires HHSC's participation on the Human Trafficking Prevention Task Force.
Texas Government Code, Chapter 403 / Comptroller of Public Accounts	Requires HHSC to appoint six regional members of the Texas Opioid Abatement Fund Council from a list of two qualified candidates provided to HHSC by the governing bodies of certain counties and municipalities.
Texas Government Code, Chapter 411 / Department of Public Safety	Provides specific authority governing HHSC's access to criminal history record information.

Citation / Title	Authority / Impact on Agency
Texas Government Code, Chapter 418 / Emergency Management	Authorizes HHSC to use a disaster case management system developed by the Texas Division of Emergency Management (TDEM). Requires HHSC's participation in TDEM's information sharing work group. Requires HHSC, to the extent practicable, to conduct community outreach on disaster preparedness. Authorizes HHSC to access the emergency assistance registry in the event of a disaster in order to assist medically fragile individuals.
Texas Government Code Chapter 420A / Texas Civil Commitment Office	Administratively attaches the Texas Civil Commitment Office (TCCO) to HHSC.
Texas Government Code, Chapter 425 / Peace Officer Wellness Program	Authorizes HHSC to establish and administer a peace officer wellness grant program.
Texas Government Code, Chapter 434 / Veterans Assistance Agencies	Provides for the establishment and governance of the Texas Veterans Commission (TVC), which supports veterans through claims assistance, education, and employment services. The statute requires HHSC to coordinate with TVC in the administration of mental health programs for veterans and developing a directory of services. House Bill 114, 89th Legislature, Regular Session, 2025, transfers certain functions to TVC as of September 1, 2025.
Texas Government Code, Chapter 455 / Governor's Task Force on Governance of Early Childhood Education and Care	Requires HHSC participation on the Governor's Task Force on Governance of Early Childhood Education and Care.
Texas Government Code, Chapter 466 / Texas Lottery Commission	Conditionally allows HHSC to receive a limited amount of unclaimed lottery prize money each year to support inpatient hospital services in certain counties.
Texas Government Code, Chapter 469 / Elimination of Architectural Barriers	Makes Texas Facilities Commission (TFC) standards and specifications expressly applicable to any building or facility occupied by HHSC.
Texas Government Code, Chapter 501 / Inmate Welfare	Requires Texas Department of Criminal Justice (TDCJ) to contract with HHSC for the provision of HHSC facilities, treatment, and habilitation for inmates with mental illness or an intellectual disability. Requires an MOU between TDCJ and HHSC describing respective responsibilities for establishing a continuity of care program for inmates with a history of drug or alcohol abuse. Requires HHSC's participation on a reentry task force and the Correctional Managed Health Care Committee.

Citation / Title	Authority / Impact on Agency
<u>Texas Government Code, Chapter 511/ Commission on Jail Standards</u>	Requires HHSC participation on an advisory committee to advise the Commission on Jail Standards on issues relating to the confinement in county jail of persons with intellectual or developmental disabilities.
<u>Texas Government Code, Chapter 521 / General Provisions</u>	Provides definitions and foundational terms, such as "Medicaid," "Medicaid managed care organization," "health and human services system," and "executive commissioner." The chapter references the transfer of functions from other agencies to HHSC.
<u>Texas Government Code, Chapter 522 / Provisions Applicable to All Health and Human Services Agencies and Certain Other State Entities</u>	Provides fiscal, contracting, and operational guidelines for HHSC and related agencies, such as OAG review of health care contracts of \$2,500,000 or more and public access to meetings of the agency and HHS advisory bodies. The chapter includes provisions regarding sharing of data for patient care, quality improvement, and cost saving purposes and memoranda of understanding with other state entities for service coordination.
<u>Texas Government Code, Chapter 523 / Health and Human Services Commission</u>	Establishes HHSC as the primary agency responsible for delivering health and human services in Texas and outlines HHSC's goals, duties, and authority. The statute includes provisions relating to the Executive Council, advisory committees, performance management, and establishment of certain offices, such as the Office of Ombudsman and Office of Policy and Performance.
<u>Texas Government Code, Chapter 524 / Authority Over Health and Human Services System</u>	Describes HHSC's responsibility for the health and human services system, including Medicaid and related programs. The chapter also mandates implementation of integrated enrollment services to centralize eligibility determination for CHIP, Medicaid, TANF, SNAP, long-term care, and community-based services; and describes the authority and responsibilities of the executive commissioner.
<u>Texas Government Code, Chapter 525 / General Powers and Duties of Commission and Executive Commissioner</u>	Provides HHSC and the executive commissioner with authority to manage health and human services, including consolidating and coordinating services and operating an internal audit program. The chapter also mandates strategic planning, monitoring the use of federal money for cost-effectiveness, conducting TANF efficiency audits, and developing an electronic health information exchange system.

Citation / Title	Authority / Impact on Agency
<u>Texas Government Code, Chapter 526 / Additional Powers and Duties of Commission and Executive Commissioner</u>	Provides a framework for information that must be included on the HHSC website and through 211; describes certain programs and services provided or administered by HHSC; provides rulemaking authority for an informal dispute resolution process in long-term care facilities; requires the executive commissioner to establish a long-term care facilities council as a permanent advisory committee to HHSC; and requires HHSC to develop and implement a strategic plan relating to rural hospital services.
<u>Texas Government Code, Chapter 531 / Health and Human Services Commission</u>	Legacy chapter that described general responsibilities of HHSC across several program areas.
<u>Texas Government Code, Chapter 532 / Medicaid Administration and Operation in General</u>	Designates HHSC as the state Medicaid agency and authorizes it to plan and direct the Texas Medicaid program, including streamlining administrative processes, managing provider enrollment, establishing a process to resolve grievances, and adopting rules regarding fees, charges, and rates. The statute includes provisions for obtaining Medicaid waivers, collecting Medicaid data, and establishing a Medicaid buy-in program.
<u>Texas Government Code, Chapter 533 / Medicaid Managed Care Program</u>	Legacy chapter that described requirements relating to Medicaid Managed Care.
<u>Texas Government Code, Chapter 540 / Medicaid Managed Care Program</u>	Provides the framework for HHSC to implement Medicaid managed care through contracts with managed care organizations. The statute includes requirements for managed care plans, integration of behavioral health services into Medicaid managed care, monitoring of provider network adequacy and development of performance measures and incentives, expansion of the STAR+PLUS program, and assisting Medicaid clients avoid lapses in coverage.
<u>Texas Government Code, Chapter 540A / Medicaid Managed Transportation Services</u>	Provides for the delivery of nonemergency medical and nonmedical transportation (rideshared) services through managed care organizations under HHSC oversight. The statute includes requirements for providers, drivers, vehicle standards, and accessibility for Medicaid recipients.
<u>Texas Government Code, Chapter 542 / System Redesign for Delivery of Medicaid Acute Care Services and Long-term Services and Supports to Individuals with an Intellectual or Developmental Disability</u>	Provides a framework for redesigning Medicaid services for individuals with intellectual or developmental disabilities to improve coordination and service delivery. The statute creates a pilot program to improve service delivery models and outlines pilot program stakeholder involvement, participation requirements, and performance evaluation.

Citation / Title	Authority / Impact on Agency
<u>Texas Government Code, Chapter 543 / Clinical Initiatives to Improve Medicaid Quality of Care and Cost/effectiveness</u>	Provides a process for HHSC to evaluate and implement clinical initiatives to enhance Medicaid quality of care and cost-effectiveness. The statute mandates maintenance of a quality improvement website and a structured review process for proposed clinical improvement initiatives.
<u>Texas Government Code, Chapter 543A / Quality/based Outcomes and Payments under Medicaid and Child Health Plan Program</u>	Provides a framework for HHSC to implement quality-based payment systems, including but not limited to alternative payment systems, to improve care quality and cost-effectiveness. The chapter requires HHSC to develop quality-based outcome and process measures to promote the provision of efficient, quality health care across all delivery models and payment systems and to advance quality improvement and innovation. These quality-based outcomes and process measures must be used by managed care organizations to develop quality-based payment systems for compensating providers. The statute also requires evaluations of these models to ensure they meet performance and financial goals.
<u>Texas Government Code, Chapter 544 / Fraud, Waste, Abuse, and Overcharges Relating to Health and Human Services</u>	Establishes the Office of Inspector General (OIG) to investigate fraud, waste, and abuse in health and human services programs. Contains OIG administrative, fraud tracking, recoupment, and notification procedures.
<u>Texas Government Code, Chapter 545 / Certain Public Assistance Benefits</u>	Provides for the integration of eligibility determinations and service delivery systems across HHSC and other state agencies and establishment of eligibility call centers. The statute includes immigration status and sponsorship information verification requirements as well as administrative and judicial procedures for reviewing benefits eligibility decisions.
<u>Texas Government Code, Chapter 546 / Long-term Care and Support Options for Individuals with Disabilities and Elderly Individuals</u>	Provides for the creation of a comprehensive plan for HHSC to coordinate long-term care services that promote independence and quality of life and Medicaid waiver program provisions, including interest list management. The statute includes development of consumer direction models and permanency planning for children residing in state-owned facilities.
<u>Texas Government Code, Chapter 547 / Mental Health and Substance Use Services</u>	Provides for the delivery and oversight of mental health and substance use services through contractor evaluations and ombudsman functions. The statute requires a Veteran Suicide Prevention action plan, implementing a Texas system of care framework, and administering behavioral health grant programs.

Citation / Title	Authority / Impact on Agency
Texas Government Code, Chapter 547A / Community Collaboratives	Establishes a grant program administered by HHSC to support the creation or expansion of community collaboratives serving individuals experiencing homelessness, mental illness, or substance use issues. The statute requires grantees to select outcome measures and secure matching non-state funds or in-kind contributions.
Texas Government Code, Chapter 548 / Health Care Services Provided Through Tele/Connective Means	Provides for the delivery and reimbursement of services under Medicaid and other public assistance services, through telemedicine, telehealth, and other telecommunications technologies. The statute encourages provider participation to increase access to a range of services, including behavioral health services.
Texas Government Code, Chapter 549 / Provision of Drugs and Information	Provides HHSC with authority to enter into joint bulk purchasing agreements for prescription drugs and implement value-based arrangements in the Medicaid vendor drug program and establishes a state prescription drug program. The chapter includes preferred drug list considerations, prior authorization requirements, and Drug Utilization Review Board provisions.
Texas Government Code, Chapter 550 / Human Services and Other Social Services Provided through Faith/and Community/based Organizations	Provides a framework for HHSC to partner with faith- and community-based organizations to deliver health and human services programs. The statute establishes the community-based navigator program, liaisons with faith- and community-based organizations, and an interagency coordination group to facilitate effective partnerships.
Texas Government Code, Chapter 664 / State Employees Health Fitness and Education	Grants the executive commissioner rulemaking authority related to the State Employee Wellness Program.
Texas Government Code, Chapter 572 / Personal Financial disclosure, Standards of Conduct, and Conflict of Interest	Makes "a member of" HHSC an "appointed officer of a major state agency" for purposes of certain ethics requirements.
Texas Government Code, Chapter 662 / Holidays and Recognition Days, Weeks, and Months	Includes specific tasks for HHSC related to Postpartum Depression Awareness Month and Neonatal Abstinence Syndrome Awareness Month.
Texas Government Code, Chapter 772 / Governmental Planning	Requires HHSC's participation on the Sexual Assault Survivors' Task Force and Interagency Work Group on Border Issues.

Citation / Title	Authority / Impact on Agency
Texas Government Code, Chapter 2001, Section 2001.223 / Administrative Procedure	Section 2001.223 specifically excepts HHSC actions relating to individual financial or medical assistance determinations from the APA's declaratory judgement, court, enforcement, and contest case requirements.
Texas Government Code, Chapter 2054 / Information Resources	Requires HHSC's participation as an ex officio member of the Department of Information Resources' governing board. Requires HHSC's participation in an electronic system for occupational licensing transactions.
Texas Government Code, Chapter 2101 / Accounting Procedures	Requires HHSC's participation on the Comptroller's Enterprise Resource Planning Advisory Council.
Texas Government Code, Chapter 2105 / Administration of Block Grants	Defines procedures for agencies designated to receive block grants, specifically includes HHSC.
Texas Government Code, Chapter 2155 / Purchasing General Rules and Procedures	Provides rules and procedures for state purchasing, including procurement methods, contract formation, and ethical standards. Describes specific standards for HHSC's acquisition goods and services at best value.
Texas Government Code Chapter 2157 / Purchase of Automated Information Systems	Provides statutory definitions and guidance regarding the purchase of IT commodities.
Texas Government Code, Chapter 2167 / Lease of Space for State Agencies	Specifically exempts HHSC residential spaces from the application of general requirements. Requires HHSC's approval to lease office space for a health and human services agency.
Texas Government Code, Chapter 2177 / Texas Pharmaceutical Initiative	Administratively attaches the Texas Pharmaceutical Initiative to HHSC. Requires HHSC's participation on the Texas Pharmaceutical Initiative Advisory Council.
Texas Government Code, Chapter 2262 / Statewide Contract Management	Requires HHSC's participation on the Contract Advisory Team.
Texas Government Code, Chapter 2273 / Prohibited Transactions	Grants the executive commissioner certain responsibilities relating to taxpayer resource transactions involving an abortion provider or affiliate of an abortion provider.
Texas Government Code, Chapter 2306 / Texas Department of Housing and Community Affairs	Requires HHSC's participation on the Texas Interagency Council for the Homeless and a housing and health services coordination council.
Texas Health and Safety Code, Chapter 12 / Powers and Duties of Department of State Health Services	Gives the executive commissioner general supervision and control over all matters relating to the health of Texans.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 13 / Department Hospitals and Respiratory Facilities	Grants the executive commissioner rulemaking and contracting authority relating to DSHS hospitals and respiratory facilities.
Texas Health and Safety Code, Chapter 31 / Primary Health Care	Establishes the Texas Primary Health Care Services Program to provide primary health care services to low-income individuals. The statute defines applicable services, including diagnosis, treatment, and preventive care, and authorizes HHSC to contract with providers.
Texas Health and Safety Code, Chapter 33 / Phenylketonuria, Other Heritable Diseases, Hypothyroidism, and Certain Other Diseases	Grants the executive commissioner rulemaking authority relating to certain congenital, inherited, and other diseases and condition.
Texas Health and Safety Code, Chapter 32 / Maternal and Infant Health Improvement	Establishes a program to improve maternal and infant health through access to perinatal services, health education, and ancillary care. The statute authorizes HHSC to enter contracts or award grants for services and describes eligibility requirements and funding. The statute includes provisions concerning the WIC program promoting fathers' involvement, perinatal health system, and Healthy Texas Women.
Texas Health and Safety Code, Chapter 34 / Texas Maternal Mortality and Morbidity Review Committee	Requires HHSC to make information on substance use and domestic violence available on its website. Requires HHSC to evaluate options for reducing pregnancy-related deaths and identify strategies to improve quality outcomes and reduce costs, and submit biennial reports to state leadership on maternal morbidity and mortality. Requires HHSC to develop a program to deliver prenatal and postpartum care through telehealth or telemedicine in certain counties. Requires the executive commissioner to apply for grants under the federal Preventing Maternal Deaths Act of 2018.
Texas Health and Safety Code, Chapter 35 / Children with Special Health Care Needs	Establishes the Children with Special Health Care Needs program to provide case management, medical, and family support services to children with chronic physical or developmental conditions and persons of any age with cystic fibrosis. The statute outlines eligibility requirements, cost-sharing payments, service coordination, and integration with other health and social programs.
Texas Health and Safety Code, Chapter 36 / Special Senses and Communication Disorders	Grants the executive commissioner rulemaking authority relating to the identification and remediation of special senses and communication disorders.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 37 / Abnormal Spinal Curvature in Children	Grants the executive commissioner rulemaking authority relating to the detection of abnormal spinal curvature in children.
Texas Health and Safety Code, Chapter 40 / Epilepsy	Establishes an epilepsy program to provide diagnostic, treatment, and support services to eligible individuals with epilepsy. The statute authorizes HHSC to adopt rules, appoint an administrator, and enter contracts to facilitate service delivery.
Texas Health and Safety Code, Chapter 41 / Hemophilia	Establishes a hemophilia assistance program to help individuals afford blood factor replacement products and related treatments. The statute includes eligibility requirements and allows HHSC to provide premium assistance.
Texas Health and Safety Code, Chapter 42 / Kidney Health Care	Provides for the development and expansion of programs for individuals with end-stage renal disease, including dialysis and other life-saving treatments. The statute authorizes HHSC to provide services, enter contracts, seek funding from public and private sources, and establish accreditation standards for end-stage renal disease facilities.
Texas Health and Safety Code, Chapter 45 / Distribution of Child Passenger Safety Seat Systems	Grants the executive commissioner rulemaking authority relating to a child passenger safety seat system program.
Texas Health and Safety Code, Chapter 46 / Congenital Cytomegalovirus	Grants the executive commissioner rulemaking authority relating to education and outreach concerning congenital cytomegalovirus.
Texas Health and Safety Code, Chapter 47 / Hearing Loss in Newborns	Grants the executive commissioner rulemaking authority relating to newborn hearing screening programs.
Texas Health and Safety Code, Chapter 48 / Promotoras and Community Health Workers	Requires health and human services agencies to use certified promotoras to the extent possible in health outreach and education programs for Medicaid recipients.
Texas Health and Safety Code, Chapter 50 / Sex Trafficking Prevention and Victim Treatment Programs	Establishes a program to improve care for victims of child sex-trafficking through designated health-related institutions of higher education. The statute creates a matching grant program for municipalities to assess and address local sex-trafficking prevention needs. It creates a trafficked persons program to provide grants for dedicated housing and treatment facilities.
Texas Health and Safety Code, Chapter 52 / Sickle Cell Task Force	Requires the executive commissioner to establish and provide administrative support to a task force to raise awareness of sickle cell disease and sickle cell trait.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 54 / Thriving Texas Families	Establishes the Thriving Texas Families program to support women with unexpected pregnancies through a statewide network of service providers. The statute authorizes HHSC to contract for services and contains eligibility requirements and performance measures concerning healthy birth outcomes, child development, and economic self-sufficiency.
Texas Health and Safety Code, Chapter 61 / Indigent Health Care and Treatment Act	Provides a framework for counties and hospital districts to deliver basic health care services to eligible low-income residents. The statute defines eligibility requirements, mandates service provision and reporting requirements, and outlines funding responsibilities.
Texas Health and Safety Code, Chapter 62 / Child Health Plan for Certain Low/income Children	Establishes CHIP as a separate program to provide primary and preventive care and disease management services to low-income, uninsured children not eligible for Medicaid. The statute outlines eligibility requirements, contracting provisions, benefits, cost sharing requirements, and coordination with federal Title XXI of the Social Security Act funding.
Texas Health and Safety Code, Chapter 63 / Health Benefits Plan for Certain Children	Provides health benefits plan coverage for certain children who are immigrants and are ineligible for Medicaid or CHIP. The statute includes eligibility requirements and cost-sharing provisions.
Texas Health and Safety Code, Chapter 65 / Prescription Drug Savings Program for Certain Uninsured Individuals	Establishes a prescription drug savings program administered by HHSC to provide discounted medications to uninsured individuals. The statute ensures cost neutrality by using rebate funds, authorizes contracting with a pharmacy benefit manager, and prohibits coverage of drugs used for elective pregnancy termination.
Texas Health and Safety Code, Chapter 81 / Communicable Diseases; Public Health Disasters; Public Health Emergencies	Requires the executive commissioner to exercise authority in matters relating to public health to prevent the introduction of disease into the state.
Texas Health and Safety Code, Chapter 82 / Cancer Registry	Grants the executive commissioner rulemaking authority relating to the operation and maintenance of a cancer registry.
Texas Health and Safety Code, Chapter 83 / Chronic Kidney Disease Task Force	Requires HHSC to provide administrative support to the Chronic Kidney Disease Task Force, including support relating to funding.
Texas Health and Safety Code, Chapter 84 / Reporting of Occupational Conditions	Grants the executive commissioner rulemaking authority relating to the reporting of occupational conditions.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 85 / Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus Infection	Requires the executive commissioner to establish the Texas HIV Medication Advisory committee.
Texas Health and Safety Code, Chapter 87 / Birth Defects	Requires the executive commissioner to establish a program at DSHS to identify, investigate, and maintain a record of birth defects.
Texas Health and Safety Code, Chapter 88 / Reports of Childhood Lead Poisoning	Grants the executive commissioner rulemaking authority relating to the reporting and prevention of lead poisoning in children.
Texas Health and Safety Code, Chapter 89 / Screening and Treatment for Tuberculosis in Jails and Other Correctional Facilities	Requires the executive commissioner to adopt rules addressing the review of local standards for tuberculosis screening tests or examinations.
Texas Health and Safety Code, Chapter 92 / Injury Prevention and Control	Grants the executive commissioner rulemaking authority relating to certain reportable injuries.
Texas Health and Safety Code, Chapter 95A / Reports on Prevention and Treatment of Diabetes	Requires HHSC to prepare a biennial report on HHSC's priorities for addressing diabetes within the Medicaid population.
Texas Health and Safety Code, Chapter 96 / Respiratory Syncytial Virus	Requires the executive commissioner to establish a program at DSHS to identify Respiratory Syncytial Virus (RSV) infections in children and maintain a database of confirmed cases for research purposes.
Texas Health and Safety Code, Chapter 98 / Reporting of Health Care/Associated Infections and Preventable Adverse Events	Grants the executive commissioner rulemaking authority relating to the required reporting of health care-associated infections and preventable adverse events.
Texas Health and Safety Code, Chapter 99 / Open Burn Pit Registry	Grants the executive commissioner rulemaking and contracting authority relating to a registry of service members and veterans who were exposed to open burn pit smoke or other airborne hazards during certain military service.
Texas Health and Safety Code, Chapter 100 / Emerging and Neglected Tropical Diseases	Requires the executive commissioner to establish a program at DSHS to identify individuals infected with emerging or neglected tropical diseases and maintain a database of confirmed cases research purposes.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 103 / Texas Diabetes Council	Requires HHSC's participation on the Texas Diabetes Council. Requires HHSC to participate in the development, production, and implementation of public awareness initiatives relating to diabetes.
Texas Health and Safety Code, Chapter 104 / Statewide Health Coordinating Council and State Health Plan	Establishes a statewide health coordinating council to guide health care resource allocation and planning. The statute requires submission of a statewide health plan every six years.
Texas Health and Safety Code, Chapter 105 / Health Professions Resource Center	Grants the executive commissioner rulemaking authority relating to data reporting and a workplace violence prevention grant program.
Texas Health and Safety Code, Chapter 107A / Center for Elimination of Disproportionality and Disparities	Establishes a center within HHSC for eliminating health and health access disparities.
Texas Health and Safety Code, Chapter 108 / Health Care Data Collection	Authorizes HHSC to direct DSHS to collect health care data from a Medicaid managed care organization to assist in the evaluation of the Medicaid managed care system/
Texas Health and Safety Code, Chapter 113 / Texas Child Mental Health Care Consortium	Requires HHSC's participation in the Texas Child Mental Health Care Consortium and the consortium's governing code.
Texas Health and Safety Code, Chapter 118 / Palliative Care Interdisciplinary Advisory Council	Requires HHSC to establish the Palliative Care Interdisciplinary Advisory Council and a statewide palliative care education program.
Texas Health and Safety Code, Chapter 119A / Pediatric Acute/Onset Neuropsychiatric Syndrome Advisory Council	Requires HHSC's participation on the Pediatric Acute-Onset Neuropsychiatric Syndrome Advisory Council.
Texas Health and Safety Code, Chapter 120 / Task Force of Border Health Officials	Requires the executive commissioner to adopt short-term and long-term border health improvement plans and to direct DSHS to implement the plans to the extent possible within available appropriations.
Texas Health and Safety Code, Chapter 121 / Local Public Health Reorganization Act	Grants the executive commissioner rulemaking authority relating to local public health services and grants for essential public health services.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 141 / Youth Camps	Requires the executive commissioner to appoint an advisory committee on youth camps and grants the executive commissioner rulemaking authority for the regulation of youth camps.
Texas Health and Safety Code, Chapter 142 / Home and Community Support Services	Provides licensing and regulatory standards for agencies delivering home health, hospice, and personal assistance services. The statute describes home and community support service types, administrative responsibilities, surveys, investigations, complaints, and penalties provisions, and compliance requirements for HHSC oversight.
Texas Health and Safety Code, Chapter 146 / Tattoo and Certain Body Piercing Studios	Grants the executive commissioner rulemaking authority relating to licensing and health and safety standards.
Texas Health and Safety Code, Chapter 161 / Public Health Provisions	Provides requirements and processes for public health initiatives, including immunizations, disease prevention, and health data reporting. The statute authorizes HHSC to implement rules and coordinate with other agencies during public health emergencies and outlines provision of information for parents of newborn children and prohibitions of Medicaid and CHIP reimbursement for gender transitioning or reassignment procedures to certain children.
Texas Health and Safety Code, Chapter 162 / Blood Banks and Donation of Blood	Requires the executive commissioner to develop and update a brochure on stem cells contained in the umbilical cord blood after delivery of an infant. Grants the executive commissioner rulemaking authority relating to the expenditure of certain funds.
Texas Health and Safety Code, Chapter 164. Treatment Facilities Marketing and Admission Practices	Provides consumer protections against deceptive marketing by mental health and chemical dependency treatment facilities. The statute prohibits facilities soliciting and contracting with certain referral sources and conditioning employee compensation based on patient revenue. The statute authorizes rule making authority to HHSC and promotes transparency through disclosure requirements.
Texas Health and Safety Code, Chapter 166 / Advance Directives	Provides a legal framework for individuals to make advance decisions about medical treatment, including directives to physicians, out-of-hospital do not resuscitate (DNR) orders, and medical powers of attorney. The statute outlines procedures for resolving disputes and authorizes HHSC to adopt rules for a DNR protocol and disposition and maintenance of DNR orders.
Texas Health and Safety Code, Chapter 170 / Prohibited Acts Regarding Abortion	Provides restrictions on performing abortions during the third trimester unless specific medical conditions are met. The statute requires physicians to certify in writing the medical necessity of such procedures and report them to HHSC.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 171 / Abortion	Provides requirements for informed consent, sonograms, and physician qualifications related to abortion procedures with prohibitions on performing an abortion on an unborn child with detectable fetal heartbeat. The statute mandates that HHSC enforce compliance and maintain oversight of abortion providers.
Texas Health and Safety Code, Chapter 181 / Medical Records Privacy	Imposes responsibilities with respect to medical privacy, including an annual report.
Texas Health and Safety Code, Chapter 191 / Administration of Vital Statistics Records	Grants the executive commissioner rulemaking authority relating to collecting, recording, transcribing, compiling, and preserving vital statistics, including fees and the prevention of fraud.
Texas Health and Safety Code, Chapter 192 / Birth Records	Grants the executive commissioner rulemaking authority relating to birth records, including fees, special and supplementary certificates, and name changes.
Texas Health and Safety Code, Chapter 193 / Death Records	Grants the executive commissioner rulemaking authority relating to death records, including the filing of a death certification and expedited death certificates in certain circumstances.
Texas Health and Safety Code, Chapter 194 / Marriage and Divorce Records	Grants the executive commissioner rulemaking authority relating to marriage and divorce records, including applications and special certificates.
Texas Health and Safety Code, Chapter 222 / Health Care Facility Survey, Construction, Inspection, and Regulation	Provides HHSC with authority to adopt rules for hospital surveys, planning, and construction in alignment with federal standards. The statute includes provisions related to surveys of health care and Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID) facilities.
Texas Health and Safety Code, Chapter 241 / Hospitals	Provides licensing provisions and operational standards for hospitals in Texas under HHSC oversight. The statute authorizes HHSC to conduct any necessary inspections, surveys, and investigations and provides authority to impose penalties.
Texas Health and Safety Code, Chapter 242 / Convalescent and Nursing Facilities and Related Institutions	Provides licensing provisions, change of ownership information, and operational standards for nursing facilities. The statute authorizes HHSC to conduct inspections, surveys, and investigations, and impose penalties for noncompliance.
Texas Health and Safety Code, Chapter 243 / Ambulatory Surgical Centers	Provides licensing provisions and operational standards for ambulatory surgical centers. The statute authorizes HHSC to set minimum standards, conduct inspections and investigations, and impose penalties for noncompliance.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 244 / Birthing Centers	Provides licensing provisions and operational standards for birthing centers. The statute authorizes HHSC to set minimum standards, conduct inspections and investigations, and impose penalties for noncompliance.
Texas Health and Safety Code, Chapter 245 / Abortion Facilities	Provides licensing provisions and operational standards for abortion facilities. The statute authorizes HHSC to set minimum standards, conduct inspections and investigations, and impose penalties for noncompliance.
Texas Health and Safety Code, Chapter 247 / Assisted Living Facilities	Provides licensing provisions and operational standards for assisted living facilities. The statute authorizes HHSC to set minimum standards, conduct inspections, surveys, and investigations, and impose penalties for noncompliance.
Texas Health and Safety Code, Chapter 248 / Special Care Facilities	Provides licensing provisions and operational standards for special care facilities. The statute authorizes HHSC to set minimum standards, conduct inspections and investigations, and impose penalties for noncompliance.
Texas Health and Safety Code, Chapter 248A / Prescribed Pediatric Extended Care Centers	Provides licensing provisions and operational standards for prescribed pediatric extended care centers. The statute authorizes HHSC to set minimum standards, conduct inspections and investigations, and impose penalties for noncompliance.
Texas Health and Safety Code, Chapter 250 / Nurse Aide Registry and Criminal History Checks of Employees and Applicants for Employment in Certain Facilities Serving the Elderly, Persons with Disabilities, or Persons with Terminal Illness	Authorizes HHSC to establish the nurse aide registry, to provide qualified nurse aides with certificates of registration, and to adopt rules related to the issuance and renewal of such certificates.
Texas Health and Safety Code, Chapter 251 / End Stage Renal Disease Facilities	Provides licensing provisions and operational standards for end stage renal disease facilities. The statute authorizes HHSC to set minimum standards, conduct inspections and investigations, and impose penalties for noncompliance.
Texas Health and Safety Code, Chapter 252 / Intermediate Care Facilities for Individuals with an Intellectual Disability	Provides licensing provisions and operational standards for intermediate care facilities for individuals with intellectual or developmental disabilities. The statute authorizes HHSC to set minimum standards, conduct surveys, inspections, and investigations, and impose penalties for noncompliance.
Texas Health and Safety Code, Chapter 253 / Employee Misconduct; Registry	Requires HHSC to investigate reports of “reportable conduct” by employees of certain facilities and to establish an employee misconduct registry containing identifying information of those employees found to have engaged in reportable conduct.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 254 / Freestanding Emergency Medical Care Facilities	Provides licensing provisions and operational standards for free standing emergency medical care facilities. The statute authorizes HHSC to set minimum standards, conduct inspections and investigations, and impose penalties for noncompliance.
Texas Health and Safety Code, Chapter 255 / Quality Assurance Early Warning System for Long-term Care Facilities; Rapid Response Teams	Establishes an early warning system and quality monitoring program to detect and respond to health, safety, and resident welfare risks in long-term care facilities. The statute authorizes HHSC to deploy quality-of-care monitors and rapid response teams to assess and improve facility conditions and quality of care.
Texas Health and Safety Code, Chapter 259 / Surgical Technologists at Health Care Facilities	Grants the executive commissioner rulemaking authority relating to surgical technologists, including practice and continuing education requirements.
Texas Health and Safety Code, Chapter 260 / Boarding Home Facilities	Provides permitting and inspection and reporting standards for boarding home facilities. The statute requires HHSC to develop model standards for safety, sanitation, and resident well-being and authorizes counties and municipalities to elect to permit and inspect such facilities
Texas Health and Safety Code, Chapter 260A / Reports of Abuse, Neglect, and Exploitation of Residents in Certain Facilities	Requires HHSC to investigate abuse, neglect, and exploitation of residents of nursing facilities, assisted living facilities, and prescribed pediatric extended care centers and to adopt rules governing such investigations. The statute also requires facilities to report and investigate such abuse, neglect, or exploitation.
Texas Health and Safety Code, Chapter 260B / Right to Essential Caregiver Visits for Certain Residents	Requires the executive commissioner to develop rules, guidelines, and processes related to essential caregiver visits in certain long term care facilities.
Texas Health and Safety Code, Chapter 260C / In/Person Visitation with Religious Counselor	Requires the executive commissioner to develop rules relating to in-person religious counselor visitation policies and procedures in certain health care facilities.
Texas Health and Safety Code, Chapter 263 / County Hospitals and Other Health Facilities	Gives the executive commissioner responsibility for certain decisions affecting county hospitals.
Texas Health and Safety Code, Chapter 311 / Powers and Duties of Hospitals	Provides hospitals with responsibilities related to billing, indigent care, and community benefit reporting. Authorizes HHSC to create rules governing reporting and collection of hospital financial and utilization data.

