TEXAS
Health and Human
Services System

Texas HEALTH AND HUMAN SERVICES COMMISSION

SELF-EVALUATION REPORT

SUBMITTED TO THE SUNSET COMMISSION

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HEALTH AND HUMAN SERVICES COMMISSION

SELF-EVALUATION REPORT

I. AGENCY CONTACT INFORMATION

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II. KEY FUNCTIONS AND PERFORMANCE

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

Mission

The Texas Health and Human Services (HHS) System includes five entities: Health and Human Services Commission (HHSC); Department of Aging and Disability Services (DADS); Department of Assistive and Rehabilitative Services (DARS); Department of Family and Protective Services (DFPS); and Department of State Health Services (DSHS). Together these agencies administer more than 200 programs, ranging from Medicaid and Child Protective Services, to regulatory and licensing functions. Their collective mission is to develop and administer an accessible, effective, and efficient health and human services delivery system that is beneficial and responsive to the people of Texas.

Within this structure, HHSC provides System oversight and administers programs, primarily focused on Medicaid and the Children's Health Insurance Program (CHIP). As an agency, HHSC's mission is to maintain and improve the Health and Human Services System in Texas, and to administer its programs in accordance with the highest standards of customer service and accountability for the effective use of funds.

Objectives

HHSC has a broad range of objectives and goals related to HHS System oversight and delivery of Medicaid, CHIP, and other programs, which are detailed in state and federal law. The agency's main objectives include the following.

- **HHS Oversight and Policy.** Improve the Health and Human Services System's business operations to maximize federal funds; improve efficiency in system operations; improve accountability and coordination throughout the System; and ensure the timely and accurate provision of eligibility determination services for all.
- **HHS Consolidated System Support Services.** Improve System operations through the coordination and consolidation of administrative services.
- **HHS Medicaid Support.** Improve service quality by serving as the single state Medicaid agency, coordinating Medicaid-related programs administered by other agencies and determining program eligibility. Provide policy direction and management of the State's Medicaid program, maximizing use of federal dollars.
- **Medicaid Health Services.** Administer programs that provide medically necessary health care in the most appropriate, accessible, and cost-effective setting.
- **CHIP Services.** Ensure health insurance coverage for eligible children in Texas.
- **Special Services for Children.** Address the specific health and dental needs of Texas' children before associated problems become chronic and irreversible.

- **Assistance Services.** Provide appropriate support services that address the employment, financial, and nutritional needs of eligible individuals.
- **Other Support Services.** Promote safety, self-sufficiency, and long-term independence for those living with domestic violence or other adverse circumstances.
- **Inspector General.** Improve health and human services programs and operations by protecting them against fraud, waste, and abuse.

Key Functions

As the lead agency in the HHS System, HHSC serves a dual role − providing System oversight and support, and developing policies, determining eligibility, and implementing health and human services programs. To fulfill these two main objectives, the agency performs the following key functions.

HHS System Oversight

Unified Policy Decisions. To ensure a cohesive approach in maximizing federal funds and enhancing client focus across the HHS System, the Executive Commissioner adopts all formal policies and rules. The Executive Commissioner also provides strategic guidance across the HHS System as well as oversees the day-to-day agency operations within HHSC. Under the Executive Commissioner's direction, HHSC provides budget and fiscal policies, such as rate setting and forecasting across the HHS System.

In addition, HHSC coordinates policies, initiatives, and services across the HHS System for child and youth programs, acquired brain injury, and elimination of health disparities.

HHSC also coordinates compliance and reporting requirements including policy, program, legal requests for information, and budget activities across HHSC and within the HHS System for cross-agency issues such as the *Frew v. Janek* lawsuit regarding Medicaid for clients age 20 and younger.

Streamlined Business Operations. To ensure consistency and accountability across the HHS System, HHSC coordinates human resource policies, contract procurement and management, ombudsman complaints monitoring, legal and IT services, and initiatives such as e-health opportunities across the HHS System.

Consolidated Support Services. To maximize System efficiencies, HHSC provides facilities management.

Eligibility Determination

Within the framework of state and federal regulations, HHSC determines eligibility for health and human services programs, including children's and adult Medicaid programs, Supplemental Nutritional Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and CHIP.

In addition to these main functions, HHSC also collaborates with DADS on the Medicaid Eligibility for Elderly and People with Disabilities program. In this program, HHSC determines the financial eligibility and DADS determines the physical need.

Medicaid Service Delivery

HHSC is the single state agency for Medicaid in Texas. To ensure clients receive efficient and cost-effective medically necessary services, HHSC implements the federal-state Medicaid program. Largely administered through contracts with multiple managed care organizations, HHSC oversees this process and other delivery systems, such as fee-for-service.

Specific functions unique to this program area include: developing client benefits policies and ways to maximize federal funds; maintaining the Medicaid State Plan, rules, and communications with the Centers for Medicare & Medicaid Services; and coordinating Medicaid long-term care services with DADS.

HHSC also operates the Texas Medicaid Medical Transportation Program, which provides free transportation or travel reimbursement to Medicaid clients for medical and dental appointments.

Other Social Services

Community-based Support

HHSC provides targeted services that enable clients to become more self-sufficient, healthier, and fiscally responsible. Through contracts with faith and community based organizations, HHSC provides services such as emergency shelter and support to victims of domestic violence, marriage and relationship education to eligible clients, and medical assistance and social services to eligible refugees.

Emergency Assistance

HHS System agencies work through the HHS System Emergency Council to respond to the demands of a particular emergency or disaster. Given the size of the state and the complexity of health and human service delivery, especially in a disaster situation, coordination ensures a prompt and effective response.

HHSC works with the Texas Division of Emergency Management and the federal government to determine emergency eligibility for SNAP, TANF, and Medicaid benefits to qualified clients. HHSC works with the agencies inside the HHS System, as well as outside partners, such as the Red Cross and Salvation Army, to coordinate essential supplies. HHSC also provides long-term, case management services to eligible recipients impacted by natural disasters and participates in post-disaster recovery plans with the Texas Division of Emergency Management.

Detect and Deter Fraud, Waste, and Abuse

Created by the Legislature in 2003, the Office of Inspector General (OIG) protects the integrity of health and human services programs in Texas, as well as the health and welfare of program

clients. To accomplish this, OIG oversees health and human services activities, providers, and clients through compliance and enforcement activities designed to identify and reduce fraud, waste, or abuse and to improve the efficiency and effectiveness of programs throughout the HHS System. OIG operates an online reporting system and toll-free hotline to receive reports of fraud, waste and abuse from the public and state employees.

B. Do your key functions continue to serve a clear and ongoing objective? Explain why each of these functions is still needed. What harm would come from no longer performing these functions?

HHSC's key functions continue to serve clear and ongoing objectives in providing System oversight and fulfilling its designation as the state's single Medicaid agency. HHSC has the primary responsibility for:

- providing HHS System oversight, including strategic direction and consolidated administrative support;
- delivering health and human service programs, including Medicaid, CHIP, TANF, SNAP, disaster assistance and family violence support; and
- preventing fraud, waste, and abuse within the HHS System.

These key functions represent a comprehensive approach to overseeing the HHS System, preventing duplication of efforts and cost inefficiencies, and providing a coordinated service delivery system. Removing HHSC's leadership, oversight, and coordination responsibilities would likely result in wasted federal funds.

In addition, through its program delivery function, HHSC ensures that eligible clients receive needed medical, nutritional, and financial assistance. The state must meet federal guidelines for processing applications accurately and within specified timeframes. HHSC implements the joint federal-state Medicaid program and no longer performing this function would result in low-income Texans not receiving needed services.

Finally, through OIG, HHSC improves health and human services programs, ensuring sound use of federal funds and safeguarding the state from risk. This function ensures accountability in the health and human services programs, as well as the health and welfare of the recipients of those programs, by identifying, communicating and correcting activities of waste, fraud or abuse in Texas.

The Guide to Agency Programs section of this report contains additional detail relating to the continuing need of each HHSC function.

C. What evidence can your agency provide to show your overall effectiveness and efficiency in meeting your objectives?

To ensure quality outcomes in all program areas, HHSC regularly reviews and evaluates its own performance, addressing significant issues raised through the process. In addition to the Legislative Budget Board (LBB) approved performance measures, the following are several ways HHSC ensures efficient and effective System oversight and program delivery. Additional detail explaining program- and division-specific methods for ensuring effectiveness and efficient service delivery can also be found in the Guide to Agency Programs section of this report.

Stakeholder Feedback

HHSC actively surveys clients, employees, and stakeholders to evaluate effectiveness and efficiencies. For example, HHSC conducts Medicaid and CHIP client surveys to measure overall quality of care and access to care, as well as satisfaction with care, benefits, and health plans. To assess issues internal to the agency, HHSC regularly surveys its employees to gauge employee satisfaction and customer service.

Also, through regular open meetings the public has an ongoing outlet to comment on potential changes in policy or rule, and to raise concerns with program delivery across the HHS System. In addition, HHSC facilitates internal communication and improves agency operational efficiency by convening work- and stakeholder groups to identify areas of change and suggest solutions for leadership to consider and implement.

By continually involving stakeholders in the policy development process, the Executive Commissioner and agency staff have a clear channel to hear outside concerns from a broad spectrum of system participants. This process allows concerns to be heard, investigated, and resolved, ensuring ongoing accountability.

Internal and External Program Evaluation

HHSC conducts legislatively required reports, including an Annual Report and Strategic Plan, which evaluate specific programs and services and identify areas for improvement. In addition, regular reporting to the Legislative Budget Board tracks the agency's success meeting certain performance measures.

Supplemental to the legislatively required reports, HHSC also contracts with external review organizations to gauge program success and identify areas for improvement. HHSC uses Business Process Reviews, an internal audit function, and OIG to identify inefficiencies in meeting HHSC objectives. In addition, HHSC cooperates with external audits conducted by state and federal agencies, such as the State Auditor's Office, and the federal Department of Health and Human Services and Centers for Medicare & Medicaid Services. These processes

serve as an internal check and balance, apprising the Executive Commissioner and other senior-level staff of programmatic inefficiencies and ensuring accountability.

Executive Management Briefing/Operational Planning

Separate from program evaluation, HHSC uses an Executive Management Briefing and Operational Planning processes to ensure that the agency achieves its oversight and programmatic responsibilities. Through these processes, each agency program identifies key objectives to improve service delivery to clients and establishes measures to monitor each key objective.

Comparison Studies

HHSC participates in federally required surveys and performance reports that allow HHSC to place Texas' performance in context of what other states achieve. These comparisons enable HHSC to identify best practices and incorporate them into Texas programs. For example, the Medicaid program participates in the Consumer Assessment of Healthcare Providers and Systems, Healthcare Effectiveness Data and Information Set, and the Review of Contractor Quality Assessment and Performance Improvement. Medicaid also has an independent External Quality Review Organization, as required by federal law, to assess managed care performance for beneficiaries.

Complaint Data Monitoring

The HHSC Office of the Ombudsman compiles complaint data for the HHS System and reports such information to the Executive Commissioner monthly. Beyond addressing agency-specific issues, this system-wide reporting process allows HHSC, in its leadership and oversight role, to identify trends or systemic issues that may need to be addressed comprehensively across the HHS System.

D. Does your agency's enabling law continue to correctly reflect your mission, objectives, and approach to performing your functions? Have you recommended changes to the Legislature in the past to improve your agency's operations? If so, explain. Were the changes adopted?

The Legislature created HHSC in 1991 by H.B. 7, 72nd Legislature, First Called Session, and its enabling statutes were codified in Chapter 531 of the Government Code in 1995 by S.B. 959, 74th Legislature, Regular Session. Section 531.002 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, Section 531.021 designates HHSC as the state agency to administer federal medical assistance, or Medicaid, funds.

In 2003, in H.B. 2292, 78th Legislature, Regular Session, the Legislature consolidated 12 health and human services agencies into the five agencies that make up today's health and human services system: HHSC, DADS, DARS, DFPS, and DSHS. The 2003 changes clarified HHSC's operational responsibilities and expanded its oversight of the health and human services system.

Since the consolidation of health and human services, HHSC has not recommended any changes to its core responsibilities and operating principles.

The information below lists some of HHSC's recommendations to accomplish these goals. Additional detail on past legislative initiatives, although not necessarily directed by the agency, is contained in the Statutory Authority and Recent Legislation section of this report.

Abolishment of Certain Advisory Committees

While the health and human services agencies were reorganized from 12 to five agencies in 2003, a multitude of advisory committees connected to the legacy agencies remained. Agency staff worked with legislators to determine a process by which the committees could be assessed for continuing need and combined or eliminated. House Bill 2292 set forth parameters by which certain advisory committees could continue and abolished all advisory committees not meeting those guidelines. The Executive Commissioner was granted authority to certify which advisory committees were exempt from abolition and the authority to appoint advisory committees as needed was preserved.

Elimination of Obsolete or Redundant Required Reports

No process currently exists for HHSC to evaluate the ongoing usefulness and effectiveness of reports required by health and human services agencies. As a result, reports that are redundant, outdated, or no longer useful to policymakers remain in statute and agency staff time and resources are ineffectively used to compile some of these reports. In response to this issue, HHSC worked with members of the Legislature to attempt to pass a bill outlining a process by which reports would be assessed for usefulness and recommended for deletion.

E. Do any of your agency's functions overlap or duplicate those of another state or federal agency? Explain if, and why, each of your key functions is most appropriately placed within your agency. How do you ensure against duplication with other related agencies?

House Bill 2292 reorganized the state health and human services system to consolidate organizational structures and functions, eliminate duplicative administrative systems, and streamline processes and procedures to maximize efficiencies across the agencies. The bill realigned operations of the existing 12 health and human services agencies by consolidating similar functions within five agencies.

As similar service populations and interdependent decision making exist across program areas, coordination amongst the HHS System agencies is key. And, although further streamlining across the HHS System is likely still needed to completely capture the intent of the H.B. 2292 consolidation efforts, duplication of efforts was largely eliminated.

House Bill 2292 transformed HHSC from an oversight and coordination agency without direct authority into an agency with oversight and operations responsibility. Clearly defined in H.B. 2292, HHSC's functions do not duplicate the functions of other state and federal agencies, as is detailed below.

HHS System Oversight

Unique to Texas' health and human services delivery system, HHSC's leadership and system oversight function is not performed by other state or federal agencies. Through H.B. 2292, the Legislature clarified HHSC's responsibility and authority for leading and overseeing the HHS agencies to ensure that they function as a System. Additionally, the legislation mandated HHSC to develop and implement consolidated support services for the HHS System. HHSC serves as the central provider to the other health and human services agencies for support services, including human resources, civil rights, procurement, strategic planning, complaint analysis, and leasing and facilities management functions. In addition, IT and legal functions exist within each agency; however, HHSC maintains system operational oversight of such key functions.

Eligibility Determination

HHSC is the sole agency responsible for determining health and human services program eligibility. Eligibility determinations for certain programs require coordination with other state and federal agencies, including HHS System agencies, namely DADS and DFPS, the Texas Workforce Commission, and the federal Social Security Administration. For example, eligibility for Medicaid for the Elderly and People with Disabilities is determined in two parts. HHSC determines the financial eligibility and DADS determines the physical need. In order for clients to receive services and for providers to receive payment from Medicaid, eligibility information must be coordinated with both agencies. HHSC also coordinates Medicaid eligibility policies and benefits with DFPS. DFPS places children and youth under age 21 in conservatorship, which results in automatic Medicaid enrollment.

Medicaid Service Delivery

HHSC expanded responsibility for implementing the Medicaid and Children's Health Insurance Program. Certain aspects of implementing these federal healthcare programs require 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 Centers for Medicare & Medicaid Services to develop and maintain the Medicaid State Plan and state plan amendments. Additionally, HHSC has oversight over the Long-term Care Services and Support programs administered by DADS.

Other Social Services

HHSC's efforts promoting self-sufficiency and safety functions do not overlap or duplicate the functions performed by any other state agency. For certain services, HHSC may contract with another state agency to directly provide that service. For example, HHSC contracts with the DSHS to provide health screening services to eligible refugees.

None of the HHSC and HHS System disaster assistance functions duplicate those of another state or federal agency. The Texas Division of Emergency Management (TDEM, formerly the Governor's Division of Emergency Management), with the Federal Emergency Management Agency, determine which agencies participate in the delivery of services and public assistance available to presidentially declared disasters. TDEM is charged with designing and implementing a comprehensive emergency plan for the state and part of that plan is to ensure roles and responsibilities are clearly understood and duplication of services does not occur.

The temporary assistance during disasters key function is most appropriately placed within HHSC because, as the agency responsible for determining financial and medical assistance eligibility on a regular basis, HHSC has the expertise to provide these services in demand following a disaster in the expedited timeframe and in response to the dramatically increased need for services.

Duplication of services does not occur because HHSC is the only agency that provides financial and medical assistance services such as SNAP (formerly known as Food Stamps), TANF and Medicaid. Following disasters, disseminating information to the populations affected and to those concerned about loved ones, as well as to volunteers, is especially important and duplication in this area is actually desired. However, the information must be accurate. Contracted by HHSC, the 2-1-1 Information and Referral service operates throughout the year and is well recognized for the broad information it provides, and utilization of 2-1-1 services increases dramatically following a disaster.

Detect and Deter Fraud, Waste, and Abuse

House Bill 2292 created OIG and charged it with investigating, reviewing, and auditing fraud, waste, or abuse within all health and human services programs. In doing so, OIG works closely with all health and human services agencies and programs, and establishes protocols for the system agencies to refer any information related to fraud, waste, and abuse to the OIG for review and investigation. In addition, OIG works closely with the Office of the Attorney General (OAG) Medicaid Fraud Control Unit, and regularly refers cases to OAG. OIG also coordinates with local, state, and federal regulatory and law enforcement agencies in the course of conducting provider, recipient, and other types of investigations. No such function exists elsewhere within the HHS System.

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, its structure and role within Texas' HHS System remain unique. The following examples describe major differences in how other states provide health and human services.

Consolidated Health and Human Services System

Texas is one of the only states with a consolidated health and human services system. In most other states, each health and human services agency administers its own support services, such as human resources and information technology. Texas is also one of the only states to outsource some support services, such as HR.

Eligibility Determination

Whereas Texas determines program eligibility at the state level, through HHSC, some states provide funding directly to counties, thus eligibility determination exists at the local level.

Medicaid Service Delivery

Medicaid healthcare delivery models vary from state to state. Texas primarily relies on a managed care model, a system in which a single provider or organization oversees patient care. Many state Medicaid programs include managed care components as a way to improve quality and control costs.

However, other states deliver services through a direct fee-for-service plan under which providers receive a payment for each unit of service they provide. Texas has multiple managed care companies that contract with the state to provide health care to Medicaid clients. In addition, Texas Star Health is a statewide program providing healthcare services to children in foster care through one managed care organization − an approach that improves consistency and coordination of care.

Other Social Services

Social service program delivery varies widely among states. Generally, some states directly provide needed services, whereas Texas and others provide the services by contracting with community based organizations. For example, HHSC contracts with the Texas Council on Family Violence to provide training and technical assistance for the Family Violence Program.

Many states have a similar disaster assistance plan in place. Structurally, these plans rely on the Governor to request the president to declare a disaster and have a comprehensive emergency response plan that is directed by the Governor's office or its designee. Respective

state health and human service agencies have significant responsibilities in these state plans due to their roles in protecting public health and providing human services in general and specifically in response to disasters.

Detect and Deter Fraud, Waste, and Abuse

All states operate a program to detect and deter fraud, waste, and abuse in their health and human services programs. However, the structure of such programs differs. For example, some states may locate this function within the state Medicaid agency or the state Attorney General's office, or it may be an independent state agency. Additionally, some states focus this effort specifically on the state Medicaid program, whereas the HHSC OIG is responsible for detecting and deterring fraud, waste, and abuse across the HHS System.

G. What key obstacles impair your agency's ability to achieve its objectives?

The Health and Human Services Commission faces a variety of obstacles that impair its ability to most effectively and efficiently achieve its strategic objectives. These include the following.

Increased Need for Services

A number of changing societal dynamics impact service need. For example, the recent economic downturn created an increased need for services including Medicaid, the SNAP, and TANF. Natural disasters such as Hurricane Ike, flooding, and tornadoes also provide unpredictable caseload growth. And finally, the aging Baby Boom population will increasingly place demands on the Medicaid system.

Additionally, although Texas is not participating in the federal healthcare reform's Medicaid expansion, Medicaid caseloads may nonetheless increase as the federal "individual mandate' causes currently uninsured individuals to seek out coverage.

Federal Restrictions

Changing federal mandates and complex federal regulations without clear implementation guidance are and will continue to be a challenge for HHSC and the HHS System. Federal legislation also imposes "maintenance of effort' requirements that restrict the State's ability to adjust eligibility standards or to modify the Medicaid program to respond to evolving populations and economic conditions.

Another ongoing issue is that the Centers for Medicare & Medicaid Services (CMS) focus primarily on the fee-for-service delivery of Medicaid benefits. Texas, however, like many other states, is increasingly using a managed care service delivery model, resulting in difficulty addressing process differences. Delayed timelines in CMS' process for approving State Plan

Amendments and waivers and providing guidance to Texas also creates an obstacle, as new regulations are often lengthy, resulting in implementation delays.

Technology

House Bill 1516, 79th Legislature, 2005, mandated the consolidation of 31 data centers (including those used by the five HHS agencies) into one statewide data center. However, since data center consolidation, numerous operational and billing issues have occurred, hindering the HHS System's ability to meet System-wide business needs through automation. In addition to operational issues caused by the data center consolidation, the contracted vendor's inability to proceed with the transformation process has prevented HHS agencies from taking advantage of technological advances to modernize the many systems currently in place. Such modernization would increase interoperability, reduce maintenance costs, and streamline operations by reducing data duplication. Until the vendor's performance complies with the State's requirements and the data center consolidation is complete, the challenges to achieving IT efficiencies within the HHS System will remain.

Technological limitations due to the normal obsolescence cycle of hardware and software in a large state agency are also an obstacle to HHS and HHSC efficiencies and effectiveness. New technology can be expensive to purchase and install in a timely manner that does not disrupt productive work.

Each HHS System agency maintains confidential client information. Numerous laws and policies govern the way that HHS is expected to protect this information during its use, transport, processing, and storage. The HHS System has a large number of database and case management systems, a majority of which have been in production for numerous years and now have outdated security models. Similarly, foreign attacks to the HHS System remain a challenge, as a successful security breach could compromise confidential data.

Resources

While staffing issues are ever-present across all agencies, inability to maintain or increasing experienced personnel at levels to match caseload growth inhibits HHSC's ability to deliver benefits. Compounding this challenge, staff retention, high turnover rates, and a less tenured eligibility workforce make it difficult to effectively respond to caseload increases and maintain performance.

Shortage of healthcare professionals is not just an individual state crisis, but a national public health crisis. The increased cost of medical education, comparatively few medical education institutions, systemic incentives towards specialization and away from primary care, and legal limits on other healthcare professionals' roles join to create a national healthcare professional shortage. In Texas, the shortage is especially acute due to the state's size and rural geography: it is difficult to recruit and retain healthcare professionals willing to live in small and isolated communities that may not have access to the latest technology. Given the shortage of

healthcare professionals in general, the specific need for healthcare professionals willing to deliver services to Medicaid and other HHS clients is compounded by low reimbursement rates. Although largely outside of HHSC's control, the small populations of healthcare professionals willing to treat clients on public insurance presents a significant challenge.

H. 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).

Federal Healthcare Reform

The federal Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act became law in 2010. Referred to as federal healthcare reform, these laws:

- include a mandate for most individuals to have health insurance;
- expand Medicaid coverage of certain populations to 133 percent of FPL (subject to the U.S. Supreme Court's decision, below);
- establish state-based insurance exchanges for individuals and small employers;
- require streamlined eligibility determinations among Medicaid, CHIP, and insurance exchanges;
- establish new community based options and programs; and
- provide flexibility for states to change provider reimbursement systems.

The scope and effect of federal healthcare reform has been limited by a decision of the United States Supreme Court holding that the expansion of Medicaid coverage is optional, not mandatory. Additionally, the federal government has delayed implementation of other parts of federal healthcare reform, such as the employer mandate and insurance exchanges.

Texas is not implementing the Medicaid expansion and is not establishing a state-run insurance exchange. However, the federal healthcare reform effort is expected to continue to cause the State budgetary and regulatory challenges in the future.

Pending Litigation

Children's Medicaid Services

In *Alberto N. v. Janek*, children with complex disabilities and chronic health conditions allege they have been denied medically necessary in-home Medicaid services, including private duty nursing, personal care services, and durable medical equipment. The parties entered into partial settlements in 2002 and 2005 resulting in substantial changes to agency policy and practice, but plaintiffs complained in 2009 that more changes are required. The parties are attempting to resolve the contested issues informally.

In *Frew v. Janek*, a class consisting of "all present and future Texas Medicaid recipients who are under the age of 21, and therefore eligible for [Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)] services, but who have not received the entire range of EPSDT services to

which they are entitled, except anyone who has knowingly and voluntarily refused EPSDT services" alleges that Texas Medicaid does not satisfy the requirements of the federal EPSDT program. A federal court entered a consent decree in 1996 that required specific systemic changes to the Medicaid program for children under age 21. Following disputes about HHSC's compliance with the consent decree, the agency is now operating under Corrective Action Orders and their associated Corrective Action Plans in 10 functional areas. The agency is under court supervision through at least 2015.

Women's Health Services

In *Planned Parenthood v. HHSC*, Planned Parenthood challenges an HHSC administrative rule that prohibits payments from the Medicaid Women's Health Program (Medicaid WHP) to providers that perform or promote elective abortions or that affiliate with entities that perform or promote elective abortions (the affiliate rule). A state district court entered an injunction in November 2012 prohibiting HHSC from enforcing the affiliate rule and from terminating the Medicaid WHP as long as federal funding continued. The case is currently on appeal, but federal funding – and the Medicaid WHP – terminated on December 31, 2012.

When the federal Centers for Medicare & Medicaid Services terminated federal funding for the Medicaid WHP, the State established the Texas Women's Health Program (Texas WHP), a completely state-funded program. Planned Parenthood sued again in *Balquinta and Planned Parenthood v. DSHS and Janek*, now challenging the administrative rules that prohibit payments from the Texas WHP to providers that perform or promote elective abortions or that affiliate with entities that perform or promote elective abortions. In January 2013, the state court denied Planned Parenthood's request for an injunction to prevent enforcement of the Texas WHP rule, but also denied the State's request to dismiss the case. The case is currently on appeal.

Supplemental Nutrition Assistance Program

In *Gonzalez v. Janek*, applicants for SNAP benefits claim that HHSC fails to make eligibility decisions within the time periods required by federal law and that the application process discourages widespread distribution of benefits. A state court denied HHSC's motion to dismiss the case in January 2011, but that decision was reversed on appeal.

Managed Care Expansion and Pharmacy Carve-In

Four separate lawsuits challenged HHSC's Medicaid Transformation Waiver and the expansion of Medicaid managed care, but only two are still pending. In *Southwest Pharmacy Solutions d/b/a American Pharmacies v. THHSC and Suehs*, pharmacy providers challenged HHSC's waiver application, complaining that the application was a rule and that HHSC failed to provide the interested public with adequate notice and opportunity for comment. A state district court dismissed the case in 2011 and an appellate court affirmed the dismissal in June 2013.

In *Southwest Pharmacy Solutions d/b/a American Pharmacies v. HHSC and Suehs*, a separate case, pharmacy providers asked a state court to prevent HHSC from including pharmacy

services in Medicaid managed care and to declare the reimbursement rates paid by pharmacy benefit managers invalid. The court dismissed the case in 2012 and an appellate court affirmed the dismissal in July 2013. The providers may appeal the case to the Texas Supreme Court.

Medical Transportation

In *Advocates for Patient Access v. HHSC*, providers challenge an HHSC administrative rule requiring a child to be accompanied by a parent or guardian in order to receive transportation services. A state court entered an injunction preventing enforcement of the rule in May 2012 and expanded the injunction in August 2012. The appellate court affirmed the injunction in March 2013. HHSC is again seeking dismissal of the case and dissolution of the injunction, but is currently prevented from implementing its administrative rules.

Medicaid Fraud and Abuse

In *Harlingen Family Dentistry v. HHSC and OIG*, a dental provider challenges the Office of Inspector General's authority to place Medicaid payments on hold during an investigation. The lawsuit is in its initial stages.

HHS System Litigation

HHSC is sometimes included as a party to litigation involving the HHS System agencies and programs operated under HHSC's oversight. Although HHSC is a party to these cases, their principal impact would be on another HHS System agency.

Pre-Admission Screening and Resident Review

In *Steward v. Perry*, individuals with intellectual or developmental disabilities who are living in nursing facilities claim the State's pre-admission screening and resident review process does not satisfy federal requirements. The U.S. Department of Justice intervened in the case. An interim settlement agreement was approved by S.C.R. 2, 83rd Legislature, First Called Session, 2013.

Foster Care

In *M.D. v. Perry*, individual foster children allege that the Texas foster care system fails to protect foster children from harm. There is a pending motion to certify the case as a class action.

State Supported Living Centers

In *G.G.E. v. Perr*y, adults who were placed in State Supported Living Centers as children now claim they have been involuntarily institutionalized without any periodic judicial review of whether they require institutionalization. A state court denied the State's motion to dismiss and the case is currently on appeal.

Finally, there are other lawsuits against the HHS System agencies that may have an impact on those agencies' key functions, but that do not include HHSC as a party. Those lawsuits are not reported here; they will be included in the agencies' Self-Evaluation Reports.

I. What are your agency's biggest opportunities for improvement in the future?

The Health and Human Services Commission has many opportunities to improve stakeholder relations, including the way in which it interacts with members of the public and elected officials. Strengthening such relationships will provide needed direction in the long-term vision of the HHS System.

Additional opportunities for improvement are directly related to the identified obstacles to HHSC efficiency and effectiveness, some of which are discussed below. Finally, major opportunities for improvement both within the HHS System and within HHSC are raised in the Major Issues section of this Report.

Technology

Enhanced technology is a significant opportunity for improvement. In addition to ensuring the HHS System's technology is secure and able to prevent a security breach, enhanced technology can increase the efficiency and effectiveness of delivering services to clients. Some examples include:

- Implementation of a data warehouse system and other health information technologies could help the agency measure and improve client health outcomes, measure programs, and better forecast caseload and financial impacts.
- New technology to track contract deliverables and monitor contract requirements. These changes would allow staff to increase their capabilities to monitor vendors more efficiently and ensure that funds are expended properly and health outcomes are improving through disease management.
- In its March 2010 report on SNAP, the State Auditor's Office (SAO) made several recommendations on how HHSC can improve its processing of SNAP applications through technology enhancements. The recommendations included better utilization of e-mail or the Internet to more effectively communicate with clients, including allowing clients to use this technology to check the status of their applications. Additionally, the SAO recommended creating electronic case files for the approximately 80 percent of SNAP cases that are still maintained as paper files.

Resources

Improving staff retention and workforce stabilization will increase staff tenure, resulting in greater accuracy and productivity. HHSC continues to make investments in its staff by soliciting feedback through surveys such as the Organizational Excellence survey and recognizing individuals and departments for exemplary work. In addition, each department is provided a statistical analysis of its performance to identify strengths and weaknesses in its specific area, and to benchmark against HHSC in its entirety. Other agency initiatives, such as the HHSC Leadership Development Program, work to reward and further develop existing staff.

The healthcare professional shortage is largely outside HHSC's control. However, HHSC will continue to conduct outreach and education programs about the importance of participating in Medicaid, identify recruitment and retention policies, and recommend innovative programs such as loan repayments for primary care physicians to attract healthcare professionals.

J. In the following chart, provide information regarding your agency's key performance measures included in your appropriations bill pattern, including outcome, input, efficiency, and explanatory measures.

Health and Human Services Commission
Exhibit 2: Key Performance Measures — Fiscal Year 2012

Key Performance Measures	Target FY 2012	Actual Performance FY 2012	% of Annual Target FY 2012
Average Medicaid and CHIP Children Recipient Months Per Month	3,166,648	3,239,521	102.30%
Average Monthly Number of Eligibility Determinations	891,406	861,069	96.60%
Average Cost Per Eligibility Determination	$47.64	$44.16	92.70%
Percent Poverty Met by TANF, SNAP, and Medicaid Benefits	87.61%	75.50%	86.18%
Total Value of SNAP Distributed	$5,561,000,000	$6,035,619,417	108.53%
Average Medicaid Acute Care (Includes STAR+PLUS) Recipient Months Per Month	3,620,829	3,649,469	100.79%
Average Number of Legal Permanent Residents Recipient Months Per Month	83,812	16,420	19.59%
Average Supplemental Medical Insurance Part B (SMIB) Recipient Month Per Month	558,424	590,593	105.76%
Average Supplemental Medical Insurance Benefits (SMIB) Premium Per Month	119	105	88.37%
Average Aged and Medicare-eligible Recipient Months Per Month: STAR+PLUS	132,224	182,980	138.39%
Average Disabled and Blind Recipient Months Per Month: STAR+PLUS	131,072	155,922	118.96%
Average Cost Per Aged and Medicare-eligible Recipient Month: STAR+PLUS Acute Care	$162.78	$94.26	57.91%
Average Number of Non-citizens Recipient Months Per Month	10,051	9,797	97.47%

Total Medicaid Prescriptions Incurred	34,682,808	35,096,145	101.19%
Average Number of Texas Health Steps (EPSDT) Comprehensive Care Program Recipient Month per Month (Fee-for-Service only)	554,929	478,376	86.20%
Medicaid Acute Care Recipient Months Per Month: Managed Care	2,705,372	2,893,407	106.95%
Average CHIP Programs Recipient Months Per Month (Includes All CHIP Programs)	584,161	606,813	103.88%
Average CHIP Programs Benefit Cost with Prescription Benefit Per Recipient Month (Includes All CHIP Programs)	$122.61	$157.94	128.81%
Average Perinate Recipient Months Per Month	36,981	37,104	100.33%
Total Number of CHIP Prescriptions (Includes All CHIP Programs)	2,490,354	2,434,693	97.76%
Average Cost Per CHIP Prescription (Includes All CHIP Programs)	$63.18	$73.46	116.27%
Average Number of TANF Recipients Per Month	118,829	103,196	86.84%
Average Number of State Two-Parent Cash Assistance Program Recipients Per Month	5,402	4,220	78.12%
Average Monthly Grant: TANF	$71.24	$70.02	98.29%
Average Monthly Grant: State Two-Parent Cash Assistance Program	$68.49	$66.87	97.63%
Number of Refugees receiving Contracted Social Services, Financial Assistance, and Medical Assistance	20,000	15,211	76.06%
Number of Persons Served by Family Violence Programs/Shelters	80,940	79,053	97.67%
Health and Human Services Average Cost Per Person Receiving Emergency Services through the Family Violence Program	$811.10	$785.37	96.83%
Number of Persons Receiving Pregnancy Support Services as an Alternative to Abortion	16,000	21,608	135.05%

III. HISTORY AND MAJOR EVENTS

Provide a timeline of your agency's history and key events, including:

- **the date your agency was established;**
- **the original purpose and responsibilities of your agency;**
- **major changes in responsibilities or statutory authority;**
- **changes to your policymaking body's name or composition;**
- **significant changes in state/federal legislation, mandates, or funding;**
- **significant state/federal litigation that specifically affects your agency's operations; and**
- **key changes in your agency's organization (e.g., a major reorganization of the agency's divisions or program areas).**

Historical Overview

Congress established the Medicaid program under Title XIX of the Social Security Act of 1965 to pay medical bills for low-income individuals who have no other way to pay for care. Medicaid program expenses and the number of Americans served have grown beyond initial expectations. Congress transformed Medicaid from a narrowly defined program for persons eligible for cash assistance into a large insurance program with complex eligibility rules. Today, the Health and Human Services Commission (HHSC) serves as the State's designated agency for delivering the federally mandated Medicaid program.

In addition, HHSC oversees the Health and Human Services System by coordinating delivery of other health-related programs administered by four departments. Outlined below are the major events in HHSC's history, as well as major events in the programs (mainly Medicaid) administered by HHSC. Events relating to the establishment of today's Health and Human Services (HHS) System are highlighted in bold.

1961 The Legislature creates the Medical Assistance Program.

1964 The federal government creates the food stamp program.

1967 Texas begins participation in the Medicaid program.

1972 Federal law establishes the Supplemental Security Insurance program, which provides federally funded cash assistance to low-income people age 65 and older and those with disabilities.

1973 Texas implements the food stamp program statewide.

1983 The Legislature creates the Texas Health and Human Services Coordinating Council to manage HHS agencies and assist in developing a more effective service delivery system. Ex Officio in nature, the Council has no formal policymaking authority.

1990 Texas' initial managed care program, State of Texas Access Reform (STAR), begins, benefitting low-income families, non-disability-related children, and pregnant women.

1991 The Legislature abolishes the Health and Human Services Coordinating Council and creates the Texas Health and Human Services Commission (HHSC) to oversee the State's major health and human services agencies:

- **Texas Department on Aging;**
- **Commission on Alcohol and Drug Abuse;**
- **Commission for the Blind;**
- **Commission for the Deaf and Hearing Impaired;**
- **Interagency Council on Early Childhood Intervention;**
- **Department of Health, Department of Human Services;**
- **Juvenile Probation Commission;**
- **TDMHMR;**
- **Department of Protective and Regulatory Services;**
- **Texas Rehabilitation Commission; and**
- **Texas Youth Commission.**

Separate governing boards for each of the agencies remain, while HHSC provides general System oversight.

The Legislature authorizes the first Medicaid managed care pilot program.

1993 HHSC becomes the single state agency for the Medicaid program.

The Legislature removes the Texas Youth Commission from the list of health and human services agencies.

Texas implements a Medicaid managed care pilot project, known as LoneSTAR, in Travis County for acute care services; the program is later known as STAR.

Texas implements the Medicaid Primary Care Case Management (PCCM) pilot for acute care services in Chambers, Jefferson, and Galveston Counties.

1995 The Legislature authorizes HHSC to expand Medicaid managed care to most urban areas across the state.

1996 Congress enacts the Personal Responsibility and Work Opportunity Act of 1996, separating cash assistance and Medicaid. If households need Temporary Aid for Needy Families (TANF) cash assistance and Medicaid, they must apply for both.

1997 The Legislature requires HHSC to investigate fraud, waste, and abuse in the Health and Human Services System, creating the Office of Inspector General.

The federal government establishes a state Children's Health Insurance Program (SCHIP), under Title XXI of the Social Security Act.

1998 Texas implements Phase I of SCHIP, providing Medicaid to children ages 15 to 18 under 100 percent of the federal poverty level (FPL). This phase of the program operates from July 1998 through September 2002.

Texas implements the STAR+PLUS pilot in the Harris service area. The nationally recognized model integrates acute care and long-term care services and support.

1999 Texas implements the Medicaid NorthSTAR behavioral health pilot in the Dallas service area.

The Legislature authorizes Phase II of SCHIP Program for children in families with incomes up to 200 percent of the FPL. This program is referred to as the Children's Health Insurance Program (CHIP).

2000 Coverage under Phase II of SCHIP program begins on May 1, 2000.

2002 The number of children enrolled in Medicaid grows sharply due to simpler Medicaid applications and six-month eligibility.

2003 **The Legislature consolidates the 12 major health and human service agencies into four new departments under the leadership of the Texas Health and Human Services Commission:**

- **Department of Aging and Rehabilitation Services;**
- **Department of Assistive and Rehabilitative Services;**
- **Department of Family and Protective Services; and**
- **Department of State Health Services.**

An Executive Commissioner replaces stand-alone boards and has rulemaking and policymaking authority over the entire HHS System.

TANF approvals begin to decline due to sanctions against adults not complying with the Personal 2-2 Responsibility Agreement, required for a child's parent or relative also approved for TANF.

2005 The Legislature directs HHSC to establish a five-year Medicaid demonstration project to expand access to women's preventive healthcare services. After federal approval, HHSC establishes the Medicaid Women's Health Program on January 1, 2007.

2006 The Legislature directs the implementation of the Medicaid Buy-In Program for Working Persons with Disabilities, which allows workers who have a disability to receive Medicaid by paying a monthly premium, based on income and other factors.

By December 2006, PCCM is included only in the Southeast region: Jefferson, Chambers, Orange, Hardin, and Liberty Counties.

2007 Texas expands STAR+PLUS from Harris service area to the following service areas: Bexar, Harris Expansion, Nueces, and Travis.

2008 Texas implements and HHSC administers the statewide Medicaid STAR Health model for children in state conservatorship.

Congress renames the food stamp program the Supplemental Nutrition Assistance Program (SNAP) effective Oct. 1, 2008.

2010 Congress enacts the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, and together they are called the Affordable Care Act (ACA). ACA makes significant changes to state healthcare programs and to the health insurance market, including mandating that all individuals have health insurance coverage. It provides individuals who earn up to and including 400 percent of the FPL to use subsidies to purchase health insurance coverage. ACA also expands Medicaid eligibility up to and including 133 percent of the FPL for individuals under age 65. Children ages 6 to 18 in families with income between 100 and 133 percent of the FPL shift from CHIP to Medicaid.

2011 The United States Supreme Court (SCOTUS) considers the constitutionality of two major provisions of ACA. Texas is among the 26 states represented in the lawsuit. On June 28, 2012, SCOTUS issues a decision on ACA provisions under consideration, ruling the ACA is constitutional.

On February 1, Texas expands STAR+PLUS to two new services areas: Dallas and Tarrant.

On September 1, Texas adds new counties to these service areas:

- STAR: Bexar, Harris, Jefferson, Lubbock, Nueces, Travis, and El Paso;
- STAR+PLUS: Bexar, Harris, Jefferson, Nueces, and Travis.

2012 On March 1, Texas expands STAR statewide and STAR+PLUS to all areas of the state, except the Medicaid rural service areas (MRSA).

- STAR: creates two new regions, the Hidalgo service area and the MRSA. PCCM ends.
- STAR+PLUS: expands into the El Paso, Lubbock, and Hidalgo service areas.
- This expansion includes prescription drugs benefits into STAR and STAR+PLUS, and inpatient hospital benefits into STAR+PLUS.

2014 September 1, 2014, Texas plans to expand STAR+PLUS to 164 counties in the STAR MRSA service area – Central, North East and West service areas.

ACA implementation begins.

IV. POLICYMAKING STRUCTURE

A. Complete the following chart providing information on your policymaking body members.

The Health and Human Services Commission Exhibit 3: Policymaking Body			
Member Name	**Term/ Appointment Dates/ Appointed by ___ (e.g., Governor, Lt. Governor, Speaker)**	**Qualification (e.g., public member, industry representative)**	**City**
Kyle L. Janek, M.D. Executive Commissioner	Appointed on September 1, 2012, by Governor Perry. Term expires February 1, 2015.	Board-certified anesthesiologist. Former State Senator and former member of the Texas House of Representatives.	Austin
Health and Human Service Council			
Jerry Kane, Council Chair	Appointed on June 30, 2009, by Governor Perry. Term expires February 1, 2015.	Public Member	Corpus Christi
Maryann Choi, M.D. Council Vice Chair	Appointed on May 4, 2011, by Governor Perry. Term expires February 1, 2017.	Public Member	Georgetown
Kathleen Angel	Appointed on May 4, 2011, by Governor Perry. Term expires February 1, 2017.	Public Member	Austin
James “Richard” Barajas	Appointed on April 24, 2013, by Governor Perry. Term expires February 1, 2019.	Public Member	Fort Worth
Manson B. Johnson	Appointed on June 30, 2009, by Governor Perry. Term expires February 1, 2015.	Public Member	Houston

Leon J. Leach, Ph.D.	Appointed on April 24, 2013, by Governor Perry. Term expires February 1, 2019.	Public Member	Houston
Thomas Craig Wheat	Appointed on April 24, 2013, by Governor Perry. Term expires February 1, 2019.	Public Member	Dallas
Teresa Durkin Wilkinson	Appointed on June 30, 2009, by Governor Perry. Term expires February 1, 2015.	Public Member	Midland
Vacant			

Appointed by the Governor, with the advice and consent of the Senate, the nine Health and Human Services (HHS) Council members serve staggered six-year terms, with the terms of three members expiring February 1 of each odd-numbered year. While HHS Council members represent the general public, individuals eligible for appointment must demonstrate an interest in and knowledge of financial and medical aid programs administered by the Health and Human Service system agencies, as detailed in Chapters 31 and 32 of the Human Resources Code.

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 entire Health and Human Services (HHS) system. The following five HHS System agency councils assist the Executive Commissioner in this system oversight role:

- Health and Human Services Council,
- Aging and Disability Services Council,
- Assistive and Rehabilitative Services Council,
- Family and Protective Services Council, and
- State Health Services Council.

Statutorily created by the 78th Legislature as part of the H.B. 2292 reorganization, the Health and Human Services Council supports the Executive Commissioner in developing policy and in rulemaking decisions specific to the functions of the Health and Human Services Commission (HHSC), including policies and rules governing Medicaid and the Children's Health Insurance Program (CHIP).

The Executive Commissioner provides briefings to the HHS Council at each quarterly meeting and works with the HHS Council Chair to call subcommittee meetings as needed. These meetings provide an effective forum for public input into HHSC-specific rules, policies, and budget priorities.

Rules and policies affecting service delivery and programs housed elsewhere in the HHS system originate within the respective department. Once drafted, the department's commissioner vets the change, seeking guidance from the related policy council; forwarding final recommendations to the HHSC policy advisor for review and final recommendation to the Executive Commissioner. The Executive Commissioner may make changes to the draft policy or rule and ultimately adopts the final product. Additional information, including membership and terms of the remaining four policy councils, can be found in the corresponding department's Self-Evaluation Report.

C. How is the chair selected?

The Governor appoints a member of the Council as the presiding officer (Council Chair), who serves at the pleasure of the Governor, as set forth in Section 531.407 of the Government Code. Agency policy requires the Council to elect a Vice Chair and also allows Council members to elect any other necessary officers. Dr. Choi currently serves as the Council's Vice Chair. The Council also established a subcommittee that focuses on eligibility issues, which is chaired by Kathleen Angel.

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

The Executive Commissioner serves as the ultimate rule and policymaking authority for the entire HHS system. However, as previously discussed, five advisory councils support this decision-making process. This structure − a single Commissioner overseeing an enterprise of five system agencies − is unique in Texas government. Furthermore, the approach of having standing advisory councils that represent each agency's functions is also unique.

E. In general, how often does your policymaking body meet? How many times did it meet in FY 2012? In FY 2013?

The Health and Human Services Council must meet at least quarterly, per Section 531.407 of the Government Code. The Health and Human Services Council met five times in 2012, and is scheduled to meet five times in 2013. In addition to these regular meetings, the Council's eligibility subcommittee met once that year, the chairs of each council met twice, and members from all five councils attended an annual coordination meeting.

Although advisory in nature, the HHS Council is subject to the Open Meetings Act, and the presence of a majority of members constitutes a quorum.

F. What type of training do members of your agency's policymaking body receive?

Statute, Government Code, Section 531.404, requires Health and Human Services Council members to complete training before participating as an official Council member. The training program consists of information on the following subjects:

- enabling legislation for the Health and Human Services Commission and the Health and Human Services Council;
- roles and functions of the Health and Human Services Commission and the Health and Human Services Council, including its advisory responsibilities;
- division of responsibility between the Executive Commissioner and the other HHS system agencies; and
- agency programs, rules, budget, and audit findings.

In addition to agency-specific subject matter training, each Council member completes ethics training, as well as a review of procedures relating to the Open Meeting Act, Public Information Act, and the Administrative Procedures Act.

G. Does your agency have policies that describe the respective roles of the policymaking body and agency staff in running the agency? If so, describe these policies.

The Legislature created the Health and Human Services Council to assist the Executive Commissioner in developing rules and policies for the Health and Human Services Commission, including policies and rules governing the delivery of services and the rights and duties of individuals served by the Health and Human Services Commission. Purely advisory in nature, and unlike the boards that oversaw the legacy agencies before system consolidation in H.B. 2292, the Council does not have a direct role in agency operations. To ensure Council members understand this unique role, training covers guiding principles, operating procedures, as well as roles and responsibilities.

H. What information is regularly presented to your policymaking body to keep them informed of your agency's performance?

During each quarterly meeting, any called meetings, and any subcommittee hearings, the Executive Commissioner and senior agency staff brief the Health and Human Services Council on a variety of subjects, including the agency's performance, current priorities, and ongoing projects. Agency staff also apprises the Council of changes in federal law that affect service and program delivery at the state level. These briefings include items presented for Council action and items intended strictly to inform the Council.

The Council also reviews and recommends the agency's annual operating budget and audit plans developed by the Internal Audit division. Council members also receive, as needed, monthly newsletters, which detail agency activities, and email notifications regarding system changes or legislative updates.

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

Negotiated Rulemaking and Stakeholder Groups. All rulemaking initiatives include a comment period during which the agency receives comments on proposed draft rules or rule revisions. As a part of this process, the agency often establishes a stakeholder working group to obtain input before drafting rules and initiating the formal public comment period. Before implementing a major new initiative, staff may conduct stakeholder meetings across the state to gain additional feedback. For example, during the fall of 2012, staff from the Medical Transportation Program held public meetings before adopting a new delivery model. Also, the agency formally responds to all comments submitted.

Open Council Meetings. Seeking public input and stakeholder feedback is a key function for the Health and Human Services Council. Ideas presented to the Council better inform members as they make policy recommendations to the Executive Commissioner. The Health and Human Services Council's guiding principles include a focus on hearing the concerns and interests of consumers and constituents.

To ensure stakeholder input is included in all Health and Human Services Council functions, open public testimony, including written testimony, is a standing agenda item.

Advisory Committees and Task Forces. A number of advisory committees exist, most statutorily required, to assist in developing policy and rules. A listing of all advisory committees follows in Section J.

J. If your policymaking body uses subcommittees or advisory committees to carry out its duties, fill in the following chart.

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
Behavioral Health Integration Advisory Committee	No required membership size, but members must include individuals with behavioral health conditions who receive publically funded services and representatives of managed care organizations that offer behavioral health services. The Executive Commissioner (EC) appoints all members.	Seeks input on implementation of S.B. 58 (83R) and issues formal recommendations to HHSC regarding bill implementation.	Government Code 533.00255(e) (Statute expires 9/1/2017)
Children and Families, Council on	14 members representing the following areas: • the EC; • the commissioners of the Department of Aging and Disability Services (DADS), Department of Assistive and Rehabilitative Services (DARS), Department of Family and Protective Services (DFPS), and Department of State Health Services (DSHS); • the Commissioner of Education; • the executive director of the Juvenile Justice Department; • the executive director of the Texas Workforce Commission (TWC); • the director of the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI); • two public representatives who are parents of children who have received services from an agency represented on the council, appointed by the EC; and • two representatives who are young	Collaborates and leverages resources in the pursuit of efficient delivery of services to children, youth, and their families.	Government Code 531.801 Subject to Sunset review in 2019.

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
	adults or adolescents who have received services from an agency represented on the council, appointed by the EC.		
Children with Special Needs, Interagency Task Force for	18 members, including: • the Commissioner, the executive director or director, or a deputy or assistant commissioner of: o HHSC, designated by the EC; o DADS, designated by the DADS Commissioner; o DARS, designated by the DARS Commissioner; o the division of early childhood intervention services, designated by the DARS Commissioner; o DFPS, designated by the Commissioner of DFPS; o DSHS, designated by the Commissioner of DSHS; o Texas Education Agency (TEA), designated by the Education Commissioner; o the Texas Youth Commission, designated by the executive Commissioner of the Texas Youth Commission; o the Texas Juvenile Probation Commission, designated by the executive director of that agency; o TCOOMI, designated by the director of that office; and • a representative of a local mental health authority or a local mental retardation authority, appointed by the Governor; • two members of the house of representatives, appointed by the	Develops recommendations to improve the coordination, quality, and efficiency of services for children with special needs.	Health and Safety Code 115.001 (Sunset date 9/1/2015)

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
	speaker of the house of representatives; • two senators, appointed by the Lieutenant Governor; and • three parents or consumer advocates, one each appointed by HHSC, TEA, and the Texas Youth Commission.		
Children's Policy Council	17 members, appointed by the EC, including: • a person who is younger than 22 years of age and is a consumer of long-term care and health programs for children; • relatives of consumers of long-term care and health programs for children; • a representative from an organization that is an advocate for consumers of long-term care and health programs for children; • a representative from a state agency that provides long-term care and health programs for children; • a person from a private entity that provides long-term care and health programs for children; • a person from a public entity that provides long-term care and health programs for children; • a person with expertise in the availability of funding and the application of funding formulas for children's long-term care and health services; • a representative from a faith-based organization; • a representative from a nonspecialized community services	Assists health and human services agencies in developing, implementing, and administering family support policies and related long-term care and health programs for children.	Human Resources Code 22.035

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
	organization; and • a representative from a business that is not related to providing services to persons with disabilities.		
Consumer Direction Work Group	26 members, appointed by the EC and agency heads, and including: • representatives of the following agencies appointed by the chief executive officer of the agency: o HHSC; o DADS; o DARS; o DSHS; • consumers or potential consumers of the array of services provided through consumer direction under Section 531.051, jointly appointed by EC and the Commissioner of the health and human services agency that administers the program providing the service; • advocates for elderly persons who are consumers of the array of services provided to elderly persons through consumer direction, appointed by the EC; • advocates for persons with disabilities who are consumers of the array of services provided to persons with disabilities through consumer direction, appointed by the EC; • providers of services to be provided through consumer direction, appointed by the EC; • representatives of TWC, appointed by the executive director; • representatives of any other state agency as considered necessary by	Advises HHSC about the delivery of services through consumer direction in all programs offering long-term services and support.	Government Code 531.052

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
	the EC, appointed by the governing body of their respective agency; • representatives of any other state agency ,as recommended by the work group and approved by the EC, appointed by the governing body of the respective agency; and • any other public representative appointed by the EC.		
Domestic Violence, Task Force on	25 members to be appointed by the EC.	Develops recommendations relating to the coordination of healthcare services for young children and pregnant and postpartum women who are victims of domestic violence, including recommendations for improving early screening and detection and public awareness efforts.	Health and Safety Code 32.062 (Statute expires 1/1/2016)
Drug Utilization Review Board	10 members, five practicing physicians and five practicing pharmacists, appointed by the EC.	Promotes appropriate use of pharmaceuticals in the Medicaid/CHIP Vendor Drug Program through education of practitioners.	42 USC 1396r-8(g)(3)(A) (Agency rule sets review date as 8/31/2016)
Electronic Health Information Exchange System Advisory Committee	16 members appointed by the EC, representing the following areas: • Medicaid providers; • child health plan program providers; • fee-for-service providers; • at least one representative of the Texas Health Services Authority established under Chapter 182, Health and Safety Code;	Advises HHSC regarding the development and implementation of an electronic health information exchange system to improve the quality, safety and efficiency of healthcare services provided through Medicaid and CHIP.	Government Code 531.904 (Agency rule indicates committee will be abolished on 8/31/2013)

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
	• at least one representative of each health and human services agency; • at least one representative of a major provider association; • at least one representative of a healthcare facility; • at least one representative of a managed care organization; • at least one representative of the pharmaceutical industry; • at least one representative of Medicaid recipients and child health plan enrollees; • at least one representative of a local or regional health information exchange; and • at least one representative who is skilled in pediatric medical informatics.		
Executive Waiver Committee	21 members, appointed by the EC.	Provides HHSC with feedback on the hospital finance component of the waiver in order to understand the potential impact of changes to hospital funding anticipated by the waiver and to provide input on the feasibility of different implementation approaches for hospital funding under the waiver.	EC-created
Faith- and Community-based Initiatives, Interagency Coordinating Group for	25 members, designated in statute, including a member representing the following: • the Texas Department of Rural Affairs; • the Texas Commission on Environmental Quality; • the Texas Department of Criminal	Works across state agencies and with the OneStar Foundation to facilitate the removal of unnecessary interagency barriers to partnerships between agencies and faith- and community-based	Government Code 535.053

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
	Justice; • the Texas Department of Housing and Community Affairs; • TEA; • the Texas Juvenile Probation Commission; • the Texas Veterans Commission; • TWC; • the Texas Youth Commission; • the office of the Governor; • the Department of Public Safety; • the Texas Department of Insurance (TDI); • the Public Utility Commission of Texas; • the office of the Attorney General; • the Department of Agriculture; • the office of the Comptroller; • the Department of Information Resources; • the Office of State-Federal Relations; • the office of the Secretary of State; and • other state agencies as determined by the Governor.	organizations.	
Guardianship Advisory Board	15 members, composed of one representative from each of the health and human services regions, as defined by HHSC; three public representatives; and one representative of DARS. The representatives of the health and human services regions are appointed by a majority vote of the judges of the statutory probate courts in each region. If a health and human services region does not contain a statutory probate court, the representative is appointed by a	Advises HHSC and DADS with respect to a statewide guardianship program and develops a proposal for a statewide guardianship program.	Government Code 531.121

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
	majority vote of the judges of the statutory probate courts in the state. The public representatives are appointed by the EC and the representative of DARS is appointed by the Commissioner of aging and disability services.		
HHS Enterprise Contract Council	Comprised of the Chief Operating Officers, or their designees, and selected agency representatives from each HHS agency.	Provides oversight of HHS system contract management and administration functions while maintaining accountable standards, consistency, and flexibility to establish a framework for accountability, best value, and desired outcomes related to enterprise-wide contract management.	HHS Circular C-003
HHSC Council	Nine public members, appointed by the Governor.	Assists the EC in developing rules and policies for the Commission.	Government Code 531.401
HIV and Hepatitis, Interagency Coordinating Council for	14 members, including a representative from each of the following agencies appointed by the executive director or Commissioner of each agency: • HHSC; • DADS; • DARS; • DFPS; • DSHS; • Texas Juvenile Justice Department; • the Texas Medical Board; • the Texas Board of Nursing; • the State Board of Dental Examiners; • TWC; and	Assists with communication and coordination among the member agencies concerning programs for prevention and services related to HIV, AIDS, and hepatitis.	Health and Safety Code 81.010

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
	• the Texas Higher Education Coordinating Board.		
Hospital Payment Advisory Committee	11 members to be appointed by the EC.	Develops recommendations to ensure reasonable, adequate, and equitable payments to hospital providers and to address the essential role of rural hospitals.	Human Resources Code 32.022(e) (Agency rule indicates committee will be abolished 8/31/2016)
Information Resources Advisory Committee	Six members, designated by the EC, representing: • information resources managers for state agencies and for private employers; and • the directors, executive directors, and commissioners of HHS System agencies.	Reviews and make recommendations within HHS relating to the consolidation and improved efficiency of information resources management functions.	Government Code 531.0273(d)
Institute of Health Care Quality and Efficiency Board of Directors, Texas	15 Governor-appointed board of directors, and the following ex-officio members: • the Commissioner of DSHS; • the EC; • the Commissioner of Insurance; • the executive director of the Employees Retirement System of Texas; • the executive director of the Teacher Retirement System of Texas; • the state Medicaid director of HHSC; • the executive director of the Texas Medical Board;	Studies and develops recommendations to improve healthcare quality, accountability, education, and cost containment by encouraging healthcare provider collaboration, effective healthcare delivery models, and coordination of healthcare services. The Institute Board of Directors consists of 15 Governor appointed members who are healthcare experts, including physicians, nurses, hospital administrators,	Health and Safety Code 1002.052 (Subject to Sunset review 2017)