Citation / Title	Authority / Impact on Agency
<u>Texas Health and Safety Code, Chapter 314 / Cooperative Agreements Among Hospitals</u>	Relates to approval by “the department” (now HHSC) of certain cooperative agreements among hospitals.
<u>Texas Health and Safety Code, Chapter 317 / Designation of Caregiver for Receipt of Aftercare Instruction</u>	Grants the executive commissioner rulemaking authority relating to a hospital’s obligations with respect to caregivers and patient aftercare.
<u>Texas Health and Safety Code, Chapter 321 / Provision of Mental Health, Chemical Dependency, and Rehabilitation Services</u>	Provides a bill of rights for patients receiving mental health, chemical dependency, or rehabilitation services in inpatient facilities. The statute requires HHSC to adopt rules ensuring patient safety, informed consent, and appropriate treatment settings, and imposes penalties for violating provisions of the chapter.
<u>Texas Health and Safety Code Chapter 322 / Use of Restraint and Seclusion in Certain Health Care Facilities</u>	Prohibits the use of certain restraints in certain facilities. The chapter requires HHSC to adopt rules defining acceptable restraints that minimize the risk of harm to residents and governing the use of seclusion. The chapter prohibits retaliation by a facility against a person that files a complaint regarding a restraint and provides for penalties for violations.
<u>Texas Health and Safety Code, Chapter 323 / Emergency Services and Forensic Examination Programs for Survivors of Sexual Assault</u>	Provides requirements for hospitals and emergency facilities to offer standardized emergency services and forensic exams to survivors of sexual assault. The statute authorizes HHSC to designate sexual assault forensic exam-ready facility (SAFE-ready facilities) and conduct investigations to ensure compliance with SAFE protocols.
<u>Texas Health and Safety Code, Chapter 324 / Consumer Access to Health Care Information</u>	Grants the executive commissioner rulemaking authority relating to consumer access to information about health care facility pricing, billing, and complaints.
<u>Texas Health and Safety Code, Chapter 326 / Staffing Requirements for Facilities Providing Care to Persons with Alzheimer's Disease or Related Disorders</u>	Gives HHSC authority to assess an administrative penalty against certain facilities for failing to maintain written policies related to the care of persons with Alzheimer’s disease and related disorders.
<u>Texas Health and Safety Code, Chapter 327 / Disclosure of Prices</u>	Makes HHSC responsible for monitoring and enforcing compliance with hospital price transparency requirements.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 341 / Minimum Standards of Sanitation and Health Protection Measures	Grants the executive commissioner rulemaking authority relating to sanitation and health protection, including rules relating to special sanitation facilities, pool and water safety, and public restrooms.
Texas Health and Safety Code, Chapter 401 / Radioactive Materials and Other Sources of Radiation	Grants the executive commissioner rulemaking authority relating the regulation of radioactive materials and other sources of radiation within health and human services system jurisdiction.
Texas Health and Safety Code, Chapter 427 / Texas Environmental Health Institute	Authorizes the executive commissioner, in coordination with the Texas Commissioner on Environmental Quality, to enter contracts relating to an institute established for the study of health problems associated with environmental contamination.
Texas Health and Safety Code, Chapter 431 / Texas Food, Drug, and Cosmetic Act	Grants the executive commissioner rulemaking authority relating to the regulation of food, drugs, and cosmetics.
Texas Health and Safety Code, Chapter 432 / Food, Drug, Device and Cosmetic Salvage Act	Grants the executive commissioner rulemaking authority to assist in preventing the sale or distribution of adulterated or misbranded food, drugs, devices, or cosmetics.
Texas Health and Safety Code, Chapter 433 / Texas Meat and Poultry Inspection Act	Grants the executive commissioner rulemaking authority relating to health and safety standards for meat and meat food products.
Texas Health and Safety Code, Chapter 435 / Dairy Products	Grants the executive commissioner rulemaking authority relating to the regulation of milk and milk products.
Texas Health and Safety Code, Chapter 436 / Aquatic Life	Grants the executive commissioner rulemaking authority relating to the regulation of molluscan shellfish and crabmeat processes.
Texas Health and Safety Code, Chapter 437 / Regulation of Food Service Establishments, Retail Food Stores, Mobile Food Units, and Roadside Food Vendors	Grants the executive commissioner rulemaking authority relating to food preparation or sale and to food handlers, food service employees, and food managers in certain settings.
Texas Health and Safety Code, Chapter 437A / Mobile Food Service Establishments Operating in Certain Counties in More Than One Municipality	Authorizes the executive commissioner to adopt rules reflecting county regulation of certain mobile food service establishments.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 438 / Public Health Measures Relating to Food	Grants the executive commissioner rulemaking authority relating to the preparation and sale of food, including unpackaged foods, food service programs, food safety training, and food manager certification.
Texas Health and Safety Code, Chapter 439 / Manufacture and Distribution of Certain Drugs	Requires the executive commissioner to adopt rules to administer Subchapter C, Preservation and Distribution of Certain Unused Drugs. Also requires the executive commissioner to adopt rules related to the written verification required in Subchapter D, Insulin.
Texas Health and Safety Code, Chapter 440 / Frozen Desserts Manufacturer Licensing Act	Grants the executive commissioner rulemaking authority relating to the operation of establishments that manufacture frozen desserts and similar food items.
Texas Health and Safety Code, Chapter 441 / Drug Cost Transparency	Requires pharmaceutical drug manufacturers to report information on certain prescription drugs to HHSC. Requires the executive commissioner to adopt rules.
Texas Health and Safety Code, Chapter 442 / Donation of Prescription Drugs	Requires the executive commissioner to adopt rules related to the donation and redistribution of prescription drugs.
Texas Health and Safety Code, Chapter 443 / Manufacture, Distribution, and Sale of Consumable Hemp Products	Grants the executive commissioner rulemaking authority relating to the regulation of food, drugs, devices, or cosmetics that contain hemp or one or more hemp-derived cannabinoids.
Texas Health and Safety Code, Chapter 444 / Wholesale Prescription Drug Importation Program	Requires HHSC to establish a wholesale prescription drug importation program.
Texas Health and Safety Code, Chapter 445	Grants the executive commissioner rulemaking authority relating to the safe consumption and distribution of kratom and kratom products.
Texas Health and Safety Code, Chapter 461A / Department of State Health Services: Chemical Dependency Services and Related Programs	Provides a framework to deliver prevention, intervention, treatment, and rehabilitation services for individuals with chemical dependency. The statute authorizes HHSC to set model standards, operate an opioid antagonist program, and provide chemical dependency services through local behavioral health authorities.
Texas Health and Safety Code, Chapter 462 / Treatment of Persons with Chemical Dependencies	Provides provisions for voluntary admission, emergency detention, protective custody, and court-ordered treatment of individuals with chemical dependencies. The statute authorizes HHSC to develop rules concerning intake, assessment, and admission to a treatment facility.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 464 / Facilities Treating Persons with a Chemical Dependency	Provides licensing provisions and operational standards for facilities offering chemical dependency treatment. The statute authorizes HHSC to set requirements and standards, conduct inspections and investigations, and impose penalties for noncompliance.
Texas Health and Safety Code, Chapter 466 / Regulation of Narcotic Drug Treatment Programs	Provides for the permitting and operational standards of narcotic treatment programs that use approved narcotic medications in the treatment of persons with a narcotic drug dependency. The statute authorizes HHSC to adopt rules, conduct inspections and investigations, and impose penalties for noncompliance.
Texas Health and Safety Code, Chapter 467 / Peer Assistance Programs	Provides for the development of minimum criteria for a peer assistance program established by a professional association or licensing or disciplinary authority. The executive commissioner is required to adopt the criteria.
Texas Health and Safety Code Chapter 469 / Voluntary Accreditation of Recovery Housing	Provides a framework for HHSC to adopt minimum standards for accreditation as a recovery house. Limits accrediting organizations to National Alliance for Recovery Residences and Oxford House. Restricts certain places from eligibility for accreditation.
Texas Health and Safety Code, Chapter 481 / Texas Controlled Substances Act	Requires the executive commissioner's approval for certain modifications of the schedules of controlled substances. Authorizes the executive commissioner to establish a controlled substance therapeutic research program for certain controlled substances.
Texas Health and Safety Code, Chapter 485 / Abusable Volatile Chemicals	Grants the executive commissioner rulemaking authority relating to the sale and labeling of inhalable abusable volatile chemical products.
Texas Health and Safety Code, Chapter 486 / Over-the-Counter Sales of Ephedrine, Pseudoephedrine, and Norpseudoephedrine	Grant the executive commissioner rulemaking authority relating to the sale of certain drug products.
Texas Health and Safety Code, Chapter 487 / Texas Compassionate Use Act	Requires the executive commissioner to adopt rules relating to compassionate use research and reporting.
Texas Health and Safety Code, Chapter 489 / Access to Investigational Treatments for Patients with Terminal Illnesses	Authorizes the executive commissioner to adopt a form to record informed consent for access and use of an investigational treatment under certain circumstances.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 490 / Access to Investigation Treatments for Patients with Severe Chronic Diseases	Grants the executive commissioner rulemaking authority relating to access to investigational treatments under certain circumstances, including eligibility and informed consent.
Texas Health and Safety Code, Chapter 491 / Ibogaine Treatment	Directs HHSC to facilitate the conduct of certain drug development clinical trials.
Texas Health and Safety Code, Chapter 501 / Hazardous Substances	Grants the executive commissioner rulemaking authority relating to the designation and regulation of hazardous substances
Texas Health and Safety Code, Chapter 502 / Hazard Communication Act	Grants the executive commissioner rulemaking authority relating to the communication of information about hazardous chemicals and potential exposures.
Texas Health and Safety Code Chapter 531 / Provisions Generally Applicable to Mental Health and Intellectual Disability Services	Establishes the state's policies and goals related to the provision of mental health and intellectual disability services. Establishes HHSC as the authority at the state and local level to ensure effective administration of mental health and intellectual disability services with an emphasis on prioritizing services to those who are most in need.
Texas Health and Safety Code Chapter 532 / General Provisions Relating to Department of State Health Services	Establishes department facilities and community services as component parts of the mental health system, and the names of the state operated mental health facilities, a medical director to oversee the clinical services provided at the state operated mental health facilities, allows for any advisory committees considered necessary to assist mental health program, and establishes a forensic director to oversee coordination of statewide forensic services
Texas Health and Safety Code Chapter 532A / General Provisions Relating to Department of Aging and Disability Services	Establishes facilities and community services as component parts of the IDD system and specifically identifies the state operated residential facilities for people with intellectual disability (SSLCs); requires appointment of the head of each SSLC and a medical director to oversee clinical services at the SSLCs; and allows for the appointment of any advisory committee considered necessary to assist in the agency's intellectual disability programs.
Texas Health and Safety Code, Chapter 533 / Powers and Duties of Department of State Health Services	Provides for the management of mental health services. The chapter includes provisions for developing model program standards, the use of criminal history record information relating to volunteers and applicants, oversight through unannounced visits, how HHSC designates and coordinates with LMHAs, and LMHA requirements for disease management practices and jail diversion. Also includes required reporting on NGRI commitments.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 533A / Powers and Duties of Department of Aging and Disability Services	Provides for the management of services for individuals with intellectual and developmental disabilities. The statute includes provisions for use of criminal history record information relating to volunteers and applicants, oversight through unannounced visits, long-range planning, comprehensive assessment and resource allocation, details how LIDDAs are designated by HHSC, and establishing Local Intellectual and Developmental Disability Authority (LIDDA) responsibilities. Also requires reporting on NGRI commitments.
Texas Health and Safety Code, Chapter 534 / Community Services	Provides for the establishment and operation of community centers offering mental health and intellectual disability services, and how such centers are approved by HHSC. The statute describes required community-based mental health services and authorizes HHSC to adopt rules requiring continuity of care for patients between facilities and local mental health authorities (LMHAs), local behavioral health authorities (LBHAs,) and LIDDAs and to design a competitive procurement process for mental health authorities awarding contracts for community-level services.
Texas Health and Safety Code, Chapter 551 / General Provisions	Provides for the general powers and duties of state hospitals and state supported living centers, their superintendents and directors, authority to design, construct, equip, furnish and maintain buildings on their campuses. Also includes when facility medical staff may consent to care.
Texas Health and Safety Code, Chapter 552 / State Hospitals	Provides authority for state hospitals with respect to their operations including the prohibition of handguns on campus premises, contracting with certain public institutions, filing claims for unpaid costs of support, maintenance treatment, and rights of essential caregivers.
Texas Health and Safety Code Chapter 553 / San Antonio State Supported Living	Statute acknowledges the existence and purpose of the San Antonio State Supported Living Center. Authorizes DADS (now HHSC) to contract with DSHS regarding the use of excess public health hospital facilities.
Texas Health and Safety Code Chapter 554 / State Centers and Homes	Designates the Waco Center for Youth as a residential treatment facility for emotionally disturbed juveniles, establishes admission criteria, and requires educational services.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code Chapter 555 / State Supported Living Centers	Establishes Mexia and San Angelo SSLCs as forensic facilities and requires all residents under a forensic commitment to be evaluated to determine whether they pose risk to other residents. Allows HHSC to conduct criminal background checks of applicants, employees, contractors, and volunteers and allows random and reasonable suspicion drug testing of certain employees. Requires HHSC to adopt a policy requiring reporting of reasonable suspicion. Establishes the Office of Independent Ombudsman. Authorizes the Inspector General to conduct certain investigations at SSLCs. Permits residents or their legally authorized representative to conduct electronic monitoring of bedrooms. Establishes right to essential caregiver visits (also included in state constitution).
Texas Health and Safety Code, Chapter 571 / General Provisions	Provides the foundational principles of the Texas Mental Health Code, ensuring appropriate treatment and legal protections for individuals with mental illness. The statute outlines rights, procedures for involuntary care, and safeguards for voluntary patients. The statute requires HHSC to increase understanding of the Texas Mental Health Code Information Program and allows HHSC to prescribe forms, applications, certificates and records for use at mental health facilities, and to visit mental health facilities to review commitment procedures and investigate complaints. This chapter also establishes which counties pay for mental health proceedings.
Texas Health and Safety Code, Chapter 572 / Voluntary Mental Health Services	Provides procedures for voluntary admission to inpatient or outpatient mental health services (including to state hospitals and HHSC funded community programs), including consent requirements for minors. This chapter allows for the self-admission of a juvenile that is 16-years of age or older and establishes how DFPS may request admission. The statute authorizes HHSC to adopt rules governing intake and assessment procedures and outlines discharge protocols. This chapter also authorizes a facility to not accept a voluntary admission if there is not sufficient space in the facility.
Texas Health and Safety Code, Chapter 573 / Emergency Detention	Provides authority for peace officers and certain medical personnel to detain individuals with mental illness who pose a risk of harm. The statute outlines criteria for detention, transportation procedures, and rights during emergency holds. The statute authorizes HHSC to adopt rules about informing persons of their rights when apprehended, detained, or transported for emergency detention. This chapter also applies when state hospitals accept admissions on an emergency detention.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 574 / Court/Ordered Mental Health Services	Provides procedures for obtaining court-ordered mental health services (including limited options for involuntary admissions for juveniles), including applications, hearings, and judicial determinations. The statute ensures due process protections and outlines criteria for temporary or extended inpatient or outpatient treatment, as well as authorizing HHSC to adopt rules concerning providing psychoactive medication upon SH discharge. This chapter also applies when SHs accept inpatient admissions, and when HHSC funded community programs accept outpatient admissions. This chapter also addresses when court-ordered psychoactive medications may be sought by a provider.
Texas Health and Safety Code, Chapter 575 / Admission and Transfer Procedures for Inpatient Services	Provides guidelines for facility administrators admitting and transferring patients within inpatient mental health facilities (including those operated by HHSC and LMHAs). The statute includes provisions for transferring persons with an intellectual disability to SSLCs, and from SSLCs to state hospitals.
Texas Health and Safety Code, Chapter 576 / Rights of Patients	Provides a bill of rights for individuals receiving mental health services, affirming their constitutional and legal protections. The statute includes provisions on confidentiality, competency, access to independent evaluations, and notifications. This chapter also addresses when psychoactive medications may be administered.
Texas Health and Safety Code, Chapter 577 / Private Mental Hospitals and Other Mental Health Facilities	Provides licensing requirements and operational standards for private mental health hospitals and other mental health facilities, including crisis stabilization units. The statute authorizes HHSC to set standards, conduct surveys, inspections, and investigations, and impose penalties for noncompliance.
Texas Health and Safety Code, Chapter 577A / Psychiatric Residential Youth Treatment Facilities	Establishes a certification process for psychiatric residential youth treatment facilities serving individuals under 21 in non-hospital settings. The chapter requires the executive commissioner to adopt rules establishing minimum standards for certification of psychiatric residential youth treatment facilities and to implement a voluntary quality standards certification process. Requires HHSC to conduct inspections and investigations and authorizes penalties for noncompliance.
Texas Health and Safety Code Chapter 578 / Electroconvulsive and Other Therapies	Establishes standards for use of electroconvulsive therapy (ECT), consent to ECT, and requires physician administration. Requires the executive commissioner to adopt rules for the consent form, and to set a fee for equipment registration and to collect provider reports.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 580 / In Patient Competency Restoration Services	Requires HHSC to enter into a memorandum of understanding with local governmental entities and LMHA/LBHA's to outline the respective powers and duties of the parties with respect to inpatient competency restoration services. Requires reporting enumerated data to HHSC and the legislature regarding inpatient competency restoration services.
Texas Health and Safety Code, Chapter 591 / General Provisions	Codifies the State's policy regarding intellectual disability services, requires the executive commissioner to ensure implementation by rule, establishes the agency's responsibilities regarding intellectual disability services, requires HHSC to develop a long-range plan regarding intellectual disability services, provides for penalties.
Texas Health and Safety Code Chapter 592 / Rights of Persons with an Intellectual Disability	Lists the rights of people with an intellectual disability, cl and addresses when psychoactive medication may be administered. Outlines the process for determining intellectual disability and requires the executive commissioner to adopt rules regarding the use of restraints. Establishes a process by which an SSLC may obtain a court order to administer psychoactive medication over the objection of the resident.
Texas Health and Safety Code, Chapter 593 / Admission and Commitment to Intellectual Disability Services	Provides procedures for voluntary and involuntary admission to intellectual disability services through HHSC or community centers. The statute includes provisions for formal determination of intellectual disability, obtaining consent for services, conducting hearings, setting fees, filing claims for unpaid support and maintenance, and planning treatment.
Texas Health and Safety Code Chapter 594 / Transfer and Discharge	Provides procedures for transferring or discharging a resident from an SSLC; provides for the temporary transfer of an SSLC resident to state hospitals for acute psychiatric services.
Texas Health and Safety Code Chapter 595 / Records	Provides that the records of people receiving services through any program relating to intellectual disabilities are confidential and may only be disclosed in accordance with this chapter. Authorizes HHSC to adopt rules to implement.
Texas Health and Safety Code, Chapter 597 / Capacity of Clients to Consent to Treatment	Provides a framework for assessing clients in an ICF/IDD capacity to consent to treatment. The statute authorizes HHSC to adopt rules for a uniform assessment process to determine client capacity to consent to treatment and allows for surrogate decision-making when certain criteria are met. This statute only applies to non-state operated ICFs.
Texas Health and Safety Code, Chapter 611 / Mental Health Records	Provides confidentiality protections for mental health records and communications between patients and professionals. The statute outlines limited confidentiality exceptions requiring or authorizing disclosure and affirms patients' rights to access their records.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code Chapter 612 / Interstate Compact on Mental Health	The chapter adopts the terms of the Interstate Compact on Mental Health which governs the process by which people needing mental health or intellectual disability services may be transferred in between member states. Authorizes the executive commissioner to adopt rules.
Texas Health and Safety Code Chapter 613 / Kidney Donation by Ward with Intellectual Disability	The chapter permits a district court to authorize the donation of a kidney by a ward (a person with a guardian) with an intellectual disability. The donation may be made to certain family members of the ward if the legal criteria are met.
Texas Health and Safety Code, Chapter 614 / Texas Correctional Office on Offenders with Medical or Mental Impairments	Requires HHSC to enter MOUs with TDCJ addressing continuity of care for elderly offenders and offenders with physical disabilities, terminal illnesses, or significant illnesses.
Texas Health and Safety Code, Chapter 671 / Determination of Death and Autopsy Reports	Requires the executive commissioner to adopt rules relating to the determination of death in certain settings.
Texas Health and Safety Code, Chapter 673 / Sudden Infant Death Syndrome	Requires the executive commissioner to adopt rules defining sudden infant death syndrome and describing the process for requesting reimbursement for the cost of an autopsy
Texas Health and Safety Code, Chapter 697 / Disposition of Embryonic and Fetal Tissue Remains	Requires “the department” (now HHSC) to establish and maintain a registry of participating funeral homes and cemeteries willing to provide free common burial or low-cost private burial and private nonprofit organizations that register to provide financial assistance for costs associated with burial or cremation of embryonic and fetal tissue remains and make this information available on request. Requires HHSC to develop a grant program using private donations for financial assistance with costs associated with disposing of embryonic and fetal tissue remains. Requires HHSC to adopt rules to implement this chapter and authorizes it to suspend or revoke the license of a health care facility that violates this chapter, or a rule adopted under it.
Texas Health and Safety Code, Chapter 711 / General Provisions Relating to Cemeteries	Provides requirements and protocols for the establishment, maintenance, and regulation of cemeteries in Texas. The statute includes provisions for abandoned cemeteries, cremation, and cemetery organizations. This chapter includes certain access requirements. This chapter does not exclude SH/SSLC cemeteries.
Texas Health and Safety Code, Chapter 751 / Mass Gatherings	Requires the executive commissioner to adopt rules relating to sanitation at mass gatherings.

Citation / Title	Authority / Impact on Agency
Texas Health and Safety Code, Chapter 768 / Children Participating in Rodeos	Requires the executive commissioner to adopt rules relating to children participating in rodeos, including rules relation to protective equipment and requirements for educational programs.
Texas Health and Safety Code, Chapter 771 / State Administration of Emergency Communications	Requires the executive commissioner's participation as a nonvoting ex officio member of the Commission on State Emergency Communications.
Texas Health and Safety Code, Chapter 773 / Emergency Medical Services	Grants the executive commissioner rulemaking authority relating to emergency medical services and personnel.
Texas Health and Safety Code, Chapter 821 / Treatment of Animals	Grants the executive commissioner rulemaking authority relating to euthanasia of animals.
Texas Health and Safety Code, Chapter 822 / Regulation of Animals	Grants the executive commissioner rulemaking authority relating to certain animals, including registration and caging.
Texas Health and Safety Code, Chapter 826 / Rabies	Grants the executive commissioner rulemaking authority relating to the prevention and control of rabies.
Texas Health and Safety Code, Chapter 828 / Dog and Cat Sterilization	Requires the executive commissioner to adopt guidelines for the expenditure of certain funds.
Texas Health and Safety Code, Chapter 841 / Civil Commitment of Sexually Violent Predators	Establishes a civil commitment process for individuals deemed sexually violent predators likely to engage in repeated acts of sexual violence. The statute authorizes long-term supervision and treatment through the TCCO. Furthermore, the statute authorizes HHSC to provide services for a committed person with an intellectual or developmental disability, mental illness, or physical disability preventing the person from effectively participating in the sex offender treatment program.
Texas Health and Safety Code, Chapter 1001 / Department of State Health Services	Provides for the organization and responsibilities of DSHS under the oversight of HHSC. The statute authorizes HHSC to administer substance use prevention and treatment programs; and inspect, license, and enforce regulations regarding substance abuse treatment facilities. In addition, the statute authorizes HHSC to award grants for mental health first aid training. This chapter also includes a requirement to screen clients for private insurance coverage, where applicable (this is used by state hospitals).
Texas Health and Safety Code, Chapter 1003 / Adult Stem Cells	Authorizes HHSC to establish eligibility criteria for the creation and operation of an autologous adult stem cell bank.

Citation / Title	Authority / Impact on Agency
Texas Human Resources Code, Chapter 12 / Penal Provisions	Makes it an offense to solicit, disclose, receive, or make use of, or to authorize, knowingly permit, participate in, or acquiesce in the use of the names of, or any information concerning, persons applying for or receiving assistance from HHSC programs.
Texas Human Resources Code, Chapter 21 / Administrative Provisions Relating to Agencies Administering Assistance Programs	Grants the executive commissioner rulemaking authority relating to the confidentiality of information. Grants certain commission staff authority to administer oaths and take acknowledgments relating to eligibility for assistance programs.
Texas Human Resources Code, Chapter 22 / General Functions Relating to Human Services	Provides HHSC with authority to administer welfare functions, including medical and financial assistance to eligible individuals and families. The statute designates HHSC as the agency to administer Titles IV, XIX, and XX of the federal Social Security Act, requires HHSC to establish case management programs for high-risk pregnant women and children through their first birthday, outlines provisions related to fraud monitoring and prevention, and authorizes HHS to administer programs serving individuals who are deaf-blind with multiple disabilities.
Texas Human Resources Code, Chapter 23 / Suspension of Driver's or Recreational License for Failure to Reimburse Commission	Provides HHSC with authority to request the suspension of a person's driver's or recreational license if the person fails to reimburse the agency for SNAP or TANF overpayments. The statute outlines procedures for notification, hearings, and reinstatement of licenses.
Texas Human Resources Code, Chapter 31 / Financial Assistance and Services Programs	Provides HHSC authorization to administer TANF financial assistance and services to families with dependent children. The statute outlines application processes, financial assistance limitations, and work requirements. Requires HHSC and the Texas Workforce Commission (TWC) to enter into a MOU for coordinated case management. Authorizes the Healthy Marriage and Strong Families Programs.
Texas Human Resources Code, Chapter 32 / Medical Assistance Program	Provides HHSC authorization to administer Medicaid. The statute mandates compliance with federal law and contains provisions regarding provider database, health information technology, and long-term care.
Texas Human Resources Code, Chapter 33 / Nutritional Assistance Programs	Provides for the operation of SNAP, Child and Adult Care Food Program, and the Summer Food Service Program. The statute includes administrative provisions, such as application assistance, technology use, fraud prevention, and workforce management improvements.

Citation / Title	Authority / Impact on Agency
Texas Human Resources Code, Chapter 34 / State Temporary Assistance and Support Services Program	Establishes a state-level assistance program distinct from TANF for two-parent families and residents of minimum service counties. The statute mandates collaboration between HHSC and TWC to jointly implement the program.
Texas Human Resources Code, Chapter 35 / Support Services for Persons with Disabilities	Authorizes HHSC to offer subsidies and support services to individuals with disabilities who live independently or with their families. The statute outlines criteria for the adoption of rules pertaining to eligibility, rates, and copayment systems as well as describing the types of assistance available to promote independence and community integration.
Texas Human Resources Code, Chapter 36 / Health Care Program Fraud Prevention	Provides HHSC and OIG with authority to investigate and pursue civil enforcement actions against fraud in Medicaid and other state-funded health care programs. The statute outlines fraudulent acts and penalties and describes HHSC actions for suspending and revoking agreements, license and certification ineligibility, and authorizes attorney general access to documentary materials.
Texas Human Resources Code, Chapter 40 / Department of Family and Protective Services	Requires HHSC to enter a contract with DFPS for certain administrative support services, including payroll, procurement, information resources, rate setting, purchasing, and contracting.
Texas Human Resources Code, Chapter 42 / Regulation of Certain Facilities, Homes, and Agencies that Provide Child/care Services	Provides HHSC with authority to license and regulate childcare facilities to protect the health, safety, and well-being of children. The statute requires minimum standards and mandates investigations of abuse or neglect in childcare settings.
Texas Human Resources Code, Chapter 43 / Regulation of Child/Care and Child/Placing Agency Administrators	Provide authority to license and regulate childcare and child-placing agency administrators.
Texas Human Resources Code, Chapter 48 / Investigations and Protective Services for Elderly Persons and Persons with Disabilities	Provides HHSC with authority to investigate abuse, neglect, and exploitation of elderly individuals and persons with disabilities receiving services from certain providers. The statute requires risk assessment criteria enabling the provision of protective services for persons in imminent risk or in a state of abuse, neglect, or exploitation.
Texas Human Resources Code, Chapter 51 / Family Violence Centers	Establishes a statewide network of nonprofit family violence centers contracting with HHSC to provide shelter and services to survivors of family violence. The chapter defines family violence and outlines the types of services and supports available to survivors and requires HHSC to develop a plan for delivering family violence services.

Citation / Title	Authority / Impact on Agency
Texas Human Resources Code, Chapter 73 / Early Childhood Intervention Services	Designates HHSC as the lead agency for the administration, supervision, and monitoring of a statewide system of ECI services for children with developmental delays. The chapter describes eligibility criteria and mandates strategic planning, interagency coordination, and the use of advisory committees to guide program performance.
Texas Human Resources Code, Chapter 74 / Quad/Agency Child Care Initiative	Requires HHSC's participation in the Quad-Agency Child Care Initiative Commission.
Texas Human Resources Code, Chapter 81 / Functions of Department of Assistive and Rehabilitative Services Relating to Persons Who are Deaf or Hard of Hearing	Provides for the development and implementation of statewide programs to support individuals who are deaf, hard of hearing, or deaf-blind. The statute requires HHSC to coordinate with public and nonprofit organizations, maintain a registry of interpreters, support interpreter education, cooperatively establish standards and create an advisory board to assist in administering the interpreter certification program. Authorizes HHSC to appoint advisory committees, contract, collect fees, develop guidelines, provide training, establish a program for interpreter certification, and take actions regarding certifications.
Texas Human Resources Code, Chapter 91 / Functions of Department of Assistive and Rehabilitative Services Relating to the Blind and Person with Visual Disabilities	Provides for the delivery of services to individuals who are blind or visually impaired. The chapter provides HHSC has primary responsibility for providing certain services, serves as an information center and referral resource, develops mechanisms and procedures to assist individuals, and operates a Blindness Education, Screening, and Treatment Program. The chapter authorizes HHSC to provide additional services, establish a loan program, and contract for goods and services.
Texas Human Resources Code, Chapter 101A / State Services for the Aging	Provides HHSC with authority to coordinate and deliver services for older adults, including employment, volunteer, and Options for Independent Living programs. The statute includes provisions relating to rules adoption, program administration, and funding.
Texas Human Resources Code, Chapter 102 / Rights of the Elderly	Establishes rights for elderly individuals. Requires HHSC to ensure individuals or entities licensed, registered, or certified by HHSC implement and enforce those rights. Authorizes suspension or revocation to address a violation.
Texas Human Resources Code, Chapter 103 / Day Activity and Health Services	Establishes programs to provide structured day activity and health services for older adults and persons with disabilities. The statute describes licensing, compliance reviews, and administrative penalty provisions.

Citation / Title	Authority / Impact on Agency
<u>Texas Human Resources Code, Chapter 111 / Rehabilitation Services for Certain Individuals with Disabilities</u>	Authorizes HHSC to deliver rehabilitation services to individuals with disabilities to help them achieve employment or greater independence. The statute outlines eligibility, service types, the comprehensive rehabilitation account, and procurement methods.
<u>Texas Human Resources Code, Chapter 112 / Developmental Disabilities</u>	Requires HHSC to coordinate activities intended to reduce the incidence and severity of developmental disabilities.
<u>Texas Human Resources Code, Chapter 114 / Autism and Pervasive Developmental Disorders</u>	Requires HHSC to coordinate resources for individuals with autism and other pervasive developmental disorders and their families.
<u>Texas Human Resources Code, Chapter 117 / Department of Assistive and Rehabilitative Services</u>	Provides for the administration of programs, such as ECI, the Comprehensive Rehabilitation program, and Children's Autism program to support individuals with disabilities. The statute includes definitions, administrative and rules provisions, and coordination with centers for independent living.
<u>Texas Human Resources Code, Chapter 123 / Community Homes for Persons with Disabilities</u>	Requires HHSC to make every reasonable effort to ensure the safety of residents of a community home operated by or under its regulatory jurisdiction and the residents of a neighborhood that is affected by the location of the community home.
<u>Texas Human Resources Code, Chapter 132 / Facilitation of Delivery of Health and Human Services</u>	Directs HHSC to plan and coordinate office space and location to improve client access and to achieve a cost-effect, one-stop or service center method of service delivery.
<u>Texas Human Resources Code, Chapter 136 / Texas Community Health Center Revolving Loan Program</u>	Requires HHSC to contract with a development corporation to administer the Texas Community Health Center Revolving Loan Program.
<u>Texas Human Resources Code, Chapter 137 / Family Support Services</u>	Establishes a system of family support services to assist children and at-risk families and prevent involvement with child welfare or justice systems. Requires HHSC to administer grants and contracts for family support services. The chapter requires coordination, outcome tracking, and local engagement to improve family stability, and requires development of a preventive services program to serve certain veterans and military families.

Citation / Title	Authority / Impact on Agency
Texas Human Resources Code, Chapter 161 / Department of Aging and Disability Services	Provides HHSC with authority over aging and disability services, including oversight of state supported living centers and applying for and serving as guardian of the person or estate for incapacitated persons referred to HHSC by DFPS or the courts in certain circumstances. The statute describes contracting for services for individuals with developmental disabilities, waiver programs, implementation of lifespan respite services program, and outlines responsibilities for ensuring quality care and compliance.
Texas Human Resources Code, Chapter 201 / General Provisions	Requires the executive commissioner to meet at least annually with the leadership of TJJD, Texas Education Agency (TEA), DFPS, DSHS, and TWC to discuss shared issues relating to at-risk youth and youthful offenders, and community support systems for families and youth; resolve conflicts in providing services to youth; and make recommendations to the governor and legislature.
Texas Human Resources Code, Chapter 203 / General Powers and Duties of Board and Department	Requires HHSC's participation on the Advisory Council on Juvenile Services.
Texas Insurance Code, Chapter 843 / Health Maintenance Organizations	Provides regulatory requirements for health maintenance organizations (HMOs) operating in Texas. The statute defines service requirements, complaint procedures, and financial standards. To implement Medicaid managed care, HHSC contracts with HMOs to serve as managed care organizations (MCOs).
Texas Insurance Code, Chapter 845 / Statewide Rural Health Care System	Establishes a statewide rural health care system and requires, to the extent consistent with federal law, the award of a Medicaid managed care contract to the system in certain areas.
Texas Insurance Code, Chapter 847 / Health Care Quality Assurance	Provides for recognition of certain national accreditations of health benefit plans and seeks to foster coordination among state agencies to reduce consumer cost in health benefit plan coverage and reduce duplication of effort by health benefit plans and state agencies. The chapter contains provisions relating to presumed compliance and regulatory requirements.
Texas Insurance Code, Chapter 1207 / Enrollment of Medical Assistance Recipients and Children Eligible for State Child Health Plan	Provides that group health plans must allow enrollment of Medicaid recipients and CHIP-eligible children outside standard enrollment periods. The statute contains further provisions related to enrollment, enrollment dates, and termination of enrollment.
Texas Insurance Code, Chapter 1301 / Preferred Provider Benefit Plans	Exempts Medicaid and CHIP from requirements otherwise applicable to a preferred provider benefit plan.

Citation / Title	Authority / Impact on Agency
Texas Insurance Code, Chapter 1369 / Benefits Related to Prescription Drugs and Devices and Related Services	Requires HHSC's participation on the Advisory Committee on Uniform Prior Authorization Forms.
Texas Insurance Code, Chapter 1380 / Human Organ Transplant	Specifically includes the Medicaid program and Medicaid managed care program in requirements relating to human organ transplant.
Texas Insurance Code, Chapter 4201 / Utilization Review Agents	Specifically exempts certain health and human services programs from certain requirements otherwise applicable in the context of utilization review.
Texas Labor Code Chapter 62 / Minimum Wage	Section 62.057 permits the payment of sub-minimum wages to patients or clients of a department facility; clarifies no employer/employee relationship between the patient/client and state agency.
Texas Labor Code, Chapter 302 / Division of Workforce Development	Provides for the administration of workforce development programs by TWC. The statute requires TWC to report on the TANF Choices Program recipients and collaborate with HHSC and other state agencies in evaluating the effectiveness of TWC's childcare program.
Texas Occupations Code, Chapter 102 / Solicitation of Patients	Provides penalties for offering or accepting payment in exchange for patient referrals to licensed health care providers. The statute authorizes HHSC to take disciplinary action against licensed health care providers committing patient solicitation offenses.
Texas Occupations Code, Chapter 110 / Council on Sex Offender Treatment	Creates the Council on Sex Offender Treatment (CSOT) to develop treatment strategies for sex offenders, set treatment standards, and recommend methods of improving programs to meet CSOT standards. Places CSOT "within the department" (now HHSC). Requires HHSC to employ an executive director and staff necessary to perform CSOT's administrative duties, including licensing and regulation of sex offender treatment providers.
Texas Occupations Code, Chapter 116 / Training Course on Human Trafficking Prevention	Provides that certain health care practitioners must complete a human trafficking prevention training course approved by HHSC to renew their licenses. The statute requires the executive commissioner to approve training courses and post a list of approved courses on the HHSC website.
Texas Occupations Code, Chapter 254 / Board Powers and Duties	Requires an agreement between the State Board of Dental Examiners and HHSC to improve coordination on issues affecting the Medicaid program, including referrals for fraud, waste, and abuse.

Citation / Title	Authority / Impact on Agency
Texas Occupations Code, Chapter 504 / Chemical Dependency Counselors	Provides licensing and regulatory standards for chemical dependency counselors, including definitions, scope of practice, and supervision requirements. The chapter requires the executive commissioner to adopt rules and establish standards of conduct and ethics for licensees, issue licenses, conduct investigations, and impose penalties for noncompliance.
Texas Occupations Code, Chapter 1954 / Asbestos Health Protection	Grants the executive commissioner rulemaking authority relating to the protection of public health relating to asbestos.
Texas Occupations Code, Chapter 1955 / Lead/Based Paint Abatement	Grants the executive commissioner rulemaking authority relating to certification of persons involved in lead-based paint abatement activities.
Texas Penal Code, Chapter 35A / Health Care Fraud	Affects HHSC by imposing criminal penalties on certain acts impacting health care programs administered by HHSC, including Medicaid.
Texas Penal Code, Chapter 46 / Weapons	Section 46.03(a)(12) provides that a firearm, location-restricted knife, club, or other prohibited weapons cannot be taken onto the premises of a mental hospital, unless the administration provides permission. Premises does not include driveways, streets, sidewalks or walkways, parking lots or garages, or other parking areas.
Texas Transportation Code, Chapter 504 / License Plates	Dedicates certain fees to be used by HHSC to fund a contract under section 264.002 of the Texas Family Code, relating to Court-Appointed Volunteer Advocate Programs.
Texas Transportation Code, Chapter 521 / Driver's Licenses and Certificates	Sections 521.371-521.376 requires HHSC to approve a substance misuse educational program for drivers whose licenses were suspended because of certain drug convictions and who are receiving services within chemical dependency treatment facilities (CDTFs). Requires HHSC and Department of Public Safety (DPS) to jointly adopt and HHSC to publish rules for the qualification and approval of equivalent education provided in a CDTF and requires HHSC to monitor compliance.
Texas Utilities Code, Chapter 17 / Customer Protection	Requires HHSC to help develop a process to identify low-income customers to certain electric and telecommunications providers to enable those providers to offer customer service, discounts, bill payment assistance, or other assistance.
Texas Utilities Code, Chapter 55 / Regulation of Telecommunications Services	Requires HHSC and the Public Utilities Commission to enter into a memorandum of understanding concerning the enrollment of eligible consumers to receive lifeline services.

Citation / Title	Authority / Impact on Agency
<u>Texas Utilities Code, Chapter 56 / Telecommunications Assistance and Universal Service Fund</u>	Requires HHSC establish a specialized telecommunications assistance program to provide financial assistance to individuals with disabilities that impair their ability to access the telephone network to assist the individuals with the purchase of basic specialized equipment or services. The statute authorizes HHSC to reimburse telecommunications providers for lifeline services and adopt relay access rules.
<u>Texas Constitution Article 1, Section 15/a / Commitment of Persons of Unsound Mind</u>	Relates to the commitment of persons of unsound mind.
<u>Texas Constitution, Article 1, Section 35 / Right of Certain Facility Residents to Designate Essential Caregiver</u>	Grants residents of nursing facilities, assisted living facilities, ICFs/IID, Home and Community-based Services (HCBS), and SSLCs the right to name an essential care giver who may not be prohibited from in-person visitation.
<u>Texas Constitution, Article 3, Section 51/a / Assistance Grants, Medical Care, and Certain Other Services for Needy Persons; Federal Matching Funds</u>	Describes the Legislature’s authority with respect to assistance grants, medical care, and related services.
<u>Texas Constitution Article 9, Section 13 / Participation of Municipalities and Other Political Subdivisions in Establishment and Operation of Mental Health, Mental Retardation, or Public Health Services</u>	Relates to the participation of political subdivisions in mental health or public health services.
<u>Texas Constitution Article 16, Section 6 / Appropriations for Private Purposes, Annual Accounting of Public Money, Acceptance and Expenditure of Certain Money for Persons with Disabilities</u>	Relates to state participation in programs for persons with mental illness.

Table 3. Attorney General Opinions.