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
	• the Commissioner of DARS; • the executive director of TWC; • the Commissioner of the Texas Higher Education Coordinating Board; and • a representative from each state agency or system of higher education that purchases or provides healthcare services, as determined by the Governor.	attorneys, researchers, and health plan administrators.	
Intellectual and Developmental Disability System Redesign Advisory Committee	Members not yet appointed.	Advises HHSC and DADS on implementation of the acute care services and long-term services and supports system redesign.	Government Code 534.053 (Statute expires 9/1/2024)
Internal Audit Oversight Committee	Nine members, appointed by the EC.	Provides guidance and oversight of HHS system internal audit functions.	EC-created
Local Governmental Entities, Advisory Committee for	Members not yet appointed.	Advises HHSC with respect to establishing flexible and responsive strategies for blending federal, state, and other available funding sources to meet local program needs and service priorities.	Government Code 531.0249
Medicaid and CHIP Program Rate and Expenditure Disparities Between the Texas-Mexico Border Region and Other Areas of the State,	Nine members, appointed by the EC, representing: • the spectrum of geographic areas included in the Texas-Mexico border region; • persons who are knowledgeable regarding the Medicaid program, including Medicaid managed care, and the child health plan program; and	Advises HHSC on efforts to eliminate the disparities in payments for Medicaid and CHIP services between the Texas-Mexico border region and other areas of the state.	Government Code 531.0223 (Statute expires 9/1/2015)

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
Advisory Committee on	• the interests of physicians, hospitals, patients, managed care organizations, state agencies involved in the management and delivery of medical resources of any kind, affected communities, and other areas of the state.		
Medicaid and CHIP Regional Advisory Committees	195 total members appointed by the EC. Each committee consists of representatives from entities and communities in the region as considered necessary by HHSC to ensure representation of interested persons, including representatives of: • hospitals; • managed care organizations; • primary care providers; • state agencies; • consumer advocates; • recipients; • rural providers; • long-term care providers; • specialty care providers, including pediatric providers; and • political subdivisions with a constitutional or statutory obligation to provide health care to indigent patients.	Provides recommendations to HHSC on the improvement of Medicaid managed care in the region.	Government Code 533.021 (Agency rule indicates committees will be abolished 8/31/2016)
Medicaid Managed Care Advisory Committee, State	Members not yet appointed, but will represent the following: • hospitals; • managed care organizations; • primary care providers; • state agencies; • consumer advocates representing low-income recipients; • consumer advocates representing recipients with a disability; • parents of children who are	Provides recommendations and ongoing input to HHSC on the statewide implementation and operation of Medicaid managed care.	Government Code 533.041

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
	recipients; • rural providers; • advocates for children with special healthcare needs; • pediatric healthcare providers, including specialty providers; • long-term care providers, including nursing home providers; • obstetrical care providers; • community-based organizations serving low-income children and their families; and • community-based organizations engaged in perinatal services and outreach. The advisory committee must include a member of each regional Medicaid managed care advisory committee.		
Medical Care Advisory Committee	18 members appointed by the EC.	Reviews and makes recommendations to the state Medicaid director on proposed rules that involve Medicaid policy or affect Medicaid-funded programs.	Human Resources Code 32.022 and 42 CFR 431.12 (Agency rule sets review date as 8/31/2016)
Neonatal Intensive Care Unit Council	16 members appointed by the EC.	Develops recommendations to HHSC on NICU standards and reimbursement through the Medicaid program.	HB 2636 (82R) (Bill text expires 6/1/2013)
Nonprofit Council, Texas	12 members, appointed by the EC, representing the following: • a statewide nonprofit organization; • local governments;	Assists and directs the Interagency Coordinating Group for Faith- and Community-Based Initiatives	Government Code 535.055

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
	• faith-based groups; • community-based groups; • consultants to nonprofit corporations; • experts in grant writing; and • a statewide association of nonprofit organizations.	in carrying out its duties related to the removal of unnecessary interagency barriers to partnerships between agencies and faith- and community-based organizations.	(Statute expires 9/1/2019)
PARIS Workgroup	Four members appointed by the EC.	Coordinates the use of data from the federal Public Assistance Reporting Information System (PARIS); investigates and analyzes this data ; and develops new strategies based on data to generate savings for the state.	SB 1 (83R) Art IX Sec 17.04
Perinatal Advisory Council	17 members appointed by the EC.	Develops and recommends a process and criteria for designating levels of neonatal and maternal care, respectively, and to make recommendations related to improving neonatal and maternal outcomes.	Health and Safety Code 241.187 (Statute expires 9/1/2025)
Pharmaceutical and Therapeutics Committee	11 Governor-appointed members, including: • six licensed physicians participating in the Medicaid program, at least one of whom is a licensed physician actively engaged in mental health providing care and treatment to persons with severe mental illness, and who has practice experience in the state Medicaid plan; and • five licensed pharmacists participating in the Medicaid vendor drug program.	Develops recommendations for the Preferred Drug Lists adopted by HHSC, considering the clinical efficacy, safety, and cost-effectiveness, and any program benefit associated with a product.	Government Code 531.074

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
Physician Payment Advisory Committee	19 members appointed by the EC.	Advises MCAC and HHSC about technical issues regarding physician payment policies.	Human Resources Code 32.022(d) (Agency rule indicates committee will be abolished on 8/31/2017)
Public Assistance Health Benefits Review and Design Committee	Nine members, appointed by the EC, representing healthcare providers participating in the Medicaid program or the child health plan program, or both. The committee membership must include at least three representatives from each program.	Reviews and provides recommendations to HHSC regarding health benefits and coverages provided under the state Medicaid program, CHIP, and any other income-based healthcare program administered by HHSC or an HHS agency.	Government Code 531.067
Qualifications for Health Care Translators and Interpreters, Advisory Committee on	12 members, appointed by the EC, which must include the following: • one member who represents a professional translators and interpreters association; • one member who is a healthcare interpreter working with people who have limited English proficiency; • one member who is a healthcare interpreter working with people who are deaf or hard of hearing; • one member who is a representative of a mental health services provider; • one member who is a representative of a hospital;	Develops strategies for implementing applicable regulations and qualifications for healthcare interpreters and translators.	Government Code 531.701 (Subject to Sunset review in 2021)

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
	• one member who represents the insurance industry; • one member who represents a business entity that provides translators and interpreters to healthcare practitioners; • one member who represents an organization that provides services to immigrants and refugees; • one member who is a representative of an institution of higher education; • at least one healthcare practitioner; and • additional members, as determined by the EC, who represent the interests of consumers.		
Medicaid/CHIP Quality Based Payment Advisory Committee	13 members, appointed by the EC, including: • at least one member who is a physician with clinical practice experience in obstetrics and gynecology; • at least one member who is a physician with clinical practice experience in pediatrics; • at least one member who is a physician with clinical practice experience in internal medicine or family medicine; • at least one member who is a physician with clinical practice experience in geriatric medicine; • at least one member who is or who represents a healthcare provider that primarily provides long-term care services; • at least one member who is a consumer representative; and	Advises HHSC on programs and reimbursement policies that encourage high-quality, cost-effective healthcare delivery models that increase appropriate provider collaboration, promote wellness and prevention, and improve health outcomes.	Government Code 536.002 (Subject to Sunset review in 2021)

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
	• at least one member who is a member of the Advisory Panel on Health Care-Associated Infections and Preventable Adverse Events and who meets the qualifications prescribed by Section 98.052(a)(4), Health and Safety Code.		
Quality Based Payment Workgroup	10 members, appointed by the EC, including the following: • a physician from an urban area who has clinical practice expertise and who may be a pediatrician; • a physician from a rural area who has clinical practice expertise and who may be a pediatrician; • a nurse practitioner; • a representative of a general acute care hospital; • a representative of a children's hospital; • a representative from a care management organization; and • a representative of healthcare consumers.		EC-created
Raising Texas Steering Committee	Nine members, appointed by the EC, including: • one member from each HHS agency ; and • a member from TEA, Texas Workforce Commission, Office of the Attorney General, and the State Center for Early Childhood Development.	Provides oversight to the implementation of the Texas Early Childhood Comprehensive Systems Plan.	EC-created
Renewing Our Communities Account Advisory Committee	Nine members, appointed by the EC, representative of the religious, cultural, geographic diversity of this state, and the diversity of organization types and sizes in this state.	Develops recommendations for the EC regarding the powers and duties with respect to the Renewing Our Communities account.	Government Code 535.108

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
STAR Kids Managed Care Advisory Committee	Members not yet appointed.	Advises HHSC on establishment and implementation of the STAR Kids managed care program.	Government Code 533.00254 (Statute expires 9/1/2016)
STAR+PLUS Nursing Facility Advisory Committee	15 members appointed by the Governor, Lt. Governor, and Speaker.	Advises HHSC on implementation of and other activities related to the provision of Medicaid benefits to recipients who reside in nursing facilities through the STAR+PLUS managed care program.	Government Code 533.00252 (Statute expires 9/1/2016)
STAR+PLUS Quality Council	Members not yet appointed.	Advises HHSC on development of policy recommendations to ensure eligible recipients receive quality, person-centered, consumer-directed acute care services and long-term services and supports in an integrated setting under the STAR + PLUS Medicaid managed care program.	Government Code 533.00285 (Statute expires 1/1/2017)
System of Care Consortium, Texas	12 members, appointed by the EC, including representatives from: DSHS, DFPS, TEA, TJJD, and Texas Commission on Alcohol and Drug Abuse and an equal number of family advocates.	Provides oversight to state efforts to expand to additional communities the network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families.	Government Code 531.251
Tele-medicine and Tele-health	14 members, appointed by the EC,	Assists HHSC in evaluating tele-medicine, tele-health,	Government Code

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
Advisory Committee	including: • representatives of health and human services agencies and other state agencies concerned with the use of tele-medical and tele-health consultations and home tele-monitoring services in the Medicaid program and the state child health plan program, including representatives of: o HHSC; o DSHS; o the Texas Department of Rural Affairs; o TDI; o the Texas Medical Board; o the Texas Board of Nursing; and o the Texas State Board of Pharmacy; • representatives of health science centers in this state; • experts on tele-medicine, tele-medical consultation, and telemedicine medical services or tele-health services; • representatives of consumers of health services provided through tele-medical consultations and telemedicine medical services or tele-health services; and • representatives of tele-medicine medical services, tele-health services, and home tele-monitoring services.	and home tele-monitoring policies, and ensures the efficient and consistent development and use of tele-medicine, tele-health and home tele-monitoring services reimbursed under government-funded health programs.	531.02172 (Agency rule indicates committee will be abolished on 8/31/2016)
Traumatic Brain Injury Advisory Council, Texas	22 members, as follows: • eight public consumer members appointed by EC, at least three of whom must be individuals related to persons with a traumatic brain	Recommends policies and practices to state leadership to meet the needs of people with brain injuries and their families.	Health and Safety Code 92.051

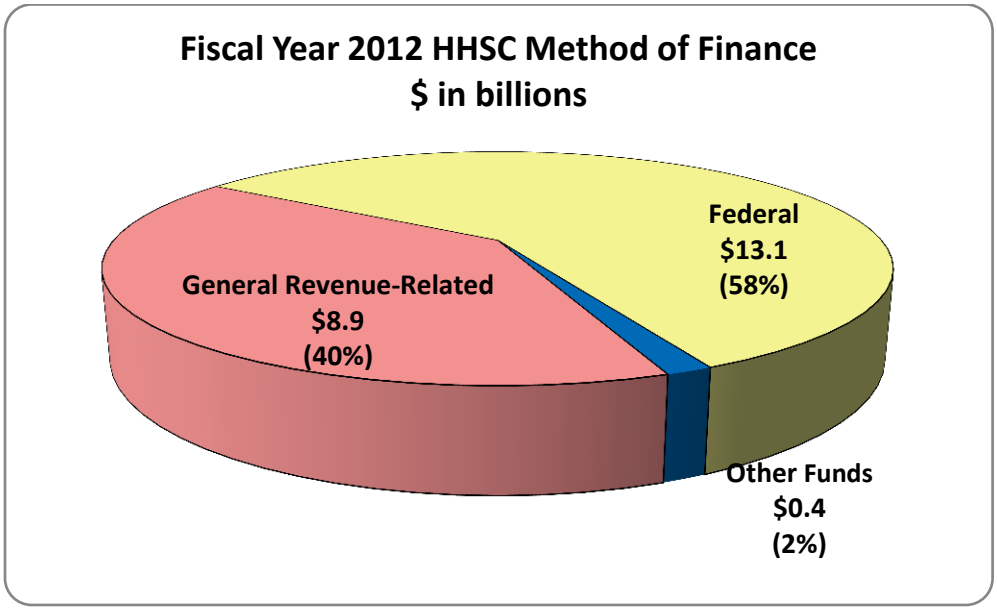
Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
	injury and at least three of whom must be persons with a brain injury; • six professional members appointed by the EC, each of whom must have special training and interest in the care, treatment, or rehabilitation of persons with a traumatic brain injury, with one representative each from: o acute hospital trauma units; o the National Institute for Disability Rehabilitation Research Traumatic Brain Injury Model System in this state; o acute or post-acute rehabilitation facilities; o community-based services; o faculties of institutions of higher education; and o providers in the areas of physical therapy, occupational therapy, or cognitive rehabilitation; and • eight state agency members, with one representative from each of the following agencies appointed by the chief executive officer of the agency: o HHSC; o DSHS; o Texas Education Agency; o Texas Planning Council for Developmental Disabilities; and o Texas Department of Insurance.		
Uncompensated Hospital Care,	14 members, appointed by the EC, including representatives from the	Assists HHSC in developing a standard methodology and	Government Code

Health and Human Services Commission Exhibit 4: Subcommittees and Advisory Committees			
Name of Subcommittee or Advisory Committee	**Size/Composition/How are members appointed?**	**Purpose/Duties**	**Legal Basis for Committee**
Work Group on	office of the Office of the Attorney General and the hospital industry.	procedure for calculating and reporting uncompensated hospital care costs.	531.552

V. FUNDING

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

The following pie chart illustrates the Health and Human Services Commission's (HHSC) funding, totaling $22.4 billion in fiscal year 2012.



Federal Funds – $13.1 billion

Almost 58 percent of the agency's revenue comes from the federal government. Of this amount, 99.5 percent funds four programs: Medicaid, the Children's Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP) Administrative Match, and Temporary Assistance for Needy Families (TANF) represent of all the agency's federal funds. In FY 2012, HHSC expended 26 federal grants.

State Funds – $8.9 billion

State funds comprise General Revenue, tobacco settlement receipts, earned federal funds, and Medicaid- and CHIP-generated revenues, such as drug rebates, client cost sharing, and experience rebates from managed care organizations. All but 0.5 percent of the agency's General Revenue (GR) appropriation is used as either federal match or to meet federal maintenance of effort requirements for the Medicaid, CHIP, TANF, SNAP, and Federal Emergency Management Agency (FEMA) Disaster assistance programs.

Other Funds – $0.4 billion:

Almost 97 percent of Other Funds can be categorized in two areas – Interagency Contracts and Other Non-GR Revenue Match for Medicaid. Interagency Contract funding represents 63 percent of Other Funds and is received primarily from the other four HHS agencies to reimburse HHSC for the provision of oversight and consolidated support services (e.g. Human Resources and Regional Administration for leases and utilities). Subrogation receipts and Appropriated Receipts (intergovernmental transfers from state and local hospitals) are non-GR revenue sources used to match federal Medicaid and represent 34 percent of Other Funds. The remaining 3 percent includes funds from local hospitals for supporting out-stationed, hospital-based eligibility workers and foundation grant funding.

The share of State and federal funding for administrative and program support functions is determined according to an annual federally approved cost allocation methodology called a 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 program 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 share and federal share billed to each HHSC revenue source as well as any of the other four HHS agencies benefiting from the program's services. Billing allows the other HHS agencies to claim federal funding.

HHSC's PACAP includes more than 60 cost allocation factors. Most of the agency's general administrative functions are charged on the following two factors:

- oversight factor, which is determined by the share of each HHS agency's salary expenditures as a percentage of total HHS salary expenses; and/or
- indirect program administration factor, which is determined by the share of HHSC employees that are supporting enterprise operations and the share that are supporting HHSC programs and operations.

In addition to appropriated funding, HHSC also processes supplemental Medicaid payments ($1.5 billion annually) to hospitals under the Hospital Disproportionate Share Program. Fiscal year 2012 is the last year of the Upper Payment Limit (UPL) Program, which made supplemental payments to certain hospitals and providers to offset the difference between what Medicaid actually paid for Medicaid services and what Medicare would have paid for the same services. The Medicaid 1115 Healthcare Transformation Waiver replaced funding available under the UPL former program with supplemental payments for Uncompensated Care (UC) and Delivery System Reform Incentive Payments (DSRIP). These supplemental payments generally are not reflected in the agency's appropriation, because the State share historically has been provided as intergovernmental transfers from local and State Hospitals. Federally funded SNAP benefits also are not appropriated directly to HHSC.

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

The 2014-15 General Appropriations Act contains 87 riders that affect HHSC. Below are brief summaries of 35 riders from the HHSC bill pattern that significantly impact the agency as well as 11 Article II Special Provisions and five Article IX General Provisions.

Funding Limitations and Transfer Authority Riders

Rider 7. Appropriation Transfers Between Fiscal Years. Authorizes HHSC to transfer funds from FY 2015 to FY 2014 to cover Medicaid and CHIP costs with Governor and Legislative Budget Board (LBB) prior approval,

Rider 12. Transfers: Authority and Limitations. Requires that transfers of funding to manage expenditures and cash flow from Medicaid strategies (Goal B) or CHIP strategies (Goal C) to other goals receive Governor and LBB approval. The transfer of funds between appropriation items in Goals A, D, E, F, and G do not require Governor and LBB prior approval, unless the transfer amount exceeds 25 percent of the originating appropriation item's amount.

Rider 15. CHIP Unexpended Balances and Allocation of Funds. Authorizes any unexpended balances in the CHIP Program for the fiscal years ending August 31, 2013, and August 31, 2014, to be appropriated for the next fiscal year with Governor and LBB prior approval. No unexpended balance is anticipated at the end of FY 2013 or FY 2014. The Comptroller is authorized to use GR in lieu of Tobacco Settlement Receipts for CHIP cash flow purposes, if tobacco settlement payments do not meet the anticipated appropriation amounts to CHIP of $315.2 million in FY 2014 and $234.5 million in FY 2015.

Rider 22. Temporary Assistance for Needy Families (TANF) Maintenance of Effort. Authorizes expenditures, should TANF caseloads decline or shift, of the agency's share of the State-funded maintenance of effort requirement for the federal TANF grant, which is $62.9 million annually, in strategy A.1.2, Integrated Eligibility and Enrollment, upon prior notification to the Governor and LBB.

Rider 34. Unexpended Balance Authority for Eligibility Determination Services. Appropriates any unexpended balances in Strategy A.1.2, Integrated Eligibility and Enrollment, for FY 2014, to HHSC for FY 2015 with Governor and LBB prior approval.

Rider 67. Information Technology Funding. Authorizes HHSC, during the 2014-15 biennium, to transfer up to $20 million GR for funding of certain IT capital projects with Governor and LBB approval.

Special Provisions, Sec. 7. Federal Match Assumptions and Limitations on Use of Available General Revenue Funds. Authorizes HHSC to expend General Revenue that becomes available

if the federal match rate in federal FY 2015 for Medicaid is more than 58 percent and for CHIP is more than 70.60 percent upon Governor and LBB approval.

Special Provisions, Sec. 10. Limitations on Transfer Authority. Authorizes HHSC to transfer funds, staff, and capital authority within Article II agencies with written notification to the Governor and LBB. Funding transfers of more than $1 million GR, 10 FTEs, or $0.1 million capital authority also require Governor and LBB approval. No single transfer may exceed 20 percent of the originating strategy's appropriation for funding or FTEs for the fiscal year.

Special Provisions, Sec. 36. Limitation on Unexpended Balances: General Revenue for Medicaid. Appropriates unexpended balances appropriated for Medicaid to HHSC, Department of Aging and Disability Services (DADS), or the Department of State Health Services (DSHS) for FY 2014 to the same agencies for FY 2015, with Governor and LBB prior approval. The initial request to use these unexpended funds must be sent by April 1, 2014, with a revised estimate required by October 1, 2014, if the amount varied more than 5 percent.

Special Provisions, Sec. 42. HHS Office Consolidation and Co-Location. Requires HHSC conduct an evaluation of any space to be vacated due to consolidation or co-location efforts and to notify the Governor, Texas Facilities Commission, and LBB, 270 days before the lease cancellation. Authorizes HHSC to use any unencumbered funding to modernize offices and business processes, with prior approval from Governor and LBB.

Special Provisions, Sec. 54. Transfer Authority Related to STAR+PLUS Managed Care Expansion Medicaid. Authorizes the Executive Commissioner to transfer funding and staff from DADS to HHSC during the fiscal 2014-15 biennium in support of expanding STAR+PLUS statewide.

Special Provisions, Sec. 62. Medicaid Unexpended Balances between Biennia. Appropriates any unexpended balances appropriated to HHSC for the Medicaid Program as of August 31, 2013, estimated to be $218.3 million GR, to the agency for the fiscal year beginning September 1, 2013. The agency must submit an explanation of any variance from that amount by October 1, 2013.

General Provisions, Sec. 14.04. Disaster Related Transfer Authority. Authorizes HHSC to transfer funds for responding to a disaster, with Governor and LBB prior notification.

Revenue-Related Authority Riders

Rider 5. Vendor Drug Rebates - Medicaid and CHIP. Appropriates HHSC $712.3 million in FY 2014 and $797.2 million in FY 2015, as the State share of Medicaid and CHIP drug rebates for expenditure as State match in their respective drug programs. The agency is also authorized to expend rebate revenues collected in excess of appropriated amounts.

Rider 6. Medicaid Subrogation Receipts (State Share). Appropriates $80 million each year of the biennium as subrogation receipts, or tort settlements, for expenditure as Statematch in the

Medicaid program. The agency is also authorized to expend subrogation receipts collected in excess of appropriated amounts.

Rider 13. Use of Additional Medicaid Program Income. Appropriates $50 million each year of the biennium as Medicaid program income for expenditure as Statematch in the Medicaid program. Examples of this revenue are rebates and refunds from the claims administrator and managed care organizations and interest earnings. The agency is also authorized to expend program income collected in excess of appropriated amounts.

Rider 14. Use of Additional CHIP Experience Rebates. Appropriates $4 million in FY 2014 and $3.0 million in FY 2015 as CHIP experience rebates for expenditure as Statematch in the CHIP program. Examples of this revenue are rebates and refunds from managed care organizations and interest earnings. The agency is also authorized to expend CHIP experience rebates collected in excess of appropriated amounts.

Rider 62. CHIP Premium Co-Pays. Appropriates approximately $5 million in CHIP cost-share revenues each year of the biennium for expenditure as Statematch in the CHIP program. Families participating in CHIP pay cost sharing based upon family income. The agency is also authorized to expend CHIP cost sharing revenues collected in excess of appropriated amounts.

Rider 64. Federal Provider Enrollment and Screening Fee. Authorizes HHSC to collect and expend the federal Medicaid and CHIP provider enrollment and screening fee to support provider enrollment and to fund certain employee benefits. Unused fee balances must be returned to the federal government.

Special Provisions, Sec. 47. Contingent Revenue, Appropriation of Cost. Contingent upon the Attorney General reporting Medicaid fraud-related judgments and settlements in excess of $124.6 million GR for the biennium, the agency is appropriated up to $25 million per year for funding the Medicaid program and reimbursing the agency for costs incurred in support of the judgment or settlement.

Federal Funds and Other Appropriation Authority Riders

Rider 3. Budget Authority for Estimated Pass-through Funds. The agency has estimated budget authority for the pass through of non-General Revenue funds.

Rider 9. Authorization to Receive, Administer, and Disburse Federal Funds. Authorizes HHSC to receive and disburse all federal funds with the exception of TANF and Social Services Block Grant (SSBG).

Rider 10. Accounting of Support Costs. Authorizes HHSC to create cost pool accounts from which to pay aggregated support costs and is required to quarterly allocate these support costs to the original strategies.

Rider 11. Disposition of Appropriation Transfers from State-owned Hospitals. The agency must obtain matching federal Medicaid funds for funds transferred from state-owned hospitals under the Disproportionate Share Program and Uncompensated Care Program.

Rider 16. Cash Basis Expenditures Authorization. Authorizes the agency to process certain Medicaid expenditures in a fiscal year without regard to the date of service.

Rider 18. Supplemental Nutritional Assistance Program Funds Appropriated. Authorizes HHSC to administer benefits under the federal SNAP program.

Rider 21. High Performance Bonus for Administration of the Supplemental Nutritional Assistance Program (SNAP). Authorizes HHSC to expend a performance bonus, if received from by the U.S. Department of Agriculture, and is required to expend the award on activities that improve low-income consumers' access to nutrition and healthy foods and performance bonuses for staff contributing to Texas' qualification for the award.

Rider 31. CHIP Enrollment. In the event CHIP funding is insufficient to sustain enrollment, Authorizes HHSC to use transfer authority prior to establishing a wait list or suspending enrollment.

Rider 40. Graduate Medical Education. Authorizes HHSC to obtain matching federal Medicaid funds for funds transferred from state-owned teaching hospitals for Medicaid Graduate Medical Education payments.

Rider 42. FTE Authority during Federally-Declared Disasters. Authorizes HHSC to increase staffing levels to provide services for a federally-declared disaster upon notification to Governor and LBB.

Rider 79. Primary Care Access Funding for Health Related Institutions. The agency may obtain matching federal funds with funding from Health Related Institutions (HRIs) and the Higher Education Coordinating Board for per-member, per-month and primary care incentive payments to HRIs providing Medicaid and CHIP primary care services.

Rider 81. Receipt of Transfers for Participation in the Healthcare Transformation and Quality Improvement program. Authorizes HHSC to receive intergovernmental transfers from institutions of higher education in Strategy B.2.6, Transformation Payments, as the Statematch for Uncompensated Care (UC) and Delivery System Reform Incentive Payments (DSRIP).

Rider 86. Transitional Medicaid Disproportionate Share Hospital (DSH) and Related Payments. Authorizes the agency, with Governor and LBB approval, to expend $160 million GR in FY 2014 and $140 million GR in FY 2015 to stabilize hospital payments, including as the State match for a portion of DSH hospital payments and/or rate adjustments designed to reward quality. The agency also is to develop a plan to stabilize and improve hospital payments for Medicaid services and for uncompensated care.

Special Provisions, Sec. 41. Appropriation Authority for Intergovernmental Transfers. Authorizes the agency to maximize federal Medicaid funding using intergovernmental transfers (IGTs) as State match with Governor and LBB approval.

Budget Requirement and Reporting Riders

Rider 28. Other Reporting Requirements. Requires HHSC to notify, submit, or report on changes in certain federal funding sources, monthly agency expenditures, and monthly enrollment levels.

Rider 43. Local Reporting on DSH, Uncompensated Care, Delivery System Reform Incentive Payment and Indigent Care Expenditures. Requires the agency to report annually on local expenditures on DSH, UC, DSRIP, and the Indigent Care Program.

Rider 44. Women's Health Services Demonstration Project: Savings and Performance Reporting. The agency reports biannually on enrollment, expenditures, outreach, and providers associated with the Texas Women's Health Program.

Rider 47. Unexpended Balances: Social Services Block Grant Funds. The agency reports annually on SSBG expenditures and balances of all state agencies appropriated this federal funding source.

Rider 49. Capitated Managed Care Model of Dental Services Reporting. The agency shall evaluate access, quality, and cost outcomes of capitated Medicaid dental services and submit a report by March 1, 2015.

Rider 55. Supplemental Payments. The agency reports annually audit findings associated with Medicaid supplemental payments.

Rider 63. Reporting Fiscal Impact of the Federal Eligibility Modernization Program on the Texas Integrated eligibility Redesign System. The agency shall report on the fiscal impact of the federal Eligibility Modernization program for fiscal years 2012-2015 to the Quality Assurance Team.

Special Provisions, Sec. 13. Caseload and Expenditure Reporting Requirements. The agency shall report quarterly caseload forecasts on Medicaid, CHIP, TANF, foster care, adoption and permanency care assistance, and Early Childhood Intervention to the Governor and LBB and provide monthly data on caseloads and expenditures.

Special Provisions, Sec. 40. Enterprise Support Services. The agency shall report annually on the estimated assessment to the HHS agencies and actual expenditures for supporting oversight and consolidated functions at HHSC. Increases in excess of $1 million require Governor and LBB notification.

Special Provisions, Sec. 44. Rate Limitations and Reporting Requirements. The agency shall report on changes to managed care rates to the LBB, Governor, and State Auditor. Rates that exceed appropriated levels require Governor and LBB prior approval.

Appropriation and Reduction Riders

Rider 46. Use of PARIS Data and Appropriation of Savings to the Texas Veterans Commission Realized from the Use of PARIS Data. The agency must transfer $50,000 annually to the Texas Veterans Commission to facilitate claims identified using federal PARIS data for veterans receiving Medicaid and other public benefits. Ten percent of the GR savings identified as a result of obtaining the PARIS data is appropriated to the Veterans' Assistance Fund.

Rider 51. Medicaid Funding Reduction and Cost Containment. The agency appropriations are reduced by $400 million GR for the biennium to achieve targeted savings and cost containment in the Medicaid program.

Rider 66. Contingency for STAR+Plus Utilization Review. The agency is appropriated $0.4 million GR in FY 2014 and $0.4 million GR in FY 2015 to implement a utilization review process for STAR+PLUS.

General Provisions, Sec. 17.08. Technical Adjustments for Data Center Services. Agency appropriations for costs paid to the Department of Information Resources (DIR) for supported services from the Data Center are increased $0.6 million GR and $1.5 million All Funds for the biennium.

General Provisions, Sec. 17.14. Eligible Expenses in the Medicaid Program. The agency Medicaid appropriations are reduced $160 million GR in FY 2014 and $140 million GR in FY 2015, which are offset by a corresponding appropriation increase with Account 5111 Trauma Facility funds contracted from DSHS.

General Provisions, Sec 18.32. Contingency for SB 8. The Office of Inspector General and the Medicaid programs are appropriated $0.5 million GR in FY 2014 and $0.8 million GR in FY 2015 with matching federal funds relating to the prevention of fraud, waste, and abuse in the Medicaid program, including the Medical Transportation Program.

General Provisions, Sec. 18.58. Contingency for SB 1803. The Office of Inspector General is appropriated $0.3 million GR in FY 2014 and $0.5 million GR in FY 2015 with matching federal funds relating to the investigation of and payment holds relating to allegations of fraud and abuse, and investigations and hearings on overpayments in the Medicaid program.

C. Show your agency's expenditures by strategy.

Health and Human Services Commission
Exhibit 5: Expenditures by Strategy — Fiscal Year 2012 (Actual)

Goal	Strategy	Description	Amount Spent	Percent of Total	Contract Expenditures included in Total Amount
A	A.1.1	Enterprise Oversight and Policy	$46,913,320	0.21%	$8,717,047
A	A.1.2	Integrated Eligibility and Enrollment	705,628,436	3.15%	226,355,842
A	A.2.1	Consolidated System Support	105,303,359	0.47%	50,835,338
Subtotal			**$857,845,115**	**3.84%**	**$285,908,227**
B	B.1.1	Aged and Medicare Related	$1,531,351,917	6.85%	
B	B.1.2	Disability Related	4,306,800,565	19.26%	
B	B.1.3	Pregnant Women	999,469,588	4.47%	
B	B.1.4	Other Adults	542,657,399	2.43%	
B	B.1.5	Children	5,682,761,798	25.41%	
B	B.2.1	Non-full Benefit Payments	645,887,175	2.89%	
B	B.2.2	Medicaid Prescription Drugs	2,767,361,356	12.37%	
B	B.2.3	Medical Transportation	183,650,485	0.82%	
B	B.2.4	Health Steps (EPSDT) Dental	1,475,680,862	6.60%	
B	B.2.5	Medicare Payments	1,128,943,002	5.05%	
B	B.2.6	Transformation Payments	5,983,724	0.03%	
B	B.2.7	Transitional DSH and Related Payments		0.00%	
B	B.3.1	Medicaid Contracts and Administration	661,034,171	2.96%	338,370,052
Subtotal			**$19,931,582,042**	**89.12%**	**$338,370,052**
C	C.1.1	Children's Health Insurance Program (CHIP)	$809,722,571	3.62%	
C	C.1.2	CHIP Perinatal Services	207,867,772	0.93%	
C	C.1.3	CHIP Prescription Drugs	134,129,000	0.60%	
C	C.1.4	CHIP Contracts and	16,260,488	0.07%	13,147,575

		Administration			
Subtotal			**$1,167,979,831**	**5.22%**	**$13,147,575**
D	D.1.1	Temporary Assistance for Needy Families Grants	$95,853,661	0.43%	
D	D.1.2	Refugee Assistance	30,110,900	0.13%	71,014
D	D.1.3	Disaster Assistance	7,924,971	0.04%	13,410
D	D.2.1	Family Violence Services	25,090,267	0.11%	1,243,527
D	D.2.2	Alternatives to Abortion	4,150,000	0.02%	4,150,000
D	D.2.3	Texas Women's Health Program		0.00%	
Subtotal			**$163,129,799**	**0.73%**	**$5,477,951**
E	E.1.1	Central Program Support	$14,958,129	0.07%	$2,705,782
E	E.1.2	Information Technology Program Support	13,621,558	0.06%	6,806,777
E	E.1.4	Regional Program Support	112,399,222	0.50%	520,805
Subtotal			**$140,978,909**	**0.63%**	**$10,033,364**
F	F.1.1	TIERS	$60,745,908	0.27%	$15,292,675
Subtotal			**$60,745,908**	**0.27%**	**$15,292,675**
G	G.1.1	Office of Inspector General	$43,640,698	0.20%	$631,746
Subtotal			**$43,640,698**	**0.20%**	**$631,746**
Grand Total			**$22,365,902,302**	**100.00%**	**$668,861,590**

D. Show your agency's sources of revenue. Include all local, state, and federal appropriations, all professional and operating fees, and all other sources of revenue collected by the agency, including taxes and fines.

Health and Human Services Commission Exhibit 6: Sources of Revenue — Fiscal Year 2012 (Actual)	
Source	**Amount**
Appropriated Receipts - Hospital Based Workers	$9,319,878
Appropriated Receipts - Match for Medicaid	$18,632,556
Medicaid Subrogation Receipts - Third-Party Reimbursements	$100,080,789
Appropriated Receipts - Other	$207,722
Interagency Contracts	$222,819,712
General Revenue	$8,295,059,800

Health and Human Services Commission Exhibit 6: Sources of Revenue — Fiscal Year 2012 (Actual)	
Source	**Amount**
General Revenue-Dedicated	$4,581,626
Earned Federal Funds - Food Stamps	$6,243,012
Federal Funds	$13,082,935,729
Medicaid Cost sharing Medicaid Buy-In	$101,911
Medicaid Program Income - Premium Credits Medicaid	$51,423,156
Vendor Drug Rebates - Medicaid	$515,658,169
Vendor Drug Rebates - Medicaid Supplemental	$41,265,025
CHIP Premium Co-Pay	$1,443,218
CHIP Experience Rebates	$8,791,225
Vendor Drug Rebates - CHIP	$7,338,774
TOTAL	**$22,365,902,302**

E. If you receive funds from multiple federal programs, show the types of federal funding sources.

Health and Human Services Commission Exhibit 7: Federal Funds — Fiscal Year 2012 (Actual)				
Type of Fund	**State/Federal Match Ratio**	**State Share**	**Federal Share**	**Total Funding**
Food Stamp			$6,070	$6,070
State Admin Matching Grants for Food Stamp Program	mostly 50/50	$174,746,230	$171,197,237	$345,943,467
Food Stamp Participation Program			$182,038	$182,038
TX Healthy Marriage Grant			$62,496	$62,496
Comprehensive Community Health Services			$336,461	$336,461
Maternal and Child Health			$108,798	$108,798
Traumatic Brain Injury			$172,952	$172,952

Health and Human Services Commission Exhibit 7: Federal Funds — Fiscal Year 2012 (Actual)				
Type of Fund	**State/Federal Match Ratio**	**State Share**	**Federal Share**	**Total Funding**
Healthcare Access - Uninsured			$671,420	$671,420
Improve Minority Health			$121,721	$121,721
ACA Home Visiting Program			$3,478,270	$3,478,270
Med Incent Prevent Chronic Disease			$1,470,571	$1,470,571
Temporary Assistance for Needy Families	MOE	$62,880,168	$58,835,171	$121,715,339
TANF to Title XX			$9,502,113	$9,502,113
Refugee and Entrant Assistance - State Admin			$24,967,389	$24,967,389
Refugee and Entrant Assistance - Discretionary Grants			$2,022,126	$ 2,022,126
Refugee and Entrant Assistance - Targeted Assist			$3,791,784	$3,791,784
Children's Justice Grants			$8,787	$8,787
Social Services Block Grant			$7,727,643	$7,727,643
Family Violence Prevention			$5,240,823	$5,240,823
ARRA - State Grants to Promote Health Info Tech			$10,640,847	$10,640,847
State Children's Health Insurance Program (CHIP)	28/72	$351,660,930	$890,462,691	$1,242,123,621
Medical Assistance Program	Varies	$8,105,633,236	$11,881,281,526	$19,986,914,762
Money Follows the Person Demo			$7,919,760	$7,919,760
State Survey and Certification	75/25	$142,381	$423,492	$565,873

Health and Human Services Commission Exhibit 7: Federal Funds — Fiscal Year 2012 (Actual)				
Type of Fund	**State/Federal Match Ratio**	**State Share**	**Federal Share**	**Total Funding**
Presidential Declared Disaster Assistance	75/25	$681,210	$2,123,543	$2,804,753
State Homeland Security			$180,000	$180,000
TOTAL		**$8,695,744,155**	**$13,082,935,729**	**$21,778,679,884**

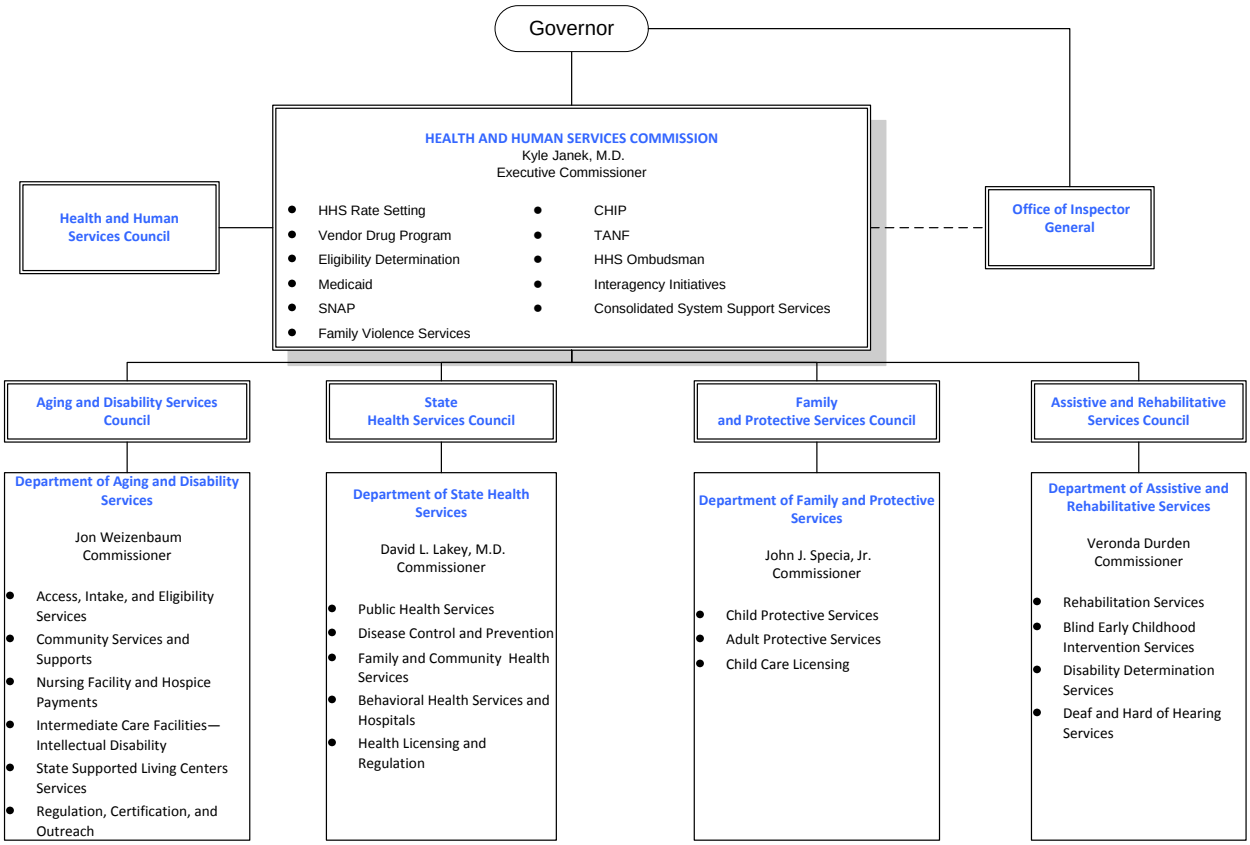
F. If applicable, provide detailed information on fees collected by your agency.

Health and Human Services Commission Exhibit 8: Fee Revenue — Fiscal Year 2012				
Fee Description/ Program/ Statutory Citation	**Current Fee/ Statutory maximum**	**Number of persons or entities paying fee**	**Fee Revenue**	**Where Fee Revenue is Deposited (e.g., General Revenue Fund)**
Federal Provider Screening and Enrollment Fee on Medicare, Medicaid and CHIP Institutional Providers - Human Resources Code Sec. 32.0322 and Affordable Care Act Section 6401	$523/ + Annual CPI	-	-	General Revenue

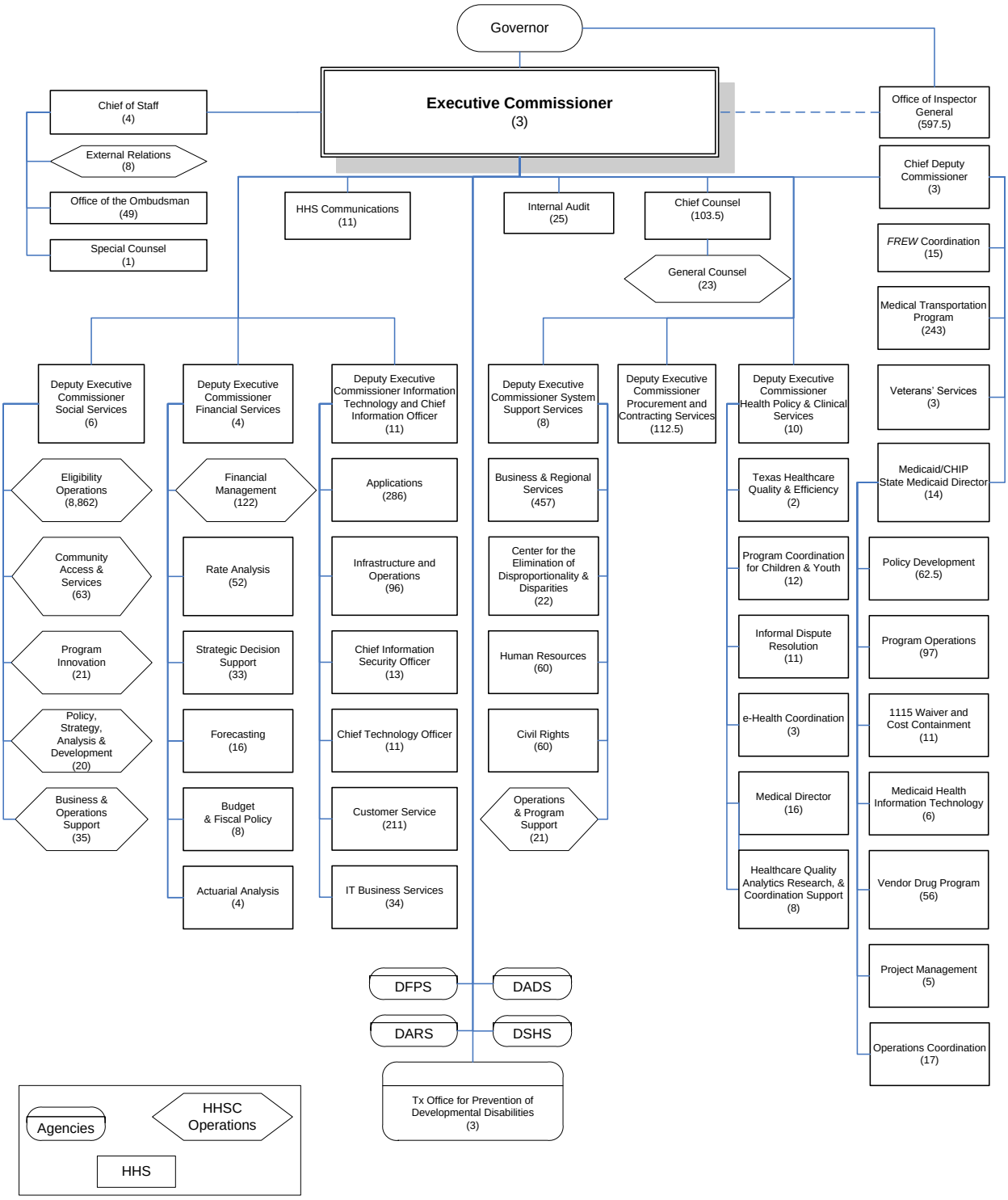
VI. ORGANIZATION

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, Department Heads with subordinates, and actual FTEs with budgeted FTEs in parenthesis.

The following chart shows the Health and Human Services System organization.



The following chart depicts the Health and Human Services Commission's organizational structure, including the number of filled full-time equivalents as of June 1, 2013 in parenthesis.



B. If applicable, fill in the chart below listing field or regional offices.

Health and Human Services Commission Exhibit 9: FTEs by Location — Fiscal Year 2012				
Headquarters, Region, or Field Office	**Location**	**Co-Located? Yes/No**	**Budgeted FTEs, FY 2013**	**Actual FTEs as of June 1, 2013**
Headquarters				
State Office	Austin	Mixed	2,603.9	2,271.4
Region 1 - High Plains				
High Plains	Amarillo	Mixed	108.0	104.0
High Plains	Borger	Mixed	9.0	9.0
High Plains	Brownfield	Mixed	8.0	8.0
High Plains	Childress	Yes	2.0	2.0
High Plains	Dalhart	Yes	1.0	1.0
High Plains	Dimmitt	Yes	2.0	2.0
High Plains	Dumas	Mixed	9.0	8.0
High Plains	Hereford	Yes	7.0	7.0
High Plains	Levelland	Yes	8.0	7.0
High Plains	Littlefield	Yes	7.0	7.0
High Plains	Lubbock	Mixed	155.0	150.0
High Plains	Pampa	Yes	13.0	13.0
High Plains	Perryton	No	2.0	2.0
High Plains	Plainview	Mixed	18.0	18.0
High Plains	Post	No	2.0	2.0
High Plains	Tulia	Yes	3.0	3.0
Region 2 - Northwest Texas				
Northwest Texas	Abilene	Mixed	95.0	92.0
Northwest Texas	Anson	Yes	7.0	7.0
Northwest Texas	Ballinger	Yes	4.0	4.0
Northwest Texas	Bowie	Yes	8.0	8.0
Northwest Texas	Breckenridge	Yes	4.0	4.0
Northwest Texas	Brownwood	Mixed	18.0	18.0
Northwest Texas	Coleman	Yes	5.0	5.0
Northwest Texas	Eastland	Yes	5.0	5.0

Northwest Texas	Graham	Yes	2.0	2.0
Northwest Texas	Haskell	Yes	7.0	7.0
Northwest Texas	Olney	No	3.0	3.0
Northwest Texas	Seymour	Yes	7.0	7.0
Northwest Texas	Snyder	Yes	8.0	8.0
Northwest Texas	Sweetwater	Yes	9.0	9.0
Northwest Texas	Vernon	Yes	8.0	8.0
Northwest Texas	Wichita Falls	Mixed	57.0	55.0
Region 3 - Metroplex				
Metroplex	Allen	No	1.0	1.0
Metroplex	Arlington	Mixed	107.0	104.0
Metroplex	Bedford	No	1.0	1.0
Metroplex	Bonham	Mixed	8.0	8.0
Metroplex	Cleburne	Mixed	34.0	34.0
Metroplex	Corsicana	Mixed	15.0	15.0
Metroplex	Dallas	Mixed	473.0	459.0
Metroplex	Decatur	Mixed	10.0	10.0
Metroplex	Denton	Mixed	69.0	65.0
Metroplex	Duncanville	Yes	32.0	32.0
Metroplex	Ennis	Mixed	9.0	8.0
Metroplex	Fort Worth	Mixed	389.0	381.0
Metroplex	Gainesville	Yes	8.0	8.0
Metroplex	Garland	Yes	3.0	3.0
Metroplex	Granbury	Mixed	8.0	8.0
Metroplex	Grand Prairie	Mixed	264.0	255.0
Metroplex	Grapevine	No	2.0	2.0
Metroplex	Greenville	Mixed	22.0	20.0
Metroplex	Hurst	Yes	1.0	1.0
Metroplex	Irving	No	42.0	42.0
Metroplex	Kaufman	Yes	22.0	22.0
Metroplex	Lancaster	No	1.0	1.0
Metroplex	Lewisville	Yes	2.0	2.0
Metroplex	McKinney	Mixed	37.0	35.0
Metroplex	Mesquite	Mixed	55.0	49.0
Metroplex	Mineral Wells	Mixed	12.0	12.0

Metroplex	N. Richland Hills	Yes	2.0	2.0
Metroplex	Plano	Mixed	5.0	5.0
Metroplex	Quinlan	Yes	6.0	6.0
Metroplex	Richardson	Yes	70.0	70.0
Metroplex	Rockwall	Mixed	9.0	9.0
Metroplex	Sherman	Yes	30.0	30.0
Metroplex	Stephenville	Mixed	7.0	7.0
Metroplex	Waxahachie	Mixed	21.0	19.0
Metroplex	Weatherford	Mixed	14.0	14.0
Region 4 - Upper East Texas				
Upper East Texas	Athens	Yes	124.0	124.0
Upper East Texas	Atlanta	Yes	5.0	5.0
Upper East Texas	Canton	Yes	13.0	13.0
Upper East Texas	Carthage	Mixed	7.0	7.0
Upper East Texas	Clarksville	Yes	3.0	3.0
Upper East Texas	Daingerfield	Yes	4.0	4.0
Upper East Texas	Gilmer	Yes	11.0	10.0
Upper East Texas	Henderson	Mixed	16.0	16.0
Upper East Texas	Jacksonville	Mixed	22.0	21.0
Upper East Texas	Kilgore	No	1.0	1.0
Upper East Texas	Linden	Yes	5.0	5.0
Upper East Texas	Longview	Mixed	50.0	49.0
Upper East Texas	Marshall	Mixed	33.0	31.0
Upper East Texas	Mineola	Yes	5.0	4.0
Upper East Texas	Mount Vernon	Yes	3.0	3.0
Upper East Texas	Mt Pleasant	Mixed	12.0	12.0
Upper East Texas	New Boston	Yes	6.0	6.0
Upper East Texas	Palestine	Mixed	20.0	20.0
Upper East Texas	Paris	Mixed	31.0	30.0
Upper East Texas	Pittsburg	Yes	4.0	4.0
Upper East Texas	Quitman	Yes	3.0	3.0
Upper East Texas	Rusk	Yes	11.0	11.0
Upper East Texas	Sulphur Springs	Mixed	25.0	25.0
Upper East Texas	Texarkana	Mixed	21.0	21.0
Upper East Texas	Tyler	Mixed	125.0	123.0

Region 5 - Southeast Texas				
Southeast Texas	Beaumont	Mixed	126.0	120.0
Southeast Texas	Buna	Yes	4.0	3.0
Southeast Texas	Center	Yes	10.0	10.0
Southeast Texas	Coldsprings	Yes	5.0	5.0
Southeast Texas	Crockett	Mixed	22.0	22.0
Southeast Texas	Hemphill	Yes	5.0	5.0
Southeast Texas	Jasper	Mixed	19.0	19.0
Southeast Texas	Kirbyville	Yes	6.0	6.0
Southeast Texas	Livingston	Mixed	17.0	17.0
Southeast Texas	Lufkin	Mixed	40.0	38.0
Southeast Texas	Nacogdoches	Mixed	36.0	35.0
Southeast Texas	Orange	Mixed	25.0	25.0
Southeast Texas	Port Arthur	Mixed	42.0	42.0
Southeast Texas	Silsbee	Yes	17.0	16.0
Southeast Texas	Trinity	Yes	4.0	4.0
Southeast Texas	Woodville	Yes	4.0	4.0
Region 6 - Gulf Coast				
Gulf Coast	Alvin	Yes	22.0	22.0
Gulf Coast	Anahuac	Yes	3.0	3.0
Gulf Coast	Bay City	Mixed	13.0	13.0
Gulf Coast	Baytown	Yes	26.0	26.0
Gulf Coast	Bellville	Yes	7.0	5.0
Gulf Coast	Cleveland	Yes	15.0	14.0
Gulf Coast	Clute	Yes	20.0	18.0
Gulf Coast	Columbus	Yes	7.0	7.0
Gulf Coast	Conroe	Mixed	66.0	61.0
Gulf Coast	Crosby	Yes	7.0	7.0
Gulf Coast	Dickinson	No	23.0	23.0
Gulf Coast	Freeport	No	1.0	1.0
Gulf Coast	Galveston	Mixed	21.0	19.0
Gulf Coast	Hempstead	No	9.0	9.0
Gulf Coast	Houston	Mixed	1,292.0	1,244.0
Gulf Coast	Humble	Yes	2.0	2.0
Gulf Coast	Huntsville	Yes	13.0	11.0

Gulf Coast	Katy	Yes	3.0	3.0
Gulf Coast	Kingwood	No	1.0	1.0
Gulf Coast	Lake Jackson	Yes	1.0	1.0
Gulf Coast	Liberty	Yes	13.0	13.0
Gulf Coast	Pasadena	Yes	47.0	47.0
Gulf Coast	Pearland	Yes	1.0	1.0
Gulf Coast	Richmond	No	6.0	5.0
Gulf Coast	Rosenberg	Yes	65.0	64.0
Gulf Coast	SUGAR LAND	No	2.0	2.0
Gulf Coast	Texas City	Mixed	18.0	18.0
Gulf Coast	The Woodlands	No	1.0	1.0
Gulf Coast	Tomball	Yes	17.0	17.0
Gulf Coast	Webster	No	1.0	1.0
Gulf Coast	Wharton	Yes	14.0	14.0
Region 7 - Central Texas				
Central Texas	Austin	Mixed	527.0	500.0
Central Texas	Bastrop	Yes	15.0	14.0
Central Texas	Bellmead	No	1.0	1.0
Central Texas	Brenham	Yes	16.0	15.0
Central Texas	Bryan	Mixed	64.0	63.0
Central Texas	Caldwell	Yes	3.0	2.0
Central Texas	Cameron	Yes	10.0	10.0
Central Texas	Centerville	Yes	5.0	5.0
Central Texas	College Station	Yes	2.0	2.0
Central Texas	Copperas Cove	Yes	11.0	11.0
Central Texas	Elgin	Yes	4.0	4.0
Central Texas	Gatesville	Yes	4.0	4.0
Central Texas	Georgetown	Yes	13.0	12.0
Central Texas	Giddings	No	11.0	10.0
Central Texas	Hamilton	Mixed	7.0	7.0
Central Texas	Hearne	Yes	5.0	5.0
Central Texas	Hillsboro	Yes	12.0	11.0
Central Texas	Killeen	Yes	46.0	46.0
Central Texas	La Grange	Yes	11.0	11.0
Central Texas	Lampasas	Yes	13.0	13.0

Central Texas	Llano	Yes	3.0	3.0
Central Texas	Lockhart	Mixed	19.0	18.0
Central Texas	Madisonville	Yes	4.0	4.0
Central Texas	Marble Falls	Yes	9.0	9.0
Central Texas	Marlin	Yes	8.0	8.0
Central Texas	McGregor	No	1.0	1.0
Central Texas	Meridian	Yes	10.0	10.0
Central Texas	Mexia	Yes	32.0	29.0
Central Texas	Navasota	Yes	7.0	7.0
Central Texas	Round Rock	Mixed	47.0	46.0
Central Texas	San Marcos	Mixed	31.0	31.0
Central Texas	San Saba	No	2.0	2.0
Central Texas	Taylor	Yes	14.0	13.0
Central Texas	Temple	Mixed	59.0	55.0
Central Texas	Waco	Mixed	108.0	105.0
Region 8 - Upper South Texas				
Upper South Texas	Bandera	Yes	4.0	3.0
Upper South Texas	Boerne	Yes	3.0	3.0
Upper South Texas	Carrizo Springs	Mixed	9.0	9.0
Upper South Texas	Crystal City	Mixed	10.0	10.0
Upper South Texas	Cuero	Yes	7.0	7.0
Upper South Texas	Del Rio	Mixed	22.0	22.0
Upper South Texas	Eagle Pass	Mixed	39.0	39.0
Upper South Texas	Edna	Mixed	1.0	1.0
Upper South Texas	Floresville	Yes	11.0	11.0
Upper South Texas	Fredericksburg	Yes	9.0	7.0
Upper South Texas	Gonzales	Mixed	10.0	9.0
Upper South Texas	Hallettsville	Yes	8.0	8.0
Upper South Texas	Hondo	Yes	17.0	16.0
Upper South Texas	Jourdanton	Mixed	15.0	15.0
Upper South Texas	Karnes City	Yes	8.0	8.0
Upper South Texas	Kerrville	Yes	20.0	18.0
Upper South Texas	New Braunfels	Mixed	4.0	14.0
Upper South Texas	Pearsall	Mixed	12.0	11.0
Upper South Texas	Port Lavaca	No	5.0	4.0

Upper South Texas	San Antonio	Mixed	1,172.0	1,074.0
Upper South Texas	Schertz	Yes	18.0	17.0
Upper South Texas	Seguin	Mixed	17.0	17.0
Upper South Texas	Uvalde	Mixed	14.0	12.0
Upper South Texas	Victoria	Mixed	41.0	39.0
Region 9 - West Texas				
West Texas	Andrews	Yes	4.0	4.0
West Texas	Big Spring	Yes	13.0	13.0
West Texas	Brady	Yes	4.0	4.0
West Texas	Fort Stockton	Yes	3.0	3.0
West Texas	Lamesa	Yes	4.0	4.0
West Texas	Midland	Mixed	158.0	155.0
West Texas	Monahans	Yes	7.0	7.0
West Texas	Odessa	Mixed	57.0	57.0
West Texas	Pecos	Yes	6.0	6.0
West Texas	San Angelo	Mixed	55.0	53.0
West Texas	Seminole	Yes	4.0	4.0
Region 10 - Upper Rio Grande				
Upper Rio Grande	Alpine	Yes	4.0	4.0
Upper Rio Grande	Canutillo	No	14.0	14.0
Upper Rio Grande	El Paso	Mixed	596.0	581.0
Upper Rio Grande	Fabens	No	6.0	6.0
Upper Rio Grande	Marfa	Yes	3.0	3.0
Upper Rio Grande	Presidio	Yes	3.0	3.0
Upper Rio Grande	Socorro	Yes	38.0	37.0
Upper Rio Grande	Van Horn	Yes	2.0	2.0
Region 11 - Lower South Texas				
Lower South Texas	Alamo	Yes	69.0	66.0
Lower South Texas	Alice	Mixed	38.0	37.0
Lower South Texas	Aransas Pass	Yes	18.0	18.0
Lower South Texas	Beeville	Mixed	17.0	17.0
Lower South Texas	Brownsville	Mixed	158.0	155.0
Lower South Texas	Corpus Christi	Mixed	177.0	169.0
Lower South Texas	Edinburg	Mixed	162.0	157.0
Lower South Texas	Elsa	Yes	27.0	26.0

Lower South Texas	Falfurrias	Yes	8.0	7.0
Lower South Texas	Harlingen	Mixed	79.0	78.0
Lower South Texas	Hebbronville	Yes	3.0	3.0
Lower South Texas	Kingsville	Yes	13.0	12.0
Lower South Texas	Laredo	Mixed	161.0	158.0
Lower South Texas	McAllen	Mixed	126.0	120.0
Lower South Texas	Mercedes	Yes	34.0	32.0
Lower South Texas	Mission	Mixed	87.0	87.0
Lower South Texas	Pharr	Yes	70.0	69.0
Lower South Texas	Raymondville	Mixed	10.0	10.0
Lower South Texas	Refugio	No	1.0	1.0
Lower South Texas	Rio Grande City	Mixed	113.0	108.0
Lower South Texas	Robstown	Yes	19.0	18.0
Lower South Texas	Roma	Yes	12.0	12.0
Lower South Texas	San Benito	Yes	42.0	42.0
Lower South Texas	San Juan	No	1.0	1.0
Lower South Texas	Sinton	Yes	7.0	7.0
Lower South Texas	Weslaco	Mixed	42.0	42.0
Lower South Texas	Zapata	Yes	5.0	5.0
TOTAL (excluding contractor FTEs)			**12,774.9**	**12,069.4**

C. What are your agency's FTE caps for fiscal years 2012-2015?

2012 – 12,383.2
2013 – 12,366.7
2014 – 12,536.9
2015 – 12,561.7

D. How many temporary or contract employees did your agency have as of August 31, 2012?

As of August 31, 2012, HHSC employed 149.6 contract employees.

E. List each of your agency's key programs or functions, along with expenditures and FTEs by program.

Health and Human Services Commission Exhibit 10: List of Program FTEs and Expenditures — Fiscal Year 2012			
Program	**Budgeted FTEs, FY 2012**	**FTEs as of August 31, 2012**	**Actual Expenditures**
System Support	**2,031.9**	**1,832.7**	**$547,979,606**
Policy/EC	**36.0**	**31.0**	**$2,329,253**
Enterprise Support Services	**675.8**	**627.0**	**$227,456,642**
Deputy for Enterprise Support Services	9.0	9.0	$696,055
Business & Regional Services	3.0	3.0	$167,597,362
- *Regional Administrative Services*	265.0	246.0	$10,936,239
- *Facility Management & Leasing*	63	58.0	$2,921,531
- *Enterprise Risk Management & Safety*	7.0	5.0	$255,073
- *Emergency Services Program*	4.0	4.0	$8,159,813
- *Facility Support Services*	143.3	136.0	$11,955,391
Center for Elimination of Disproportionality and Disparities	24.0	22.0	$1,451,383
Human Resources/Training & Organizational Development	68.5	64.0	$19,376,157
Civil Rights	65.0	59.0	$3,040,612
HHSC Operations and Program Support	24.0	21.0	$1,067,026
Financial Services	**262.4**	**238.4**	**$53,336,498**
Deputy for Financial Services	4.0	4.0	$311,783
Systems Forecasting	17.0	15.0	$1,035,466
Fiscal Policy	8.0	7.0	$685,916
Rate Analysis	57.0	53.0	$40,122,597
Actuarial Analysis	4.0	4.0	$1,259,171
Strategic Decision Support	37.6	32.6	$2,225,640
Financial Management	134.8	122.8	$7,695,925
Chief Counsel	**140.0**	**125.0**	**$8,545,886**
System Coordination	21.0	17.0	$2,605,616
HHSC General Counsel	25.0	23.0	$1,710,845

Appeals	74.0	68.0	$3,270,795
Regional Legal Services	20.0	17.0	$958,630
Internal Audit	**27.0**	**26.0**	**$2,879,320**
Procurement & Contracting Services	**132.5**	**113.0**	**$5,721,451**
Ombudsman	**68.0**	**52.0**	**$2,424,796**
Information Technology	**690.3**	**620.3**	**$245,285,761**
Social Services	**9,312.3**	**8,963.3**	**$718,004,996**
OSS Intro	59.0	48.0	$170,842,184
TANF	0	0	$95,853,660
Eligibility Operations	9,179.3	8,852.3	$362,899,305
Community Access & Services	74.0	63.0	$88,409,846
Health Program Services	**320.5**	**270.5**	**$19,854,148,125**
Deputy for Health Program Services	24.0	16.0	$707,565
Medicaid	**296.5**	**254.5**	**$19,853,440,560**
Overview			$19,476,457,237
Transformation Waiver Policy and Operations	10.0	6.0	$518,580
Policy Analysis, Program Development, and Waiver Oversight	80.5	73.5	$6,620,599
Cost Containment	2.0	2.0	$140,000
Health Information Technology	7.0	6.0	$267,994,693
Vendor Drug Program	66.0	51.0	$3,382,840
Program Operations and Contract Management	21.0	19.0	$92,191,700
Oversight	101.0	91.0	$4,562,458
Project Management	5.0	3.0	$1,372,196
Operations Coordination	4.0	3.0	$200,257
CHIP			
Overview			$1,157,542,965
Medical Transport Program	**348.0**	**300.0**	**$12,831,894**
FREW	**21.0**	**19.0**	**$8,418,397**
Health Policy & Clinical Services	**67.6**	**56.6**	**$30,567,348**
Deputy for Health Policy and Clinical Services	13.0	9.0	$4,865,653
Office of Acquired Brain Injury	1.0	1.0	$172,953
Informal Dispute Resolution	14.0	11.0	$565,873

Office of E-Health Coordination	3.0	3.0	$10,784,149
Office for Program Coordination & Youth	11.0	11.0	$12,833,113
Office of the Medical Director	15.6	14.6	$1,108,409
Healthcare Quality Analytics Research & Coordination Support	8.0	6.0	$204,962
Texas Institute for Health Care Quality & Efficiency	2.0	1.0	$32,236
OIG	**648.0**	**586.0**	**$36,080,657**
Sanctions/Chief Counsel	21.0	20.0	$1,172,282
Enforcement	256.0	230.0	$12,403,292
Compliance	218.0	195.0	$11,508,608
Internal Affairs	66.0	63.0	$3,220,955
Operations	87.0	78.0	$7,775,520
Texas Office for the Prevention of Developmental Disabilities	**4.0**	**2.0**	$328,314
Grand Total	**12,753.3**	**12,030.0**	**$22,365,902,302**

VII. GUIDE TO AGENCY PROGRAMS

Introduction

The passage of H.B. 2292 in 2003 established a clear directive for a unified health and human services system. With that charge, the bill transformed the Health and Human Services Commission (HHSC) from a small oversight and coordination agency, with little direct system control, to a large, complex agency with three distinct areas of responsibility.

First, HHSC provides leadership and oversight to the health and human services agencies − the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services (DARS), the Department of Family and Protective Services (DFPS), and the Department of State Health Services (DSHS) − and ensures they function as a unified system. Similarly, HHSC oversees all support services for the Health and Human Services (HHS) System.

Finally, HHSC determines eligibility and provides client services for a number of health and human service programs, including the Supplemental Nutritional Assistance Program (SNAP), Medicaid, the Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), family violence services, refugee services, and women's health and early childhood program coordination. In addition, HHSC houses the Office of the Inspector General (OIG), responsible for preventing and investigating system fraud, and the Texas Office for the Prevention of Developmental Disabilities (TOPDD).

As the integrated System matures, HHSC's oversight role has also evolved, becoming stronger with time. For example, the Executive Commissioner recently consolidated contract procurement oversight within HHSC, providing system coordination and an additional level of oversight to the thousands of contracts within the System. As such, the following overview of agency operations includes narrative descriptions of support systems within the agency that also play a significant role in HHS System oversight and coordination. While standard to all agencies, these divisions within HHSC often wear two hats, supporting both the agency's program operations and providing strategic support to the entire System.

Following the narrative descriptions of the HHS System Support functions are full descriptions of HHSC's other health and human services programs, as well as OIG, TOPDD, and the Task Force for Children with Special Needs, which has a separate Sunset date.

Health and Human Services System Support

Office of the Executive Commissioner – Dr. Kyle Janek; 31 FTEs

A full-time Commissioner, appointed by the Governor with the advice and consent of the Senate, oversees operations of both the Health and Human Services System and the Health and Human Services Commission. Responsible for all rulemaking and policy decisions throughout the System, the Executive Commissioner relies on input from the Health and Human Services Commission Council – a nine-member, Governor-appointed advisory council established to guide decisions relating to HHSC's programs. Similarly, the other System agency councils and their respective commissioners make recommendations on rule and policy changes related to their agency operations and programs.

Associated with the Executive Commissioner's office, the Chief of Staff oversees day-to-day agency operations and advises the Executive Commissioner. Also reporting to the Chief of Staff, the External Relations and Communications divisions work with external stakeholders, including elected officials and clients, to serve as points-of-contact for questions and ensure proper notice of system changes.

Chief Deputy Commissioner – Chris Traylor; 3 FTES

Created in 2012, the Office of Chief Deputy Commissioner oversees several major program areas, including the Medical Transportation and Veterans' Services programs. The State Medicaid Director also reports to the Chief Deputy Commissioner.

System Support Services (SSS) – Rolando Garza; 628 FTEs

House Bill 2292 mandated HHSC manage administrative functions for the entire HHS System. Created with efficiency and cost savings in mind, the Office of System Support Services (SSS) provides a wide array of critical services, from managing more than 600 regional HHS facilities to delivering food to the State Supported Living Centers (SSLCs) and State Hospitals. SSS has the following key functions.

Deputy Executive Commissioner's (DEC) Office – 8 FTEs

Responsible for general management of System Support Services, the DEC oversees eight system-wide functions and one HHSC support function. The DEC office houses the Chief Learning Officer, director of the HHS Leadership Academy, a staff support and contracting specialist, and special projects. The DEC is the executive sponsor of the HHS Leadership Academy. The DEC also sponsors, with HHSC IT, the HHS Electronic Information Resources (EIR) Committee responsible for ensuring electronic and information resources are available to people with disabilities.

Business and Regional Services – 457 FTEs

The Associate Commissioner for Business and Regional Services is responsible for the provision of system-wide administrative services to all HHS agencies in five key areas.

Regional Administrative Services (RAS)

RAS manages more than six million square feet of office space located in approximately 600 regional HHS offices and monitors performance of all administrative contracts and services that support those facilities, including security, janitorial, supplies, document processing, utilities, and postage.

In addition, RAS has significant emergency response and recovery responsibilities, including assessing the nature and extent of threats to staff and property, and responding to ensure the safety and security of staff. Typical responses might include setting up temporary, alternate sites for intake and other service delivery needs or providing on-the-ground logistics for the distribution of water and ice to first responders. RAS also supports DSHS emergency response functions, including courier services for lab samples and meds, logistics for receipt and distribution of Strategic National Stockpile shipments, and financial operations and support for mass care incidents.

Facility Management and Leasing (FML)

FML provides office support services that include:

- facility lease procurement and management;
- facility management for assigned State-owned and leased buildings in Austin;
- HHS mail services;
- space management, design and move coordination;
- warehousing and distribution services; and

- contracting for services in support of facility operations.

Enterprise Risk Management and Safety (ERM)

ERM develops, implements, coordinates and continually evaluates risk management, safety, insurance, fire safety, workers' compensation, and facility inspection programs designed to mitigate and manage losses incurred by HHS agencies. ERM also has oversight of risk management and safety for DADS SSLCs and DSHS State Hospitals.

Emergency Services Program (ESP)

ESP coordinates with the Texas Division of Emergency Management in state planning for preparedness, response, and recovery, and it administers three critical response and recovery programs:

- Other Needs Assistance Program, which provides federally funded grants to people who have serious needs and necessary expenses associated with presidentially declared disasters;
- federally funded Disaster Case Management program, which provides individual recovery plans for families; and
- Repatriation Plan, which coordinates non-emergency repatriation of unaccompanied children and individuals with medical or mental health issues and emergency repatriation of non-combatant U.S. citizens and their dependents in foreign countries.

Facility Support Services (FSS)

This unit provides support services oversight for the DADS SSLCs and DSHS State Hospitals. The division provides both direct services, such as food delivery and centralized food buying, and indirect services, such as technical assistance and consultation. FSS develops best practices for the maintenance and operations of the buildings, grounds, and mechanical equipment, and it oversees the infrastructure of 24 facility complexes, comprised of 1,422 buildings with approximately 10.5 million square feet located on 5,342.6 total acres. The oldest of the buildings was originally built in 1857.

Eight units comprise the division:

- Supply Services,
- Fleet Operations,
- Risk Management,
- Maintenance and Construction,
- Competency, Training and Development,
- Computer Assisted Facility Management,
- Nutrition and Food Services, and
- Real Estate Management.

The division also manages the online e-training system for all HHS agencies.

Center for Elimination of Disproportionality and Disparities (CEDD) − 22 FTEs

The statutorily mandated Center provides leadership to state and federal agencies, universities, private groups, communities, foundations, and offices of minority health to decrease and eliminate health and health access disparities among racial, multicultural, disadvantaged, ethnic, and regional populations. The Center provides data and research, curriculum development and training, technical assistance, strategic planning, and operation and implementation of specific tools and practices that inform and guide work to improve equity in systems for all populations.

The Center leads the legislatively established Interagency Council for Addressing Disproportionality to review state agency outcomes for children and make recommendations. The Council collected and examined data from the Texas Juvenile Justice Department, the Texas Education Agency, DFPS, DSHS, and DARS and issued its report to the Legislature in December 2012. The Texas data shows that disproportionality and disparities exist for the same populations in multiple systems, such as child welfare, juvenile justice, education, criminal justice, and health.

Human Resources (HR) − 60 FTEs

The HR Office provides policy and workforce planning, records management, employee relations, and training and organizational development services to HHS staff. A private-sector contractor manages an electronic HR self-service portal, the Centralized Accounting and Payroll/Personnel System (CAPPS, which was previously known as AccessHR).

Three years ago, the Texas State Comptroller of Public Accounts (CPA) initiated Project One — the Legislature's requirement to have all Texas agencies use the same accounting, payroll, and human resources software. The Comptroller selected HHS' AccessHR as the basis for CAPPS, which is intended to be the HR portal for all state agencies.

Civil Rights Office (CRO) − 60 FTEs

CRO is responsible for matters related to equal employment opportunity, accessibility, program compliance, and service delivery. The CRO investigates discrimination complaints from employees, clients, and customers; processes reasonable accommodation requests; provides conflict resolution and mediation services; conducts Management Initiated Investigations; and provides guidance and technical assistance to HHS management, executive staff, and employees on civil rights-related issues.

HHSC Operations and Program Support − 21 FTEs

Responsible for HHSC administrative business operations, the division provides administrative contract management, asset management, business continuity planning, records management, and centralized supply services. The division coordinates the Wellness program, Internship program, Volunteer program, Employee Assistance Program, and the Survey of Employee Excellence. The division also manages HHSC's Employee Advisory Committee and provides telework/mobile work coordination.

Financial Services – Greta Rymal; 239 FTEs

The Financial Services division is responsible for the overall financial management of HHSC and oversight of the HHS System. The major functions of the division are listed below.

Financial Management – 122 FTEs

Financial Management is responsible for supporting and maintaining HHSC's financial viability and coordinating with staff throughout HHSC as well as federal and state parties (including the Legislative Budget Board (LBB), Governor's office, and the Comptroller's office) outside the agency to address HHSC financial issues. The responsibilities and functions are divided between Budget Management and Fiscal Management.

Budget Management

Budget Management is responsible for the following:

- Manages HHSC's program and administrative budget, including providing analysis and recommendations to executive management of decisions impacting HHSC budgets;
- Prepares the biennial legislative appropriations request and the itemized operating budget;
- Compiles and reports on performance measures, FTEs, and contractors;
- Prepares the billing invoices for HHSC consolidated services, submits other required federal and state budget reports, such as monthly financial reports, and prepares cost estimates on proposed legislation and rules; and
- Reviews Advance Planning Documents, primarily those required by the Centers for Medicare & Medicaid Services (CMS) and Food and Nutrition Service (FNS).

Fiscal Management

Fiscal Management manages the agency's finances, ensuring the integrity of accounting records, and maintaining adequate internal controls. Fiscal Management has four major operational areas: Accounting Operations; Fund Accounting; Accounts Receivable Tracking (ART) for HHSC; and Payroll, Time Labor, and Leave functions supporting the HHS System agencies.

- Accounting Operations is responsible for administrative and program expenditure payments, including both manual and interfaced vouchers; vendor/traveler maintenance, distribution of vendor and payroll warrants; and the management of digital imaging of all payment documents.
- Fund Accounting is responsible for the maintenance of the agency's financial system, cash management and expenditure reporting of federal programs, the agency Annual Financial Report (AFR), and various financial reconciliations.
- The ART staff is responsible for managing and collecting claims, revenues and refunds of expenditure; initiating benefit reductions (recoupment); and billing clients and handling delinquencies.
- HHS Payroll, Time Labor and Leave is responsible for pay and timekeeping services for over 54,000 employees across the HHS System and the interpretation and implementation of payroll policies.

HHS System Rate Analysis − 52 FTEs

HHS System Rate Analysis develops reimbursement rates for health and human services programs, which are approved by the Executive Commissioner. Rate Analysis develops more than 200,000 different rates, primarily for the Medicaid program, and coordinates with the five HHS agencies to establish these rates. Rate analysis includes various methodologies, such as cost report-based systems, cost reimbursement services, and fee schedules/payment codes established by governmental or other professional fee entities. Rates are prospective, cost-reimbursed, or based on a percentage of Medicare or American Dental Association fees, while vendor drug fees use market-based cost information.

Acute Care rates are reviewed 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 (HCPCS) and conducts special rate reviews such as to support new benefits, to implement appropriation rate changes, and to address access to care issues. Hospital rates are reviewed upon rebasing, and Long Term Services and Supports rates are reviewed biennially.

This division also determines supplemental payments under the Medicaid disproportionate share hospital (DSH) and uncompensated care (UC) programs and processes payments for the 1115 Texas Healthcare Transformation and Quality Improvement Program Waiver delivery system reform incentive payments (DSRIP).

Strategic Decision Support − 33 FTEs

Strategic Decision Support (SDS) provides research and analytic support to the HHS System. Broadly, SDS staff conducts quantitative analysis of health and human services program data; compiles, analyzes, and reports relevant third-party data (e.g., Census Bureau, Labor Statistics, CDC programs); collects, analyzes, and reports survey data; conducts program evaluation studies; and conducts innovative research studies on various topics of interest to executive management staff. SDS is functionally organized into five sections (Research, Planning and Evaluation, Data Quality and Dissemination, Data Management, and the Enterprise Data Warehouse Business Intelligence Competency Center).

Research

The research section conducts specialized research projects on healthcare-related issues (examples include an analysis of the migration for services from Galveston County in the aftermath of Hurricane Ike and the impact of the 2008 Frew provider rate increase in provider participation and client utilization). This section is also responsible for oversight activities for the Texas Medicaid and Healthcare Partnership (TMHP) on fiscal analyses of potential benefit changes; conducting or monitoring research activities for the *Frew* consent decree; special reports (examples include the *Medicaid Opt-Out* paper and HHSC's *Fact Book*). This section is also responsible for the development of fiscal estimates for program policy initiatives and for legislative fiscal notes.

Planning and Evaluation

The Planning and Evaluation section develops the biennial HHS Strategic Plan. This section is also responsible for conducting program evaluation projects as requested by program staff or funding entities (e.g., CMS waivers). This group also coordinates and monitors external evaluation entities to ensure that the proper evaluation methods are being used. This section, in collaboration with Texas A&M University, is conducting the federally required evaluation of the Texas Healthcare Transformation and Quality Improvement Program 1115 waiver.

Data Quality and Dissemination

The Data Quality and Dissemination section primarily is responsible for providing data analysis support and technical consultation to HHSC and HHS agency staff for various research and evaluation projects; coordinating with HHSC agencies and contractors to ensure data quality and integrity before disseminating analysis to internal and external customers; generating monthly program statistics reports that contain data and information regarding program performance and participation; and responding to data requests regarding client eligibility, utilization, costs, and provider information. Requests for data originate from Federal and State agencies, State legislators, media, internal staff, and the public.

Data Management

The Data Management section is responsible for designing and implementing database systems to meet the information needs of the SDS staff and other areas within HHSC; analyzing current and future hardware and data management/analysis software requirements for SDS; maintaining existing database systems; implementing strategies for the acquisition, standardization and consolidation of data from multiple sources; and establishing protocols for the exchange of information in electronic form between agencies and other entities, as well as preparing information for public release.

Enterprise Data Warehouse Business Intelligence Competency Center (BICC)

The BICC is a newly formed, cross-functional team that will be responsible for supporting and promoting the effective use of the Enterprise Data Warehouse (EDW) and business intelligence tools across the HHS System. The BICC coordinates the activities and resources to ensure that a fact-based approach to decision making is systematically implemented throughout an organization. This division has responsibility for the governance structure for business intelligence and analytical programs, projects, practices, software, and architecture.

<u>HHS System Forecasting – 16 FTEs</u>

HHS System Forecasting is responsible for the caseload and cost forecasting functions for many health and human services programs, including Medicaid, the Children's Health Insurance Program, Early Childhood Intervention, and Protective Services programs such as Foster Care and Adult Protective Services. As such, the division is responsible for communicating the dynamic workings of caseloads and costs to the HHSC Executive Commissioner and the legislative committees overseeing HHS policies and appropriations.

The range of activities included as part of projecting and communicating the overall caseload and cost dynamic include:

- impact analyses, simulations, and fiscal notes for proposed policy changes, rate changes, and eligibility changes;
- support to HHS budget areas during the legislative appropriations process, including detailing crosswalks between specific client services and appropriations strategies;
- monthly and quarterly reporting to the Legislative Budget Board;
- analytical support for the managed care rate-setting process, managed care expansions, and procurements; and
- analytical support and budget neutrality exhibits for federal waiver programs, including the Texas 1115 Transformation Waiver.

Forecasters may specialize in certain topics (e.g., Medicaid managed care or Child Protective Services) but are cross-trained to fill other areas as needed.

System forecasting provides some information specific to HHSC agency-level functions (e.g., data for cost allocation) but more often focuses on the broad HHS System functions.

HHS System Budget and Fiscal Policy – 8 FTEs

HHS System Budget and Fiscal Policy provides oversight of financial issues affecting all five health and human services agencies. Working in conjunction with agency Chief Financial Officers (CFOs), the division, also referred to as "Enterprise Budget and Fiscal Policy," acts as the primary source of information for the Executive Commissioner, Deputy Executive Commissioners, and other HHS staff on budget matters across the HHS System.

This responsibility encompasses a broad range of functions, including, but not limited to the following.

- Identifying and resolving cross-agency financial issues in collaboration with agency CFOs and budget offices.
- Assisting in the development and prioritization of Legislative Appropriations Requests (LARs).
- Coordinating with legislative offices, the Comptroller of Public Accounts, and other state and federal officials to address significant budget issues in the HHS System.
- Managing the financial elements of major HHSC procurement and contract amendments.
- Monitoring and assessing the impact of federal actions on the fiscal affairs of the HHS agencies.
- Performing cost estimates and analysis on bills filed during the legislative session.
- Preparing, submitting, and negotiating approval of the HHSC Public Assistance Cost Allocation Plan with the federal Division of Cost Allocation.
- Providing guidance and coordination on federal cost allocation to all HHS System agencies.
- Developing, maintaining, and tracking cost containment initiatives across the HHS System.

Actuarial Analysis − 4 FTEs

Actuarial Analysis calculates the capitated premium rates paid to the Medicaid and CHIP managed care organizations (MCOs). HHSC uses an external actuary to certify these rates as meeting the actuarial soundness guidelines established by the Centers for Medicare & Medicaid Services (CMS). HHSC contracts with Rudd and Wisdom to certify the rates, with oversight and direction by the Chief Actuary. Additionally, the division calculates capitated premium rates for the Program for All-Inclusive Care for the Elderly (PACE).

Actuarial Analysis is involved with benefit and rate changes, program expansions, and legislative mandates that affect MCOs. The division also completes portions of the required federal waiver filings with CMS for 1915(b) waivers, including the Texas Medicaid Wellness Program, NorthSTAR, and Non-emergency Medical Transportation (NEMT). In addition, Actuarial Analysis provides actuarial support services for other HHSC initiatives; examples include Medicare Advantage Special Needs Plans (SNPs), the 1115 Texas Healthcare Transformation and Quality Improvement Program Waiver, the Affordable Care Act (ACA) primary care physician increases, and the Dual Eligible Demonstration Project.

Chief Counsel – Steve Aragón; 126.5 FTEs

Through H.B. 2292, the Legislature directed HHSC to implement an efficient and effective centralized system of administrative support services, including legal services, for the HHS System agencies. To implement this statutory directive, the Executive Commissioner determined that each HHS agency would retain a legal division to support the day-to-day administration of the agency and created the Office of Chief Counsel at HHSC to ensure that the agencies' legal positions are coordinated and consistent with HHS System policies and objectives.

The Office of Chief Counsel has three divisions: System Coordination, General Counsel, and System Support Services. Under the direction of the Chief Counsel, staff provide legal advice and assistance to HHSC in the agency's day-to-day operations, provision of centralized services, and oversight of the HHS System. Staff also provide advice and support to the other HHS System agencies directly, consistent with HHSC's oversight role and statutory mandate.

<u>System Coordination – 19.5 FTEs</u>

Staff assigned to System Coordination work directly with HHSC and the other HHS System agencies and are responsible for identifying legal issues that impact the HHS System, assessing risk, evaluating the agencies' positions relative to HHS System policy, advising the agencies, and, through the Chief Counsel, making recommendations to the Executive Commissioner to ensure the HHS System's interests are protected. Staff support HHSC and the HHS System agencies in the following areas.

- System Services − Advise and support staff on legal issues involving the HHS System's consolidated support, compliance, and policymaking functions and advise the Executive Commissioner of problem areas, recurring issues, and potential or actual conflicts of interest between the HHS System agencies.
- Project Management − Provide oversight and assistance for executive management assignments, legal services projects, cross-agency issues, and system-wide coordination.
- Litigation − Identify and coordinate major litigation involving HHS System agencies, participate in strategic decision-making with agency staff and the Office of the Attorney General (OAG), and inform the Executive Commissioner of issues and potential liabilities.
- Contracts − Support high value contracts, review proposed system-wide procurement or contracting policy, coordinate information and resources to support HHS System contracting activities, and provide direct assistance to HHS System agencies on specialized legal issues relating to IT, outsourcing, or other complex contracts.
- Research and Practice Support − Provide research and related drafting support on policy and legal issues for HHSC and the other HHS System agencies.
- Legislative Activities − Review and analyze proposed legislation, advise agency staff during the legislative session, and provide ongoing research and support to staff on legislative issues affecting the HHS System.
- Consumer Privacy and Protection − Advise the HHS System agencies on compliance with state and federal laws governing information privacy and security, support risk assessments

and other compliance activities, coordinate agency responses to actual and possible breaches of confidentiality and security, and advise on reporting obligations.

- *Frew* Litigation − Advise the HHS System agencies on compliance with the consent decree and corrective action plans in Frew v. Janek, a class action lawsuit impacting millions of Texas Medicaid clients under age 21, and support the Office of the Attorney General (OAG) in the ongoing litigation of the case, including identifying witnesses and other resources, responding to discovery, formulating arguments, and drafting pleadings.
- Collections − Pursue Medicaid third party recovery for HHSC and refer cases as necessary to the OAG, work with the Medicaid estate recovery program at DADS, and coordinate with HHSC Regional Legal Services on collections relating to the DADS-operated State Supported Living Centers and the DSHS-operated State Hospitals.
- Emergency/Crisis Management − Assist HHSC and HHS agencies at the direction of Executive Commissioner with legal support related to declared public emergencies and HHS agency administrative and regulatory actions that have significant public impact.

General Counsel – 23 FTEs

Staff assigned to the General Counsel support HHSC's day-to-day operations and its administrative or operational needs. Their responsibilities include the following.

- Research and Legal Support − Monitor legislative, regulatory, and judicial developments relevant to HHSC; conduct research and provide legal counsel to HHSC staff; issue legal opinions; and inform executive management of potential risks or liabilities.
- Personnel Management − Provide legal support for specific personnel and human resources actions by HHSC.
- Legislative Implementation − Review and analyze legislation that may affect HHSC programs or operations, advise staff on legislative requirements, and participate in implementation through the rulemaking and contract processes.
- Open Records − Coordinate HHSC's responses to public information requests, identify responsive materials, advise on the applicability of exceptions to disclosure, draft requests for a ruling by OAG on exceptions, and train HHSC staff on open records issues.
- Open Meetings − Support HHSC's Council and advisory councils, advise on open meeting requirements, post public notices and agendas, assist in the development of procedural rules, and participate in training on open meeting issues.
- Subpoenas − Coordinate the agency's responses to subpoenas in third party litigation, including demands from state and federal law enforcement entities.

In addition to these general responsibilities, staff provide specialized legal support to HHSC staff in three practice areas: policy, contracts, and litigation.

Policy

The Policy group supports HHSC management and program staff in the development and implementation of agency policy and administrative rules. Their responsibilities include the following

- Policymaking − Support the development of strategies and programs to implement legislative, programmatic, and policy initiatives.
- Administrative Rules − Advise staff on the development of administrative rules for HHSC programs, draft or review administrative rules and related documents, and support staff throughout the rulemaking process. In fiscal year 2012, the Policy group completed 171 reviews of rules developed, proposed, or adopted by the agency.
- State-Federal Public Assistance Program Support and Coordination − Advise HHSC staff on the development of State Plan amendments, waiver applications, audit responses, regulatory compliance materials, and related documents for Medicaid, CHIP, SNAP (formerly the Food Stamp Program), TANF, and other programs that are administered by HHSC. In fiscal year 2012, the Policy group completed 62 assignments related to Medicaid state plan amendments, 145 assignments related to Medicaid waiver programs, and more than 30 assignments related to other HHSC programs.
- Deferrals and Disallowances − Assist staff responding to decisions to defer or disallow federal funds and, where appropriate, represent HHSC's interests in federal administrative appeals of adverse actions taken by federal agencies.

Contracts

The Contracts group supports HHSC management and programs in all aspects of the procurement and contracting process. In fiscal year 2012, staff facilitated approximately 700 contract projects, including HHSC operational contracts, amendments, interagency agreements, inter-local agreements, data use agreements, business associate agreements, memoranda of understanding, service and commodity contracts, and solicitation documents. The Contracts group supports the following agency activities.

- Contract Planning − Support HHSC staff throughout the procurement and contract process, advise on compliance with state and federal laws and regulations related to the procurement and contracting process, and ensure compliance with the Agency Procurement Policy Development Guidelines.
- Procurements and Solicitations − Draft, review, and approve the procurement solicitation, including evaluation criteria. Review and draft responses to vendor questions associated with the procurement. Conduct vendor conferences for procurements.
- Contract Negotiation and Development − Represent HHSC in all aspects of contract negotiations with potential and contracted vendors and draft the terms and conditions of new contracts and contract amendments.
- Contract Management − Advise and provide ongoing support for HHSC staff on contract management issues. Draft and administer the Managed Care Manual to ensure consistency with the relevant contracts.
- Grant Administration − Advise and support staff administering HHSC grants.

Litigation

The Litigation group is responsible for representing and advocating HHSC's interests in administrative, civil, and criminal litigation. The Litigation group's responsibilities include the following.

- Litigation Risk Management − Monitor external litigation and legal issues relevant to HHSC programs, identify litigation risks and advise HHSC staff on mitigation strategies, and negotiate with parties threatening litigation.
- Defense Litigation − Support the OAG in the defense of HHSC's interests in state and federal court, including applying litigation holds to preserve evidence, responding to discovery requests, identifying and preparing witnesses for deposition and trial, researching arguments, and drafting pleadings for filing with the court. As of August 1, 2013, the Litigation group is responding to 86 lawsuits against HHSC and its interests.
- Civil Medicaid Fraud Litigation − Assist the OAG's Civil Medicaid Fraud Division with investigation and litigation of Medicaid fraud cases. According to OAG, these efforts have resulted in recoveries of more than $400 million on behalf of the State since 2002, with total recoveries for the state and federal governments of more than $1 billion.
- Administrative Hearings − Represent HHSC in administrative hearings before the Appeals section, discussed below, and the State Office of Administrative Hearings (SOAH). HHSC's Medicaid claims administrator estimates that representation in 48 Medicaid Fair Hearings between September 2010 and July 2013 has resulted in direct cost savings of more than $1.2 million.
- Bankruptcy and Collections − Monitor provider bankruptcies, file proofs of claim, refer cases to the OAG, as appropriate, and assist with research and resolution of old accounts receivable. Advise HHSC staff on collections issues and procedures.
- Criminal history reviews − Participate in the review of criminal history information during the enrollment process for Vendor Drug Program providers.
- Expunctions − Assist the Office of Inspector General with processing expunction orders and confirm the agency's compliance.

<u>System Support Services – 84 FTEs</u>

Staff assigned to System Support Services provide specialized services to HHSC and the other HHS System agencies and are responsible for ensuring the consistent application of HHS System policy in the provision of those services.

Appeals

The Appeals Division manages certain appeals functions for the HHS System agencies, including administrative and contested case appeals authorized by law, employee grievance hearings for the HHS System agencies, and client fraud and fair hearings regarding eligibility. The Appeals Division comprises personnel formerly assigned to the Hearings Department of the Texas Department of Human Services (DHS). Upon the consolidation of HHS agencies in 2004, its role was expanded to provide services to all HHS agencies. The Appeals Division is divided into two sections: Contested Cases and Fraud and Fair Hearings.

- Contested Cases − Three attorney administrative law judges are responsible for conducting administrative appeals and issuing final orders on behalf of the HHS System agencies in contested cases and adversarial proceedings brought under the Texas Administrative Procedure Act, other state laws, and HHS System policy. These proceedings include: appeals of adverse actions by HHSC; appeals of adverse personnel actions by any of the HHS System agencies; appeals involving programs of the former Department of Mental Health and Mental Retardation now administered by DADS and DSHS; appeals by individuals seeking to avoid placement on the Texas Employee Misconduct Registry; and appeals of agency action in certain DADS programs. In addition, at DADS' request, staff provide pre-hearing support for appeals involving certain DADS programs before those matters are transferred to SOAH. The Contested Case section processed approximately 958 appeal requests during fiscal year 2012.
- Fraud and Fair Hearings − Lay hearing officers conduct fair hearings – appeals by disappointed clients and applicants to any of the HHS System's assistance programs – and issue the agency's final decision on client benefits. This section also hears client fraud appeals – also known as disqualification hearings – in which the appellant is an applicant for or recipient of SNAP, TANF, or Medicaid benefits and is determined by HHSC to have committed an intentional program violation. In fiscal year 2012, the Fraud and Fair Hearings section received 40,138 fair hearing requests and 1,464 client fraud appeal requests.

Regional Legal Services

HHSC regional legal services staff are located in seven HHSC regional headquarters offices and provide local, onsite assistance to HHS agency regional staff. Regional Legal Services responsibilities include the following activities.

- Policy, Contract, and Litigation Support − Review financial and property documents and advise on their impact on Medicaid eligibility (reviews have increased from an average of 207 per month in fiscal year 2012 to 452 per month in fiscal year 2013); issue legal opinions on eligibility for various HHS System programs; respond to questions from regional staff on eligibility policy and legal requirements; review revisions to the eligibility policy manuals; review memoranda of understanding and intergovernmental lease agreements involving regional resources; and, in conjunction with the General Counsel, assist the OAG in litigation involving HHSC's regional staff.
- Hearings − Represent the agency in grievance hearings conducted by the Appeals Division and in appeals filed with the Texas Workforce Commission; support the Appeals Division by acting as Administrative Law Judges as needed in grievance hearings and Employee Misconduct Registry cases defended by DFPS legal personnel; and testify as needed in fair hearings conducted by the Appeals Division.
- Administrative Reviews − Conduct statutorily-required administrative reviews of fair hearing decisions and administrative disqualification hearings. Regional Legal Staff performed 287 administrative reviews in fiscal year 2012 and have averaged 25 reviews per month in fiscal year 2013.

- Collections − Work with System Coordination staff on third party recovery and subrogation cases and collections relating to the DADS-operated State Supported Living Centers and the DSHS-operated State Hospitals.
- Subpoenas and Open Records − Support regional responses to subpoenas and public information requests, including identifying responsive materials and advising on the applicability of exceptions to disclosure and the assertion of privileges.
- Personnel Actions − Advise and support regional supervisory staff in personnel and other human resources actions.
- Regional Coordination − Participate in the HHS System agencies' Regional Administrative Council and the regional Incident Management Team.
- Training − Provide training to regional staff on basic job skills, subpoenas, open records, disciplinary actions, documents, hearings, safety, and confidentiality. Provide training to Appeals Division hearing officers.

Internal Audit – David Griffith; 25 FTEs

The Internal Audit Division provides objective assurance and advisory services that provide timely and relevant information for use in managing risks and achieving efficient and effective operations. Audit responsibility includes coverage of both HHSC and the HHS System. Audit coverage consists of programs, processes, and systems under the operational oversight of HHSC and those programs, processes, and systems under the oversight of HHSC deputy executive commissioners or that involve two or more HHS agencies. Internal Audit may audit any HHS agency at the request of executive management.

When presenting the results of operational and information technology audits, management advisory projects, and special projects it performs, Internal Audit offers recommendations to reduce risk and increase the ability of HHSC business areas to meet their goals and objectives. Internal Audit completes eight to ten assessments of HHSC and HHS enterprise programs, processes, and systems each year.

Internal Audit provides external audit coordination services, including serving as liaison with all external federal and state audit entities who perform audits of HHSC. When audits are completed, Internal Audit assists management in coordinating management responses to external audit recommendations and periodically tracks the status of management's actions to address issues identified in external audits. At any point in time, there are typically over 25 external audits of HHSC in progress.

Internal Audit also serves as Texas' single point of contact with the Centers for Medicare & Medicaid Services for payment error rate measurement (PERM) reviews and Medicaid Integrity Group audits.

Procurement and Contracting Services – Wayne Wilson; FTEs 112.5

The Office of Procurement and Contracting Services (PCS) is responsible for the procurement and contracting functions and oversight policy and procedures for the five Health and Human Services agencies. In 1997, the Legislature directed HHSC to adopt rules that govern the purchase of goods and services by all HHS agencies; develop a single, statewide risk analysis procedure for contracts; and publish a contract management handbook that establishes consistent contracting policies and practices to be followed by HHS agencies. In 2003, H.B. 2292 further amended statute to centralize the administrative functions for procurement and contracting for the five HHS agencies within HHSC. Most recently, in February 2013, the Executive Commissioner fully consolidated oversight for all HHS procurement and contracting activities within HHSC.

During fiscal year 2012, HHS reported 33,800 administrative and client services contracts totaling $21.3 billion. The division maintains a Procurement Manual, available to all staff, that outlines state and federal procurement requirements, the HHS procurement rules, and other state oversight entities, including The Comptroller of Public Accounts, Texas Procurement and Support Services. The HHS Procurement Manual includes authorized methods of procurement, evaluation and selection of the awarded vendor, federal and state debarment and suspension requirements, and requires purchasers to screen vendors.

PCS also establishes the HHS System's Historically Underutilized Business (HUB) goals and ensures a good faith effort to use HUBs in contracts for goods and services. The division is responsible for HUB administration, coordination, and reporting for all five HHS agencies.

Office of the Ombudsman – Elisa Hendricks; 49 FTEs

Created by the 78th Legislature, the Office of the Ombudsman (OO) assists the public when the agencies' normal complaint process cannot or does not satisfactorily resolve the issue. The OO serves the entire HHS System. It is the mission of the OO to serve consumers through prompt, professional, and courteous service as a neutral resource for resolution of HHS-related inquiries and complaints. Inquiries and complaints relate to all five HHS agencies.

The Ombudsman assists and addresses concerns of clients, providers, public officials, other stakeholders, and the general public regarding the delivery of services. The OO's primary functions are the following.

- Coordinate the resolution of consumer complaints regarding HHS-related programs and services.
- Conduct independent reviews of complaints concerning agency policies or practices.
- Ensure policies and procedures are consistent with agency goals.
- Make referrals to other agencies as appropriate.
- Serve as the sponsoring office for the HHS Enterprise Administrative Reporting and Tracking (HEART) system, a centralized system designed to support enterprise agencies in the gathering and tracking of stakeholder complaints and inquiries,
- Serve as the central point of contact for the Center for Consumer and External Affairs (CCEA) for each HHS agency.
- Compile and analyze inquiry and complaints data to prepare ad hoc and routine reports for internal and external use, and to identify serious, systemic and emerging issues.

During fiscal years 2011 and 2012, the OO handled an average of 193,500 complaints and inquiries. The office has three primary units to assist consumers in resolving complaints. Below is the description of the functions for each unit.

<u>Hotline Unit</u>

The Hotline Unit responds to contacts from members of the public, clients, and providers who have questions or complaints relating to HHS programs. The Hotline team:

- serves as an intake team, receiving, screening, documenting, and tracking issues and complaints received from three toll-free lines, online-submission forms, fax, email, and mail;
- provides interpretation of rules, regulations, and policies related to HHS programs and services;
- makes appropriate referrals to internal and external departments such as DADS, DARS, DFPS, DSHS, OIG and OAG;
- promotes awareness of programs and services available through the HHS enterprise as well as private sector resources;
- prepares and reviews periodic customer service surveys;
- coordinates with the Centralized Benefit Services office and Voluntary Agency (VolAgs) to resolve refugee-related complaints and inquiries; and

- assists in establishing, developing, and meeting the OO program goals, objectives, and guidelines.

The Hotline staff escalates all complex inquiries and complaints to the Special Services Unit.

Special Services Unit

The Special Services Unit performs complex complaint resolution assisting consumers with HHS-related complaints and issues. This team initiates resolution for consumers who have not been able to achieve satisfaction with divisions or agencies. The Special Services team:

- handles consumer complaints or requests for information received by phone, mail, e-mail, or fax;
- provides interpretation of rules, regulations, and policies related to HHS programs and services;
- performs in-depth research to determine the required level of contact necessary to resolve an issue;
- handles high-priority and urgent issues, such as assignments from the Executive Commissioner's Office and legislative offices as well as other issues that require immediate resolution;
- establishes and maintains contact with departments and agencies while resolving inquiries and complaints, preparing related correspondence, and escalating issues that require mediation;
- receives, documents, and tracks issues and complaints received from a dedicated legislative line for public officials;
- assists the External Relations Division with legislative requests for assistance with constituent concerns;
- serves as liaisons to internal stakeholders; and
- assists in establishing, developing, and meeting the OO program goals, objectives, and guidelines.

Medicaid Managed Care Helpline (MMCH)

The Medical Managed Care Helpline is a statewide bilingual toll-free line designed for consumers encountering problems with Medicaid managed care. The unit and existing staff merged with OO on September 1, 2007, from an external non-profit entity. The toll-free line and services provided are mandated by S.B. 601, 74th Legislature, Regular Session, 1995. The primary purpose of the helpline is to educate and assist Medicaid managed care clients who may be experiencing barriers to healthcare. The staff members, known as Advocates, perform complex complaint and inquiry intake and resolution of issues. The MMCH team:

- logs and handles calls received through the toll-free line, responding to statewide inquiries and complaints related to barriers to accessing healthcare services;
- manages and resolves complex Medicaid benefits issues in accordance with policy;
- intervenes with the state Medicaid office, managed care organizations, providers and other agencies;

- educates clients so they understand concepts of managed care, their rights, and can advocate for themselves;
- provides guidance on how to access services.;
- provides referrals to other offices or helplines, when appropriate;
- resolves complex issues by coordinating with state agency staff as well staff of entities contracted with HHSC, such as Medicaid managed care organizations;
- tracks and follows-up on inquiries and complaints; and
- assists in establishing, developing, and meeting the OO program goals, objectives, and guidelines.

Operations and Reporting Unit

The Operations and Reporting Unit provides administrative support, analyzes inquiry and complaint data to develop internal and external reports, including critical high-level reports for senior and executive level review, and provides systems management and quality assurance. In addition, the Operations and Reporting Unit:

- manages and analyzes contacts data to identify serious, systemic, and emerging issues, trends, and themes arising from inquiries and complaints.
- informs program/service delivery areas and agency leadership for further consideration, including resolution and changes as necessary;
- submits monthly, quarterly, and annual reports related to consumer contacts and workloads. Develop regular and ad hoc reporting for program areas, such as the Office of Social Services, the Medicaid/CHIP Division, and others, indicating the number and type of complaints and inquiries received related to their respective programs;
- serves as the central point of contact for development and submittal of the monthly enterprise complaints reports from HHSC and CCEA organizations;
- manages the Ombudsman's complaint management and tracking system and workforce system;
- assesses the Ombudsman's processes and procedures to determine necessary modifications and changes, and devises implementation strategies;
- evaluates Ombudsman program activities to ensure efficiency and promote excellent customer service;
- undertake outreach, education, and liaison and other activities to ensure awareness and accessibility to the Ombudsman's office; and
- assists in establishing, developing, and meeting the OO program goals, objectives, and guidelines.

Information Technology – Bowden Hight; 662 FTEs

House Bill 2292 directed a consolidated approach to Information Technology, including a consolidated help desk and HHS-wide license agreements for technology goods and services. The Office of Information Technology partners with Texas oversight agencies, agency program management, information resource management, administration, and stakeholders to deliver optimal value, cost-effective, customer-focused IT services that help both HHSC and the HHS agencies serve their clients.

To better manage information technology services and help align HHSC information technology with its core business, the Chief Information Officer established a governance structure comprised of five portfolios. Each portfolio − Administrative Systems Portfolio, Infrastructure and Shared Services Portfolio, Client Systems Portfolio, Eligibility Systems Portfolio, and Health Services Portfolio − represents a customer area and has its own governing body.

In addition to the 662 state FTEs, HHSC IT employs more than 140 contractor resources who perform short-term work or work that requires specialized skills. HHSC IT has an active *Contractor to State Staff Transition Plan* that converts contractors to State staff when the skill requirement will be long-term. These conversions achieve cost savings and do not increase the overall FTE count. In addition to State and contractor staff, where appropriate, HHSC IT uses contracts to acquire "managed services" for work such as seat management, data loss prevention, and applications development. Resources under "managed services" contracts do not count toward the division's FTE totals.

The Office of Information Technology oversees HHS IT projects and systems through six major functions.

<u>Applications</u>

IT Applications develops and manages applications and databases that support both HHSC and HHS cross-agency system-level operations and is standing up a Software Engineering Process Group to standardize enterprise application development.

HHSC IT Applications facilitates investigations, evaluations, and documentation of business processes and system requirements, and strategically aligns applications with business vision, goals, and objectives. Examples of systems developed and maintained include the Texas Integrated Eligibility Redesign System (TIERS) and Health and Human Services Administrative System (HHSAS) Financials system.

In addition, Applications coordinates with the Office of Social Services and the Medicaid/CHIP Division to provide IT oversight to major HHS contracts with technology components, including the Electronic Benefits Transfer system (Lone Star Card), Medicaid Management Information Systems, Enrollment Broker, and managed care organizations.

Infrastructure and Operations (I&O)

IT Infrastructure and Operations (I&O) manages core IT infrastructure services and assets in support of HHSC and the HHS system. These services include internal and external data center operations (including statewide consolidated data center services), wide area networking, access provisioning, enterprise telecommunications, and enterprise messaging and collaboration services. Major functions include the day-to-day management and operations of TIERS and other systems production data center services and assets. Examples include activities in support of three data centers housed within the Winters building complex comprised of approximately 550 servers, as well as oversight of the statewide consolidated data center services for HHSC.

Infrastructure and Operations manages and supports the statewide Local Area Network (LAN) for HHSC and the Wide Area Network (WAN) infrastructure for the enterprise, manages email and other messaging tools and services for the enterprise, as well the telephony infrastructure for over 27,000 telephones in the enterprise. I&O also provides user access permissions to various applications, systems, and tools.

Chief Information Security Officer (CISO)

IT Customer Service provides help desk support, desk-side support, seat management, end user computing management and support, mobile computing management and support, account provisioning, telephone/smart phone provisioning and support, asset tracking, request fulfillment, office move coordination, IT procurement oversight, and contract oversight.

IT Customer Service Help Desk provides a variety of support services to HHSC, DADS, State Supported Living Centers, State Hospitals, DFPS, private providers, and community centers. These services include initial intake via phone and email, documenting problems, password resets, change request tickets, managing HHSC and DADS broadcast notifications, as well as, providing basic troubleshooting and problem resolution. In addition, the IT Customer Service Help Desk works with each agency to collect and report on enterprise-wide call center metrics.

Chief Technology Officer (CTO)

The office of the CTO is responsible for developing the HHSC and the HHS System technology vision, architecture, and technology strategic plans and evaluating current and emerging technology solutions that enable and facilitate business improvement and future growth across the HHS System.

The Office of the CTO coordinates the HHS cross-agency IT Standards Workgroup, which establishes common HHS-wide IT standards, and chairs the Technology Architecture Review Board (TARB), which helps steer the HHS System IT architectural direction in such areas as Cloud Computing and Telework.

Customer Service

Customer Service provides for state office and regional desk-side support, end user computing support and provisioning, and telephone/smart phone provisioning.

IT Customer Service provides Help Desk support to HHSC, DADS, State Supported Living Centers, State Hospitals, DFPS, private providers, and community centers. These Help Desk services include taking calls, documenting problems, password resets, and change request tickets, as well as, providing basic troubleshooting and problem resolution.

IT Customer Service has established an enterprise-wide Help Desk Workgroup and collects and reports on enterprise-wide call center metrics.

IT Business Services (ITBS)

ITBS provides HHSC IT with contract management, audit support, communications, oversight and standards, financial management, project/program/portfolio management, external and internal reporting, software asset management, service catalog management, and administrative support. ITBS coordinates IT project planning for the HHS enterprise and provides assistance to the HHS agencies with development of Advanced Planning Documents (APDs) and Quality Assurance Team (QAT) deliverables.

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

The Office of Social Services − Stephanie Muth; 9,007 FTEs

Introduction

The Office of Social Services (OSS) connects Texans to services by determining social service program eligibility, including cash (Temporary Assistance for Needy Families), medical (Medicaid and the Children's Health Insurance Program), and food assistance (Supplemental Nutrition Assistance Program). In addition, OSS contracts and collaborates with community organizations to provide social services including, but not limited to, family violence services, 2-1-1 information and referral, and refugee services.

Organizational Structure

The Office of Social Services focuses on improving service quality and efficiency in the following ways.

Empowering clients to manage their case through self-service options.

- Features are being added to enhance YourTexasBenefits.com functionality including various ways to promote usage.

Giving Texans application decisions quickly.

- A business process redesign effort is underway to reduce determination days and improve operation efficiencies.

Providing staff the tools and technology necessary for success.

- Enhancements are being made to the automated system that supports eligibility determination.

Strengthening program integrity and accuracy.

- Expanding the use of third party data sources.

Promoting a culture of excellence.

- Targeted internal communication strategies are being employed including intranet page redesign and regular video messages from leadership on key topics.

Within the Office of Social Services, exist six main divisions, as described below.

Office of the Deputy Executive Commissioner

The Deputy Executive Commissioner, hired by the Executive Commissioner, manages day-to-day operations of the Office of Social Services. Major responsibilities include: directing the operations of over 9,000 employees in 269 statewide offices, developing and implementing eligibility policy directed by the Legislature, the federal government, and the Executive

Commissioner, and identifying and implementing business process changes to increase operational efficiencies. The Office of the Deputy serves as a coordination point for rules and memos from the Department of Assistive and Rehabilitative Services and the Department of Family and Protective Services to the Executive Commissioner.

To efficiently and effectively serve Texans eligible for social services, OSS must be a flexible and dynamic organization with a culture of continuous improvement. In 2012, OSS underwent an organizational redesign to support the need for a dynamic culture. OSS consists of five divisions under the oversight of the deputy executive commissioner. The divisions include: Eligibility Operations, Community Access and Services, Program Innovation, Policy Strategy, Analysis, and Development, and Business and Operations Support.

Eligibility Operations

Eligibility Operations connects Texans to services by determining eligibility for food, medical care, and cash assistance.

Community Access and Services

Community Access and Services connects Texans to local resources and services that promote self-sufficiency and enhance safety and well-being through partnerships with faith and community based organizations.

Program Innovation

Program Innovation identifies and facilitates more efficient ways to do business through technology, business process changes, communication tools, and improved project management procedures. Program Innovation was created in 2012 to drive a culture of continuous improvement and change management. The major initiative underway in this area is a review of local office business processes to identify how efficiencies can be gained and how the eligibility determination days can be reduced.

Policy, Strategy, Analysis, and Development

Policy Strategy, Analysis, and Development (PSAD) researches and recommends best practices and policy innovations, analyzes state and federal policy impacts, and works strategically with partners to develop policies that achieve OSS goals. PSAD is responsible for developing eligibility policies including the Medicaid eligibility policy changes under the Affordable Care Act.

Business and Operations Support

Business Operations Support provides contract management and monitoring for the eligibility vendor contracts and OSS financial management.

In fiscal year 2012, the Office operated with a total budget of $170,842,185, comprised of the following sources of revenue.

General Revenue:	$80,485,656
Federal:	$89,831,381
Other:	$525,148

General Revenue sources are primarily state-match funding for the Medicaid (50 percent), SNAP (50 percent), and CHIP (28 percent) programs, with corresponding federal funds and the addition of federal TANF and Refugee funds. Several different cost allocation factors using primarily HHSC program client counts and random moment time studies determine the share of federal and state charges. Other funds represent interagency contract funding from cost allocation billings based on the oversight factor.

The following sections provide additional detail for the programs administered by Social Services.

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Supplemental Nutrition Assistance Program (SNAP) Client Benefits
Location/Division	4900 N. Lamar Blvd., Austin, Texas Brown-Heatly Building/Policy Strategy, Analysis, and Development/Office of Social Services
Contact Name	Stephanie Stephens, Director
Actual Expenditures, FY 2012	See Section VII: Eligibility Operations
Number of Actual FTEs as of June 1, 2013	See Section VII: Eligibility Operations
Statutory Citation for Program	• Code of Federal Regulations, Title 7, Chapter 2, Part 273, Food Stamps • Texas Human Resources Code, Chapter 33 Nutritional Assistance Programs

B. What is the objective of this program or function? Describe the major activities performed under this program.

Supplemental Nutrition Assistance Program (SNAP), formerly known as the food stamp program, provides nutrition assistance to eligible low-income individuals and families by providing a monthly benefit that can be used to purchase food. The stated purpose of the program is "to permit low-income households to obtain a more nutritious diet by increasing their purchasing power" (Food and Nutrition Act of 2008). SNAP is an entitlement program and is available to all individuals who meet the eligibility guidelines established by Congress. In general, eligible recipients include low-income children, adults, families, people who are age 65 and older and those who have disabilities.

The federal government defines allowable food items that can be purchased with SNAP benefits. Allowable food items include breads, cereals, fruits, vegetables, meats, fish, poultry, and dairy products. Seeds and plants which produce food for the household to eat can also be purchased. SNAP benefits cannot be used to purchase non-food items, vitamins, medicines, hot foods, alcohol, or tobacco products.

HHSC staff in the Eligibility Operations division determines SNAP eligibility, through an integrated eligibility system that also includes Temporary Assistance for Needy families (TANF)

cash assistance and Medicaid for children and families. (For a detailed description of eligibility functions, please see **Section VII: Eligibility Operations – Program Management**).

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

Performance Measure Fiscal Year 2012	Statistics
Annual Number of Active Cases - Unduplicated	2,252,793
Monthly Average of Number of Active Cases	1,489,718
Annual Number of Individuals Served - Unduplicated	5,281,104
Monthly Average of Individuals Served	3,612,648
Percent of Eligible Population Receiving SNAP Benefits	56.7%
Monthly Average of Applications Processed	174,536
Monthly Average Renewal Determinations	150,807
Annual Statewide Average of Recipients Age 60 or Older	299,190
Annual Statewide Percentage of Recipients Age 60 or Older	8.3%
Annual Statewide Average Recipients Who are Children Under Age 18	1,984,188
Annual Statewide Percentage of Recipients Who are Children Under Age 18	54.9%
Annual Amount SNAP Benefits Issued (100% federal)	$5,220,344,498
Monthly Average of SNAP Benefits Issued (100% federal)	$435,028,708

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

1964 Congress establishes the food stamp program with the dual purpose of strengthening the agricultural economy and providing improved levels of nutrition among low-income households. This program requires households to purchase food stamps, paying an amount consistent with their normal expenditures for food and receiving an amount of food stamps representing a nutritionally adequate diet.

1974 The program operates nationwide. By this time, uniform national standards of eligibility are in place; the federal government pays 50 percent of all states' costs for administering the program, and establishes a requirement for efficient and effective state administration.

1977 Federal legislation eliminates the purchase requirement of food stamps, established several eligibility rules, and added several program access provisions. Access provisions include telephone interviews, bilingual materials, 30-day processing standards, expedited service, and disaster plans. Enhanced funding for anti-fraud activities and financial incentives for low error rates are also introduced.

1995 The Texas Department of Human Services replaces the paper system of delivering food stamp benefits with an electronic funds transfer and modern technologies known as Lone Star Electronic Benefit Transfer (EBT) system.

1996 Congress passes The Personal Responsibility and Work Opportunities Reconciliation Act of 1996, which places time limits on food stamp benefits for able-bodied adults without dependents (ABAWDs), provides additional Employment and Training funds targeted toward providing work program opportunities for ABAWDs, and allows states to exempt up to 15 percent of the estimated number of ABAWDs who would otherwise be ineligible.

2002 Congress passes the Farm Bill of 2002 to reauthorize and simplify the food stamp program, as well as increase program access.

2008 The federal Food, Conservation, and Energy Act of 2008 changes the name of the food stamp program to SNAP effective Oct. 1, 2008. The Act formally reauthorizes the nutrition program and strengthens integrity, simplifies administration, maintains state flexibility, improves health through nutrition education, and improves access.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

While households receiving SNAP benefits range from families with young children to older adults receiving Social Security Income (SSI), all are low-income individuals and families using SNAP to purchase food.

- Texas SNAP households have an average of 2.5 recipients.
- 3.2 percent of the SNAP caseload receives TANF.
- 19.4 percent of the SNAP caseload receives SSI.
- More than half of SNAP recipients are children under the age of 18.
- The average SNAP household in Texas receives slightly more than $300 per month to purchase food.
- 42.6 percent of SNAP households have earned income and 83.3 percent of SNAP households have some type of income from a job, child support, or federal benefits.

Qualifications or Eligibility Requirements

SNAP Eligibility is based on financial and non-financial factors. HHSC must verify each of the following eligibility criteria:

- Texas residency;
- U.S. citizenship or eligible alien status;
- resources (described below);
- income and allowable deductions;
- work requirements and time limited participation for able-bodied individuals, age 18-49, without dependent children;
- ineligibility due to student status, or living in an institution that offers more than half of monthly meals;
- compliance with SNAP employment and training services; and
- Social Security Number (SSN), or that the applicant is applying for one.

HHSC staff must also verify the following factors which would disqualify an individual:

- ineligible undocumented immigrants;
- Able-Bodied Adults Without Dependents (ABAWD) time limits established by the program;
- individuals who are fugitives or have felony drug convictions for offenses committed after 8/22/1996;
- individuals determined to have committed an intentional program violation (fraud); and
- Individuals who failed to comply with work requirements, SSN requirements, or the quality control review process.

Resources

HHSC excludes resources of households in which everyone receives TANF cash assistance or Social Security's Supplemental Security Income (SSI) program. HHSC determines eligibility for other households using the resource criteria below.

- The household must have $5,000 or less in countable liquid resources combined with excess vehicle value.
- Exempt up to $15,000 of the fair market value (FMV) for the highest valued countable vehicle. Count the excess over $15,000 FMV toward the combined resource limit.
- Exempt up to $4,650 FMV for all other countable vehicles. Count the excess over $4,650 FMV toward the combined resource limit.
- The household is not eligible if countable resources exceed the $5,000 resource limit.

Income

SNAP has gross and net income limits. Gross income includes a household's total, non-excluded income, before any deductions have been made. Net income equals gross income minus allowable deductions.