Attorney General Opinion No.	Impact on Agency
<u>Opinion No. LO95-063 (1995)</u>	Concludes that the “good cause” language contained in Texas Health and Safety Code, Section 551.022(d)(3), provides that certain state facility employees hold a property interest in their employment that is protected by the 14th Amendment.
<u>Opinion No. GA-0403 (2006)</u>	Concludes that an establishment that furnishes food and shelter to four or more persons who are unrelated to the proprietor and that requires those persons to obtain personal care services through the proprietor’s licensed home health agency is an assisted living facility (ALF) that must be licensed under Health and Safety Code, Section 247.021(a). An ALF may not require a resident to use a particular personal care services provider for health care services, but an ALF may restrict the resident’s ability to contract with personal care services providers for services other than health care. To the extent an ALF’s contract with the resident requires the resident to obtain non-health care personal care services from a specified provider, the facility may enforce the contract.
<u>Opinion No. GA-0844 (2011)</u>	Concludes that federal law does not preempt Texas Human Resources Code, Section 32.0248(h), which prohibited HHSC, in the operation of the women’s healthcare demonstration project, from contracting with entities that are affiliates of entities that perform or promote elective abortions. (Note: Section 32.0248 expired by its terms August 31, 2011, and the Medicaid Women’s Health Program is no longer in operation.)
<u>Opinion No. GA-0845 (2011)</u>	Concludes that HHSC has authority to define by rule the term “affiliate,” if the definition is consistent with Texas Human Resources Code, Section 32.0248(h). (Note: Section 32.0248 expired by its terms August 31, 2011, and the Medicaid Women’s Health Program is no longer in operation.)
<u>Opinion No. GA-0983 (2013)</u>	Concludes that, to the extent HHSC’s rule at 1 Texas Administrative Code Section 354.1143(b) limits HHSC’s obligation to pay Medicare deductibles and coinsurance for an ambulance service provided to a person eligible for both Medicare and Medicaid benefits, the rule conflicts with Texas Human Resources Code, Section 32.050(c), and is unenforceable.
<u>Opinion No. GA-1004 (2013)</u>	Concludes that the Employee Retirement System (ERS) is authorized to require the payment of interest to establish service credit of an employee who has been reinstated following a grievance proceeding and that it is up to HHSC to determine how it will pay interest to ERS to establish service credit for an employee who is reinstated after a grievance.
<u>Opinion No. KP-0300 (2020)</u>	Concludes that Texas Government Code, Section 551.007, permits a governmental body to hold one public comment period at the beginning of an open meeting to address all agenda items; and it also permits a government body to adopt reasonable rules regarding public comment, including time limitations.

Attorney General Opinion No.	Impact on Agency
<u>Opinion No. KP-0353 (2021)</u>	Concludes that whether and the extent to which a physician must supervise a certified registered nurse anesthetist depends on the act delegated, the type of facility, and any relevant regulations of the facility. Concludes that questions of physician liability in a specific context, including the delegation of the administration of anesthesia, are highly fact-dependent and not an appropriate question for the opinion process.
<u>Opinion No. KP-0362 (2021)</u>	Concludes that stemming the spread of COVID-19 is a compelling government interest. However, to the extent other less restrictive safety protocols further the government interest, a court would likely conclude that restricting an individual's access to clergy, unless the individual is facing death, violates the state and federal constitutions and the Texas Religious Freedom Restoration Act because it is not the least restrictive means to address the compelling government interest.
<u>Opinion No. KP-0372 (2021)</u>	Concludes that the Behavioral Health Executive Council (BHEC) lacks authority to adopt a rule prohibiting discrimination beyond what the Legislature authorized it to address.
<u>Opinion No. KP-0401 (2022)</u>	Concludes that certain medical procedures performed on children can constitute child abuse. "Sex change procedures and treatments," including surgical interventions, puberty-blocking drugs, and cross-sex hormones, performed to transition individuals with gender dysphoria, can legally constitute child abuse. A court would likely consider the fundamental right to procreation, issues of physical and emotional harm, consent laws, and existing child abuse standards. The opinion does not apply to the rare circumstances where such procedures may be medically necessary.
<u>Opinion No. KP-0475 (2024)</u>	Concludes that Texas Government Code, Section 551.041, requires notice of each subject the governmental body will address at both open and closed meetings; and boilerplate language that a closed meeting may commence under certain provisions of the Open Meetings Act is insufficient to alert the public of the subject to be considered at the closed meeting.
<u>Opinion No. KP-0489 (2025)</u>	Concludes that district courts do not have the power to order state agencies to amend a person's biological sex on driver licenses or birth certificates. State agencies must correct driver licenses or birth certificates that were changed pursuant to the now-void orders.

B. Provide a summary of significant legislation regarding your agency by filling in the tables below or attaching information already available in an agency-developed format. Briefly summarize the key provisions. For bills that did not pass but were significant, briefly explain the key provisions and issues that resulted in failure of the bill to pass (e.g., opposition to a new fee or high cost of implementation). Place an asterisk next to bills that could have a major impact on the agency. See Exhibit 16 Examples.

In the 89th Regular Legislative Session, HHSC tracked nearly 2,300 bills and provided fiscal notes on more than 300 bills that could have had a large financial impact to agency operations but did not pass. Below are the lists of significant legislation (enacted and not passed) regarding HHSC during the 89th Regular Legislative Session.

Health and Human Services Commission

Exhibit 16: 89th Legislative Session

Table 4. Legislation Enacted

Bill Number	Author	Summary of Key Provisions
H.B. 0012	Bell, Keith	The bill introduces a new definition for “Regulatory agency” as a state agency with authority to manage licenses and authorizations; and requirements related to: • Soliciting public input during the review of a state agency by the Sunset Commission; • Analyzing and evaluating state agency performance measures and related targets during the review of a regulatory agency; • Recommendations to improve state agency performance measures and related targets; and • Recommending and completing a limited review of a regulatory agency and the agency’s rulemaking process prior to the next Sunset Review period, accompanied by a corresponding report that is public record. The Health and Human Services Commission (HHSC), as a regulatory agency, will comply with these requirements.
H.B. 0018	VanDeaver	The "Rural Health Stabilization and Innovation Act" modifies health care services in rural Texas by establishing new support structures and funding mechanisms. Key provisions include: • Amends the requirements for the Rural Hospital Strategic Plan to require HHSC to include a rural hospital financial needs assessment and financial vulnerability index and changes the dates that the report is due. HHSC will need to travel to Rural Hospitals for site visits and coordination. • Requires the establishment of a temporary advisory committee to advise on creation of a curriculum for the Texas Rural Hospital Officers Academy. HHSC will need to hire additional staff, procure contracts to administer the Fiscal Officer Academies, as well as curriculum development and maintenance support. HHSC will also be required to reimburse academy participants for travel. • Establishes a financial stabilization grant program, an emergency hardship grant program, an innovation grant program, and a hospital supports grant program. This will require HHSC to hire additional staff with training and software

Bill Number	Author	Summary of Key Provisions
		needs. • Requires HHSC to modify reimbursement rates every two years to the updated costs of delivering care and creates a maternal add-on rate for Medicaid services provided by a rural hospital that has an obstetrics and gynecology department. • Amends the statutes for the Pediatric Tele connectivity Grant Program to make the grant funds available to rural hospitals, and to remove certain limitations for eligibility to receive the grant funding.
H.B. 0026	Hull	The bill authorizes Medicaid managed care organizations in Texas to provide nutrition support services in-lieu-of (ILOS) other state Medicaid services. Key provisions include: • Allows for the inclusion of nutrition counseling and instruction services within Medicaid contracts while removing previous restrictions tied to mental health or substance use services. HHSC will perform rate setting functions associated with this service and provider type. • HHSC may establish a new pilot program to provide nutrition support services to pregnant recipients at risk due to chronic conditions, allowing for medically tailored meals as part of their care. • Services like home-delivered meals, food prescriptions, and grocery support are expressly prohibited from this expanded list of services. • HHSC is tasked with collecting data on health outcomes associated with these services and will report findings by August 31, 2030, when the pilot program concludes. Additionally, these changes will require Manage Care Organizations (MCOs) contract amendments and IT changes and may require an amendment to the 1115 demonstration waiver.

Bill Number	Author	Summary of Key Provisions
H.B. 0037	Plesa	This bill amends Chapter 328, Health and Safety Code, establishing an initiative and recognition program for perinatal bereavement care in Texas. Key provisions include: • Requires hospitals with a maternal designation (Levels I – IV per the Department of State Health Services (DSHS) guidelines) to provide perinatal bereavement care counseling options and a perinatal bereavement (e.g., cooling) device to parents and family members following an intrauterine fetal demise, neonatal death, or stillbirth. HHSC will coordinate with DSHS to enforce these requirements. • Directs DSHS to create and implement a Perinatal Bereavement Care Initiative and grant program for hospitals with a maternal designation to increase the accessibility to and quality of perinatal bereavement care, i.e., care to alleviate the suffering of parents and family members following an intrauterine fetal demise, neonatal death, or stillbirth. • Hospitals that receive funds can use the money for necessary costs related to the grant program, such as training staff to support patients and families, purchasing and maintaining cooling devices, and cooling device training. Additional examples of allowable costs will be determined by DSHS. • DSHS is directed to 1) award grant dollars prioritizing hospitals that lack access to a perinatal bereavement device; 2) treat a high number of high-risk maternal patients; and 3) deliver a greater number of babies. DSHS is allowed to accept gifts, grants, and donations from any source to help fund the grant program. • Directs the HHSC executive commissioner, in collaboration with the Perinatal Advisory Council (PAC) to develop a program to recognize hospitals with a maternal designation that provide perinatal bereavement care training to hospital staff and adopt criteria for awarding recognition to a hospital under this program.

Bill Number	Author	Summary of Key Provisions
H.B. 0114	Cortez	The bill relates to the transfer the administration of certain veteran mental health programs from HHSC and DSHS to the Texas Veterans Commission (TVC). Key provisions include: • Transfers Mental Health Programs for Veterans from HHSC to TVC. TVC must develop and administer a mental health program for veterans and outlines requirements of the program. • Transfers Texas Veterans and Family Alliance Grant Program from HHSC to TVC. TVC must establish a matching grant program to support community mental health programs that provide services and treatment to veterans and their families. • Transfers Veteran Suicide Prevention Action Plan from HHSC to TVC. • Transfers any obligations and contracts of HHSC that are directly related to a power, duty, function, program or activity transferred under this Act to TVC. • Transfers all property and records in the custody of HHSC that are related to a power, duty, function, program, or activity transferred under this Act, and all funds appropriated by the legislature for that power, duty, function, program, or activity to TVC. • HHSC and TVC must establish a plan for the transfer of personnel whose functions predominantly involve a power, duty, function, program, or activity transferred under this Act in anticipation of the Act becoming effective September 1, 2025. This will include required IT changes.
H.B. 0136	Hull	The bill introduces new provisions for Medicaid coverage and reimbursement for lactation consultation services and requires the separate reimbursement of lactation consultation services when delivered by an eligible provider who has a certification in lactation consultation by either an international or national certification program approved by the commission. HHSC will create a separate provider type for lactation consultant providers, which will include enrolling documentation/attestation of certification for delivering lactation counseling services. HHSC will perform rate setting functions associated with this new service and provider type. Additionally, these changes will require Medicaid and CHIP state plan amendments (SPAs), MCO contract amendments, and IT changes.

Bill Number	Author	Summary of Key Provisions
H.B. 0142	Noble, Candy	The bill updates several sections of the Texas Government Code related to HHSC's Office of Inspector General (OIG). Key provisions include: • Modifies language for selection and contracting of qualified experts to review investigative findings, classifying those experts and expert witnesses under Texas Government Code Section 2151.005. • Allows the OIG to share information with certain governmental entities in the course of conducting administrative oversight activities. • Specifies that, except as required by federal law, a fingerprint-based criminal background check (FCBC) is prohibited when a Medicaid provider is required to undergo the FCBC process if their license is in good standing. • Changes the requirement of a toll-free hotline to report suspected fraud to "an appropriate communications system." • Expands the OIG's Recovery Audit Contractor (RAC) program into managed care and allows for the recovery of overpayments from a provider or managed care organization. Additionally, to avoid duplicative recovery efforts, it prevents the RAC from initiating a review of a claim unless the OIG determines that it is cost effective and approves the review. It also requires at least one year to elapse since the claim was received by the managed care organization and prohibits the RAC from engaging in recovery efforts on a claim that the managed care organization has informed OIG it is auditing. Requires HHSC to adopt a process by rule for RAC appeals, in consultation with the OIG, as well as make required IT changes. • Repeals Texas Government Code, Section 544.0202, which required OIG to select a sample of all Medicaid claims and review the sample for potential fraud, waste, or abuse. • Repeals Texas Government Code, Section 544.0252(a), which required OIG to begin all preliminary investigations of fraud or abuse against a provider within 30 days, and complete them no later than 45 days after receipt.

Bill Number	Author	Summary of Key Provisions
H.B. 0149	Capriglione	The Texas Responsible Artificial Intelligence Governance Act introduces several key regulatory frameworks for artificial intelligence systems in Texas. Key provisions include: • Establishes certain guidelines and prohibitions on the use of AI for individuals and governmental agencies. The attorney general has exclusive enforcement authority punishable through civil penalty, with the exception of permitted sanctions by state agencies for individuals licensed, registered or certified by that agency. • Establishes a regulatory sandbox program through the Department of Information Resources (DIR), allowing for a legally protected environment to develop and test artificial intelligence systems. Periodic quarterly reporting is required of program participants as well as yearly reporting by the department. • Establishes the Texas Artificial Intelligence Advisory Council for certain purposes including the mitigation of risks or harms from AI, identifying barriers to innovation in development of AI, opportunities for AI to improve efficiency and effectiveness of state agencies, and the monitor the ethical and legal use of AI in this state. The council is administratively attached to DIR with appointments made by the governor, the lieutenant governor and the speaker of the house. HHSC will comply and work with DIR under this regulatory framework.
H.B. 0426	Bernal	The bill concerns Medicaid and child health plan coverage and reimbursement for childhood cranial remolding orthosis. Key provisions include: • Requires HHSC to reimburse the full cost of a cranial remolding orthosis for a child enrolled in Medicaid who has been diagnosed with: (1) craniosynostosis (premature fusing of the skull bones); or (2) plagiocephaly or brachycephaly (abnormal flattening of the skull) for children who are 3 months to 18 months of age; and have had documented failure to respond to conservative therapy for at least two months; and has one of the following sets of measurements or indications: § (i) asymmetrical appearance confirmed by a right/left discrepancy of greater than six millimeters in a craniofacial anthropometric measurement; or § (ii) brachycephalic or dolichocephalic disproportion in the comparison of head length to head width confirmed by a cephalic index of two standard deviations above or below mean. • Directs HHSC to provide coverage for cranial remolding orthosis in a manner equal to or more than the coverage required for other orthotics under the medical assistance

Bill Number	Author	Summary of Key Provisions
		program. HHSC will perform rate setting functions associated with expanding the Medicaid service/benefit and adding a new Children's Health Insurance Plan (CHIP) service/benefit. Additionally, these changes will require Medicaid and CHIP SPAs, MCO contract amendments, and IT changes.
H.B. 0913	Frank	This bill modifies the Texas Health and Safety Code by updating the list of state hospital names and introducing new management requirements. Key provisions include: • Splits North Texas State Hospital into two separate state hospitals: Vernon State Hospital and Wichita Falls State Hospital. • Adds Panhandle State Hospital and Lubbock Psychiatric Center to the list of state hospitals • Requires EC of HHSC establish rules requiring the employ of a superintendent at each state hospital.
H.B. 1188	Manuel	The Caytlin Handley Act introduces requirements for school districts to provide information about local intellectual and developmental disability authorities to parents or guardians of students with intellectual disabilities or developmental delays. Key provisions include: • During the first individualized education program (IEP) meeting, parents must be informed about services and public benefits offered by the local authority, including waiver program services under Section 1915(c) of the Social Security Act. • The Texas Education Agency (TEA), in collaboration with HHSC must develop and distribute informational materials to school districts.
H.B. 1393	Metcalf	This bill introduces year-round daylight saving time in Texas, under new Subsection (d) of Section 312.016 of the Government Code. It establishes that Texas will observe this practice regardless of whether regions within the state use central standard time or mountain standard time. The official term for the state's standard time will be designated as Texas Time. The enactment of this bill is contingent upon the United States Congress passing legislation that allows Texas to implement this change. If such federal legislation is not enacted, the bill will have no effect. If put into effect, HHSC would need to make IT changes to remove daylight savings time settings and modify WIC's Management Information System and Electronic Benefit System. Additionally, HHSC staff would need to travel and test each contracted grocer vendor's point-of-sale (POS) configuration.

Bill Number	Author	Summary of Key Provisions
H.B. 1500	Bell, Keith	This bill introduces changes to the DIR in Texas. Key changes/additions include: • The composition and training of the DIR governing board; • Training and certification on purchases and procurements for information resources; • Establishment of DIR advisory committees; • Acting on complaints to DIR; • Changes to the performance report on use of information resources technologies in state government; • Establishment of an information resources Procurement Services Pilot Program; • Changes to assessments on information security, now termed data governance; and • Revised direction to state agencies and the legislature on use of the telecommunications capitol complex system. The Act includes new direction to the comptroller to develop an electronic advertising system for certain state assistance opportunities. Corresponding changes to other currently available grant systems are included. HHSC will participate in the newly established advisory committees, the additional reports, required trainings, and certifications.
H.B. 2402	Rose	The bill states that the fee, charge, or rate for a covered prescription drug should be the usual and customary fee, charge or rate that prevails in the community unless the payment is limited by state or federal law. The bill excludes any fee, charge, or rate offered as part of a fee-based membership discount program from the usual and customary rate. The usual and customary price for a prescription drug is determined by individual pharmacies at the point of sale. Excluding rates offered as part of a fee-based membership discount program may have a fiscal impact on HHSC.

Bill Number	Author	Summary of Key Provisions
H.B. 2464	Hefner	This bill defines “home-based business” and introduces new regulations. Key provisions include: • Municipalities cannot enact ordinances that prohibit no-impact home-based businesses or require licenses for their operation. • Municipalities may enforce compliance with various federal, state, and local laws and can limit or prohibit home-based businesses that sell alcohol, illegal drugs, run sober living homes, or operate as sexually oriented businesses. • The bill clarifies that enforcement of homeowners' association restrictions and regulations on short-term rentals are unaffected. Concerning sober living homes, HHSC may need to develop contract amendments with current providers to incorporate regulations and requirements as outlined by governing municipal bodies. If the governing municipal bodies limits or prohibits the operation of a structured sober living home, any currently existing recovery home contracts may require contract terminations, amendments, and/or new contracts may need to be procured due to prohibition or limitation of current sober living homes.
H.B. 2768	Capriglione	The bill introduces a state information technology apprenticeship credential aimed at addressing workforce shortages in Texas' information resources sector. Key provisions include: • Collaboration with Educational Institutions: State agencies can partner with public junior colleges and technical institutes to offer apprenticeship programs that lead to this credential. • Program Requirements: These programs need approval from the Texas Higher Education Coordinating Board and must include a one-year apprenticeship with relevant organizations. • Substitution for Degree Requirements: The executive director of the Higher Education Coordinating Board is tasked with updating career ladder programs to allow the apprenticeship credential combined with an associate degree to substitute for a four-year degree. • Funding Sources: Agencies can utilize available funds or seek external donations if the program is not fully funded through tuition. HHSC would enter a memorandum of understandings (MOU) or interagency contracts (IAC) with education institutions to participate in apprenticeship programs.

Bill Number	Author	Summary of Key Provisions
H.B. 2789	Frank, James	The bill introduces exemptions and regulatory updates regarding child care regulation. Key provisions include: • Exempts Single Source Continuum Contractors (SSCC) from being required to be licensed • Removes tuberculosis screening for children in facilities regulated by HHSC • Reduces the amount of liability insurance coverage required from \$300,000 to \$100,000 for Licensed or Registered operations within HHSC and Listed Family Homes • Modifies the time that an initial license for a child care facility is valid from 6 months to 12 months • Modifies the requirements for "No Trespassing" signs • Replaces experience and educational qualifications including bachelors and masters degrees for Licensed Administrators at General Residential Operations (GRO) and Child Placing Agencies with "an experiential or educational equivalent to that of a bachelor's degree in social work, child development, or a similar field" • Lowers the fee for a late renewal for an Administrator's License. • Repeals Texas Human Resources Code, Section 42.0431(b), which required "Each day-care center or group day-care home licensed under this chapter shall maintain individual screening records for children attending the facility who are required to be screened, and the department may inspect those records at any reasonable time. The department shall coordinate the monitoring inspections in compliance with protocol agreements adopted between the department and the Department of State Health Services pursuant to Section 42.0442." HHSC Child Care Regulation will adopt new/update rules to align with the bill, make associated IT changes, and train staff on these new policies.

Bill Number	Author	Summary of Key Provisions
H.B. 2818	Capriglione	The bill establishes a new Artificial Intelligence (AI) division within the DIR. Key provisions include: • The creation of the division to be overseen by the executive director of DIR, who is responsible for its administration and organization. • The division may hire personnel, potentially from institutions of higher education, to fulfill its functions. • The division will assist state agencies in implementing generative artificial intelligence technology for modernizing legacy systems and other appropriate projects. • The division has the authority to use either internally developed or contracted generative AI technology for these projects and must ensure that the contracted technology completes the majority of project work. • A cost analysis report must be prepared for each project completed, detailing the savings and efficiencies realized by employing generative AI technology compared to traditional methods. • The DIR is tasked with coordinating division activities to ensure efficient use of resources and integration with other AI-related laws. • The bill also grants DIR the authority to adopt necessary rules for the administration of this new division. HHSC will accept assistance with DIR in implementing generative artificial intelligence technology for modernizing legacy systems and other appropriate projects.
H.B. 3153	Kerwin, Helen	The bill establishes employment requirements for HHSC regarding personnel who may have direct contact with children at HHSC regulated residential treatment facilities and group homes. Key provisions include: • Mandatory criminal history reviews and employment verifications for applicants, employees, volunteers, and independent contractors who may have direct contact with children. • A facility is prohibited from employing individuals found to have engaged in certain criminal offenses related to child abuse. • Training requirements are established for all personnel in direct contact with children, focusing on recognizing abuse, reporting procedures, and maintaining professional relationships with minors. • Additionally, any separation agreement for personnel cannot include clauses preventing reporting of child abuse offenses.

Bill Number	Author	Summary of Key Provisions
H.B. 3284	Frank	This bill establishes the Texas Commission on Marriage and Family (TCMF) to promote strong marriages and healthy families. Key provisions include: • Creation of a seven-member commission composed of appointees from the governor, lieutenant governor, and speaker of the house. • The commission will evaluate existing laws that could hinder marriage and child-rearing, assess state-funded marriage education programs, and make recommendations for legislative changes aimed at enhancing family structures. • Meetings be open and available to the public. • A report summarizing findings and recommendations to be submitted by November 1, 2026. The commission will dissolve on December 31, 2026. HHSC, if requested by the TCMF, would be required to provide administrative support services, including the provision of meeting spaces and assistance in drafting and compiling the report required under the bill.
H.B. 3512	Capriglione	This bill introduces mandatory AI training for specific employees and officials of state agencies and local governments, alongside existing cybersecurity training, as established and directed by DIR. Key provisions include: • Annual Training Requirements: The entity's cybersecurity coordinator is required to complete both cybersecurity and AI training annually; other employees will complete training as determined by the entity. • Grant Compliance: Local governments must certify compliance with both cybersecurity and AI training when applying for grants. • Creation of AI Training Programs: The bill mandates the certification of at least five AI training programs, which will be updated annually and must align in length with cybersecurity training programs. • Content of AI Training Programs: AI programs must aim to promote understanding of AI technologies relevant to employees' duties and teach best practices. • Verification and Reporting: Local and state agencies must report compliance, conduct periodic audits, and provide written certifications regarding completed cybersecurity and AI training. HHSC will comply with DIR requirements in accordance with this bill.

Bill Number	Author	Summary of Key Provisions
H.B. 3560	Pierson, Katrina	This bill introduces updates to the definition of "facility" under the Texas Health and Safety Code. Key provisions include: • Adds private psychiatric hospitals to the definition of "facility". • Requiring HHSC to investigate reports that a private psychiatric hospital employee committed a reportable action. • Requires HHSC to add a facility employee to the Employee Misconduct Registry when the agency finds the employee committed a reportable action. • Requires applicants for a private psychiatric hospital license to list on the application the name and address of the person responsible for daily facility operations.
H.B. 3595	Barry	This bill establishes new requirements for emergency preparedness and contingency plans in assisted living facilities (ALF)s. Key provisions include: • ALFs must provide a climate-controlled area of refuge of at least 15 square feet for non-bedfast residents, a climate-controlled room for bedfast residents, and notification to the commission for electric service interruptions lasting over 12 hours. • ALFs are mandated to maintain temperatures between 68 and 82 degrees Fahrenheit in areas of refuge and rooms for bedfast residents. • HHSC must also establish construction and licensure standards for ALFs constructed after September 1, 2026, regarding the integration of backup power sources and emergency evacuation plans for ALF residents. • HHSC can assess penalties for non-compliance, overriding any local regulations that conflict with the state law.
H.B. 3963	Capriglione	The bill directs the following state entities to collaborate to develop an early childhood integrated data system: Department of Family and Protective Services (DFPS); DSHS; HHSC; TEA; and the Texas Workforce Commission (TWC). Key provisions include: • Establishes the early childhood integrated data system (ECIDS) to facilitate and strengthen data sharing for entities that provide early childhood services and programs in Texas, including HHSC Early Childhood Intervention (ECI) and Family Support Services (FSS). • The bill designates the TEA as the lead agency who will take the lead in developing the system and coordinating with other participating entities, as well as in submitting a report to the legislature annually. • The data system must allow for the integration of existing state and federal data systems and be used to meet specific reporting requirements. • The system must allow for the integration of existing state

Bill Number	Author	Summary of Key Provisions
		and federal data systems accessible to the cooperating agencies that contain data derived from early childhood services and programs serving families with children from birth through eight years of age.
H.B. 4219	Capriglione	The bill amends the Texas Government Code relating to public information requests which HHSC are subject to. Key provisions include: • Requires notice to a requestor by the tenth business day if no responsive information to their request is found or if the information is subject to a previous determination. If the notice is because the bill is subject to a previous determination, the notification must tell the requestor that information is being withheld and identify the specific previous determination it is being held under. • Requires a governmental body to state the specific exceptions to disclosure that apply to the information when notifying the Attorney General that it will be seeking a ruling. • Adds Complaint to the caption of Subchapter H, Civil Enforcement. • Allows a requestor to send a written complaint to the attorney general if a governmental body fails to respond to a requestor as required by Texas Government Code, Section 552.221. If the Attorney General determines that the governmental body has improperly failed to comply with Section 552.221, the attorney general must notify the governmental body and require the public information officer or designee to complete open records training within 6 months of receiving said notification. The governmental body may not assess costs to the requestor for producing information in response to the request and, if the governmental body seeks to withhold information in response to the request, the governmental body only has 5 business days to request an attorney general decision after the notification is received and must release the requested information unless there is a compelling reason to withhold the information.

Bill Number	Author	Summary of Key Provisions
H.B. 4748	Curry, Pat	This bill introduces changes to the purchasing methods and procedures for state agencies, which HHSC is subject to. Key provisions include: • Contracts for professional services, as defined in Texas Government Code, Section 2254.002, are explicitly excluded from the provisions of Chapter 2156. • A new subchapter (Subchapter E) is added to establish a multiple award purchasing procedure, which allows the comptroller or state agencies to award contracts to multiple vendors. • A "multiple award" is defined as the awarding of contracts to more than one vendor for similar goods or services. The criteria and intent for using multiple award contracts must be disclosed in the solicitation. • A written justification must be maintained when opting for a multiple award purchasing procedure. The requirement to document the method for determining the "best value" to the state is emphasized, ensuring transparency and accountability in the ordering process under a multiple award contract.
H.B. 4783	VanDeaver	The bill requires a biennial report by HHSC on state opioid antagonist programs aimed at reversing and preventing opioid overdoses. Key provisions include: • HHSC to coordinate with each state agency and institution of higher learning that receives funding or other resources for the distribution of opioid antagonists to conduct a detailed assessment of the opioid antagonist program • The report should include: - o Evaluation of opioid antagonist distribution in Texas - o A needs assessment for opioid antagonist programs established by state agencies and institutions of higher education - o A statewide saturation goal for opioid antagonists with data methodology to highlight insufficiencies - o A communications plan to address opioid overdoses in areas of this state at higher risk, opioid distribution strategies for Texas - o A list and description of all available state and federally funded purchase and distribution programs and state and federal money appropriated to governmental antagonist programs - o Recommendations for addressing overdoses among high-risk populations. The report must be submitted to the governor, lieutenant governor, and the speaker of the House of Representatives.

Bill Number	Author	Summary of Key Provisions
H.B. 4903	Harris Davila, Caroline	The bill would establish the Quad-Agency Child Care Initiative Commission, whose goal would be the fostering collaboration, coordination of policies, and the reviewing and streamlining of regulations between the four agencies participating: TWC, HHSC, DFPS, and TEA. Key provisions include: • Defining terms related to the initiative and its governance • Describes the commission's responsibilities involving coordinating policies to enhance childcare quality, accessibility, and affordability, as well as reviewing and streamlining related regulations • Mandates provisions for regular public meetings, involve subject matter experts in the review process, and establish a public comment period concerning agency actions that affect childcare • Allows the HHSC to request reviews of existing regulations and, if found inconsistent with its objectives, to recommend their cessation or replacement.
H.B. 5061	Leach, Jeff	The Texas Integrity in State Contracting and Privacy Protection Act introduces several key provisions aimed at enhancing the integrity and accountability of state contracting: • Defines terms such as "surveillance," "undue influence," and expands the applicability of these regulations to various state procurement processes. • Prohibit contractors and vendors from engaging in surveillance of state employees, legislators, or whistleblowers, as well as from intimidation or the misuse of confidential information. Violations lead to serious consequences, including contract termination, substantial administrative penalties up to \$2 million for severe violations, and permanent disqualifications from state contracts. • Establishes a complaint process, including an online portal for submitting complaints and clearly defined investigation protocols. • Reinforces protections against employee retaliation and a require submission of an annual report on violations and complaints.

Bill Number	Author	Summary of Key Provisions
H.B. 5129	Noble, Candy	This bill introduces the State Contracting and Privacy Protection Act, which applies to each procurement of goods or services made by a state agency, including HHSC. Key provisions include: • Prohibits contractors and vendors from engaging in unauthorized surveillance, intimidation, or undue influence over state agency employees, legislative members and staff or their families, or individuals making complaints regarding state agency operations or contracting, establishing administrative penalties for violations. • The State Auditor's Office (SAO) is tasked with overseeing and enforcing these provisions and may collaborate with the Texas Ethics Commission to ensure compliance and transparency. • The Texas Rangers Division of the Department of Public Safety is responsible for investigating alleged criminal offenses related to violations of this subchapter. • If a criminal offense is suspected during the investigation, the matter will be referred to the Texas Rangers Division for a comprehensive criminal investigation and potential prosecution by the Attorney General's Office. • A contractor, subcontractor, vendor or respondent is found to be in violation if the violation is committed by associated entities and individuals. The SAO notifies the Comptroller of Public Accounts (CPA) of the final determination of violation. The comptroller will notify each agency of the debarment. • Employees of contractors, subcontractors, or vendors are protected from suspension, termination, or other forms of discrimination or retaliation for reporting violations to supervisors, state regulatory agencies, or law enforcement; and initiating or cooperating in investigations or proceedings related to state contracts.

Bill Number	Author	Summary of Key Provisions
H.B. 5195	Capriglione	The bill requires state agencies, including HHSC, to assess websites and online service portals to identify areas for improved user accessibility, navigation, and digital service efficiency. Agencies are required consider the following in their assessment: • Simplify user access to forms, applications, and agency services; • Reduce or eliminate paperwork requirements if digital alternatives exist; • Ensure compliance with accessibility standards under Subchapter M; • Use responsive web design to ensure websites are equally accessible using a desktop, laptop, or mobile device, including a tablet or cellular telephone; • Adopt best practices for search functionality, page load speed, and service integration; and • Use DIR templates and design guidelines to provide consistency among state agency websites and improve the usability of websites. DIR is required to develop statewide guidance and provide technical assistance for use by state agencies in standardizing modernization efforts, including best practices, web page templates and web design guidelines that provide a consistent look and simplify user navigation.
H.B. 5196	Capriglione	This bill establishes and regulates the telework arrangements for state employees, including HHSC employees, in Texas. Key provisions include: • Definition of Telework: New definition added that describes "telework" as a work arrangement permitting state agency employees to conduct work at locations other than their assigned workplace during established work hours. • Authorization Requirement: Employees must now obtain authorization to telework under Texas Government Code, Section 658.011 rather than prior written approval from agency heads. • Telework Agreement: New provisions for telework agreements clarify that they must be in writing, state the reasons for teleworking, outline revocation terms, and require annual renewal. Additionally, telework can be revoked at any time without notice. • Agency Telework Plans: New requirement for agencies to develop a telework plan detailing policies and procedures, including standards for employee performance and security controls. • Prohibition on In-Person Work at Home: Teleworking employees cannot conduct in-person business at their personal

Bill Number	Author	Summary of Key Provisions
		residence.
H.B. 5331	Dean, Jay	The bill establishes that contract language is null and void if it prohibits or restricts state or local government, including HHSC, compliance with notification requirements on computerized data security incidents, in cybersecurity insurance contracts or other contracts for goods and service.
H.B. 5342	Landgraf	The bill establishes the 988 Suicide and Crisis Lifeline trust fund and directs HHSC to conduct a study on the implementation of funding mechanisms to support the operation of the 988 Suicide and Crisis Lifeline. Key provisions include: • Establishes the 988 Suicide and Crisis Lifeline Trust Fund outside the state treasury, administered by HHSC, to consist of: - o Gifts, grants, and donations, including federal funds, received by this state for the purposes of the trust fund; and - o Interest, dividends, and other income of the trust fund. • Money deposited in the trust fund may only be used to: - o implement, maintain, or improve the 988 Suicide and Crisis Lifeline, including personnel and technological infrastructure improvements necessary to achieve operational and clinical standards and best practices - o pay the trust company's expenses of managing the trust fund's assets • Authorizes the trust company to hold and invest the trust fund and allows the trust fund to be invested in the state treasury pool with other state assets for purposes of investment. • It permits the trust company to acquire, exchange, sell, supervise, manage, or retain any kind of investment that a prudent investor would acquire or retain. • Directs HHSC to provide the trust company an annual forecast of the cash flows. • Directs HHSC to prepare and present an annual report on the usage of and services provided by the crisis centers to the legislature and the Substance Abuse and Mental Health Services Administration. • Directs HHSC to work with the Commission on State Emergency Communications and any other appropriate state agency to study the implementation of funding mechanisms to support the operation of the 988 Suicide and Crisis Lifeline. This study will evaluate the feasibility of establishing a service fee on telecommunication services.
H.B. 5629	Wilson	The bill requires a state agency, including HHSC, that issues a license to issue a license to a military service member, military veteran, or a military spouse who holds an out-of-state license of similar scope of practice.

Bill Number	Author	Summary of Key Provisions
S.B. 0379	Middleton, Mayes	This bill introduces new restrictions under the Supplemental Nutrition Assistance Program (SNAP) by prohibiting recipients from using benefits to purchase sweetened drinks and candy. Key provisions include: • The definition of a "sweetened drink" includes any nonalcoholic beverage containing five or more grams of added sugar or any amount of artificial sweeteners, excluding drinks with milk products, milk substitutes, or high volumes of vegetable or fruit juice. • The definition of candy that is packaged and sold for consumption without further preparation. HHSC will seek a waiver from the Food and Nutrition Services (FNS) to implement the bill.
S.B. 0457	Kolkhorst	The bill introduces several changes regarding the regulation of nursing facilities in Texas. Key provisions include: • Establishes a patient care expense ratio for certain nursing facility providers; • Amends the nursing facility license application to require: - o The name of each person with an ownership interest in the nursing facility, including a subsidiary or parent company of the NF; and the real property on which the nursing facility is located, including any owner, common owner, tenant, or sublessee; and - o The exact ownership interest of each of those persons in relation to the nursing facility or property. • Requires the nursing facility license holder to notify the HHSC of any change in the information on the application in the form and manner specified by HHSC. • Requires HHSC, notwithstanding any other law, to provide a process by which nursing facilities who undergo a change in ownership (CHOW) are able to continue receiving Medicaid reimbursement for continued service to individuals, as long as the facility under new ownership meets the specified requirements. - o This section does not apply to a supplemental payment program or a directed payment program, as defined by Texas Government Code, Section 532.0102, operated or administered by HHSC. • Adds a new section defining "patient care expense" for purposes of the patient care expense ratio created by this bill. HHSC must implement rules and a process to establish an annual patient care expense ratio applicable to the reimbursement of Medicaid nursing facilities and other long-term care (LTC) facility providers. • Requires HHSC to prepare and submit a legislative report including an assessment of the impact of the patient care

Bill Number	Author	Summary of Key Provisions
		expense ratio on nursing facility care provided to Medicaid recipient during the preceding state fiscal biennium, the impact on the cost and quality of care and any other information the commission determines appropriate by November 1, 2027.
S.B. 0502	Perry	The bill requires the OIG to compensate its peace officers according to Schedule C of the position classification salary schedule of the General Appropriations Act, like other State of Texas law enforcement officers. The bill also added OIG peace officers to the list of recognized peace officers in Art. 2A.001 of the Code of Criminal Procedure.
S.B. 0513	Sparks	The bill establishes a pilot program to implement community-based child welfare services in under-served rural areas of Texas. Key provisions include: • Mandates a comprehensive range of services, including family preservation, foster care, and youth transition programs, while addressing rural-specific challenges such as transportation costs and workforce shortages • Emphasizes flexibility, innovation, and accountability, with annual legislative reporting and a review deadline by 2031 to determine its future viability. HHSC is responsible for establishing and maintaining proforma models and analysis for existing Community Based Care (CBC) catchment areas. The enactment of this bill may expand this scope of work to include rate setting and financial modeling for rural catchment areas under the proposed pilot program.
S.B. 0528	Schwertner	The bill amends the Texas Health and Safety Code to direct the HHSC executive commissioner to establish rules requiring that each facility providing inpatient competency restoration services under a contract or subcontract with HHSC enter into a MOU with the county and municipality in which the facility is located, as well as each Local Mental Health Authority (LMHA) and Local Behavioral Health Authority (LBHA) that operates in the county and municipality to outline the powers and duties of each party with respect to inpatient competency restoration services. The bill requires that each contracted facility annually report to HHSC the number and outcomes of patients served and clarifies that the data must be separated by whether the individual was charged with a misdemeanor or felony, and by any other applicable demographics determined by HHSC.