Gross income

All households, except those that include a person who is age 60 or older or has a disability, must meet a gross income test of 165 percent of the federal poverty income limit (FPIL) to be eligible for SNAP. For a household of four, 165 percent of FPIL is $3,170 a month (see chart below for additional examples). Households who pass the $5,000 resource test and have gross income less than or equal to 165 percent FPIL are categorically eligible for SNAP, unless a member is disqualified for an intentional program violation.

Net income

All households who are not categorically eligible must pass a net income test of 100 percent FPIL. The household is not eligible if its net income is more than the net income limit for that size household. The maximum gross income limits, adjusted annually to reflect current federal poverty guidelines, are based on the number of persons in the household and are as follows:

Household Size	Gross (165%)*	Gross (130%)	Net (100%)
1	$1,536	$1,211	$931
2	$2,081	$1,640	$1,261
3	$2,625	$2,069	$1,591
4	$3,170	$2,498	$1,921
5	$3,714	$2,927	$2,251
6	$4,259	$3,356	$2,581
7	$4,803	$3,785	$2,911
8	$5,348	$4,214	$3,241

9	$5,893	$4,643	$3,571
10	$6,438	$5,072	$3,901
For each additional person, add:	+$545	+$429	+$330

*The figures in the 165 percent column are used to determine if an elderly or person with a disability living with others may claim separate household status even though he purchases or prepares food with the others. The figures in this column are also the income limits for categorically eligible households.

Deductions are allowed as follows:

- a 20 percent earned income deduction;
- a standard deduction of $149 for household sizes of 1 to 3 people and $160 for a household size of four (higher for some larger households);
- a dependent care deduction when needed for work, training, or education;
- medical expenses for household members who are elderly or have a disability that exceed $35 for the month, and are not paid by insurance or someone else;
- legally owed child support payments;
- a set deduction of $143 for homeless households; and
- excess shelter costs that are more than half of the household's income after the other deductions. 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.

Texas allows a set amount for utility costs instead of actual costs. For federal fiscal year 2013, the standard utility deduction is $308. The amount of the shelter deduction cannot be more than $459 unless one person in the household is elderly or has a disability.

Work Requirements

Generally, able-bodied adults who do not have dependent children or other dependents between the ages of 18 and 50, who do not work or participate in a workfare or employment and training program (other than job search) can get SNAP benefits for only three months in a 36-month period. This time limit is waived in counties with unemployment rates exceeding 10 percent.

With some exceptions, able-bodied adults between 16 and 60 must register for work, accept suitable employment, and take part in an employment and training program to which they are referred by the local office. Failure to comply with these requirements can result in disqualification from the program.

Statistical Breakdown of Persons or Entities Affected							
	Number of Cases	**Number of Recipients**	**Recipients Ages < 5**	**Recipients Ages 5-17**	**Recipients Ages 18-59**	**Recipients Ages 60-64**	**Recipients Ages 65+**
FY 2013 Monthly Average	1,477,032	3,550,700	635,692	1,314,295	1,291,595	86,361	222,756

Maximum Monthly SNAP Allotment*	
Family Size	Maximum Benefit
1	$200
2	$367
3	$526
4	$668
5	$793
6	$952
7	$1,052
8	$1,202
For each additional person, add:	$150

*Benefit amounts are revised annually by Food and Nutrition Service. These amounts are effective October 1, 2012, through September 30, 2013.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

Federal and state governments share in the cost of administering the SNAP program. The federal government funds SNAP benefits and the state and the federal government pay equal shares of the administrative costs.

The U.S. Department of Agriculture's (USDA) Food and Nutrition Service (FNS) administers the SNAP program. Congress establishes eligibility guidelines, while FNS publishes federal regulations establishing basic eligibility and certification policies. Federal regulations allow Texas some options, and HHSC is authorized to administer those options subject to Texas statute requirements.

FNS is responsible for enrolling retailers into the SNAP program and for regulation of retailers. Congress, in the Food and Nutrition Act of 2008, defines eligible food items.

HHSC administers program policy, delivers client benefits through the Electronic Benefit Transfer card, and determines eligibility. (For a detailed description of eligibility functions, please see **Section VII: Eligibility Operations – Program Management**.)

The Texas Workforce Commission (TWC) coordinates the Employment and Training Program. Individuals who are determined eligible and are subject to work requirements are referred to TWC for employment and training services.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

SNAP

HHSC does not receive direct appropriations for SNAP benefits. SNAP benefits are 100 percent federal and are processed directly on the Lone Star card (the State's electronic benefit card). The benefit dollars are paid directly by the federal government and are not reflected in HHSC Appropriations. The value of SNAP benefits distributed in FY 2012 was $6,035,319,417.

Federal Funds and Other Appropriation Authority Riders

- **HHSC Rider 18** authorizes SNAP appropriations at HHSC for administrative costs related to the program. Funding information relating to that authority is provided in **Section VII: Eligibility Operations – Program Management**.

Federal Funds and Other Appropriation Authority Riders

- **HHSC Rider 21** authorizes federal SNAP performance bonus funds if Texas qualifies.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides Federal grants to states for:

- supplemental foods;
- healthcare referrals and nutrition education for low-income, pregnant, breastfeeding and non-breastfeeding postpartum women; and
- infants and children up to age five found to be at nutritional risk.

The Department of State Health Services administers this program.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

The Women, Infants, and Children (WIC) nutritional program is handled through a distinct application process and has unique eligibility requirements. Some families may qualify for both programs under federal guidelines.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

HHSC has a Memorandum of Understanding and works with TWC to coordinate the SNAP Employment and Training program. HHSC and TWC exchange data related to SNAP recipients required to participate in the Employment and Training program. TWC works with SNAP recipients to help them obtain employment, education, or training.

Since SNAP is a federal program, HHSC works closely with FNS on program administration and to obtain approvals for state plans, waivers, contracts, and advanced planning documents for technology systems. Additionally, FNS certifies retailers that accept SNAP benefits in Texas.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

HHSC contracts with vendors to provide eligibility determination support services. These contracts are described in **Section VII: Eligibility Operations – Program Management.**

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

Currently, federal regulations (Code of Federal Regulations, Title 7, Chapter 273.2) require states to accept an application as valid if it contains at least a name, address, and signature whether submitted via an online process or paper process (in person, mail, or fax). States may not require applicants to provide any additional information to establish the file date for the application. Regulations also require verification of identity for all households that apply for SNAP, which must be provided as follow-up if the applicant submits the minimally required information at application.

Many states, including Texas, developed robust third-party electronic verification systems that are used to verify applicant information (including identity), which results in improved program integrity. HHSC asked the USDA FNS to allow Texas the ability to only accept an online application if the applicant is authenticated through an integrated online verification process. FNS has indicated this change would require Congressional action. An amendment to the Farm Bill could allow states the ability to accept online applications with at least a name, address, and signature only if the signature can be authenticated through an automated process.

As HHSC encourages more online business and less face to face interaction with clients, new ways to prevent and detect fraud are necessary. Applicants currently provide an electronic signature for applications filed online. With federal authorization, HHSC's proposed new process would generate authentication questions for the applicant and identify attempts to submit fraudulent applications as part of the signature process.

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

N/A

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A. The U.S. Department of Agriculture's (USDA) Food and Nutrition Service certifies SNAP retailers.

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Temporary Assistance for Needy Families (TANF) Client Benefits
Location/Division	4900 N. Lamar Blvd., Austin, Texas Brown-Heatly Building/Policy Strategy, Analysis, and Development/Office of Social Services
Contact Name	Stephanie Stephens, Director
Actual Expenditures, FY 2012	$95,853,660
Number of Actual FTEs as of June 1, 2013	See Section VII: Eligibility Operations
Statutory Citation for Program	• Code of Federal Regulations, Title 45, Subtitle B: Regulation Relating to Public Welfare, Chapter II - Office of Family Assistance (Assistance Programs), Administration for Children and Families, Department of Health and Human Services • Texas Human Resources Code, Title 2, Chapter 31 - Financial Assistance And Service Programs

B. What is the objective of this program or function? Describe the major activities performed under this program.

Temporary Assistance for Needy Families (TANF) cash assistance provides temporary financial assistance to needy families. The receipt of TANF cash assistance is time-limited. The temporary nature of the TANF program is designed to help move recipients into work and self-sufficiency.

States receive a TANF block grant from the federal government which funds the cash assistance program and other services in Texas. Under the federal program, the four purposes of the TANF block grant are:

- assisting needy families allowing children to be cared for in their own homes;
- reducing the dependency of needy parents by promoting job preparation, work and marriage;
- preventing out-of-wedlock pregnancies; and

- encouraging the formation and maintenance of two-parent families.

Eligibility for the TANF cash assistance program is performed by HHSC staff in Eligibility Operations. Eligibility is integrated with eligibility for SNAP and Medicaid for children and families. For a detailed description of eligibility functions, please see **Section VII: Eligibility Operations – Program Management**.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

Key statistics and performance measures that reflect the effectiveness and efficiency of TANF Client Benefits are shown in the table below.

Performance Measure FY 2012	Statistics
Annual Number of Active Cases	79,688 (unduplicated)
Annual Number of Individuals Served	182,341 (unduplicated)
Amount and Percent of Recipients – Age 60 or older	1,094 (0.6%)
Amount and Percent of Recipients – Children 18 and under	139,989 (76.77%)
Monthly Average of TANF Issued	$166 per month per case
Annual TANF Monthly Benefits Issued	$7,157,745
Monthly Average of Clients Served	102,613
Monthly Average of Active Cases	43,243

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

1935 Congress passes the Social Security Act, creating the TANF predecessor, Aid to Families with Dependent Children (AFDC), which provided federal funds under Title IV to match state funds.

1995 The 74th Legislature, Regular Session, 1995, passes H.B. 1863, a comprehensive welfare reform bill. The Department of Human Services (DHS) receives federal waivers to operate under the state's requirements for financial assistance. The waiver includes

eligibility changes, benefit time limits, personal responsibility agreements, cooperation with child support collection, participation in work programs, immunization of children, and abstinence from abuse of drugs or alcohol.

1996 Congress passes the Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (PRWORA), which merges AFDC, JOBS (work-related training), and the Emergency Assistance program into one block grant called the TANF program. TANF replaces AFDC as part of an overall initiative to change welfare administration. Individual states receive TANF in the form of a block grant and each state determines how to use the funding within certain federal requirements. Eligible families must comply with a number of requirements designed to help them gain independence from government assistance.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

TANF provides financial help for children and their parents or relatives living with them. Monthly cash payments help pay for food, clothing, housing, utilities, furniture, transportation, telephone, laundry, household equipment, medical supplies not paid for by Medicaid, and other basic needs.

Texas has the following TANF cash assistance programs:

- TANF Basic Program − one-parent and child only cases;
- TANF State Program − two-parent cases;
- TANF One-Time Program − cash-only alternative to Basic or State Program available to qualifying families once a year; and
- TANF Grandparent Program − cash-only supplement to Basic or State Program benefits is available to grandparents responsible for raising their qualifying grandchild or grandchildren.

TANF Cash Assistance – State and Basic Program

To receive TANF, a family must be below established program 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 are ineligible for TANF cash assistance.

To determine eligibility, HHSC reviews at a family's income and compares it with the amount the family pays for basic needs such as rent, utilities, child care, and work-related expenses. Resources such as cash on hand, money in the bank, and vehicle values are also considered. States set their own income eligibility guidelines for TANF. Texas' income cap for a mother with

two children is $188 per month with an asset limit of $1,000. Vehicles worth less than $4,650 are exempt from the asset limit.

To receive and maintain TANF cash assistance, recipients must sign and cooperate with a Personal Responsibility Agreement (PRA) that requires recipients to:

- cooperate with child support requirements;
- participate in the Choices work program, unless exempt;
- agree not to voluntarily quit employment;
- refrain from abusing alcohol or drugs;
- attend parenting skills classes, if referred;
- obtain medical screenings for their children; and
- ensure their children are immunized and are attending school.

Failure to cooperate with these requirements results in a loss of benefits. The family loses cash assistance for one month or until PRA cooperation occurs, whichever is longer. If they fail to cooperate for two consecutive months, the TANF case is denied and the family must reapply and demonstrate 30 days of cooperation before receiving cash assistance. Adult members who fail to cooperate with work or child support requirements also lose Medicaid coverage for one month or until cooperation, whichever is longer.

Demographics of TANF Cash Assistance Recipients

Eighty-five percent of TANF recipients are children. The average case size has 2.4 recipients. The median age of children receiving TANF benefits is 7 years and the care taker is 28 years old. Approximately 95 percent of the caretakers are female with the majority having less than a high school education.

In June 2013 there were 34,748 TANF Basic cases and 1,056 TANF State cases. The average payment for each Basic case was $168 and the average payment for State cases was $261.

TANF Cash Assistance Time Limits

Federal law prohibits an adult and the adult's household from receiving TANF cash assistance for more than five years. Federal time limits do not apply to cases where there is no adult in the household. States have the option to establish TANF time limits less than the five-year federal time limit. Texas has adopted 12, 24, and 36 months tiered TANF time limits based on education level and work experience.

TANF One-time Payment

There are two types of one-time payments available to families who meet certain criteria – one-time TANF and grandparent payments.

One-time TANF provides $1,000 in cash for families in crisis. It can be given only once in a 12-month period. To qualify for a one-time TANF payment, families must meet the same income

and resource limits required for the regular TANF program. Additionally, a household must have experienced a recent loss of employment or financial support from a spouse. Those families who are receiving ongoing monthly TANF payments are not eligible for a one-time TANF payment. In June 2013, 172 one-time TANF payments were made.

The purpose of one-time TANF is to help with a short-term crisis such as:

- loss of a job or a home;
- loss of financial support for a child, such as child support or help paying living expenses (rent, utilities, and food);
- inability to find a job after graduating from a university, college, junior college, or technical training school;
- inability to get a job because vehicle is not working; or
- medical emergency.

The one-time TANF grandparent payment is $1,000 cash assistance given to a grandparent who cares for a child receiving TANF. In June 2013, 35 grandparent payments were made. To receive this assistance, a grandparent must meet certain criteria:

- 45 years old or older and meets income and resource limits;
- gross family income of less than or equal to 200 percent of the federal poverty limit; and
- resources less than $1,000.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

At the federal level, the U.S. Department of Health and Human Services (DHHS), Administration for Children and Families (ACF) regulates the program and administers the TANF block grant. States have broad discretion to determine who is eligible for TANF funded benefits and services.

In Texas, administration of the cash assistance program is shared between HHSC and TWC. HHSC is responsible for TANF eligibility determination, eligibility-related policies, and making cash assistance payments. TWC is responsible for work-related policies and for delivering employment services through local workforce development boards. HHSC is designated as the single state TANF agency and is responsible for federal reporting requirements. TWC coordinates with HHSC in submitting information and requests to the federal government.

For a detailed description of eligibility functions, please see **Section VII: Eligibility Operations – Program Management**.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

The following represent funding for TANF client benefits provided through the cash assistance and state programs. Administrative funding is discussed in **Section VII: Eligibility Operations – Program Management**.

Temporary Assistance for Needy Families

General Revenue: $66,335,246
Federal: $29,518,415

	General Revenue	Federal	Other
Strategy D.1.1 TANF Cash Assistance	$66,335,246	$29,518,415	0

General Revenue funding includes HHSC's portion of the State's federal MOE requirement for the TANF program as well as 100 percent General Revenue for TANF-State Program. This strategy and the eligibility strategy are the only places where HHSC can expend the TANF MOE funding. Federal funding sources are TANF.

Federal Funds and Other Appropriation Authority Riders

- **HHSC Rider 22** requires expenditure of the TANF Maintenance of Effort funding.
- **Art. IX Section 13.03** relates to use of TANF and related funds.

Budget Requirement and Reporting Riders

- **HHSC Rider 28** requires submission of TANF-related reports, waivers, petitions, and plan amendments.
- **Art. II Section 13** requires the submission of TANF quarterly forecasts and monthly data.
- **Art. II Section 44** relates to rate limitations and reporting requirements, including TANF federal funds.

Programmatic Riders

- **HHSC Rider 20** authorizes the payment of a one-time emergency assistance TANF grant to individuals likely to be unemployed within a short period of time.
- **HHSC Rider 23** requires an earned income disregard for TANF cash assistance.

- **HHSC Rider 25** requires the TANF family poverty level at 17 percent and the annual payment of a one-time grant of $30 for each TANF child on August 1.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

HHSC also oversees the Refugee Cash Assistance (RCA) Program, which provides cash grants to eligible refugees for eight months after their arrival to the United States. Applicants must have a qualifying immigration status and show they have been denied for TANF cash assistance to qualify for RCA. As with TANF, RCA recipients must also agree to participate in work programs. Eligibility policies for RCA are set by HHSC, but eligibility is determined through contracted entities that provide refugee services.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

The RCA is handled through a distinct application process and has unique eligibility requirements to ensure duplicate benefits are not issued through RCA and TANF.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

HHSC has an Interagency Agreement and works with TWC to coordinate TANF work participation requirements. HHSC and TWC exchange data related to TANF recipients including referrals for services and notice of noncompliance with work requirements that can result in sanctions and program disqualification. TWC works with TANF recipients to help them obtain employment, education, or training.

HHSC also has an Interagency Agreement with the Office of Attorney General (OAG) that permits data exchanges relating to child support payments. HHSC verifies child support payments/income with OAG. OAG then notifies HHSC of TANF recipients' noncompliance with child support orders.

ACF is responsible for overall administration of federal programs that promote the economic and social well-being of families, children, individuals, and communities, including the TANF program. HHSC's TANF state plan must be approved by ACF, and the agency is required to submit regular reports that include Texas TANF recipient data.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

HHSC contracts with vendors to provide eligibility determination support services. These contracts are described in **Section VII: Eligibility Operations – Program Management**.

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

N/A

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

N/A

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Medicaid and Children's Health Insurance Program Client Benefits
Location/Division	4900 N. Lamar Blvd., Austin, Texas Brown-Heatly Building Policy Strategy, Analysis, and Development/Office of Social Services
Contact Name	Stephanie Stephens, Director
Actual Expenditures, FY 2012	See Section VII: Medicaid/CHIP
Number of Actual FTEs as of June 1, 2013	See Section VII: Eligibility Operations
Statutory Citation for Program	• Code of Federal Regulations, Title 42, Chapter IV, Part 435, Medicaid • Code of Federal Regulations, Title 42, Chapter IV, Part 457, State Children's Health Insurance Program • Texas Human Resources Code, Chapter 32, Medical Assistance Programs • Texas Health and Safety Code, Chapter 62, Child Health Plan for Certain Low-income Children

B. What is the objective of this program or function? Describe the major activities performed under this program.

Congress created the Medicaid and the Children's Health Insurance Program (CHIP) programs to provide medical assistance to low-income Americans.

Medicaid is an entitlement program, which means the federal government does not, and the state cannot, limit the number of eligible people who can enroll. Eligibility can be based on income, age, and resources/assets. In general, eligible recipients include children, adults with dependent children, pregnant women, and people who are age 65 and older and those who have disabilities or chronic illnesses. Adults who have no dependent children, do not have a disability, or are not age 65 and older are not eligible for Texas Medicaid.

CHIP is not an entitlement program. Therefore, the state can establish age and income eligibility requirements and cap enrollment. Federal funding for CHIP is limited and based on a federal allocation to each state. In Texas, uninsured children under the age of 19 may qualify for CHIP if they meet citizenship, income, and resource criteria.

HHSC administers the Medicaid and CHIP programs through two divisions. The Office of Social Services oversees eligibility policies and eligibility determinations for Medicaid and CHIP via staff in the Eligibility Operations Division. Eligibility is integrated for Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) cash assistance. The Medicaid/CHIP Division is responsible for client benefits delivery and health plan management.

HHSC performs many functions necessary to determine Medicaid and CHIP eligibility. Those functions are discussed in **Section VII: Eligibility Operations – Program Management.** Benefit delivery for the Medicaid and CHIOP programs is described in **Section VII: Medicaid/CHIP Division Overview**.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

The tables below include performance measures showing the latest enrollment figures for Medicaid and CHIP in Texas.

Medicaid Enrollment July 2013 Preliminary Point-in-Time Data	
Performance Measure	
Aged	237,935
Disabled and Blind	528,688
TANF Adults	102,263
Pregnant Women	106,755
Medically Needy	1
Children's Medicaid (total of below)	2,402,002
TANF Children	376,792
Foster Care Children	31,898
Newborns	189,396
Children Age 1-5	713,573
Children Age 6-18	1,090,343
Total - All Medicaid Enrollment	3,377,644

CHIP Enrollment, Renewal, and Disenrollment July 2013	
Performance Measure	
New Enrollment	39,348
Renewals	18,386
Completed Renewals Deemed Ineligible	7,606
Total Disenrollment	36,570
Actual Renewal Rate	56.8%
Attempted Renewal Rate	65%
Total Disenrollment Rate	6%
Total CHIP Enrollment	605,824

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

1965 – 1967 Congress establishes the Medicaid program under Title XIX of the Social Security Act of 1965 to pay medical bills for low-income persons who have no other way to pay for care. Texas begins participating in the Medicaid program in September 1967.

1993 Federal Medicaid regulations require each state to designate a single state agency responsible for the state's Medicaid program. State statute designates HHSC as the single state agency for the Texas Medicaid program, effective January 1993.

2007 Title XXI of the Social Security Act, enacted in 1997 by the Balanced Budget Act, authorizes federal grants to states for provision of child health assistance to uninsured, low-income children. Texas begins covering uninsured children from birth through 18 years of age in CHIP in May 2000. The CHIP Perinatal program begins in January 2007, operated by the Medicaid and CHIP Division within HHSC.

2013 In October 2013, HHSC will begin using a single, streamlined application form for Medicaid, CHIP, and the federal Marketplace in preparation for implementation of the Affordable Care Act (ACA).

2014 Effective January 1, 2014, the ACA mandates changes to Medicaid and CHIP eligibility requirements. States will begin determining financial eligibility for most individuals based on the modified adjusted gross income (MAGI), which uses federal income tax rules for determining income and household composition. Additionally, Medicaid will expand to cover former foster youth through age 25 and children ages 6 to 18 above 100 percent of the Federal Poverty Level (FPL) and up to and including 133 percent of the FPL.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

Federal and/or state law defines the Medicaid client population. The target population includes individuals eligible for either full or limited benefits.

Full Benefits

There are three primary categories of Medicaid clients eligible for full benefits.

Families and Children

This group comprises the majority of eligible clients for full Medicaid benefits. Eligibility requirements include age, family income, resources, or pregnancy. Eligible groups also include newborns born to Medicaid certified mothers, children in foster care who are either under age 18, "age out" of the foster care system at age 18, or who are adopted from the foster care system.

Cash Assistance Recipients

These individuals receive state/federal financial assistance through TANF or Supplemental Security Income (SSI). TANF eligibility guidelines are established by the state, which in Texas is currently set at an asset limit of $1,000. SSI eligibility is for individuals with disabilities who have a monthly income limit of $710 with an asset limit of $2,000.

Elderly and People with Disabilities

The elderly and persons with disabilities who do not receive SSI may qualify for Medicaid services while receiving care in a nursing facility, intermediate care facility for persons with intellectual and developmental disabilities (IDD), State Supported Living Center or state mental health facility. They may also qualify under a Medicaid waiver program if their income status changes. Within this group are individuals who qualify for full or partial Medicare benefits and full or partial Medicaid assistance and are referred to as "dual eligibles." Eligibility for this population is both financial and functional. HHSC determines the financial eligibility, and the Department of Aging and Disability Services (DADS) oversees the functional assessment.

Limited Benefits

There are two primary categories of Medicaid recipients who qualify for limited benefits.

Medicare Beneficiaries

Based on income level and age, certain Medicare beneficiaries qualify for partial Medicaid benefits.

Non-Citizens

Legal permanent residents and undocumented persons who are not eligible for Medicaid based on citizenship status may receive emergency services – full Medicaid benefits, but only for the emergent period of time. Emergency services do not include ongoing client services, but provide a hospital payment source for hospitals that provide emergency care services.

Medicaid Qualifications or Eligibility Requirements

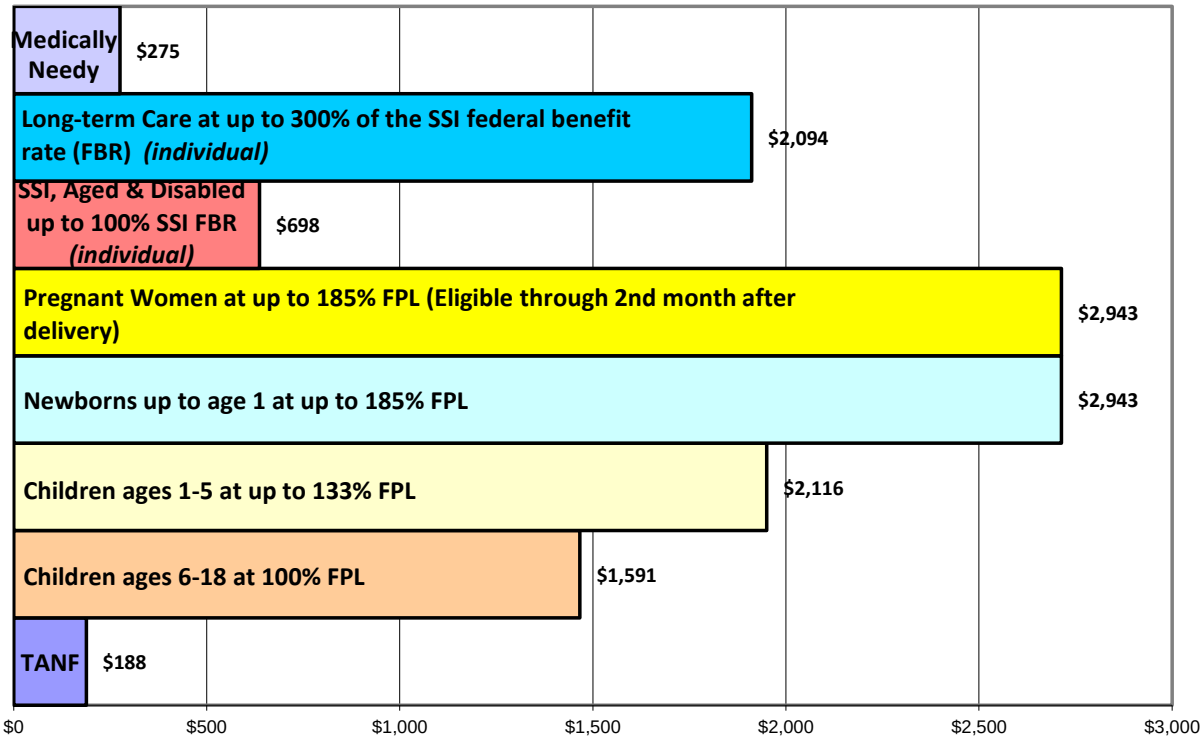
Individuals that receive TANF or SSI are categorically eligible for Medicaid. For others, Medicaid eligibility is financial and categorical. Eligibility requirements include:

- family income and resources;
- age;
- residence;
- citizenship status;
- Social Security Number;
- third-party resources/private health insurance;
- medical necessity or level of care for those in an institution; and
- other factors such as being pregnant or disabled.

Medicaid Eligibility in Texas, 2012

Maximum Monthly Countable Income* Limit

(family of three unless otherwise specified)



*"Countable income" is gross income adjusted for allowable deductions, typically work related.

The following tables provide a statistical breakdown of persons or entities affected by Medicaid.

Texas Medicaid Recipients by Gender FY 2012	
Male	1,624,446 / 44%
Female	2,027,450 / 56%
Unknown	593 / 0%
Total Enrollment	**3,652,489**

Texas Medicaid Recipients by Age FY 2012	
0-5	1,120,514 / 31%
6-14	1,115,983 / 31%
15-20	387,225 / 11%
21-64	686,359 / 19%
65+	342,408 / 9%

Texas Medicaid Recipients by Ethnicity FY 2012	
African-American	602,289 / 16%
Caucasian	763,123 / 21%
Hispanic	1,877,295 / 51%
Other/Unknown	409,782 / 11%

Qualifications or Eligibility Requirements for CHIP

To qualify for CHIP, a child must be:

- age 18 or younger;
- a Texas resident;
- a U.S. citizen or legal permanent resident;
- uninsured for at least 90 days[1];
- living in a family whose income is at or below 200 percent of Federal Poverty Level (FPL); and
- living in a family that passes an assets test if family income is above 150 percent of the FPL.

The following tables provide a statistical breakdown of persons or entities affected by CHIP.

[1] There are exemptions to the 90-day waiting period for families who lose their health insurance or for whom available health insurance costs 10 percent or more of the family's net income. A complete list of the exemptions can be found at http://www.chipmedicaid.org/english/qualify.asp.

CHIP Enrollment by Income Group July 2013	
Number by FPL < 101%	35,656 / 5.9%
Number by FPL 101%-150%	347,938 / 57.4%
Number by FPL 151%-185%	184,008 / 30.4%
Number by FPL 186%-200%	38,222 / 6.3%
Total Enrollment	**605,824**

Average Monthly CHIP Enrollment by Gender, FY 2012	
Male	291,725 / 51.2%
Female	277,962 / 48.8%

Average Monthly CHIP Enrollment by Age FY 2012	
< 1	823 / 0.1%
1-5	94,492 / 16.6%
6-14	346,678 / 60.9%
15-18	127,716 / 22.4%

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

Congress and the Centers for Medicare & Medicaid Services (CMS) established the general rules under which Medicaid and CHIP operate. Each state covers the required services and eligibility groups, but develops a unique program by determining which optional services and eligibility groups receive benefits.

In Texas, HHSC's OSS determines eligibility for individuals seeking Medicaid and CHIP benefits. This process is detailed in **Section VII – Eligibility Operations**.

Policies for the programs are included in the Medicaid State Plan, which is managed by HHSC's Medicaid and CHIP division (See **Section VII – Medicaid/CHIP Division – Policy Analysis, Program Development, and Waiver Oversight** for more information.).

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

See **Section VII: Medicaid/CHIP Division Section** for Medicaid and CHIP funding. Administrative funding related to eligibility determination is discussed in **Section VII: Eligibility Operations – Program Management**.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

The County Indigent Health Care Program (CIHCP), administered by the Department of State Health Services, provides healthcare services to eligible residents through counties, hospital districts, and public hospitals in Texas. There is no duplication of services with Medicaid because individuals who qualify for Medicaid are ineligible for CIHCP services.

In Texas, the Department of Assistive and Rehabilitative Services is contracted by the Social Security Administration (SSA) to perform SSI disability determinations. Since individuals receiving SSI are categorically eligible for Medicaid benefits, HHSC receives SSI eligibility information via a SSA electronic file. For individuals who apply and have not yet been determined to have a disability by SSA, HHSC will determine if they are eligible for other Medicaid programs or will await SSA's determination.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

HHSC determines eligibility for the programs. This information is maintained in a single system of record, the Texas Integrated Eligibility Redesign System (TIERS) (**see Section VII – Eligibility Operations**). TIERS interfaces with multiple data systems to provide benefits that are delivered effectively.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

CMS is the federal agency responsible for the administration of Medicaid and CHIP programs. CMS establishes coverage groups and levels of coverage that must be provided by states. States develop their own eligibility policies and define which optional groups will be covered. These policies must be approved by CMS as part of the Medicaid State Plan. OSS provides input to support waiver and state plan amendment development regarding eligibility policies and operations in conjunction with the Medicaid and CHIP Division.

Once an individual has been determined eligible for Medicaid or CHIP, the process of selecting a health plan and paying enrollment fees (if required) begins. HHSC's eligibility system updates other systems managed by the Medicaid and CHIP Division, and enrollment packets are mailed to eligible households. Administration of enrollment fees, benefits, health plans, and providers is managed by the Medicaid and CHIP Division.

HHSC also coordinates eligibility determinations for the Elderly and People with Disabilities with the Department of Aging and Disability Services (DADS). HHSC staff determines financial eligibility of applicants and DADS is responsible for overseeing the functional assessment of individuals applying for certain types of Medicaid coverage. Beginning in Fall 2013, certain Medicaid programs managed by DADS will begin to be carved into managed care. As those programs convert to managed care, the health plans overseen by HHSC will be responsible for the functional assessments (**see Section VII: Medicaid/CHIP Division - Programs Operations and Contract Management Oversight**).

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

HHSC contracts with vendors to provide eligibility determination support services. These contracts are described in **Section VII: Eligibility Operations – Program Management.**

HHSC contracts with vendors to support the delivery of health services through Medicaid and CHIP. These contracts are described in **Section VII: Medicaid/CHIP Division Section.**

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

N/A

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

ACA makes the following changes to Medicaid and CHIP eligibility standards effective January 1, 2014.

Modified Adjusted Gross Income (MAGI)

- requires the use of MAGI for most Medicaid and CHIP financial eligibility determinations;
- requires the use of tax filing status to determine household composition. Individuals in each household may have different household sizes;
- prohibits assets and resource tests and most income disregards;
- requires a 5 percentage point income disregard for all MAGI groups;
- certain Medicaid groups are exempt from using MAGI methodologies for determining eligibility, such as individuals who qualify for Medicaid on the basis of being blind or disabled; or individuals eligible for Medicaid on a basis that does not require a determination of income by the Medicaid agency (e.g., Supplemental Security Income, Medicaid for Breast and Cervical Cancer, etc.); and
- requires states to convert current income eligibility limits to MAGI-equivalent limits. The one-time income conversion establishes the maximum income eligibility limits for MAGI groups. States are required to submit an income conversion plan for federal approval.

Verifications

- requires use of electronic verifications to the extent possible;
- requires the federal government to establish an electronic service (known as the federal data hub) to facilitate electronic verifications with data from the Internal Revenue Service, Social Security Administration, and the Department of Homeland Security;
- allows self-attestation of all information for Medicaid and CHIP (except for citizenship and immigration status), such as household composition, non-financial eligibility status, and residency; and
- requires states to accept self-attestation of pregnancy in Medicaid and CHIP.

Applications & Renewals

- requires a single streamlined application for Medicaid, CHIP, and the Insurance Exchange. States may use the federal application or a state application with federal approval;
- allows states to use supplemental forms or an alternative application for non-MAGI groups;
- requires eligibility must be re-determined once every twelve months and no more frequently unless a change in circumstance is received that may affect eligibility;
- requires passive or administrative renewals for both MAGI and non-MAGI groups;
- requires that states to use available information to make eligibility determinations without requesting information or a renewal application from clients to the extent possible.

Performance Standards

- requires states to establish timelines and performance standards for determining eligibility promptly.
- possibly implements "real-time" eligibility determinations in most cases as indicated by the federal government; and
- maintains 45 days as maximum limit for determining Medicaid eligibility for clients without disabilities.

Coordinating Medicaid, CHIP, and Exchange Eligibility Determinations

State Medicaid and CHIP programs must establish an interface with the Insurance Exchange to coordinate eligibility determinations. States will have the option of delegating eligibility determinations to the Insurance Exchange. In addition, the ACA expands Medicaid to some mandatory populations effective January 1, 2014.

Mandatory Medicaid Expansion for Former Foster Care Youth

The Medicaid Expansion increases Medicaid coverage to include individuals in foster care who are between 19 and 26 years of age; in foster care in the state on their 18th birthday or up to their 21st birthday[2]; and enrolled in Medicaid. Further, there is neither a FPL income limit nor a resource/asset limit.

Mandatory Medicaid Expansion for Children Ages 6-18

The Medicaid Expansion increases coverage to children:

- ages 6 to 18; and
- with incomes above 100 percent up to 133 percent FPL.

The expansion moves these children from participation in CHIP to Medicaid.

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A

[2] States are required to cover former foster care youth who were in foster care in the state on their 18th birthday (or up to age 21 when they left the foster care program).

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Eligibility Operations
Location/Division	4900 N. Lamar Blvd., Austin, Texas Brown-Heatly Building/Office of Social Services
Contact Name	Stephanie Muth, Deputy Executive Commissioner
Actual Expenditures, FY 2012	$362,899,305
Number of Actual FTEs as of June 1, 2013	8,862
Statutory Citation for Program	Texas Government Code, Chapter 531, Sec. 531.0055 Executive Commissioner: General Responsibility for Health and Human Services Agencies

B. What is the objective of this program or function? Describe the major activities performed under this program.

Through the Office of Social Services Eligibility Operations division, HHSC determines whether applicants for cash, medical, and food assistance are eligible for enrollment in accordance with federal regulations and state statutes. HHSC oversees this process for the following programs:

- Medicaid (including Medicaid for children and families and financial eligibility for Medicaid Eligibility for the Elderly and People with Disabilities (MEPD));
- Children's Health Insurance Programs (CHIP);
- Supplemental Nutrition Assistance Programs (SNAP); and
- Temporary Assistance for Needy Families (TANF).

HHSC eligibility determination staff is organized by regions and are supported by specialized units dedicated to performing certain eligibility-related tasks (such as processing client reported changes that could impact eligibility or benefit levels). Eligibility determination is processed and benefit cases are maintained in HHSC's system of record, the Texas Integrated Eligibility Redesign System (TIERS). HHSC contracts with external vendors that support eligibility operations by performing routine clerical tasks such as document imaging and operating call centers that assist with basic HHSC client inquiries. Regional eligibility determination activities are supported by state office staff. State staff perform functions including quality assurance,

quality control, training delivery, curriculum development, policy support, and contract operations oversight.

Field Operations Primary Functions

- Determine HHSC programs eligibility.
- Conduct client interviews (as required) and verify applicant information.
- Collect, process, and maintain applicant information.
- Respond to applicant and client questions and complaints.
- Support and facilitate applicant requested administrative reviews, appeals, and fair hearings.

External Vendors Primary Functions

- Operate call centers to assist with application support and eligibility determination.
- Image application documents received in paper form.
- Provide data broker services allowing eligibility staff to authenticate application materials with independent third party data sources.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

In recent years, HHSC has experienced dramatic growth in program recipients (up nearly 46 percent between 2007 and 2012) without a proportionate increase in HHSC staff. Due to this rapid caseload growth, between 2007 and 2010 several performance measures were not met. However, by the end of 2010, these challenges were overcome, and HHSC's performance related to key measures, such as timeliness improved. In 2007, only 58 percent of SNAP applications were processed within federal timeliness standards with an error rate of 7 percent. By 2010, application processing timeliness increased to 98 percent and the error rate fell to below 4 percent. This was achieved primarily through improvements to management practices, reporting, business processes, the implementation of the TIERS system statewide, and staff training to increase effectiveness and efficiency to better serve citizens of Texas.

Performance Measure	FY 2007	FY 2010	FY 2012	% Change 2007-2012
Annual Average Number of Clients Served	5,464,548	7,002,128	7,974,014	45.9%
Monthly Average Number of Active Cases	2,080,772	2,884,335	2,787,998	34.0%
Monthly Average Number of Applications Processed	302,310	363,225	378,037	25.1%

Performance Measure	FY 2007	FY 2010	FY 2012	% Change 2007-2012
Monthly Average Number of Renewal Determinations	328,944	380,120	375,004	14.0%
Annual Average Number of Field Operations Staff	6,381	8,323	8,492	33.1%

HHSC benefit programs have performance standards either established by the agency to ensure quality or by federal agencies to monitor performance. Timeliness is a measure that relates to processing applications within specific timeframes (most commonly, 30 or 45 days), with a standard of 95 percent. Error rates track determination accuracy by monitoring the eligibility decision, calculation of benefit amounts, and compliance with policies and required procedures.

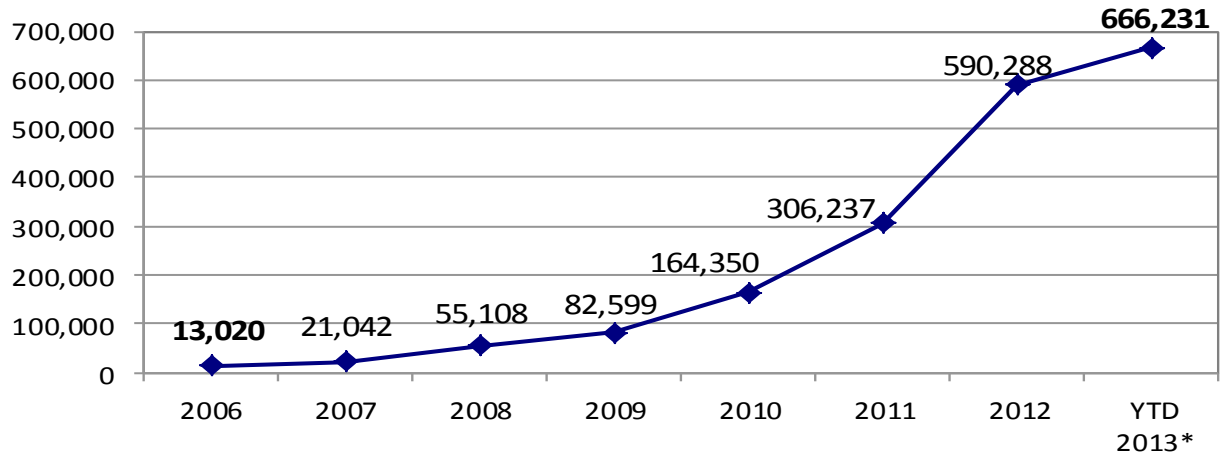
Program	Performance Measure (Annual Average)	FY 2007	FY 2010	FY 2012	% Change/ Improvement 2007–2012
SNAP	Timeliness of Eligibility Determinations	87.6%	94.4%	98.5%	12.4%
	Accuracy of Eligibility Determinations	6.38%	2.13%	3.63%	43.1%
TANF	Timeliness of Eligibility Determinations	90.3%	89.4%	98.9%	9.5%
	Accuracy of Eligibility Determinations	15.47%	5.53%	3.1%	80.0%
Medicaid	Timeliness of Eligibility Determinations	89.0%	84.5%	97.3%	9.3%
	Accuracy of Eligibility Determinations	6.51%	4.23%	5.45%	16.3%

To meet growing caseloads within existing resources, one of HHSC's key initiatives is to expand and improve clients' access to self-service options. Increased use of self-service options helps manage workload by reducing data entry, client traffic, and calls to eligibility offices. This allows staff to focus on their core function of making accurate and timely eligibility decisions. Vendor costs are also reduced because fewer documents are imaged and call volume is decreased. These efforts have proved advantageous for the agency, as the number of web-based applications completed more than tripled between 2010 and 2012. In addition, clients are able to submit changes related to their case information online. Since this functionality was added in 2012, more than 1.4 million changes have been submitted through YourTexasBenefits.com.

To educate clients about self-service options on YourTexasBenefits.com, HHSC placed computers in the lobbies of 239 eligibility offices and is working with community partners

(more information about the Community Partner Program can be found in **Section VII, Community Access and Services**). As the number of clients using YourTexasBenefits.com increases, it provides clients and applicants with greater flexibility while increasing the capacity of eligibility staff to focus on completion of timely and accurate eligibility decisions. As of late July 2013, more than 47 percent of the applications processed by HHSC are submitted via YourTexasBenefits.com.

YourTexasBenefits.com
Applications Submitted
Calendar Years 2006–2013 Year to Date*



*through July 28, 2013

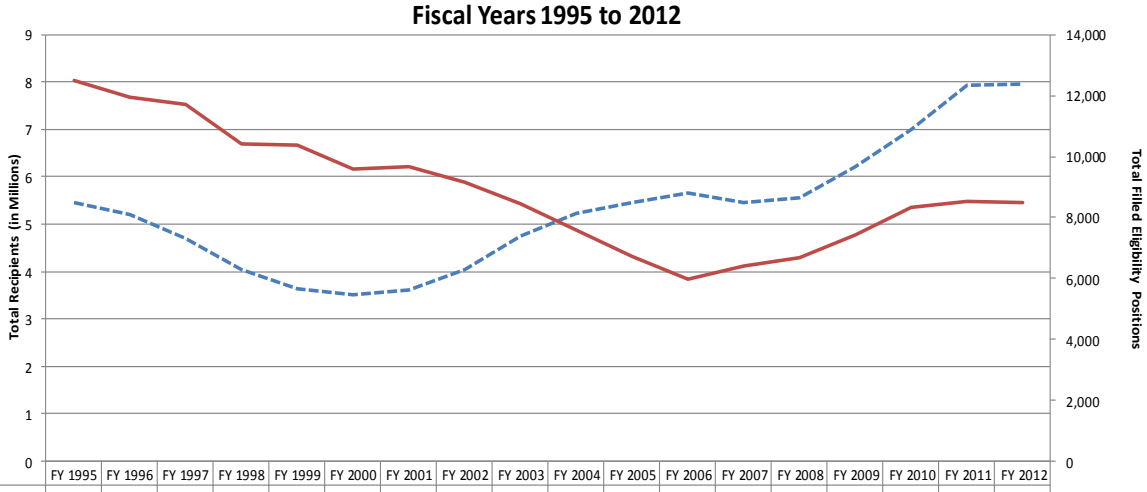
YourTexasBenefits.com Utilization				
Performance Measure	**Functionality/ Measurement Introduced**	**Initial Performance**	**June 2013 Performance**	**% Change**
Web-based Applications as a Percentage of all Applications Received by HHSC	August 2011	12.9% Aug 2011	46.6%	261%
Documents Uploaded*	Sept 2011	391 Oct 2011	13,995	3,479%
Number of Web-based Client-reported Changes	April 2012	4,242 May 2012	164,350	3,774%
Number of Web-based Renewals	August 2012	15,150 Sept 2012	31,740	110%
Number of Applications Submitted via Lobby Computers	February 2012	573 March 2012	30,286	5,186%

*Upload functionality was initially only available to certain community-based organizations providing application assistance. In June 2013, functionality expanded to allow applicants and clients to upload documents.

Staffing, Caseload, and Performance

The chart below provides a historical perspective on staffing levels and caseloads. As caseloads have increased over time, staffing levels have decreased. As a result, the nature of the job has shifted and business process changes were employed to increase efficiency.

Average Monthly Benefit Recipients and Filled Eligibility Determination Positions Fiscal Years 1995 to 2012



	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Total Recipients	5.45	5.20	4.70	4.04	3.64	3.52	3.61	4.04	4.74	5.24	5.45	5.65	5.46	5.56	6.21	7.00	7.94	7.97
Filled Positions	12,487	11,933	11,710	10,404	10,378	9,606	9,668	9,142	8,446	7,573	6,703	5,975	6,381	6,659	7,429	8,323	8,515	8,492

Note: Total Recipients count for Medicaid/TANF/SNAP is not an unduplicated total - recipients may be in all three categories

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

Texas Integrated Eligibility Redesign System (TIERS) and Technology Improvements

Technology improvements through the implementation of TIERS allowed HHSC to change from an office and paper-based system depending on face-to-face interactions to a system that supports client self-service features, and various access channels for applicants to apply and manage their benefits outside of business hours.

1997 House Bill 2777, 75th Legislature, authorizes a new project to streamline the eligibility determination process by creating a single system to operate statewide. The new integrated enrollment system replaces several systems used for eligibility determination and benefits issuance systems since the 1970s. The initiative is intended to increase program efficiencies by reducing fraud, eliminating duplicate paperwork, and reducing service delivery costs.

1999 The 76th Legislature appropriates funds to develop TIERS.

2003 The initial TIERS pilot begins in four eligibility offices in Travis and Hays counties. Expansion of TIERS is suspended to ensure the system could be transformed to accommodate the new delivery of eligibility services via multiple access channels envisioned under H.B. 2292.

2006 HHSC introduces YourTexasBenefits.com, allowing individuals not already known to HHSC to screen for potential eligibility and complete an online benefit application. In its initial form, applications did not populate the eligibility system. Eligibility staff printed the applications and data entered information into the automation system to determine eligibility.

2007 House Bill 3575, establishes the HHS Eligibility System Legislative Oversight Committee to monitor the transition from System Application, Verification, Eligibility Referral and Reporting (SAVERR) to TIERS. The bill requires HHSC to issue quarterly transition plans outlining progress to the Committee and increased legislative oversight of the conversion process. Additionally, the State Auditor's Office releases a report identifying key areas for improvement.

2008 In June, HHSC receives federal approval to expand TIERS for up to 22 percent of its SNAP caseload. HHSC develops a conversion schedule (the first occurring in Region 7 (Central Texas) converting approximately 30,500 cases from SAVERR to TIERS.

2009 Under the 22 percent approval, all remaining SAVERR cases in Region 7 are converted into TIERS.

2010 By September, HHSC completes conversions of two additional regions (Region 1 – Lubbock and Region 10 – El Paso) under the 2008 federal approval. HHSC receives approval to proceed with the regional conversions and converts Region 4 (Tyler) and Region 5 (Beaumont) by the end of the year. Remaining regions continue to process cases in both SAVERR and TIERS, which creates challenges for eligibility staff and clients in navigating both systems.

2011 HHSC completes the statewide conversion of all cases to TIERS in December 2011 through a series of regional rollouts. Improvements are made to YourTexasBenefits.com, including integration of client-entered applicant information directly into TIERS, rather than eligibility staff having to manually enter information. Functionality is added to allow select community-based organizations to upload documentation via the website on behalf of applicants.

2012 HHSC releases a series of YourTexasBenefits.com enhancements that include allowing the system to accept applications from existing and former clients already known to HHSC. New functionality gives clients the ability to submit online renewals, print temporary Medicaid identification, create authenticated accounts to see benefit details, and submit changes impacting their case.

2013 Expanded YourTexasBenefits.com functionality gives clients the ability to upload documents when submitting an application, renewal, or change.

Business Process Changes

Legislative changes and the need for additional efficiencies have driven significant changes to how eligibility services are provided. Notably, with the move to electronic case records stored in TIERS, call centers and centralized document processing became possible. Vendors were able to take on responsibility for eligibility support functions since TIERS' technologies could provide the tools necessary for call centers and centralized document processing.

2003 The 79th Legislature passes H.B. 2292, requiring HHSC to contract with private vendors to establish call centers to support eligibility determination and recertification for TANF, SNAP, and Medicaid.

2004 In July, HHSC receives federal approval to proceed with the consolidation and procurement of the Integrated Eligibility and Enrollment Services (IEES) contract. HHSC publishes the vendor request for proposals to maintain TIERS and establish and operate call centers for eligibility determination and recertification for TANF, SNAP, and Medicaid.

2005 In June, HHSC requests approval of the negotiated IEES contract and announces a tentative award to the Texas Access Alliance (TAA) led by Accenture. TAA assumes responsibility for CHIP, Enrollment Broker services, and TIERS contracts previously held by various contractors.

2006 In January, TAA, in conjunction with HHSC, implements an IEES pilot in Travis and Hays counties. The pilot is suspended after four months due to performance issues.

2007 HHSC and TAA mutually agree to suspend the IEES contract after failing to reach agreement on costs and service levels to implement the new business model. To avoid disruption in client services, HHSC transfers specific responsibilities to qualified subcontractors or previous contractors.

2008 HHSC issues requests for proposals for new Eligibility Support Services and Document Processing Services contracts.

2009 New Document Processing Services contract begins and includes primary responsible for creating electronic images of inbound mail and faxes related to benefit applications and renewals.

2010 New Eligibility Support Services contract begins, including HHSC client and applicant support via call center services, CHIP eligibility determination, association of electronic

images received from the Document Processing vendor to client cases, and assigning tasks to state staff for further processing.

2013 In preparation for implementation of significant Medicaid changes under the ACA, HHSC will move CHIP eligibility determination into TIERS in August. State staff will assume all responsibility for determining eligibility for CHIP. The vendor will continue to provide eligibility support.

System Performance

Caseload changes, staffing levels, technology changes, and business process changes combined with external factors such as natural disasters impacted eligibility system performance over time.

2009 In December, the number of recipients reaches a historic high of 3 million in SNAP and 2.5 million in Medicaid. By September, workload demands impact performance and the percentage of SNAP applications processed within the 30-day federal requirement declines to 57.5 percent. Payment error rates in 2009 exceed the national standard for the second year in a row, triggering federal sanctions. A settlement agreement is reached requiring Texas to make several planned program enhancements, including enhancements to telephone systems. In December 2009, HHSC requests that the State Auditor's Office perform an audit of SNAP eligibility determination businesses processes to clarify underlying issues.

2010 Improvements in management practices and data reporting results in improvements in performance. By the end of 2010, timeliness for SNAP applications improves to 94.4 percent. The annual SNAP payment error rate for Texas is 1.54 percent and the Texas negative error rate is 0.59 percent. Texas receives a $6,083,577 high performance bonus for having the most improved payment accuracy in the nation from fiscal year 2009 to fiscal year 2010.

2012 HHSC exceeds federal timeliness standards of 95 percent for Medicaid, SNAP, and TANF applications and renewals.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

Eligibility Operations supports and performs eligibility determinations for CHIP, Medicaid, TANF, and SNAP, serving millions of Texans. Information about eligibility criteria and a statistical breakdown of the persons served by program type can be found in the Section VII overviews for each of these programs.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

Eligibility Operations is overseen by an Associate Commissioner who manages three functional areas: Field Operations, Vendor Operations, and Eligibility Support.

Field Operations

Eligibility is determined in an integrated fashion utilizing two types of generic eligibility workers. Texas Works Advisors determine eligibility for TANF, SNAP, Medicaid for children and families, and some CHIP cases. Beginning in September 2013, all CHIP eligibility will be determined by state staff. Texas Works staff are divided into ten geographic regions each headed by a regional director. As of July 25, 2013, there were 6,276 Texas Works eligibility determination staff located in the regions (includes Texas Works advisors, supervisors, and clerical staff).

MEPD staff determine financial eligibility for long term care Medicaid programs (functional assessments are required and performed by Department of Aging and Disability Services). MEPD staff are divided into two geographical regions headed by a regional director. As of July 25, 2013, there were 1,054 MEPD eligibility determination staff located in the regions (includes MEPD advisors, supervisors, and clerical staff).

Texas Works and MEPD eligibility staff in HHSC's 269 local offices provide information, process applications, and perform other eligibility casework functions. Eligibility offices are supported by clerical staff who handles front-desk and lobby area tasks, phones, mail, faxes, schedule applicant interviews, and other clerical duties.

Geographic regions are supported by state staff in centralized functions in the Customer Care Centers (CCC), Assistance Response Team (ART), Fair Hearings, Centralized Benefit Services, and Disability Determination for Medicaid Buy-in programs. The out-stationed worker program places eligibility workers in certain facilities such as hospitals, nursing facilities, and other medical facilities to process patient eligibility. General Revenue costs for these workers are paid by the facility.

Customer Care Centers

CCCs are located in Athens, Austin, El Paso, Houston, Midland, and San Antonio. State staff, along with vendor staff, process client and agency-generated changes. Inquiries and concerns that cannot be resolved by vendor staff through the call center are escalated to CCC state staff. CCC state staff also performs data broker and other third-party inquiries, collect data, assess missing information, determine eligibility, issue benefits, process individual- and agency-generated changes, and perform other non-interview tasks.

Assistance Response Team

ART staff housed throughout the state serves as on-site support to regional staff. These employees are experienced eligibility staff who provides TIERS technical support for Texas Works and MEPD. They provide on-the-job-trainings and on-site technical support to eligibility staff before a problem is escalated to Information Technology staff. ART staff also provides support for special initiatives such as TIERS roll-out and assist as needed with workload.

Fair Hearings Unit

The Fair Hearing Units manage case preparation and provide agency representation for fair hearings statewide. This process includes case preparation and agency representation at hearings. The units began in September 2007.

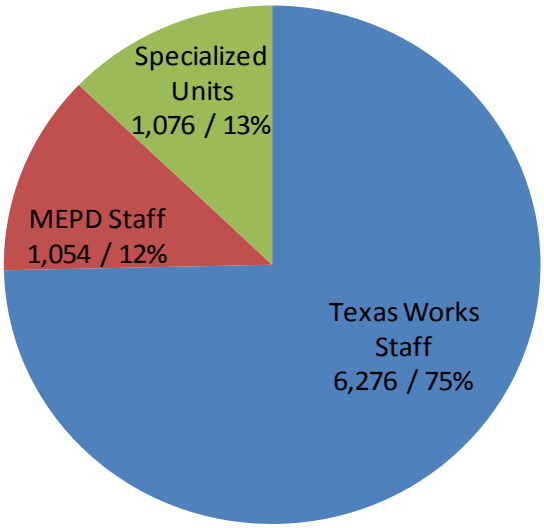
Centralized Benefits Services

The Centralized Benefits Services staff determine eligibility and process renewals for special populations, which include households where all residents receive Supplemental Security Income (SSI), refugees in need of medical assistance, infants of incarcerated mothers, individuals who have aged out of foster care, and children leaving the juvenile justice system.

Disability Determination Unit

The Disability Determination Unit (DDU) is responsible for determining eligibility for people applying for the Medicaid Buy-in Programs. This includes a required disability assessment for certain buy-in programs.

Eligibility Staffing Overview
(Filled positions as of July 25, 2013)



Vendor Operations

Vendor Operations manages day to day operations of the vendors that support SNAP, Medicaid, CHIP, TANF, and MEPD eligibility determination performed by state staff. State staff has regular operational interaction with the vendor to meet standards for timeliness, accuracy, and quality.

Eligibility Support Services

The Eligibility Support Services vendor provides support to the eligibility determination process by operating call centers, creating electronic files, registering applications and client documents, and rescheduling eligibility appointments.

Document Imaging Services

The Document Imaging Services vendor manages incoming mailed documents from applicants and existing clients. Documents processed include verification documents, applications, requests for recertification, and change requests. The incoming mail is opened, sorted, and scanned to be stored in an electronic format on the HHSC server. The electronic information is used to assist field operations and vendor staff in determining eligibility and client support.

Electronic Benefit Transfer Services

The Electronic Benefit Transfer (EBT) Services vendor provides retailer management services to assist in the delivery of the *Lone Star* Card (a magnetic-stripe plastic debit card) and to provide access to SNAP food benefits and TANF cash assistance. The Lone Star Card is used in the same way a debit card is used at authorized retailers.

The EBT Services vendor provides point-of-sale device management, processor support, settlement and reconciliation services, and card and personal identification number management services to clients.

Data Broker Services

The Data Broker Services vendor provides eligibility staff with information from various external data sources to verify applicants qualify for programs before benefits are issued. The service enables eligibility staff to research additional income sources, current address for renewals, and assets. Data Broker Services help determine proper eligibility is properly determined, reduce income calculation errors and prevent fraud.

Eligibility Support

Austin-based state office staff oversee support functions for eligibility operations. These functions include training, curriculum development, and eligibility staff policy support. This area conducts sampling and case reviews for quality assurance and conducts quality control reviews required to determine state measures and report to federal partners for the SNAP and Medicaid programs.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

As discussed above, HHSC utilizes an integrated approach to determine eligibility for SNAP, TANF, Medicaid and CHIP. The related expenses are cost-allocated to each of the benefit programs. These funds relate to SNAP administration, TANF administration, and eligibility-related Medicaid/CHIP administration.

Eligibility Operations

General Revenue:	$166,279,962
Federal:	$187,299,465
Other:	$9,319,878

	General Revenue	Federal	Other
Strategy A.1.2 Integrated Eligibility & Enrollment	$165,936,569	$186,956,073	$9,319,878
Strategy B.3.1 Medicaid Contracts & Administration	$343,393	$343,392	

General Revenue sources are primarily administrative matches for the Medicaid (50 percent), SNAP (50 percent) and CHIP (28 percent) programs with corresponding federal funds with the addition of federal TANF and Refugee funding. Several different cost allocation factors using primarily HHSC program client counts, number of eligibility FTEs, and random moment time studies determine the share of federal and state charges. Other funds represent the matching state share from local hospitals that support out-stationed hospital-based eligibility workers.

Funding Limitations, Transfer Authority Riders

- **HHSC Rider 34** provides authority to transfer eligibility funding within fiscal years of a biennium.

Federal Funds and Other Appropriation Authority Riders

- **HHSC Rider 21** authorizes the federal SNAP performance bonus funds, if Texas qualifies.
- **HHSC Rider 26** authorizes capital budget purchases for out-stationed and hospital based eligibility workers.