Bill Number	Author	Summary of Key Provisions
S.B. 0897	Blanco	The bill amends the Grant Program for Mental Health Services for Veterans and Their Families by reducing the 100 percent matching requirement to 75 percent. Key provision include: • Striking 100 percent and replacing with 75 percent, to now read: 75 percent of the grant amount in non-state sources if program provides services and treatment in a county with a population of 250,000 or more. • Striking 100 percent and replacing with 75 percent, to now read: 75 percent of the grant amount in non-state sources, if the county with the largest population in which the program provides services and treatment has a population of 250,000 or more. • Changes only apply to grants awarded after the effective date of this bill. • HHSC is only required to implement Senate Bill 897-ENR if the legislature appropriates money specifically for that purpose in an amount greater than the amount appropriated for that purpose for the state fiscal biennium ending August 31, 2025. If the legislature does not appropriate money specifically for that purpose and in such amount, HHSC may, but is not required to, implement those changes in law using other money available to HHSC for that purpose.
S.B. 1012	Kolkhorst	This bill instructs HHSC to enter into one or more leases for the 7.5-acre parcel located south of 45th Street and east of Lamar Blvd in accordance with Texas Health and Safety Code, Section 533.087 with proceeds being deposited in the Texas capital trust fund to benefit HHSC. The lease(s) must allow HHSC to approve or restrict the proposed use of the property and grant HHSC easements to the property adjacent to the leased property.

Bill Number	Author	Summary of Key Provisions
S.B. 1038	Sparks	The bill introduces modifications to the administrative remedies and penalties related to fraud and abuse within Medicaid; and clarifies the scope of conduct that is subject to enforcement, including: • Procuring services for a Medicaid recipient that the recipient isn't qualified for, by knowingly misrepresenting information. • Knowingly applying for services for one individual and providing those services to another individual. • Making false statements about the condition of operation of a facility so the facility can falsely meet certification or recertification standards. • Knowingly presenting a claim for payment by a person who is improperly licensed, or not including the identification number of the rendering provider. • Obstructing OIG from carrying out official duties. • Knowingly making or using false records. It clarifies monetary thresholds for certain violation types. It also amends Texas Government Code, Chapter 32.039(k), and repeals Texas Government Code, Section 32.039(a)(4), which states proof of intent is not required for a violation if the person should have known about the error, and Texas Government Code, Section 32.039(b-1), which states a person who fails to maintain documentation for a claim is liable to the commission for the amount paid, or an administrative penalty of up to \$500 for each violation.
S.B. 1044	Parker	The bill adds Duchenne Muscular Dystrophy (DMD) to diseases for which the DSHS uses its laboratory to combat morbidity, help early detection, determine prevention, and identify treatment method. Key provisions include: • Refers individuals under age 21 who have been found presumptively positive for DMD, and are financially eligible, for the DSHS children with special health care needs program (CSHCN). • Must screen for it in its newborn screening program, including collecting blood specimens. • Newborn screening testing for Medicaid newborns is conducted by the DSHS laboratory. HHSC pays DSHS for Medicaid newborn screening testing through an IAC.

Bill Number	Author	Summary of Key Provisions
S.B. 1188	Kolkhorst	The bill introduces Chapter 183 to the Texas Health and Safety Code, establishing comprehensive requirements related to electronic health records (EHRs). Key provisions include: • Definitions for terms such as "biological sex," "covered entity," and "sexual development disorder." • Storage rules mandate covered entities to maintain EHRs containing patient information within the U.S. or its territories. • Personal health records must not contain an individual's credit score or voter registration status. • Mandatory inclusion of biological sex information in EHR alongside provisions for amending this information under specific conditions. • Health care practitioners can use artificial intelligence for diagnoses, provided they disclose its use to patients. • The bill outlines the roles of regulatory bodies, including HHSC, and mandates the adoption of rules to implement its provisions. • HHSC or other appropriate agencies must investigate credible allegations of violations of this chapter. • Allows HHSC or other appropriate agencies to take disciplinary actions against covered entities that violate the chapter three more times as if they had violated a licensing or regulatory; including a revocation of license, registration, or certification. • Allows the Attorney General to take action for civil penalties and lists these penalties.
S.B. 1233	Hancock	The bill introduces Perinatal Palliative Care Act. Key provisions include: • Direct HHSC to develop, regularly update, and post resources for medical, mental, and social counseling and specialty perinatal palliative care services on the HHSC website, including a geographically indexed list of perinatal palliative care program and providers. • Requires HHSC to work with DSHS and the Palliative Care Interdisciplinary Advisory Council in implementing the bill. • HHSC is also directed to develop a form for the client to certify the receipt of perinatal palliative care resources and providers/programs. • Health care providers must provide the form to client whose preborn child has been diagnosed with a life-threatening disability a written copy of the informational materials and the list of providers and keep a signed copy of the certification form in the client's medical record. • The bill provides an exception for the provider if the client's medical record already contains a signed perinatal palliative care certification form for that pregnancy. • The bill imposes a written warning on the health care provider

Bill Number	Author	Summary of Key Provisions
		for an initial violation and a \$1,000 administrative penalty for subsequent violations.
S.B. 1266	Alvarado	This bill introduces new requirements for the Medicaid provider enrollment and credentialing processes. Key provisions include: • Establishment of a support team for providers, aimed at assisting them with enrollment and credentialing while reducing administrative burdens. • An annual evaluation requirement for the support team’s performance, with results to be posted online. • A procedure for providers to electronically submit complaints and feedback about enrollment processes. • Notice must be provided to providers at least 30 days prior to disenrollment for failing to complete revalidation, allowing them to address application deficiencies before disenrollment. • The initial evaluation of the support team is required to be conducted by September 1, 2026.
S.B. 1610	Perry	The bill enhances penalties and clarifies obligations regarding sexually violent predators in Texas. Key provisions include the following: • Added punishments for defendants civilly committed as sexually violent predators, mandating imprisonment for life or terms between 25 to 99 years for felony offenses they commit. • Increased penalties for harassment, raising classifications from Class B misdemeanors to third-degree felonies if the perpetrator is civilly committed as a sexually violent predator. • Defined presumptions of knowledge for offenses targeting employees or contractors of the Texas Civil Commitment Office, which is administratively attached to HHSC. • Specified that arrests can be made based on probable cause for felonies committed by civilly committed individuals. • Introduced mandatory compliance with civil commitment orders as a condition of bond for defendants civilly committed. • Stipulated that any offenses committed while civilly committed, including failing to comply with registration requirements, will lead to consecutive sentences. • Expanded the definition of reportable convictions to include offenses by those civilly committed for sexual violence, holding them accountable under sex offender registration laws.

Bill Number	Author	Summary of Key Provisions
S.B. 1952	Paxton	The bill establishes in statute the role of HHSC in administering the School Health and Related Services (SHARS) program. Key provisions include: • Requires HHSC to oversee participation of local education agencies (LEAs) in SHARS, including the administration of provider training and providing information and guidance to providers, including applicable federal and state regulatory requirements. • Requires HHSC to collaborate with regional education service centers to provide resources and technical assistance to LEAs in SHARS. • Requires HHSC to enter a memorandum of understanding with the Texas Education Agency (TEA) on the responsibilities for each agency.
S.B. 1964	Parker, Tan	The bill directs the Department of Information Resources (DIR) to provide policy, standards, and guidance to state and local entities, including HHSC, and the general public on the development, deployment and use of AI. Key provisions include: • DIR shall establish by rule an AI system code of ethics and minimum standards for heightened scrutiny AI systems as defined by this Act which state agencies and local governments must adopt. • An AI Advisory Board appointed by the governor is established to assist state agencies in the use of AI in consultation with and provided administrative support from DIR. • A regulatory sandbox program is established under DIR for eligible entities contracting with vendors to engage in AI research, development, testing, and other pre-deployment activities. • AI systems, including heightened scrutiny artificial intelligence (HSAI) systems, are newly included in the requirements for each state agency to report to DIR in the Information Technology Infrastructure Report, as well as newly included in the Information Resources Deployment Review (IRDR). • A new confidential impact assessment is required of each state agency that deploys or contracts with a vendor that deploys a heightened scrutiny AI system.

Bill Number	Author	Summary of Key Provisions
S.B. 2069	Zaffirini, Judith	The bill establishes a work group under the HHSC to study the feasibility of an acute psychiatric bed registry for inpatient mental health facilities. Key provisions include: • The work group consists of members from various medical and mental health organizations, including representation from rural and urban hospitals, substance use treatment, public health, and technology fields. • The work group shall meet periodically and at the call of the presiding officer. • HHSC must submit a thorough report by November 1, 2027, analyzing the effectiveness of bed registries, public awareness, financial incentives, hospital reimbursements, and psychiatric treatment capacity. • The work group will be abolished, and the section will expire on November 1, 2028.
S.B. 2308	Parker	The bill requires HHSC to select a consortium established in accordance with requirements set forth in the bill for the purpose to conduct drug development clinical trials with ibogaine and secure the United States Food and Drug Administration's (FDA) approval of ibogaine as a medication for the treatment of opioid use disorder, co-occurring substance use disorder, and any other neurological or mental health condition for which ibogaine demonstrates efficacy. Key provisions include: • The consortium include one or more drug developers, an institution of higher education, and a hospital, and must be led by an institution of higher education from among the consortium members. The lead will represent the consortium and perform administrative functions, including contracting with and reporting to HHSC through an interagency agreement. • Requires the lead institution submit to the commission a proposal and request for funding on behalf of the consortium for purposes of conducting ibogaine drug development clinical trials. This section also outlines the requirements of the proposal. • Requires a member of the consortium that is selected by HHSC, after notification that a consortium is selected, to, as soon as practicable submit an investigational new drug (IND) application to the FDA in addition to seeking a breakthrough therapy designation for ibogaine from the FDA. • Provides that for the purposes of conducting a drug development clinical trial only an institution of higher education or a hospital may serve as a trial site. • Allows HHSC and consortium members, to fund work under Chapter 491, to solicit and accept gifts, grants, and donations of any kind received from sources other than the state. It also

Bill Number	Author	Summary of Key Provisions
		allows the commission to disburse funds incrementally based on the completion of objectives negotiated in the consortium's contract. • Requires the consortium to prepare and submit quarterly reports to HHSC. • Requires HHSC to submit a report to the legislature on the progress of the drug development clinical trials conducted not later than December 1 of each year. • Establishes the allocation of revenue attributable to intellectual property and other rights. • Requires the CPA to deposit any revenue from this bill to the credit of the general revenue fund. • Establishes the Ibogaine Treatment Administration, which is only applicable if ibogaine is approved by the FDA to treat a medical condition and sets forth certain requirements for licensed physicians that have prescribed ibogaine.
S.B. 2312	Hughes	This bill establishes the Texas Advisory Committee on Geopolitical Conflict under a newly added Chapter 438 in the Government Code. Key provisions include: • Policy Statement outlining the state's commitment to support U.S. military and civilian commands and to prepare for potential geopolitical conflicts affecting supply chains and critical infrastructure. • Formation of the advisory committee consisting of nine members appointed by various state leaders, with specific roles and responsibilities to enhance Texas's security strategies. • The committee is required to produce a series of reports by October 1, 2026, including audits on supply chains, critical procurements, drug supply chains, and infrastructure protection; and conduct investigations, hold hearings, and issue subpoenas relates directly to its powers and duties. HHSC will provide information as requested by the committee.

Bill Number	Author	Summary of Key Provisions
S.B. 2587	Zaffirini, Judith	The bill amends the Texas Government Code regarding criminal history record information. Key provisions include: • Removes the requirement of persons to provide the social security number of a subject in a criminal history record information background check for persons providing information to the Department of Public Safety (DPS), including through DPS rules or requirements of a hospital or hospital district. • Expands authority of HHSC to obtain criminal history record information of persons required to be fingerprinted and with access to sensitive personal or financial information as determined by the executive commissioner. The Act removes previous limitations of criminal background check authority to employees or applicants of the OIG, as well as the HHSC eligibility services division and the regulatory services division. • Clarifies HHSC's access to criminal history record information with the insertion of "public benefits" in reference to programs administered by HHSC. HHSC and HHS OIG may access criminal history record information relating to persons that: - o Have direct ownership interests equaling 5 percent or more in a provider or a person applying to enroll as a provider. - o Owns an interest of 5 percent or more in a debt obligation secured by a provider. - o Is an officer or director of a provider. - o Is a partner in a provider. - o Is a managing employee of a provider.

Table 5. Legislation Not Passed

Bill No.	Author	Summary of Key Provisions / Reason Bill Did Not Pass	Impacted Area
H.B. 0404	Harrison, Brian	The bill aimed to amend Texas Government Code, Section 2001.039 to include several new requirements for state agency reviews of adopted rules. Key additions included: • Assessment Criteria: Agencies would have assessed whether the reasons for a rule’s initial adoption continued to exist and would have considered any costs imposed on regulated persons that made the rule subject to specific financial provisions. • Public Disclosure: Agencies would have been required to publish their assessments online, including links to supporting data, working papers, and materials used for the assessment. • Automatic Expiration: If an agency failed to conduct the required rule review by the specified date, the rule would have automatically expired and would have been deemed void. • Legal Recourse: Individuals harmed by the enforcement of an expired rule could have filed a civil action for declaratory and injunctive relief in court, with the potential to recover costs and attorney fees if they prevailed.	Agency Operations
H.B. 0587	Harrison	The bill aimed to introduce new requirements for rules proposed by state agencies within the executive branch of the Texas state government. Notably, it mandated that the notice of proposed rules includes a certification confirming that the rules had been reviewed and approved by the governor or an elected state officer of the agency, and that the certification be signed by the applicable authority. Additionally, for emergency rules, the bill stipulated that these rules be submitted for approval within 10 days of adoption. If an emergency rule was disapproved, it could not be renewed or replaced by a substantially similar rule. These changes applied only to rules proposed on or after the effective date of the Act, September 1, 2025.	Agency Operations

Bill No.	Author	Summary of Key Provisions / Reason Bill Did Not Pass	Impacted Area
H.B. 2873	Lalani	The bill would have introduced several notable changes to the Texas Government Code related to the management of information resources by state agencies. Key additions included: • It would have added a new subsection (8) requiring the development of a statewide legacy system modernization strategy to be integrated into the planning process for technology improvements. • It would have established a new Texas Government Code Section (2054.5725), which required each state agency to identify its legacy systems and create a replacement plan aimed at enhancing the technological environment. Agencies were required to submit this plan by September 1 of each odd-numbered year. • It also would have modified existing sections to expand on best practices for managing information resources, improve the alignment of technology with state needs, and enhance approaches to technology acquisition and reuse.	Agency Operations
H.B. 0720	Flores, Lulu	The bill would have established a Ketamine Treatment Grant Program under the newly added Subchapter K of Chapter 547 in the Texas Government Code, aimed at providing mental health treatment for active-duty military personnel, first responders, and veterans at ketamine clinics. Key elements would have included: • Definitions: Inclusion of specific definitions for "first responder," "physician," "program," and "veteran." • Grant Program: HHSC would have been required to create a program to award grants to ketamine clinics. • Grant Usage: Clinics could have used the funds to cover uncompensated mental health treatment and for other necessary services and resources as determined by the commission. • Selection and Accountability: HHSC would have been required to establish eligibility criteria for grant applicants and implement accountability controls to ensure public benefits. • Gifts and Donations: HHSC would have been able to solicit gifts, grants, and donations for program purposes. Work Group: A work group may be formed to assist in program development and	Behavioral Health/ Substance Use

Bill No.	Author	Summary of Key Provisions / Reason Bill Did Not Pass	Impacted Area
		evaluation, and members will serve without compensation. • Reporting: HHSC would have been required to submit a biennial report detailing program activities and outcomes. The program is mandated to be established by December 1, 2025, with the first report due by December 1, 2026.	
H.B. 4420	Rose, Toni	This bill aimed to enhance the collection of data on inpatient mental health facilities in Texas, particularly those providing acute psychiatric treatment. The proposed amendments to Texas Health and Safety Code, Section 311.0335, would have required hospitals providing mental health services to report a comprehensive set of financial and utilization data. This data would have included the total number of inpatient psychiatric beds and a distinction between online and offline beds, thereby ensuring more detailed oversight of bed availability. The bill also would have mandated a new study by HHSC to evaluate the availability of these beds. The study would have assessed the current number of psychiatric beds across different facility types, categorized patients based on specific criteria, and projected requirements for the next decade. The commission would have been required to submit its findings and recommendations to the legislature by December 1, 2026. The study provisions would have expired on September 1, 2027.	Behavioral Health/ Substance Use
S.B. 0719	Eckhardt, Sarah	Enhancement of Mental Health Facility Oversight: The bill would have enhanced the existing statutory framework governing mental health facilities in Texas to improve data collection and patient care capabilities. Amendments to Texas health and Safety Code, Section 311.0335 would have required hospitals to provide detailed financial and utilization data related to mental health services. The bill emphasized key additions, including the requirement to track the total number of inpatient psychiatric beds and to segregate this data by age group and by whether beds were online (available) or offline (unavailable). • Statewide Study Requirement: The bill mandated a comprehensive study to assess the availability of psychiatric beds and the broader treatment	Behavioral Health/ Substance Use

Bill No.	Author	Summary of Key Provisions / Reason Bill Did Not Pass	Impacted Area
		landscape across the state. This study would have analyzed various factors, including the distribution of beds, the demographic breakdown of patients, and projected needs over the next decade. It encouraged collaboration with educational institutions to enhance research quality. Funding Contingency: The commission's ability to implement the bill's provisions depended on the availability of specific appropriations. Effective Date: The legislation would have taken effect immediately upon two-thirds legislative approval or on September 1, 2025, otherwise.	
H.B. 0038	Bucy, John	This bill aimed to enhance the Texas Information and Referral Network (TIRN) to better serve the needs of the community while preparing for emergencies and disasters. Planned to be effective from April 1, 2025, if passed, the amended law sought to strengthen TIRN's role in disaster preparedness, response, and management through coordination with relevant agencies and interstate agreements for effective operation in crises. The bill would have placed emphasis on utilizing electronic communication technology to improve client interaction, thereby enhancing accessibility, reducing wait times, and ensuring timely dissemination of information during emergencies. The addition of real-time data sharing on client demographics, the bill would have allowed TIRN to address community needs more effectively by focusing on nonmedical drivers of health such as housing and transportation. The bill was to introduce a new requirement for a biennial report to assess network operations and service gaps, ensuring that services offered remained relevant and effective. Furthermore, to maintain service quality, it mandated that area information centers gain accreditation from recognized organizations, promoting operational standards. The legislation was set to take effect on September 1, 2025.	Eligibility/ 211 Operations

Bill No.	Author	Summary of Key Provisions / Reason Bill Did Not Pass	Impacted Area
H.B. 0314	Walle, Armando	This bill aimed to revise the eligibility criteria for individuals applying for SNAP benefits under Texas law. It specifically would have added Texas Human Resources Code, Section (33.016), establishing that individuals whose eligibility was initially determined or recertified could have received benefits for a period of 12 months. Furthermore, the bill empowered the commission to adjust this eligibility period as necessary to synchronize the recertification of SNAP benefits with the eligibility determinations of medical assistance benefits for children living in the same household. The legislation outlined exclusions from the 12-month eligibility rule for specific demographics. Notably, it included individuals who anticipated a change in eligibility status within the next six months, as well as those aged 60 or older or with disabilities living in households where all members lacked earned income. Additionally, individuals aged between 18 and 50 without dependents and not disabled were also exempted. The changes were set to apply to all initial determinations or recertifications made on or after the effective date of the Act, which was set for September 1, 2025. If any provisions required a waiver or authorization from a federal agency for enforcement, the relevant state agency had the discretion to delay implementation until such approvals were obtained.	Eligibility/ 211 Operations

Bill No.	Author	Summary of Key Provisions / Reason Bill Did Not Pass	Impacted Area
H.B. 0321	Bucy, John	This bill focused on implementing an express lane option under Medicaid and the CHIP by streamlining the process for determining a child's eligibility based on data from the SNAP. In Texas Health and Safety Code, Section 62.1011, the bill clarified HHSC's authority to verify household income, specifying that verification was not required if the reported income exceeded eligibility thresholds. Texas Health and Safety Code, Section 62.1012, established the express lane process, mandating that the commission use applicant data from SNAP to quickly assess eligibility for children. This section highlighted the importance of timely benefit provision by ensuring a new case was opened for each child's eligibility determination, allowing for efficient enrollment in the Child Health Plan Program once eligibility was confirmed. Sections related to the recertification of medical assistance for children were also updated to allow for reviews via telephone or mail, unless personal appearances were required due to exceptional circumstances. A new section, Texas Health and Safety Code, Section 32.026102, was introduced, mirroring the express lane processes for medical assistance. Overall, the bill aimed to streamline eligibility assessments and provide timely access to health services for children by leveraging existing data and enhancing administrative efficiencies. The Act would have taken effect on September 1, 2025, pending any required federal waivers for implementation.	Eligibility/ 211 Operations

Bill No.	Author	Summary of Key Provisions / Reason Bill Did Not Pass	Impacted Area
H.B. 2202	Guillen, Ryan	The bill would have established and modified several provisions concerning the SNAP within the Texas Human Resources Code. It would have mandated the creation of a monthly quality control review process to evaluate the eligibility and benefit allotments of households participating in SNAP, including those whose applications had been denied. HHSC would have been authorized to use electronic data sources to facilitate this evaluation, ensuring that benefits were appropriately allocated based on eligibility criteria. The legislation further stipulated that individuals whose eligibility had been established or recertified would maintain their benefits for a continuous period of 12 months. Exceptions to this eligibility term were outlined for individuals who anticipated changes in their circumstances, those over 60 or disabled and residing in specific income situations, and eligible adults aged 18 to 54 without dependents. To maintain compliance, individuals would be required to submit periodic reports detailing any changes to their income, household structure, or residence, with submissions expected between the fourth and sixth month following the initial determination. The bill would have authorized HHSC to automate the reporting process in cases where no changes were reported, streamlining the management of SNAP benefits. Notably, the bill would have applied to any eligibility determination or recertification made on or after the effective date of the act, which was set for September 1, 2025. Additionally, provisions requiring waivers from federal agencies could be delayed until such waivers were obtained.	Eligibility/ 211 Operations

Bill No.	Author	Summary of Key Provisions / Reason Bill Did Not Pass	Impacted Area
S.B. 0238	Johnson, Nathan	The bill would have enhanced Medicaid and Child Health Plan Program procedures in Texas by introducing an express lane option for determining children’s eligibility. HHSC would have been directed to evaluate data from the SNAP to expedite eligibility assessments under the Child Health Plan Program. • By adding Texas Health and Safety Code, Section 62.1012, the bill emphasized the need for swift enrollment, requiring the commission to open a new case upon determining eligibility to prevent delays in benefit delivery. Once a child’s eligibility was confirmed, the commission was tasked with notifying the child’s parent, guardian, or relative through their preferred contact method and obtaining affirmative consent for enrollment in the appropriate health programs. • Additionally, the bill stipulated that if any provision required a federal waiver for implementation, the enactment of that provision could be postponed until the waiver was obtained. The act was set to take effect on September 1, 2025.	Eligibility/ 211 Operations
S.B. 0961	Kolkhorst, Lois	The bill would have introduced specific measures to enhance fraud prevention and the verification of eligibility for Medicaid benefits. Noteworthy additions included: • Mandatory Data Matches: HHSC would have been prohibited from waiving the requirement for periodic electronic data matches to verify the income eligibility of Medicaid recipients. • Lottery Winnings Reporting: The bill expanded monthly electronic matches to include not only SNAP recipients but also Medicaid recipients, to check for reportable lottery winnings. • Deceased Recipient Protocol: Protocols for verifying the eligibility of deceased individuals were updated to include Medicaid benefits, requiring prompt termination of eligibility upon confirmation of death. • Self-Attestation Limitations: The bill prohibited HHSC from accepting self-attestation for key eligibility criteria such as income or citizenship without additional verification. Attempts had to be made to obtain this information through electronic data matching first.	Eligibility/ 211 Operations

Bill No.	Author	Summary of Key Provisions / Reason Bill Did Not Pass	Impacted Area
		• Voter Registration Checks: A potential new requirement mandated that the commission review voter registration cancellations quarterly to assess any potential changes in Medicaid eligibility. • Expanded Fraud Definitions: The bill expanded the definitions of unlawful acts related to healthcare programs to include new provisions concerning misrepresentations and violations by managed care organizations.	
H.B. 0899	Jones, Jolanda	The bill aimed to expand the definition of eligible defendants to include those discharged from a facility, jail-based competency restoration program, or outpatient competency restoration program. • New Requirement for Medication Administration: The bill would have required law enforcement to not only provide prescribed medications but also compel defendants to take all prescribed medications to ensure continuity of care. • Continuity for Psychotropic Medications: The bill included a new subsection mandated that if a defendant was on psychotropic medication at discharge, the sheriff had to ensure that administration of the medication continued, with any changes requiring proper documentation from the jail physician. • Reimbursement Policy Update: The bill would have updated the reimbursement process for sheriffs to clarify that the commission would reimburse sheriffs for medication costs, removing the previous stipulation that funds must be appropriated for this purpose. • Repeal of a Subsection: The bill would have repealed Subsection (c) of Article 46B.0825 in its entirety.	Forensic/ Justice Issues

Bill No.	Author	Summary of Key Provisions / Reason Bill Did Not Pass	Impacted Area
H.B. 1461	Frank	The bill aimed to introduce new requirements for timely custody transfers by state agencies in Texas, establishing specific deadlines for taking custody of defendants and children. Key provisions included: • Article 46B.014: The bill would have mandated the commission to take custody of defendants within 45 days of a court order. If the commission failed to do so, it was required to compensate counties for daily confinement costs, reflecting the commission’s expected expenses. • Texas Family Code Section 54.04: The bill would have implemented a similar 45-day rule for the Texas Juvenile Justice Department regarding children committed to custody, with compensation obligations for delayed transfers. • Texas Government Code Section 508.285: The bill would have established a 45-day custody requirement for releases or individuals held on administrative violations and introduced compensation for counties if the department failed to take custody in a timely manner. • Compensation Provisions: These provisions would have applied specifically to costs incurred on or after January 1, 2026.	Forensic/ Justice Issues
H.B. 0197	Bucy, John	The bill aimed to expand Medicaid eligibility in Texas by adding a new subchapter to the Texas Human Resources Code specifically designed for this purpose. Its primary provision, Section 32.351, would have stipulated that regardless of existing laws, HHSC must have offered medical assistance to individuals eligible for federal matching funds under the Affordable Care Act. To ensure ongoing evaluation of this initiative, Section 32.352 called for an annual report to be submitted by December 1 each year to key state leaders, analyzing the expansion’s results on uninsured individuals, state and local healthcare costs, as well as charity care in hospitals. The legislative action was set to take effect on January 1, 2026, but this was contingent upon the approval of a related constitutional amendment by voters in 2025, which would have mandated the state to expand Medicaid coverage to eligible individuals. If the amendment was not approved, the act would have had no effect.	Medicaid Expansion

Bill No.	Author	Summary of Key Provisions / Reason Bill Did Not Pass	Impacted Area
H.B. 3072	Howard, Donna	The proposed legislation would have focused on enhancing access to Medicaid for women of reproductive age in Texas. It introduced Texas Human Resources Code, Section 32.02473, expanding eligibility criteria for medical assistance. Specifically, the expansion targeted women aged 19 to 49 with household incomes not exceeding 133 percent of the federal poverty level. To qualify for the program, applicants had to meet these age and income requirements, and the provision was designed to leverage available federal matching funds to ensure coverage. The bill would have required the HHSC executive commissioner to establish rules necessary for the effective application of this section. It stipulated that the expanded eligibility would apply only to initial determinations or recertifications of eligibility occurring after the new section took effect, regardless of the application date. Furthermore, before implementing any provisions of the bill, the responsible state agency would have had to secure any required waivers or authorizations from federal entities. The Act would have taken effect on September 1, 2025.	Medicaid Expansion
H.B. 2938	Gonzalez, Mary	The bill would have allowed personal attendants to be family members, including parents and spouses, under specific Medicaid and Social Security programs. • Minimum Base Wage: It would have established a minimum base wage of \$20 an hour for personal attendants, exceeding the federal minimum wage, regardless of other laws. • Definitions Added: It would have provided detailed definitions of “attendant care services” and “personal attendant” to clarify the scope of services and roles. • Implementation Timeline: The minimum wage provision would have been set to apply to services provided beginning in the 2026 calendar year. • Federal Waiver Provisions: It would have allowed for implementation delays if a state agency required a waiver from a federal agency for any aspect of the bill.	Medicaid Operations

Bill No.	Author	Summary of Key Provisions / Reason Bill Did Not Pass	Impacted Area
H.B. 3105	Goodwin	The bill would have established a minimum base wage for personal attendants providing services under Medicaid and other programs administered by HHSC. • It would have required that personal attendants be paid no less than \$19 an hour or the applicable federal minimum wage, whichever was greater. • It would have provided definitions for “attendant care services” and “personal attendant,” detailing the scope of services and roles. • It would have tasked the HHSC executive commissioner with adopting rules for the implementation of this section. • The wage provisions would have been set to apply beginning in the 2026 calendar year.	Medicaid Operations
H.B. 4845	Guerra	The bill aimed to introduce Texas Government Code, Section 532.01511, detailing new requirements for Medicaid provider enrollment revalidation. Written notice would have been required to be provided to providers 120 days prior to enrollment expiration, including information about the expiration date and revalidation processes. If providers submitted their revalidation application 90 days before expiration, HHSC would have been required to review it for obvious deficiencies, notify providers of any issues 60 days before expiration, and allow 10 days for corrections. HHSC would have been required to finalize applications for providers who met correction deadlines, ensuring that applications were processed before the enrollment period expired, regardless of the number of corrections needed. This section would have applied to providers whose enrollment periods expired on or after January 1, 2026.	Medicaid Operations

Bill No.	Author	Summary of Key Provisions / Reason Bill Did Not Pass	Impacted Area
H.B. 2677	Thompson, Senfronia	This bill would have introduced new provisions for Medicaid coverage related to the treatment of obesity and diabetes prevention programs. Key additions: • It would have added two new sections, Texas Human Resources Codes 32.02461 and 32.02462, specifically addressing obesity treatment and diabetes prevention. • It would have introduced several definitions, including "anti-obesity medication," "intensive health behavioral and lifestyle treatment," and "diabetes prevention program." • It would have mandated that Medicaid provide reimbursement for intensive health behavioral and lifestyle treatment, metabolic and bariatric surgery, and anti-obesity medication. • It would have ensured reimbursement to diabetes prevention program suppliers for eligible recipients enrolled in such programs. • It would have required the establishment of rules for determining the medical necessity of anti-obesity medications, which could not be more restrictive than FDA-approved indications. • It would have directed HHSC to provide written notice regarding the availability of obesity treatment options under Medicaid.	Non-expansion Medicaid Coverage
H.B. 3589	Campos, Liz	This bill aimed to establish and regulate a framework for group home facilities in Texas under the newly designated Texas Health and Safety Code, Chapter 260E, previously Chapter 769. It would have mandated that any individual seeking to establish or operate a group home facility obtain a license. The legislation provided detailed definitions to clarify what constituted a group home and its services. Key provisions included the introduction of a six-month provisional license for existing facilities needing time to meet standards. The bill emphasized safety and compliance and would have required facilities to undergo inspections every two years and adopt minimum standards set by the HHSC executive commissioner. A nonrefundable license fee would have been set by the HHSC executive commissioner for applicants. Furthermore, it would have mandated criminal background checks for applicants and employees to protect residents,	Regulatory Operations

Bill No.	Author	Summary of Key Provisions / Reason Bill Did Not Pass	Impacted Area
		prohibiting the hiring of individuals with serious criminal convictions. In the event of imminent threats to resident safety, the commission had the authority to enforce an emergency suspension or closing order. The act would have taken effect on September 1, 2025.	
S.B. 0085	Hall, Bob	The bill would have modified the procedures governing child abuse and neglect investigations in Texas by enhancing the framework for a central registry maintained by DFPS. It would have amended Texas Family Code, Section 261.002, to define specific severity codes that categorized abusive incidents and stipulated how long a name would remain in the registry based on the severity of the abuse or neglect determined by investigations. The bill would have added new subsections requiring prior notification before an individual's name could be entered into the registry. It also would have established rules for maintaining, reviewing, and expunging entries, with a designated expungement review panel responsible for evaluating requests for name removal. Key provisions included criteria for removing juveniles' names from the registry after a specified period and procedures for notifying individuals when their name might be added. If approved, these changes would have taken effect immediately upon receiving a two-thirds legislative vote, or by September 1, 2025, if not.	Regulatory Operations

Bill No.	Author	Summary of Key Provisions / Reason Bill Did Not Pass	Impacted Area
S.B. 0481	Alvarado	The bill would have established new requirements for assisted living facilities in Texas to strengthen emergency preparedness and response protocols. It added Texas Health and Safety Code, Section 247.073, and mandated the adoption of comprehensive emergency preparedness and contingency operations plans by January 1, 2026. • Definition of Emergency Incidents: The bill defined emergency incidents as events that threaten the health and safety of residents, including power outages lasting more than 12 hours. • Emergency Preparedness Plans: Each facility would have been required to adopt a plan ensuring resident care and the maintenance of essential systems during emergencies. Plans had to include: • A climate-controlled area of refuge with at least 15 square feet per resident; • Maintenance of indoor temperatures between 68°F and 82°F; • Installation of backup power systems or connection points for portable generators; • A fuel supply sufficient for at least 96 hours; and • A carbon monoxide alarm. • Resident Safety Strategies: Plans had to address: • Prevention of heat exposure; • Safe transport of residents in extreme conditions; • Communication protocols for responding to family inquiries; and • Training and dissemination of emergency policies to personnel. • Oversight and Enforcement: The HHSC would have been tasked with reviewing and approving emergency plans. It was authorized to assess penalties for non-compliance starting January 1, 2027. The bill would have directed the HHSC executive commissioner to adopt rules to enforce the new standards. • Construction Standards: New construction and licensure standards for facilities built after September 1, 2026, would have been established, including requirements for integrated backup power systems or evacuation protocols to nearby buildings with power support.	Regulatory Operations

IX. Major Issues

The Health and Human Services Commission (HHSC) leadership has identified six major issues that Sunset could help address through changes in statute to improve our agency's operations and service delivery. These issues relate to:

- Improving the customer experience;
- Increasing agency flexibility;
- Enhancing data and data analytic capabilities;
- Increasing regulatory efficiency and addressing gaps;
- Improving Intellectual and Developmental Disabilities (IDD) coordination; and
- Ensuring effective contract management.

Addressing these issues will significantly improve HHSC's operational efficiency and ability to serve Texas.

Note: The major issues discussed on the subsequent pages reflect the responses to Self-Evaluation Instructions Section IX questions A-E. Question F is not applicable.

Major Issue 1: Improve the Customer Experience

A. Brief Description of Issue:

While prior Sunset recommendations helped consolidate and align like-services and functions, more work is to be done to transform how the public, clients, providers, and contractors navigate the health and human services (HHS) system.

B. Discussion:

HHSC wears many hats when serving more than 7.5 million Texans every month. The agency administers the state's Medicaid, Supplemental Nutrition Assistance Program (SNAP), and other client services programs; provides a comprehensive array of long-term services and supports for people with disabilities and people aged 60 and older; operates the state's mental health hospitals and state supported living centers (SSLCs); regulates health care professions and facilities; sets policies,

defines covered benefits, and determines eligibility for programs; and provides oversight and administrative support service to the HHS system. While HHSC has made great strides to run services more efficiently by consolidating services and functions under a single agency, more work is to be done to improve the customer experience for the public, clients, providers, and contractors.

Engaging with the Public: HHSC interacts with the public and stakeholders every day in a variety of ways, including its websites, call centers, eligibility offices, state operated health facilities, ombudsman office, advisory committees, and published reports. However, HHSC's size and scope creates inherent challenges for even the savviest people trying to interact with decision makers, navigate the agency to access services, or receive information.

- HHSC's eligibility offices, website, YourTexasBenefits.com, and the 2-1-1 hotline serve as major points of entry for a handful of key programs, but no single "front door" exists for the agency's other programs, leaving people on their own to figure out how to access which services to address their needs.
- The public can contact one of six different types of ombudsmen, to seek help or resolve complaints. While these functions are centrally housed, each of these ombudsmen address distinct types of issues, are statutorily structured differently, and, in certain circumstances, serve other agencies. Additionally, the public can contact the Medically Dependent Children Program (MDCP)/Deaf Blind with Multiple Disabilities (DBMD) escalation phone line for complaints related to their services.
- HHSC supports 37 advisory committees, many with multiple subcommittees, comprised of over 450 members, that receive input and provide a public forum on various issues. The number of advisory committees the agency manages contributes to workload challenges, creates overlapping scopes, and strains leadership attention on critical issues raised by these groups.
- The HHS Executive Council has no decision-making authority, and its current role with respect to rulemaking is duplicative of other mechanisms for the public to provide meaningful input.
- In addition to posting information on its website, HHSC has 168 legislative reporting requirements that directed the agency to publish 468 reports during the 2024-25 biennium. Many of these reports are duplicative, shared with varying audiences, and published on inconsistent schedules. These reports create a sizeable workload for staff and leads to information overload for external audiences that they are intended for.

Receiving Essential Services: HHSC administers nearly 200 programs through a vast network of providers and contractors. As part of the HHS ecosystem, the agency also coordinates with other state and federal agencies to ensure people have access to needed services and supports. Without strong partnerships, gaps and inefficiencies may emerge. Below are examples of challenges HHSC faces coordinating services.