Provider and Programmatic Riders

- **HHSC Rider 56** directs maximization of fraud prevention efforts in eligibility determinations.
- **HHSC Rider 57** requires the promotion of online benefit applications.

Budget Requirement and Reporting Riders

- **HHSC Rider 63** requires a report on eligibility modernization efforts in TIERS

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

HHSC is the only agency that provides financial eligibility determinations for SNAP, TANF, Medicaid and CHIP. Within HHSC, the Medicaid and CHIP Division (MCD) provides services to people determined eligible by the Office of Social Services staff. There is coordination with other state and federal agencies to determine eligibility and administer programs as described below. At the state and local level, entities may rely on an HHSC eligibility determination as the basis for eligibility for other benefit programs such as utility assistance provided by the Public Utilities Commission or free- or reduced-school lunch provided through the Texas Department of Agriculture.

In Texas, the Department of Assistive and Rehabilitative Services (DARS) is contracted by the Social Security Administration (SSA) to perform Social Security Disability Insurance and SSI disability determinations. That process is similar to the function performed within the Disability Determination Unit related to Medicaid Buy-In Programs eligibility determinations. If a Medicaid Buy-in applicant has already been determined to have a disability via DARS and the SSA, DDU accepts that determination without duplication of effort. If an individual has not yet been determined disabled by SSA, DDU will review additional information to check that applicants meet the disability criteria established for the Medicaid Buy-in program. A disability determination granted by DDU does not make an individual eligible for SSI.

Externally, HHSC works with several community-based organizations that provide application assistance to individuals seeking HHSC benefits. These applications are submitted to HHSC and state staff reviews the applications for completeness, perform verifications and interviews, and make the eligibility determination. This program is detailed in **Section VII: Community Access and Services**.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

TIERS is the eligibility system of record for the programs described above. Other Health and Human Services agencies administer programs for which HHSC determines eligibility. There is coordination between the HHS agencies that share clients. However there are not duplicate or conflicting eligibility determinations.

Interagency agreements and memoranda of understanding are in place to clarify roles and responsibilities and complete data exchanges between agencies when necessary. Certain populations are categorically eligible for some HHSC benefit programs. For example, children in the conservatorship of the Department of Family and Protective Services (DFPS) are automatically eligible for Medicaid benefits. Interfaces between TIERS and DFPS systems help ensure eligibility information is updated to provide access to benefits.

One example of cooperative practices is MEPD eligibility determination. HHSC coordinates MEPD eligibility determinations with DADS. HHSC staff determine financial eligibility of applicants and DADS is responsible for overseeing the functional assessment of medical necessity for individuals applying for certain types of Medicaid coverage. HHSC MEPD staff have access to DADS' automated system to enter financial eligibility data and indicate certification or denial of MEPD financial eligibility.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

State Agency Coordination

HHSC has an interagency agreement and works with TWC to identify potential clients for TANF work programs and SNAP Employment and Training programs operated by TWC. TWC refers clients to HHSC who should be sanctioned for not complying with work requirements. TWC also provides data to verify wages and employment applicants for HHSC programs.

To help provide utility subsidy programs to eligible Texans, HHSC provides data to the Public Utilities Commission to help identify low-income utility customers.

HHSC also has an Interagency Agreement with the Office of Attorney General (OAG) that permits data exchanges relating to child support payments. HHSC verifies child support payments/income with OAG. OAG then notifies HHSC of TANF recipients' noncompliance with child support orders.

Federal Agency Coordination

CMS is the federal agency responsible for the administration of Medicaid and CHIP programs. CMS establishes coverage groups and levels of coverage that must be provided by states. States develop their own eligibility policies and define which optional groups will be covered. These policies must be approved by CMS as part of the Medicaid State Plan. OSS provides input

to help support development regarding eligibility policies and operations with the Medicaid and CHIP Division.

HHSC also works closely with the FNS on SNAP program administration and to obtain approvals for state plans, waivers, contracts, and advanced planning documents for technology systems. FNS also certifies retailers that accept SNAP benefits in Texas.

ACF is responsible for overall administration of federal programs that promote the economic and social well-being of families, children, individuals, and communities including the TANF program. HHSC's TANF state plan must be approved by ACF and the agency is required to submit regular reports including data on TANF recipients in Texas.

Under a SSA contract, HHSC receives client eligibility data for all SSI recipients and Medicare recipients who also receive HHSC services. HHSC has a contract with the Internal Revenue Service to receive HHSC client income tax data.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

Eligibility Operations contracts for eligibility determination process support. Contract services include, but are not limited to:

- verification of applicants' information (financial, assets, residence, etc.);
- call center operations (call inquiries/escalation), administrative processing of eligibility documentation;
- translation services to assist staff working with applicants who speak a language other than English;
- placement of designated eligibility staff in hospitals; and
- support for hiring activities in certain regions.

HHSC monitors performance of contracted vendors through key performance requirement measures and operational monitoring procedures that include annual risk assessments.

Amount of contracted expenditures in fiscal year 2012: **$171,508,479**

Number of contracts accounting for those expenditures: **287**

The top five program contracts are listed below.

1. Eligibility Support Services
   Fiscal year 2012 expenditures: $119,904,619

   MAXIMUS provides call center operations (call inquiries/escalation) and initial administrative processing of eligibility applications and supporting documentation. MAXIMUS creates tasks to be processed by state staff from images received to support HHSC's eligibility determination process for Medicaid, CHIP, SNAP, and TANF.

2. Document Processing Services
   Fiscal year 2012 expenditures: $15,018,856

   HHSC contracts with Image API to provide document processing services for opening, classifying, and scanning inbound mail into electronic images.

3. Electronic Benefit Transfer (EBT)
   Fiscal year 2012 expenditures: $14,512,396

   SNAP and TANF benefits are delivered to clients on the Lone Star Card via an EBT each month. HHSC contracts with three private vendors for EBT services that provide client and retailer support related to Lone Star card transactions. The Texas EBT call center provides help desk services for clients with questions or benefit related issues regarding to the Lone Star Card. Affiliated Computer Services currently provides EBT call center services for Texas clients and retailer management services. Simpatico Software Systems, Inc. provides application software support for EBT, and state staff ensure the multi-vendor EBT program functions seamlessly for Texas clients. HHSC is in the process of transitioning to a new EBT vendor obtained through a competitive procurement.

4. Data Broker
   Fiscal year 2012 expenditures: $5,691,974

   Dallas Computer Services is the data broker vendor that supports the eligibility determination process by collecting and combining information from several electronic data sources. Data broker reports are used by eligibility staff to verify information needed to complete the eligibility decision (including information the applicant provided and attested to on an application). Types of information collected in the data broker report include driver's license and residence data, vehicle data, real property ownership, credit reports, and related information needed to accurately determine an applicant's eligibility.

5. Language Interpretation by Telephone
   Fiscal year 2012 expenditures: $3,700,000

Language Line Services provides over the phone translation services to assist staff working with applicants who speak a language other than English.

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

Currently the agency is not authorized under state statute to perform background checks for eligibility employees. Since these employees handle sensitive personal information it would improve the integrity of operations if the agency was authorized to conduct background checks on employees and establish some bars to employment.

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

N/A

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Community Access and Services
Location/Division	4900 N. Lamar Blvd., Austin, Texas Brown-Heatly Building/Community Access and Services/Office of Social Services
Contact Name	Liz Garbutt, Associate Commissioner
Actual Expenditures, FY 2012	$88,409,846
Number of Actual FTEs as of June 1, 2013	63
Statutory Citation for Program	• 2-1-1 Texas Information and Referral Network, Chapter 531, Texas Government Code • Alternatives to Abortion, 2006-07 General Appropriations Act, S.B. 1, 79th Texas Legislature, Regular Session, 2005 (Article II, Special Provisions Related to All Health and Human Services Agencies, Section 50) • Family Violence Program, Chapter 51, Texas Human Resource Code • Refugee Program, Chapter 752, Texas Government Code • SNAP Education, Chapter 33, Texas Human Resources Code Other Community Services • Community Partner Program, Chapter 531, Texas Government Code • Community Resource Coordination Groups, Chapter 41, Human Resources Code, and Chapter 531, Texas Government Code • Computers for Learning, Chapter 2175, Texas Government Code • Healthy Marriage Program, Chapter 31, Human Resources Code

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Community Access and Services (CAS) Division connects people to local resources and services that promote self-sufficiency and well-being through partnerships and contracts with faith and community based organizations. CAS works with a variety of organizations that provide services at the local level to ensure that Texans in need of HHSC programs are served in the most convenient and efficient way possible. CAS staff collaborate with a diverse group of stakeholders from across the state to establish networks, share information and resources, provide guidance, and promote best practices to enhance the quality and availability of health and human services. Each health and human services region has a designated CAS community liaison to work with and provide information about HHSC services to community stakeholders. Staff coordinates local resources for the Healthy Marriage Program, Computers for Learning, and the Community Partner Program. Staff supports local programs and increase coordination by providing information to local Community Resource Coordination Groups and through the Border Affairs unit.

CAS manages and oversees contracts for services funded by HHSC and delivered by community and faith-based organizations. A brief description of the goals of each service is provided below.

Contracted Social Services

2-1-1 Texas Information Referral Network

This telephone-based service provides Texans with free information and referrals to critical health and human services provided by government agencies and community organizations.

Alternatives to Abortion

This program provides low-income pregnant women with pregnancy and parenting information and supports, including pregnancy and parenting information, mentors, access to social service programs, and material goods (e.g. car seats).

Family Violence Program

This program promotes self-sufficiency, safety, and long-term independence from family violence for adult victims and their children by contracting with providers that offer emergency support and prevention services.

Refugee Program

The purpose of this program is to assist people who resettled in Texas through the United States Refugee Program by providing short-term cash, medical assistance, and social services.

SNAP Education

The program delivers nutrition education to recipients of SNAP benefits in accordance with federal guidelines.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

The services of the CAS projects and their target populations vary. In response, the summary statistics provided below are not uniform. However, the data does demonstrate the demand and effectiveness in delivering them.

The Community Partner Program (CPP) plays an important role in helping promote self-service options, especially YourTexasBenefits.com, to clients and applicants of HHSC programs. Since CPP began in January 2012, participation has steadily grown from 8 community organizations to an anticipated 357 organizations by the end of fiscal year 2013. Currently, 249 staff and volunteers of the community partners have been trained and certified as Your Texas Benefits Navigators. Promoting self-service options improves efficiency by allowing eligibility staff to focus on their core responsibility. Additional data for the Community Partner program and the other state and local partnerships are included below.

While the majority of community partner organizations receive no state funding, HHSC contracts with the Texas Food Bank Network who provides application assistance and eligibility support through 21 food banks across the state. This contractual relationship ensures statewide coverage for application assistance while the CPP is developing.

Key Summary Statistics September 2011 – July 2012	
Number of Community Partners	216
Number of Certified Staff and Volunteers	249
Number of CPP Assisted Client Accounts Created	8,873
Number of CPP Assisted Online Applications	5,431
Number of CPP Assisted Online Renewals	2,858
Number of CPP Assisted Online Case Changes	465
Number of CPP Assisted Document Uploads	31,549
Colonias Residents Served through Border Affairs	250,000
Number of Computers Donated and Distributed through Computers for Learning	685
Number of Unique Visitors to the Healthy Marriages Website	143,906
Number of Healthy Marriage Course Participants	58,276

Contracted Social Service Programs

Family Violence Program (FVP)

In fiscal year 2012, FVP assisted more than 79,000 women and children experiencing domestic violence. Through contracts with 94 organizations around the state, these women and children received emergency shelter and medical care, legal advocacy, and support necessary to ensure the safety. As part of these contracted family violence services, the organizations also provide local telephone hotlines to link individuals with emergency services, which assisted to nearly 200,000 Texans in distress.

Key Summary Statistics FY 2012	
Number of Clients Served	79,053
Number of calls received by the Hotline	191,301

Refugee Affairs Program

In fiscal year 2012, the Refugee Affairs Program, through 57 contracts with 37 organizations statewide, provided assistance to 11,279 individuals granted official status as a refugee by the federal government. The federally funded program seeks to resettle refugees as quickly as possible, providing them with short-term medical and cash assistance, as well as employment, training, or other necessary social services. Within a year, 82 percent of clients who received employment training had secured a job. Seventy-seven percent of participants held jobs that offered health benefits empowering clients to be independent.

Key Summary Statistics FY 2012	
Number of Clients Served	11,279
Number of Employment Program Participants	6,696
Percentage of Employment Program Participants Placed in Full-time Jobs	82%
Percentage of Employment Program Participants Placed in Full-time Jobs with Health Benefits	77%

2-1-1 Texas Information and Referral Network

The 2-1-1 network provided information about food, rental assistance, counseling, child care, and other services to more than 17 million callers from 2006 to 2012. In addition to the phone services, 2-1-1 also operates a website that provides information about services.

Key Summary Statistics FY 2012	
Number of Callers	3,322,629
Number of hits to the 2-1-1 Website	3,300,778

Alternatives to Abortion

In fiscal year 2012 the Alternatives to Abortion Program served 17,527 women across Texas who sought information and support during pregnancy. More than 80,000 visits were completed by clients in the program.

Key Summary Statistics FY 2012	
Number of Clients Served	17,527
Number of Services Provided	83,910

SNAP Education

The SNAP Education Program provides individuals and families receiving food assistance with information about healthy eating and living to improve health outcomes. In fiscal year 2012 HHSC contracted with thirteen organizations clients with nutrition related classes across Texas.

Key Summary Statistics FY 2012	
Number of Clients Served	424,055
Number of Participants in SNAP-Ed Classes	1,353,905

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

CAS was formed in July 2012, bringing together units within the Office of Social Services that work with community stakeholders to improve coordination of resources and information distributed to communities. The size and geography of Texas presents a number of challenges to individuals trying to coordinate and connect to social services. CAS serves as a centralized point of information.

Community Partners Program

2011 The Texas Legislature formed the Community Partner Program (CPP) via H.B. 2610, 82nd Regular Session, 2011. CPP enhances OSS eligibility modernization efforts by training and certifying staff, community volunteers, and faith-based organizations to assist applicants and clients using self-service options, including YourTexasBenefits.com. CPP's network of Navigators improves applicants and clients' experience while improving the eligibility system efficiency.

Alternatives to Abortion

2005 The Alternatives to Abortion program was established by the 2006-2007 General Appropriations Act, S.B. 1, 79th Legislature, Regular Session, (Article II, Special Provisions Related to All Health and Human Services Agencies, Section 50). In 2006, the contract

was awarded to Texas Pregnancy Care Network (TPCN) TPCN was awarded the contract when the services we re-procured in 2009.

Healthy Marriage Program

2004 House Bill 2292, 78th Legislature, Regular Session, 2003 established the Healthy Marriage program. HHSC initially received funding to contract with community and faith-based organizations to recruit community educators to provide workshops on healthy relationships. CAS maintains the database of organizations that deliver marriage education services.

2-1-1 Texas Information and Referral Network

2001 The Federal Communications Commission (FCC) assigned the dialing code 2-1-1 for access to health and human service information. In 2012, the Texas Information and Referral Network (TIRN) completed a transfer of 25 unrelated local databases into a single web-based database, inclusive of federal, state, regional, and local resources for health and human services. TIRN also implemented a flexible statewide call routing system that was designed to improve the caller's experience.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

CAS provides services to a diverse population of Texans in need of specific services, including:

- victims and survivors of family and dating violence;
- individuals designated as refugees;
- residents of Colonia;
- clients with complex needs served by multiple health and human services agencies;
- pregnant women seeking alternatives to abortion;
- couples considering marriage or in need of support;
- SNAP recipients seeking nutrition and health education; and
- Texans in need of social service information.

Additionally, CAS provides training, information, resources, technical support, and other assistance to a wide variety of stakeholders, including:

- community and faith-based organizations;
- health and social services providers;
- leaders of local communities and colonias;
- school district administrators;
- local and state government agencies; and
- internal HHSC staff.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

CAS is divided into two primary sections.

- Community Access coordinates with local community-based organizations and governmental entities in service delivery. Currently, there are 34 FTEs dedicated to Community Access activities, and staff is located in state office as well as in the HHSC regions.
- Community Services is responsible for the programs with contracted social services. There are 29 FTEs dedicated to administering these programs, and staff is located in state office.

Community Services

CAS operates several internal programs and is responsible for program development, implementation, stakeholder technical assistance and program administration.

Border Affairs Unit (BAU)

BAU coordinates and promotes health and human services, education, and employment services along the Texas border. BAU contracts with local entities to stabilize the promotoras workforce. Promotoras are credentialed advocates who work directly with colonias residents to link residents with available services to improve health outcomes and reduce regional disparities. Additionally, CAS staff provides training to HHSC staff to increase cultural competency and improve client customer service.

Community Partner Program

CPP has built a statewide network of local organizations that help Texans navigate HHSC's self-service options including YourTexasBenefits.com. CAS contracts with the Texas Hunger Initiative at Baylor University to assist in recruiting new community partners. CAS staff develops promotional and training materials to communicate the benefits of self-service options.

Computers for Learning

CAS works with local businesses, organizations, and school districts to provide refurbished computers and Internet service to qualified families in Central Texas.

Community Resource Coordination Groups (CRCGs)

CRCGs bring together representatives of state and local human services agencies, faith and community-based organizations, and social service case managers to craft individualized service plans to address the complex needs of clients with multiple service needs. CRCGs' structure maximizes awareness of available local resources and saves time and money for the client and multiple case managers involved. Coordinated plans provide a comprehensive strategy to serve

the clients across multiple agencies, reduce client confusion, service duplication, and improve outcomes. Currently, 193 CRCGs provide support to all 254 Texas counties.

Healthy Marriage Program

The Twogether in Texas website provides information about a network of community, faith-based, and volunteer organizations providing classes and workshops to couples intending to marry.

Contracted Social Service Programs

The Contracted Social Services section is responsible for overseeing all aspects of CAS program including:

- program development and implementation in accordance with specific state and federal regulations, and guidelines;
- contract management, including procurement, execution, management, monitoring, and close-out/terminations;
- technical assistance and training, including communications and support for contractors providing direct services; and
- program administration, including oversight of program budget, staffing, data, and reporting requirements.

Family Violence Program

FVP contracts with providers that offer emergency, support, and prevention services to promote self-sufficiency, safety, and long-term independence from family violence for adult victims and their children. The FVP accomplishes this via contracts between HHSC and family violence service providers across Texas.

Refugee Program

The Refugee program provides assistance to individuals who have been designated as refugees by the federal government. HHSC contracts for refugee services with faith- and community-based organizations as well as local and state agencies. The objectives of contracted services are to help individuals and families become employable, self-sufficient, healthy, and integrated into their new communities.

2-1-1 Texas Information and Referral Network (TIRN)

2-1-1 TIRN is the single point of coordination for health and human services information and referral in Texas. 2-1-1 is the abbreviated telephone dialing code for individuals and families that need to be connected to health and human services provided by government agencies and community organizations. TIRN staff:

- Maintains a statewide database of federal, state, and local resources;
- Support a single statewide telephone system; and
- Contract with 25 area information centers to identify available community resources and provide direct access to callers.

Alternatives to Abortion

The Alternatives to Abortion Program provides pregnant women with options and support to encourage childbirth. CAS manages and oversees the contracts with local service providers that deliver parenting information, mentors, access to social service programs, and material goods, such as car seats, to pregnant women seeking assistance.

SNAP Education

The SNAP Nutrition Education Services (SNAP-Ed) program provides nutrition education to recipients of SNAP benefits consistent with the USDA Food Guidance System and Dietary Guidelines for Americans. HHSC contracts with community-based organizations to deliver these education services. The contracted services educate individuals and families about healthy food choices, food safety practices, stretching their budget for food, and increasing physical activity.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Community Access and Services

General Revenue:	$14,900,929
GR-Dedicated:	$4,581,626
Federal:	$67,002,094
Other:	$1,925,197

	General Revenue/GRD	Federal	Other
Strategy A.1.1 Enterprise Oversight & Policy	$106,023	$110,492	$764,782
Strategy A.1.2 Integrated Eligibility & Enrollment	$10,307,298	$16,556,258	$1,002,907
Strategy A.2.1 Consolidated System Support	$228,737	$30,698	$157,509
Strategy D.1.2 Refugee Assistance		$30,013,722	0
Strategy D.2.1 Family Violence Services	$7,690,496	$17,290,925	0
Strategy D.2.2 Alternatives to Abortion	$1,150,000	$3,000,000	0

General Revenue sources are primarily administrative matches for the Medicaid (50 percent), SNAP (50 percent) and CHIP (28 percent) programs with corresponding federal funds with the addition of federal TANF and Refugee funding. In FY 2012, the Family Violence Program was appropriated GR dedicated funding from the Compensation to Victims of Crime Account 469.

The following programs have specific federal grant funding or utilize federal TANF or TANF to Title XX funding: Family Violence, Refugee, Healthy Marriage, Healthy Marriage and Alternatives to Abortions. The Refugee Program is 100 percent federally funded. The allocation of administrative funding is primarily derived using a cost allocation factor of eligibility client counts of HHSC programs. Other Funds represent interagency contracts with the Texas Workforce Commission and the Texas Department of Agriculture to provide child care and summer nutrition information and referral as well as cost allocation billings based on the oversight and indirect administration factors.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

External Programs

Texas Department of Family & Protective Services (DFPS)

FVP and DFPS both provide services to children who are victims of abuse. However, the focus is different. DFPS focuses on protecting/removing the children from harm and FVP protects and serves both the adult victim and children.

Texas A&M University/Local Governments

HHSC and these organizations have established community resource centers along the border region and manage promotoras working for the university. The Border Affairs unit has specific contracts to increase the number of promotoras in the border region.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

Family Violence Program

A MOU between DFPS and the FVP service providers establishes a guiding framework for working together. The agreement acknowledges the critical importance of confidentiality when providing services to victims of family violence and their children. The agreement also provides clear parameters for FVP centers navigating disclosure of identifying information and promotes cross-training.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

Department of State Health Services (DSHS)

DSHS coordinates with local health departments to provide health screenings services for all newly arriving refugees through the Refugee Health Screening Program (RHS). The program screens refugees for health problems and conducts follow-up services for treatment. HHSC contracts with DSHS to provide these services. HHSC also contracts with DSHS to provide information and referral services for flu-symptoms through 2-1-1.

Department of Family and Protective Services

DFPS' Unaccompanied Refugee Minors Program provides foster care and child welfare services for refugee children who arrive in the United States without parents or other relatives. HHSC contracts with DFPS to provide these services.

Texas Workforce Commission

TWC educates parents about the availability of quality child care and child care subsidies through the Child Care Information and Referral Services. HHSC contracts with TWC to provide Texans with information on these services through 2-1-1.

Texas Department of Agriculture (TDA)

TDA delivers a Summer Nutrition Program to feed children living in low-income areas. HHSC contracts with TDA to provide Texans with information on these services through 2-1-1.

Texas Department of Housing and Community Affairs (TDHCA)

TDHCA provides information about housing and related resources for people with disabilities. HHSC contracts with TDHCA to provide Texans with disabilities information on these services through the 211Texas.org website

Administration for Children & Families (ACF)

ACF promotes the economic and social well-being of families, children, individuals, and communities. It also provides federal funding, which is managed by CAS staff and allocated to family violence service providers through HHSC's FVP contracts.

Office of Refugee Resettlement (ORR)

ORR provides newly arriving populations in need with critical resources to assist them in becoming integrated members of American society. ORR provides funding and discretionary grants to HHSC to provide resources and services for trafficking victims.

U.S. Department of Agriculture, Food and Nutrition Service (FNS)

FNS funds the SNAP-Ed program to improve the likelihood that persons eligible for SNAP will make healthy choices within a limited budget and choose active lifestyles. FNS guidance for SNAP-Ed program activities and FNS Regional Office in Dallas provides technical assistance and clarification of policies and procedures. FNS also reviews and approves HHSC's SNAP outreach plan, and funding.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The majority of CAS programs contract with faith and community-based organizations and state agencies to provide direct health and human services to eligible recipients of the program. Most of the contracts are financial, but the Community Partner Program primarily operates with non-financial Memorandums of Understanding. Additionally, some CAS programs have contracts with organizations to provide program support services such as Training and Technical Assistance for Family Violence contractors. CAS Program and Contract staff prepare and review contracts, budgets, and plans of operation, provide technical assistance, and review monthly and quarterly activity reports for compliance with fiscal and program performance requirements. CAS staff conducts programmatic and fiscal onsite monitoring based on an internal risk assessment process. Most contractors are required to submit an independent audit conducted in accordance with the Federal Office of Management & Budget (OMB) Circular A-133. This information is sent directly to the HHSC Office of Inspector General and subsequently results are forwarded back to the program staff.

Federal allocations are often received late in the fiscal year which can prevent HHSC from finalizing all contracts in a timely manner.

The amount of contracted expenditures in fiscal year 2012: **$87,519,986**

The number of contracts accounting for those expenditures: **227**

1. Refugee Health Screening
   Fiscal year 2012 expenditures: $9,787,856
   The Department of State Health Services provides refugee health screening services through local clinics.

2. Community Partner Program
   Fiscal year 2012 expenditures: $4,446,160
   The Texas Food Bank Network provides community education, client application assistance, and SNAP interviews.

3. SNAP-Ed
   Fiscal year 2012 expenditures: $7,021,665
   Texas Agrilife provides nutrition education.

4. Refugee Support Services
   Fiscal year 2012 expenditures: $6,289,693
   Department of Family and Protective Services provides support services to unaccompanied refugee minors

5. Alternatives to Abortion
   Fiscal year 2012 expenditures: $4,150,000
   Texas Pregnancy Care Network provides pregnancy and parenting information, mentors, access to social service programs, and material goods.

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

N/A

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

N/A

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

The Medicaid/CHIP Division – Kay Ghahremani; 268.5 FTEs

Introduction

The Medicaid/CHIP Division (MCD) develops and oversees Texas Medicaid and Children's Health Insurance Program (CHIP) polices that determine client services and provider reimbursements while complying with federal program mandates. MCD develops fee-for-service and managed care client services through key program areas such as implementation and operations of the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver and Cost Containment, Policy Development, Medicaid-related Health Information Technology, Vendor Drug Program, Program Operations, Project Management, and Operations Coordination.

Organizational Structure

The Medicaid/CHIP Division is focused on improving the quality and efficiency of services in the following ways.

Developing clear client program services including individual policy interpretations.

- Encouraging agency-wide policy development discussions (including daily client policy interpretations) for consistent client policy direction.

Paying provider reimbursements quickly and correctly.

- Working with the Medicaid claims administrator to identify, address, and remedy all provider payment issues in a timely manner.

Proactively engaging with federal partners on Texas Medicaid program development.

- Interacting on each project to manage federal program/project mandates with Texas interests.

Effective contract management including quality care measurement.

- As Medicaid processing and projects become more contract based, focus employee time and skills toward effective contract management.

Office of the Associate Commissioner

The Associate Commissioner, who is hired by the chief deputy commissioner, is responsible for managing the day-to-day operations of the Medicaid/CHIP Division. Major responsibilities include directing the operations, development, and implementation of Medicaid and CHIP program policy as directed by the legislature, the federal government, and the executive commissioner. This area identifies and implements business process changes to increase the efficiency of Medicaid and CHIP program operations.

To efficiently and effectively serve Medicaid and CHIP clients, providers, and federal requirements, MCD must provide current policy expertise while developing and implementing legislative mandated program changes. In 2012, in response to the expansion of the managed care service model, MCD underwent an organizational redesign. MCD consists of seven areas under the oversight of the Associate Commissioner. The areas include: Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver and Cost Containment, Policy Development, Medicaid Health Information Technology, Vendor Drug Program, Program Operations, Program Management, and Operations Coordination.

1115 Waiver and Cost Containment

The 1115 Healthcare Transformation and Quality Improvement Waiver allows the state to expand Medicaid managed care while preserving hospital funding, providing healthcare improvement incentive payments, and directing more funding to hospitals that serve large uninsured patient populations. The Cost Containment area oversees analysis and implementation of Medicaid and CHIP cost savings proposals identified by the Legislature or developed by HHSC staff. The 1115 Waiver and Cost Containment functions are described in Section VII.

Policy Development

The Policy Development area develops policies and procedures to support Medicaid programs and services including implementation in accordance with federal and state laws, regulations, and guidance. This area is responsible for MCD program policy analysis, development, and implementation; rules coordination; Medicaid state plan amendments (SPAs); and Medicaid waivers oversight. Policy Development functions are described in Section VII.

Medicaid Health Information Technology

The Medicaid Health Information Technology area fosters innovative use of health information technology and enabling evidence-based decisions for continuous improvement of Medicaid care quality. This area implements solutions to display health information to Medicaid providers and clients through web-based portals via the Medicaid Eligibility and Health Information Services (MEHIS) system and administers the electronic health records incentive program. Medicaid Health Information Technology functions are described in Section VII.

Vendor Drug Program

The Vendor Drug Program provides statewide access to covered outpatient drugs for recipients enrolled in Medicaid, the Children with Special Health Care Needs (CSHCN) Services program, and the Kidney Health Care (KHC) program. VDP oversees the administration of drug benefits by Medicaid managed care plans and manages fee-for-service client drug benefits. VDP helps ensure appropriate use of medications; monitors pharmacy provider compliance with program-related laws, regulations, and policies; and directly resolves pharmacy issues. Vendor Drug Program functions are described in Section VII.

Program Operations

The Program Operations area's objectives are to provide better access to healthcare services, improve quality, promote service appropriate utilization and contain costs. Program Operations' major activities include developing and operating managed care models to provide a medical and dental home; develop and maintain provider networks; performing utilization reviews and utilization management; managing Medicaid and CHIP contracts; and quality assessment and performance improvement. Program Operation functions are described in Section VII.

Project Management

The Project Management area is responsible for ensuring coordination across MCD for all major legislative and leadership-directed initiatives. This area works with other MCD program areas to identify major implementation timelines and milestones for complex initiatives. The area also oversees implementation of federally-required initiatives, including those related to the Affordable Care Act. Project Management functions are described in Section VII.

Operations Coordination

The Operations Coordination area develops, oversees, and performs functions related to information technology operational systems processing, data management, analysis, and reporting. Operations Coordination works on eligibility and enrollment operations within MCD, MCD information technology program development and oversight, and provider claims oversight. Operations Coordination functions are described in Section VII.

Introduction: Medicaid Overview

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 for themselves and their children. Initially, federal law limited Medicaid program participation to people receiving cash assistance (Temporary Assistance for Needy Families or Supplemental Security Income). However, Texas Medicaid is now available for low-income families, non-disabled children, related caretakers of dependent children, pregnant women, the elderly, and people with disabilities. As of June 28, 2013, approximately 3.4 million Texans received Medicaid benefits.

Funding

The federal government does not, and states cannot, limit the number of eligible people who can enroll, and Medicaid must pay for any services covered under the program. Medicaid is jointly financed by the federal government and the states. The federal share is determined annually based on the average state per capita income compared to the U.S. average, known as the federal medical assistance percentage (FMAP). Each state's FMAP is different. In Texas,

for federal fiscal year 2011, the federal government funded 60.41 percent of the cost of the Texas Medicaid program, while the state funded the other 39.59 percent.

Federal Oversight

All states must administer the Medicaid program within the general requirements of federal law and regulations as overseen by the Centers for Medicare & Medicaid Services (CMS). Required by federal law, each state completes a Medicaid State Plan that functions as the state's contract with CMS. The State Plan documents the specific services, eligible populations, and payment methodologies that comprise the Texas Medicaid program.

Significant changes to a state's Medicaid program require the state to submit a state plan amendment 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. The following section contains additional information regarding the waiver process.

HHSC Program Delivery

Federal Medicaid regulations require each state to designate a single state agency responsible for the state's Medicaid program. Designated in 1993 as the single state agency to oversee Texas' Medicaid program, the Health and Human Services Commission's (HHSC) responsibilities include:

- serving as the primary point of contact with the federal government;
- establishing policy direction for the Medicaid program;
- administering the Medicaid State Plan;
- working with the various state departments to carry out certain operations of the Medicaid programs;
- operating the state's acute care, vendor drug, 1115 Transformation Waiver, and managed care programs (except NorthSTAR, a managed care program overseen by the Department of State Health Services (DSHS) that provides integrated behavioral health care to eligible residents in Dallas and contiguous counties);
- determining Medicaid eligibility (the Social Services section of this report contains a description of the eligibility determination process);
- approving Medicaid policies, rules, reimbursement rates, and oversight of operations of the state departments' operating Medicaid programs; and
- organizing and coordinating initiatives to maximize federal funding.

Under federal law, HHSC is allowed to delegate some of its functions to other state agencies and departments, so long as it retains administrative discretion in program administration or supervision and the adoption or approval of program policy. HHSC must also monitor delegation function for quality-of-care initiatives and program integrity. The passage of H.B.

2292, in 2003, resulted in the reorganization of Texas' health and human services operating departments. The figure below shows the Medicaid-related responsibilities of each operating department as it exists today.

Unique Aspects of Texas Medicaid

System Delivery

Texas Medicaid is offered through two service models: fee-for-service and managed care. In traditional Medicaid fee-for-service, physicians and other providers receive payment for each unit of service they provide. In Texas, most Medicaid services are delivered through managed care organizations (MCO) under state contract. Medicaid Managed Care is the system where the overall care of a patient is overseen by a single provider organization. During the past few years, Texas Medicaid has moved towards a managed care model to provide better access to healthcare services, improve quality, promote appropriate utilization of services, and contain costs. As of June 28, 2013, approximately 2.8 million members (86 percent) of the Medicaid population were enrolled in managed care.

Contracting

The Medicaid/CHIP programs have become more complex through the years. In response, HHSC administers these programs through a large number of contracts. The five largest contracts within the Medicaid/CHIP Division (MCD) are as follows:

- Vendor Drug Program Pharmacy Providers – $12.2 billion;
- MCO service contracts which include dental maintenance organizations – $10.3 billion;
- Texas Medicaid & Healthcare Partnership (TMHP) claims administrator contract – $166.4 million. The TMHP contract is funded by multiple agencies within the HHS System including the Department of Aging and Disability Services and the Department of State Health Services;
- Enrollment Broker Services – $71.2 million; and
- External Quality Review Organization (EQRO) – $11.6 million.

Contracts are explained in more detail in the following Guides to Agency Programs:

- Program Operations and
- Vendor Drug Program.

Introduction: CHIP Overview

The Balanced Budget Act of 1997 established a new state children's health insurance program under Title XXI to 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. Similar to Medicaid, the Children's Health Insurance Program (CHIP) is jointly funded by the federal government and states. However, unlike Medicaid, the total amount of yearly federal funds allotted to the program is capped as is the amount of funds allotted to each state. Each state is allotted a federal portion

based on a formula set in federal statute and receives federal matching payments up to the established allotment.

To be eligible for this program, states must submit a state plan, which like Medicaid, must be approved by the Centers for Medicare & Medicaid Services (CMS). The State Plan documents the specific services, eligible populations, and payment methodologies that comprise the Texas CHIP program, and functions as the State's contract with CMS. Significant changes to the program require the state to submit an amendment for CMS approval. CMS also approves any waivers for which states can apply. These waivers allow for flexibility to test new or existing ways to deliver and pay for healthcare services. After obtaining state and federal approval, in July 1998 Texas began providing Medicaid to children ages 15 to 18 under 100 percent of the federal poverty level (FPL). In May 2000, Texas began covering, in CHIP, uninsured children from birth through age 18 with family incomes up to 200 percent of the FPL. The CHIP program is offered statewide and serves xx number of Texas children.

In 2013, the following are services covered under CHIP:

- inpatient general acute and inpatient rehabilitation hospital services;
- surgical services;
- transplants;
- skilled nursing facilities (including rehabilitation hospitals);
- outpatient hospital, comprehensive outpatient rehabilitation hospital, clinic (including health center), and ambulatory healthcare center services;
- physician/physician extender professional services (including well-child exams and preventive health services such as immunizations);
- laboratory and radiological services;
- durable medical equipment, prosthetic devices, and disposable medical supplies;
- home and community-based health services;
- nursing care services;
- inpatient and outpatient mental health services;
- inpatient and residential substance abuse treatment services;
- rehabilitation and habilitation services (including physical, occupational, and speech therapy, and developmental assessments);
- hospice care services;
- emergency services (including emergency hospitals, physicians, and ambulance services);
- emergency medical transportation (ground, air, or water);
- care coordination;
- case management;
- prescription drugs;
- dental services;
- vision;
- chiropractic services; and
- tobacco cessation.

Some families in CHIP pay an annual enrollment fee to cover all children in the family. CHIP families also pay co-payments for doctor visits, prescription drugs, inpatient hospital care, and non-emergent care provided in an emergency-room setting. CHIP annual enrollment fee amounts and co-payments, also referred to as cost-sharing, vary based on family income. In addition, the total amount that a family is required to contribute out-of-pocket toward the cost of healthcare services is capped based on family income.

The 2006-2007 General Appropriations Act, 79th Legislature, Regular Session, 2005, authorized HHSC to expend funds to provide unborn children with health benefit coverage under CHIP. The result was the CHIP Perinatal program which began in January 2007. CHIP perinatal services are for the unborn child of pregnant women who are uninsured and do not qualify for Medicaid. Premium rates for the CHIP Perinatal program are derived using a methodology similar to CHIP, with the differences being the absence of acuity adjustment with more focused scope of benefits and membership in CHIP Perinate.

CHIP services are delivered by managed care organizations (MCOs) selected by the state through a competitive procurement. As of March 1, 2012, there were 10 service delivery areas with a total of 17 MCOs statewide. Enrollees residing in a CHIP service delivery area have a choice of at least two or more MCOs. To provide CHIP members with a choice of dental plans, HHSC expanded the number of dental managed care plans from one to two.

Today, the CHIP caseload is approximately 593,000 clients with $975.2 million total expenditures (federal and state).

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	1115 Healthcare Transformation and Quality Improvement Waiver and Cost Containment
Location/Division	4900 N. Lamar Blvd., Austin, Texas Brown-Heatly Building/Medicaid/Chip Division (MCD)
Contact Name	Lisa Kirsch, Deputy Director
Actual Expenditures, FY 2012	$658,580
Number of Actual FTEs as of June 1, 2013	11
Statutory Citation for Program	The 2012-2013 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011 and S.B. 7, 82nd Legislature, First Called Session, 2011, required HHSC to expand Medicaid managed care services to achieve program savings. HHSC was directed to preserve federal hospital funding (historically received as supplemental payments under the Upper Payment Limit (UPL) program) to make up the difference between what Medicaid pays for a service and what Medicare would pay for the same service. HHSC received CMS approval for an 1115 Transformation Waiver to comply with this requirement. Cost Containment: General Appropriations Act, Rider numbers change each legislative session.

B. What is the objective of this program or function? Describe the major activities performed under this program.

The 1115 Healthcare Transformation and Quality Improvement Waiver allows the state to expand Medicaid managed care while preserving hospital funding, provide incentive payments for healthcare improvements, and direct more funding to hospitals that serve large uninsured patient populations. The federal Centers for Medicare & Medicaid Services (CMS) allows states

the option of federal funding for demonstration projects. This option allows CMS and the states more flexibility in designing programs to ensure delivery of Medicaid services. Through a waiver, CMS waives a state's compliance with various aspects of the Social Security Act. The federal authority for a demonstration project is Social Security Act, Section 1115(a).

Texas submitted a waiver application to CMS for the Healthcare Transformation and Quality Improvement Waiver. In December 2011, Texas received federal approval for an 1115 waiver. The 1115 Waiver demonstration period is from December 2011 through September 30, 2016. There are $11.4 billion (all funds) available over five years (December 12, 2011 - September 30, 2016) to support Delivery System Reform Incentive Payment (DSRIP) projects to improve healthcare delivery in Texas, targeting the Medicaid and low-income uninsured populations. The Transformation Waiver Operations area oversees the implementation and roll-out of the DSRIP portion of the waiver.

Major activities include:

- review and submission of more than 1,300 proposed DSRIP projects from all 20 Regional Healthcare Partnerships (RHPs) to the federal Centers for Medicare & Medicaid Services (CMS);
- review and submission of outcome measures associated with each project;
- development of policies and protocols, reporting measures, tools and guidelines;
- ongoing and extensive technical assistance for Regional Healthcare Partnership anchoring entities and providers related to areas including project plan corrections, milestone and metrics reporting, and outcome measures;
- ongoing and extensive submission of information to CMS to support waiver implementation; and
- monitoring of DSRIP projects, including through formal waiver evaluation, review of metric reporting, and a monitoring contract that is planned to be in place by fall 2013.

The Cost Containment area (CC) oversees analysis and implementation of Medicaid and Children's Health Insurance Program (CHIP) cost savings proposals identified by the Legislature or developed by Health and Human Services Commission (HHSC) staff. Medicaid CC activities are reductions to Medicaid programs or mandated efficiencies required to achieve overall Medicaid and CHIP and HHSC cost savings. These requirements are included in HHSC's budget assumptions for the upcoming biennium. Since reductions are already assumed in the budget assumptions, it is the responsibility of HHSC to find and make policy and program reductions that correspond with the budget reductions. The projects identified in the rider text have assumed savings, but once the agency begins implementation of those items there could be increased or decreased cost savings.

Conversations are ongoing with legislative leadership to provide status updates to cost savings including additional savings or projects with savings amount lower than the assumptions. Some examples of cost containment initiatives from fiscal years 2012-2013 include the expansion of Managed Care, reductions in provider rates, and the expansion of prescription drug benefits to

managed care. Examples of cost containment initiatives from fiscal years 2014-2015 include stronger prior authorization requirements, the expansion of utilization and prior authorization reviews, and improved care coordination through a capitated managed care program for a fee-for-service populations.

CC coordinates with and supports HHSC's Financial Services Division (FSD) in the analysis of proposed Medicaid and CHIP savings initiatives. Staff works closely with System Forecasting and Actuarial Services within FSD when developing cost savings proposals of publicly funded programs administered by HHSC or in analyzing legislative proposals. CC assists HHSC program staff in identifying operational details involved in the implementation of cost containment initiatives and monitors compliance with implementation deadlines.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

For the 1115 Waiver, since the DSRIP program is still in early implementation, HHSC plans to evaluate its effectiveness and efficiency both through federally required waiver evaluation and a state DSRIP monitoring contractor, which is expected to be procured by Fall 2013.

For the 2012-2013 biennium, cost containment activities overseen by CC saved state taxpayers an estimated $650.7 million. The 2012-2013 General Appropriations Act, included several cost-containment initiatives and additional savings were also achieved through funding reductions and the expansion to new service areas within existing managed care programs.

CC had direct monitoring and oversight responsibility for HHSC Rider 61 (Medicaid Funding Reductions) and for the additional cost containment Article II, Special Provisions, Section 17(c)(3), Medicare Equalization.

The 82nd Legislature, 2011, identified savings targets for each item. In October 2012, FSD estimated savings achieved to date for each Rider 61 initiative. FSD is in the process of updating these estimates based on recent claims data. As of the October estimate, nearly 80 percent of the cost containment objectives had been achieved.

CC also had responsibility for implementation of the Medicare Equalization policy, as required by Article II, Special Provisions, Section 17(c)(3). The estimated savings associated with this policy change is $295.7 million in General Revenue. The policy became operational on January 1, 2012.

The 2014-2015 General Appropriations Act, directed HHSC to implement several cost-containment initiatives to realize savings during the biennium.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

The 1115 waiver was approved by CMS in December 2011. While the overall focus of the waiver has not changed, the staffing and operations of the program have evolved over time to support waiver implementation. Services and functions are also contingent on agreement from CMS. Some of the key items that have changed since CMS approved the waiver are as follows.

- In addition to hospitals, certain providers are eligible to perform DSRIP projects, including physician groups affiliated with academic health sciences centers, community mental health centers, and local health departments.
- Timelines have shifted for DSRIP project implementation due to ongoing federal project approvals, including decisions regarding acceptable monetary valuation of each project.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The 1115 Transformation Waiver affects all areas of the state. The patient focus of the projects is on persons who have Medicaid or who are low-income and uninsured, but every Texan is potentially impacted. Regarding participating DSRIP entities, there are 20 anchoring entities (largely public hospitals) that coordinate each of the 20 Regional Healthcare Partnership plans across the state. Based on the RHP plans that HHSC submitted to CMS, there were about 300 DSRIP providers that proposed projects, including 224 hospitals (public and private), 38 community mental health centers, 20 local health departments, and 18 physician practices.

The functions of CC affect HHSC's overall success at achieving legislatively directed cost-containment objectives. Successful cost containment outcomes benefit millions of state and federal taxpayers and could yield cost savings that are redistributed back into Medicaid/CHIP programs.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

The 1115 Waiver and Cost Containment area consists of two functional areas: Transformation Waiver Operations group and Cost Containment. This area is managed by the Deputy Director for Healthcare Transformation Waiver Operations and Cost Containment.

Transformation Waiver Operations

The Transformation Waiver Operations group oversees the implementation and roll-out of the DSRIP portion of the waiver. This group's responsibilities include: 1) ongoing communication with CMS; 2) working with RHP on a continuous basis; 3) verifying appropriate documentation is provided to CMS; and 4) making any necessary changes to the waiver itself. This area works with policy development support to submit waiver amendments.

Cost Containment

The Cost Containment area (CC) oversees analysis and implementation of Medicaid and Children's Health Insurance Program (CHIP) cost savings proposals identified by the Legislature or developed by Health and Human Services Commission (HHSC) staff. CC also supports the HHSC Financial Services Division (FSD). In the legislative interim, the focus shifts to implementation and operations, where CC works closely with Medicaid/CHIP Division Policy Development and Program Management staff to identify policy and operational issues related to individual cost-containment items and to assess the fiscal impact of program changes. CC tracks compliance to cost-containment milestones and objectives on an ongoing basis, alerts program staff with operational responsibility regarding upcoming deadlines, and reports the status of individual items to HHSC executive leadership. CC is currently tracking the progress of a number of Rider 51 items.

All of the program's employees operate in the central office of HHSC.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Transformation Waiver Policy and Operations

General Revenue:	$240,978
Federal:	$277,602

	General Revenue/GR-D	Federal	Other
B.3.1 Medicaid Contracts & Administration	$215,282	$215,282	0
C.1.4 CHIP Contracts & Administration	$25,695	$62,320	0

General Revenue sources are administrative matches for the Medicaid (50 percent) and CHIP (28 percent) programs with corresponding federal funds. The allocation of funding is derived using a cost allocation factor of Medicaid and CHIP client counts.

Cost Containment

General Revenue:	$70,000
Federal:	$70,000

	General Revenue/GR-D	Federal	Other
B.3.1 Medicaid Contracts & Administration	$70,000	$70,000	0

General Revenue sources are administrative matches for the Medicaid (50 percent) program with corresponding federal funds.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

N/A

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

N/A

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

The program works extensively with local, regional, and federal units of government. The Centers for Medicare & Medicaid Services provides guidance and oversight. Various local and regional entities, including units of government, are involved in the Regional Healthcare Partnerships and/or are performing providers for DSRIP projects.

CC does not work with local or regional units of government. However, CC may coordinates with the federal Centers for Medicaid and Medicare Services regarding operation of the Texas Section 1115 Demonstration Waiver when cost-containment initiatives impact the Section 1115 Demonstration waiver.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The Medicaid/CHIP programs have become more complex through the years. In response, HHSC administers these programs through a large number of contracts. Many of these contracts cover various areas within the Medicaid/CHIP Division. For this reason, the five largest contracts are outlined in the following areas responsible for contract management and oversight:

- Program Operations Guide to Agency Programs, Section K, and
- Vendor Drug Program Guide to Agency Program, Section K.

L. Provide information on any grants awarded by the program.

This area does not award grants.

M. What statutory changes could be made to assist this program in performing its functions? Explain.

N/A

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver preserves former Upper Payment Limit funding under a new methodology and allows for Medicaid managed care expansion to additional areas of the state. Under the waiver, supplemental payment funding, managed care savings, and negotiated funding are in two statewide pools worth $29 billion (all funds) over five years (the waiver ends September 30, 2016). Funding from two pools will be distributed to hospitals and other providers to support the following objectives: 1) an uncompensated care (UC) pool to reimburse for uncompensated care costs (Medicaid shortfall and uncompensated care for the uninsured) as reported in the annual waiver application/UC cost report; and 2) a Delivery System Reform Incentive Payment (DSRIP) pool to incentivize hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness.

Both the UC and DSRIP pools are funded at the federal matching assistance percentage (FMAP) rate, which varies by federal fiscal year. For Texas the FMAP is approximately 58 percent federal funds matched with 42 percent non-federal funds. The non-federal share for the UC and DSRIP pools comes from intergovernmental transfers (IGT) primarily from local public entities.

Within HHSC, the Transformation Waiver Operations team focuses on the DSRIP program, while the Rate Analysis team focuses on the UC program. The managed care portion of the waiver is administered by the Medicaid/CHIP managed care unit. The waiver will operate over five years, ending in September 2016. It is expected that the state will request a renewal of the waiver.

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Medicaid/CHIP is not a regulatory program.

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Policy Development
Location/Division	4900 N. Lamar Blvd., Austin, Texas Brown-Heatly Building/MCD
Contact Name	Michelle Harper, Deputy Director
Actual Expenditures, FY 2012	$6,620,599
Number of Actual FTEs as of June 1, 2013	62.5
Statutory Citation for Program	42 United States Code (U.S.C.) §§1396, et seq. (Medicaid) 42 U.S.C. §§ 1397aa, et seq (CHIP) Title 1 Part 15, Texas Administrative Code Chapter 32, Texas Human Resources Code

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Policy Development area includes Policy Development (PD) and Policy Development Support (PDS). These units are responsible for MCD program policy analysis, development, and implementation; rules coordination; Medicaid State Plan Amendments (SPAs) for both Texas Medicaid and CHIP Programs; and Medicaid waivers oversight, including waivers administered by HHSC, DADS, and DSHS. The primary objective of this area is to develop policies and procedures to support Medicaid and CHIP programs and services including implementation in accordance with federal and state laws, regulations, and guidance. Functions of this area include the following.

- Lead legislative analysis for Medicaid/CHIP during the Legislative Session. During the interim, staff work on legislative reports and respond to information requests.
- Research, develop, and coordinate program and medical policy implementation resulting from federal or state legislation, regulations, or other official guidance.
- Research and respond to legislative and stakeholder information requests related to Medicaid and CHIP.
- Serve as the single point of contact for the Centers of Medicare & Medicaid Services (CMS);
- Submit and coordinate Medicaid and CHIP State Plan amendments to accurately reflect reimbursement rates and program policy for compliance with federal Medicaid requirements.

- Coordinate the Medicaid and CHIP rules process and develop timelines to ensure to adopt rules as required by state law.
- Oversight of Medicaid waivers for compliance with federal regulations and timely submission of reports and waiver amendments.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

- During the 83rd Legislative Session 2013, PD completed 543 bill analyses.
- PD averages 42 rule packets per year.
- PDS averages 60 SPAs per year. Each year, PDS processes an average of 70 CMS requests for additional information (RAIs) for the SPA submissions (both informal and formal RAIs).
- PDS is responsible for the oversight of 11 Medicaid waivers, including the renewal and submission of waiver amendments to CMS. In 2013, PDS has completed four CMS requests for evidentiary information and seven waiver renewals. PDS completes annual reporting on each waiver to demonstrate program compliance and budget or cost neutrality, or cost effectiveness, depending on waiver type.
- CMS requires states to have a comprehensive quality strategy with quality measures for each individual waiver. PDS meets with CMS on a monthly and quarterly basis to analyze and review quality data reports, identify trends, remediate concerns, and determine improvement plans.
- PD compiles CHIP program quality data and submits the CHIP annual report to CMS.
- PD was responsible for implementing changes to ensure CHIPRA compliance. PD and PDS also coordinate with MCD Project Management and Office of Social Services to implement new initiatives related to the Affordable Care Act (ACA) CHIP eligibility requirements. This will include five CHIP SPA submissions.
- PD processes approximately three CHIP SPAs per biennium.
- PD and PDS meet with CMS on an ad hoc basis to discuss new initiatives and any other issues related to CHIP.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

N/A

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The Policy Development area engages in regular internal communications among HHSC System staff. Staff responds to requests from internal stakeholders, coordinates with them to complete assignments, and jointly develops information to be communicated to CMS (rules, SPAs, and waivers). The PD staff works closely with Texas Medicaid & Healthcare Partnership (TMHP), the Medicaid claims administrator and the CHIP vendor, MAXIMUS, on communicating policy changes to all Medicaid provider types to accurately implement medical benefits. Policy staff share pertinent information with internal staff overseeing managed care operations and presents updates as requested at various provider stakeholder meetings. The Policy Development area has recently established a stakeholder communications area to provide accurate and consistent information to both provider and client groups regarding rules, state plan amendments, waivers and waiver amendments, policy-related programmatic changes, and medical policy. This area's functions affect/impact Medicaid clients, Medicaid providers, CMS (our federal partner), TMHP contract staff, MAXIMUS contract staff, internal HHS staff and various stakeholders.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

The Policy Development area is overseen by a Deputy Director and consists of two functional areas: Policy Development (PD) and Policy Development Support (PDS). These units are responsible for MCD program policy analysis, development, and implementation; rules coordination; Medicaid State Plan amendments (SPAs) for both Texas Medicaid and CHIP Programs; and Medicaid waivers oversight, including waivers administered by HHSC, DADS, and DSHS.

Policy Development

PD is responsible for research, analysis, and development of Medicaid and CHIP program policy and collaboration on medical policy.

Policy Development Support

PDS is responsible for rules coordination, State Plan amendments and support, waiver oversight, and stakeholder communications.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Policy Development

General Revenue: $1,948,607
Federal: $4,443,827

	General Revenue/GR-D	Federal	Other
A.1.1 Enterprise Oversight & Policy	$269,462	$269,462	0
B.3.1 Medicaid Contracts & Administration	$1,679,146	$4,174,366	0

The Medicaid share of Policy Development appropriations is in Strategy B.3.1 Medicaid Contracts and Administration. General Revenue is the 50 percent and 25 percent administrative match for Medicaid with corresponding Medicaid federal funds. The allocation of funding is derived using a cost allocation factor of Medicaid and CHIP client counts or direct charges to the Medicaid program. There is also a 100 percent federally funded grant and 100 percent GR for the Texas Women's Health Program.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

PD leads legislative analysis for bills impacting Medicaid/CHIP. One main objective of identifying a lead area within Medicaid/CHIP is to limit duplication of efforts by Medicaid/CHIP staff during the legislative analysis process. During medical policy development, PD leads analysis and research related to the non-clinical policy and works closely with the Office of the Medical Director staff performing clinical analysis. During the development of program policy, PD performs initial research, analysis, and implementation recommendations. Once a policy is ready to implement, PD staff work with other areas within MCD and HHSC to transition the project to the appropriate operational area.

PDS functions (rules, State Plan, and waiver oversight) are unique and targeted to key internal stakeholders. These functions provide administrative structure to support programs, while program staff (internal stakeholders) are responsible for program implementation and operations. The new stakeholder communications area within PDS is collaborating with MCD Communications to ensure no duplication of efforts.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

Only MCD is responsible for development of program policy. However, PD participates in weekly meetings with the Office of the Medical Director to ensure staff is performing tasks unique to their role in the medical policy development process. PD staff develops work plans for each project and work closely with Program Operations staff to ensure roles and responsibilities are clearly defined.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

Medicaid State Plan Amendments (SPAs) and waiver oversight functions regularly involve federal CMS communications. PDS engages in electronic and telephone conversations with CMS on a daily basis. In general, these communications relate to:

- CMS approval of State Plan or waiver submissions;
- CMS formal and informal questions regarding such submissions and HHSC's responses;
- general updates on pending or upcoming activities;
- CMS clarification of information at HHSC's request; and
- annual CHIP reporting requirement.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The Medicaid/CHIP programs have become more complex through the years. In response, HHSC administers these programs through a large number of contracts. Many of these contracts cover various areas within the Medicaid/CHIP Division. For this reason, the five largest contracts are outlined in the following areas responsible for contract management and oversight:

- Program Operations Guide to Agency Programs, Section K, and
- Vendor Drug Program Guide to Agency Program, Section K.

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

N/A

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

The PD area are responsible for MCD program policy analysis, development, and implementation; rules coordination; Medicaid State Plan amendments (SPAs) for both Texas Medicaid and CHIP Programs; and Medicaid waivers oversight, including waivers administered by HHSC, DADS, and DSHS. The primary objective of this area is to develop policies and procedures to support Medicaid and CHIP programs and services including implementation in accordance with federal and state laws, regulations, and guidance.

The following links contain general Medicaid/CHIP program information, the Texas' Medicaid State Plan agreement with the federal government, and Medicaid provider instructions.

Texas Medicaid and CHIP in Perspective ("The Pink Book")**:**
http://www.hhsc.state.tx.us/medicaid/reports/PB9/TOC.shtml

Texas Medicaid State Plan:
http://www.hhsc.state.tx.us/medicaid/StatePlan.html

CMS information on Texas Medicaid, including waivers:
http://www.medicaid.gov/medicaid-chip-program-information/by-state/texas.html

TMHP Texas Medicaid Provider Manual:
http://www.tmhp.com/pages/medicaid/Medicaid_Publications_Provider_Manual.aspx

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Medicaid/CHIP is not a regulatory program.

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Medicaid Health Information Technology
Location/Division	4900 N. Lamar Blvd., Austin, Texas Brown-Heatly Building/MCD
Contact Name	Ramdas Menon, Deputy Director
Actual Expenditures, FY 2012	$267,994,693
Number of Actual FTEs as of June 1, 2013	6
Statutory Citation for Program	American Recovery and Reinvestment Act (ARRA) of 2009; H.B. 1218 (81st Legislature, Regular Session, 2009).

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Medicaid Health Information Technology (HIT) area focuses on fostering innovative use of health information technology and enabling evidence-based decisions for the continuous improvement of Medicaid care quality. Health Information Technology also implements solutions to display health information to Medicaid providers and clients through web-based portals.

Medicaid HIT has two primary functions.

Administer the Electronic Health Records (EHR) Incentive Program

Two sections of the American Recovery and Reinvestment Act (ARRA) of 2009 comprise the Health Information Technology for Economic and Clinical Health (HITECH) Act. The goal is to promote the adoption and meaningful use of health IT, including Electronic Health Records (EHR) and Health Information Exchanges (HIE). One of the goals of this area is to use statewide HIE networks to improve access to client clinical data, thus improving evidence-based decision-making within Medicaid. The HITECH Act specifically authorizes the EHR Incentive Program, which incents eligible medical professionals and hospitals to adopt and use certified EHR technology.

Implement and Administer the Medicaid Eligibility and Health Information Services (MEHIS) System

The Center for Medicaid & Medicare Services (CMS) funded MEHIS to replace paper Medicaid documentation with cards and automate eligibility verifications. In 2010, the project expanded by combining it with other legislatively mandated requirements in H.B. 1218 (81st Legislature, Regular Session, 2009). Key goals of MEHIS include:

- the replacement of paper Medicaid identification forms with plastic cards, including creating a call center for clients to report card issues (H.B. 2292, 78th Legislature, Regular Session, 2003);
- automation of Medicaid eligibility verification via provider and client portals;
- the ability to offer client and provider notification of Texas Health Steps (THSteps) services and to generate standard and ad-hoc reporting for THSteps and other health data via these portals;
- the ability to provide access to client health records electronically, which requires HHSC to develop a process to ensure the privacy and security of Medicaid client information; and
- development of an electronic HIE system to improve the quality, safety, and efficiency of healthcare services provided under Medicaid/CHIP.

Between May 2010 and June 2012, MEHIS deployed functionality above and beyond the HB 1218 requirements in several software releases. Improvements and additions to the systems are ongoing.

To ensure coordination of services, MEHIS works closely with the following entities:

- HHSC-IT on all computer related issues;
- Office of Eligibility Services (OES) – For access to the most current eligibility data on clients; and
- Department of State Health Services – To gain access on immunization data from the State's Immtrac Registry.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

EHR Incentive Program

The EHR Incentive Program began issuing incentives to eligible hospitals and professionals in February 2011. As of July 2, 2013:

- eligible hospitals and professionals serving the Medicaid population received payments totaling $519.3 million; and
- 285 HER eligible hospitals (EH) and 6,152 eligible professionals (EP) received incentive payments.