- There are numerous stakeholders, provider groups, contractors, and state agencies involved in delivering and coordinating services for individuals with IDD. At HHSC alone, nine separate divisions must work hand in hand to establish policies and rules, determine eligibility, enroll and pay providers, oversee contracts, perform utilization reviews, and regulate and terminate providers. While HHSC has designated a point of contact for IDD issues and the IDD System Redesign Advisory Committee supports related work, coordination and communication challenges persist due to the number of internal and external entities involved in the delivery of services and various other initiatives.
- Following implementation of Sunset recommendations in 2015, all women's health programs transferred to HHSC and several of these programs were merged into a single program, the Healthy Texas Women (HTW) program. However, HHSC continues to administer multiple programs – family planning, breast and cervical cancer, and primary health care – that provide women's health services. Many of these programs have overlapping eligibility requirements, services, and providers. This can result in confusion for recipients and providers and duplication of effort and services.

The landscape of women's health in Texas has also changed in the last 10 years – the Centers for Medicare & Medicaid Services (CMS) approved HHSC's waiver request to incorporate HTW fee-for-service into Medicaid managed care; the Legislature directed, and CMS approved, HHSC to expand post-partum Medicaid services to women for 12 months; and the provider network has expanded significantly. These recent developments provide an opportunity for the state to chart the path forward for these crucial women's health services. Additionally, HHSC continues to administer the HTW Cost Reimbursement program, which provides administrative capacity building funds to providers under the HTW fee-for-service program. This program no longer serves its initial purpose to support a provider base for the program given the significant expansion of providers under the HTW fee-for-service program, and could be re-invested in direct services for women.

Doing Business with the State: To provide Medicaid or certain healthcare services in Texas, healthcare providers must go through HHSC. HHSC licenses and regulates long-term care facilities, inpatient hospitals, and other providers; manages the provider enrollment process for anyone wanting to participate in and be reimbursed by Medicaid, the Children's Health Insurance Program (CHIP), Children with Special Healthcare Needs (CSHCN), and the Kidney Health Program; contracts with providers; and sets rates for Medicaid and other health and human service programs. While HHSC has made great strides to standardize regulatory processes, streamline Medicaid enrollment, and consolidate rate setting functions, Texas continues to face challenges with provider participation in the Medicaid program. This is exacerbated by a healthcare workforce shortage in many areas of the state.

- Following implementation of past Sunset recommendations, HHSC centralized regulatory functions to realize improved consistency and best practices of similar activities. Additionally, HHSC recently launched a multi-year initiative to evaluate regulatory requirements to lessen administrative hurdles for healthcare providers and facilities the agency licenses and to encourage others to join the healthcare workforce.
- Providers across Texas face significant administrative barriers when engaging with HHS programs. A primary challenge is the complexity and inconsistency of state and federal requirements – applications often span hundreds of criteria across licensing, enrollment, credentialing, and contracting. These requirements vary across programs and are frequently unclear, leading to delays in provider participation and service delivery. Additionally, providers must navigate multiple disconnected systems that lack integration, require redundant data entry, and offer limited visibility into application status or points of contact. These burdens are especially challenging for smaller or newer providers without dedicated administrative support.
- A high percentage of service contracts HHSC pursues at its state hospitals and SSLCs have been awarded to Group Purchasing Organizations (GPOs). GPOs are an important contracting tool for HHSC that allows the agency to receive service contract awards quicker at a predetermined rate. While this is advantageous to HHSC, it is a disadvantage to small businesses who are not typically members of GPOs due to upfront administrative requirements that these smaller companies are not equipped to handle.
- HHSC develops more than 100,000 rates for acute care services, long-term services and supports, hospital and clinical services, and other healthcare services, many of which are updated annually. The Legislature frequently

directs the agency to set specific rates through the General Appropriations Act. HHSC is required to navigate through an extensive rules process to implement the rates directed by the legislature, which are not subject to change. This process is duplicative, inefficient, and leads to wasted staff time, and delays in getting money into the pockets of healthcare providers.

C. Possible Solutions and Impact:

Engaging with the Public:

- Direct HHSC to create a designated stakeholder relations office to assist stakeholders in navigating HHSC and providing information to agency leadership.
- Consolidate advisory committees into broader, topical groups to streamline public input and more effectively impact agency decisions.
- Eliminate the HHS Executive Council and direct the above consolidated advisory committee structure to report recommendations to the Executive Commissioner biannually.

Receiving Essential Services:

- Further consolidate and streamline women's health services to reduce confusion and maximize state dollars being spent on necessary client services.

Doing Business with the State:

- Continue to evaluate the current landscape of state and federal requirements for long-term care, acute care, and childcare providers to streamline regulations necessary to protect the health and safety of Texans by identifying and eliminating outdated, redundant, or unnecessary regulations.
- Modernize and integrate provider-facing systems, including creating a unified provider portal and "smart application" that guides users through processes based on their specific needs. Streamlining and standardizing workflows across divisions would reduce duplication and improve consistency. Equally important is reviewing and streamlining the underlying program requirements themselves. Aligning and simplifying enrollment, credentialing, and contracting criteria across programs would reduce complexity and administrative burden for providers. Providing real-time application status updates, creating a centralized provider support unit and comprehensive training resources would help providers better navigate agency requirements.

Finally, regularly engaging providers through feedback loops will ensure ongoing improvements are informed by real-world experience.

- Amend statute to lengthen and/or standardize licensure periods, as appropriate.
- Review, streamline, and align provider enrollment and credentialing requirements and processes, where feasible.
- Advertise the state's GPO process to local businesses and create a support mechanism to assist local service providers in registering as GPOs.
- Exempt legislatively directed Medicaid rate changes from the rulemaking process required by the Administrative Procedures Act (APA).

Major Issue 2: Increase Agency Flexibility

A. Brief Description of Issue:

Current procurement laws restrict HHSC's ability to be nimble and move swiftly to procure vital client services, information technology (IT) systems, and outside expertise.

B. Discussion:

HHSC's size (more than \$46 billion per year and 38,000 FTEs) and scope (nearly 200 programs) is unlike any other agency in state government. The agency manages more than 16,000 active contracts and executes nearly 25,000 purchase orders each year. Because contracting plays an integral role in how HHSC delivers services, state procurement requirements directly impact how the agency goes about its day-to-day business. However, the state's patchwork of procurement laws is antiquated and no longer support the unique needs of the agency and contributes to lengthy timelines for procuring goods and services. Several examples are discussed below.

Central Master Bidders List (CMBL): The Comptroller of Public Account's (CPA's) CMBL is a database used by state agencies to develop a mailing list for vendors to receive bids based on the products or services they can provide. However, there are often not enough vendors listed in CMBL. For example, HHSC operates 13 SSLCs, 10 state hospitals, and one residential treatment facility that provides direct healthcare services to residents and patients at these facilities. In the absence of in-house medical staff, HHSC must contract with outside medical professionals to

provide services. However, these medical professionals are not in the business of responding to solicitations and HHSC often must repost these invitations to bid multiple times with little success. Ultimately, the agency issues spot purchases for the same service multiple times throughout the year to provide healthcare services to residents and patients. This process is inefficient and can lead to a delay in care being provided.

Contract Advisory Team (CAT): CPA's CAT assists state agencies in improving contract management practices by reviewing and making recommendations on solicitation documents for contracts that have a value of at least \$5 million during the full term of the contract. While serving a noble purpose, HHSC has many more contracts that exceed this threshold as compared to other state agencies and, because of this requirement, this additional review adds 30 days to HHSC's already lengthy procurement timeline.

Re-Procurement Requirements: IT is the backbone of HHSC's operations, underpinning every aspect of the agency's operations and the services it delivers to millions of Texans. In fiscal years 2024-25, HHSC IT managed a \$780 million operational budget and more than \$1.1 billion in capital assets. Together, these IT systems manage more than five petabytes of data. Like any other contract HHSC manages, these major IT systems are required to be re-procured every five years, which leads to lengthy approval cycles, slows the purchase of technology, and impacts the agency's ability to implement timely solutions. For many large systems, the time from procurement development to the operational start date takes at least three years. Due to the complicated nature of these systems, a five-year procurement cycle is compressed.

Request for Offer (RFO): The Department of Information Resources (DIR) goes through a competitive procurement process using the RFO method to procure Automated Information System (AIS) and IT products and services. While intended to save time, this method contributes to contract negotiations taking 30-220 business days, which reduces HHSC's ability to award contracts in a timely manner.

Deliverable Based Information Technology Services (DBITS): DIR's DBITS provide project-based IT solutions and services for developing new IT applications, upgrading legacy systems, or for general IT procurement assistance. The current \$10 million cap on DBITS contracts is often too restrictive for large-scale IT initiatives, forcing HHSC to complete an RFO or to break projects into smaller pieces which increases complexity and costs.

Funding Uncertainty: Like many agencies, HHSC's IT solutions are constrained by the state's biennial budget cycle. Most HHSC IT projects span multiple years, but the two-year budget cycle creates uncertainty for continued funding which can lead to delays, re-planning, and higher costs.

Outside Expertise: When HHSC does not have in-house expertise for special projects, the agency sometimes contracts with consultants to provide these specialized services. However, the agency must go through a full procurement process and does not have access to a list of pre-approved vendors to select from to serve these time limited purposes. This contributes to delays and is not always an efficient use of staff resources.

C. Possible Solutions and Impact:

- Evaluate state procurement laws, including CMBL, CAT, re-procurement, RFO, and DBIT requirements, and grant HHSC broad authority to procure statutorily directed services.
- Increase the minimum threshold for CAT to review HHSC contracts.
- Increase DBITS contract caps and simplify vendor solicitation rules to accelerate IT project delivery and reduce costs.
- Create a flexible, multi-year funding pool for IT projects authorized by the Legislature and approved by DIR to help HHSC complete large-scale IT projects more efficiently.
- Establish a consultant pool, pre-approved by CPA, to allow agencies to procure short-term, outside expertise when specialized skillsets are not available in-house.

Major Issue 3: Enhance Data and Analytics Capabilities

A. Brief Description of Issue:

Despite making significant strides since its last Sunset review, HHSC's data and analytic capabilities are limited due to inconsistent and poor data quality and the absence of a universal governance strategy that prioritizes data connectivity and sharing.

B. Discussion:

HHSC manages more than five petabytes of data, twice the amount maintained by the U.S. Census Bureau, some of which dates to the early-1970s. When properly managed, data of this scale is an invaluable tool for operating the agency's nearly 200 programs which provide vital services to millions of Texans. HHSC's size, array of services, and history – formed through the consolidation of multiple standalone agencies over the years – have heightened the difficulty of effectively managing and using information to make data-driven decisions.

Quality: Given HHSC's size and complexity, the agency's data landscape has not been thoroughly inventoried. Agency-led assessments reveal significant variation in data quality, consistency, and governance maturity. This is largely because HHSC's data resides in hundreds of unique program business applications – many of which were built years ago under different organizational structures, designed to meet specific business needs. As a result, the quality, availability, and documentation of data assets vary widely across systems.

Many systems remain largely ungoverned, incomplete, or are of questionable quality. Much of the data is self-reported by providers, grantees, or contractors, or manually entered by HHSC staff with little or no quality monitoring. This results in data entry errors and other quality issues that require extensive, often manual, efforts to clean, organize, and interpret the data before it can be reliably used by agency staff, the legislature, or the public. Additionally, the lack of access to timely, quality data means decision-makers are often left to either endure delays in getting answers to basic questions or forgo the use of data when making decisions.

Connectivity and Sharing: HHSC's Performance Management & Analytics System (PMAS) is designed to address a wide range of data and analytics needs while maintaining a coordinated approach to data quality and governance. However, the agency's size, data quality, and programmatic constraints have hindered its ability to adopt a universal data and analytics governance approach that prioritizes agency-wide interoperability, connectivity, and data sharing. Many legacy systems still in use today were built before effective data sharing was feasible and resource limitations have restricted system improvements to only critical, program-specific enhancements. Additionally, some state and federal laws and regulations present obstacles to data connectivity and sharing.

C. Possible Solutions and Impact:

- Enhance HHSC's ability to leverage data for strategic decision-making by providing a dedicated focus on improving and maintaining data quality at the

source through data stewardship; promoting data sharing; and strengthening strategic alignment and coordination between data governance, IT governance, and project management approaches.

- Strengthen data stewardship and fully leverage HHSC's data to inform decision-making. To build on current efforts, HHSC requested funding during the 89th Legislative Session to support an agency-wide data stewardship program. In addition to maintaining base resources for PMAS, this initiative would establish a core of data experts embedded within individual HHSC programs. These experts would be dedicated to:
 - ▶ Understanding and documenting how program functions, policies, and operational nuances affect data collection, interpretation, and analytics;
 - ▶ Evaluating program system data to identify data quality concerns, anticipate technical adjustments needed due to policy changes, and recommend solutions;
 - ▶ Leveraging new and existing technologies to manage and monitor system data, ensuring its reliability for both ad hoc and recurring analytics; and
 - ▶ Guiding, supporting, and coordinating efforts of program staff who are responsible for enhancing documentation and improving data quality within the source systems they use regularly.
- Direct HHSC to adopt a strategy that proactively prepares program data for both current and future connectivity while identifying and removing institutional barriers to data sharing. This effort should include a thorough review of existing obstacles and the development of a plan to reduce these barriers. To achieve this, HHSC should:
 - ▶ Document available data resources and assess benefits of increased connectivity;
 - ▶ Identify and categorize barriers to data sharing, including technological limitations, program policy restrictions, statutory constraints, and federal funding requirements; and
 - ▶ Evaluate the resources and actions needed to address these barriers.
- Direct HHSC to continue accelerating efforts to facilitate data sharing by developing streamlined processes, including creating a metadata repository that documents all datasets. Additionally, HHSC should develop a data sharing process that allows programs to request data from designated owners for specific purposes. This process should support streamlined

program and service delivery, enhance efficiencies, and improve client outcomes.

- Direct HHSC to adopt a unified approach to data and analytics governance that all technology projects resulting in tools – such as operational dashboards, databases, data marts, ad hoc data reporting tools, and AI analytics – are reviewed by a governance committee and incorporated into PMAS. Analytics solutions under the PMAS umbrella should encompass a broad range of tools and prioritize, where feasible, integration into the agency’s overarching cloud-based data and analytics infrastructure.

Major Issue 4: Increase Regulatory Efficiency and Address Gaps

A. Brief Description of Issue:

The state’s “one-size-fits-all” approach to regulating a growing healthcare industry ties HHSC’s hands from efficiently managing its resources and prioritizing oversight of providers who present the highest risk to the health and safety of the individuals they serve. Additionally, HHSC lacks clear statutory authority to regulate certain long-term care providers or to require some healthcare providers to screen and conduct background checks of employees.

B. Discussion:

Regulatory Efficiency: HHSC regulates more than 65,000 long-term care, acute care, and childcare facilities and 150,000 healthcare professionals, such as licensed chemical dependency counselors and nursing facility administrators. Although the legislature has invested generously to support the agency’s regulatory activities, Texas’ provider base has grown along with the state’s population. As a result, HHSC’s workload has increased and contributed to backlogs in surveys and inspections.

HHSC’s workload challenges are further exacerbated by the frequency of surveys and inspections prescribed in statute without consideration of the risk each facility or provider may pose to the individuals they serve. This limits the agency’s ability to manage limited resources as efficiently and effectively as possible and is overly burdensome for providers who are performing well on regular surveys and complying with all laws and rules.

Regulatory Gaps and Abuse, Neglect, and Exploitation (ANE): HHSC manages the Home and Community-based Services (HCS) and Texas Home Living (TxHML) waivers, both authorized by Section 1915(c) of the Social Security Act, which includes contracting with certified providers to deliver a range of Medicaid-funded services to individuals with IDD. These provider types are not licensed under a formal regulatory framework but are approved through a certification and contracting process with HHSC. While both waivers support individuals living in the community, HCS is distinct in that it authorizes residential services such as those provided in group homes, whereas TxHmL does not include residential options in its service array. Despite these differences, a single provider may operate under both waiver programs, serving individuals in various non-institutional settings.

Although HHSC oversees HCS and TxHmL providers, the absence of a formal, statutorily authorized licensing and regulatory framework for these provider types creates significant risks – particularly for individuals receiving residential services through the HCS waiver. Current oversight activities include:

- HHSC conducts routine and targeted contract monitoring or provider compliance with Medicaid waiver requirements, focusing on service delivery, documentation, and adherence to program standards.
- HHSC performs scheduled, annual program reviews to assess overall provider performance, including review of progress notes, staff qualifications, and person-centered planning processes.

HHSC is also responsible for investigating allegations of ANE involving individuals served under the HCS and TxHmL waiver programs. These investigations are critical for identifying immediate risks and preventing harm. However, under the current certification and contract-based model, HHSC's authority to impose sanctions in response to confirmed ANE findings is limited. Unlike other licensed provider types, there is no statutory authority to issue fines, suspend operations, or revoke a license in cases of systemic failure or serious mistreatment.

This gap is particularly concerning for HCS providers, which may offer residential services where individuals are more dependent on staff and have fewer opportunities for independent oversight or advocacy. Without licensing authority, HHSC's ability to take swift corrective action – especially in situations involving repeated or serious ANE – is constrained to contract remedies that may be slower or less impactful.

Other gaps that currently exists in overseeing HCS providers include:

- No initial health and safety survey is conducted prior to residents moving into a home;
- No system or process to identify, track, and address trends or patterns;
- No centralized intake system for non-ANE complaints exists;
- Enforcement options are limited to minimal administrative penalties or full decertification, resulting in contract termination; and
- Regulatory authority is tied to individuals enrolled in the Medicaid waiver program, not HCS providers.

In practice, these gaps present situations where serious harm or even death may occur in an HCS waiver home, and while the individual perpetrator of the abuse is held accountable, HHSC is limited in its authority to hold the provider accountable, particularly when the client is not enrolled in the HCS waiver program. HHSC's authority is tied to the contractual arrangement with the waiver provider to deliver services to participants in the waiver, creating jurisdictional confusion when non-waiver recipients are involved in allegations or incidents. In all other long-term care settings regulated by HHSC, the license allows the agency to hold the provider accountable for any non-compliance, including ANE, without regard to the payor of services for the clients or residents involved.

Background Checks: HHSC lacks statutory authority, as a condition of issuing or renewing a license, to require hospitals, chemical dependency treatment facilities, and Narcotic Treatment Programs to conduct background checks on prospective employees. Background checks are a valuable tool for HHSC to gather information about an individual employed by a regulated healthcare provider before the agency officially endorses the facility's fitness to operate and not present a risk to the people they serve. HHSC also does not have statutory authority to require these facilities to verify employees are not on the Employee Misconduct Registry (EMR) for committing ANE. Verifying employees are not on EMR is vital to ensuring bad actors do not move between long-term care, hospitals, childcare, juvenile justice, and educational settings.

C. Possible Solutions and Impact:

- Regulatory Efficiency: Provide authority for HHSC to apply a risk-based approach to determine the frequency and priority of surveys and inspections of providers. HHSC would operationalize this approach by creating a risk assessment tool for each provider type which considers compliance history,

including past incidents of ANE, to determine the frequency and timing of surveys and inspections. Additionally, amend statute to ensure all providers are surveyed at least once within a longer, defined period.

- Regulatory Gaps: Formalize the HCS “certification” process in statute, which would have the same effect as requiring a license and require providers to register with HHSC prior to serving waiver or non-waiver recipients. Additionally, direct HHSC to receive non-ANE complaints related to HCS through the agency’s Complaint & Incident Intake line. Finally, authorize HHSC to create a formal enforcement structure with a range of enforcement options to address non-compliance issues, such as requiring the closure of specific homes, suspension or emergency suspension, or probation.
- Background Checks: Authorize HHSC to require certain healthcare provider types to conduct criminal background checks of prospective employees as a condition of licensure. Additionally, mandate that these healthcare facilities screen prospective employees through EMR prior to being hired.

Major Issue 5: Improve IDD Coordination

A. Brief Description of Issue:

While the Texas Legislature and HHSC has made great strides to better coordinate services for people with an IDD, including designating a point of contact for IDD issues and establishing the IDD System Redesign Advisory Committee, barriers still exist in ensuring services are delivered collaboratively and the needs for this vulnerable population are addressed.

B. Discussion:

HHSC’s IDD-related responsibilities span across five separate chief areas and nine divisions and include: determining eligibility for prospective recipients; establishing policies and rules for healthcare providers; enrolling and paying providers; managing contracts and regulating certain provider types; performing utilization review; and operating 13 SSLC that provide 24-hour campus-based residential care. HHSC operates four Medicaid waiver programs specifically for people with IDD – HCS, Community Living Assistance and Support Services (CLASS), TxHmL, and DBMD. HHSC served approximately 38,000 people in IDD waivers at the beginning of fiscal year 2025, an additional 174,000 people remained on one of several interest lists, and nearly 2,600 people resided at an SSLC.

While a single HHSC division, contracted entity, or health provider may only be responsible for one aspect of the IDD system, people with IDD do not experience the system in pieces; they rely on a coordinated, consistent experience. An efficient and coordinated service delivery system requires clear access points for people to navigate services, programs, and other supports. This ensures services are accessed timely and needs are being met by a capable and available provider network. Internal alignment and streamlined operations are also critical to creating a nimble IDD service delivery system that can respond to people's needs and sustain a robust community network.

Initial eligibility and enrollment involve multiple entities, including: HHSC Access and Eligibility Services, HHSC Medicaid and CHIP Services, Local Intellectual and Developmental Disability Authorities (LIDDAs), and contracted providers. Adding to the complexity, the enrollment pathways differ by waiver program. For example, LIDDAs play a central coordination role for some IDD waivers (like HCS and TxHmL) but are not involved in others (such as CLASS and DBMD). This variation creates confusion, increases administrative burden, and leads to inconsistent experiences for individuals and providers.

Beyond eligibility and enrollment, effective service delivery also requires ongoing collaboration to manage participant transfers, service authorizations, and state and federal policy changes. Texas' IDD service delivery system includes a continuum of services and supports accessed throughout a person's lifespan to address their emerging and evolving needs. For example, some people live independently with few supports in their own home, host home, or group home. Whereas other people may have complex support needs based on physical limitations, mental health needs, extensive dietary supports, and limited communication abilities. When service needs cannot be met in a community setting, a person with IDD may be better served in an Intermediate Care Facility (ICF) or SSLC. These needs, and how and where they can best be addressed, change throughout someone's life and require seamless coordination.

HHSC's capacity to serve individuals with IDD in the community is also dependent on available funding for waiver slots. The legislature has funded additional waiver slots over the past several biennia, but demand continues to exceed supply. While Texas serves people on the interest list on a first come, first served basis, some other states manage their programs in a different way. For example, some states prioritize access based on urgency of need and others enroll individuals in the lowest level of service to meet their needs, reserving residential services for those who cannot be served by other programs.

Also impacting the state's ability to serve people with IDD is that many of their needs are changing, and HHSC's brick and mortar infrastructure and provider network was not built to properly address these needs. For example, inquiries for SSLC admission are increasing for younger, forensically involved people with behavioral and psychiatric needs. However, statute authorizes only two SSLCs to accept forensic admissions. This limits capacity, delays service delivery, and may result in people waiting in jail or acute hospital settings. Staffing constraints and the lack of intensive services to meet these needs also present challenges for the SSLCs.

C. Possible Solutions and Impact:

- Review the IDD landscape and identify opportunities for improved coordination.
- Consolidate HCS and TxHmL eligibility and enrollment functions to minimize touchpoints, improve workflow, and ensure successful progression with enrollments and transfers.
- Strengthen existing IDD coordination by establishing a governance structure that reports directly to HHSC leadership, and is responsible for articulating the scope, priority, and needs impacted divisions. This entails creating a high-level, dedicated role leading a team of designated IDD points of contact within all impacted chief offices, that reports directly to the executive commissioner.
- Authorize HHSC to designate other SSLCs to accept new forensic admissions to help alleviate wait times and make admissions from state hospitals or other settings more expedient.

Major Issue 6: Ensure Effective Contract Management

A. Brief Description of Issue:

The state's universal approach to contracts combined with HHSC's size and scope present unique challenges to managing contracts effectively.

B. Discussion:

The HHS System is big and has changed tremendously over the last two decades – merging 12 agencies into five following the 2003 Sunset review, and further consolidating into three agencies in 2015; overseeing nearly 200 programs that touch the lives of virtually all Texans, from providing food benefits and mental health care to regulating nursing homes and hospitals; managing a \$53 billion annual budget, which represents a third of the state’s total budget; and transitioning from a direct service agency to primarily a contracting agency, including shifting Medicaid from a fee-for-service delivery system to a manage care contract model.

Over the last 20 years, the legislature has continued to add and amend laws that serve as the bedrock of how state agencies manage contracts and ensure tax dollars are spent appropriately. HHSC has also provided focused attention to ensure quality services are delivered, timelines are met, and vendors are held accountable. The agency has achieved this by creating and refining policies and processes, developing tools and automating tasks, and training staff. However, this Sunset review provides the first in depth look since transformation at whether the agency is organizationally setup in a way to best manage contracts and evaluate whether the state’s universal approach to contract management meets HHSC’s unique needs.

Contract Management Framework: Embedded within HHSC's functionally aligned structure are staff who manage nearly 16,000 active contracts. These staff ensure contractors are compliant with the provisions of their contract, aligned with HHSC goals and business needs, and services are delivered on time. HHSC equips contract managers with a variety of tools, resources, and training to help them in their day-to-day job, including:

- CPA State of Texas Procurement and Contract Management Guide: Provides a framework for navigating Texas procurement law and offers practical, step-by-step guidance to ensure agencies acquire goods and services.
- CPA Contract Manager Training: Certifies staff as “Certified Texas Contract Manager” to engage in contract management functions on behalf of HHSC.
- HHSC Procurement and Contract Management Handbook: Establishes consistent procurement and contract management policies and procedures that must be followed by staff.
- HHSC Planning Tools: Provides guidance for comprehensive planning, including funding, solicitation, performance outcomes, and performance measures.

- HHSC Statement of Work Desk Guide: Provides tools for contract managers to use when drafting a statement of work.
- HHSC Contract Development Checklist: Helps identify goals, set expectations, define terms and conditions, and assess risk.
- HHSC Assessment of Contract Requirements Guide: Aids in evaluating the adequacy of contract requirements and determining the need for migration strategies.
- HHSC Dashboards: Alerts staff of required contract monitoring actions, remedies, and vendor checks.
- HHS Contract Management Academy: Expands the CPA's training to address the complexities of HHSC contract.

To further enhance contract oversight, HHSC created a contract management support team to conduct compliance reviews of various requirements, develop best practices for planning and monitoring contracts, and advise on how to provide better financial management. Additionally, HHSC's Internal Audit department and the State Auditor Office monitor contracts by identifying risks, providing recommendations for improvement, and reporting issues to state and agency leadership.

However, HHSC's size and the complexity of what and how services are delivered creates unique challenges for managing contracts. The agency would benefit from an independent look to determine whether the organizational framework and tools available meet HHSC's needs for managing the wide variety of services the agency provides.

Statutory Limitations: State law takes a cookie cutter approach to managing contracts with little consideration for what service is procured, other than the value of the contract. For example, the same laws that govern contracts for building roads and purchasing office supplies also applies to providing competency restoration services for people found incompetent to stand trial and multi-billion contracts that provides a wide array of healthcare and social services. Because the scope of HHSC is unlike its counterparts in state government, the agency would benefit from tailoring statute to the services it provides.

C. Possible Solutions and Impact:

- Direct HHSC to develop a risk-based quality and compliance tool to assess contract management compliance and effectiveness on an agency-wide level.

- Identify additional tools to support HHSC's contract management workforce, including automating additional forms and processes, providing renewal calendaring and status tools, creating dashboards, adding alerts and reports, and integrating DocuSign into CAPPS.
- Direct HHSC to create agency-specific training and a professional development program for contract managers.
- From a structural and staffing perspective, evaluate whether HHSC is organizationally setup in a way to effectively manage contracts.
- Review and recommend changes to statute so that state requirements are tailored to the types of services HHSC provides and how those services are delivered.

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X. Other Contacts

A. Fill in the following tables with updated information on people with an interest in your agency. Be sure to include their most recent email address.

See attached [Exhibit 17: Other Contacts](#) for lists of:

- **Interest Groups** (*groups affected by agency actions or that represent others served by or affected by agency actions*)
- **Interagency, State, or National Associations** (*that serve as an information clearinghouse or regularly interact with your agency*)
- **Liaisons at Other State Agencies** (*with which your agency maintains an ongoing relationship, e.g., the agency's assigned analyst at the Legislative Budget Board, or attorney at the Attorney General's office*)

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XI. Additional Information

A. Texas Government Code, Section 325.0075 requires agencies under review to submit a report about their reporting requirements to Sunset with the same due date as the SER. Include a list of each agency-specific report the agency is required by statute to prepare and an evaluation of the need for each report based on whether factors or conditions have changed since the statutory requirement was put in place. Please do not include general reporting requirements applicable to all agencies, reports that have an expiration date, routine notifications or notices, posting requirements, federally mandated reports, or reports required by G.A.A. rider. If the list is longer than one page, please include it as an attachment. See Exhibit 18 Example.

Health and Human Services Commission

Exhibit 18: Evaluation of Agency Reporting Requirements

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Information Matching System Relating to Immigrants and Foreign Visitors Report	Texas Human Resources Code, Section 22.0292(d)	October 1; Annual	Governor, Legislative Budget Board, State Auditor's Office, HHS Executive Council	(d) The commission shall submit to the governor and the Legislative Budget Board an annual report on the operation and success of the information matching system required by this section. The report may be consolidated with any other report relating to the same subject matter the commission is required to submit under other law.	Yes. This report is still needed. HHSC continues to conduct matches to verify immigration status as also required by federal law.
All Texas Access Report - Mental Health	Texas Government Code, Section	December 1; Annual	HHS website	(e) Not later than December 1 of each year, the commission shall produce and publish on its Internet website a report containing the most recent version of	Yes. The report compiles updated local plans by the local mental health

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Services development plan	547.0005(e)			each mental health services development plan developed by the commission and a local mental health authority group.	authorities.
Community Resource Coordination Groups Report	Texas Government Code, Section 522.0157(2)	N/A; Biennial	Governor, Texas Legislature, Administrative Heads of agencies in MOU	(2) a biennial report to the administrative head of each agency, the legislature, and the governor that includes: (A) the number of persons served through the local-level interagency staffing groups and the outcomes of the services provided; (B) a description of any barriers identified to the state's ability to provide effective services to persons needing multiagency services; and (C) any other information relevant to improving the delivery of services to persons needing multiagency services.	Yes. The report highlights data related to services for youth and families with complex needs whose needs cannot be met by one agency and require interagency coordination by the MOU partner agencies.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Healthy Community Collaboratives Biennial Report	Texas Government Code, Section 539.010	September 1 of even-numbered years; Biennial	Lt. Governor, Speaker of the House, Legislative Committees (House Public Health, Senate Finance Committee, House Appropriations Committee, Senate Health and Human Services, House Human Services)	(a) The department shall prepare a report that includes: - (1) the method by which the department chose entities to award grants to under this chapter; - (2) the amount of each grant awarded to an entity under this chapter; - (3) the number of individuals served by each community collaborative receiving grant funds under this chapter; and - (4) the results of the annual review of outcome measures required by Section 539.006. (b) Not later than September 1 of each even-numbered year, the department shall submit a report described by Subsection (a) to: - (1) the lieutenant governor; - (2) the speaker of the house of representatives; - (3) the standing committees of the legislature having primary jurisdiction over the department and state finance; and - (4) the Legislative Budget Board.	No. Healthy Community Collaboratives is also reported as part of the Community Mental Health Grant Programs rider, which combines all state-funded matching grant program outputs and outcomes into one report submission. This standalone report just for Healthy Community Collaboratives is duplicative/redundant.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Local Mental Health Authority (LMHA) Mental Health Training Compilation Report (Report on Mental Health First Aid Program)	Texas Health and Safety Code, Section 1001.205(b)	December 1; Annual	Texas Legislature, HHS Website	Not later than December 1 of each year, the department shall compile the information submitted by local mental health authorities as required by Subsection (a) and submit a report to the legislature containing the number of: (1) authority employees and contractors trained as mental health first aid trainers during the preceding fiscal year; (2) university employees, school district employees, and school resource officers who completed a mental health first aid training program provided by an authority during the preceding fiscal year; and (3) individuals who are not university employees, school district employees, or school resource officers who completed a mental health first aid training program provided by an authority during the preceding fiscal year.	Yes. The report shows how many people are trained each year and how much state funds are used, which provides openness and transparency.
LMHA financial and compliance audits	Texas Health and Safety Code, Section 534.068(c)	N/A; Annual	Governor, Legislative Budget Board	(c) The local mental health authority shall file the required number of copies of the audit report with the department by the date prescribed by the executive commissioner. From the copies filed with the department, copies of the report shall be submitted to the governor and Legislative Budget Board.	Yes. The submission of financial and compliance audits is needed in order to perform financial reconciliation and oversight activities.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Matching Grant Program for Community Mental Health Services Report	Texas Government Code, Section 531.0991(k)	December 1 of even-numbered years; Biennial	Governor, Lt. Governor, Texas Legislature	(k) Not later than December 1 of each even-numbered year, the executive commissioner shall submit to the governor, the lieutenant governor, and each member of the legislature a report evaluating the success of the matching grant program created by this section.	No. Information on the Matching Program for Community Mental Health Services (Community Mental Health Grant) is also reported as part of the Community Mental Health Grant Programs rider, which combines all state-funded matching grant program outputs and outcomes into one report submission. This standalone report just for Community Mental Health Grant is redundant.
Mental Health for Veterans Report	Texas Health and Safety Code, Section 1001.224	December 1; Annual	Governor, Texas Legislature	Not later than December 1 of each year, the department shall submit a report to the governor and the legislature that includes: (1) the number of veterans who received services through the mental health program for veterans; (2) the number of peers and peer service coordinators trained; (3) an evaluation of the services provided under this	N/A. This program and report are transferring to the Texas Veterans Commission in fiscal year 2026.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				subchapter; and (4) recommendations for program improvements.	
Outcomes of the Statewide Behavioral Health Partnership Program (LMHAs Mental Health Outcome in Schools Report)	Texas Education Code, Section 8.158(b)	January 31; Annual	Lt. Governor, Speaker of the House, Texas Education Agency, Legislative Committees (Senate Health and Human Services, Senate Education Committee, House Public Education, House Public Health)	LMHAs must prepare a report regarding outcomes for school districts and students resulting from services provided by the non-physician mental health professionals. Not later than January 31 of each following calendar year, HHSC must compile the information submitted under this section and submit the report after providing TEA with a reasonable opportunity to review and provide input on the contents of the report.	Yes. HHSC compiles the information provided by LMHAs and Local Behavioral Health Authorities (LBHAs) to produce a comprehensive report for submission to the Texas Legislature by January 31 of each calendar year. Per Texas Education Code, Section 8.158, HHSC also submits its annual report to the Collaborative Task Force on Public School Mental Health Services established under Texas Education Code, Section 38.3024. HHSC recommends to keep the report but amend the

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
					reporting due date for LMHAs from calendar year to state fiscal year and adjust the reporting period for HHSC to the legislature from annual to biennial reporting.
Summary of Significant Audit Findings for Mental Health and Mental Retardation Community Centers	Texas Health and Safety Code, Section 534.068(f)	N/A; Annual	Governor, Legislative Audit Committee	The department shall annually submit to the governor, Legislative Budget Board, and Legislative Audit Committee a summary of the significant findings identified during the department's reviews of fiscal audit activities.	Yes. This requirement is important to keep for oversight and monitoring.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Systems of Care Services Evaluation (Submitted with Community Resource Coordination Group Report)	Texas Government Code, Section 531.423	N/A; Annual	HHS Website	(a) The commission shall create a summary report based on the evaluations in the reports submitted to the commission by community resource coordination groups under Section 531.422. The commission's report must include recommendations for policy and statutory changes at each agency that is involved in the provision of systems of care services and the outcome expected from implementing each recommendation. (b) The commission shall coordinate, where appropriate, the recommendations in the report created under this section with recommendations in the assessment developed under Chapter 23 (S.B. 491), Acts of the 78th Legislature, Regular Session, 2003, and with the continuum of care developed under Section 533.040(d), Health and Safety Code. (c) The commission may include in the report created under this section recommendations for the statewide expansion of sites participating in the Texas System of Care and the integration of services provided at those sites with services provided by community resource coordination groups. (d) The commission shall provide a copy	Yes. This report provides information to help carry out statutory requirements in Texas Government Code, Section 547.0052, to implement the system of care framework. Statute does not specify frequency of this report; HHSC updates every 3-5 years.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				of the report created under this section to each agency for which the report makes a recommendation and to other agencies as appropriate.	