EPs and EHs are encouraged to attest to meaningful use and clinical quality measures for receiving additional incentive funds after the first year. About 50 percent of EHs and just more than 20 percent of EPs have attested to meaningful use after a year in the program. Under program rules, providers are allowed to skip years before attesting to meaningful use.

MEHIS

MEHIS began generating plastic Medicaid cards in August 2011. Eligibility verifications began in September 2011. MEHIS established web-based client and provider portals to check eligibility. Clients are allowed to reorder or print a new Medicaid card. MEHIS works closely with the Office of Eligibility Services and HHSC-IT to provide eligibility data as current as possible.
The web-based portals have been functional since August 2011. To facilitate access to the portal (create a registration process for clients and providers), HHSC also implemented the following technical elements required by H.B. 1218 (81st Legislature, Regular Session, 2009):

- an authentication process that uses multiple forms of identity verification before allowing access to the system;
- technology that allows for patient identification across multiple systems; and
- the capability of appropriately and securely sharing health information with state and federal emergency responders.

No clinical or claims-based information is available except for immunization registry data for Medicaid clients.

The MEHIS metrics would include the following average monthly client and provider portal usage statistics from April to June 2013:

- 106,829 eligibility verifications; and
- 66,659 client logins.

MEHIS issues plastic cards to Medicaid clients that replace paper identification forms. On average, 446,929 cards per month were mailed during the April-June 2013 period.

MEHIS provides help-desk assistance to both providers and clients so that client-related issues may be resolved. To help address provider and client issues, an interactive voice response system was developed and implemented. On average, 1,620 provider calls and 20,858 client calls were handled per month from April-June 2013. HHSC has taken the following additional key steps to implement the requirements in H.B. 1218:

- establishing an HIE Advisory Committee which convenes four times annually to provide oversight over all HHSC HIT and HIE related activities;
- providing access to client electronic health records (This required a comprehensive review of federal and state laws regarding privacy and management of private patient information. HHSC adopted the opt-out consent model for clients so they may opt out of having their medical information shared with Medicaid providers. An agency-wide workgroup (comprised of legal, clinical, and policy staff) was created to develop a comprehensive policy

for displaying, using and exchanging sensitive Medicaid data electronically. Work is ongoing and recommendations are expected in October 2013.); and

- completing the Medicaid HIE pilot requiring the exchange of prescriptions and information between Medicaid and two local HIEs.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

In 2012, Texas Medicaid began enrolling more clients into managed care organizations (MCOs). This expansion impacted MEHIS by increasing the number of cards needed, since fee-for-service clients transitioning to MCOs necessitated the production of new cards.

MCOs are contractually required to establish patient portals. However, the scope of these portals is still under discussion. As more Medicaid clients are served by MCOs, MEHIS has to ensure no duplication of services between its services and those established by the MCOs.

A collection of federal and state laws discuss the treatment of sensitive client-level data, including personal health information (PHI). HHSC does not currently have a comprehensive policy in place that spells out who, when, and for what reasons PHI may be displayed, shared or exchanged electronically. This delayed the deployment of a key MEHIS functionality: providing access to client health records electronically. An agency-wide workgroup (comprising of legal, clinical, and policy staff) is currently developing a comprehensive policy regarding these matters.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The EHR Incentive program targets eligible hospitals and professionals serving Medicaid clients. Medicaid providers must meet the following eligibility requirements to participate in this program.

Hospitals

- acute care hospitals (including Critical Access Hospitals and cancer hospitals) with at least 10 percent Medicaid patient volume; and
- children's hospitals (no Medicaid patient volume requirements).

Professionals

- physicians (primarily doctors of medicine and doctors of osteopathy);

- nurse practitioners;
- certified nurse-midwives;
- dentists;
- physician assistants who furnish services in a federally qualified health center or rural health clinic that is led by a physician assistant; and
- optometrists (newly eligible).

To qualify for participation in the Medicaid EHR Incentive Program, an eligible professional must also meet one of the following criteria:

- have a minimum 30 percent Medicaid patient volume;
- have a minimum 20 percent Medicaid patient volume, and be a pediatrician or pediatric dentist; and
- practice predominantly in a federally qualified health center or rural health clinic and have a minimum 30 percent patient volume attributable to needy individuals.

Under the Medicaid EHR Incentive Programs, eligible providers can qualify for incentive payments if they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology during the first participation year, or successfully demonstrate meaningful use of certified EHR technology in subsequent participation years (skipping years is permissible in the Medicaid incentive program).

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

The Medicaid HIT area is administered by the Deputy Director and consists of two functional areas: Electronic Health Records incentives (EHR) and Medicaid Eligibility and Health Information Services (MEHIS). Health Information Technology implements solutions to display health information to Medicaid providers and clients through web-based portals.

EHR

This area uses statewide HIE networks to improve access to client clinical data, thus improving evidence-based decision making within Medicaid. This area's responsibility includes issuing incentives to eligible hospitals and professionals serving the Medicaid population.

MEHIS

This area works to replace paper Medicaid documentation with cards and automated eligibility information. This area's responsibilities also include a call center for clients to report card issues and creation/maintenance of provider and client portals. In addition to FTEs, the MEHIS team is supported by three contracted employees, who perform a variety of functions ranging from independent verification and validation to assisting with customer service.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Health Information Technology

General Revenue: $5,523,175
Federal: $262,471,518

	General Revenue/GR-D	Federal	Other
B.3.1 Medicaid Contracts & Administration	$5,523,175	$262,471,518	0

The technology grants are financed a federal grant authorized in the American Recovery and Reinvestment Act at a 90 percent match rate, with the health provider certifying their state share. The Medicaid and Eligibility Health Information System project and other administrative support are matched at the Medicaid 50 percent rate.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

N/A

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

Coordination of HIT and HIE activities within Texas is done via HHSC's Office of e-Health Coordination (OEHC). The Medicaid-HIT area works closely with OEHC to coordinate all HIT-related activities within the Health and Human Services Commission through the auspices of the HIE Advisory Committee, which monitors HIE related activities statewide.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

The EHR Incentive Program works closely with the Office of National Coordinator for Health Information Technology and CMS since this program receives 90:10 federal financial participation. CMS provides oversight of all HIT spending, including approving all contracts for the EHR Incentive Program.

The program also works closely with the Office of e-Health coordination at HHSC as well as the Texas Health Services Authority. MEHIS works closely with CMS because this program receives federal financial participation.

K. If contracted expenditures are made through this program please provide:
- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The Medicaid/CHIP programs have become more complex through the years. In response, HHSC administers these programs through a large number of contracts. Many of these contracts cover various areas within the Medicaid/CHIP Division. For this reason, the five largest contracts are outlined in the following areas responsible for contract management and oversight:

- Program Operations Guide to Agency Programs, Section K, and
- Vendor Drug Program Guide to Agency Program, Section K.

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

The following statutory changes would assist Medicaid HIT in performing necessary functions:

- eliminating or removing the statutory barriers that inhibit the electronic distribution (use, share and display) of personal health data, including clinical data, amongst health and human service agencies in Texas; and
- eliminating or removing statutory barriers that inhibit the development of a centralized consent model for Medicaid clients to share their medical facts with their Medicaid providers.

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

N/A

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Medicaid/CHIP is not a regulatory program.

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

II. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Vendor Drug Program
Location/Division	4900 N. Lamar Blvd., Austin, Texas Brown-Heatly Building/ MCD
Contact Name	Andy Vasquez, Deputy Director
Actual Expenditures, FY 2012	$3,382,840
Number of Actual FTEs as of June 1, 2013	56
Statutory Citation for Program	Title XIX of the Social Security Act § 1927 (42 U.S.C. 1396r-8) Title XXI of the Social Security Act (42 U.S.C. §§ 1397aa - 1397mm) Insurance Code § 533.005(a)(23) and (a-1) Government Code §§531.069 - 531.0697, 531.070 - 531.075

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Vendor Drug Program (VDP) provides statewide access to covered outpatient drugs for recipients enrolled in Medicaid, the Children's Health Insurance Program (CHIP), the Children with Special Health Care Needs (CSHCN) Services program, and the Kidney Health Care (KHC) program. VDP oversees the administration of drug benefits by Medicaid managed care plans and their pharmacy benefits managers. VDP continues to manage the drug benefits for recipients who remain in the fee-for-service delivery model. VDP also administers the drug manufacturer rebate program that collects more than $1.5 billion per year in revenue.

VDP contracts with more than 4,600 pharmacies, mostly community retail pharmacies, to provide pharmaceutical services. VDP manages the formulary (list of Medicaid covered drugs) and preferred drug list for all Medicaid and CHIP recipients. VDP 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 multiple vendors.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

Drug Use Review/Formulary

The Drug Utilization Review (DUR) area conducts at least eight major educational reviews each year, which retrospectively address clinical areas that may have inappropriate drug usage. VDP saved approximately $18 million in fiscal year 2012 through its retrospective DUR initiatives, and $84 million through its prospective DUR program. There are prospective DUR systematic processes that check for drug interactions, therapeutic and/or ingredient duplications, drug-disease contraindications, age restrictions, and maximum dosages at the point of sale. The Formulary area maintains a drug list of more than 30,000 line items. Maintenance duties include price changes, unit changes, and drug product additions and deletions. More than 75,000 different physicians, dentists, podiatrists, and optometrists are supported by this function.

Texas has a unique methodology and process for setting drug prices. Ninety percent of pharmacy benefit costs are due to the drug price. Therefore small increases in average drug prices would result in large net increases in expenditures. Most state Medicaid programs and third-party plans use prices from a national pricing service. Texas requires drug manufacturers to submit their wholesale prices directly to HHSC.

Field Administration

Field staff visited approximately 1,100 pharmacies in fiscal year 2012 to provide on-site education and review of provider practices. Staff also handled more than 13,000 telephone inquiries from clients, providers, HHSC staff, and other state agency staff, patient advocates, and other entities. Many calls were region-specific and could only be answered with knowledge of in-area resources.

Prior to the managed care expansion in March 2012, the Field Administration unit annually recouped more than $5 million paid inappropriately to contracted pharmacies. In fiscal year 2009, more than $5.8 million was recouped due to monthly desk review determinations. Post managed-care carve-in, in fiscal year 2012, more than $2 million was recouped for fee-for-service claims. Direct support from VDP pharmacists led to the arrest and conviction of fraudulent pharmacy providers and thousands of dollars were recouped by the Office of the Attorney General and the Office of Inspector General from pharmacies that committed fraudulent acts.

Pharmacy Resolution

Pharmacy Resolution is a call center where provider and client claim processing and payment error calls are received and addressed. Pharmacy Resolution averages more than 8,000 phone calls each month with call statistics that mirror national averages for similar-sized call centers. In addition to phone calls, more than 30 inquiries about payments are resolved each month. New processes for the claims adjudication system are tested and approved by Pharmacy Resolution staff. The helpdesk is the most immediate and reliable source for identification and reporting of claim processing and payment errors. VDP has reimbursed pharmacy providers within a 12-day payment cycle for more than 20 years. It is the shortest payment cycle of any state.

Texas is recognized by other states as a leader in point-of-sale pharmacy claims management. Texas has consistently been one of the first public or private entities to adopt new features allowed under the National Council for Prescription Drug Programs standards.

Pharmacy Claims and Rebate Administration

This area provides change management, contract monitoring, and oversight procedures for the Pharmacy Claims and Rebate Administration (PCRA) vendor. Change management processes have helped implementation of required system enhancements. As a result of contract monitoring, process and processing errors have been identified and corrected. In addition to resolving problems, corrective actions included the assessment and collection of actual damages and liquidated damages.

Historically, VDP has been effective in invoicing and collecting rebates from drug manufacturers. The federal government is responsible for the primary Medicaid rebate program. However, HHSC has developed a supplemental Medicaid rebate program and rebate programs for its other state-federal pharmacy programs and the Medicaid Managed Care programs.

<u>Medicaid – Fee-For-Service</u>

- VDP collected $10.1 billion in basic Medicaid rebates since 1991.
- Fiscal year 2013 collections are estimated to be $369.5 million.
- In fiscal year 2012, 50 percent of all VDP expenditures were recovered through the federal and supplemental rebate programs.
- VDP collection rate for federal rebates is more than 99 percent.

<u>Medicaid – Managed Care Organizations</u>

- VDP has collected $947.1 million in basic Medicaid rebates since 2012.
- Fiscal year 2013 collections are estimated to be $945.3 million.
- VDP collection rate for federal rebates is more than 81 percent.

CHIP Rebates (started in 2002)

- $166.5 million has been collected in rebates since 2002.
- State fiscal year 2013 collections were $23.6 million.

CSHCN & KHC Rebates (started in 1997)

- $67.8 million has been collected in rebates to date.
- Fiscal year 2013 collections are estimated to be $5.8 million.

Pharmacy Program Management

The Pharmacy Program Management area coordinates multiple, ongoing pharmacy-related audits, legislative bill analyses, administrative rule and Medicaid/CHIP state plan amendments, survey responses, VDP projects, and general program inquiries. This includes coordination with CMS and Federal OIG.

Pharmacy Program Management is coordinating 35 individual internal, state, and federal pharmacy related audits. Many require active management of incoming data requests for the program or the pharmacy vendor. These requests require coordinating results between multiple MCD and HHSC areas, such as Budget Management, Accounts Receivable, Fiscal Management, and Contract Administration.

Pharmacy Program Management routinely coordinates with other MCD areas to develop and distribute VDP communications to contractors, medical providers, pharmacies, drug manufacturers, and managed care entities. This area routinely communicates via email to more than 11,000 stakeholders and associations that signed up to receive HHSC's VDP notices. Program Management also communicates program updates and policy reminders to pharmacies and to MCOs, and keeps the VDP website content up to date.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

1997 The 75th Legislature required the state programs, CSHCN and KHC, to use VDP to provide services to their clients to reduce administrative costs. VDP had served only Medicaid clients.

2002 Pharmacy benefits for CHIP move from the managed care organizations that had administered these benefits. VDP provided those benefits to save money by collecting drug rebates.

2003 The Legislature creates a Preferred Drug List (PDL) and supplemental rebates, as required by H.B. 2292.

2005 On December 31, HHSC contracts for the administration of IT claims processing functions and all rebate functions for VDP. These functions were previously performed in-house by agency staff.

2008 The federal Deficit Reduction Act requires additional data to be provided on Medicaid acute care claims for physician-administered drugs (drugs administered in a practitioner's office or in a hospital outpatient setting). Physician-administered drug claim data is provided to VDP for rebate invoicing. This new drug information increased the amount of Medicaid rebate revenue.

2009 VDP implements a cost-avoidance model for benefit coordination to confirm HHSC as a payer of last resort. HHSC contracts with Health Management Systems to identify clients with third-party pharmacy benefits. The pharmacy claims system rejects claims for those clients and refers the provider to the primary payer. HHSC covers the client's deductible or co-pay, if applicable, and covers the drug if there is evidence the client is no longer enrolled in the third-party plan.

2010 In November, VDP transitioned to a new pharmacy claims and rebate administrator, Xerox, which streamlined drug rebate collections processes.

2012 HHSC expands pharmacy services into the Medicaid and CHIP managed care programs. Prior to this, the MCOs were not responsible for outpatient prescription drug services, which remained the responsibility of HHSC directly, provided by VDP. With this change, the MCO premium amount includes prescription drug services and MCOs are financially responsible for those services. While MCOs can develop their own prior authorization requirements, they are required to use the VDP formulary and PDL. These changes create the need to develop tools and conduct oversight of MCOs' pharmacy benefits for compliance, usage trends, PDL adherence, finances, complaints, policies and procedures, marketing materials, and other measures. VDP continues to develop and implement MCO pharmacy program oversight policies.

MCOs enroll dispensing pharmacies into their provider networks that also have a contract with VDP to provide Medicaid drug benefits to members. MCOs typically offer pharmacies a standard contract and may negotiate fees/rates with potential providers to develop a pharmacy provider network in each service delivery area that meets adequate client access contract requirements. Similar to FFS, members have access to prescription delivery services. However, MCOs may not require members to use mail-order pharmacies. MCOs also do not currently collect drug rebates.

2013 VDP began collecting rebates from drug manufacturers for recipients in the Breast and Cervical Cancer Services program.

House Bill 595 and S.B. 7 require MCOs to adhere to the single, state-managed formulary and PDL. This requirement will continue through August 31, 2018.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

VDP provides statewide access to outpatient prescription medications as prescribed by the treating physician, or other healthcare provider, for recipients eligible for Medicaid/CHIP, Children with Special Health Care Needs (CSHCN), and the Kidney Health Care (KHC) Program.

- Medicaid FFS: approximately 937,000 Medicaid recipients were eligible to receive prescription drug benefits each month for the latter half of fiscal year 2012;
- Medicaid managed care: beginning March 2012, an average of 2.7 million Medicaid recipients were eligible to receive prescription drug benefits each month through Medicaid managed care;
- CHIP: In fiscal year 2012, there were 606,901 CHIP clients (37,192 Perinatal and 569,709 Traditional CHIP);
- CSHCN: approximately 2,744 recipients were enrolled; and
- KHC: approximately 18,313 recipients were enrolled.

More than 35 million Medicaid FFS and managed care prescriptions were filled in fiscal year 2012.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

VDP is comprised of five functional areas managed by the deputy director. The functional areas include the following.

Drug Utilizations Review (DUR)/Formulary Management

The Drug Utilization functions include prospective clinical prior authorizations, prospective system edits, retrospective analysis of prescribing patterns and client medical history, and retrospective provider education. HHSC is required by state law to convene a Drug Utilization Review Board to provide direction on the appropriate use of medications. With guidance and consultation from the board, DUR reviews and implements prior authorization criteria for both clinical appropriateness and prescription cost effectiveness. The DUR Board makes recommendations on retrospective DUR by sending educational letters to practitioners whose prescribing patterns fall outside normal and nationally accepted practice guidelines. The DUR area also reviews and approves prior authorization criteria proposed by Medicaid/CHIP managed care organizations.

The Formulary area enrolls and maintains lists of pharmaceutical products provided to Medicaid/CHIP, CSHCN and KHC recipients. The Formulary area also maintains information of

licensed prescribers including: physicians, dentists, podiatrists, therapeutic optometrists, advanced practice registered nurses, and physician assistants.

The DUR area administers the PDL program, oversees the PDL vendor, and supports the Pharmaceutical and Therapeutics (P&T) Committee. The P&T Committee is required by state law to review classes of drugs and make recommendations to designate reviewed drugs as preferred or non-preferred. Preferred drugs are safer, more effective, or have a lower net cost than non-preferred drugs, so a prior authorization is required to obtain a non-preferred drug. VDP collects supplemental rebates on preferred drugs.

Unlike Medicaid, there is not a PDL program for CHIP. There is no federal rebate program for CHIP. VDP does operate a state CHIP rebate program that yields rebate revenue.

Pharmacy Field Administration

VDP Pharmacy Field Administration educates contracted pharmacy providers on state and federal policies, procedures, and laws through biennial onsite pharmacy visits. They are also responsible for monitoring and evaluating program compliance to ensure proper drug utilization and cost containment through monthly desk reviews of higher-risk pharmacy claims.

A pharmacy outreach coordinator provides targeted pharmacy provider education for new or more complex Medicaid benefits. Regional staff helps resolve issues between pharmacies, clients, prescribers and the managed care plans. Field staff coordinates with Medicaid/CHIP Division MCO Health Plan Management to approve or deny communications from the plans before they are sent to prescribers, clients, pharmacies, and other stakeholders. Field pharmacists analyze encounter data from managed care plans to monitor pharmacy benefit contract compliance. Field pharmacists also lead in monitoring managed care PBM performance.

Regional staff also provides assistance to Medicaid, CSHCN, and KHC clients by phone. Field staff directly assists Medicaid recipients in obtaining critically needed medications when problems arise. They also assist physicians, nurses, hospitals, nursing homes and other healthcare professionals in issues relating to VDP clients and benefits.

Field Administration also identifies and requests audits, and may impose sanctions. The area may initiate monetary recoupment for invalid reimbursements to contracted pharmacies based on desk reviews. Regions also coordinate resolution of Vendor Drug related issues with and serve as a resource for auditors; the Texas Office of the Attorney General; HHSC Office of Inspector General (OIG); the Texas State Board of Pharmacy; and local, state and federal law enforcement agencies. Regional pharmacists are included in the appeals hearing panel for OIG audits of pharmacies.

Pharmacy Resolution

Pharmacy Resolution operates a helpdesk (call center), which serves as a resource for pharmacy providers contracted with VDP. The helpdesk provides support to help pharmacies dispense prescriptions to VDP clients and resolve issues.

Pharmacy Resolution staff coordinate with the HHSC Ombudsman, HHSC Office of Eligibility Services, MCD Program Operations, and other areas to resolve client access issues. Pharmacy Resolution management staff may also correct system data that is incorrectly preventing pharmacies from dispensing medications.

Pharmacy Claims & Rebate Administration (PCRA)

The Pharmacy Claims & Rebate Administration provides program oversight for the pharmacy claims and rebate administration contract. The current contractor, Xerox Pharmacy, processes FFS pharmacy claims, and is responsible for all of Texas' rebate invoicing, collecting, and reporting.

PCRA's responsibilities include:

- oversight of Xerox Pharmacy's performance and deliverables, and notifying HHSC Contract Manager of compliance issues and recommending actual or liquated damages;
- serving as subject matter experts for the program's multiple drug rebate programs;
- helping ensure the quality of managed care organizations' pharmacy claims data submitted to HHSC; and
- participation 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.

Pharmacy Program Management

The Program Management area develops and implements processes for project and contract management, monitoring, communication, and coordination of VDP functions. Program Management oversees pharmacy communications with all other areas in the Medicaid/CHIP Division and HHSC. Responsibilities include:

- overseeing implementation and compliance of pharmacy policies, procedures, rules, and state and federal statutes related to pharmacy benefits;
- initiating and developing Medicaid/CHIP administrative rules, state plan, and waiver amendments for pharmacy benefits;
- coordinating audits, bill analyses, and legislative inquiries related to pharmacy benefits;
- developing pharmacy-related managed care contract language and communications; and
- coordinating responses to Centers for Medicare & Medicaid Services and to open records requests related to pharmacy benefits.

VDP provider enrollment and maintenance functions are provided by MCD's Contract Management area. Individual pharmacies must sign a contract with HHSC to be reimbursed for providing pharmacy services to Medicaid recipients.

To provide services to CHIP clients, contracted pharmacies must sign additional contract agreements.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Vendor Drugs Administration

General Revenue: $858,596
Federal: $2,099,840

	General Revenue/GR-D	Federal	Other
B.3.1 Medicaid Contracts & Administration	$858,596	$2,099,840	0

The Medicaid share of Vendor Drug Administration is in Strategy B.3.1 Medicaid Contracts and Administration. General Revenue is the 50 percent and 25 percent administrative match for Medicaid with corresponding Medicaid federal funds. The allocation of funding is derived using a cost allocation factor of Medicaid and CHIP client counts or direct charges to the Medicaid program.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

N/A

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

N/A

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

VDP works closely with the Centers for Medicare & Medicaid Services (CMS). CMS provides federal regulations and guidance for many aspects of prescription drug delivery for Medicaid recipients, including formulary management, drug utilization review, reimbursement, managed care organizations, and rebates.

VDP receives guidance and provides information to the Federal Office of Attorney General along with many state governmental agencies including Texas Office of Attorney General(OAG), HHSC Office of Inspector General (OIG), Texas Comptroller of Public Accounts, Texas State Board of Pharmacy, and the Texas Board of Medical Examiners. VDP regularly responds to inquiries from OAG and OIG related to pharmacy-related lawsuits and audits.

K. If contracted expenditures are made through this program please provide:
- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The Medicaid/CHIP programs have become more complex through the years. In response, HHSC administers these programs through a large number of contracts. Many of these contracts cover various areas within the Medicaid/CHIP Division. For this reason, the five largest contracts are outlined in the following areas responsible for contract management and oversight:

- Program Operations Guide to Agency Programs, Section K, and
- Vendor Drug Program Guide to Agency Program, Section K (this one).

One of the five largest MCD contracts is monitored by the Vendor Drug Program area. The following is the contract monitored by VDP and background information.

Fiscal Year 2012 Expenditures: **$12.2 billion**

Number of active contracts accounting for those expenditures: **4,604**

Current Contracting Issues: None at this time.

Contractors: The contractor list is more than 20,000 printed pages. An electronic copy of this list is available.

HHSC Vendor Drug Program Pharmacy Provider

Under this contract, a pharmacy provider dispenses prescription drugs authorized as covered benefits to Medicaid-eligible individuals. These are fee-for-service contracts. HHSC may assess a remedy, sanction, penalty, or other action authorized by law and consistent with due process including, but not limited to, payment hold, recoupment, administrative penalties, debarment, suspension, cancellation of contract, or exclusion from participation. Fiscal year 2012 expenditures were generated from the Health and Human Services Contract Administration and Tracking System (HCATS) as HHSC's official repository for contract information.

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

Modify the Texas State Board of Pharmacy Texas Administrative Code rule, 22 TAC 291.8(b)(3)(D), which requires healthcare facilities and penal institutions to send a copy of their returned drug inventory to HHSC. This rule was designed to comply with state law requiring reduction of drug waste when patients leave a healthcare or penal facility.

This rule requires all pharmacies that service healthcare facilities or institutions to report all medications that are returned to the pharmacy after a patient leaves the facility/institution to the VDP. The reporting is required for all patients, regardless of their coverage (e.g., Medicaid, CHIP, commercial health insurance, no insurance). Reviews of reports revealed that many of the patients are ineligible for Medicaid. There is no practical process that HHSC can implement to apply the reported information to achieve cost savings.

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

N/A

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Medicaid/CHIP is not a regulatory program.

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Program Operations and Contract Management Oversight
Location/Division	4900 N. Lamar Blvd., Austin, Texas Brown-Heatly Building/MCD
Contact Name	Gary Jessee, Deputy Director
Actual Expenditures, FY 2012	$96,754,158
Number of Actual FTEs as of June 1, 2013	97
Statutory Citation for Program	Title XIX of the Social Security Act, Texas Administrative Code Chapter 353, Human Resources Code Chapter 32, and Code of Federal Regulations Title 42, Part 435 and 437; Balanced Budget Act of 1997; Title XVII of the Social Security Act, TAC 370; HHS Code Chapter 62

B. What is the objective of this program or function? Describe the major activities performed under this program.

Overview

Program Operation's objectives are to provide better access to healthcare services, improve quality, promote service appropriate utilization and contain costs. Program Operations' major activities include developing and operating managed care models to provide a medical and dental home; developing and maintaining provider networks; performing utilization reviews and utilization management; managing Medicaid and Children's Health Insurance Program (CHIP) contracts; and quality assessment and performance improvement.

CHIP Benefits

The state's package includes a basic set of healthcare benefits that is cost effective and focuses on primary healthcare needs. Covered services must meet the CHIP definition of medically necessary and are subject to limitations and exclusions.

CHIP Dental

The Texas CHIP dental benefit package previously consisted of three tier levels that covered certain preventive and therapeutic services up to capped dollar amounts per 12-month coverage period. CHIPRA of 2009 required all state CHIP programs to cover dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. To comply with this requirement, Texas CHIP was required to cover certain services that were not previously covered including periodontics and prosthodontics services.

Effective March 1, 2012, Texas eliminated the three-tier benefit package. All CHIP members now receive up to $564 in dental benefits per enrollment period. Emergency dental services are not included under this cap. Members can also receive certain preventive and medically necessary services beyond the $564 annual benefit limit through a prior authorization process. To offset the costs of covering additional dental services, HHSC raised CHIP cost-sharing amounts.

CHIP Pharmacy Benefits

Effective March 1, 2012, CHIP members began receiving outpatient prescribed drug benefits through pharmacy benefits managers contracted with MCOs. CHIP members receive unlimited prescriptions for CHIP-covered drugs and biologicals.

Texas Medicaid Managed Care Programs

Medicaid's State of Texas Access Reform (STAR) program is a managed care program in which HHSC contracts with managed care organizations (MCOs) to provide, arrange for, and coordinate preventative, primary, and acute care covered services, including pharmacy needs. STAR administers services to different eligible populations in different locations. STAR members receive all benefits of traditional Medicaid plus unlimited prescriptions, and unlimited medically necessary hospital stays as well as value-added services. The STAR program operates under the Texas Health Care Transformation and Quality Improvement Program 1115 Waiver.

STAR+PLUS integrates the delivery of acute care and long-term services and support through a managed care model. Eligible individuals include Supplemental Security Income (SSI) related members with a disability or who are age 65 and older with a disability. Acute care, pharmacy, and long-term services and supports are coordinated and provided through a provider network contracted with MCOs. STAR+PLUS members receive the benefits of traditional Medicaid plus unlimited prescriptions, waiver of the $200,000 individual annual limit on inpatient services, value-added services, and service coordination. STAR+PLUS operates under the Texas Health Care Transformation and Quality Improvement Program 1115 Waiver.

HHSC and the Texas Department of Family and Protective Services (DFPS) developed a medical care delivery system for children in foster care who are:

- a high-risk population with greater medical and behavioral healthcare needs than most children in Medicaid; and
- in changing circumstances making continuity of care an ongoing challenge.

STAR Health is a managed care program that began in April 2008. STAR Health members receive medical, dental, and behavioral health benefits, including unlimited prescriptions through a medical home. STAR Health members receive all the benefits of traditional Medicaid for children along with service coordination and service management.

NorthSTAR is an integrated behavioral health delivery system in the Dallas service area serving Medicaid-eligible individuals or individuals who meet certain eligibility criteria. NorthSTAR is an initiative of the Texas Department of State Health Services (DSHS). Services are provided via a fully capitated contract with a licensed behavioral health organization.

As of March 1, 2012, Medicaid dental services are provided through a managed care model to children under age 21, including SSI recipients. Clients who receive their dental services through a Medicaid managed care dental plan are required to select a dental plan and a main dentist.

Also effective March 1, 2012, Medicaid managed care clients in the STAR, STAR+PLUS, and STAR Health programs began receiving prescription benefits through pharmacy benefits managers contracted with their MCOs.

Service Delivery

Medicaid managed care is delivered through MCOs, such as health maintenance organizations and exclusive provider benefit plans. The Texas Department of Insurance licenses and approves MCOs to deliver and manage health services under a risk-based arrangement. MCOs contract with providers and hospitals to form a network that serves the MCO's members (Medicaid and CHIP clients). The MCO receives a per-member-per-month capitation payment to provide these services.

MCOs are selected by the state through a competitive procurement process. As of March 1, 2012, there were 11 service areas with a total of 18 MCOs.

As of February 2012, almost 2.9 million of the State's 3.7 million Medicaid clients were in managed care.

STAR+PLUS Support Units and Utilization Management

Development of the Program Support and Utilization Management sections are underway with plans to implement in Fall 2013. This section will have two branches, the STAR+PLUS Support Unit (SPSU) and the Utilization Management team.

Effective October 1, 2013, the STAR+PLUS Support Units are transferring from the Texas Department of Aging and Disability Services (DADS) to HHSC. SPSUs are located regionally in the managed care service areas and assist fee-for-services are above 100 percent of SSI limits;

- sending enrollment packets to individuals released from the lists;
- providing consumer notices;
- entering STAR+PLUS member requests for appeals for denials of services into the fair hearing system; and
- registering the waiver service in the state system.

The Utilization Management staff function is a result of S.B. 348, 83rd Legislature, Regular Session, 2013. HHSC is required to establish an annual utilization review process for managed care organizations participating in the STAR+PLUS program.

Texas Medicaid Wellness Program

The Texas Medicaid Wellness Program is a community-based, holistic-care management program that enrolls high-risk traditional Medicaid clients with complex, chronic, or co-morbid conditions. Extensive case management focuses on the whole person, rather than the disease, through telephone and face-to-face conversations focused on improving health outcomes. The client's care team is led by a registered nurse, and may include social workers, community health workers, pharmacists, and behavioral health specialists. In addition to working on the client's care plan with the provider, the care team also assists with transportation and housing issues, medical equipment assistance, education on disease management, and nutrition. Clients receive between one and four telephone and/or face-to-face visits per quarter, and educational mailings quarterly. Clients also have access advice via a 24-hour nurse line.

Fee-for-service Contract Compliance Monitoring

The Claims Administration Contract Compliance (CACC) area, a part of Program Operations Section, coordinates contract compliance for the Texas Medicaid & Healthcare Partnership (TMHP) contract.

CACC provides oversight for TMHP administration and contracted services. CACC ensures services to fee-for-service Medicaid clients are delivered at a cost consistent with the contract. TMHP provides contracted services under the Texas Medicaid Claims /Children with Special Health Care Needs Services Program, Medicaid Services Claims Processing, Primary Care Case Management, and the Pharmacy Claims and Rebate Administration to HHSC. TMHP is comprised of Xerox (formerly ACS State Healthcare LLC), the prime contractor, and its subcontractors. Services include full-life cycle claims processing.

Fee-for-service pays healthcare providers for each approved service (e.g. office visit, test, or procedure). Medicaid managed care is a service model in which HHSC contracts with MCOs to provide, arrange for, and coordinate preventative, primary, and acute care covered services, including pharmacy.

Under this contract, Xerox provides an array of services including claims administration and claims processing for Texas Medicaid and the operation of the state's Medicaid Management Information System.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

Federal law requires State Medicaid programs to contract with an External Quality Review Organization (EQRO) to evaluate Medicaid managed care programs. The EQRO produces an annual report with data to support HHSC's efforts to provide managed care clients with access to timely and quality care in each managed care program.

STAR Quality of care

The EQRO quality-of-care studies conducted in fiscal year 2010 indicate 63 percent of STAR children received six or more well-child visits in the first 15 months of life. Eighty percent of STAR children received one or more well-child visits in their 3rd, 4th, 5th and 6th years of life (HHSC's standard is 56 percent). Sixty-three percent of adolescents enrolled in the STAR program had one or more well–care visits (HHSC's standard is 38 percent).

STAR+PLUS Quality of care

The fiscal year 2010 STAR+PLUS Quality-of-Care Report provides descriptive information about the STAR+PLUS population and evaluation of members' access to care, utilization of services, and effectiveness of preventive care and treatment. The report shows the Texas STAR+PLUS program was good overall in most quality-of-care measures.

NorthSTAR Quality of care

In an EQRO 2010 analysis, NorthSTAR achieved a 62 percent rate for follow-up care within 30 days after discharge from an inpatient psychiatric facility. The national mean is 60 percent. In addition, there are numerous quality and performance measures DSHS NorthSTAR staff monitor and track closely.

STAR Health Service Management

The STAR Health MCO conducts a telephonic screening for each child within the first month of enrollment. The screening gathers information about medical history and current health status from each child's medical consenter. This information is used by the MCOs service management team to determine the medical and behavioral health needs of all STAR Health members.

Under the terms of the 1115 Healthcare Transformation Waiver, HHSC is required to provide routine status reports on the effectiveness of the program (including updates on network participation; access to care; member and provide complaints; and other operational and consumer issues).

Texas uses a variety of performance measures to assess program quality including national Healthcare Effectiveness Data and Information Set average, HHSC Performance Indicator Dashboard standard, and/or national Agency for Healthcare Research and Quality Pediatric Quality Indicator.

The Quality-of-Care Report for fiscal year 2010 data shows Texas CHIP continues to improve access and effectiveness of care and utilization of healthcare services to children under age 19 on a statewide level.

Results include the following observations.

For children and adolescents' access to primary care practitioners (PCPs), the rates of access to PCPs were very high for all age groups, with more than 90 percent of children visiting a provider during the measurement period.

For preventive care for children and adolescents, 68 percent of children age 3 to 6 in CHIP had a well-child visit. This exceeded the HHSC Performance Indicator Dashboard standard of 56 percent; however, the rate was slightly below the rate reported by Medicaid managed care plans to the National Committee for Quality Assurance (NCQA) for this measure (72 percent). Fifty percent of adolescents in CHIP had a well-care visit, which exceeded both the national rate reported by NCQA (48 percent) and the HHSC Performance Indicator Dashboard standard (38 percent).

For ambulatory care outpatient utilization, CHIP members on average had 261 outpatient visits per 1,000 member months, which is significantly lower than the national average of 367 visits per 1,000 member months.

For pediatric inpatient admissions, rates of Ambulatory Care Sensitive Conditions related pediatric inpatient admissions were below the national rates reported by the AHRQ. The highest rate of pediatric inpatient admissions in CHIP was for asthma (70 per 100,000), which was considerably lower than the AHRQ national rate (124 per 100,000).

For emergency department (ED) utilization, overall program-level utilization rates at 23 ED visits per 1,000 member months were considerably lower than the national HEDIS mean of 67 visits per 1,000 member months. CHIP reported improvement from fiscal year 2009 to fiscal year 2010 on well-child visits and adolescent visits:

- well-child visits (66 percent increase to 68 percent); and
- adolescent well-care visit (47 percent increase to 50 percent).

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

1991 The 72nd Legislature requires the state to establish Medicaid managed care pilot programs.

1995 Senate Bill 10 and related legislation establish a comprehensive statewide restructuring of Medicaid by incorporating a managed care delivery system. Texas continues to expand its Medicaid managed care program through 1915(b) waivers (Social Security Act).

1997 House Bill 2913 and S.B. 1163, 1164, and 1165, strengthen Medicaid managed care client and provider protections.

1998 In July, Texas implements Phase I of CHIP, providing Medicaid to children ages 15 to 18 under 100 percent of the federal poverty level (FPL). Phase I of CHIP operates from July 1998 through September 2002. The program is phased out as Medicaid expands to cover those children.

1999 Through S.B. 2896, a moratorium is placed on further managed care expansion. However, this legislation allows the state to complete the Dallas and El Paso service area implementations.

2003 House Bill 2292, directs HHSC to provide Medicaid managed care services through the most cost-effective models.

2005 PCCM (formerly known as the Texas Health Network) is removed in September as a non-capitated plan choice in the STAR service areas.

Senate Bill 6 directs HHSC and DFPS to develop a statewide healthcare delivery model for all Medicaid children in foster care. STAR Health is implemented on April 1, 2008.

The 2006-2007 General Appropriations Act, S.B. 1, and H.B. 1771 directs HHSC to use cost-effective models to better manage Medicaid care for individuals age 65 and older and those with physical disabilities in certain areas of the state. HHSC develops the Integrated Care Management model and the STAR+PLUS Hospital Carve-Out model to integrate acute care and long-term services and supports.

2008 The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) requires certain group health plans that offer behavioral health benefits (mental health and substance use disorder treatment) to provide those services at

parity with medical and surgical benefits. CHIPRA applies MHPAEA requirements to all state CHIP programs.

2011 Effective in December, STAR+PLUS receives federal approval to operate under the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver. Previously STAR+PLUS required federal approval of both a 1915(b) and a 1915(c) waiver to mandate participation and to provide home and community-based services. CMS approves a CHIP state plan amendment to remove the treatment limitations from existing CHIP behavioral health benefits, effective March 1, bringing CHIP into compliance with the mental health parity requirements in CHIPRA. To offset increased costs in the CHIP program, HHSC increases certain co-payments for CHIP members above 150 FPL effective March 1.

The 2012 General Appropriations Act, H.B.1, assumes a cost savings resulting from the expansion of Medicaid managed care statewide. HHSC eliminates the PCCM program on February 29, 2012. Effective March 1, 2012, services under PCCM become an MCO responsibility.

Senate Bill 7 requires HHSC's contracts with MCOs to include pharmacy benefits. Effective March 1, 2012, Medicaid managed care clients in the STAR, STAR+PLUS, and STAR Health programs begin receiving prescription benefits through pharmacy benefits managers contracted with their MCOs.

2012 As of March 1, children's Medicaid dental services are provided through a managed care model to children birth through age 20, including SSI clients.

2013 Effective October 1, the SPSU transfers from DADS to HHSC. SPSUs were created in 1998 to facilitate eligibility verifications and service plan entries in the Service Authorization System for STAR+PLUS waiver services.

HHSC anticipates that beginning January 1, 2014, the Affordable Care Act, enacted in 2010, will require states to make significant eligibility changes for existing Medicaid and CHIP groups, add new required populations, and require coordination between Medicaid and CHIP eligibility determinations and the Health Insurance Marketplaces. States must provide Medicaid to children ages 6 to 18 from 100 to 133 percent of the FPL (currently eligible for CHIP).

Fee-for-service Contract Compliance Background

The Claims Administration Contract Compliance (CACC) area coordinates TMHP contract compliance activities. Actual contract monitoring is conducted by business owners (managing, primary, and secondary) from various sections of HHSC, DADS, and DSHS. Business owners conduct contract monitoring for their various contract requirements and document monitoring in the State's Medicaid Contract Administration Tracking System. When it is determined that TMHP has failed to deliver services required by the contract, the business owners consult with

CACC staff to identify the most appropriate method to obtain TMHP compliance. CACC staff provides the following services:

- developing contract requirements;
- managing the Change Order Request (COR) process. The COR is used to amend the current contract or scope of project; and
- monitoring contract requirements/deliverables as a business owner.

CACC also provides guidance to state business owners regarding escalating performance issues by:

- issuing performance State Action Requests (SARs) requesting corrective measures. SARs are state correspondence to the vendor requiring a response;
- coordinating repeat unsatisfactory vendor responses with the Contract Compliance Quality Assurance or performance group. This may result in issuance of deficiency notice(s) for a corrective action plan; and
- requesting and assessing liquidated/actual damages, as needed.

CACC finance staff provides TMHP billings and expenditures oversight to review all charges to the state and ensure supportive documents are consistent with the TMHP contract. CACC finance also reviews TMHP financial data and provides assurance all charges are consistent with the cost model included in any CORs.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

Medicaid's STAR program is a statewide managed care program. HHSC contracts with MCOs to provide, arrange for, and coordinate preventative, primary, and acute care covered services. STAR is a statewide program that mandatorily covers pregnant women, newborns, children with limited income and TANF recipients. SSI children birth through age 20 may also choose to participate in STAR. Beginning January 1, 2014, former foster care children, ages 21-26, will also be eligible for STAR.

STAR+PLUS is designed to integrate the delivery of acute care and long-term services and supports. The STAR+PLUS program serves SSI and SSI-related clients. SSI and SSI-related adults are required to participate in the program, while SSI and SSI-related children may choose to participate.

SPSU functions affect eligibility verification and registration of services in the DADS' Service Authorization System for individuals released from the STAR+PLUS Waiver (SPW) interest list. SPSU staff coordinates the transition of services for individuals aging out of children's Medicaid programs or leaving nursing facilities, and registers upgrades from STAR+PLUS services to SPW

services in the SAS. SPSU functions include handling members' requests to file an appeal through HHSC when SPW services are reduced and/or terminated.

NorthSTAR is an integrated behavioral health delivery system in the Dallas service area, serving people who are eligible for Medicaid or who meet eligibility criteria. Most Medicaid-eligible recipients residing in the service area are automatically enrolled with a need for behavioral health services.

STAR Health is a statewide program designed to provide coordinated health services to children and youth in foster care and kinship care. Clients can begin receiving services as soon as they enter state conservatorship. The STAR Health program also extends to young adults (up to the month of their 22nd birthday) in voluntary foster care placement agreements, young adults (up to the month of their 21st birthday) who aged-out of foster care at 18 and are eligible for Medicaid for Transitioning Foster Care Youth. Young adults enrolled in a higher education program are eligible through the month of their 23rd birthday. Starting January 1, 2014, all former foster care children under age 21 will be enrolled in STAR Health, and those ages 21-26 are eligible for STAR.

CHIP covers children in families who have incomes too high to qualify for Medicaid but who cannot afford private health insurance.

The majority of CHIP clients are over age 5. Sixty-one percent of clients are between ages 6 and 14, and 22 percent of clients are between ages 15 and 18. Slightly fewer than 17 percent are between ages 1 and 5, while less than 1 percent of clients enrolled in CHIP in state fiscal year 2012 were under age 1.

The higher proportion of CHIP clients in the older age groups is due in part to the different income eligibility requirements for CHIP and Medicaid. CHIP serves all children up to 200 percent of FPL. Medicaid serves infants (12 months of age and younger) up to 185 percent of FPL, children ages 1 through 5 up to 133 percent of FPL, and children ages 6 through 18 up to 100 percent of FPL.

All clients in the CHIP Perinatal program are under age 1 because a woman can only enroll her child in the program prior to delivery. The majority of clients are at or under 185 percent of FPL with approximately 2.5 percent of all clients above this amount.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

Administration

HHSC administers the Texas Medicaid managed care program. CMS provides federal oversight. HHSC administers Medicaid managed care and CHIP under a single management structure. NorthSTAR is administered by DSHS.

Health Plan Management

Health Plan Management (HPM) monitors MCOs' compliance with the managed care contracts, the Uniform Managed Care Manual, and the Texas Government Code Section 533 and Texas Administrative Code §353. HPM's major activities include monitoring, service delivery, provider networks, claims processing, deliverables, and marketing and other administrative requirements.

Operations

While most of the day-to-day activity within HPM does not require timeliness standards, staff monitors significant administrative requirements including service delivery and provider networks.

Service delivery includes evaluating and trending provider and client complaints. It also includes monitoring service coordination, MCO call center services, claims processes, and encounters. Encounters are MCO data for medical services rendered to covered members. Staff monitors quality of care and access to care. Monitoring provider networks involves analyzing MCO provider data and geographic access reports. Staff reviews provider turnover rates, network panel status reports and provider directories. Staff monitors for timely network file submissions. Some of the other HPM administrative requirements include coordination with other departments within HHSC by:

- assisting with the resolution of complex issues;
- facilitating contractor, agency, or provider meetings;
- obtaining or developing policy clarifications;
- resolving encounter data issues, enrollment files, and premium payment issues; and
- clarifying contract requirements and coordinating or providing training to MCO staff.

Quarterly Reports

MCOs provide reports to HPM throughout each fiscal quarter. HPM staff collects and compiles the MCO reports by health plan code. A health plan code is assigned to a specific MCO for a specific product for a specific service area. Each MCO may have multiple quarterly reports. These reports are used for monitoring purposes.

Marketing

MCOs submit marketing material to HHSC for review and approval. HPM staff reviews submissions for compliance with the Uniform Managed Care Marketing Policy and Procedures Manual and makes a decision within 15 business days. If the deadline is not met, it constitutes

approval. HHSC reserves the right to require discontinuation of any marketing materials that violate marketing policies.

Research and Resolution

HPM staffs a unit to respond to provider and member inquiries and complaints, which as described by 42 C.F.R. §438.400 may include the quality of services provided, rudeness of a provider or employee, or failure to respect a Medicaid member's rights.

The MCO is the initial point of contact to address member or provider concerns. HPM will assist with any escalated issues. Inquiries and complaints are referred to HPM from a variety of sources including elected officials, the Office of the Ombudsman, and other agencies and departments. Provider inquiries and complaints are received directly from providers through email. HPM is considering adding a call center to field provider inquiries and complaints.

Program Operations Finance

Program Operations Finance monitors the MCO financial compliance with the Uniform Managed Care Contact and with the Uniform Managed Care Manual. This group has primary responsibility for:

- monitoring financial performance of MCOs, including the financial aspects of subcontracts and affiliate relationships, and recommending strategies to address issues and concerns;
- reviewing and validating MCO financial deliverables;
- administering the recovery of excess profits through the experience rebate process;
- managing the MCO external audit process;
- developing financial reporting principles;
- supporting HPM and other stakeholders within the Medicaid/CHIP Division regarding financial reporting and related issues;
- providing ad hoc analysis as requested;
- participating in legislative bill analyses;
- providing financial expertise for request for proposal and contract amendments;
- responding to and implementing recommendations of State and HHSC internal auditors;
- performing financial aspects of MCO readiness reviews;
- serving as liaison with HHSC Legal on contract and reporting issues; and
- providing orientation, training and technical assistance to MCO staff regarding financial reporting.

Program Management

Program Management implements initiatives which directly impact Medicaid and CHIP service delivery. Program Management provides program expertise and coordinates with healthplan managers, quality analysts, and the contracts, finance and policy development areas to refine existing or implement new healthcare delivery models. Program Management staff manage the program and managed care policies of the various managed care programs (STAR,

STAR+PLUS, STAR Health, CHIP, Dental), and the Texas Medicaid Wellness Program. Program Management also manages certain state or federally-directed projects for the division, monitors MCO compliance with the *Linda Frew*, *et al.* vs. *Kyle Janek* lawsuit, and works with EQRO on quality-improvement initiatives.

Managed Care Contract Development and Support

The Managed Care Contract Development and Support unit oversees the development and amendment of MCO contracts and the Uniform Managed Care Manual. This area coordinates with Program Management, Health Plan Management, Vendor Drug, MCO Operations Coordination, Contract Compliance, HHSC Legal, and other staff to develop contracts and Uniform Managed Care Manual language that addresses applicable federal, state, and programmatic requirements. The unit distributes draft amendments to the MCOs, conducts face-to-face meetings with the MCOs, and coordinates the agency's responses to all MCO comments. This area also prepares the final contracts for submission to CMS.

Claims Administration Contract Compliance Process

CACC monitors compliance with contract requirements, processes SARS and ACS-TMHP Initiated Memorandums, manages the financial contract costs and transactions, processes CORs and contract amendments, and performs quality assurance performance reviews.

MCATS

MCATS automates many of the current contract monitoring processes. The automated process assists with:

- systematic tracking efforts;
- communicating both internally and with the vendor to reduce errors, confusion and overall work effort;
- systematically prompting all users of key tasks awaiting action; and
- tracking and trending performance to guide future monitoring efforts.

Contract Auditing

CACC routinely reviews for contract compliance and quality, and procures independent audit services to review contractor performance, delivery, security, financial transactions, and performance. The audits and frequency are:

- risk assessments audits performed every other year, which determine the area to be audited in the performance audit and/or financial audit;
- performance audits every one to two years;
- retrospective cost settlements annually;
- financial audits based on frequency of risk and performance issues; and
- SSAE16 (Suitability of the Design and Operating Effectiveness of Its Controls) Audit annually.

Quality Assurance

CACC Quality Assurance (QA) conducts trend analysis on performance issues. Quality analysis includes the review of contract requirements to capture and isolate trends/problems. If the CCAC QA identifies two or more requirements with the same performance issue, the vendor is asked to provide a cause and analysis process to determine if there is a defined issue that needs to be evaluated.

HHSC's CHIP responsibilities include:

- serving as the primary point of contact with the federal government;
- establishing policy directions for the CHIP program;
- administering the CHIP State Plan;
- contracting with health plans and the enrollment broker;
- determining CHIP eligibility;
- approving CHIP policies, rules, reimbursement rates, and oversight of operations of entities contracted to operate CHIP functions or provide services; and
- organizing and coordinating initiatives to maximize federal funding.

Delivery of CHIP Services

CHIP services are delivered by managed care organizations (MCOs) selected through competitive procurement. As of March 1, 2012, there were 10 service areas with a total of 17 MCOs delivering services to CHIP members statewide. Enrollees residing in a CHIP service area have a choice of at least two or more MCOs. To provide CHIP members with a choice of dental plans, HHSC expanded the number of dental managed care plans from one to two.

CHIP Rates

The CHIP rate setting process is essentially the same as for the STAR managed care program. CHIP MCO rates are derived primarily from MCO historical claims for a particular base period. This base cost data is totaled and trended forward to the time period for which the rates are to apply. The cost data is adjusted for MCO expenses such as reinsurance, capitated contract payments, changes in plan benefits, administrative expenses, and other miscellaneous costs. A provision is made for the possible fluctuation in claims cost through the addition of a risk margin.

Pharmacy costs associated with all CHIP clients became part of the managed care capitation rates March 1, 2012. The methodology for calculating pharmacy rates is similar to the CHIP medical rates above with two exceptions. Base costs are derived primarily from the state's Vendor Drug Program historical claims. As managed care pharmacy data become available, MCO pharmacy claims costs will be used for the base cost. There is no acuity risk adjustment to the rates.

CHIP dental benefits are reimbursed through a separate set of premium rates. The rate setting process for the CHIP dental plans are similarly derived from MCO historical claims experience for a particular base period of time. This base cost data is totaled and trended forward as with other programs. However, trend rates and cost adjustments for programmatic changes, administrative expenses, and other miscellaneous costs are considered specifically for the CHIP dental plans. A provision for possible fluctuation in claims cost is made through the addition of a risk margin.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Medicaid Program Operations and Contract Management

General Revenue:	$42,164,639
Federal:	$50,026,011
Other:	$1,050

	General Revenue/GR-D	Federal	Other
A.1.2 Integrated Eligibility & Enrollment	$254,300	0	0
B.3.1 Medicaid Contracts & Administration	$39,450,961	$44,065,116	$1,050
C.1.4 CHIP Contracts & Administration	$2,459,378	$5,960,895	0

General Revenue primarily is the administrative match rates for Medicaid (10 percent, 25 percent, and 50 percent) and CHIP (28 percent) programs with corresponding federal funds. The allocation of funding is derived using cost allocation factors of Medicaid and CHIP client counts served by the Enrollment Broker, Medicaid and CHIP client counts or direct charges to the Medicaid program. Other funds represent appropriated receipts.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

A child's eligibility may change between Medicaid and CHIP. Coordination is key to avoid duplication of services.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

Management of both programs is integrated with support operations serving both Medicaid and CHIP programs.

Coordination with both programs is achieved through coordinated outreach efforts and a joint children's application. CHIP outreach efforts are coordinated through contracts with local community-based organizations selected based on their local expertise and experience with low-income populations.

If a child's eligibility status changes from Medicaid to CHIP (or vice versa), data regarding the child is electronically referred from one program to the other. HHSC eligibility specialists deem children eligible for CHIP when they find children ineligible for Medicaid based on income, resources, or immigration status, but have family incomes at or below the CHIP-qualifying upper limit of 200 percent of the FPL and resources at or below $10,000. If a CHIP eligibility specialist determines a child may be eligible for Medicaid, the child is referred to Medicaid.

CHIP and Medicaid health benefits are delivered through a managed care model. Procurement of health plan services for CHIP is aligned as closely as possible with other plans, such as Medicaid, to improve continuity of care. The majority of the Texas MCOs have contracts to provide services to both Medicaid and CHIP members.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

Federal Government

Medicaid managed care is a state-federal partnership program. CMS oversees the federal aspects of the Medicaid program. CMS approves the Medicaid State Plan and managed care waiver agreements. These documents outline the Texas Medicaid program requirements.

State Government

Within the state, the Medicaid program works with other HHS agencies. Medicaid managed care also shares information and coordinates efforts related to managed care with the Texas Department of Insurance.

CMS has federal oversight of SCHIP programs. CMS approves Texas' CHIP State Plan, which outlines Texas' CHIP requirements. Through a combination of federal and state dollars, a

partnership is formed between the state and CMS to provide healthcare coverage to eligible children whose families would otherwise not be able to afford private health insurance for them.

Within the state, HHSC shares information and coordinates efforts when needed with the Texas Department of Insurance, MCOs, and internal and external stakeholders, including provider associations and advocacy groups.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The Medicaid/CHIP programs have become more complex through the years. In response, HHSC administers these programs through a large number of contracts. Many of these contracts cover various areas within the Medicaid/CHIP Division. For this reason, the five largest contracts are outlined in the following areas responsible for contract management and oversight:

- Program Operations Guide to Agency Programs, Section K (this one), and
- Vendor Drug Program Guide to Agency Program, Section K.

The Program Operations area monitors four of the five largest MCD contracts. The following is a list of the four major contracts monitored by Program Operations and background information.

Managed Care Organizations (MCOs) Contract

Texas Medicaid provides healthcare services to most clients through managed care systems. HHSC has contracts with MCOs which include standards for service delivery. If those standards are not met, statute requires HHSC (S.B. 1188, 79th Legislature, Regular Session, 2005) to impose sanctions. Sanctions include assessment or imposition of any or all of the following contract remedies: penalty, liquidated damages, consequential damages, corrective action plan, debarment, involuntary suspension of a contract or portion of a contract, involuntary termination of a contract or portion of a contract, and/or any other remedy intended to correct deficient activities or contract non-compliance.

Dental Maintenance Organizations (DMOs) Contract (considered part of the main MCO contract)

All children and teens with Children's Health Insurance Program (CHIP) coverage get dental services through a CHIP dental plan. Most children and teens with Medicaid coverage get dental services through one of two Medicaid dental plans, with these exclusions:

- individuals age 21 and older;
- individuals who live in facilities such as nursing facilities, State Supported Living Centers, or intermediate care facilities; and
- children and young adults in the State's foster care program receiving dental services through STAR Health.

Fiscal Year 2012 Expenditures: **$10.3 billion**

Number of active contracts accounting for these expenditures: **70**

Current contracting issues: Currently, only one Medicaid/CHIP Division (MCD) Contract

Compliance Contract Manager is responsible for contract administration and management of all 70 MCO and two DMO contracts. The MCD Contract Compliance area is beginning to evaluating current contract management responsibilities and workloads. This evaluation will help implement process improvements.

MCO Contractors

Aetna Better Health, Amerigroup, Blue Cross and Blue Shield of Texas, Christus Health Plan, Community First Health Plans, Community Health Choice, Cook Children's Health Plan, Driscoll Children's Health Plan, El Paso First Premier Plan, FirstCare Star, Molina Healthcare of Texas, Parkland HealthFirst, Right Care from Scott and White Health Plans, Sendero Health Plans, Superior Health Plan, Texas Children's Health Plan, United Healthcare Community Plan, Health Spring, El Paso First CHIP, FirstCare CHIP, Parkland KidsFirst, and Seton Health Plan

DMO Contractors

DentaQuest and MCNA Dental. Delta Dental's contract ended December 31, 2012.

Claims Administrator

Processes and adjudicates claims for "non-capitated services," or services that are Medicaid program benefits but are not provided by the MCOs. The claims administrator also collects encounter data from MCOs to evaluate quality and utilization of services.

Eligibility Support Services and Enrollment Contractor

Assists in educating clients who are enrolling in Medicaid managed care about their dental plan, health plan and PCP choices; enrolls clients into Medicaid managed care and processes changes in the client's selection of dental and health plans.

Quality Monitor

Provides external reviews of managed care service delivery models, including Medicaid HMOs, to assess client and provider satisfaction, access to care, cost effectiveness, and quality of care.

Texas Medicaid Claims /Children with Special Healthcare Needs Services Program Claims Processing Contract – Texas Medicaid and Healthcare Partnership (TMHP)

TMHP provides contracted services to HHSC under the Texas Medicaid Claims/Children with Special Healthcare Needs Services Program Claims Processing, Primary Care Case Management, and Pharmacy Claims and Rebate Administration Agreement. TMHP (part of Xerox) processes both paper and electronic claims through receipt, adjudication, and payment/denial. Contract services include: primary care case management (PCCM)* administration; pharmacy claims and rebate administration; long-term care form and claim processing; Children with Special Healthcare Needs Services Program services; and Medical Transportation Program claims administration. The following remedies are available for contract noncompliance:

- mandated corrective action by TMHP;
- assess liquidated damages in accordance with the agreement;
- decline to renew or extend the agreement; or
- terminate the agreement in accordance with the agreement's terms and conditions.

Multiple categories of administrative services related to the claims administration include:

- provider enrollment, recruitment and relations;
- medical and program policy;
- prior authorization;
- surveillance and utilization review;
- third-party resources (other insurance and recoveries);
- family planning and Texas Women's Health Program;
- reference file pricing;
- funds management including accounts receivable and hospital audit;
- systems administration including data warehouse ad hoc reporting, MCO encounters data warehouse, and eligibility verification; and
- call center.

*The PCCM services ended on February 29, 2012. Case management of the Medicaid clients in PCCM transitioned to managed care organizations (MCOs) effective March 1, 2012.

Fiscal Year 2012 Expenditures: **$166.4 million**

Number of active contracts accounting for these expenditures: **1**

Contractor Name: Xerox

Current Contracting Issues: This contract is subject to frequent amendments using CORs for additional or modified scope of work as needed. CORs are used to implement mandated federal or state law changes, to improve Medicaid or other medical programs, and remedy various compliance issues. HHSC is currently in the process of contract procurement.

Enrollment Broker Services Contract

The mission of HHSC contract procurement is to improve Texans' access to eligibility and enrollment in health and human services programs in a manner that assures the highest levels of quality, accuracy, and efficiency. HHSC achieves this through the development and operation of call centers that leverage current technology, enhance fraud detection, and implement flexible business solutions. MAXIMUS Incorporated is the current Texas contractor for enrollment broker services. HHSC may require MAXIMUS to submit a plan to correct or resolve an agreement breach. HHSC may impose one or more of the following remedies for noncompliance on a case-by-case basis.

- Assess liquidated damages in accordance with the terms of the agreement;
- Conduct accelerated monitoring of MAXIMUS including more frequent or more extensive monitoring by HHSC;
- Require MAXIMUS to submit additional, more detailed financial and/or programmatic reports;
- Decline to renew or extend the agreement; or
- Terminate the agreement in accordance with the agreement terms and conditions.

Fiscal Year 2012 Expenditures: **$71.2 million**

Number of Active Contracts accounting for those expenditures: **1**

Current Contracting Issues: HHSC is considering an amendment to extend the current enrollment broker contract to allow time for the complete procurement process. Due to unforeseen delays, the proposed date of September 1, 2013, may not be met. HHSC is actively pursuing this approach to avoid any service disruptions.

External Quality Review Organization Contract

The Balanced Budget Act of 1997 requires state Medicaid agencies to provide an annual external independent review of quality outcomes, timeliness of services, and access to services provided by a Medicaid MCO and prepaid inpatient health plans. To comply with this requirement, HHSC contracted with the Institute of Child Health Policy (ICHP) at the University of Florida as the External Quality Review Organization for Medicaid managed care and CHIP. ICHP validates performance improvements, performance measures, contract compliance, and verifies CMS' standards compliance. ICHP is expected to meet or exceed the objectives and standards set forth in this agreement. All areas of responsibility and requirements listed in the agreement are subject to HHSC's performance evaluation. Performance reviews may be conducted at HHSC's discretion at any time and may relate to any responsibility and/or

requirement. Upon HHSC's request, ICHP will provide documentation that supports the fulfillment of the objectives and requirements. Any unfulfilled responsibilities and requirements may be subject to the remedies set forth in HHSC's Uniform Contract Terms and Conditions.

Fiscal Year 2012 Expenditures: **$11.6 million**

Number of Active Contracts accounting for these expenditures: **1**

Current Contracting Issues: Contract negotiations within HHSC are underway considering the procurement timeline and ensuring no service disruptions. The contracting process may take until October 2014.

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

N/A

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

Program Operation's objectives are to provide better access to healthcare services, improve quality, promote service appropriate utilization and contain costs. Program Operations' major activities include developing and operating managed care models to provide a medical and dental home; developing and maintaining provider networks; performing utilization reviews and utilization management; managing Medicaid and CHIP contracts; and quality assessment and performance improvement. The following links provide Medicaid and CHIP overview, contracts, and a contract manual.

Texas Medicaid and CHIP in Perspective:
http://www.hhsc.state.tx.us/medicaid/reports/PB9/PinkBook.pdf

Texas Medicaid/CHIP Uniform Managed Care Contract:
http://www.hhsc.state.tx.us/Medicaid/UniformManagedCareContract.pdf

Texas Medicaid/CHIP Uniform Managed Care Manual:
http://www.hhsc.state.tx.us/Medicaid/UMCM/index.shtml

STAR Health Contract:
http://www.hhsc.state.tx.us/Medicaid/STAR_Health.pdf

Dental Services Contract:
http://www.hhsc.state.tx.us/Medicaid/Dental-Services-Contract-0312.pdf

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Medicaid/CHIP is not a regulatory program.

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Project Management
Location/Division	4900 N. Lamar Blvd., Austin, Texas Brown-Heatly Building/MCD
Contact Name	Tania Colon, Deputy Director
Actual Expenditures, FY 2012	$1,372,196
Number of Actual FTEs as of June 1, 2013	5
Statutory Citation for Program	N/A

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Associate Commissioner for the Medicaid/CHIP Division established the Critical Projects process in 2012 to identify and prioritize key the Medicaid/CHIP Division (MCD) initiatives and provide coordination both within the Division and across HHSC.

The MCD Project Management area has the following key responsibilities:

- critical projects structure facilitation;
- development/management of large and complex projects impacting multiple divisions and/or agencies;
- Affordable Care Act (ACA) initiatives coordination and tracking; and
- ad hoc assignments and special projects.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

The Project Management unit is responsible for ensuring coordination across MCD for all major legislative and leadership-directed initiatives. The unit works with other MCD program areas to identify major implementation timelines and milestones for complex initiatives. A detailed process was developed for:

- conducting assessment of major initiatives; and

- identifying opportunities to streamline implementation processes and reduce cost by grouping major initiatives to ensure efficiencies.

In addition, the unit oversees implementation of various federally required initiatives, including those related to ACA. The unit has analyzed, tracked and/or implemented more than 200 individual initiatives outlined in the ACA, in addition to other non-ACA related items.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

The Project Management unit was established in 2012 to identify and prioritize key MCD initiatives, and ensure coordination across the division and agency to align with the MCD vision. The Project Management team is responsible for working with all MCD areas to identify resources needed for large initiatives, group similar projects to gain efficiencies and leverage existing resources, and organize key MCD initiatives.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The Project Management unit works internally with other MCD areas and unites other HHS divisions to ensure the completion of large-scale, complex projects. This unit regularly communicates with the Centers for Medicare & Medicaid Services (CMS) as the State's federal partner. The unit staff makes presentations to various stakeholder groups to provide project initiative(s) information.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

General processes for project management and implementation are:

- research and analyze the initiative;
- provide comprehensive and high-level project assessment;
- evaluate the program, operations, systems, cost, agency and state impacts;
- develop and present implementation options, key assumptions, timelines, and cost projections for each option to MCD leadership;
- prepare and document project structure, framework, assign roles and responsibilities and develop transition plan;
- prepare and document comprehensive timelines and work plans for the implementation of initiatives;
- facilitate and oversee project activities;

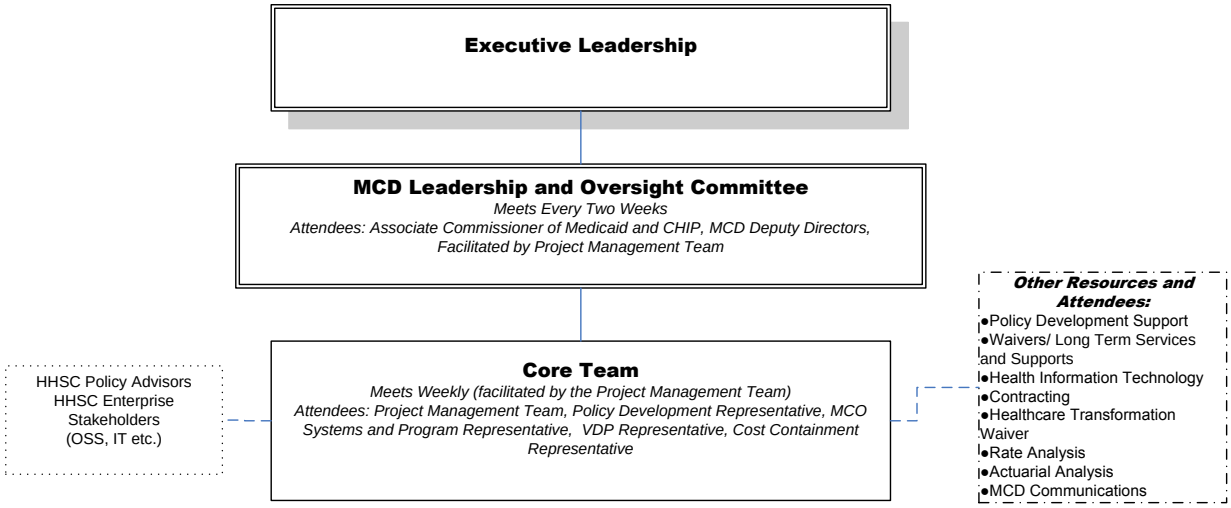
- identify and assess project issues and develop solutions;
- report on Level 1 & 2 initiatives to Core Team on an ongoing basis;
- identify project risk and risk-mitigation strategies and recommendations; and
- identify and escalate issues.

The unit also oversees the Critical Projects structure comprised of an Oversight Committee and Critical Projects Core Team. The Oversight Committee consists of the Associate Commissioner for Medicaid/CHIP and MCD Deputy Directors. The Oversight Committee meets every two weeks for updates and to oversee/direct the work of the Critical Projects Core Team.

The Critical Projects Core Team meets weekly to assess and discuss projects, tracks Level 1 and 2 initiatives, and serves as resource to project leads across the MCD division. The Critical Projects Core Team is comprised of standing members from various program areas across the division, and all members of the Project Management Team. Other attendees and subject matter experts may participate in weekly meetings as needed.

The Division holds a bi-monthly meeting with internal stakeholders to share updates on key initiatives.

MCD Critical Projects



G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Project Management

General Revenue:	$430,598
Federal:	$483,702
Other:	$457,895

	General Revenue/GR-D	Federal	Other
B.3.1 Medicaid Contracts & Administration	$394,134	$394,135	$457,895
C.1.4 CHIP Contracts & Administration	$36,463	$89,568	0

General Revenue sources are primarily administrative matches for the Medicaid (50 percent) and CHIP (28 percent) programs with corresponding federal funds The allocation of funding is derived using a cost allocation factor of Medicaid and CHIP client counts. Other funds are a specific interagency contract.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

There are currently no internal or external programs that provide identical or similar services to the functions provided by MCD Project Management.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

There are currently no internal or external programs that provide identical or similar services to the functions provided by MCD Project Management.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

Project Management is the single point of contact within MCD responsible for tracking ACA guidance and initiatives. Project Management also provides general coordination for ACA-related activities by:

- tracking, summarizing, analyzing, and disseminating federal ACA guidance and announcements;
- conducting impact assessments; and

- developing state responses/comments, and working with other areas to negotiate with CMS.

K. If contracted expenditures are made through this program please provide:
- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The Medicaid/CHIP programs have become more complex through the years. In response, HHSC administers these programs through a large number of contracts. Many of these contracts cover various areas within the Medicaid/CHIP Division. For this reason, the five largest contracts are outlined in the following areas responsible for contract management and oversight:

- Program Operations Guide to Agency Programs, Section K, and
- Vendor Drug Program Guide to Agency Program, Section K.

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

N/A

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

MCD Project Management seeks to attain the following goals.

- Ensure MCD initiatives are coordinated and prioritized across the division.
- Ensure coordination and communication of key projects.
- Establish standards for implementation and tracking of key initiatives.
- Support project development and management activities.
- Ensure strategic planning and problem solving across the division.
- Identify and evaluate project impacts across all MCD areas.

- Identify initiatives that overlap and can be combined or linked to gain efficiencies and optimize staff resources.
- Ensure initiatives do not conflict with other priorities or agency goals.
- Ensure shared knowledge and understanding of MCD priorities and initiatives in the division.
- Ensure all projects receive appropriate level of review and oversight.
- Establish and communicate a common understanding of the primary goals and objectives of the division and agency to ensure key initiatives align with those goals and objectives.

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:
- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Medicaid/CHIP is not a regulatory program.

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Operations Coordination
Location/Division	4900 N. Lamar Blvd., Austin, Texas Brown-Heatly Building/MCD
Contact Name	Alan Scantlen, Deputy Director
Actual Expenditures, FY 2012	$200,257
Number of Actual FTEs as of June 1, 2013	17
Statutory Citation for Program	N/A

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Operations Coordination (OC) area develops, oversees, and performs functions related to operational systems processing, data management, analysis, and reporting. OC is currently comprised of four units with a fifth unit under development. The four existing units are: Eligibility and Enrollment Operations; Program Development and Oversight; Claims Administrator Oversight Operations; and Enrollment Broker Operations. The fifth unit under development, the Data Analytic Unit, is based on a directive from S.B. 8, 83rd Legislature, Regular Session, 2013. Specific examples of functions performed by the four existing units include the following.

Eligibility and Enrollment Operations

- Participate in the augmentation or development of new member eligibility and enrollment initiatives.
- Coordinate with the managed care organizations (MCOs) on eligibility and enrollment system issues.
- Perform case research on escalated cases or errors identified in normal client system processing.
- Coordinate actions to resolve case-specific issues and identification of procedural or systematic issues.

Program Development and Oversight

- Review data that support administrative oversight to identify, isolate, and resolve data discrepancies.
- Report data that support enrolled population, provider networks, capitation expenditures, and healthcare services.
- Perform operational business processes such as administration of the deliverables tracking system that captures MCO contract deliverables, capitation expenditure processing and validation, and assists in the collection of quality-measure data.
- Coordinate technical and procedural actions between the MCOs, enrollment broker, claims administrator, and other technology system areas of the HHS System.

Claims Administrator Oversight Operations

- Oversee fee-for-service claims processing (acute, pharmacy, and long-term services and supports) and the provider enrollment function.
- Manage Electronic Data Interface functions and actions that support the maintenance of the Vision21 Data Warehouse.
- Coordinate claims administrator reporting.
- Research and resolve provider claims appeals.
- Manage system processes that support client and provider eligibility verification.

Enrollment Broker Operations

- Review and track contract deliverables from the enrollment broker.
- Coordinate actions performed by the enrollment broker (both internal processes and within the HHS System and related contractors).
- Oversee enrollment data, data interface management, call center operations, communications, and reporting.
- Facilitate changes to business processes and systems for the enrollment broker.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

Based on the nature of the area's activities, we do not measure effectiveness and efficiency with performance measures or deliverables, but instead overall Medicaid/CHIP system operations performed.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

N/A

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

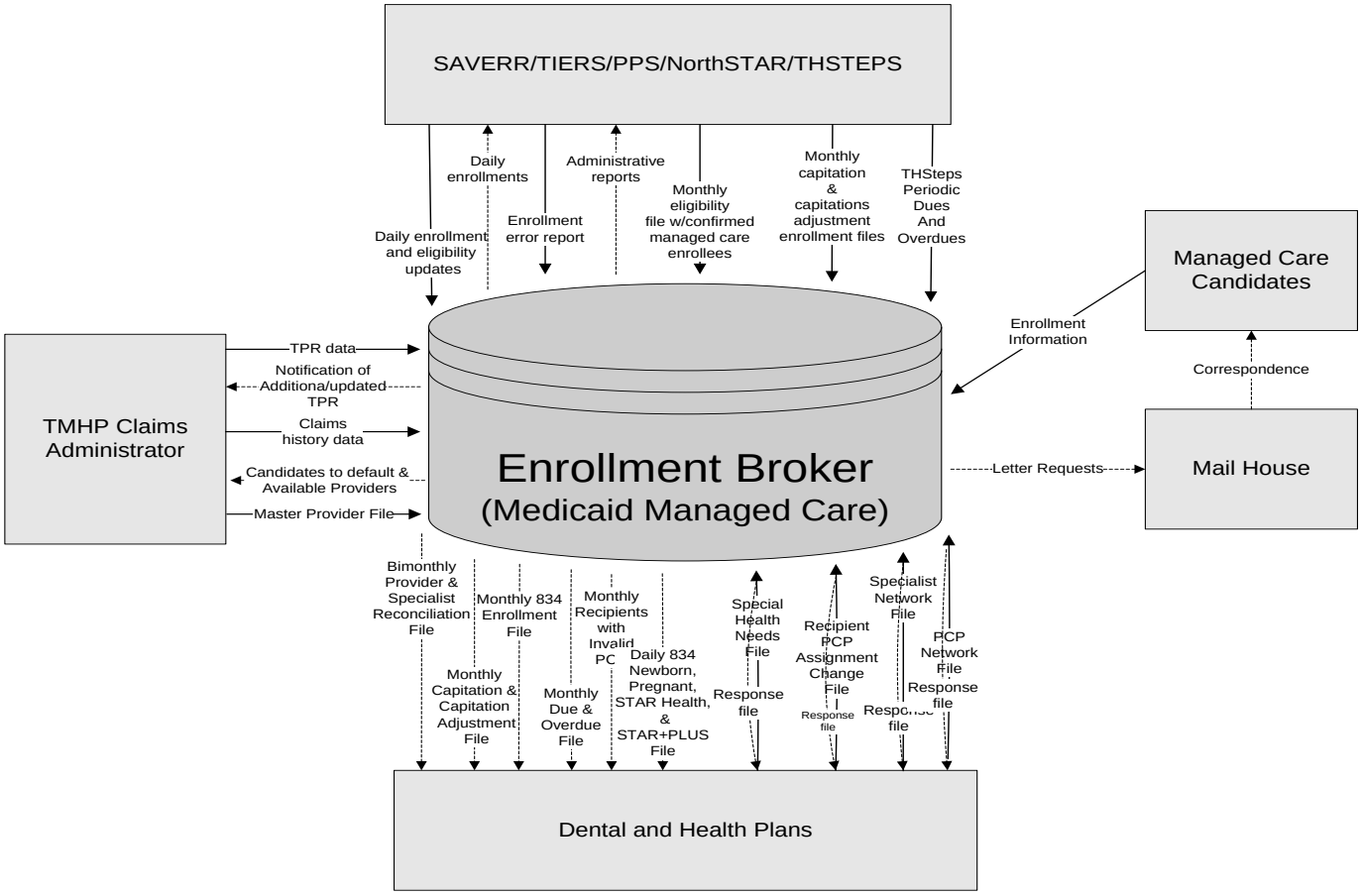
Since actions performed by this area impact both service delivery fee-for-service and managed care models and populations within both Medicaid and CHIP, this area impacts all Medicaid and CHIP recipients. The coordination and data management functions performed by this department support all contracts (MCOs, enrollment broker, and claims administrator) functions and oversight by HHSC.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

The Operations Coordination (OC) area develops, oversees, and performs functions related to operational systems processing, data management, analysis, and reporting. OC is currently comprised of four units with a fifth unit under development. The four existing units are: Eligibility and Enrollment Operations; Program Development and Oversight; Claims Administrator Oversight Operations; and Enrollment Broker Operations. The fifth unit under development, the Data Analytic Unit, is based on a directive from S.B. 8, 83rd Legislature, Regular Session, 2013. Specific examples of functions performed by the four existing units are outlined in Section B of this area's report.

The following diagram shows the flow of data among entities. This is one example of member eligibility and enrollment information systems exchange.

Interface and Entity Diagram for Medicaid Managed Care for MAXIMUS (Enrollment Broker)



G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Operations Coordination

General Revenue: $83,656
Federal: $83,656

	General Revenue/GR-D	Federal	Other
B. 3.1 Medicaid Contracts & Administration	$83,656	$83,656	0

General Revenue is the 50 percent administrative match for Medicaid with corresponding Medicaid federal funds. The allocation of funding is derived using a cost allocation factor of Medicaid and CHIP client counts served by the Enrollment Broker.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

N/A

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

N/A

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

Operations Coordination does not coordinate with local, regional, or federal units of government.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The Medicaid/CHIP programs have become more complex through the years. In response, HHSC administers these programs through a large number of contracts. Many of these contracts cover various areas within the Medicaid/CHIP Division. For this reason, the five largest contracts are outlined in the following areas responsible for contract management and oversight:

- Program Operations Guide to Agency Programs, Section K, and
- Vendor Drug Program Guide to Agency Program, Section K.

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

N/A

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

N/A

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Medicaid/CHIP is not a regulatory program.

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Medical Transportation Program
Location/Division	1106 Clayton Lane, Suite 430W Austin, Texas/Office of Chief Deputy Commissioner
Contact Name	Dimitria D. Pope
Actual Expenditures, FY 2012	$183,624,456
Number of Actual FTEs as of June 1, 2013	243
Statutory Citation for Program	Title XIX of the Social Security Act 42 CFR 431.53 Government Code, Section 531.02414 Human Resource Code, Chapter 32, and Section 22.002 (f) Texas Administrative Code (TAC) Chapter 380

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Texas Medical Transportation Program (MTP) is responsible for arranging and administering cost-effective, non-emergency medical transportation services to eligible Medicaid beneficiaries, Children with Special Healthcare Needs Services Program clients who do not have access to and from healthcare services, and Transportation for Indigent Cancer Patients clients who are diagnosed with cancer or cancer-related illness and meet program financial and residential eligibility criteria.

To ensure necessary transportation for clients to and from visits with enrolled Medicaid providers, MTP uses several transportation methods that comply with federal regulations, are efficient and cost effective, and meet client needs. The primary functional areas include the following.

Call Center Operations

Transportation Service Centers (TSCs), also known as call centers, are located in Austin, San Antonio, McAllen and Grand Prairie. Staff assigned to the TSCs is responsible for authorizing transportation services for eligible recipients to a covered healthcare event.

Contracted transportation services

MTP offers a variety of transportation services.

Mass Transit

Transportation by bus, rail air, ferry or intra-city bus either publicly or privately owned, which provides general or special service on a regular or continuing basis. Mass transit is intercity or intra-city transportation. Mass transit also involves using commercial air service to transport eligible program clients to an authorized covered healthcare service.

Demand Response

Dispatched vehicles respond to requests for individual or shared one-way trips provided by Regional Contracted Brokers using buses, vans or sedans, and transportation services offered when fixed-route transportation is not available or may not meet the client's needs. Currently, MTP contracts with 15 Regional Contracted Brokers referred to as Transportation Service Area Providers to provide these services.

Full-risk Broker

Vendors that receive capitation payment to provide a full array of transportation services to clients in a specified geographic area. HHSC has contracted with two full-risk brokers: Medical Transportation Management (MTM), Inc. provides service in the Houston/Beaumont area, and Logisticare, LLC provides service in the Dallas/Fort Worth area.

Individual Contracted Transportation

Transportation by an individual provider that is enrolled in the Texas Medicaid program and has an approved agreement with the state to receive mileage reimbursement at a state established rate to provide transportation to an eligible client. The enrolled ITP must submit documents to substantiate conformance to legal requirements, such as vehicle registration, vehicle insurance coverage and a valid driver's license. Additionally, clients under 20 years of age may qualify for the following additional services.

Upfront Funds

Money provided to families facing financial hardships that do not have the resources to transport an eligible client to a healthcare appointment.

Meals And Lodging

Services provided to clients to access medically necessary healthcare services that require overnight or extended stays.

Contract Management

Staff assigned to ensure vendor compliance with contractual agreements, including vehicle safety and compliance with state and federal laws. Reviews include on-site and desk reviews,

driver compliance with training requirements and criminal history checks, development of corrective action, follow-up and implementation.

Financial Management

Ensures validity of vendor claims payment requests, processing of purchase vouchers, and the reconciliation of vendor claims/invoicing and funds distribution to ensure the integrity of claims.

Information Technology and Support

This unit is responsible for monitoring the accuracy of automated system operations and interfaces designed to process transportation services requests, and ensure program staff's compliance with software functionality and security. The collection of data through the two systems used to manage MTP data (Claims Administrator and the Texas Medical Transportation System) allows program staff to measure the success of vendor service delivery as defined through a paid transportation claim and a matched healthcare event.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

The program has not historically collected performance related data on vendors as reflected in existing contracts between HHSC and the vendors. However, data is collected through trip scheduling to identify whether the provision of transportation services is linked to a healthcare event and the degree to which there is a match. A recent analysis of this data reflected that 96.4 percent of the trips provided by Regional Contracted Brokers were matched with a healthcare event attended by the client. Additionally, MTP collects the level of usage and the cost of transportation services by clients.

MTP collects call metric data which allows management to determine the timely delivery level of service to clients seeking transportation service. All recordings also measure the quality of service provided by MTP staff.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

Title XIX of the Social Security Act mandates that the Medicaid State Plan "specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers and described method that the agency will use to meet these requirements." The premise of the federal requirement "is based upon the recognition from past experience in Medicaid

operations, that unless beneficiaries can actually get to and from providers of services, the entire goal of a state Medicaid program is inhibited."

1974 MTP is added as a Texas Medicaid benefit under the Department of Public Welfare. The agency was renamed the Department of Human Services and administered MTP through 1993.

1993 The Texas Legislature transfers the Texas Medicaid program and MTP to the Texas Department of Health (TDH).

2000 A procurement of the advanced funds contract is let, resulting in the award of a single statewide contract for the administration and distribution of advanced funds.

2003 House Bill 2292 and H.B. 3588 transfer MTP from TDH to the Health and Human Services Commission (HHSC). The legislative direction also requires HHSC to contract medical transportation services to the Texas Department of Transportation (TxDOT). The administration of MTP remained with TxDOT until 2008 and oversight of MTP remained at HHSC. New contracts are awarded for demand response services, and the state operated call centers were reduced from 10 to four.

2007 Senate Bill 10, 80th Legislature, Regular Session, transfers the operation of MTP back to HHSC from TxDOT, beginning on May 1, 2008. Additional MTP locations moved from TxDOT to HHSC facilities later in 2008.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

MTP provides services for the following clientele:

- Medicaid-eligible clients;
- Children with Special Healthcare Needs (CSHCN); and
- Transportation for Indigent Cancer Patients (TICP), which is restricted to eight counties in South Texas.

During fiscal year 2012, 226,145 unduplicated recipients (not including full-risk broker clients) were provided transportation services. The following provides a breakdown by program type:

- Medicaid: 99.76 percent;
- CSHCN: 0.23 percent; and
- TICP: 0.01 percent.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

Administration

The delivery of non-emergency medical transportation services is managed by the MTP Headquarters' office staff that performs the following functions:

- management and oversight of statewide program operations;
- financial management (oversight of vendor/provider payments);
- contract administration and management;
- policy and rule development and guidance;
- management of claims administrator functions related to processing vendor payments;
- facilitating public/stakeholder forums;
- special project oversight; and
- training.

Contract Administration and Management

Regional Contract Specialists (RCS) are located throughout the state and are responsible for ensuring that regional contracted brokers comply with terms and conditions of their contract, including vehicle maintenance and inspections and driver compliance with state and federal laws and agency rules. RCSs are also responsible for educating contracted vendors or any new or changes to existing policies.

Transportation Service Centers (TSCs or Call Centers)

MTPs call centers are located in four regions of the state: San Antonio, Grand Prairie, Austin and McAllen. The primary functions include the following activities:

- scheduling services for eligible clients;
- advancing funds to clients experiencing financial hardships;
- providing information to callers regarding available services;
- educating healthcare providers and advocates regarding MTP operations;
- developing policies to ensure consistent application of business processes;
- training of assigned staff on agency operations;
- receiving and responding to client or vendor complaints; and
- responding to legislative inquiries.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Transportation

General Revenue:	$6,420,069
Federal:	$6,403,402
Other:	$8,424

	General Revenue/GR-D	Federal	Other
B.3.1 Medicaid Contracts & Administration	$6,420,069	$6,403,402	$8,424

General Revenue is primarily the 50 percent administrative match for Medicaid with corresponding Medicaid federal funds. Administrative costs related to transportation provided to certain DSHS clients are 100 percent GR. Other funds are appropriated receipts.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

In November 2012, HHSC transferred the contract administration and oversight of the full-risk broker contracts from MTP operations to another division within HHSC, the Medicaid/CHIP Health Plan Management (MCD-HPM) division. This action preceded legislative changes that would significantly change how nonemergency transportation services are delivered in Texas. Currently, the bifurcated structure maintains contract management and oversight of the regional contract broker, financial management, information technology and support with MTP.

Senate Bill 8, 83rd Legislature, Regular Session, changes the delivery of non-emergency services from a fee-for-service model to a capitated rate system. This new funding system will pay the Managed Transportation Organization a per member per month amount using historical cost data average utilization of services, number of eligible Medicaid and Children with Special Healthcare Needs; population growth rates; and geographical structure in a region. The law also creates two service delivery models: Managed Transportation Service Delivery and the Transit Service Delivery. Under this new system, Managed Transportation Organizations will be competitively procured within designated regions of the state. Additionally, the law broadens the type of vendors eligible to participate and requires selected vendors to accept full financial risk under the new broker model.

HHSC plans to maintain the existing program structure for the organizational management of the new transportation service delivery models.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

MTP is working closely with MCD-HPM to ensure smooth division of responsibilities. As currently defined, the contract management and oversight will rest with MCD-HPM, and policy development, rule-making, complaints/resolution and administrative services will remain with MTP. With the proposed structure, there will not be a duplication of services. Once the new system is established, HHSC plans to conduct an extensive outreach and educational campaign. Because both entities are in the HHSC System, memorandums of understanding or other agreements are not needed.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

HHSC currently contracts with rural and urban transits and private providers that serve as regional contracted brokers. "Rural transit district" means a political subdivision that provides and coordinates rural public transportation in its territory. "Urban transit district" means a local governmental body or political subdivision that operates a public transportation system in an urbanized area with a population of more than 50,000 but less than 200,000. Fifteen contracted vendors, provide fixed route and demand response services to eligible program clients.

The MTP program is a Medicaid benefit and abides by federal regulations in order to receive a federal match rate. For these reasons, HHSC staff often communicates with the Centers for Medicare and Medicaid (CMS), the federal agency responsible for ensuring the state complies with federal regulations.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

MTP contracts with a number of rural and urban transit districts and private transportation providers. Additionally, MTP contracts with other transportation services providers for meals, lodging, mass transit, airlines, and other social services.
HHSC uses several types of transportation that comply with federal assurance of nonemergency medical transportation rules and regulations, are efficient and cost effective, and meet the transportation needs of the client. HHSC makes payment for the most effective and efficient transportation that meets the need for the client and does not endanger the client's health.

Total contract expenditures FY 2012: **$183,624,456**

MTP has **34,386** contracts to provide client services.

Top five contracts by dollar amount:

1. LeFleur Transportation ($51,190,802): Provides demand response transportation services.
2. Medical Transportation Mgmt. ($13,472,846): Full-risk broker for transportation services.
3. LogistiCare Solutions, LL. ($12,521,455): Full-risk broker for transportation services;
4. Irving Holdings Inc. ($11,682,459): Provides demand response transportation services.
5. American Medical Response (49,925,854) Provides demand response transportation services.

MTP uses approved performance measures to forecast expenditures and utilization, identify anomalies to target performance monitoring of certain key providers, and factors in economic indicators that could increase costs, such as fuel price and insurance premiums. MTP conducts onsite review and desk reviews of contracted providers to ensure contract compliance. MTP also matches transportation expenditures to a paid healthcare event to gauge accountability with performance factors.

Contracts transferred from TxDOT to HHSC do not include performance measures or a venue to apply liquidated damages for non-compliance.

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

Senate Bill 8, 83rd Legislature, Regular Session (2013) mandated transformation of the delivery of non-emergency transportation services, effective September 1, 2014. Highlights of the changes include:

- implementation of two service delivery models: Managed Transportation Service Delivery and Transit Service Delivery;
- defined eligibility requirements;
- establishment of regions with designated Managed Transportation Organizations;
- creation of a capitated rate system to fund the new models, and requiring that selected vendors assume full financial risk for operations;
- providing data as determined by HHSC; and
- identifying specific requirements for providers with whom the MTO may contract.

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

Since implementation, decision makers have appeared to struggle with the correct placement of the program both internally (HHSC) and externally with the assignment to TxDOT. While a Medicaid benefit, the business model appears to align more closely with transportation services and not with social services. Prior to the most recent legislative changes, HHSC made sweeping administrative and management changes to the program, due in part to fraud concerns and unexplained program cost increases. Internal Audit findings and the hiring of qualified staff to manage operations contributed to a more solid program infrastructure, redefinition of functional areas, creation of business process flows and development of supporting policies and procedures. Since implementing these changes, performance has improved, including significant reductions in operational costs of key program functional areas.

Changes were also made to executive management. Program operations shifted from a single management structure to one that divides program operations once again between MTP management and MCD-HPM. This structure will also be used to support operations of the new transportation service delivery model. MTP has improved cost efficiencies by revamping certain client service policies to align with state and federal mandates. This has cut $20 million from and FY 2012 operational costs.

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	*Frew* Coordination Office
Location/Division	4900 N. Lamar Blvd. Brown-Heatly Building / Office of the Chief Deputy Commissioner
Contact Name	Michelle Long, *Frew* Coordinator
Actual Expenditures, FY 2012	$8,418,398
Number of Actual FTEs as of June 1, 2013	15
Statutory Citation for Program	None

B. What is the objective of this program or function? Describe the major activities performed under this program.

Created in 2007, the *Frew* Coordination Office provides high-level program and enterprise direction and oversight in order to strengthen the State's legal strategy and ensure compliance with court requirements. This office provides regular reports to the court, Legislature, and the Office of the Attorney General.

The Legislature transferred Medicaid administration from the Texas Department of Human Services to the Health and Human Services Commission (HHSC) on September 1, 1993. On the same day, the *Frew, et al. v. McKinney, et al.* (*Frew*) lawsuit was filed against the commissioners of Health and Human Services and the then Texas Department of Health in their official capacities. The allegations of the *Frew* lawsuit include:

- Medical and dental preventive checkups are not provided in accordance with recognized Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit periodicity schedules. The EPSDT, known in Texas as Texas Health Steps, provides comprehensive and preventive healthcare services for children under age 21 who are enrolled in Medicaid. EPSDT helps ensure that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.
- Texas does not effectively inform children enrolled in Medicaid about the benefits of the EPSDT program.
- Texas does not provide adequate case management services.
- The Medical Transportation Program fails to meet the needs of children enrolled in Medicaid.

- EPSDT program access is denied or limited because of an inadequate supply of providers, which is the result of inadequate reimbursement rates, red tape, and providers' lack of knowledge of the EPSDT program.

The case was filed as a class action suit. In 1994, the U.S. District Court certified the class. The parties negotiated a settlement agreement, reaching agreement in 1995. Texas must now comply with the requirements outlined in the 1996 *Frew* consent decree, the product of that agreement.

In September 2007, the court presiding over *Frew, et al. v. Hawkins, et al.* (now *Frew, et al. v. Janek, et al.*) approved 11 agreed corrective action plans (collectively referred to as the Corrective Action Orders or CAOs) to address Defendants' violations of the 1996 *Frew* consent decree. The 80th Legislature appropriated approximately $1.8 billion for the 2008-09 biennium to support state responsibilities associated with the lawsuit 2007 CAOs. These obligations include, among others, the following obligations.

- Conduct studies of various components of Texas Medicaid, develop corrective action plans (CAPs) to address study findings, and conduct a subsequent study to assess CAP effectiveness.
- Meet stricter call center standards for four toll-free numbers.
- Provide specific training to pharmacists and providers.
- Maintain certain contractual standards for managed care organizations (MCOs).
- Increase Medicaid reimbursement rates to physicians and dentists.
- Implement strategic medical and dental initiatives.

The *Frew* Coordination Office coordinates and oversees all HHS enterprise activities to comply with *Frew* court orders. Efforts include coordinating direction and activities associated with the 1996 *Frew* consent decree, 2007 corrective action orders and corrective action plans created to address study findings. The office examines and suggests program changes that will result in long-term, fundamental improvements to the Medicaid program. The office also supported the 17-member *Frew* Advisory Committee (September 2007-August 2012) established to advise HHSC on the proposals to fund using the strategic initiative allocation that best support established objectives to address the issues in the *Frew* lawsuit.

In addition, the *Frew* Coordination Office coordinates compilation of the *Frew Quarterly Monitoring Report*. This report is due to the court at the end of January, April, July, and October and must contain a status summary on each of obligations contained within the consent decree and corrective action orders.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

The court orders do not have key performance measures that allow HHSC to determine if the Corrective Action Orders have been effective or efficient mechanisms to make fundamental improvements to the Medicaid program. However, through various independent studies, and annual reports, HHSC has been able to show improvements.

After five years of reporting on services in each county and taking corrective action in counties that lagged behind a statewide average number of medical checkups and/or dental checkups, HHSC and DSHS were able to show improvements in almost all counties. In March 2013, the Court found that the Corrective Action Order: Checkup Reports and Plans for Lagging Counties (CAO) as well as several related paragraphs of the consent decree had been satisfied. The Court issued an order ending the CAO and eliminating the 11 "Statewideness" paragraphs of the consent decree.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

1993		Lawsuit filed.
1994		District court certifies case as a class-action lawsuit. The class is defined as "all present and future Texas Medicaid recipients who are under the age of 21, and therefore eligible for EPSDT services, but who have not received the entire range of EPSDT services to which they are entitled, except anyone who has knowingly and voluntarily refused EPSDT services."
1996		Consent decree signed by district court with agreement of parties.
1998		Plaintiffs file motion to enforce certain provisions of consent decree.
2000		District court issues order and memorandum opinion finding the defendants in violation of certain provisions of the consent decree and required submission of a corrective action plan to the court.
2002		Upon appeal by defendants, Fifth Circuit vacates the district court's orders of August 14, 2000.
2004	January	U.S. Supreme Court held that the consent decree is enforceable because it is a federal court order. The case was remanded to the Fifth Circuit.
	July	Fifth Circuit dismisses defendants' appeal. The case is remanded to the district court.
	October	Defendants file rule 60(b) motion to vacate the consent decree.
2005	June	Hearing held on defendants' 60(b) motion.
	August	District court issues order denying defendants' 60(b) motion.

2006 July — The Court of Appeals for the Fifth Circuit affirms the District Court's denial of defendants' 60(b) motion.

September — By *per curiam* decision (by the court as a whole), the Fifth Circuit denies the defendants' Petition for Rehearing *en banc* (by the bench), stating that the district court's mandate is to be issued immediately.

2007 April — The parties present a set of 11 negotiated corrective action plans to the District Court.

September — The District Court orders the 11 corrective action plans be implemented after determining they were fair, reasonable, and adequate. The resulting corrective action orders (CAOs) include:

- case Management,
- Checkup Reports and Plans for Lagging Counties,
- checkups,
- health outcomes measures and dental assessment,
- managed care,
- outreach and informing,
- prescription and non-prescription medications; medical equipment and supplies,
- adequate supply of healthcare providers,
- healthcare provider training,
- toll-free numbers, and
- transportation.

Together, the 11 CAOs require 10 separate studies, each requiring anticipated corrective action and a subsequent study. Several of these studies have been completed, and others are currently underway. Some of the orders also require the parties to agree upon corrective action before the plans are implemented.

Most of the CAOs require studies and/or actions to be taken for a certain period of time, after which a "period of conference" between the parties begins. During this time, the parties must confer as to what, if any, further action is required under the orders. If no agreement is reached, either party may approach the Court for resolution of any dispute(s).

2013 March — The District Court denied Plaintiffs' motion to require further action on the CAO: Checkup Reports and Plans for Lagging Counties and granted defendants motion to eliminate the CAO and related paragraphs of the decree.

August — Defendants will respond to plaintiffs' motion to enforce the CAO Adequate Supply of Healthcare Providers. At the same time, defendants will file a motion to request elimination of the CAO and related paragraphs of the

decree.

September — The District Court will hear oral argument on plaintiffs' motion to enforce the CAO: Prescription and Non-prescription Medications; Medical Equipment and Supplies and defendants' motion to eliminate the CAO and relevant paragraphs of the decree.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The Office assists agency leadership and program areas in implementation of *Frew* lawsuit activities.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

The *Frew* Coordination Office works with *Frew*-dedicated staff located in the Department of State Health Services (DSHS) and multiple programs and divisions within HHSC.

- DSHS Texas Health Steps program staff supply subject matter expertise on Texas Health Steps medical services, dental services, and case management for children and pregnant women services, develop and support training for healthcare professionals, and prepare court ordered reports about training or providers and about outreach to children enrolled in Medicaid.
- HHSC's Medicaid/CHIP Division support efforts by providing project management of various independent studies, corrective action plans and by participating in contract monitoring.
- Staff within Health Policy and Clinical Services support development of Medicaid policy that assures coverage of health services that are medically necessary for children enrolled in Medicaid.
- The HHSC Office of Social Services maintains a training staff that trains HHSC eligibility workers about Texas Health Steps medical checkups, so that eligibility workers have the necessary knowledge to provide Texas Health Steps outreach and information during face-to-face interviews with applicants for Children's Medicaid.
- HHSC Strategic Decision Support conducts analysis of health outcomes and prepares reports on Texas Health Steps participation by children enrolled in Medicaid and Medicaid enrolled providers.
- The office of HHSC's Chief Counsel has designated special counsel to provide legal guidance, develop legal strategy, and prepare documents for court filing.

In addition, program staff across the HHS System support efforts to address obligations within the lawsuit.

- The Medical Transportation Program's call center operations must adhere to the toll-free number requirements, and program staff has taken the lead on the studies and corrective action required by the CAO: Transportation.
- HHSC Communications developed and maintains a communications tool kit that aids in consistent language in outreach and education to clients about Medicaid services and operates as the project manager for the CAO required independent study on outreach effectiveness.
- Staff within Medical/CHIP Operations Coordination assists with contract monitoring and provides direction to the claims administrator and the enrollment broker on lawsuit related activities.
- Staff within Eligibility Operations coordinates posting notice to class members within eligibility offices. These notices are required one to two times per year to inform class members about attorney fees or other information related to the case.
- Each quarter, staff from DSHS and 10 HHSC program areas provide summary information and exhibits to document status of each obligation within the court orders that is compiled for the quarterly monitoring report.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Frew

General Revenue: $4,187,272
Federal: $4,231,126

	General Revenue/GR-D	Federal	Other
B.3.1 Medicaid Contracts & Administration	$4,187,272	$4,231,126	0

General Revenue is the 50 percent and 25 percent administrative match for Medicaid with corresponding Medicaid federal funds.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

None

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

N/A

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

The Office of the Attorney General, General Litigation Division (OAG-GLD) provides legal representation for HHSC on this case. In this role OAG-GLD communicates directly with plaintiffs' counsel on behalf of HHSC, and files documents with the court.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The CAOs require a number of specific actions by the Medicaid claims administrator, the enrollment broker and managed care organizations. In addition, the orders require a number of studies be conducted by independent vendors.

In 2012, HHSC expended **$6,868,764** on **nine** contracts associated with the *Frew* corrective action orders. This does not include contract expenses associated with the Medicaid claims administrator or Medicaid managed care organizations. The five contracts with the highest expenditures in 2012 were as follows.

1. MAXIMUS – expenses associated with the Corrective Action Order: Outreach and Informing and the Corrective Action Order: Toll-Free Numbers. These orders required additional outreach activities and more stringent call center standards for the Texas Health Steps hotline and the Enrollment Broker line. This contract is both performance and deliverables based. HHSC has a contract monitoring plan for ensuring accountability with contract requirements. ($6.4 million)
2. Health Information Design (HID) – As part of the Vendor Drug Prior Authorization Contract, HID translates the Texas Medicaid formulary and preferred drug list into formats that can be used and uploaded to the proprietary Epocrates® site to provide ongoing, routine updates of information. Epocrates® offers online and smartphone applications for prescribers on prescription drug choices for Medicaid clients. ($131,000)

3. Texas Publishers Association – outreach campaign using print advertising in Texas minority newspapers to inform families about the importance of preventive services for children, to promote the use of Children's Medicaid and CHIP benefits to ensure their children get regular medical and dental checkups, and to stress the importance of renewing a child's coverage on time. This is a deliverables based on contract. HHSC Communications monitors information placed in minority publications. ($100,000)
4. Coplan and Co. – validation of data reported to the court about compliance with call center standards required by the Corrective Action Order: Toll-Free Numbers. This is a deliverables based on contract. Deliverables are reviewed to ensure scope of work is adequately addressed. ($60,250)
5. University of Texas at Austin School of Social Work – with the HHSC Center for Elimination of Disproportionality and Disparities, conducted research in Houston and Austin to identify reasons African Americans enrolled in Medicaid managed care receive health care at lower rate than other groups enrolled in Medicaid managed care. ($72,040)

The procurement of these contracts follows the processes and procedures established by HHSC Enterprise Procurement and Contracting Services. Contract monitoring is conducted according to the monitoring plan for each contract which may include review of contract deliverables, service level agreements and utilization reports. There are no ongoing issues with the procurement or contracting process.

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

N/A

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

N/A

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

The Office of Health Policy and Clinical Services − Mark Chassay, M.D.

Division: 60 FTEs

Texas Institute of Healthcare Quality and Efficiency: 2 FTEs

Introduction

In 2011, the Executive Commissioner created the Health Policy and Clinical Services (HPCS) division for the purpose of coordinating medical policy, clinical services, and the integration of behavioral health services within HHSC and across the Health and Human Services (HHS) System. The new division is one part of the former Office of Health Services, which also housed the Medical Transportation Program.

The HPCS division leads work on quality and strategic initiatives and projects; coordinates referral services for individuals with acquired brain injury; leads cross-agency efforts on health information technology; and oversees the development of health, medical, and dental policy. The division also works on the following initiatives.

State Health Access Program Grant

HPCS also administers the State Health Access Program Grant (SHAP). Awarded to HHSC in 2009, the grant funds the implementation of the state health access program in Texas and supports the State's Healthy Texas small employer reinsurance program through the Texas Department of Insurance. The SHAP grant's goal is to allow currently uninsured, lower-income employed individuals access to affordable health coverage through employer-sponsored coverage. The grant period ends August 31, 2013.

Texas Institute of Health Care Quality and Efficiency

The HPCS division also provides administrative support and oversight for the independent Texas Institute of Healthcare Quality and Efficiency, created in 2011 by S.B. 7. The Institute is governed by a Board of 15 directors appointed by the Governor. Staff coordinates administrative responsibilities with the Institute to streamline and integrate the Institute's administrative operations. The Institute is subject to Sunset review in 2017 and, as such, is not discussed in this report.

Within HCPS five main programs exist.

Office of Program Coordination for Children and Youth

The Office of Program Coordination for Children and Youth assists HHSC staff and health and human services agencies in coordinating child and youth programs and initiatives (with a couple that include adult populations) across the health and human system. The program oversees

various children's programs and initiatives including a federal home visiting program, state funded nurse family partnership, early childhood coordination, and children's long-term care and permanency planning. The program also supports various Councils and Task Forces and provides oversight for the Office of Acquired Brain Injury.

Office of Acquired Brain Injury

The office serves as the state's primary resource to provide education, awareness, and service referral and coordination to brain injury survivors, family members, caregivers, services providers, and other agencies, including Texas Military Forces and veterans. The office provides direct communication and coordination with consumers, state and federal elected officials on behalf of constituents, and the HHS Ombudsman office.

Office of Informal Dispute Resolution

The Informal Dispute Resolution program performs a professional and impartial review of long-term care facility disputed issues from regulatory health and life safety code survey findings. Professional clinical staff make recommendations based on the documentation presented by providers and the Department of Aging and Disability state survey agency.

Office of e-Health Coordination

The Office of e-Health coordinates federal and state initiatives that relate to making health information of HHS program clients more available to providers and allowing providers to securely transmit information to other healthcare entities.

Office of the Medical Director

The Office of the Medical Director clinical staff provides expert medical consultation to the Medicaid and Children's Health Insurance Program, Texas Women's Health Program, and Texas Health Steps program. The office offers general consultation to internal and external stakeholders on clinical matters, develops medical, dental and behavioral policy and reviews medical appeals.

Office of Healthcare Quality Analytics, Research, and Coordination Support (HQARCS)

The HQARCS program works within the health and human services system and with external stakeholders to improve enterprise collaboration and coordination on quality initiatives, and to reduce duplication of effort. The program is charged with identifying initiatives that focus on increased quality and cost effectiveness, promote transparency and efficiency, and enhance internal and external understanding of quality and performance. It manages several quality related projects.

In fiscal year 2012, HCPS programs operated with a total budget of $30,567,348.

General Revenue sources are 100 percent state funds as well as administrative matches for the Medicaid (50 percent) and CHIP (28 percent) programs with corresponding federal funds, depending upon the program.

Several programs have specific federal grant funding. The State Health Access Program grant is 100 percent federal funds. Other funds represent interagency contract funding from cost allocation billings based on a factor using the number of Medicaid and CHIP client counts, including long-term care clients at the Department of Aging and Disability Services (DADS).

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Office of Program Coordination for Children and Youth
Location/Division	1106 Clayton Lane, Austin, Texas/ Health Policy and Clinical Services
Contact Name	Sherry Broberg, Acting Director
Actual Expenditures, FY 2012	$12,833,113
Number of Actual FTEs as of June 1, 2013	10
Statutory Citation for Program	Senate Bill 665, 77th Legislature, Regular Session, 2001

B. What is the objective of this program or function? Describe the major activities performed under this program

Created by S.B. 665, 77th Legislature, Regular Session, 2001, the Office of Program Coordination for Children and Youth (OPCCY), considered the Office of Early Childhood Coordination, functions to assist state agencies develop customer-focused, relevant, timely and cost-effective programs with the goal of promoting community support for parents of all children younger than 6 years of age through an integrated state and local-level, decision-making process. The OPCCY's objective is to provide for the seamless delivery of health and human services to all children younger than 6 years of age to ensure that all children are prepared to succeed in school.

Major activities include the following:

- coordinating and overseeing cross-agency policy initiatives for children and youth, their families, people with disabilities or complex behavioral health needs;
- creating and implementing a statewide strategic plan for the delivery of health and human services to children from birth through five years of age. The OPCCY is mandated to work with other state agencies and stakeholder groups to identify gaps in services for children, and to make recommendations to address the gaps;
- support for Councils and Task Forces: Supports the Children's Policy Council and the Council on Children and Families; and
- oversight of the following programs and initiatives

Program and Initiative Oversight

Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Matches parents with trained professionals to provide information and support during pregnancy and throughout their child's first five years. The legislative purpose of this program is to strengthen and improve the programs and activities carried out under Title V of the Social Security Act; to improve coordination of services for at-risk communities; and to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. There are two components of this voluntary program: Evidence-based home visiting programs, including: Early Head Start (Home-Based), Family Check-Up, Healthy Families America, Healthy Steps, Home Instruction for Parents of Preschool Youngsters (HIPPY), Nurse Family Partnership, and Parents as Teachers.

The second component is Early Childhood Comprehensive System development, which provides a coordinated network of comprehensive services and support that meet the overall health and developmental needs of young children in the context of their culture. An early childhood system also recognizes that to optimize child outcomes, families of young children must be supported through access to adequate housing, jobs, parenting support and education, health care, and adult mental health services.

Nurse Family Partnership Program (NFP): Oversees the home visiting programs intended to promote maternal, infant, and early childhood health, safety, and development. The Nurse Family Partnership program is a voluntary, evidence-based home visitation program shown to improve the health and well-being of low-income first-time mothers and their children. Specially trained registered nurses regularly visit the homes of participating mothers to provide NFP services. TNFP follows the three-goal national NFP model, and includes a fourth goal.

System of Care Program: Manages the federally funded initiative; strives to address the service and support needs of children and youth with serious mental health challenges and their families in coordinated and efficient ways.

Healthy Children Texas Initiative: Oversees the Texas Early Childhood Comprehensive Systems (ECCS) initiative funded by HRSA, is a recognized source for early childhood information, planning and coordination across early childhood agencies, providers and sectors. Contractors provide information, coordination, and training services on early childhood issues relevant to the initiative and the grant requirements.

Healthy Child Care Texas: Directs Healthy Child Care Texas (HCCT). Funded with Title V dollars transferred from the Department of State Health Services, the program is a state initiative dedicated to promoting optimal health, safety, nutrition, and development for children in out-of-home child care programs and offering other means of support while training health and early childhood professionals to become Child Care Health Consultants (CCHCs). The training consists of four components, pre-training; two day on-site training; distance learning composed of a 12-hour online modules that are supported by the Texas AgriLife Extension Service, and

Capstone and Training Registry Application. Upon completion of the training, CCHCs in turn provide training and consultation to out-of-home child care providers on child health, safety, and development as well as child care program quality.

HCCT trains qualified early childhood and health professional to become Child Care Health Consultants (CCHCs) and Medical Consultants (MCs) and maintains a website linking providers to consultants and other child care health and safety resources.

Family Based Alternatives (FBA) and Permanency Planning: Directed in S.B. 368, 77th Legislature, Regular Session, 2001, HHSC monitors child (defined in legislation as a person with a developmental disability under 22 yrs.) placements and ensures ongoing permanency plans for each child with a developmental disability residing in a state institution. The Office oversees the FBA contract with EveryChild, Inc., to ensure continued implementation of the project in areas with high concentrations of children living in institutional setting.

Council and Task Force Support

The Children's Policy Council (CPC): Originally authorized in H.B. 1478, 77th Legislature, 2001, Regular Session, and codified in Section 22.035, of the Human Resources Code, the CPC assists agencies in in developing, implementing, and administering family support policies and related health programs, and programs offering long-term services and supports for children and with studying and making recommendations relating to services for children with disabilities and their families, and to report those recommendations to the Health and Human Services Commission Executive Commissioner and to the Legislature not later than September 1 of each even numbered year.

The Council on Children and Families: Established by the Legislature in 2009, the Council on Children and Families helps improve the coordination of state services for children. This Council is intended to serve much like a state level 'children's cabinet' with membership from agency heads of child-serving state agencies and four public members: two parent representatives and two youth representatives.

Task Force for Children with Special Needs: The OPCCY also provides support for the Task Force for Children with Special Needs, however, a separate section of this report covers those functions, as it has its own Sunset date.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

The home visiting programs are evidence-based programs that improve outcomes for children and their families. The work of various task forces, councils and advisory committees has

resulted in changes to delivery of service and initiatives at participating agencies. The following examples indicate the success of such initiatives.

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

MIECHV implemented four evidence based home visiting models in seven Texas Communities: the Home Instruction for Parents of Preschool Youngsters (HIPPY), Nurse Family Partnership, and the Early Head start - Home Based and Parents as Teachers (PAT). These programs began operations in June of 2012. As of September 29, 2012, seven targeted communities had implemented 24 evidence-based home visiting program sites. A total of 701 families, consisting of 679 children and 95 pregnant women, were enrolled in evidence-based home visiting programs with communities continuing to actively recruit.

Recognized immediate impacts to families include increased positive parenting practices, improvement in maternal and newborn health, and decreased child maltreatment. Recognized long-term impacts include improved school outcomes and achievement and increased parent employment and self-sufficiency.

The Nurse Family Partnership Program (NFP)

The Nurse Family Partnership uses performance indicators from the Nurse Family Partnership National Service Office (NFPNSO) to measure each grantee's performance. These performance indicators were implemented as 18 NFP model "standards" that cover seven areas of implementation. The program model for the nurse family partnership enrolls women before the 29th week of pregnancy and graduates them when their child reaches the age of two. All data on program effectiveness is collected and reported over a two-year span for each client. Therefore, the evidence reported for this section assesses adherence to NFP program model standards from September 1, 2008 through June 30, 2012. Outcomes for children and families participating in Texas Nurse Family Partnership are evaluated using the Annual Legislative Report, Quarterly Summary Report, and Monthly TNFP Implementing Agency reports.

The FY 2012 Annual Legislative Report noted that, with the exception of the newest TNFP site the remaining 12 TNFP grantees met all of the 18 NFP model standards. A client satisfaction survey was added as part of the FY 2012 Annual Legislative Report. Of 985 client surveys evaluated, 99 percent of clients responded having high levels of satisfaction with the program.

<u>Monthly Deliverables</u>

A Narrative and Staff Requirements Summary report are submitted to HHSC on a monthly basis by each TNFP implementing agency. Implementing agencies use the narrative report to explain events influencing successful program implementation, describe quality improvement process for those outcome variables below standards and to track required staff training. Texas has exceeded national standards on all indicators. See the comparison of results of the Texas NFP and the National NFP summary statistics for selected outcomes under question N.

The System of Care Program

Under the current Texas System of Care initiative, the Substance Abuse and Mental Health Services Administration (SAMHSA) has funded HHSC for an expansion planning grant to yield a statewide strategic plan for expanding practices under the system of care framework. A comprehensive strategic plan has been developed and published. More recently, HHSC has been awarded a four-year a system of care expansion implementation cooperative agreement. This funding will provide support for the implementation of that comprehensive system of care strategic plan.

System of care has been shown to Increase the behavioral and emotional strengths of children and youth; reduce behavioral and emotional problems; increase child and youth functioning; reduce anxiety in children and depression in adolescents; increase school attendance and school performance; reduce violent crimes, property crimes, and status offenses; reduce the use of alcohol and cigarettes in adolescent participants; reduce strain and stress for caregivers; reduce the number of children with multiple out-of-home placements; and avoid costs across child-serving systems by reducing inpatient services, residential treatment, and out-of-home placements.

For example, the impact of school performance: student attendance and performance at school was improved over 50 percent after entering a system of care. Community includes: Travis County reported 71 percent of children and youth had reductions in delinquent behavior after entering a system of care; Fort Worth and Harris County reported less caregiver strain, i.e., less worry, anger, resentment, lost work time and financial hardship; Tarrant and surrounding counties targeting younger children report increases in protective factors and felt that service providers attended to the family's cultural needs.

Healthy Child Care Texas

As of December 2012, the HCCT has certified 112 Child Care Health Consultants (CCHC) and has 18 Texas National Training Institute CCHC trainers.

Family Based Alternatives and Permanency Planning

EveryChild, Inc., is HHSC's family-based alternatives contractor, exploring support family alternatives to institutional care, wrap-around, and other services for children with disabilities in an effort to transition children from institutional settings into the community. With assistance from HHSC's family-based alternatives contractor (EveryChild, Inc.), DADS, DFPS, child placement agencies, and Medicaid waiver providers have continued to work together to enable children to return to their natural home, finding family-based alternatives, or placing children in less restrictive living arrangements. During the 12-month period ending February 28, 2013, 254 children moved into less restrictive or family based settings.

- 101 children were moved from institutions (not including Residential Treatment Centers) to family-based settings.

- 153 children moved from an institution (not including Residential Treatment Centers) to a less restrictive setting under an arrangement other than a family or family-based alternative.
- Since 2003, over 2,200 children have moved back to their birth families or to family-based alternatives and a similar number have moved to other less restrictive environments, bringing the total number of children moved from institutions to over 4,400.

The Children's Policy Council

In 2012, the CPC met its statutory deliverable by preparing and presenting its Legislative Recommendations report. Since its inception the Legislative reports have been instrumental in affecting important legislation to improve services to children with disabilities. Examples of these are Family Based Alternatives and Medicaid Buy-In. The CPC prepared and presented two white papers on Managed Care Dental Carve-in and Managed Care Pharmacy Carve-in. These papers resulted in Medicaid and the CPC working together to resolve issues for Children with disabilities in the STAR programs. Additionally the CPC make two major presentations to staff from Medicaid, DADS and DARS on Long-Term Care Reform and Acute Care Medicaid Reform. These presentations had significant influence on the projects submitted under the Balancing

The Council on Children and Families. Since it was established in 2009, the Council on Children and Families has met its statutory deliverables: a biennial legislative appropriation request (LAR) report analysis and a biennial legislative report, including data related to children and youth in Texas. Confidence in the Council's operation has resulted in additional responsibilities mandated in each legislative session.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

2001 The Legislature creates the Office of Early Childhood Coordination (OECC) in S.B. 665. Once a federal Maternal and Child Health Bureau grant became available, members of the OECC advisory committee and staff from DSHS apply for funding. The office is under the Office of Program Coordination for Children and Youth.

2002 The Legislature creates the Children's Policy Council.

2004 The Legislature creates the Texas Early Childhood Comprehensive Systems (TECCS) and the Healthy Child Care Texas (HCCT) to support the OECC's goals. A waiver was requested and granted from the federal Maternal and Child Health Bureau authorizes the program move to HHSC in May.

2006 TECCS completes an implementation plan to take on the responsibilities of the OECC advisory committee beginning in 2007.

2007 Senate Bill 156 provides funding for the Nurse Family Partnership and 13 new NFP sites are funded in Texas.

2009 The Legislature creates the Task Force for Children with Special Needs and Council on Children and Families.

2010 Texas receives funding through the Affordable Care Act from the Maternal Infant and Early Childhood Home Visiting (MIECHV) program for seven home visiting programs including Parents as Teachers, Home Instruction for Parents of Preschool Youngsters, Nurse Family Partnership, and Early Head Start. In 2011, OPCCY establishes an additional program, the MIECHV home visiting programs.