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Voluntary Accreditation of Recovery Housing Report	Texas Health and Safety Code, Section 469.005	N/A; Annual	Governor, Speaker of the House, Legislative Committees (Senate Health and Human Services, House Public Health)	The commission shall prepare an annual report that includes information on: (1) the total number of accredited recovery houses; (2) the number of recovery houses accredited during the preceding year; (3) any issues concerning the accreditation or reaccreditation process; (4) the number of accredited recovery houses that had an accreditation revoked during the preceding year; and (5) the reasons for the revocation.	Yes. The report provides key data on recovery houses.
Annual Federal Funds Report	Texas Government Code, Section 525.0052	December 15; Annual	Governor, Lt. Governor, Speaker of the House	The commission, within the limits established by and subject to the General Appropriations Act, shall be responsible for planning for, and managing the use of, all federal funds in a manner that maximizes the federal funding available to the state while promoting the delivery of services. Subsection (c) requires an annual report with respect to the results of the implementation of Section 531.028(b) 1-7	Yes. The report identifies strategies to maximize the receipt and use of federal funds and to improve federal funds management.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Annual Revenue and Expenditure Report (Supplemental and DPP Retained Funding Report)	Texas Government Code, Section 532.0102(f)	N/A; Annual	Governor, Legislative Budget Board	(f) The commission shall submit an annual report to the governor and the Legislative Budget Board that: (1) details the amount of money retained and spent by the commission under this section during the preceding state fiscal year, including a separate detail of any increase in the amount of money retained for a program under Subsection (e); (2) contains a transparent description of how the commission used the money described by Subdivision (1); and (3) assesses the extent to which the money retained by the commission under this section covered the estimated costs to administer the applicable program and states whether, based on that assessment, the commission adjusted or considered adjustments to the amount retained.	No. This report details how application fees are used. When HHSC first implemented fees there was concern the agency would use the fees for other functions, but stakeholders seem comfortable with the structures the fees support now that it has been in place for a few years.
Rural Hospital Services Strategic Plan Progress Report (Access to Hospital Services Report)	Texas Government Code, Section 526.0301(c)	November 1 of even-numbered years; Biennial	Governor, Legislative Budget Board, Texas Legislature	(d) Not later than November 1 of each even-numbered year, the commission shall submit a report regarding the commission's development and implementation of the strategic plan described by Subsection (b) to: (1) the legislature; (2) the governor; and (3) the Legislative Budget Board.	Yes. This report is necessary to outline the state's strategy for rural hospitals, which is intended to ensure that the citizens in this state residing in rural areas have access to hospital services. This is a

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
					demonstrated priority of the Legislature, and the requirement was updated with the passage of House Bill 18, 89th Legislature, Regular Session, 2025. The report is now due in December of each even-numbered fiscal year.
Wholesale Prescription Drug Importation Program Report	Texas Health and Safety Code, Section 444.007	December 1; Annual	Governor, Texas Legislature	Not later than December 1 of each year, the commission shall submit a report to the governor and the legislature regarding the operation of the program during the preceding state fiscal year, including: (1) which prescription drugs and Canadian suppliers are included in the program; (2) the number of health benefit plan issuers, health care providers, and pharmacies participating in the program; (3) the number of prescriptions dispensed through the program; (4) the estimated cost savings to consumers, health plans, employers, and this state since the establishment	Yes. However, without appropriations for this program, the report will be similar to the one provided previously.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				of the program and during the preceding state fiscal year; (5) information regarding the implementation of the audit procedures under Section 444.006; and (6) any other information: - (A) the governor or the legislature requests; or - (B) the commission considers necessary.	
State Long Term Care Ombudsman Report	Texas Human Resources Code, Section 101A.262	November 1 of even-numbered years; Biennial	Governor, Lt. Governor, Speaker of the House	The State Long Term Care Ombudsman shall submit a report every even-numbered year on information and findings related to the problems and concerns of residents. Title 42 U.S. Code, Section 3058g(h)(1) requires this report annually, so it is submitted annually. This a both federally and state required report; federal annual requirement and state biennial requirement.	Yes. The HHS Ombudsman has the statutory authority to report on their work annually or ad hoc. Additionally, it is standard practice for ombudsman programs to report on their work.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Family Based Alternatives for Children	Texas Government Code, Section 531.060(o)	January 1; Annual	Texas Legislature, HHS Website	Not later than January 1 of each year, the commission shall report to the legislature on the implementation of the system. The report must include a statement of: (1) the number of children currently receiving care in an institution; (2) the number of children placed in a family-based alternative under the system during the preceding year; (3) the number of children who left an institution during the preceding year under an arrangement other than a family-based alternative under the system or for another reason unrelated to the availability of a family-based alternative under the system; (4) the number of children waiting for an available placement in a family-based alternative under the system; and (5) the number of alternative families trained and available to accept placement of a child under the system.	Yes. This report allows HHSC to monitor trends involving children in care, including those in institutional settings like nursing facilities. Without this report, there is not another comprehensive document that pulls this data together.
Kidney Health Care Program Report	Texas Health and Safety Code, Section 42.016	August 31; Annual	Governor, Texas Legislature	Report program findings, progress and activities as well as the state's total need in the field of kidney health care to the OOG and legislature.	Yes. The report allows HHSC to present progress and activities that represent the state's need in the field of kidney

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
					health care and helps inform our stakeholders and the Chronic Kidney Disease Task Force.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Permanency Planning Report	Texas Government Code, Section 531.162(b)	January 1, July 1; Semi-annual	Governor, Legislative Committees (Senate Health and Human Services, House Human Services, House Public Health)	The executive commissioner shall submit a semiannual report to the governor and the committees of each house of the legislature that have primary oversight jurisdiction over health and human services agencies regarding: (1) the number of children residing in institutions in this state and, of those children, the number for whom a recommendation has been made for a transition to a community-based residence but who have not yet made that transition; (2) the circumstances of each child described by Subdivision (1), including the type of institution and name of the institution in which the child resides, the child's age, the residence of the child's parents or guardians, and the length of time in which the child has resided in the institution; (3) the number of permanency plans developed for children residing in institutions in this state, the progress achieved in implementing those plans, and barriers to implementing those plans; (4) the number of children who previously resided in an institution in this state and have made the transition to a community-based residence;	Yes. The report allows HHSC to monitor trends involving children in care, including those in institutional settings like State Supported Living Centers (SSLCs). Without this report, there is not another comprehensive document that pulls this data together.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				(5) the number of children who previously resided in an institution in this state and have been reunited with their families or placed with alternate families; (6) the community supports that resulted in the successful placement of children described by Subdivision (5) with alternate families; and (7) the community supports that are unavailable but necessary to address the needs of children who continue to reside in an institution in this state after being recommended to make a transition from the institution to an alternate family or community-based residence.	

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Promoting Independence Report	Texas Government Code, Section 531.0244(g)	December 1; Annual	Governor, Texas Legislature	(g) Not later than December 1 of each even-numbered year, the commissioner shall submit to the governor and the legislature a report on the status of the implementation of the plan required by Subsection (a). The report must include recommendations on any statutory or other action necessary to implement the plan.	Yes. The Promoting Independence Plan (PIP) acts as Texas' 'Olmstead Plan' associated with the Supreme Court decision Olmstead v. L.C., 527 U.S. 581 (1999) and aligns with Executive Order RP-13 and Texas Government Code, Section 531.0244; previously authorized through Executive Order GWB 99-2. PIP serves as Texas' plan for implementing its obligation to provide individuals with disabilities opportunities to live, work and be served in integrated settings.
State Services for Aging: Unit Cost for Services (Unit Cost for	Texas Human Resources Code, Section	September 30; Annual	Governor, Legislative Budget Board	The department shall file with the Legislative Budget Board and the Governor's Office of Budget, Planning, and Policy a report that clearly identifies in a state fiscal year the unit cost of	No. The statewide average cost per unit is a calculation based on the average of the cost

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Services) Report	101A.107			each service, other than services related to community service volunteering and subsidized employment services, provided by an area agency on aging. The report must be filed annually on or before the date specified by the Legislative Budget Board. The report must be in the form required by the Legislative Budget Board.	per unit per Area Agencies on Aging (AAA). The cost per unit for each AAA varies significantly depending on their service area; therefore, the statewide average cost per unit is skewed.
Texas Cares Annual Program Report	Texas Health and Safety Code, Section 65.204	December 1; Annual	Governor, Lt. Governor, Speaker of the House, Legislative Committees (Senate Health and Human Services, House Human Services)	The commission must prepare and post an annual report that includes: a line-item list of all program administrative costs incurred by the commission; the amount of the pharmacy benefit manager and third-party administrator fees; the aggregate amounts of rebates anticipated and received for the program; and other program expenditures as the commission determines appropriate, no later than December 1, 2022 and December 1 of each year thereafter.	Yes. However, the following two items will not have reporting data due to the implementation model used by the program: *the amount of the pharmacy benefit manager and third-party administrator fees; and *the aggregate amounts of rebates anticipated and received for the program.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Texas Statewide Interagency Aging Services Strategic Plan	Texas Government Code, Section 531.491-499	March 1; Every five years	Executive Commissioner or Administrative Head for each member agency. (Note: The Executive Commissioner or Administrative Head for each member agency is required to submit an agency implementation plan to the Governor, Lieutenant Governor and Legislature within 90-days of receiving the plan.)	The Statewide Interagency Aging Services Strategic Plan offers state agencies with a roadmap to identify priority areas that impact aging Texans and methods for addressing the needs of older Texans and their caregivers.	No. Each state agency could include strategies within the Aging Texas Well (ATW) Strategic Plan which is the state's multisector plan on aging (MPA). This would allow for consolidation of plans but maintain the intention while also providing two two-year progress updates which is not currently required of this plan.
Abortion Complications Report	Texas Health and Safety Code, Section 171.006 (i)	September 1; Annual	HHS website	(i) The commission shall develop and publish on the commission's Internet website an annual report that aggregates on a statewide basis each abortion complication required to be reported under Subsection (f) for the previous calendar year. The annual report may not include any duplicative data.	Yes. HHSC also posts monthly reports to the agency's website.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Medical Ethics Committee Reporting (was Ethics or Medical Committee Process Report)	Texas Health and Safety Code, Section 166.054(c-e)	April 1; Annual	HHS website	(c) Not later than April 1 of each year, the commission shall prepare and publish on the commission's Internet website a report that contains: - (1) aggregate information compiled from the reports submitted to the commission under Subsection (a) during the preceding year on: -- (A) the total number of written notices provided under Section 166.046(b)(1); -- (B) the average number of days described by Subsection (a)(1); -- (C) the total number of meetings held by ethics or medical committees to review cases under Section 166.046; -- (D) the average number of days described by Subsection (a)(2); -- (E) the total number of patients described by Subsections (a)(3)(A), (B), and (C); -- (F) the total number of patients described by Subsection (a)(4); -- (G) the total number of patients for whom life-sustaining treatment was withheld or withdrawn after expiration of the time period described by Section 166.046(e); -- (H) the total number of cases for which the facility was notified of and able to reasonably verify the public	Yes. Medical Ethics Committee Reporting is required by Health and Safety Code 166.054 as added by H.B. 3162, 88th Legislature, Regular Session, 2023. Per the H.B. 3162 author's/sponsor's statement of intent, H.B. 3162 was written to address the shortcomings of existing law and improve protections for patients, medical professionals, and medical facilities. HHSC does not use the collected information in its decision-making, but tracks and publishes for public consumption information about when an attending physician refuses

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				disclosure of the contact information for the facility's personnel, physicians or health care professionals who provide care at the facility, or members of the ethics or medical committee in connection with the patient's stay at the facility; and -- (I) the total number of cases for which the facility was notified of and able to reasonably verify the public disclosure by facility personnel of contact information for the patient's immediate family members or person responsible for the patient's health care decisions in connection with the patient's stay at the facility; and - (2) if the total number of reports submitted under Subsection (a) for the preceding year is 10 or more, aggregate information compiled from those reports on the total number of patients categorized by: -- (A) sex; -- (B) race; -- (C) age group, based on the categories described by Subsection (a)(6); -- (D) health insurance coverage status, based on the categories described by Subsection (a)(7); and -- (E) for patients for whom life-sustaining treatment was withheld or	to honor an advance directive or health care decision made by or on behalf of a patient who is determined to be incompetent or is otherwise mentally or physically incapable of communication.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				withdrawn at the facility after expiration of the period described by Section 166.046(e), the total number of patients described by each of the following: --- (i) Subsection (a)(5)(A); --- (ii) Subsection (a)(5)(B); --- (iii) Subsection (a)(5)(C); and --- (iv) Subsection (a)(5)(D). (d) If the commission receives fewer than 10 reports under Subsection (a) for inclusion in an annual report required under Subsection (c), the commission shall include in the next annual report prepared after the commission receives 10 or more reports the aggregate information for all years for which the information was not included in a preceding annual report. The commission shall include in the next annual report a statement that identifies each year during which an underlying report was submitted to the commission under Subsection (a). (e) The annual report required by Subsection (c) or (d) may not include any information that could be used alone or in combination with other reasonably available information to identify any individual, entity, or facility.	

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Actions Taken to Address Maternal Mortality Rates Report	Texas Health and Safety Code, Section 34.0158	December 1 of even-numbered years; Biennial	Governor, Lt. Governor, Speaker of the House, Legislative Budget Board, Legislative Committees (Senate Finance Committee, House Appropriations Committee, Senate Health and Human Services House Human Services, House Public Health)	Not later than December 1 of each even-numbered year, the commission shall submit to the governor, the lieutenant governor, the speaker of the house of representatives, the Legislative Budget Board, and the appropriate standing committees of the legislature a written report summarizing the actions taken to address maternal morbidity and reduce maternal mortality rates. The report must include information from programs and initiatives created to address maternal morbidity and reduce maternal mortality rates in this state, including: (1) Medicaid; (2) the children 's health insurance program, including the perinatal program; (3) the Healthy Texas Women program; (4) the Family Planning Program; (5) this state 's program under the Maternal and Child Health Services Block Grant Act (42 U.S.C. Section 701 et seq.); (6) the Perinatal Advisory Council; (7) state health plans; and (8) the Healthy Texas Babies program.	Yes. This is combined with HHSC's Maternal Health Strategic Plan.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Family Support Services Outcomes Report	Texas Human Resources Code, Section 137.059	December 1 of even-numbered years; Biennial	Legislative Committees (Senate Health and Human Services, Senate Finance Committee, House Human Services, House Appropriations Committee, House Public Health)	(a) Not later than December 1 of each even-numbered year, the commission shall prepare and submit a report on state-funded prevention and early intervention programs and practices to the standing committees of the senate and house of representatives with jurisdiction over child protective services.	Yes. The report is a useful reference for the public and programs.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Family Violence Statewide Report	Texas Human Resources Code, Section 51.006	November 1 of even-numbered years; Biennial	Governor, Lt. Governor, Speaker of the House, Legislative Budget Board, Legislative Committees (Senate Health and Human Services, House Human Services, House Public Health)	(a) Not later than November 1 of each even-numbered year, the commission shall publish a report that summarizes reports from family violence centers under contract with the commission and that analyzes the effectiveness of the contracts authorized by this chapter. The reports must include information on the expenditure of funds authorized under this chapter, the services provided, the number of persons for whom a service was provided, and any other information relating to the provision of family violence services. Copies of the report shall be submitted to the governor, the lieutenant governor, the speaker of the house of representatives, the Legislative Budget Board, and the standing committees of the senate and house of representatives having primary jurisdiction over the commission. (b) The report required under Subsection (a) may be published electronically on the commission's Internet website. The commission shall notify each agency entitled to receive a copy of the report that the report is available on the commission's Internet website on or before the date the report is due.	Yes. The information in this report is often used as a resource by agency staff and external stakeholders.
Office of	Texas	February 1	Texas	ODPC must submit by February 1 of	No. Family Health

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Disability Prevention for Children Report	Human Resources Code, Section 112.051	of odd-numbered years; Biennial	Legislature	each odd numbered year a report to the legislature detailing findings of the office and the results of programs under Section 112.048 and recommending improvements in the delivery of developmental disability prevention services.	Services (FHS) focused the Office of Disability Prevention in Children's (ODPC) work on the prevention of disabilities caused by maternal health issues during pregnancy to avoid duplication of efforts and redundancy with other HHS programs. ODPC, now referred to as Child Disability Prevention, aligned its strategies with the existing Maternal Health Strategic Plan to foster consistency and efficiency across FHS' reporting process. This change will promote child disability reporting metrics, uniformed data and aligned stakeholder and

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
					community engagement with other FHS maternal health programs. HHSC recommends removing the statutory ODPC reporting requirement since child disability prevention will be incorporated in the Maternal and Infant Health Strategic Plan.
Primary Health Care Program Status	Texas Health and Safety Code, Section 31.015	N/A; Annual	Governor, Texas Legislature	HHSC must annually submit a report to the governor and the legislature relating to the status of the Primary Health Care program. The report must include the number of individuals receiving care, the total cost of the program, the average cost per recipient of services, the number of individuals who received services in each public health region, and any other information required by the executive commissioner.	Yes. HHSC is enhancing the report to provide more detailed information about services provided.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
State Plan for Family Support Services Child Abuse and Neglect Program	Texas Human Resources Code, Section 137.052	N/A; N/A	Not specified	(a) The commission shall operate the children's trust fund to: (1) set policy, offer resources for community prevention programs, and provide information and education on family support services and prevention of child abuse and neglect; (2) develop a state plan for expending funds for child abuse and neglect prevention programs that includes an annual schedule of transfers of trust fund money to the operating fund; (3) develop eligibility criteria for applicants requesting funding for child abuse and neglect prevention programs; and (4) establish funding priorities for child abuse and neglect prevention programs. (b) The children's trust fund shall accommodate the commission's existing rules and policies in procuring, awarding, and monitoring contracts and grants. (c) The commission may: (1) apply for and receive funds made available by the federal government or another public or private source for administering programs under this subchapter and for funding for child abuse and neglect prevention programs; and (2) solicit donations for child abuse and neglect prevention programs.	No. This has never been a standing report. This is specific to a funding stream HHSC receives and the work is incorporated into the standing strategic plan.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Texas Home Visiting Report	Texas Human Resources Code, Section 137.257	December 1 of even-numbered years; Biennial	Legislative Committees (Senate Health and Human Services, House Human Services)	(a) Not later than December 1 of each even-numbered year, the commission shall prepare and submit a report on state-funded home visiting programs to the Senate Committee on Health and Human Services and the House Human Services Committee or their successors. (b) A report submitted under this section must include: - (1) a description of home visiting programs being implemented and the associated models; - (2) data on the number of families being served and their demographic information; - (3) the goals and achieved outcomes of home visiting programs; - (4) data on cost per family served, including third-party return-on-investment analysis, if available; and - (5) data explaining what percentage of funding has been used on evidence-based programs and what percentage of funding has been used on promising practice programs.	Yes. This statutorily required report is incorporated into the Prevention Outcomes report and includes specific information about Family Support Service's home visiting outcomes that is shared publicly for stakeholder, including legislative partners.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Texas Nurse-Family Partnership Performance Report	Texas Human Resources Code, Section 137.107	December 1; Annual	Legislative Committees (Senate Health and Human Services, House Human Services)	(a) The commission shall: - (1) adopt performance indicators that are designed to measure a grant recipient's performance with respect to the partnership program standards adopted by the executive commissioner under Section 137.105; - (2) use the performance indicators to continuously monitor and formally evaluate on an annual basis the performance of each grant recipient; and - (3) prepare and submit an annual report, not later than December 1 of each year, to the Senate Health and Human Services Committee, or its successor, and the House Human Services Committee, or its successor, regarding the performance of each grant recipient during the preceding state fiscal year with respect to providing partnership program services.	No. Most of the information is already contained in the Outcomes report.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Volunteer Advocate Programs Report (Children's Advocacy Programs Report)	Texas Family Code, Section 264.608	December 1; Annual	Governor, Lt. Governor, Speaker of the House, Legislative Budget Board, Texas Legislature	Sec. 264.608. REPORT TO THE LEGISLATURE. (a) Not later than December 1 of each year, the commission shall publish a report that: (1) summarizes reports from volunteer advocate programs under contract with the commission; (2) analyzes the effectiveness of the contracts made by the commission under this chapter; and (3) provides information on: (A) the expenditure of funds under this chapter; (B) services provided and the number of children for whom the services were provided; and (C) any other information relating to the services provided by the volunteer advocate programs under this chapter. (b) The commission shall submit copies of the report to the governor, lieutenant governor, speaker of the house of representatives, Legislative Budget Board, and members of the legislature.	No. This report has very low readership. It has only been downloaded 29 times in the past 18 months.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Forensic Report	Texas Health and Safety Code, Section 555.002(e)	N/A; Annual	Governor, Lt. Governor, Speaker of the House, Legislative Committees (Senate Health and Human Services, House Human Services)	Alleged offender resident commitments to SSLC report; includes data on alleged offender resident commitments to SSLC, including the offence, location of committing court, etc.	No. This report could be combined with the SSLC Long-Range Planning Report as a subsection.
Persons Found Not Guilty by Reason of Insanity Report (Confidential)	Texas Health and Safety Code, Section 533.0095(c)	N/A; Annual	Lt. Governor, Speaker of the House	A report containing the name of each person found not guilty of an offense by reason of insanity who is ordered by a court to receive inpatient mental health services under Ch 574 or under Chapter 46C, Code of Criminal Procedure; or ordered by a court to receive outpatient or community -based treatment and supervision. The report shall also include the name and address of any facility to which the person is committed, the length of the person's commitment to the facility and any post-release outcome.	Yes. However, this report presents a privacy risk as it includes confidential information on patients found not guilty by reason of insanity. Due to the confidential nature, this report is printed and hand delivered to the speaker's and lieutenant governor's offices.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
SSLC Long Range Planning Report	Texas Health and Safety Code, Section 533A.032(c)	Attached to the LAR; Biennial	Governor, Lt. Governor, Speaker of the House, Legislative Budget Board	The department shall develop a report containing information and recommendations regarding the most efficient long-term use and management of the department's campus-based facilities. The report must:(1) project future bed requirements for state supported living centers;(2) document the methodology used to develop the projection of future bed requirements;(3) project maintenance costs for institutional facilities;(4) recommend strategies to maximize the use of institutional facilities; and(5) specify how each state supported living center will:(A) serve and support the communities and consumers in its service area; and(B) fulfill statewide needs for specialized services.	Yes. The long-range planning reports provide an opportunity to produce a public facing document that details the progress achieved and planned initiatives for enhancing the facilities for staff and persons served; however, HHSC recommends removing the statutorily required public hearings as there is a lack of interest (1-2 people testifying), and substitute with a written comment period if necessary.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
State Hospital Bed Day Allocation Methodology and Utilization Review Protocol	Texas Health and Safety Code, Section 533.0515(e)	December 1 of even-numbered years; Biennial	Governor, Lt. Governor, Speaker of the House, Legislative Committees (Senate Finance Committee, House Appropriations Committee, Senate Health and Human Services, House Human Services, House Public Health)	Not later than December 1 of each even-numbered year, the department, in conjunction with the commission and the advisory panel, shall prepare and submit to the governor, the lieutenant governor, the speaker of the house of representatives, the senate finance committee, the house appropriations committee, and the standing committees of the legislature having jurisdiction over mental health and human services a report that includes: (1) a summary of the activities of the commission, department, and advisory panel to develop or update the bed day allocation methodology and bed day utilization review protocol; (2) the outcomes of the implementation of the bed day allocation methodology by region, including an explanation of how the actual outcomes aligned with or differed from the expected outcomes; (3) for planning purposes, for each region, the actual value of a bed day for the two years preceding the date of the report and the projected value of a bed day for the five years following the date of the report, as calculated by the department; (4) for each region, an evaluation of the factors in Subsection (c)(1)(A), including the availability of resources in the region, that impact the use of state-funded beds in state	Yes. However, HHSC recommends modifications - The December 2024 State Hospital Bed-Day Allocation Methodology and Utilization Review Protocol report submitted by JCAFS outlines multiple barriers to meeting the report content requirements presently in Texas Health and Safety Code, Section 533.0515(e), including: • inability to discern the impact of the utilization review protocol on the use of state-funded beds due to the complexity of factors that influence the care provided by state hospitals; • no consensus as to how the

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				hospitals and other inpatient mental health facilities by the patients described by Subsection (b); (5) the outcomes of the implementation of the bed day utilization review protocol and the impact of the use of the protocol on the use of state-funded beds in state hospitals and other inpatient mental health facilities by the patients described by Subsection (b); and (6) any recommendations of the department, commission, or advisory panel to enhance the effective and efficient allocation of state-funded beds in state hospitals and other inpatient mental health facilities for the patients described by Subsection (b).	availability of resources should be considered in allocating bed days and on the method to assess the availability of local resources; • challenges compiling and maintaining a comprehensive and reliable inventory of available resources to use in a bed day allocation methodology; • limited data to measure acuity for local service areas; • limited data on the prevalence of serious mental illness for local service areas; and • the proportion of state hospital beds allocated to forensic commitments complicates the

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
					assessment of the bed-day allocation methodology and the identification of ways to improve access to state hospital beds for local communities. The tasks associated with this report- developing a bed-day allocation methodology and utilization review protocol- are outdated, no longer reflective of the current landscape and burdensome. With changes, this report can be streamlined, modernized and completed with less time and staff resources.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
State Hospitals Long-Range Planning Report	Texas Health and Safety Code, Section 533A.032(c)	Attached to the Legislative Appropriations Request; Biennial	Governor, Lt. Governor, Speaker of the House, Governor's Office of Budget and Planning, Legislative Budget Board	(c) The department shall develop a report containing information and recommendations regarding the most efficient long-term use and management of the department's campus-based facilities. The report must: - (1) project future bed requirements for state hospitals; - (2) document the methodology used to develop the projection of future bed requirements; - (3) project maintenance costs for institutional facilities; - (4) recommend strategies to maximize the use of institutional facilities; and - (5) specify how each state hospital will: -- (A) serve and support the communities and consumers in its service area; and -- (B) fulfill statewide needs for specialized services. (d) In developing the report under Subsection (c), the department shall: - (1) conduct two public meetings, one meeting to be held at the beginning of the process and the second meeting to be held at the end of the process, to receive comments from interested	Yes. The long-range planning reports provide an opportunity to produce a public facing document that details the progress achieved and planned initiatives for enhancing the facilities for staff and persons served; however, suggest removing the statutorily required public hearings as there is a lack of interest (1-2 people testifying), and substitute with a written comment period if necessary.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				parties; and - (2) consider: -- (A) the medical needs of the most medically fragile of its patients with mental illness; and -- (B) input solicited from consumers of services of state hospitals. (g) The department shall: - (1) attach the report required by Subsection (c) to the department's legislative appropriations request for each biennium; - (2) at the time the department presents its legislative appropriations request, present the report to the: -- (A) governor; -- (B) governor's budget office; -- (C) lieutenant governor; -- (D) speaker of the house of representatives; -- (E) Legislative Budget Board; and -- (F) commission; and - (3) update the department's long-range plan biennially and include the report in the plan.	

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Annual Review of STAR Health Services	Texas Government Code, Section 540.0804(c)	January 31; Annual	Senate Health and Human Services, House Human Services	Texas Government Code, Section 533.00521, requires HHSC to annually evaluate the use of benefits under the STAR Health program for children in foster care and provide recommendations to DFPS and each SSCC in the state to better coordinate the provision of health care and use of those benefits. HHSC must annually report findings of the evaluation to the standing committees of the Senate and House of Representatives having jurisdiction over DFPS.	No. There is limited public interest based on viewing information (62 downloads).

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Competitive and Integrated Employment Initiative for Certain Medicaid Recipients Report	Texas Government Code, Section 531.02448(e)	December 31 of even-numbered years; Biennial	Governor, Lt. Governor, Speaker of the House, Texas Legislature	(e) Not later than December 31 of each even-numbered year, the executive commissioner shall prepare and submit to the governor, lieutenant governor, speaker of the house of representatives, and legislature a written report that outlines: (1) the number of individuals to whom this section applies who are receiving employment services in accordance with rules adopted under this section; (2) whether the employment services described by Subdivision (1) are provided by the Texas Workforce Commission, through the waiver program in which an individual is enrolled, or both; and (3) the number of individuals to whom this section applies who have obtained competitive and integrated employment, categorized by waiver program and, if applicable, an individual's level of care. SB 50 SECTION 3. Notwithstanding Section 531.02448(e), Government Code, as added by this Act, the executive commissioner of the Health and Human Services Commission shall submit the first report required by that section not later than December 31, 2024.	Yes. This report has only been completed once, so it is difficult to determine the utility of this report at this time.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Exchange of Electronic Health Information (Interoperability for Texas)	Texas Government Code, Section 531.0162(f)	December 1; Biennial	Governor, Legislative Budget Board, State Auditor's Office, HHS Executive Council	Report on HHSC's and all HHS agencies' progress in ensuring that all information systems maintained by the state in sending or receiving protected health information from a health care provider after September 1, 2015, are interoperable with one another and meet the appropriate specified standards. The report must include an assessment of the measurable progress made in achieving goals related to the exchange of health information, including facilitating care coordination among the agencies, ensuring quality improvement, and realizing cost savings.	No. There is limited public interest based on viewing information (21 downloads of most recent publicly posted report).

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Implementation of Acute Care Services and LTSS System Report	Texas Government Code, Section 534.054	September 30; Annual	Texas Legislature, HHS Website	Sec. 534.054. ANNUAL REPORT ON IMPLEMENTATION. (a) Not later than September 30 of each year, the commission, in consultation and collaboration with the advisory committee, shall prepare and submit a report to the legislature that must include: (1) an assessment of the implementation of the system required by this chapter, including appropriate information regarding the provision of acute care services and long-term services and supports to individuals with an intellectual or developmental disability under Medicaid as described by this chapter; (2) recommendations regarding implementation of and improvements to the system redesign, including recommendations regarding appropriate statutory changes to facilitate the implementation; and (3) an assessment of the effect of the system on the following: (A) access to long-term services and supports; (B) the quality of acute care services and long-term services and supports; (C) meaningful outcomes for Medicaid recipients using person-centered planning, individualized budgeting, and	Yes. The report shows how many people are trained each year and how much state funds are used, which provides openness and transparency.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				self-determination, including a person's inclusion in the community; (D) the integration of service coordination of acute care services and long-term services and supports; (E) the efficiency and use of funding; (F) the placement of individuals in housing that is the least restrictive setting appropriate to an individual's needs; (G) employment assistance and customized, integrated, competitive employment options; and (H) the number and types of fair hearing and appeals processes in accordance with applicable federal law. (b) This section expires January 1, 2026.	

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Medically Dependent Children Waiver Program Biannual Report (was Quarterly)	Texas Government Code, Section 531.06021(b)	The 30th day after the last day of each state fiscal quarter; Quarterly	Governor, Lt. Governor, Speaker of the House, Legislative Budget Board, Legislative Committees (Senate Finance, House Appropriations Committee, Senate Health and Human Services, House Human Services)	(b) Not later than the 30th day after the last day of each state fiscal quarter, the commission shall submit to the governor, the lieutenant governor, the speaker of the house of representatives, the Legislative Budget Board, and each standing legislative committee with primary jurisdiction over Medicaid a report containing, for the most recent state fiscal quarter, the following information and data related to access to care for Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program.	No. There is limited public interest based on viewing information (19 downloads of most recent report).
Nonmedical Health-Related Needs of Certain Pregnant Women Summary Report	Texas Government Code, Section 531.024183 (f)	December 1 of even-numbered years; Biennial	Texas Legislature	(f) Not later than December 1 of each even-numbered year, the commission shall prepare and submit to the legislature a report that, using de-identified information, summarizes the data collected and provided to the commission under Subsection (e) during the previous biennium. In accordance with Section 531.014, the commission may consolidate the report required under this subsection with any other report to the legislature required under this chapter or another law that relates to the same subject matter.	Yes. The report provides insight into non-medical needs of pregnant women, which is useful in coordinating services.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Pediatric Tele-Connectivity Resource Program for Rural Texas Report	Texas Government Code, Section 548.0351	December 1 of even-numbered years; Biennial	Governor, Texas Legislature	Not later than December 1 of each even-numbered year, the commission shall submit a report to the governor and members of the legislature regarding the activities of the program and grant recipients, including the results and outcomes of grants awarded under this chapter.	Yes. To outline the state's strategy for programs benefiting rural hospitals. The Legislature recently streamlined this reporting requirement through House Bill 18, 89th Legislature, Regular Session, 2025, under Texas Government Code, Section 548.0352 (current code is Section 548.0351). This report may now be combined with the report submitted by the State Office of Rural Hospital Finance under Texas Government Code, Section 526.0301.
Quality Measures and Value-based Payments	Texas Government Code, Section	November 30; Annual	Texas Legislature	(a) The commission shall submit to the legislature and make available to the public an annual report regarding: (1) the quality-based outcome and	Yes, this report is a requirement of Texas Government Code, 543A.0008(a) and

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Annual Report	536.008			process measures developed under Section 536.003, including measures based on each potentially preventable event; and (2) the progress of the implementation of quality-based payment systems and other payment initiatives implemented under this chapter. (b) As appropriate, the commission shall report outcome and process measures under Subsection (a)(1) by: (1) geographic location, which may require reporting by county, health care service region, or other appropriately defined geographic area; (2) recipient population or eligibility group served; (3) type of health care provider, such as acute care or long-term care provider; (4) number of recipients who relocated to a community-based setting from a less integrated setting; (5) quality-based payment system; and (6) service delivery model. (c) The report required under this section may not identify specific health care providers.	the 89 th legislature recently updated the cadence of the reports via House Bill 4666 . Efforts are in progress to implement legislative direction.
Quality Monitoring Early Warning	Texas Health and Safety	November 30; Annual	Governor, Lt. Governor, Speaker of the	The department shall assess and evaluate the effectiveness of the quality assurance early warning system and	Yes, this report is a requirement of Texas Health and

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
System for Long-term Care Facilities	Code, Section 255.005		House	shall report its findings annually to the governor, the lieutenant governor, and the speaker of the house of representatives.	Safety Code, 255.005 and the 89 th legislature recently updated the cadence of the reports via House Bill 4666 . Efforts are in progress to implement legislative direction.
Required Contract Provisions Medicaid MCO Mental Health Services (Medicaid BH in lieu of Services Annual Report)	Texas Government Code, Section 533.005(h)(1)	November 30; Annual	Texas Legislature	HHSC must submit an annual report to the legislature on the number of times during the preceding year a service from the list included in the contract is used	No. There is limited public interest based on viewing information (81 downloads).
Statewide Initiatives to Improve Quality of Maternal Health Care Report	Texas Health and Safety Code, Section 32.155(d)	November 30; Annual	Texas Legislature	The commission shall prepare and submit to the legislature and make available to the public an annual report that summarizes: (1) the commission's progress in developing or enhancing initiatives under this section; and (2) each managed care organization's progress in incorporating the required initiatives in the organization's managed care plans. (e) The	Yes. This report provides valuable information on improving the quality of maternal health services. This report is a requirement of Texas Health and Safety Code,

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				commission may submit the report required under subsection (d) with the report required under Section 536.008, Government Code.	32.155(d) and the 89 th legislature recently updated the cadence of the reports via House Bill 4666 . Efforts are in progress to implement legislative direction.
Telemedicine, Telehealth, and Home Telemonitoring Report	Texas Government Code, Section 531.0216(f)	December 1 of even-numbered years; Biennial	Lt. Governor, Speaker of the House	(f) Not later than December 1 of each even-numbered year, the commission shall report to the speaker of the house of representatives and the lieutenant governor on the effects of telemedicine medical services, teledentistry services, telehealth services, and home telemonitoring services on Medicaid in the state, including the number of physicians, dentists, health professionals, and licensed health care facilities using telemedicine medical services, teledentistry services, telehealth services, or home telemonitoring services, the geographic and demographic disposition of the physicians, dentists, and health professionals, the number of patients receiving telemedicine medical services, teledentistry services, telehealth services, and home telemonitoring services, the types of services being provided, the cost of utilization, and the	No. There is limited public interest based on viewing information (42 downloads).

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				cost savings of telemedicine medical services, teledentistry dental services, telehealth services, and home telemonitoring services to Medicaid.	

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Utilization Review in STAR PLUS Managed Care	Texas Government Code, Section 533.00281(d)	December 1; Annual	Legislative Committees (Senate Finance Committee, Health Appropriations Committee, Senate Health and Human Services, House Human Services)	(d) In conjunction with the commission's office of contract management, the commission shall provide a report to the standing committees of the senate and house of representatives with jurisdiction over Medicaid not later than December 1 of each year. The report must: (1) summarize the results of the utilization reviews conducted under this section during the preceding fiscal year; (2) provide analysis of errors committed by each reviewed managed care organization; and (3) extrapolate those findings and make recommendations for improving the efficiency of the program.	No. There is limited public interest based on viewing information (46 downloads).
Annual Internal Audit Report	Texas Government Code, Section 2102.009	November 1; Annual	Governor, Lt. Governor, Legislative Budget Board, State Auditor's Office, HHS Executive Council	The internal auditor shall prepare an annual report and submit the report before November 1 of each year to the governor, the Legislative Budget Board, the state auditor, the state agency's governing board, and the administrator. The state auditor shall prescribe the form and content of the report, subject to the approval of the legislative audit committee.	Yes. This report provides information to external oversight entities on the status of the internal audit plan as well as related work completed by the Internal Audit Division.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Audits of Covered Entities	Texas Health and Safety Code, Section 181.206	December 1; Annual	Legislative Committees (Senate Health and Human Services, Senate Finance, House Human Services, House Appropriations , House Public Health)	(c) The commission annually shall submit to the appropriate standing committees of the senate and the house of representatives a report regarding the number of federal audits of covered entities in this state and the number of audits required under Subsection (b).	Yes. However, in each report, HHSC has noted that some of the required information - information concerning federal audits of covered entities - is not made available by the federal government.
Annual Joint Interagency Coordination Report	Texas Government Code, Section 544.0051(f)	N/A; Annual	Governor, Lt. Governor, Speaker, Comptroller of Public Accounts	(f) The [OIG] and the office of the attorney general shall jointly prepare and submit to the governor, lieutenant governor, and speaker of the house of representatives an annual report concerning the activities of those agencies in detecting and preventing fraud, waste, and abuse under Medicaid or another program the [OIG] or a health and human services agency administers. The [OIG] and the office of the attorney general may consolidate the report with any other report relating to the same subject matter the [OIG] or the office of the attorney general is required to submit under other law.	Yes. This report is important to demonstrate the joint efforts in detecting and preventing Medicaid fraud, waste, and abuse.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Annual Public Assistance Reporting Information System (PARIS VA Match) Report	Texas Government Code, Section 526.0603(d)(e)	October 1; Annual	Governor, Legislature, Legislative Budget Board	(d) Not later than October 1 of each year, the commission, the Texas Veterans Commission, and the Veterans' Land Board collectively shall submit to the legislature, the governor, and the Legislative Budget Board a report describing: (1) interagency progress in identifying and obtaining United States Department of Veterans Affairs benefits for veterans receiving Medicaid and other public benefits; (2) the number of veterans benefits claims awarded, the total dollar amount of veterans benefits claims awarded, and the costs to this state that were avoided as a result of state agencies' use of the system; (3) efforts to expand the use of the system and improve the effectiveness of shifting veterans from Medicaid and other public benefits to United States Department of Veterans Affairs benefits, including any barriers and the manner in which state agencies have addressed those barriers; and (4) the extent to which the Texas Veterans Commission has targeted specific veteran populations, including populations in rural counties and in specific age and service-connected disability categories, in order to	No. this reporting requirement should be eliminated or moved to Texas Veterans Commission as they provide most of the content.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				maximize benefits for veterans and savings to this state. (e) The report may be consolidated with any other report relating to the same subject matter the commission is required to submit under other law.	

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Annual Report on Certain Fraud and Abuse Recoveries from Managed Care Organizations	Texas Government Code, Section 544.0505	December 1; Annual	Texas Legislature	Sec. 544.0505. ANNUAL REPORT ON CERTAIN FRAUD AND ABUSE RECOVERIES. Not later than December 1 of each year, the commission shall prepare and submit to the legislature a report on the amount of money recovered during the preceding 12-month period as a result of investigations and recovery efforts made under Subchapter H and Section 544.0502 by special investigative units or entities with which a managed care organization contracts under Section 544.0352(a)(2). The report must specify the amount of money each managed care organization retained under Section 544.0502(d).	Yes. This is measure of effectiveness of Managed Care Organization (MCO) Special Investigation Units (SIUs). OIG is implementing new federal regulations on MCO overpayment reporting. This report could possibly be combined with prompt recoveries report in the future.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Annual Report on State Hospital Investigations	Texas Health and Safety Code, Section 552.103	N/A; Annual	Governor, Lt. Governor, Speaker of the House, HHSC Executive Commissioner, DSHS Commissioner, DFPS Commissioner, State Health Services Council, Jurisdictional Senate and House committees, State Auditor's Office, Comptroller	(a) The inspector general shall prepare an annual status report of the inspector general's activities under this subchapter. The annual report may not contain personally identifiable information of an individual mentioned in the report. (b) The annual status report must include information that is aggregated and disaggregated by individual state hospital regarding: (1) the number and type of investigations conducted with the assistance of the inspector general; (2) the number and type of investigations involving a state hospital employee; (3) the relationship of an alleged victim to an alleged perpetrator, if any; (4) the number of investigations conducted that involve the suicide, death, or hospitalization of an alleged victim; and (5) the number of completed investigations in which commission of an alleged offense was confirmed or unsubstantiated or in which the investigation was inconclusive, and a description of the reason that allegations were unsubstantiated or the investigation was inconclusive.	Yes. Provides useful information regarding investigations.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				(c) The inspector general shall submit the annual status report to the: (1) executive commissioner; (2) commissioner of state health services; (3) commissioner of the Department of Family and Protective Services; (4) State Health Services Council; (5) Family and Protective Services Council; (6) governor; (7) lieutenant governor; (8) speaker of the house of representatives; (9) standing committees of the senate and house of representatives with primary jurisdiction over state hospitals; (10) state auditor; and (11) comptroller. (d) An annual status report submitted under this section is public information under Chapter 552, Government Code.	

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Audit, Inspection and Investigations Reports	Texas Government Code, Section 544.0110(a)	Various; As Completed	HHSC Executive Commissioner, select HHS executives, the contractor or provider audited, the HHS program area audited that manages audited contractors providers, HHS website	Sec. 544.0110. REPORTS ON AUDITS, INSPECTIONS, AND INVESTIGATIONS. (a) The office of inspector general shall prepare a final report on each audit, inspection, or investigation conducted under Section 544.0102, 544.0103, 544.0252(b), 544.0254, or 544.0257. The final report must include: (1) a summary of the activities the office performed in conducting the audit, inspection, or investigation; (2) a statement on whether the audit, inspection, or investigation resulted in a finding of any wrongdoing; and (3) a description of any findings of wrongdoing. (b) A final report on an audit, inspection, or investigation is subject to required disclosure under Chapter 552. All information and materials compiled during the audit, inspection, or investigation remain confidential and not subject to required disclosure in accordance with Section 544.0259(e). (c) A confidential draft report on an audit, inspection, or investigation that concerns the death of a child may be shared with the Department of Family and Protective Services. A draft report that is shared with the Department of Family and Protective Services remains confidential and is not subject to	Yes. Promotes transparency in Office of Inspector General (OIG) audit, inspections, and investigations.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				disclosure under Chapter 552.	

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Consolidated Annual Report	Texas Government Code, Section 544.0202 (e)	October 1; Annual	Governor, Legislature, Legislative Budget Board	Not later than October 1 of each year, the [OIG] shall submit to the governor and Legislative Budget Board a report on the results of computerized matching of commission information with information from neighboring states, if any, and information from the Texas Department of Criminal Justice.	Yes. Provides useful information to the agency.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Monthly State Hospital and SSLC Reports	Texas Health and Safety Code, Section 552.102	Last day of each month; Monthly	Governor, Lt. Governor, Speaker of the House, HHSC Executive Commissioner, DSHS Commissioner, DFPS Commissioner, State Health Services Council, Jurisdictional Senate and House committees, State Auditor's Office, the victim or their legal representative	(a) The inspector general shall prepare a summary report for each investigation conducted with the assistance of the inspector general under this subchapter. The inspector general shall ensure that the report does not contain personally identifiable information of an individual mentioned in the report. (b) The summary report must include: (1) a summary of the activities performed during an investigation for which the inspector general provided assistance; (2) a statement regarding whether the investigation resulted in a finding that an alleged criminal offense was committed; and (3) a description of the alleged criminal offense that was committed. (c) The inspector general shall deliver the summary report to the: (1) executive commissioner; (2) commissioner of state health services; (3) commissioner of the Department of Family and Protective Services; (4) State Health Services Council; (5) governor; (6) lieutenant governor; (7) speaker of the house of	Yes. Provides useful information regarding investigations.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				representatives; (8) standing committees of the senate and house of representatives with primary jurisdiction over state hospitals; (9) state auditor; and (10) alleged victim or the alleged victim's legally authorized representative. (d) A summary report regarding an investigation is subject to required disclosure under Chapter 552, Government Code. All information and materials compiled by the inspector general in connection with an investigation are confidential, not subject to disclosure under Chapter 552, Government Code, and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than the inspector general or the inspector general's employees or agents involved in the investigation, except that this information may be disclosed to the Department of Family and Protective Services, the office of the attorney general, the state auditor's office, and law enforcement agencies.	

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
OIG Quarterly Report	Texas Government Code, Section 544.0114	Last day of the month following the end of the quarter; Quarterly	Governor, HHSC Executive Commissioner, Legislature	Sec. 544.0114. REPORT (a) At each quarterly meeting of any advisory council responsible for advising the executive commissioner on the commission's operation, the inspector general shall submit to the executive commissioner, the governor, and the legislature a report on: (1) the office of inspector general's activities; (2) the office's performance with respect to performance measures the executive commissioner establishes for the office; (3) fraud trends the office has identified; (4) any recommendations for policy changes to prevent or address fraud, waste, and abuse in the delivery of health and human services in this state; and (5) the amount of money recovered during the preceding quarter as a result of investigations involving peace officers employed and commissioned by the office for each program for which the office has investigative authority. (b) The office of inspector general shall publish each report required under this section on the office's Internet website.	Yes. Provides useful information in a timely manner.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Annual Report on SSLC Investigations	Texas Health and Safety Code, Section 555.103	October 1; Annual	Governor, Lt. Governor, Speaker of the House, HHSC Executive Commissioner, Jurisdictional Senate and House committees, State Auditor's Office, Comptroller	(a) The inspector general shall prepare an annual status report of the inspector general's activities under this subchapter. The annual report may not contain personally identifiable information of an individual mentioned in the report. (b) The annual status report must include information that is aggregated and disaggregated by individual center regarding: (1) the number and type of investigations conducted with the assistance of the inspector general; (2) the number and type of investigations involving a center employee; (3) the relationship of an alleged victim to an alleged perpetrator, if any; (4) the number of investigations conducted that involve the suicide, death, or hospitalization of an alleged victim; and (5) the number of completed investigations in which commission of an alleged offense was confirmed or unsubstantiated or in which the investigation was inconclusive, and a description of the reason that allegations were unsubstantiated or the investigation was inconclusive.	Yes. Provides useful information regarding investigations.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Long Term Care Plan for Individuals with Intellectual and Developmental Disabilities (IDD)	Texas Health and Safety Code, Section 533A.062	July 1 of even-numbered years; Biennial	Governor, Legislative Budget Board, Texas Register	(a) The [commission] shall biennially develop a proposed plan on long-term care for persons with an intellectual disability. (b) The proposed plan must specify the capacity of the HCS waiver program for persons with an intellectual disability and the number and levels of new ICF-IID beds to be authorized in each region. In developing the proposed plan, the [commission] shall consider: - (1) the needs of the population to be served; - (2) projected appropriation amounts for the biennium; and - (3) the requirements of applicable federal law. (b-1) As part of the proposed plan, the commission shall review the statewide bed capacity of community ICF-IID facilities for individuals with an intellectual disability or a related condition and, based on the review, develop a process to reallocate beds held in suspension by the commission. The process may include: - (1) criteria by which ICF-IID program providers may apply to the commission to receive reallocated beds; and - (2) a means to reallocate the beds among health services regions.	Yes. House Bill 3117 and Rider 173 (86th Legislature, Regular Session, 2019) directed HHSC to review the statewide bed capacity of community Intermediate Care Facilities for Individuals with IDD (ICF/IIDs) and develop a process to reallocate beds held in suspension by HHSC. This plan is intended to inform how HHSC reallocates Medicaid beds in ICF/IDDs, regardless of whether or not it is submitted downtown.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				(c) Each proposed plan shall cover the subsequent fiscal biennium. The [commission] shall conduct a public hearing on the proposed plan. Not later than July 1 of each even-numbered year, the [commission] shall submit the plan to the commission for approval. (d) The commission may modify the proposed plan as necessary before its final approval. (e) Repealed by Acts 2021, 87th Leg., R.S., Ch. 856 (S.B. 800), Sec. 25(8), eff. September 1, 2021. (f) After legislative action on the appropriation for long-term care services for persons with an intellectual disability, the commission shall adjust the plan to ensure that the number of ICF-IID beds licensed or approved as meeting license requirements and the capacity of the HCS waiver program are within appropriated funding amounts. (g) After any necessary adjustments, the commission shall approve the final biennial plan and publish the plan in the Texas Register.	

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Boarding Home Facilities Report	Texas Health and Safety Code, Section 260.010(b)	January 1 of odd-numbered years; Biennial	Texas Legislature	(b) The commission shall establish and maintain a standardized compilation of information reported to HHSC from counties or municipalities related to boarding home facility permitting under this section and provide to the legislature a report of this information.	No. The report only provides high-level data being provided by five cities that adopted the full array of HHSC boarding room standards. Lots of cities have adopted their own standards and therefore don't report their data.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Child Injuries and Fatalities Report	Texas Human Resources Code, Section 42.0412 and 42.042	N/A; Annual	Texas Legislature, HHS Website	(e) The commission, using existing resources, shall provide an annual report to the legislature that includes: (1) the number of confirmed serious injuries and fatalities for children four years of age and younger, aggregated by the age of the injured or deceased child, including information collected by the department, that occurred: (A) at each licensed day-care center; and (B) at a location other than a licensed day-care center; (2) the priority assigned to the investigation conducted by the commission or department in response to an incident that resulted in a serious injury or child fatality; (3) the number of investigations conducted by the commission or department at each licensed day-care center involving a child four years of age or younger that were assigned the highest priority or second-highest priority, aggregated by the age of the youngest affected child; (4) the number of violations the commission found at each licensed day-care center during investigations described by Subdivision (3); and (5) a comparison on whether children	Yes. This report ensures public transparency to guide decision making when selecting a child care facility.

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
				under the supervision of a licensed day-care center are more likely than children outside the supervision of a licensed day-care center to suffer a serious injury or death.	

Report Title	Legal Authority	Due Date; Frequency	Recipient	Description	Is the Report Still Needed? Why?
Regulatory Services Annual Report	Texas Health and Safety Code, Section 242.005	October 1; Annual	Governor, Texas Legislature	(a) The department shall prepare annually a full report of the operation and administration of the department's responsibilities under this chapter, including recommendations and suggestions considered advisable. (b) The Legislative Budget Board and the state auditor shall jointly prescribe the form and content of reports required under this section, provided, however, that the state auditor's participation under this section is subject to approval by the legislative audit committee for inclusion in the audit plan under Section 321.013(c).	Yes. Providers are interested in a lot of the data provided in the report each year.

B. Does the agency's statute use "person-first respectful language" as required by Texas Government Code, Section 325.0123? Please explain and include any statutory provisions that might supersede or create challenges in implementing these changes.

Senate Bill 219, 84th Legislature, Regular Session, 2015, an omnibus statutory recodification bill, clarified and updated health and human services statutes including person-first respectful language.

The Texas Health and Human Services Commission (HHSC) is not aware of any statutory provisions that supersede or create challenges to implement or continue person-first respectful language. HHSC uses person-first respectful language.

C. Please describe how your agency receives and investigates complaints about the agency and its operations.

Office of Ombudsman: The Office of the Ombudsman (Ombudsman) encourages clients to initially resolve complaints or issues directly with program areas. If no resolution is made, the client contacts the Ombudsman for assistance via phone, online submission, email, fax, or regular mail.

The Ombudsman:

- Provides an impartial viewpoint;
- Seeks to determine if policy and procedure were followed properly; and
- Resolves complaints and provides recommendations to the agency to prevent future occurrences of the same issues.

Exhibit 19, titled "Complaints Against the Agency – Fiscal Years 2020-24" includes the total number of complaints received by the Ombudsman – after the consumer has exhausted their resolution alternatives. Please note, the data are a subset of all contacts received by the Ombudsman – as the office receives both complaints and inquiries about the agency. In fiscal year 2024, the total number of contacts received by the Ombudsman was 124,148; this figure, and the breakdown across Ombudsman teams, is discussed in Section 7.

The Ombudsman categorizes the complaints it receives as:

- Substantiated: A complaint where research clearly indicates HHS policy was violated, or HHS expectations were not met;

- Unable to Substantiate: A complaint where research does not clearly indicate if HHS policy was violated, or HHS expectations were met;
- Unsubstantiated: A complaint where research clearly indicates HHS policy was not violated, or HHS expectations were met; or
- Referred: A contact where no investigation was made because a referral was made instead.

Civil Rights Office: HHSC's Civil Rights Office manages complaints and inquiries for HHSC, Office of the Inspector General (OIG), Department of State Health Services (DSHS), and Department of Family and Protective Services (DFPS) including:

- Investigating complaints of discrimination made by clients and people applying for benefits;
- Responding to inquiries from clients and people applying for benefits about civil rights;
- Taking other appropriate steps and actions to ensure compliance with civil rights laws and regulations to prevent discrimination in the provision of services; and
- Conducting periodic compliance reviews of offices, programs, and contractors to ensure accessibility of programs and services.

Clients applying for or receiving benefits or services who feel they have been discriminated against by an employee of HHSC, OIG, DSHS, and DFPS, or an employee of an entity that provides services through an HHS contract, may file a complaint of discrimination with the Civil Rights Office in writing (email, letter, or fax) or by phone. Employees may file complaints of discrimination with the Civil Rights Office if they feel they have been discriminated against.

The Civil Rights Office determinations of discrimination complaints generally fall into one of the following categories:

- Substantiated: A complaint where investigation indicates by preponderance of evidence that discrimination has occurred.
- Unsubstantiated: A complaint where investigation does not indicate by preponderance of evidence that discrimination has occurred.
- Administratively Closed: A complaint where research does not clearly indicate that complaint is within Civil Rights Office jurisdiction.

- Referred: A contact or complaint where no investigation was made because a referral was made instead.

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Exhibit 19: Complaints Against the Agency — Fiscal Years 2020-24

Office of Ombudsman*	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023**	Fiscal Year 2024
Number of complaints received	28,620	33,228	42,621	39,396	54,967
Number of complaints resolved	28,366	33,030	41,858	39,778	53,934
Number of complaints dropped / found to be without merit	23,777	28,819	32,299	30,989	40,267
Number of complaints pending from prior years	693	558	667	846	1,470
Average time period for resolution of a complaint (business days)	6	5	4	5	6

Civil Rights Office	Fiscal Year 2020	Fiscal Year 2021	Fiscal Year 2022	Fiscal Year 2023	Fiscal Year 2024***
Number of complaints received	648	685	747	608	825
Number of complaints resolved	11	12	26	12	24
Number of complaints dropped / found to be without merit	570	672	662	488	1,088
Number of complaints pending from prior years	0	0	1	8	105
Average time period for resolution of a complaint (business days)	35	29	31	32	36

* The Ombudsman does not categorize complaints as “complaints dropped/found to be without merit,” as used in the table provided above. The Ombudsman complaint categories “unsubstantiated,” “unable to substantiate,” and “referred” were combined to respond to the category “complaints dropped/found to be without merit.”

** Starting in fiscal year 2023, the HHS Enterprise Administrative Report and Tracking System (HEART) allowed Ombudsmen to file additional complaints under one contact reason if they were found during an investigation. Because of this, the total number of complaints resolved in fiscal year 2023 is greater than the number of complaints received.

*** The Civil Rights Office does not always receive and close complaints within the same fiscal year. In fiscal year 2024, the Civil Rights Office closed over 300 service-related complaints that had been pending with the United States Department of Agriculture (USDA) Food and Nutrition Services (FNS). Complaints related to the Supplemental

Nutrition Assistance Program (SNAP) require concurrence from USDA FNS.

D. Fill in the following tables detailing your agency's historically underutilized business (HUB) purchases. Sunset is required by law to review and report this information to the Legislature. If your agency has set specific goals and not statewide goals, please provide the goal percentages and describe the method used to determine those goals. (TAC Title 34, Part 1, Chapter 20, Rule 20.284).

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Exhibit 20: Purchases from HUBs

Heavy Construction

Fiscal Year	Total \$ Spent	Total HUB \$ Spent	Percentage of Total Spent on HUB	Agency Specific Goal	Statewide Goal
2022	\$467,249	\$129,774	27.77%	11.2%	11.2%
2023	\$329,829	\$25,855	7.84%	11.2%	11.2%
2024	\$694,691	\$48,852	7.03%	11.2%	11.2%

Building Construction

Fiscal Year	Total \$ Spent	Total HUB \$ Spent	Percentage of Total Spent on HUB	Agency Specific Goal	Statewide Goal
2022	\$147,388,423	\$19,367,676	13.14%	21.1%	21.1%
2023	\$136,337,598	\$15,474,219	11.35%	21.1%	21.1%
2024	\$113,293,135	\$12,364,236	10.91%	21.1%	21.1%

Special Trade

Fiscal Year	Total \$ Spent	Total HUB \$ Spent	Percentage of Total Spent on HUB	Agency Specific Goal	Statewide Goal
2022	\$13,711,063	\$2,579,753	18.82%	32.9%	32.9%
2023	\$14,594,446	\$2,594,396	17.78%	32.9%	32.9%
2024	\$23,458,116	\$3,185,973	13.58%	32.9%	32.9%

Professional Services

Fiscal Year	Total \$ Spent	Total HUB \$ Spent	Percentage of Total Spent on HUB	Agency Specific Goal	Statewide Goal
2022	\$71,397,068	\$3,967,715	5.56%	23.7%	23.7%
2023	\$103,438,739	\$5,694,210	5.50%	23.7%	23.7%
2024	\$107,194,590	\$8,772,363	8.18%	23.7%	23.7%

Other Services

Fiscal Year	Total \$ Spent	Total HUB \$ Spent	Percentage of Total Spent on HUB	Agency Specific Goal	Statewide Goal
2022	\$914,865,966	\$137,675,220	15.05%	26.0%	26.0%
2023	\$1,094,539,257	\$170,232,810	15.55%	26.0%	26.0%
2024	\$1,182,775,747	\$142,948,691	12.09%	26.0%	26.0%

Commodities

Fiscal Year	Total \$ Spent	Total HUB \$ Spent	Percentage of Total Spent on HUB	Agency Specific Goal	Statewide Goal
2022	\$174,994,967	\$35,260,818	20.15%	21.1%	21.1%
2023	\$195,266,523	\$37,938,046	19.43%	21.1%	21.1%
2024	\$204,214,402	\$39,082,254	19.14%	21.1%	21.1%

F. Does your agency have a HUB policy? How does your agency address performance shortfalls related to the policy? (Texas Government Code, Section 2161.003; TAC Title 34, Part 1, Rule 20.286c)

HHSC has a HUB policy which includes the management of a HUB program. The HUB Program Office provides customer service to the agency's procurement and contracting staff, respondents, HUB businesses and prime contractors. Team members develop and implement policies to ensure strict compliance with the state statutes and administrative rules that govern the program. Their tasks include educating the agency's internal and external customers on HUB requirements; facilitating the inclusion of HUB contract requirements on solicitations valued at \$100,000 or more through the entire life cycle of a contract; marketing the agency's HUB Program and procurement opportunities; administering the Texas

Mentor Protégé Program; and tracking and preparing HUB data for reporting and analytical analysis.

The HUB Program Office reports to the deputy executive commissioner of Procurement and Contracting Services. HUB staff include the HUB Director, HUB Manager, four (4) HUB Coordinators, HUB Technical Advisor, three (3) HUB Reporting Specialists and a HUB Outreach Specialist.

HHSC adopted the Comptroller of Public Accounts (CPA) HUB rules by reference in Texas Administrative Code, Section 391.501.

HHSC is committed to promoting full and equal business opportunities for all businesses in state contracting in accordance with the state and agency HUB goals.

HHSC's policy on the use of HUBs relates to all contracts with an expected value of \$100,000 or more, and whenever practical, in contracts less than \$100,000. It is the policy of HHSC and its contractors to accomplish these goals either through contracting directly with HUBs or indirectly through subcontracting opportunities. HHSC and its contractors make a good faith effort to meet or exceed the goals and assist HUBs in receiving a portion of the total contract value of all contracts that HHSC expects to award in a fiscal year.

To address performance shortfalls, HHSC monitors its contracts monthly to determine the level of HUB participation and strives to eliminate shortfalls by:

- Analyzing the expenditures and payments made to its vendors;
- Improving the expertise of HHSC program and division staff in evaluating contract opportunities for HUBs or minority firms; and
- Assisting each program and division to implement good faith efforts to meet or exceed the goals.

Because most of HHSC's contracts are highly specialized, HHSC is continuously demonstrating its commitment to the use of HUBs by:

- Participating in external Economic Opportunity Forums (EOFs) and related HUB Outreach events;
- Hosting HUB forums which provide HUBs the opportunity to give business presentations to agency management, purchasing, and agency HUB staff;
- Notifying HUBs about procurement opportunities with HHSC;

- Sponsoring and assisting in the development of mentor-protégé relationships with Prime Contractors and HUBs;
- Recruiting new HUBs for potential contracting opportunities in procurement categories where there has been lower HUB utilization;
- Hosting HUB Subcontracting Plan (HSP) trainings for internal program division staff, agency purchasers, and the vendor community to help ensure proper submission HUB subcontracting plan and compliance with the advertised specifications;
- Offering HUBs assistance and training on state procurement procedures;
- Assisting HUBs with the certification and recertification process for the Statewide HUB Program; and
- Encouraging HUBs to register on the CPA's centralized Master Bidders List (CMBL).

During fiscal years 2022-23, HHSC ranked third in total HUB expenditures amongst all state agencies, spending more than \$5 million per year. In fiscal year 2024, HHSC ranked second in total HUB expenditures amongst all state agencies spending more than \$5 million per year.

G. For agencies with contracts valued at \$100,000 or more: Does your agency follow a HUB subcontracting plan to solicit bids, proposals, offers, or other applicable expressions of interest for subcontracting opportunities available for contracts of \$100,000 or more? (Texas Government Code, Section 2161.252; TAC Title 34, Part 1, Rule 20.285)

HHSC has an established process to ensure consideration is given to HUB goals when HHSC enters a contract with an expected value of \$100,000 or more. HHSC determines whether subcontracting opportunities are probable under the contract before soliciting bids, proposals, offers, or other applicable expressions of interest.

HHSC's HUB Program Office reviews the solicitation document prior to advertisement to ensure the solicitation:

- Allows for the greatest amount of competition possible;
- Ensures bonding and insurance requirements are reasonable;
- Lists potential subcontracting opportunities;
- Lists the HUB percentage participation goal;

- Lists the prime contractor's performance requirements related to the HUB program; and
- Includes HUB subcontracting plan requirements.

In addition, the HUB Program Office works with HHSC staff to administer comprehensive HUB subcontracting plans that:

- Provides an overview of the HUB subcontracting plan requirements during the vendor conference;
- Evaluates proposal or bid responses for compliance;
- Hosts post-award meetings with the selected vendor which details the contractor performance expectations related to fulfilling the HUB requirements of the contract; and
- Monitors ongoing progress assessment and reporting to ensure the vendor maintains the agreed upon HUB participation percentage commitment, when applicable.

During the solicitation process, all respondents are required to make a good faith effort to complete a HUB subcontracting plan. If a good faith effort is not made or a subcontracting plan is not submitted or is incomplete, the proposal/bid will be disqualified. If subcontractors are used, then the vendor will be required to demonstrate what effort was made to solicit a certified HUB subcontractor. HHSC encourages vendors to use the CPA HUB directory for the inclusion of HUBs in its contract opportunities. If the subcontractor selected is not a certified HUB, the respondent must provide written justification for their selection process.

H. For agencies with biennial appropriations exceeding \$10 million, answer the following HUB questions:

- 1. Do you have a HUB coordinator? If yes, provide name and contact information. (Texas Government Code, Section 2161.062; TAC Title 34, Part 1, Rule 20.296)**

Letisha Metayer, HUB Director, letisha.metayer@hhs.texas.gov

- 2. Has your agency designed a program of HUB forums in which businesses are invited to deliver presentations that demonstrate their capability to do business with your agency? (Texas Government Code, Section 2161.066; TAC Title 34, Part 1, Rule 20.297)**

HHSC complies with Texas Government Code, Section 2161.066, and Texas Administrative Code, Title 34, Part 1, Rule 20.297. HHSC hosts quarterly and annual HUB forums in which businesses are invited to deliver presentations that demonstrate their capability to do business with HHSC. HHSC also coordinates with other state agencies to cosponsor events that educate and inform HUBs on “Doing Business with HHSC”.

3. Has your agency developed a mentor-protégé program to foster long-term relationships between prime contractors and HUBs and to increase the ability of HUBs to contract with the state or to receive subcontracts under a state contract? (Texas Government Code, Section 2161.065; TAC Title 34, Part 1, Rule 20.298)

HHSC has an established mentor-protégé program to foster long-term relationships between prime contractors and HUBs and to increase the ability of HUBs to contract with the state or to receive subcontracts under a state contract.

Table 1. Mentor Protégé agreements.

Year	New Agreements executed	Total Agreements
2022	2	7
2023	8	15
2024	9	24

HHSC ranked first for the past three years with the most Mentor Protégé agreements amongst other state agencies and universities who have a Mentor Protégé Program.

I. Fill in the tables below detailing your agency’s Equal Employment Opportunity (EEO) statistics. Sunset is required by law to review and report this information to the Legislature. Please use only the categories provided below. For example, some agencies use the classification “paraprofessionals,” which is not tracked by the state civilian workforce. Please reclassify all employees within the appropriate categories below.

Health and Human Services Commission

Exhibit 21: Equal Employment Opportunity Statistics

1. Officials / Administration

Fiscal Year	Total Number of Positions	Percent African-American	Statewide Civilian Workforce Percent	Percent Hispanic	Statewide Civilian Workforce Percent	Percent Female	Statewide Civilian Workforce Percent
2020	1497	16.77%	8.50%	20.91%	24.70%	65.60%	41.70%
2021	1537	17.11%	8.50%	20.69%	24.70%	65.45%	41.70%
2022	1613	17.30%	8.50%	21.02%	24.70%	65.90%	41.70%
2023	1737	16.35%	8.50%	21.99%	24.70%	65.75%	41.70%
2024	1786	15.96%	8.50%	22.28%	24.70%	65.68%	41.70%

2. Professional

Fiscal Year	Total Number of Positions	Percent African-American	Statewide Civilian Workforce Percent	Percent Hispanic	Statewide Civilian Workforce Percent	Percent Female	Statewide Civilian Workforce Percent
2020	11843	20.67%	10.90%	24.74%	21.80%	71.38%	54.10%
2021	11903	20.67%	10.90%	25.19%	21.80%	71.33%	54.10%
2022	11574	20.43%	10.90%	25.95%	21.80%	72.24%	54.10%
2023	12368	20.47%	10.90%	26.41%	21.80%	72.70%	54.10%
2024	13017	21.10%	10.90%	26.83%	21.80%	73.03%	54.10%

3. Technical

Fiscal Year	Total Number of Positions	Percent African-American	Statewide Civilian Workforce Percent	Percent Hispanic	Statewide Civilian Workforce Percent	Percent Female	Statewide Civilian Workforce Percent
2020	7302	28.57%	15.10%	40.33%	29.80%	83.58%	56.90%
2021	6922	27.85%	15.10%	41.22%	29.80%	83.21%	56.90%
2022	7171	28.36%	15.10%	41.78%	29.80%	82.37%	56.90%
2023	8287	29.75%	15.10%	40.52%	29.80%	83.02%	56.90%
2024	8635	29.87%	15.10%	40.24%	29.80%	83.34%	56.90%

4. Administrative Support

Fiscal Year	Total Number of Positions	Percent African-American	Statewide Civilian Workforce Percent	Percent Hispanic	Statewide Civilian Workforce Percent	Percent Female	Statewide Civilian Workforce Percent
2020	3228	23.05%	14.60%	35.32%	36.50%	90.74%	74.70%
2021	3032	22.10%	14.60%	36.08%	36.50%	90.70%	74.70%
2022	2884	22.61%	14.60%	35.78%	36.50%	90.40%	74.70%
2023	2973	22.17%	14.60%	37.98%	36.50%	89.84%	74.70%
2024	2948	21.81%	14.60%	37.75%	36.50%	89.52%	74.70%

5. Service / Maintenance

Fiscal Year	Total Number of Positions	Percent African-American	Statewide Civilian Workforce Percent	Percent Hispanic	Statewide Civilian Workforce Percent	Percent Female	Statewide Civilian Workforce Percent
2020	1991	27.37%	13.30%	36.66%	53.00%	61.18%	54.00%
2021	1839	25.50%	13.30%	38.06%	53.00%	60.36%	54.00%
2022	1725	26.09%	13.30%	37.86%	53.00%	58.84%	54.00%
2023	1960	25.66%	13.30%	38.57%	53.00%	59.49%	54.00%
2024	2012	26.89%	13.30%	38.47%	53.00%	59.39%	54.00%

6. Skilled Craft

Fiscal Year	Total Number of Positions	Percent African-American	Statewide Civilian Workforce Percent	Percent Hispanic	Statewide Civilian Workforce Percent	Percent Female	Statewide Civilian Workforce Percent
2020	587	6.98%	11.50%	29.81%	52.30%	4.43%	14.00%
2021	575	6.61%	11.50%	30.09%	52.30%	4.70%	14.00%
2022	541	6.28%	11.50%	29.94%	52.30%	4.81%	14.00%
2023	567	6.35%	11.50%	32.28%	52.30%	4.23%	14.00%
2024	567	6.88%	11.50%	32.28%	52.30%	4.23%	14.00%

J. Does your agency have an equal employment opportunity (EEO) policy? If yes, please provide an attachment. How does your agency address performance shortfalls related to the policy?

HHSC's Human Resources Policy Manual, Chapter 1.A., contains the agency's equal opportunity policy. Through its EEO policy, HHSC provides equal employment opportunities for all employees and individuals seeking employment. HHSC recruits, hires, trains, and promotes the most qualified persons without regard to protected class.

HHSC EEO policy has the following objectives:

- Provide clear and understandable information to employees regarding personnel policies;
- Provide an internal complaint procedure for processing employment discrimination complaints;
- Provide a process for qualified employees with a disability to receive reasonable accommodations; and
- Provide training for employees required by state and federal law on equal employment and non-discrimination.

Through its internal complaint process, the Civil Rights Office investigates discrimination complaints filed by employees, and, if shortfalls are identified, will recommend action by management consistent with agency policy.

HHSC personnel policies and procedures are certified by the Texas Workforce Commission Civil Rights Division as compliant with Texas Labor Code, Chapter 21.

XII. Agency Comments

Provide any additional information needed to gain a preliminary understanding of your agency.

No additional information.

Appendix: Acronym Dictionary

Below you will find the acronyms used by Health and Human Services Commission (HHSC) programs and divisions. Included in the table are definitions for acronyms used within the Self-Evaluation Report (SER) and exhibits. Due to the length of the SER, acronyms are redefined at the start of each section.

Table 1. Acronym definitions and location.

Acronym	Definition
AA	Administrative Applications
AAA	Area Agency on Aging
ABA	Applied Behavior Analysis
ABAWD	Able-Bodied Adult Without Dependent
ABLE	Texas Achieving a Better Life Experience
ABO	Abortion Facility
AC	Advisory Committee
ACA	Affordable Care Act
ACCO	Advisory Committee Coordination Office
ACF	Administration for Children and Families
ACL	Administration for Community Living
ACS	Acute Care Services
ACS	Acute Care Surveillance
ACT	Achieving Change for Texans
ACTS	ASPEN Complaints/Incidents Tracking System
ACUR	Acute Care Utilization Review
ADA	Americans with Disabilities Act
ADD	Inattentive Type of ADHD
ADH	Administrative Disqualification Hearing
ADHD	Attention-Deficit/Hyperactivity Disorder
ADRC	Aging and Disability Resource Center
AEP	Abstinence Education Program
AES	Access and Eligibility Services

Acronym	Definition
AFC	Adult Foster Care
AFDC	Aid for Families with Dependent Children
AFM	Audit Findings Management
AIC	Area Information Center
AI	Artificial Intelligence
AI/ML	Artificial Intelligence/Machine Learning
ALF	Assisted Living Facility
ALJ	Administrative Law Judge
ALM	Application Lifecycle Management
ALP	Aspiring Leaders Program
A&M	Appeals and Mitigation
AMD	Application Maintenance and Development
AMH	Adult Mental Health
AMO	Asset Management Office
ANE	Abuse, Neglect, and Exploitation
ANSA	Adult Needs and Strength Assessment
APA	Administrative Procedure Act
APC	Ambulatory Payment Classification
APCD	All Payor Claims Database
APD	Advanced Planning Documents
APDU	Advance Planning Document Update
APM	Alternative Payment Model
APS	Adult Protective Services
AR	Accounts Receivable
ARB	Architecture Review Board
ARPA	American Rescue Plan Act
ARTS	Accounts Receivable Tracking System
ASAC	Attrition Slot Allocation Committee
ASC	Ambulatory Surgical Center
ASL	American Sign Language
ASOIG	Automated System for the Office of Inspector General
ASPEN	Automated Survey Process Environment

Acronym	Definition
ATLIS	Aligning Technology by Linking Interoperable Systems
ATW	Aging Texas Well
ATWAC	Aging Texas Well Advisory Committee
AUP	Agreed-Upon Procedures
AWARE	Advancing Wellness and Resilience in Education
BAS	Business Automation Support
BCCS	Breast and Cervical Cancer Services
BCP	Blind Children’s Vocational Discovery and Development Program
BEI	Board for Evaluation of Interpreters
BEST	Blindness Education, Screening and Treatment
BHAC	Behavioral Health Advisory Committee
BHEC	Behavioral Health Executive Council
BHPP	Behavioral Health Partnership Program
BHS	Behavioral Health Services
BHSMS	Behavioral Health Management System
BIA	Bureau of Indian Affairs
BMI	Body Mass Index
BOE	Basis of Estimate
BOS	Business Operations Support
BPI	Business Process Integrity
BPI	Benefits Program Integrity
BRM	Business Relationship Manager
BRS	Business and Regional Services
BSCA	Bipartisan Safer Communities Act
Bus Ops	Business Operations
CA	Community Access
CAB	Change Approval Board
CACE	Consolidated Application Control Environment
CACFP	Child and Adult Care Food Program
CACO	Claims Administrator Contract Oversight
CAD	Clinician-Administered Drugs
CADS	Center for Analytics and Decision Support

Acronym	Definition
CAE	Chief Audit Executive
CAF	Credible Allegation of Fraud
CAFM	Computer Aided Facility Management
CAIO	Chief Artificial Intelligence Office
CAMP	Contract Application and Management for Providers
CANS	Child and Adolescent Needs and Strengths
CAO	Corrective Action Order
CAP	Corrective Action Plan
CAPER	Corrective Action Plan Payment Error Rate
CAPM	Contract Administration and Provider Monitoring
CAPPS	Centralized Accounting and Payroll/Personnel System
CAPPS FIN	Centralized Accounting and Payroll Personnel System Financials
CAPPS HCM	Centralized Accounting and Payroll Personnel System Human Capital Management
CARE	Credentialing and Registry Enforcement
CARE	Client Assignment and Registration
CART	Communication Access Realtime Translation
CAS	Community Attendant Services
CAS	Contract Administrative Services
CASA	Court Appointed Special Advocate
CAT	Contract Advisory Team
CAT	Chief Advisory Team
CBA	Cost Benefit Analysis
CBC	Criminal Background Check
CBC	Community Based Care
CBO	Community Based Organization
CBS	Centralized Billing System
CCATP	Crisis Counseling Assistance and Training Program
CCD	Contested Case Department
CCDF	Child Care and Development Fund
CCE	Child Care Enforcement
CCP	Community Coalition Partnership

Acronym	Definition
CCPBO	Cross Coordination and Pharmacy Benefit Oversight
CCR	Child Care Regulation
CCR	Children's Crisis Respite
CCRG	Community Resource Coordination Group
CCS	Community Care Services
CCS AC	Community Care Services Associate Commissioner
CCSC	Community Care Services Contracts
CCSE	Community Care Services Eligibility
CCU	Contract Compliance Unit
CDA	Chief Data Architect
CDC	U.S. Centers for Disease Control and Prevention
CDCG	Cross Division Coordination Group
CDPS	Chronic Illness and Disability Payment System
CDTF	Chemical Dependency Treatment Facility
CEU	Continuing Education Unit
CF	Cystic Fibrosis
CFC	Community First Choice
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CGS	Core Grouping Software
CHIC	Comprehensive Health Homes for Integrated Care
CHIP	Children's Health Insurance Program
CHIP-P	Children's Health Insurance Program - Perinatal
CHIRP	Comprehensive Hospital Increased Reimbursement Program
CHOW	Change of Ownership
CIHCP	County Indigent Health Care Program
CII	Complaint and Incident Intake
CIL	Centers for Independent Living
CIN2	Cervical Intraepithelial Neoplasia 2
CIN3	Cervical Intraepithelial Neoplasia 3
CIO	Chief Information Officer
CIS	Carcinoma in Situ

Acronym	Definition
CJIS	Criminal Justice Information Services
CLASS	Community Living Assistance and Support Services
CLASS	Child Care Licensing Automation Support System
CLIA	Clinical Laboratory Improvement Amendments
CLOIP	Community Living Options Information Process
CM	Contract Manager
CMA	Case Management Agency
CMBHS	Clinical Management Behavioral Health Services
CMBL	Centralized Master Bidders List
CMCSO	Chief Medicaid and CHIP Services Officer
CMDS	Children's Medicaid Dental Services
CMH	Children's Mental Health
CMHC	Community Mental Health Center
CMHG	Community Mental Health Grant
CMHH	Community Mental Health Hospital
CMHS	Child Mental Health Service
CMMI	Center for Medicare and Medicaid Innovation
CMP	Civil Monetary Penalty
CMPAS	Consumer Managed Personal Attendant Services
CMS	US Centers for Medicare and Medicaid Services
CMS	Contract Management Support
CMS	Centers for Medicare & Medicaid Services
CNA	Certified Nurse Aides
CO	Contract Operations
COE	Center of Excellence
COO	Chief Operating Officer
COOP	Continuity of Operations Plan
CoP	Conditions of Participation
COPA	Certificate of Public Advantage
COR	Change Order Requests
CORF	Comprehensive Outpatient Rehabilitation Facility
COSP	Consumer Operated Service Provider

Acronym	Definition
CPA	Comptroller of Public Accounts
CPB	Contracted Psychiatric Bed
CPAO	Chief Public Affairs Officer
CPB	Crisis Psychiatric Bed
CPP	Community Partner Program
CPRIT	Cancer Prevention and Research Institute of Texas
CPRO	Chief Policy and Regulatory Officer
CPS	Child Protective Services
CPSO	Chief Program and Services Officer
CPW	Children and Pregnant Women
CQC	Compliance and Quality Control
CR	Cost Reimbursement
CRF	Comprehensive Rehabilitation Fund
CRM	Customer Relationship Management
CRO	Civil Rights Office
CRO	Center for Regional Operations
CRS	Comprehensive Rehabilitation Services
CRU	Crisis Residential Unit
CS	Community Services
CSG	Community Services Grant
CSHCN	Children with Special Health Care Needs
CSIE	Community Support and Integration Enforcement
CSIL	Community Services Interest List
CSME	Clinical Subject Matter Expert
CSOT	Council on Sex Offender Treatment
CSP	Clinical Services and Programming
CSS	Customer Service and Support
CSSA	Communication Services for State Agencies
CSU	Crisis Stabilization Unit
CTCM	Certified Texas Contract Manager
CTO	Chief Technology Officer
CTS	Constituent Tracking System

Acronym	Definition
CWP	Comprehensive Waiver Provider
CYBHS	Children and Youth Behavioral Health Subcommittee
CYSHCN	Children and Youth with Special Health Care Needs
DAB	Department Appeals Board
DADS	Department of Aging and Disability Services
DAHS	Day Activity and Health Services
DAP	Data, Analytics, and Performance
DAPP	Disaster Assistance Payment Program
DARS	Department of Assistive Rehabilitative Services
DBHC	Disaster Behavioral Health Coordination
DBMD	Deaf-Blind with Multiple Disabilities
DBITS	Deliverable Based Information Technology Services
DBS	Data Broker Services
DC	Day Care
DCFO	Deputy Chief Financial Officer
DCIS	Ductal Carcinoma in Situ
DCM	Disaster Case Management
DD	Developmental Disability
DDAS	Deputy Director Application Services
DDC EOC	Disaster District Coordinator Emergency Operations Center
DD&R	Data Dissemination and Reporting
DDI	Design, Development and Implementation
DEC	Deputy Executive Commissioner
DFPS	Department of Family and Protective Services
DGPM	Data Governance and Performance Management
DHH	Deaf or Hard of Hearing
DHHS	U.S. Department of Health and Human Services
DHHS	Deaf and Hard of Hearing Services
DHS	Department of Human Services
DID	Determination of Intellectual Disability
DIR	Department of Information Resources
DIT	Determination of Immediate Threat

Acronym	Definition
DMD	Duchenne Muscular Dystrophy
DMO	Dental Maintenance Organization
DMR	Data Management and Reporting
DO	Data Operations
DOJ	U.S. Department of Justice
DPP	Directed Payment Programs
DPS	Texas Department of Public Safety
DPS	Document Processing Services
DRTS	Demand Response Transportation Services
DRTx	Disability Rights Texas
DSA	Direct Service Agencies
DSHS	Disproportionate Share Hospital
DSHS	Department of State Health Services
DSO	Director of Strategic Operations
DSP	Delivery Supplemental Payments
DSQI	Delivery System Quality & Innovation
DSRIP	Delivery System Reform Incentive Payment Program
DTS	Deliverables Tracking System
DUR	Drug Utilization Review
DURFM	Drug Utilization Review and Formulary Management
EaaS	Eligibility as a Service
EAC	Employee Advisory Committee
EB	Enrollment Broker
EBBP	Evidence-Based Best Practices
EBT	Texas Electronic Benefit Transfer
EBT	Electronic Benefits Transfer Tracking
ECC	Enhanced Community Coordination
ECI	Early Childhood Intervention
ECIDS	Early Childhood Integrated Data System
ECP	Extraordinary Contributor Program
ECT	Electroconvulsive Therapy
EDI	Electronic Data Interchange

Acronym	Definition
eDRS	Electronic Disqualification Recipient System
EEG	Electroencephalogram
EEO	Equal Employment Opportunity
EEOC	Equal Employment Opportunity Commission
EFND`	Early Family Nutrition and Development
EFSC	Encounters, File Support, and Coordination
EHR	Electronic Health Records
EIM	Enterprise Information Management
EIN	Employer Identification Number
EIR	Electronic Information Resource
ELA	Executive Leadership Academy
EM	Emergency Management
EMR	Employee Misconduct Registry
EMR	External Medical Reviews
EMS	Emergency Medical Services
EOF	Economic Opportunity Forums
EOR	Executive Operations and Reporting
EOU	Extended Observation Unit
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
ER	Experience Rebates
ERM	Emergency and Risk Management
ERP	Enterprise Resource Planning
ERS	Emergency Response Services
ERS	Employee Retirement System
ESC	Executive Steering Committee
ESC	Educational Service Center
ESRD	End Stage Renal Disease Facility
ESRD	End-Stage Renal Disease
ESSA	Every Student Succeeds Act
ESEC	Emergency Service and Escalation Services
ESS	Eligibility Support Services

Acronym	Definition
ESVO	Eligibility Support Vendor Operations
ETS	Enterprise Telephony Systems
ETW	Enforcement Tracking Worksheet
EVV	Electronic Visit Verification
EWS	Early Warning System
FA	Fraud Analytics
FACM	Fiscal Analysis and Case Management
FACT	Fairness, Accountability, Consistency, and Transparency
FADO	Fraud Analytics and Data Operations
FAIR	Feedback Assessment Improvement Review
FARM	Fiscal Analysis and Recovery Management
FBA	family-based alternatives
FBCP	Facility Based Competency Program
FBI	U.S. Federal Bureau of Investigation
FC	Family Care
FCC	Federal Communications Commission
FCL	Foster Care Litigation
FCO	Foster Care Ombudsman
FCS	Family Clinical Services
FDA	U.S. Food and Drug Administration
FEMA	Federal Emergency Management Agency
FEMC	Freestanding Emergency Medical Care Facility
FFH	Fair and Fraud Hearings
FFM	Federally-Facilitated Marketplace
FFP	Federal Financial Participation
FFS	Fee-for-Service
FHS	Family Health Services
FGP	Foster Grandparent Program
FMAP	Federal Medical Assistance Percentage
FMSA	Financial Management Services Agencies
FMU	Fiscal Monitoring Unit
FNS	Food and Nutrition Service

Acronym	Definition
FO	Finance Operations
FOSS	Facility Operations and Support Services
FPO	Fraud Prevention Operations
FPL	Facilities Planning and Leasing
FPL	Federal Poverty Level
FPP	Family Planning Program
FQHC	Federally Qualified Health Center
FRAC	Financial Reporting and Audit Coordination
FRAT	Forensics Research and Analysis Team
FS	Facility Services
FSE&T	Food Stamp Employment and Training
FSR	Financial Statistical Report
FSS	Family Support Services
FST	Forensic Support Team
FTE	Full-Time Equivalent
FVP	Family Violence Program
FVPSA	Family Violence Prevention and Services Act
FWA	Fraud, Waste, and Abuse
FYSS	Family and Youth Services and Supports
GAA	General Appropriations Act
GASB	Governmental Accounting Standards Board
GCPD	Governors Committee for People with Disabilities
GED	General Education Development
GIS	Geographic Information System
GME	Graduate Medical Education
GOLD	Guardianship Online Database
GPO	Group Purchasing Organization
GR	General Revenue
GR	Government Relations
GRO	General Residential Operation
GSP	Guardianship Services Program
GSR	Government and Stakeholder Relations

Acronym	Definition
HAP	Hemophilia Assistance Program
HARP	Hospital Augmented Reimbursement Program
H.B.	House Bill
HBD	Hemoglobin A1c Control for Patients with Diabetes
HC	Health Care
HCBS	Home and Community-Based Services
HCBS-AMH	Home and Community-Based Services - Adult Mental Health
HCC	Healthy Community Collaboratives
HCFE	Health Care Facilities Enforcement
HCM	Human Capital Management
HCPCS	Healthcare Common Procedure Coding System
HCR	Health Care Regulation
HCS	Home and Community-based Services
HCSSA	Home and Community Support Services Agency
HDIS	Health, Developmental and Independence Services
HDM	Home Delivered Meals
HEART	HHS Enterprise Administrative Report and Tracking System
HEDIS	Healthcare Effectiveness Data and Information Set
HFCA	Health Care Financing Administration
HHS	Texas Health and Human Services system
HHSC	Health and Human Services Commission
HIE	Health Information Exchanges
HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health Insurance Premium Payment
HM	Heightened Monitoring
HMP	Healthy Marriage Program
HOPD	Medicare Hospital Outpatient Department
HOPES	Healthy Outcomes through Prevention and Early Support
HP	Hewlett Packard
HPED	OAG Healthcare Program Enforcement Division
HPPH	Houston Preventative and Primary Health
HQBPP	Hospital Quality-Based Payment Program

Acronym	Definition
HR	Human Resources
HRSA	Health Resources and Services Administration
HSAI	Heightened Scrutiny Artificial Intelligence
HSCS	Health and Specialty Care System
HSE	Health Services Executive
HSIL	High-Grade Squamous Intraepithelial Lesion
HSP	Historically Underutilized Business Subcontracting Plan
HTW	Healthy Texas Women
HUB	Historically Underutilized Business
HUR	Hospital Utilization Review
HVAC	Heating, Ventilation, and Air Conditioning
I&DM	Information and Data Management
IA	Implementing Agency
IA	Internal Affairs
IA	Individual Assistance
IAC	Interagency Contract
IAPD	Implementation Advanced Planning Document
IAPDU	Implementation Advance Planning Document Update
IBIS	Integrated Business Information System
IBM	International Business Machines
ICF	Intermediate Care Facilities
ICF/IID	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions.
ICMRS	Inpatient Comprehensive Medical Rehabilitation Services
ICR	Inpatient Competency Restoration
ICRG	Indirect Cost Rate Group
ID	Intellectual Disability
IDD	Intellectual and Developmental Disability
IDD PES	IDD Program Eligibility and Support
IDD SRAC	IDD System Redesign Advisory Committee
IDD UR	IDD/Hospice Utilization Review
IDEA	Individuals with Disabilities Education Act

Acronym	Definition
IDDO	Intellectual and Developmental Disabilities Ombudsman
IDR	Informal Desk Review
IDR	Informal Dispute Resolution
IIDR	Independent Informal Dispute Resolution
IDT	Interdisciplinary Team
IEP	Individualized Education Program
IFR	Interim Final Rule
IHP	Individual and Household Program
IJ	Immediate Jeopardy
ILM	Interest List Management
ILS	Independent Living Services
ILOS	In-Lieu-of Other State
IMPACT	Information Management Protecting Adults and Children in Texas
IMS	Information Management System
IND	Investigational New Drug
IPC	Individual Plan of Care
IPV	Intentional Program Violation
iQIES	Internet Quality Improvement and Evaluation System
IR	Informal Reconsideration
I&R	Information and Referral
IRAC	Issue, Rule, Analysis, and Conclusion
IRDR	Information Resources Deployment Review
IRIS	Integrated Resident Information System
IRO	Independent Review Organization
IRP	Individual Recovery Plan
IRS	Internal Revenue Service
IRU	Intake Resolution Unit
IS	Infrastructure Services
ISD	Independent School District
ISS	International Social Services
ISS	Individualized Skills Services
IST	Investigative Strategy Team

Acronym	Definition
IST	Incompetent to Stand Trial
IT	Information Technology
ITCSHD	Information Technology Customer Service Help Desk
ITEPA	Texas Identity Theft Enforcement And Protection Act
ITSAC	Information Technology Staff Augmentation Contract
ITSM	Information Technology Service Management
ITSP	Information Technology Strategy and Prioritization
IUR	Investigations and Utilization Reviews
IWRP	Individualized Written Rehabilitation Plan
IVR	Interactive Voice Response
JBCR	Jail-Based Competency Restoration
JCAFS	Joint Committee on Access and Forensic Services
JDC	Jail Diversion Center
KHC	Kidney Health Care
KPI	Key Performance Indicator
KPM	Key Performance Metric
KPR	Key Performance Requirement
LA	Local Agency
LA	Local Authority
LARC	Long-Acting Reversible Contraceptive
LBB	Legislative Budget Board
LBHA	Local Behavioral Health Authority
LCDC	Licensed Chemical Dependency Counselor
LHD	Local Health Department
LIDDA	Local Intellectual and Developmental Disability Authority
LD	Liquidated Damages
LDP	Leadership Development Program
LEA	Local Education Agency
LEIE	List of Excluded Individuals/Entities
LEP	Limited English Proficiency
LMHA	Local Mental Health Authority
LOC	Level-of-Care

Acronym	Definition
LON	Level of Need
LPDS	Local Procedure Development and Support
LRC	Last Resort Communication Services
LPPF	Local Provider Participation Funds
LRN	Learning Resource Network
LS	Language Services
LSBS	Lone Star Business Services
LSC	Life Safety Code
LSD	Legal Services Division
LSOTP	Lost, Stolen, or Not Received
LSRH	Limited Services Rural Hospital
LTC	Long-Term Care
LTCE	Long-Term Care Enforcement
LTCFE	Long-Term Care Facility Enforcement
LTCO	Long-Term Care Ombudsman
LTCOP	Long-Term Care Online Portal
LTCR	Long-Term Care Regulation
LTS	Legislative Tacking System
LTSS	Long-Term Services and Supports
LVN	Licensed Vocational Nurse
MA	Medication Aide
MAC	Medicaid Administrative Claiming
MAC	Multi-Assistance Center
MAGI	Modified Adjusted Gross Income
MAR	Medication Aide Registry
MAT	Medication Assisted Treatment
MBCC	Medicaid for Breast and Cervical Cancer
MBOW	Mental and Behavioral Health Outpatient Warehouse
MCAC	Medical Care Advisory Committee
MCCO	Managed Care Contract Oversight
MCDA	Medicaid and Children's Health Insurance Program (CHIP) Data Analytics
MCO	Managed Care Organization

Acronym	Definition
MCOT	Mobile Crisis Outreach Team
MCS	Medicaid and CHIP Services
MCSA	Medicaid and CHIP Systems Applications
MCU	Major Case Unit
MCUR	Managed Care Utilization Review
MDBP	Medical and Dental Benefits Policy
MDCP	Medically Dependent Children Program
MDL	Management Decision Letter
Med-IT	Medical Information Tracking System
MERP	Medicaid Estate Recovery Program
MES	Medicaid Enterprise System
MFADS	Medicaid Fraud Abuse Detection System
MFCU	Medicaid Fraud Control Unit
MFP	Money Follows the Person
MH	Mental Health
MHFA	Mental Health First Aid
MHGJII	Mental Health for Justice Involved Individuals Grant
MHP	Mental Health Program
MHU	Mobile Health Units
MI	Mental Illness
MIECHV	Maternal, Infant, and Early Childhood Home Visiting
MIPPA	Medicare Improvements for Patients and Providers Act
MIRPS	Major Information Resource Projects
ML	Machine Learning
MLR	Medical Loss Ratio
MMHSUD	Maternal Mental Health and Substance Use Disorder
MMIS	Medicaid Management Information System
MMP	Medicare-Medicaid Plan
MMR	Monthly Monitoring Report
MN	Medical Necessity
MOA	Memorandum of Agreement
MOM	Maternal Opioid Misuse Model

Acronym	Definition
MOU	Memorandum of Understanding
MPA	Multisector Plans on Aging
MPD	Mission and Priority Document
MPED	Medicaid for the Elderly and People with Disabilities
MPF	Master Personnel File
MPI	Medicaid Provider Integrity
MPO	Major Procurements Office
MPRO	Michigan Peer Review Organization
MPS	Minimum Performance Standards
MRI	Magnetic Resonance Imaging
MRMRTC	My Health My Resource of Tarrant County
MRR	Medical Record Requests
MST	Multisystemic Therapy
MSU	Maximum-Security Unit
MT	Medium Term
MTM	Medicaid Technology Modernization
MTO	Managed Transportation Organizations
MTP	Medical Transportation Program
MVP	Motor Vehicle Program
NAC	North Austin Complex
NACDD	National Association of Councils on Developmental Disabilities
NACDS	National Association of Chain Drug Stores
NAIP	Network Access Improvement Program
NAR	Nurse Aide Registry
NARR	National Alliance for Recovery Residences
NAS	Neonatal Abstinence Syndrome
NAS-MOUD	Neonatal Abstinence Syndrome Medication for Opioid Use Disorders
NATCEP	Nurse Aide Training and Competency Evaluation
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NCCCP	National Comprehensive Cancer Control Programs
NCI	National Core Indicators
NEMT	Nonemergency Medical Transportation

Acronym	Definition
NF	Nursing Facility
NFA	Nursing Facility Administrator
NFO	Nursing Facility Orientation
NFUR	Nursing Facility Utilization Review
NGRI	Not Guilty by Reason of Insanity
NIP	Nutrition Incentive Program
NMDOH	Non-Medical Drives of Health
NoA	Notice of Award
NOV	Notice of Violation
NPCR	National Program of Cancer Registries
NPI	National Provider Identifier
NPMHP	Non-Physician Mental Health Professional
NSK	Non-Stop Kernel
NSPL	National Suicide Prevention Lifeline
NTP	Narcotic Treatment Program
OAA	Older Americans Act
OAAA	Office of Area Agencies on Aging
OAAPS	OAA Performance System
OAC	Office of Audit and Compliance
OADRC	Office of Aging and Disability Resource Centers
OASC	Office of Aging Services Coordination
OACT	CMS Office of the Actuary
OAG	Texas Office of Attorney General
OB/GYN	Obstetrician/Gynecologist
OBA	Outcomes-Based Assessment
OBH	Ombudsman for Behavioral Health
OBI	Outpatient Biopsychosocial Intervention
OCC	Office of Chief Counsel
OCS	Ombudsman Complaint Services
OCSE	Office of Child Support Enforcement
ODHHS	Office of Deaf and Hard of Hearing Services
ODP	Texas Open Data Portal

Acronym	Definition
OABI	Office of Acquired Brain Injury
ODPC	Office of Disability Prevention for Children
ODSC	Office of Disability Services Coordination
OECO	Open Enrollment Contracts and Operations
OFSC	Office of Forensic Services and Coordination
OFVPS	Office of Family Violence Prevention and Services
OGS	Office of Guardianship Services
OHI	Oxford House Inc.
OIG	Office of Inspector General
OIO	Office of Independent Ombudsman
OLC	Office of Legal Counsel
Ombudsman	Office of the Ombudsman
OMCAT	Ombudsman Managed Care Assistance Team
OMD	Office of the Medical Director
OMHC	Office of Mental Health Coordination
ONA	Other Needs Assistance
OOG	Office of the Governor
OP	Office of Performance
OPDD	Office for the Prevention of Developmental Disabilities
OPR	Office of Policy and Rules
OPT	Outpatient Physical Therapy
ORDG	Open Records and Data Governance
ORR	Open Records Requests
OSAR	Outreach, Screening, Assessment, and Referral
OSEP	Office of Special Education Programs
OST	Outpatient Speech Therapy
OTI	Office of Transformation and Innovation
OTPI	Over-the-Phone Interpreting
OD	Opioid Use Disorder
OVSC	Office of Veteran Services Coordination
P4Q	Pay-for-Quality
PA	Prior Authorization

Acronym	Definition
PABI	Post-Acute Brain Injury
PAC	Perinatal Advisory Council
PACAP	Public Assistance Cost Allocation Plan
PACE	Program for All-Inclusive Care for the Elderly
PACT	Project Advisory and Coordination Team
PADRES	Parenting Awareness and Drug Risk Education Services
PAI	Performance and Analytics Integration
PAIMI	Protection and Advocacy for Individuals with Mental Illness
PAIYC	Providers Available in Your County
PALTS	Procurement Action Lead Time Schedule
PANS	Pediatric Acute-Onset Neuropsychiatric Syndrome
PAP	Pharmaceutical Assistance Program
PARIS	Public Assistance Reporting Information System
PASCI	Post-acute Spinal Cord Injury
PASD	Placenta Accreta Spectrum Disorders
PASRR	Preadmission Screening and Resident Review
PATH	Projects for Assistance in Transition from Homelessness
PBH	Private Psychiatric Bed
PBHP	Prevention and Behavioral Health Promotion
PBM	Pharmacy Benefit Manager
PCD	Project Controls Document
PCFI	Performance and Cross Functional Initiatives
PCIP	Procurement and Contracting Improvement Plan
PCM	Purchasing and Contract Management
PCMH	Procurement and Contract Management Handbook
PCMOC	Procurement and Contract Management Oversight Committee
PCO	Policy Coordination Office
PCR	Policy Clarification Request
PCS	Procurement and Contracting Services
PDA	Property Damage Assessments
PDCT	Potentially Disrupted Community Transition
PDD	Pervasive Developmental Disorder

Acronym	Definition
PDIU	Program Development and Innovation Unit
PDL	Preferred Drug List
PDP	Person-Directed Plan
PDP	Prescription Drug Plan
PEARS	Program Evaluation and Reporting System
PEI	Prevention and Early Intervention
PEIPS	PEI Public Site
PEIRS	Prevention and Early Intervention Reporting System
PEIS	Provider Enrollment Integrity Screenings
PEMS	Provider Enrollment Management System
PER	Payment Error Rate
PeriPAN	Perinatal Psychiatry Access Network
PES	Program Enrollment and Support
PFAP	Procurement Forecast and Action Plan
PFD	Provider Finance Department
PFD	Proposal for Decision
PFI	Provider Field Investigations
PHA	DSHS Public Health Applications
PHC	Primary Health Care
PHC	Primary Home Care
PHE	Public Health Emergency
PHP-CCP	Public Health Provider Charity Care Program
PI	Provider Investigations
PI	Policy Integration
PIA	Texas Public Information Act
PIA	Privacy Impact Assessment
PIDS	Program Integrity Development and Support
PIN	Personal Identification Number
PIP	Performance Improvement Project
PIP	Promoting Independence Plan
PIRBO	Post Implementation of Business Outcomes
PM	Product Management

Acronym	Definition
PM	Provider Monitoring
PMAS	Performance Management & Analytics System
PMCoE	Project Management Center of Excellence
PMI	Project Management Institute
PMO	Project Management Office
PMO	Project Management Organization
PMU	Performance Management Unit
PN	Patient Navigator
PO	Purchase Order
POS	Point-of-Sale
PPECC	Prescribed Pediatric Extended Care Centers
PPEs	Potentially Preventable Events
PPM	Project Portfolio Management System
PPPM	Pharmacy Provider Procedures Manual
PPR	Potentially Preventable Readmissions
PPW	Postpartum Women
PPV	Potentially Preventable Emergency Department Visits
PRA	Personal Responsibility Agreement
PRAA	Provider Resolution and Administrative Appeals
PRBA	Pharmacy Claims & Rebate Administration
PRC	Prevention Resource Center
PRH	Provider Recoupments and Holds
ProDUR	Prospective Drug Utilization Review
PRS	Texas Department of Protective and Regulatory Services
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
PRYCRP	Peer Run Youth Crisis Respite Program
PSI	Policy and Strategic Initiatives
PSORT	Program Support Operations Review Team
PSR	Peer Support and Recovery
PST	Program Support and Training
PSU	Program Support Unit
PTA	Privacy Threat Assessments

Acronym	Definition
PTS	Prevention Training Services
PUC	Public Utility Commission of Texas
PULSE	Project and Patient Unified Lookup System for Emergencies
PTLL	Payroll, Time, Labor, and Leave
QA	Quality Assurance
Q&C	Quality and Control
Q&PI	Quality and Program Improvement
QAFS	Quality Assurance Field Services
QAPI	Quality Assessment and Performance Improvement Programs
QAT	Quality Assurance Team
QAU	Quality Assurance Unit
QC	Quality Control
QDAR	Quality Data Analytics and Reporting
QIDP	Qualified Intellectual Disability Professional
QIPP	Quality Incentive Payment Program
QIS	Quality Improvement Support
QLTCC	Quality in Long-Term Care Conference
QM	Quality Management
QM	Quality Monitor
QMP	Quality Monitoring Program
QMR	Quarter Monitoring Report
QRU	Quality Reporting Unit
QSR	Quality Service Review
RA	Reference Architecture
RAC	Recovery Audit Contractor
RAPPS	Rural Access to Primary and Preventive Services
RAR	Reasonable Accommodations Request
RAS	Regional Administrative Services
RC	Residential Care
RCA	Root Cause Analysis
RCCR	Residential Child Care Regulation
RCO	Rules Coordination Office

Acronym	Definition
RCPS	Recovery Coordination and Program Support
RDAC	Regional Disaster Area Coordinator
RDT	Random Drug Testing
RDUR	Retrospective Drug Utilization Review
RE	Regulatory Enforcement
REI	Request for Evidentiary Information
RFA	Request for Application
RFID	Radio Frequency Identification
RFO	Request for Offer
RFP	Request for Proposal
RHC	Rural Health Clinic
RHFC	Rural Hospital Finance and Coordination
RLA	Rising Leaders Academy
RLHO	DSHS Regional and Local Health Operations
RMDF	Release Migration Documentation Form
RMO	Records Management Office
RMS	Risk Management and Safety
RN	Registered Nurse
ROR	Regional Offsite Review
RPA	Robotics Process Automation
RRH	Recovery Residence House
RRS	Residential Support Services
RRT	Rapid Response Team
RSD	Regulatory Services Division
RTC	Residential Treatment Center
RUG	Resource Utilization Group
SaaS	Software as a Service
SAFe	Scaled Agile Framework
SAFE	Sexual Assault Forensic Exam
SAMHSA	Substance Abuse and Mental Health Services Administration
SAO	State Auditor's Office
SAS	Service Authorization System

Acronym	Definition
SASO	Service Authorization System Online
SAU	Single Audit Unit
S.B.	Senate Bill
SBO	Strategic Business Operations
SCC	Surrogate Consent Committee
SCCS	Standardized Clinically Based Competency Screen
SCF	Special Care Facility
SCIT	State Center Investigations Team
SCOR	System of Contract Operation and Reporting
SCP	Senior Citizens Program
SDLC	Software Development Life Cycle
SDMP	Surrogate Decision-Making Program
SDVP	Signal Detection, Visualization and Performance
SECC	State Employee Charitable Campaign
SED	Serious Emotional Disturbance
SEE	Survey of Employee Engagement
SEMM DIA	Salud En Mis Manos Dissemination and Implementation Assistance
SEPA	Senior Executive Policy Advisor
SES	Supported Employment Services
SFC	Sustainable Food Center
SHARP	State Health Analytics and Reporting Platform
SHARS	School Health and Related Services
SHSDP	State Hospital Step-Down Program
SHSS	Specialized Health and Social Services
SHIP	State Health Insurance Assistance Program
SI	Special Investigations
SIASCC	Statewide Interagency Aging Services Coordinating Council
SICM	Special Investigations Case Management
SILC	State Independent Living Council
SISS	Strategic Innovation and System Supports
SIT	Strategy and Innovation Team
SITP	Substance Intervention and Treatment Program

Acronym	Definition
SLA	Service Level Agreement
SLEB	State Law Enforcement Bureau
SLRM	State and Local Records Management Division
SLTCOP	State Long-Term Care Ombudsman Program
SMA	State Medicaid Agency
SMART	Supporting Mental Health and Resiliency in Texans
SMDL	State Medicaid Director Letter
SME	Subject Matter Expert
SMHF	State Mental Health Facility
SMI	Serious Mental Illness
SMIB	Supplemental Medical Insurance Benefits
SMMCAC	State Medicaid Managed Care Advisory Committee
SMS	Short Message Services
SMVF	Service Members Veterans, and Families
SN	System Navigator
SN-Plus	System Navigator Plus
SNAP	Supplemental Nutrition Assistance Program
SNAP-Ed	Supplemental Nutrition Assistance Program-Education
SNAP E&T	Supplemental Nutrition Assistance Program Employment & Training
SO	Strategic Operations
SOAH	State Office of Administrative Hearings
SOAR	System of Automated Records
SOM	State Operations Manual
SORM	State Office of Risk Management
SOS	Specialized Ombudsman Services
SOW	Statement of Work
SPA	State Plan Amendment
SPA	State Property Accounting
SPAP	State Pharmaceutical Assistance Program
SPIL	State Plan for Independent Living
SPR	State Performance Report
SPURS	State Unit on Aging Programs Uniform Reporting System

Acronym	Definition
SPA	Medicaid and CHIP State Plan Amendments
SPA	State Property Accounting
SR	Software Review
SRO	State and Regional Operations
SRU	Solicitation Review Unit
SSA	Support Services Agreement
SSA	Social Services Applications
SSBG	Social Services Block Grant
SSCC	Single Source Continuum Contractor
SSI	Supplemental Security Income
SSLC	State Supported Living Center
SSPD	Special Services to Persons with Disabilities
SSS	System Support Services
SST	Specialized Skill Training
STAP	Specialized Telecommunications Assistance Program
STAR	State of Texas Access Reform
STATE	Sustainable, Technical Assistance, Training and Engagement
STEAR	State of Texas Emergency Assistance Registry
STC	Special Term and Condition
STI	Sexually Transmitted Infection
STS	Shared Technology Services
SUA	State Unit on Aging
SUD	Substance Use Disorder
SUMD	Substance Use Medical Director
SUP	Substance Use Program
SUR	Surveillance Utilization Review
SWI	Statewide Intake
SYSN	Statewide Youth Services Network
T-MSIS	Transformed-Medicaid Statistical Information System
TAC	Texas Administrative Code
TANF	Temporary Assistance for Needy Families
TAO	Talent Acquisition Office

Acronym	Definition
TARRC	Texas Autism Resource and Research Center
TAS	Transition Assistance Services
TBI	Traumatic Brain Injury
TBIAC	Texas Brain Injury Advisory Council
TCCCP	Texas Comprehensive Cancer Control Program
TCCO	Texas Civil Commitment Office
TCID	Texas Center for Infectious Disease
TCM	Targeted Case Management
TCMF	Texas Commission on Marriage and Family
TCOOMMI	Texas Correctional Office on Offenders with Medical or Mental Impairments
TCR	Texas Cancer Registry
TCR	Targeted Case Reviews
TCRx	Texas Cares Rx (Prescription Drug) Program
TDA	Texas Department of Agriculture
TDCJ	Texas Department of Criminal Justice
TDEM	Texas Division of Emergency Management
TDH	Texas Department of Health
TDHCA	Texas Department of Housing and Community Affairs
TDHS	Texas Department of Human Services
TDI	Texas Department of Insurance
TDMHMR	Texas Department of Mental Health and Mental Retardation
TEA	Texas Education Agency
TEC	Texas Ethics Commission
TFC	Texas Facilities Commission
TGC	Texas Government Code
THLC	Texas Healthcare Learning Collaborative
THSteps	Texas Health Steps
TICP	Transportation for Indigent Cancer Patient program
TIERS	Texas Integrated Eligibility Redesign System
TIN	Taxpayer Identification Number
TIPPS	Texas Incentives for Physicians and Professional Services

Acronym	Definition
TIRN	Texas Information and Referral Network
TJJD	Texas Juvenile Justice Department
TJPC	Texas Juvenile Probation Commission
TLOC	Transition Legislative Oversight Committee
TLRCP	Texas Lifespan Respite Care Program
TMB	Texas Medical Board
TMDP	Texas Medical Disclosure Panel
TMHP	Texas Medicaid & Healthcare Partnership
TPE	Transaction Payment Engine
TPI	Texas Provider Identifier
TPP	Third Party Partnership
TPL	Third Party Liability
TPR	Third Party Recoveries
TQ	Targeted Query
TRR	Texas Resilience and Recovery
TRS	Teacher Retirement System
TSCI	Traumatic Spinal Cord Injury
TSH	Texas State Hospital
TST	Transition Support Team
TSLAC	Texas State Library and Archives Commission
TTF	Thriving Texas Families
TTOR	Texas Targeted Opioid Response
TULIP	Texas Unified Licensure Information Portal
TV MCH FFS	Title V Maternal and Child Health Fee-for-Service
TVC	Texas Veteran Commission
TW	Texas Works
TWC	Texas Workforce Commission
TWC-VR	Texas Workforce Commission-Vocational Rehabilitation
TWPS	Texas Works Path to Success
TXCASA	Texas Court Appointed Special Advocate
TxGMS	Texas Grant Management Standards
TxHmL	Texas Home Living

Acronym	Definition
TxHSN	Texas Health and Human Services System
TxSOC	Texas System of Care Consortium
TXIN	Texas WIC Information Network
TYC	Texas Youth Commission
UAT	User Acceptance Testing
UC	Uncompensated Care
UHRIP	Uniform Hospital Rate Increase Program
UMCC	Uniform Managed Care Contract
UMCM	Uniform Managed Care Manual
UR	Utilization Review
U.S.	United States
USC	United States Code
USDA	U.S. Department of Agriculture
USDA FNS	U.S. Department of Agriculture Food and Nutrition Service
US DHHS	U.S. Department of Health and Human Services
US SSA	U.S. Social Security Administration
UT	University of Texas
UTHSC	University of Texas Health Sciences Center
UTMB	University of Texas Medical Branch Galveston
UTSA	University of Texas San Antonio
UTSON	University of Texas at Austin School of Nursing
VA	Vulnerability Assessment
VAOS	Vaccine Allocation and Ordering System
VBE	Value-based Enrollment
VDP	Vendor Drug Program
VEP	Vendor Engagement Program
VPN	Virtual Private Network
VPTS	Vendor Performance Tracking System
VR	Vocational Rehabilitation
VRP	Voluntary Repayment Program
WAFERS	Waste, Abuse and Fraud Electronic Referral System
WAN	Wide-Area Network

Acronym	Definition
WCY	Waco Center for Youth
WIC	Special Supplemental Nutrition Program for Women, Infants and Children
WIC VMU	Special Supplemental Nutrition Program for Women, Infants and Children Vendor Monitoring Unit
WIOA	Workforce Innovation and Opportunity Act
WOA	Workforce Orientation for Applicants
WOM	Workforce Operations Management
WPR	Work Participation Rate
WS	Warehouse Services
YCOT	Youth Crisis Outreach Team Services
YES	Youth Empowerment Services
YRC	Youth Recovery Communities
YTB	YourTexasBenefits.com
YTD	Year to Date
2-1-1 TRIN	2-1-1 Texas Information and Referral Network

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