2013 The 83rd Legislature establishes the State Home Visiting program and Domestic Violence Task Force.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

Overall the Office of Program Coordination for Children and Youth serves children birth to 6 and their families, youth with special healthcare or developmental needs, youth and adults with complex behavioral health needs, and people with acquired brain injuries.

The Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program

MIECHV enhances home visiting services options for families and promotes access to coordinated community support for pregnant women, young children from birth to age five, and their families. Under this project, communities across Texas provide evidence-based home visiting services and promote a seamless, strategic delivery of health and human services to ensure that all young children are healthy and ready for school.

Nurse Family Partnership

NFP serves low-income first-time mothers and their children. Women eligible to enroll in the TNFP program must meet all of the following requirements: have no previous live births, have an income at or below 185 percent of the federal poverty level, must be a Texas resident, and be enrolled before the end of the 28th week of pregnancy. Because of the program model all statistical data is reported from September 1, 2008.

- The median age of TNFP clients at enrollment was 18 years.
- The median gestational age at enrollment was 18.5 weeks.
- Race of TNFP Clients:

American Indian or Alaska Native	0.8 percent
Asian or Pacific Islander	1 percent

Black or African American	27.4 percent
White	41.5 percent
Multiracial	1.5 percent
Decline to Self-Identify	6.1 percent
No Response/Unknown	21.6 percent

- 12 percent of NFP clients were married at the time of intake.
- 44 percent of clients have completed high school at intake. The median household income was $16,000 and ranged between $3,000 and $45,000.
- Of clients with known employment status at intake, 33 percent of TNFP clients reported they were working either part- or full-time while 40 percent of NFP clients nationally were working.
- Use of Public Assistance at time of enrollment of 4,294 clients:

SNAP	Medicaid	TANF	WIC
28.0%	68.2%	3.9%	66.7%

System of Care Program

The Texas System of Care expansion initiative is focused on children and youth with serious emotional disturbances, whose support and service needs span multiple disciplines and typically are resource intensive. Under the most recent statute, the targeted population is: "minors who are receiving residential mental health services or inpatient mental health hospitalization or who are at risk of being removed from the minor's home and placed in a more restrictive environment to receive mental health services, including an inpatient mental health hospital, a residential treatment facility, or a facility or program operated by the Department of Family and Protective Services or an agency that is part of the juvenile justice system." HHSC will begin to capture current service delivery data under the system of care expansion implementation grant by January 2014.

The Health Children Texas initiative (Raising Texas)

Raising Texas Provides the coordination of stakeholders and agencies providing services for children up to age 6.

Healthy Childcare Texas

A Child Care Health Consultant is a specially trained professional who offers consultation, training, and technical assistance to child care centers and home-based programs to support and promote the health and safety of children, families, and child care providers. Child Care Health Consultants help child care providers face daily health and safety challenges and work to improve the outcomes of all children by promoting quality care. Application is open to anyone who has an interest.

Family Based Alternatives (FBA) and Permanency Planning

This function serves children with disabilities under the age of 22 who reside in institutions, or who are at risk for placement in an institution. HHSC contracts with EveryChild.

Children's Policy Council

The Children's Policy Council addresses long term services and supports for children younger than 23 years of age with disabilities or special healthcare needs under a Medicaid waiver for home or community-based services. Council membership consists of a majority of geographically and culturally diverse family members of consumers who receive children's long-term care or health services, a youth member under 22 years, a representative from advocacy, from a state agency, a person from a public and a private entity that provides long-term care and health programs for children; a person with expertise in the availability of funding and the application of funding formulas for children's long-term care and health services; a representative from a faith based organization; a representative from a non-specialized community services organization; and a representative from a business that is not related to providing services to persons with disabilities. The CPC also has two ex-officio physician members, and a resource member from each of the child serving agencies and Texas Education Agency.

Council on Children and Families

As an interagency oversight body, the Council on Children and Families involves representation from all the Health and Human Service System, the Texas Education Agency, the Texas Workforce Commission, the Texas Juvenile Justice Department and the Texas Correctional Office on Offenders with Medical and Mental Impairment under the Texas Department of Criminal Justice. Four public members are also represented on the Council offering perspectives from family and youth who have received services from one or more of the above state agency systems and there is interest to select members who represent cultural and geographic diversity. Council members are the agency heads of those state agencies or their authorized designee, usually a deputy-level staff member.

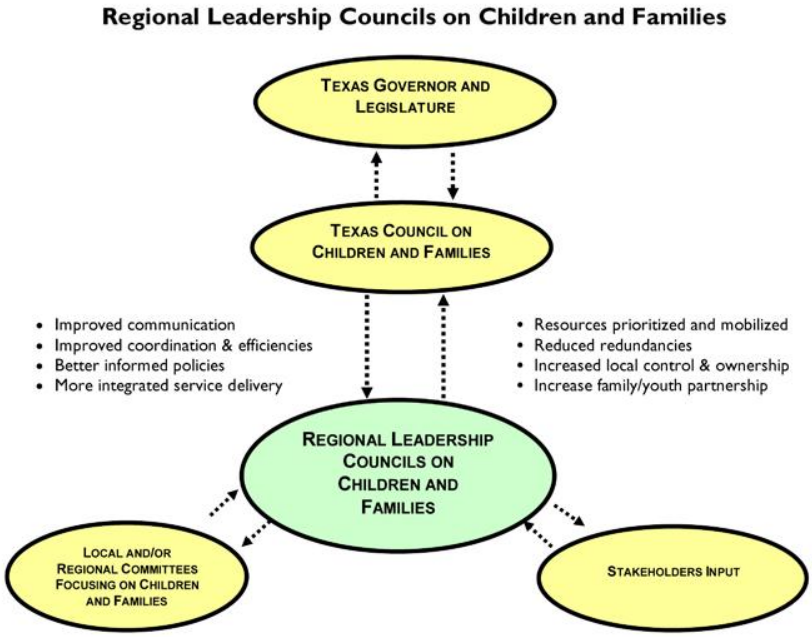
F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

The OPCCY Director reports directly to the Deputy Executive Commissioner. The director oversees the program and leads the coordination of programs and initiatives that serve children across health and human service systems. The OPCCY office works with staff across the HHS System to carry out initiatives, programs and advisory committees, task forces and councils.

The Council on Children and Families, the Children's Policy Council, and Healthy Childcare Texas are each provided full administrative and project support by OPCCY staff. This includes all

deliverables, Legislative Report production, facilitation, project management, technical assistance, and scheduling.

Texas Home visiting (MIECHV) and Nurse Family Partnership have dedicated operational staff.



Texas System of Care

The Texas System of Care (TxSOC) Initiative is led by a Project Director at HHSC and administered in partnership with the children's mental health and substance abuse unit at the Department of State Health Services. An operating arm of the TxSOC is the Texas Institute for Excellence in Mental Health at the Center for Social Work Research at the University of Texas at Austin. An interagency TxSOC Consortium provides oversight to the activities of the initiative with membership as follows: representatives of the Department of State Health Services, Department of Family and Protective Services, Health and Human Services Commission's Medicaid program, Texas Education Agency, Texas Juvenile Justice Department, and Texas Correctional Office on Offenders with Medical or Mental Impairments, with one youth or young adult who has a serious emotional disturbance and has received mental health services and supports; or a family member of a youth or young adult.

The consortium may coordinate with the Children's Policy Council for the purposes of including the youth, young adult or family representation required. As previously noted, much consultation is coordinated with local community representatives who have done or are doing work under a system of care approach.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Office for Program Coordination for Children and Youth

General Revenue:	$6,234,776
Federal:	$6,578,693
Other:	$19,644

	General Revenue/GR-D	Federal	Other
A.1.1 Enterprise Oversight & Policy	$5,935,377	$6,279,294	$19,644
B.3.1 Medicaid Contracts & Administration	$299,399	$299,399	0

General Revenue sources are 100 percent state funds as well as administrative matches for the Medicaid (50 percent) and CHIP (28 percent) programs with corresponding federal funds, depending upon the program. Several programs have specific federal grant funding. Other funds represent interagency contract funding from cost allocation billings based on a factor using the number of Medicaid and CHIP client counts, including long-term care clients at DADS as well as a specific DSHS contract.

Provider and Programmatic Riders

- **HHSC Rider 70** provides FY 2014-15 funding information on the Home Visiting and Nurse Family Partnership Programs.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

The Office of Program Coordination for Children and Youth serves as the dedicated area within the agency and HHS system to coordinate multiple services across state agencies to ensure efficient and effective services for its target population. There is one other home visiting program at the Department of Family and Protective Services that concentrate on a different population, primarily children at risk of abuse and neglect, however, those home visits are unlike the home visiting programs.

Current and Future Directions developed by TexProtects, the Texas Association for the Protection of Children lists all home visiting programs currently in Texas. HHSC is not the only funder of PAT, HIPPY and Early Head Start in Texas so those programs are included in this chart.

Specific similarities and differences are not provided in the interest of brevity. Similar functions to the Council on Children and Families are provided by the Task Force for Children and Special Needs (TFCSN) and the Children's Policy Council (CPC). Both the TFCSN and CPC are statutorily charged to improve coordination of services for children and youth with special needs or disabilities and to make recommendations.

The Council for Children and Families looks at ways to coordinate services for all children and youth and their families regardless if there is a disability or not.

The Children's Policy Council, consists of family and youth representatives (with consultation of state agency staff) and their recommendations are not driven by state agencies influences.

The TxSOC initiative coordinates efforts with a broad interagency approach including health and human services enterprise and education and juvenile justice. A similar program is the YES program, which targets children and youth with serious emotional disturbances, from a Medicaid eligible service delivery approach. The TxSOC initiative takes a broader perspective, inclusive of the Consortium oversight team, to look at state and local infrastructure that provides the background to being able to provide coordinated service delivery services and supports.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

The Office of Program Coordination for Children and Youth provides System oversight to align policies and actions to better leverage funding and prevent duplication of efforts. By helping agencies coordinate their efforts, state and federal funds are spent in the most efficient manner. Home Visiting clients are only eligible for a single home visiting program at a time. Each community where home visiting programs are located has local advisory boards that include representatives from each program, in addition to representatives for other services often used by home visiting clients.

The Council on Children and Families serves as an over-arching interagency council to receive and discern priorities from other related councils. Additionally, the Council has a standing agenda item for a status report from the TFCSN and from the Center for the Elimination of Disproportionality and Disparity to ensure that there is not duplication of effort.

The TxSOC initiative receives quarterly updates from the YES program to ensure that activities are not duplicated. The YES program uses the Institute for Excellence for Mental Health for evaluation aspects and wraparound training and therefore, those efforts are coordinated with TxSOC. Additionally, there are common staff, such as the Project Director of TxSOC who serves on the State CRCG Workgroup, coordinating efforts.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

Name	Description	Relationship to HHSC
Corpus Christi-Nueces County Public Health District	City/County Health Department	NFP Contractor
City of Houston Dept. of Health & Human Services,	City/County Health Department	NFP Contractor
Dallas County Hospital District-Parkland Health & Hospital System	City/County Health Department	NFP Contractor
City of Laredo Health Department,	City/County Health Department	NFP Contractor
City of Port Arthur Health Department	City/County Health Department	NFP Contractor
Texas Tech University Lubbock	State funded university based outpatient clinic	NFP Contractor
University Health System- San Antonio	State funded university based outpatient clinic	NFP Contractor
University Medical Center of El Paso	State funded university based outpatient clinic	NFP Contractor
Texas Tech University Amarillo	State funded university based outpatient clinic	NFP Contractor
University of Texas at Austin	State funded university	Contracted to provide technical assistance with data collection and management for the MIECHV funded home visiting programs.
Health Resources Services Administration	Texas receives funding through the Affordable Care Act from the Maternal Infant and Early Childhood Home	Grantor

Federal Units of Government

Name	Description	Relationship to HHSC
Health Resources a & Services Administration	The primary federal agency for improving access to healthcare services for people who are uninsured, isolated, or medically vulnerable.	Federal grantor to Texas Home Visiting Program.
Health Resources & Services Administration	The primary federal agency for improving access to healthcare services for people who are uninsured, isolated, or medically vulnerable.	Federal grantor to the Office program – Raising Texas grant.

Name	Description	Relationship to HHSC
U.S. District Court for the Eastern District of Texas	*Frew v. Janek* lawsuit.	The court receives quarterly reports and other *Frew vs. Janek* lawsuit information from HHSC.
The National Forum for Youth Investment	A small federal group that provides information and coordination to state children's cabinets and state councils nationally.	Council staff support at HHSC participate in periodic webinars, conference calls and national meetings to consider national best practice.
Texas Association for Regional Councils of Government	Coordinates to use regional boundaries to implement the Regional Councils for Children and Families construct.	Currently communication and coordination with Deep East Texas COG as a demonstration site.
Substance Abuse & Mental Health Services Administration	Completing 2nd year of the TxSOC expansion planning grant. Just received first year of the four-year TxSOC expansion implementation cooperative agreement.	Federal Funder to HHSC of the Texas System of Care Expansion Initiative.
Local Texas System of Care Communities	Coordination of information and consultation with these communities who have received or are receiving federal funding to implement a local system of care for children's mental health.	Coordination and communication to local key staff: Project leaders, family partners, youth engagement specialists for the purpose of consultation toward expansion of practice to other Texas communities.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The Office of Health Coordination and Consumer Services Facilities Division (HCCS) coordinates programs and initiatives that serve children and adults across the HHS System. HCCS uses agency staff and contract vendors depending on legislative and program requirements. Contracted vendors provide direct services to eligible clients, support for program functions such as data collection and management, web development, support of legislatively mandated advisory boards and councils, and special projects to develop innovative approaches to delivering services across program models.

The amount of contracted expenditures in FY 2012: **$14,626,109.75**

Due to a four-month delay the contracts were not signed until the last six months of the grant period and HRSA did not award the funds until late 2011. Therefore, the figure above is $3,293,168.09 less than the full 12 month amount for all contracts.

The number of contracts accounting for those expenditures: **49**

The top five contracts by dollar amount, including contractor and purpose.

1.	YMCA - Dallas	$1,236,906.00	The contract funds the Nurse-Family Partnership program and covers salaries and fringe for program staff, operational expenses and fees for training required by the program model.
2.	Bexar County Hospital District	$828,145.45	Same as above
3.	Tarrant	$822,553.00	Same as above
4.	The Children's Shelter	$794,010.93	Same as above
5.	Any Baby Can Of Austin, Inc.	$849,088.00	Same as above

For accountability purposes the division monitors the performance of all contracts to assess the quality of service, adherence to contract requirements and fidelity to the program model, where appropriate.

There are no current contracting problems.

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

- Consolidate all home visiting under one program or committee or council to reduce any possible duplication.
- Council on Children and Families statutory requirement to ensure Council staff support.
- Texas System of Care initiative statutory requirements to ensure staff support for state infrastructure.

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

TNFP AND NATIONAL NFP SUMMARY STATISTICS		
GOAL	**TNFP**	**National NFP**
Improve pregnancy Outcomes		
Change in Maternal Smoking During Pregnancy (relative change)	-28%	-16%
Change in Maternal Alcohol Use During Pregnancy (relative change)	-28	-26
Change in Experience of Violence Reported During Pregnancy (relative change)	-52%	-38%
Premature Births	10.7%	9.5%
Low-birth Weight	9.1%	9.7%
Improve child health and development		
Occurrence of Breastfeeding Initiated breastfeeding	86.8%	79.7%
Breastfeeding at 6 months	21.6%	28.7%
Breastfeeding at 12 months	12.5%	17.4%
Current with Immunizations		
At 6 months At 12 months At 18 months At 24 months	90.5% 88.8% 89% 93.1%	88% 87.1% 88.8% 91.7%
Increase self-sufficiency		
Subsequent pregnancy 6 months post-partum 12 months post-partum 18 months post-partum 24 months post-partum	 3.7% 10.7% 20.3% 24.3%	 3.7% 12.1% 22% 29.1%

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Office of Acquired Brain Injury
Location/Division	1106 Clayton Lane, Austin, Texas/ Health Policy and Clinical Services
Contact Name	Bettie Beckworth, Manager
Actual Expenditures, FY 2012	$172,953
Number of Actual FTEs as of June 1, 2013	1
Statutory Citation for Program	House Bill 1, 80th Legislature, Regular Session, 2007

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Office of Acquired Brain Injury (OABI) serves as the State's primary source of service coordination and referral for survivors of Acquired Brain Injury (ABI), their families and caregivers, including veterans and service members. The Office is mandated to bring about statewide education, awareness, and prevention programs. Highly successful initiatives through collaboration, partnership and coordination with state, national, and municipal agencies and private/public entities are in place. The OABI provides support for the Texas Traumatic Brain Injury Advisory Council (TBIAC).

Major activities include the following.

- Texas Traumatic Brain Injury (TBI) Juvenile Justice Screening Pilot Project is funded by a federal TBI grant through the Health Resources and Services Administration (HRSA): The OABI is the sole recipient of the first grant award from the U.S. Department of Health and Human Services' Federal TBI Program for the purpose of screening youth in juvenile justice systems to determine if a brain injury may have contributed to misbehavior/criminality.
- "Re-Entry of Students with a TBI to the School Setting", a web-based and/or onsite course for educators, accredited by Texas Education Agency (TEA).
- "Making a Difference: Meeting the Needs of Individuals with Brain Injury," web-based course accredited through the Department of State Health Services (DSHS) for all Texas public health workers; required training for all 2-1-1 Texas call center specialists to become certified through online "Making a Difference" and complete annual re-certification.

- 2-1-1 International uses the course in a number of states. "Brain Injury – The Silent Epidemic" is the OABI's second DSHS- accredited web-based course.
- Production and distribution of English and Spanish DVDs; Brain Injury Manual for Disaster and Emergency Response Management; Veteran Tactical Response: Guide to Keeping Law Enforcement Officers, First Responders and Veterans Safe; Texas Brain Injury Resources and Services Directory; Consumer and constituent service coordination and referral for individuals, family members and elected officials; and educational conferences and presentations.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

The OABI does not report performance measures. Some qualitative findings include the following.

Youth offenders in TBI pilot project have had more than 75 percent decrease in referrals to security by self or staff and in injury to self or others. A specialized treatment center for TBI and behavioral issues was developed at the Corsicana State School.

More than 300 juvenile justice professionals, including superintendents, department directors, physicians, psychologists, social workers, case managers probation and parole officers have been trained about TBI and how to use the Brain Injury Screening Questionnaire (BISQ). More than 450 law enforcement officers have received Veteran Tactical Response training, including all special agents in the Firearms Division of the Bureau of Alcohol, Tobacco and Firearms. The OABI does not report performance metrics on training activities but rather provides training as requested.

A specialized "pilot within the pilot" cognitive rehabilitation therapy (CRT) program was developed by contractor Dr. Gordon, Ph.D., to train youth offenders in the three El Paso County Justice Department programs for offenders with the most serious offenses and highest recidivism rates. Approximately 80 percent have demonstrated the utilization of the therapy and reduced recidivism rates.

More than 800 continuing education certificates have been issued for the web-based courses; 8,400 English and 3,100 Spanish brain injury awareness DVDs are in use throughout the United States and in eight foreign nations. "Re-Entry to the Classroom Following a TBI" has been/and is being taught across the state, and the accredited course is available on the OABI, TEA and TJJD websites.

Disaster and emergency response brain injury manuals have been provided to all statewide Regional Advisory Councils (RACs), the program has been taught at three annual Texas

Department of Emergency Management conferences, HHSC Disaster and Emergency Council, the HHSC Business Continuity Council and is available on the OABI website.

A website provides information about brain injury, down-loadable information and courses, locations for services and support groups. The office receives numerous calls that result from information on the website; however, HHSC does not have the capability to formally assess the number of viewers visiting a website.

The OABI is the only state-legislated brain injury in the United States and serves in a national leadership role. In 2009, OABI was designated by HRSA, Federal TBI Program as the national model. In March 2013, the U.S. Department of Health and Human Services, Health Resources and Services Administration recognized the OABI with the 2013 Leadership Award for its achievements and contributions.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

The Legislature created the OABI in 2007 to assist, coordinate, and refer services for Texans with acquired brain injury, including veterans, service members and families. Beginning in February 2008, the OABI expanded beyond serving as a brain injury-specific call center. The office has become the state and national provider of educational resources. By developing partnerships and collaborations linking state, local, federal, and private entities, the office provides service coordination at a great cost-saving to the State.

A major outreach effort on acquired brain injury, its causes and prevention across age levels, professions, and demographics has shown success in educating athletic trainers, teachers, law enforcement, state disability determination specialists, legislators, and others.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The program affects all Texans in the areas of education, awareness, and prevention of brain injury. Through education, this often preventable condition can be avoided saving lives and decreasing the economic burden on families and on the state fiscal resources. Brain injury survivors and family members benefit. Many professionals (law enforcement, disability determination specialists, coaches) are more effectively recognizing and preventing brain injuries.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

The Office of Acquired Brain Injury is under Health Policy and Clinical Services, OPCCY. The office is overseen by a Director. It does not provide direct services but identifies and coordinates services across the HHS enterprise as well as federal, state, and local resources. Through a HRSA grant, screenings for children with traumatic brain injuries are conducted at local probation offices and TYC facilities. The office utilizes existing infrastructure of HHS field offices and regional services to provide training and information, and to coordinate and refer services across the state. This effort is a cost-saving measure and a major outreach to underserved rural areas and populations.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Acquired Brain Injury

Federal: $172,952

	General Revenue/GR-D	Federal	Other
A.1.1 Enterprise Oversight & Policy	0	$172,952	0

The Office of Acquired Brain Injury appropriation is in Strategy A.1.1 Enterprise Oversight and Policy and is funded in FY 2012 with a federal grant for Traumatic Brain Injury.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

The Department of Assistive Rehabilitation Services (DARS) Comprehensive Rehabilitation Services (CRS) provides post- acute rehabilitation services for individuals sustaining only TBI and spinal cord Injuries. That agency's Vocational Rehabilitation section provides services to a broader range of consumers and their Veterans' Rehabilitation serves that population. The OABI collaborates and partners closely with them to coordinate services and referrals for their target population. DARS is also restricted in the age range it can serve. The OABI serves all ages and types of brain-injured consumers including TBI, stroke, heart attack, anoxia from chemicals, near-drowning, choking, and other causes.

The Office for the Prevention of Developmental Disabilities' (TOPDD) major emphasis is supporting the Fetal Alcohol Spectrum Disorder (FASD) public awareness program. FASD is a congenital developmental disability and not considered an acquired brain injury by the Centers for Disease Control, the U.S. Department of Health and Human Services, the World Health Organization, or other fields of specialization. ABI occurs after the moment of birth, is not congenital or degenerative. The TOPDD does not provide comprehensive information, statewide education, nor referral and coordination of services for individuals with brain injury, their family members or caregivers, including veterans and service members. The TOPDD is involved with one brain injury project for bicycle safety for children.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

No interagency agreements are necessary, and there is no duplication or conflict. DARS is a direct service provider while the OABI is not. It is the function of this office to provide access to their programs to direct consumers for services provided by Comprehensive Rehabilitation Services and the Vocational Rehabilitation program at DARS Veterans Services or Blind Services.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

Name	Description	Relationship to HHSC
Texas Juvenile Justice Department	Texas TBI Juvenile Justice Screening Pilot Project	State Agency
Texas Education Agency	Collaborate on training of TBI	State Agency
Texas Veterans Commission	Veteran Tactical Response	Represent HHSC/OABI on the TVCC
El Paso County	Juvenile Justice TBI Pilot	Pilot Site
Lubbock County	"	Pilot Site
Dallas County	"	Pilot Site
Harris County	"	Pilot Site
Cameron County	"	Pilot Site
Bexar County	"	Pilot Site
San Antonio Military Medical Center	Referral and coordination of veteran services	
Brooke Army Medical Center	"	
Centers for Disease Control and Prevention	Health Systems and Trauma Systems Branch Division of Unintentional Injury Prevention Atlanta, Georgia	The CDC is a key collaborator and provides education, awareness, and prevention materials and information, including shipping, with no cost to OABI/HHSC and

Name	Description	Relationship to HHSC
		technical assistance and statistical data.
U.S. Health Resources and Services Administration	Maternal and Child Health Bureau Federal TBI Program Washington, D.C.	Federal grantor to the OABI program – Juvenile Justice/Traumatic Brain Injury grant
U.S. Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF&E)	Veteran Tactical Response training for all special agent hostage and crisis negotiators in the Firearms Division	

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

In 2009 The U.S. Health Resources and Services Administration, Federal TBI Program awarded the OABI its sole-recipient one million dollar grant to conduct a pilot program to screen children and youth in the Texas Juvenile Justice Department (TJJD) [(legacy Texas Juvenile Probation Department and Texas Youth Commission (TYC)] who had pre-diagnoses of mental illness and/or substance abuse. The screening would determine if youth offenders had pre-occurring TBI that potentially was a contributor to their behavioral dysfunction or criminality.

Wayne A. Gordon, Ph.D., Co-Chair of New York's Mt. Sinai Institute for Brain Injury Research and leading expert on juvenile TBI and behavior, was contracted as consultant, educator, and principal investigator on the project. Dr. Gordon co-developed the Brain Injury Screening Questionnaire (BISQ) which is used in the pilot program. Seven probation departments were selected by OABI to represent the geographic, cultural, and ethnic diversity of the state: El Paso, Lubbock, Dallas, Tarrant, Bexar and Harris Counties and the two intake facilities for the former TYC at Mart (male) and Brownwood (female). Individuals whose screens indicate a probability for TBI receive either coordination or referral of appropriate interventions such as Cognitive Rehabilitation Therapy (CRT). Case management teams consisting of medical and psychological professionals, social workers and counselors develop an Individual Plan of Care specifically for this program for youth remanded to state-operated correctional facilities. Parental/guardian participation is included.

Expenditures for fiscal year 2012 are **$96,499.68**, including one contract with Dr. Gordon who maintains direct contact with the OABI, TDJJ. Performance measures are gauged by successful

outcomes, pilot site evaluations, and reduction of recidivism rates among pilot participants. Other programs are evaluated by participants.

Ensuring accountability for funding and performance. The OABI purchases any grant related items for the grant sites and conducts project site visits when possible. OABI communicates with Dr. Gordon regarding pilot, consultation with the sites and discussion of pilot data. Additionally, the contract deliverables are monitored to ensure they are met by Dr. Gordon.

Current Contracting Problems: None

L. Provide information on any grants awarded by the program.

Project costs are paid through the OABI. No grants have been awarded at this time, but staff anticipates that this will be the case for 2014 and 2015.

M. What statutory changes could be made to assist this program in performing its functions? Explain.

N/A

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

N/A

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Informal Dispute Resolution
Location/Division	1106 Clayton Lane, Austin, Texas/Health Policy and Clinical Services
Contact Name	Allison Levee, Manager
Actual Expenditures, FY 2012	$565,873
Number of Actual FTEs as of June 1, 2013	11
Statutory Citation for Program	Texas Government Code, Chapter 531, Health and Human Services

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Informal Dispute Resolution (IDR) program performs a professional and impartial review of long-term care facility disputed issues from regulatory health and life safety code survey findings. Professional clinical staffs make recommendations based on the documentation presented by providers and the Department of Aging and Disability (DADS) state survey agency

During the 1990s, the federal government passed Title 42, Chapter IV, §488.331, in the Code of Federal Regulations establishing the IDR process requiring certain long-term care facilities have the opportunity to dispute survey findings cited in the official federal Statement of Deficiencies. IDR reviews are conducted under a Memorandum of Understanding with DADS Long Term Care Regulatory Services.

In January 2012, the IDR unit began conducting the Independent Informal Dispute Resolution (IIDR) process that was mandated by the Patient Protection and Federal Affordable Care Act of 2010. The purpose of the IIDR process is to give facilities one informal opportunity to refute cited deficiencies after any health survey in which federal civil monetary penalties are imposed.

In the IIDR process, the Long-term Care Ombudsman and involved residents/resident representative may provide comments regarding the cited deficiencies. Since it is a federal process, no state violations may be reviewed. Additionally, while HHSC drafts the recommendation regarding the deficiencies for consideration, the final decision regarding the

IIDR is decided by DADS/Centers for Medicare & Medicaid Services CMS and is not distributed by HHSC.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

The IDR program is mandated by federal and state requirements to complete IDR reviews within 30 calendar days from receipt of the request, and to complete IIDR reviews within 60 calendar days from receipt of the request. The performance measure reports for fiscal years 2010-2012 demonstrate that the program completed all reviews within the mandated timeframes, meeting the performance measure at 100 percent.

Additionally, for the same time period, the program recommended modifying approximately 34 percent of the deficiencies/violations reviewed. Although fiscal year 2013 is not yet complete, performance measures thus far reflect all reviews meeting 100 percent of the performance measure.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

In January 2012, the IDR unit began conducting the Independent Informal Dispute Resolution (IIDR) process that was mandated by the Patient Protection and Federal Affordable Care Act of 2010.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The IDR program affects the regulation of certain long-term care facilities. Specifically, IDR reviews are conducted for nursing facilities (NF), assisted living facilities (ALF), and intermediate care facilities for persons with intellectual disability (ICF-PIDD). The IDR recommendations may affect the determination of compliance or non-compliance with state and federal requirements for these providers, and may affect residents of these facilities.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

The IDR Director oversees the IDR program and reports to the Deputy Executive Commissioner. The unit includes professional case reviewers with experience in long-term care services and regulatory procedures. The case reviewers work on a caseload of IDR requests received from the three types of provider facilities: ALFs, NFs and ICF-PIDD.

For **IDRs**, facilities must request the process within 10 days of receiving the official federal Statement of Deficiencies. The IDR program must acknowledge receipt of the IDR request within three business days from receipt of the request. The facility is then provided five days to submit a rebuttal letter and supportive documentation for consideration. If eligible for and informal conference, the conference must be help no later than the 22nd day from the day the IDR request was received. The IDR review must be completed by the 30th calendar day from when the request was received.

For **IIDR**s, facilities must request the process within 10 days of receipt of the notification from CMS. The IDR program must acknowledge receipt of the IIDR request within two business days from receipt of the request. The facility is then provided 10 calendar days to submit a rebuttal letter and supportive documentation for consideration.

Any comments from the Long-Term Care Ombudsman or residents/resident representatives should be received by the 25th calendar day. If a phone conference is selected, it must be conducted by the 30th day. The IDR Program will distribute the report and recommendations to DADS for final decision by the 50th calendar day. The IIDR process must be completed by the 60th calendar day from when the request was received.

The IDR program reviews deficiencies/violations upon request by a long-term care facility representative. When reviewing the deficiencies/violations, the IDR reviewer is limited to the information contained in the official federal Statement of Deficiencies and information presented to IDR by the facility representative.

Possible outcomes of an IDR review are a recommendation to: delete the entire deficiency/violation, delete a portion or finding within the deficiency/violation, move a deficiency/violation, or modify a portion or finding within the deficiency/violation.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Informal Dispute Resolution

General Revenue:	$142,381
Federal:	$423,492

	General Revenue/GR-D	Federal	Other
B.3.1 Medicaid Contracts & Administration	$142,381	$423,492	0

General Revenue sources are administrative matched at the Medicaid rates of 50 percent and 25 percent with corresponding federal Medicaid funds.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

The HHSC IDR Program is the only IDR function in HHS for the three facility types listed above.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

A Memorandum of Understanding (MOU) between DADS and HHSC documents the respective authority and responsibility of these two State agencies, regarding the IDR process for certain long-term care facilities. The MOU delineates authority to make IDR decisions and defines a process, if DADS disagrees with an IDR Unit's decision.

A MOU between DADS and HHSC also documents the respective authority and responsibility of these two State agencies, regarding IIDR for Nursing Facilities. This MOU recognizes the HHSC IDR Unit meets requirements to perform the IIDR process as a component of an umbrella State agency that is organizationally separate from the State survey agency. The MOU delineates authority to make IDR decisions and defines a process, if DADS disagrees with an IDR Unit's decision.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

Name	Description	Relationship to HHSC
State Government		
Department of Aging and Disability Services	DADS is responsible for the regulation of the long-term care facilities that IDR serves.	HHSC IDR has a MOU with DADS for both the IDR and IIDR processes. DADS also provides IDR with important CMS communications.
Federal Units of Government		

Name	Description	Relationship to HHSC
Centers for Medicare & Medicaid Services	CMS oversees the survey and certification of the long term-care facilities that IDR serves.	CMS provides funding for the IDR process. Additionally, CMS retains the ultimate authority regarding IDR recommendations.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

N/A

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

N/A

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

N/A

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Office of e-Health Coordination
Location/Division	4900 N. Lamar Blvd, Brown-Heatly Building/ Health Policy and Clinical Services
Contact Name	Stephen Palmer, Director
Actual Expenditures, FY 2012	$10,784,149
Number of Actual FTEs as of June 1, 2013	3
Statutory Citation for Program	N/A

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Office of e-Health coordinates federal and state initiatives that relate to making health information of HHS program clients more available to providers and allowing providers to securely transmit information to other healthcare entities. The objective of the office is to promote efficiency, decrease costs, and improve the quality of healthcare for clients through better sharing of data internally and across the HHS system.

The office is responsible for key functions such as coordinating the American Reinvestment and Recovery Act (ARRA) Funding for Health Information Projects, coordinating the development of the HIE activities outlined in legislation, supporting the Health Information Exchange Advisory Committee, managing the State's Health Information Exchange Cooperative Agreement Program, and serving as the liaison with the statutorily created Texas Health Services Authority (THSA). The office is also managing the HELP for Texans Project funded by the Cooperative Agreements for Prescription Drug Monitoring Program (PDMP) Electronic Health Record (EHR) Integration and Interoperability Expansion from the federal Substance Abuse and Mental Health Services Administration.

This project is collaborating with the Department of Public Safety and the Governor's Office regarding the recently implemented prescription drug monitoring program and the exchange of controlled prescription clinical information among providers through health information exchanges. Funds to support the Health Exchange Leveraging Program (HELP) for Texans are through the Affordable Care Act and the grant started 9/30/12 and will end 9/29/14.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

Through the Local health information exchange (HIE) Grant Program under the State HIE Cooperative Agreement Program, OeHC helped start 12 local HIE networks around Texas. The HIEs have participation commitments from 22,899 physicians and 345 hospitals in the state. These HIEs are in the process of becoming operational, but to date:

- all of the HIEs have selected technology vendors;
- 11 have enabled DIREC secure messaging services;
- nine are actively exchanging patient summaries;
- eight are capable of delivering electronic lag results; and
- 1,792 are actively conducting query-based exchange.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

Formally created in 2010 by the Executive Commissioner, on March 15, 2010, HHSC received notice of a $28.8 million grant award from the federal Office of the National Coordinator for Health Information Technology to implement the Texas HIE Cooperative Agreement Program.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The Office of e-Health Coordination office affects healthcare providers and patients in Texas through the work in developing a statewide infrastructure for health information technology and health information exchange, assisting in the development of state-level policy around health information technology, and increasing the quality and efficiency of the Texas healthcare system.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

The Office of e-Health Coordination operates under the direction of the Office of Health Policy and Clinical Services. A Director leads the three staff unit and reports to the Deputy Executive Commissioner. Currently, the OeHC administers a major contract with the Texas Health Services Authority (THSA), a statutorily created public-private nonprofit for the purpose of

developing a secure statewide health information technology infrastructure. The THSA assists in the development and implementation of the Texas Health Information Exchange plans.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

E-Health Coordination

General Revenue:	$64,159
Federal:	$10,712,816
Other:	$7,174

	General Revenue/GR-D	Federal	Other
A.1.1 Enterprise Oversight & Policy	$64,159	$10,712,816	$7,174

General Revenue sources are primarily administrative matches for the Medicaid (50 percent), and CHIP (28 percent) programs with corresponding federal funds. Federal funding is a grant authorized in the American Recovery and Reinvestment Act, Section 3013. Other funds represent interagency contract funding from cost allocation billings based on a factor using the number of Medicaid and CHIP client counts, including long-term care clients at DADS.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

The Office of e-Health Coordination functions does not duplicate services internally or externally to the agency.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

N/A

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

Name	Description	Relationship to HHSC
Federal Office of the National Coordinator (ONC) for Health Information Technology	The ONC is organizationally located within the Office of the Secretary for the U.S. Department of Health and Human Services (HHS) and is the principal federal entity charged with coordination of nationwide efforts to implement and use health information technology and the electronic exchange of health information.	The ONC oversees funding and national coordination of the State HIE Cooperative Agreement Program. Also responsible for developing standards for HIT and supporting the national HIE. OeHC is the primary liaison between the ONC and HHSC.
Texas Health Services Authority (THSA)	The THSA was created by the Texas Legislature in 2007 as a public-private partnership, legally structured as a nonprofit corporation, to support the improvement of the Texas healthcare system by promoting and coordinating HIE and health information technology (HIT) throughout the state to ensure that the right information is available to the right healthcare providers at the right times.	HHSC was awarded the HIE Cooperative Agreement Program in 2010. Part of the funding is used to develop state-level shared services that included funds to stand up the THSA. The THSA has also administered the White Space Strategy under that program. OeHC is the HHSC's primary liaison to the THSA.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

OeHC contracts are to support the State HIE Cooperative Agreement Program. Generally, contracts are for awardees under the Local HIE Grant Program, the Texas Health Services Authority for state-level shared services and the administration of the White Space Program, and to support grant management and oversight. We also anticipate new contracts in fiscal year 2013 for IV&V services and through the Texas HIE Infrastructure Initiative to support advanced health information exchange projects.

The amount of those expenditures in fiscal year 2012: **$10,858,664**

The number of contracts accounting for those expenditures: **16**

Top five contracts (in fiscal year 2012) by dollar amount, including contractor and purpose.

1.	Greater Houston Health Connect	$3,361,950	Local HIE Grant Program
2.	North Texas Accountable HealthCare Partnership	$2,208,960	Local HIE Grant Program
3.	Texas Health Services Authority	$1,286,687	State-Level Shared Services and White Space
4.	Integrated Care Collaborative	$1,214,258	Local HIE Grant Program
5.	Healthcare Access San Antonio	$1,150,333	Local HIE Grant Program

The methods used to ensure accountability for funding and performance: Monthly report for sub-recipients. FY 2013 contracts with HORNE LLC for additional financial oversight and with Maximus to support grant management and document internal controls.

Current contracting problems: Local HIE Grant Program: iHealth Trust − not in compliance with reporting requirements and Health Information Network of South Texas − not in compliance with reporting requirements.

L. Provide information on any grants awarded by the program.

OeHC has managed grants with 16 participants in the Local HIE Grant Program. When the planning period for the grant ended only 12 HIEs continued in the program − two HIEs chose to merge with other HIEs and two left the program. The following table summarizes these grants.

Local HIE	Total Award	Close Out Date (actual or projected)
Coalition of Health Services	$75,000	May 25, 2012
FirstNet Exchange	$924,885	March 31, 2013
Gainsville Hospital District (Red River)	$58,500	May 25, 2012
Greater Houston HealthConnect	$5,487,200	March 31, 2013
Healthcare Access San Antonio	$2,032,267	March 31, 2013
Health Information Services Network of South Texas	$442,083	March 31, 2013
Integrated Care Collaborative	$2,381,700	March 31, 2013
iHealth Trust	$546,176	March 31, 2013

Local HIE	Total Award	Close Out Date (actual or projected)
Health Information Partnership of South East Texas (Montgomery County)	$335,479	March 31, 2013
Northeast Texas	$37,500	July 9, 2012
North Texas Accountable Healthcare Partnership	$4,908,800	March 31, 2013
Paso del Norte	$454,314	March 31, 2013
Rio Grande Valley	$290,000	March 31, 2013
RioONE	$194,644	March 31, 2013
Southeast Texas Health Services	$493,000	March 31, 2013
Southeast Texas	$75,000	May 25, 2012

M. What statutory changes could be made to assist this program in performing its functions? Explain.

In the 83rd Session, S.B. 1643 explicitly permitted DPS' prescription drug monitoring program to transmit data to providers through health information exchanges. Nowhere in statute is there a prohibition on the use of HIEs, but some agencies are cautious on permissibility discussions which have delayed projects that would better enable providers reporting to and accessing data from to state-level data sources. Legislative clarity similar to SB 1643 for all state programs accessed by authorized providers (for example, the immunization registry, electronic lab reporting program, and cancer registry, all at DSHS) could expedite the state's efficiency gains.

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

The OeHC is currently coordinating the development of a State Health Information Technology Plan that includes all of the Programs funded through the Health Information Technology for Economic and Clinical Health (HITECH) act within (ARRA) and state-level initiatives. The plan will help HHSC identify gaps in the state's HIT infrastructure. OeHC will continue to assist the agency to improve efficiency through HIT and coordinate projects with outside agencies and organizations.

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Office of the Medical Director
Location/Division	6330 Highway 290 East, Austin, Texas/ Health Policy and Clinical Services
Contact Name	William Brendle Glomb, M.D., Medical Director
Actual Expenditures, FY 2012	$1,108,409
Number of Actual FTEs as of June 1, 2013	16
Statutory Citation for Program	Texas Government Code, Chapter 531.009, Health and Human Services Commission

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Office of the Medical Director (OMD) clinical staff provides expert medical consultation to the Medicaid and Children's Health Insurance Program (CHIP), Texas Women's Health Program (TWHP), and Texas Health Steps (THSteps) programs. They also offer general consultation to internal and external stakeholders on clinical matters and review medical appeals. The OMD works closely in partnership with the Medicaid/CHIP program on the development of clinical policy for both programs. The OMD helps lead quality initiatives in close collaboration with the Texas Institute for Health Care Quality and Efficiency and the Quality Unit. A Medicaid Dental Director assists with implementation of dental policy changes and updating of dental procedures.

Dental Quality in Texas Medicaid is now on par with other state Medicaid programs. A Director for Mental and Behavioral Health focuses on integrating physical and behavioral health policy and addressing related initiatives and issues. The OMD, communicates directly with outside stakeholder groups such as the Texas Medical Association, the Texas Pediatric Society, the Texas Academy of Family Physicians, and the Texas Association of Obstetrics and Gynecology.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

The Medical Policy Nurses routinely work on 10 open policies each as well as other projects assigned by the Medical Director. The unit reviews 100-120 policies annually in partnership with Texas Medicaid & Healthcare Partnership (TMHP).

In addition the nurses complete the quarterly Healthcare Common Procedure Coding System (HCPCS) review. This is a review of all new procedure codes approved by the Centers for Medicare & Medicaid Services (CMS) for claims payment by the state Medicaid programs. This is a review of perhaps thousands of new codes each year. In 2012, 1,222 new, revised and discontinued codes were reviewed in addition to 635 plus additional variations of codes.

The Medical Appeals Unit receives and responds to appeals from providers and determines their validity. Examples include: Utilization Review appeals, Medical Necessity appeals, Diagnosis-Related Group (DRG) appeals, Provider Denial appeals, Disability Determinations, and Medical Transportation approvals. The goal is to have an appeal completed and returned to the party in 60 days. They are 100 percent compliant with the 60 day review process and have completed approximately 3,200 appeals in the last four quarters.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

N/A

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The Office of the Medical Director affects most, if not all, of the multiple clinical programs throughout Medicaid/CHIP as the issues these programs confront require clinical input. It also affects clients, providers, managed care plans, other areas of state government, and other multiple stakeholders.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

Organizationally, the Office of the Medical Director reports to the Deputy Executive Commissioner of Health Policy and Clinical Services. The Medical Director oversees the physician directors, manager, program staff, and nurses. The office is responsible for consulting internally and externally on Medicaid benefits, reviewing medical appeals, and working with stakeholders, supporting the Public Assistance Benefits Review and Design Committee,

coordinating research and implementation of benefits with the HHSC claims administrator contractor, and participating in the benefits development process in conjunction with the Medicaid program.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Office of the Medical Director

General Revenue: $339,149
Federal: $769,260

	General Revenue/GR-D	Federal	Other
B.3.1 Medicaid Contracts & Administration	$295,748	$663,904	0
C.1.4 CHIP Contracts & Administration	$43,401	$105,357	0

General Revenue sources are primarily administrative matches for the Medicaid (50 percent and 25 percent) and CHIP (28 percent) programs with corresponding federal funds. The cost allocation factor is determined by the share of client counts in the Medicaid and CHIP programs.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

There are no similar programs.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

OMD's function is to respond with consultative clinical assistance when requested. No other duplication or conflict exists.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

The Medical Director works with the Centers for Medicare & Medicaid Services, as indicated, as well as with numerous state and local agencies when requested.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

N/A

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

N/A

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

N/A

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Healthcare Quality Analytics, Research, and Coordination Support (HQARCS)
Location/Division	6330 Highway 290 East, Austin, Texas/ Health Policy and Clinical Services
Contact Name	Matthew Ferrara, Director
Actual Expenditures, FY 2012	$204,962
Number of Actual FTEs as of June 1, 2013	8
Statutory Citation for Program	N/A

B. What is the objective of this program or function? Describe the major activities performed under this program.

The HQARCS program works within the System and with external stakeholders to improve enterprise collaboration and coordination on quality initiatives, and to reduce duplication of effort. The program is charged with identifying initiatives that focus on increased quality and cost effectiveness, promote transparency and efficiency, and enhance internal and external understanding of quality and performance.

Program staff facilitates and supports legislatively mandated committees as part of its quality initiative activities, including the Neonatal Intensive Care Unit Council, Quality Based Payment Advisory Committee, the Physician Payment for Quality Committee, and the Perinatal Advisory Council.

Other quality initiative efforts include: leading the implementation and management of HHSC Riders 69 and 71, 82nd Session to test new models of service provision to Medicaid populations, and leading the work on H.B. 1983, 82nd Session to reduce elective inductions prior to 39 weeks gestation. It will also take the lead on H.B. 1542, 83rd Session, to review suggested clinical initiatives for Medicaid.

Other initiatives include the following.

- Grant-funded multi-state project with Agency Healthcare Research and Quality and Rutgers University (MEDNET) that has resulted in $25,000 in funding ($25,000 more due in CY 2013). The project has overseen the calculation and analysis of various performance metrics

related to the use of psychotropic medications in Medicaid. This work is supporting the development of meaningful quality metrics for behavioral health, which is often a high-cost population.

- Two-year, $2 million dollar Adult Quality Measures grant from the Centers for Medicare & Medicaid (CMS).
- Development of performance outcomes reimbursement approaches that were more meaningful in terms of producing outcome and efficiency improvements. This work supported the restructuring of the Medicaid managed care At Risk and Quality Challenge programs, and the creation of a service area collaborative Performance Improvement Project approach for Medicaid HMOs.
- Research into Medicaid "hotspots" and "super-utilizer." This work is informing the development of initiatives to address regions of Texas with unusually high utilization (such as high C-Section rates) and the better management of complex clients with very high rates of utilization of certain services (such as the emergency department). This includes changes to the Uniform Managed Care Contract effective on September 1, 2013, that place additional requirements upon Medicaid-CHIP HMOs to identify and manage super-utilizer populations. HCQARCS will play the lead role in evaluating super-utilizer management strategies by the HMOs and quantifying results.
- Integration of the recommendations related to overused medical procedures of the Physician Payment for Quality Committee, Rider 68, 82nd Regular Session.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

The unit was formed 18 months ago. The work products described below will take a year or more after implementation before the results can be quantified for outcomes and costs:

- initiation of reimbursement policy to not pay for elective inductions prior to 39 weeks gestation;
- development of performance outcomes reimbursement approaches for managed care that places more focus on measurement of items with the greatest potential for increased healthcare quality and cost savings;
- requirements in managed care contracts to address the outlier population;
- acquisition of data from DADS to further our understanding of the long-term care population service use;
- initiation of performance improvement projects under the CMS Adult Quality Measures grant;
- initiation of prospective changes in the management of antipsychotic medications (the most expensive class of medication in Medicaid) as lessons learned from the MEDNET project are integrated into ongoing practice; and
- better management of high-cost/high-utilization clients.

One quantifiable outcome of the unit is the identification of duplicative vendor data analyses related to calculating potential preventable readmissions. The consolidation of this analysis with one vendor will result in a cost savings greater than $1 million/per year.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

N/A

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The HQARCS unit works directly with legislatively mandated committees, the public, other area within HHSC including the Medicaid program, other HHS agencies, and external state and national stakeholders such as universities, medical societies, and commercial managed care companies.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

Organizationally, the HQARCS unit is overseen by a Director who reports to the Deputy Executive Commissioner for Health Policy and Clinical Services (HPCS). The unit's role is to function as the quality research, analysis, and policy formulation area for HHSC, but also works very closely with the Medicaid/CHIP division on coordination and implementation of a quality program within the MCO contracting model.

In addition to serving a lead role in development of a quality strategy, the unit receives a variety of assignments from leadership from both HPCS and Medicaid/CHIP. These are generally implemented by unit staff as a team, rather than singular assignments. However, individual staff may be assigned as project leads to coordinate the work on a specific topic area within the unit. The work of the unit crosses departments within the HHS System. Staff serve on the DSHS Healthy Texas Babies committees, as well as participate in numerous ongoing activities in the Office of the Medical Director and other MCD areas.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Healthcare Quality Analytics Research & Coordination Support

General Revenue: $96,623
Federal: $108,340

	General Revenue/GR-D	Federal	Other
B.3.1 Medicaid Contracts & Administration	$88,468	$88,468	0
C.1.4 CHIP Contracts & Administration	$8,154	$19,871	0

General Revenue sources are primarily administrative matches for the Medicaid (50 percent) and CHIP (28 percent) programs with corresponding federal funds. The cost allocation factor is determined by the share of client counts in the Medicaid and CHIP programs.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

N/A

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

HQARCS participates and collaborates with activities in the OMD, Medicaid and CHIP division, and other HHS System areas to avoid duplication.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

The HQARCS unit is the project lead on a federal grant (the CMS Adult Quality Measures grant) and is in frequent communication with the CMS staff on the project deliverables. The HQARCS unit also has the lead role in the MEDNET psychotropic medication monitoring project (AHRQ

funded and coordinated by Rutgers) and received $25,000 for finishing the year two project deliverable. Another $25,000 is due in year three.

Federal Units of Government

Name	Description	Relationship to HHSC
Centers for Medicare & Medicaid Services	Approves Health and Human Services initiatives and projects	Funds and provides direction to agency
Rutgers University	Office of Research and Sponsored Programs	Contracted vendor that will be assisting HHSC review data

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The HQARCS unit contracts with a vendor for services to support committee facilitation, targeted research, data analytics not available within the agency, and other services as needed. The HQARCS unit was formed the Winter of 2011 and only utilized contracted services during fiscal year 2012 with the Litaker Group for meeting facilitation and targeted research. The unit did not have a separate contract with the vendor but was able to use the existing Medicaid program contract for Litaker Group. The total funds paid in fiscal year 2012 were **$50,156.26**. The funds listed above represent only what was paid on behalf of the unit.

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

N/A

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

N/A

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Office of Inspector General
Location/Division	HHSC Office of Inspector General
Contact Name	Juanita Henry, Deputy Inspector General
Actual Expenditures, FY 2012	$43,574,207.95
Number of Actual FTEs as of June 1, 2013	597.5

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Office of Inspector General (OIG) is responsible for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services. OIG's responsibilities include monitoring services the state provides through any state-administered health or human services program that is wholly or partly federally funded, including enforcing state law relating to the provision of those services. OIG ensures the integrity of all health and human services programs, with particular emphasis on provider and recipient oversight in the Medicaid, Temporary Assistance for Needy Families (TANF), and Supplemental Nutrition Assistance Program (SNAP) programs, ensuring compliance by both providers and recipients with state and federal laws and rules governing these programs, and ensuring proper and legitimate use of tax dollars in related health and human services programs. OIG fulfills this objective through these activities.

Researching, detecting, and identifying events of fraud, waste, and abuse to ensure accountability and responsible use of resources

OIG uses a variety of mechanisms to achieve this goal, from provider self-reporting and a public fraud reporting hotline, to automated detection technology and human intelligence.

Investigating, reviewing, and monitoring cases internally, with appropriate referral to outside agencies for further action

OIG's Enforcement Division consists of a General Investigations section, a Medicaid Provider Integrity section and an Intelligence Unit. General Investigations investigates allegations of fraud committed by program recipients. Medicaid Provider Integrity investigates Medicaid providers. The Intelligence Unit, which will be fully staffed in FY 2014, is responsible for using

the new LYNXeon technology to detect hidden patterns and relationships suggestive of waste, fraud, or abuse.

OIG's Sanctions section takes administrative enforcement action in response to Medicaid Provider Integrity investigations. OIG also sends cases to local prosecutors or the Attorney General's Medicaid Fraud Control Unit or Civil Medicaid Fraud Division.

OIG's Internal Affairs Division investigates employees of HHS System agencies, allegations of criminal offenses involving clients at State Supported Living Centers and State Hospitals, and vital statistics fraud.

Auditing and reviewing the use of state or federal funds

OIG monitors contract and grant funds administered by a person or entity receiving the funds from an HHS agency. OIG audits seek to ensure that all state and federal tax dollars are used in accordance with state and federal law, as well as applicable administrative rules and program policies. Further reviews of nursing facilities and hospitals which receive Medicaid are performed throughout the state. Nurse reviewers review Medicaid charges to nursing facilities to ensure that the appropriate charges accompany the level of care. Nurse reviewers review hospital diagnostic related group codes to ensure that the diagnosis supports the charges.

Recommending policies to prevent and detect fraud, waste, and abuse

The Center for Policy and Outreach studies and recommends policies, including new prevention and detection mechanisms, as well as changes to existing policies, processes and procedures.

Investigating and verifying the background of provider applicants

OIG's Program Integrity Research unit conducts criminal background checks on providers seeking to enroll or re-enroll in Medicaid to prevent high-risk providers from enrolling. PIR also coordinates with OIG's Medicaid Provider Integrity section to conduct on-site visits for moderate and high-risk providers, as required by the Affordable Care Act.

Providing education, technical assistance, and training to promote cost avoidance and sustain improved relationships with providers

OIG provides assistance, education, and training to providers - including at provider conferences and seminars - by making presentations on new legislation and rules as well as on how to avoid and report fraud, waste, and abuse.

The Office of Inspector General's general activities and duties include the following:

- ensuring integrity and accountability in each health and human services program;
- preventing, detecting, and recovering overpayments to program providers and recipients;
- referring cases of fraud to local police, prosecutors, and the Attorney General; and

- educating the public and the provider community of ways to prevent, reduce, and report fraud, waste, and abuse.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

Since its creation in 2003, the Office of Inspector General has recovered, identified for recovery or cost avoided more than $6 billion in erroneous, fraudulent, or wasteful payments in the state's health and human services programs. The state's portion of recovered funds is returned directly to the state's health and human services programs, allowing them to be used to help more Texans without placing additional demands on the state budget.

OIG uses a variety of metrics to measure performance. Two primary benchmarks for measuring success are cost recovery and cost avoidance.

Cost Recovery

Cost recovery is money already recovered or identified for collection because it was paid in error. For example, a Medicaid provider performs a routine procedure on a patient. However, when sending the claim to Medicaid, the provider's office manager classifies the routine procedure as an advanced procedure which qualifies for a higher reimbursement rate. Through review of medical records, OIG determines the provider's reimbursement should have occurred at the routine procedure rate, then moves to recoup from the provider the difference between the amount actually reimbursed and the amount that should have been reimbursed.

Cost Avoidance

Cost avoidance is money that is not paid because of OIG action. For example, a Medicaid provider files a claim for reimbursement and the patient has private insurance as well as Medicaid coverage. Because Medicaid is payer of last resort, the claim is denied or diverted to the private insurance company for payment. Because Medicaid avoided paying the claim, the amount of the claim is reported as cost avoidance. In an investigative paradigm, OIG measures a provider's historical monthly billings prior to OIG intervention and compares them to post-intervention billing rates. Assuming an immediate post-intervention decrease is attributable to the cessation of improper billing practices. OIG then multiplies the difference, if any, by a standard 36 months to arrive at a cost avoidance amount. The 36-month period ensures encompassing an entire biennial funding cycle and is a reasonable calculation of Title XIX dollars that would otherwise have been lost.

The combination of the amount of money that is identified for recovery and the amount of costs that are avoided results in a calculation of return on investment, which is an additional overall measure of the Office of Inspector General's effectiveness. OIG has recently

implemented even more robust metrics which will allow measuring relative success down to the program and individual investigator level.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

2009 The Legislature passes Senate Bill 643, which expands the duties of the OIG to include assisting state and local law enforcement agencies in investigating allegations of criminal acts involving clients at the state's 13 State Supported Living Centers (formerly State Schools) located in Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, Rio Grande, San Angelo, and San Antonio. The legislation authorized the OIG to employ and commission peace officers to assist in these investigations.

2013 The Legislature passes S.B. 152, extending the OIG's criminal investigatory authority to allegations involving clients or residents of State Hospitals located in Austin, Big Springs, El Paso, Kerrville, Rio Grande, Rusk, San Antonio, Terrell, Vernon, Waco, and Wichita Falls. The legislation authorized and requires the OIG to employ and commission peace officers to assist in these investigations.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The Office of Inspector General's role in the prevention, detection, and pursuit of fraud, waste, abuse, neglect and exploitation affects:

- all Medicaid providers, such as physicians, pharmacies, home health agencies, other contracted providers, and intermediate care facilities by providing background checks on all new providers and some existing providers, and investigating payment claims made by these entities;
- Medicaid, SNAP, CHIP, and TANF recipients, by investigating the abnormal or suspicious use of benefits;
- employees at State Supported Living Centers and State Hospitals suspected of abuse, neglect, or exploitation of residents or clients;
- employees in the HHS System suspected of fraud or abuse, or violations of HHS policy;
- insurance companies, which are liable for payment of claims before payment by Medicaid;
- hospitals, such as by conducting Medicaid utilization reviews;
- Medicaid and CHIP Managed Care Organizations, such as by conducting performance audits;
- nursing facilities and inpatient hospitals, by reviewing Medicaid utilization; and

- vendors in the Women, Infants, and Children (WIC) program, through monitoring compliance with state and federal law.
-

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

The Office of Inspector General is led by the Inspector General, and is comprised of five divisions, each led by a deputy inspector general: Chief Counsel, Compliance, Enforcement, Internal Affairs, and Operations.

Chief Counsel Division

OIG's Chief Counsel Division is comprised of two sections, Legal and Sanctions, both headed by the Chief Counsel.

Legal

The Legal section provides OIG with general legal support and advice and opinions on Health and Human Services Commission programs and operations. In addition, the Legal section helps ensure OIG adopts legally sound policies, procedures, and practices.

Sanctions

The Sanctions section imposes administrative sanctions and penalties on Medicaid providers, and represents the agency in contested administrative case hearings against those providers who wish to appeal sanctions OIG imposes. It assists the Office of Attorney General in civil litigation and prosecution against Medicaid providers. The Sanctions section has the authority to levy civil monetary penalties, suspend payments to providers, restrict a provider's reimbursement, exclude or terminate providers from participation in the Medicaid program, and cancel a provider's contract with Medicaid.

Sanctions may also take other administrative actions against providers, such as requiring providers to undergo further training, requiring prior authorization for services, requiring claims be reviewed before they are paid, requiring a post-payment review of payments, requiring corrective action meetings, requiring a provider to post surety bonds, and referring cases to other agencies for additional review.

Compliance Division

The Compliance Division audits and reviews providers, vendors, contractors, and recipients to ensure compliance with all state and federal laws, rules, regulations, and guidelines related to payment for reimbursable services. This division also facilitates, through HHS System agencies or OIG Sanctions, the collection of overpayments identified by OIG's Utilization Review unit and Women, Infants, and Children Vendor Monitoring, and educates providers, vendors, and

contractors on how to submit accurate information for reimbursable services. The Compliance Division also refers cases of suspected fraud, waste, and abuse by providers, vendors, and contractors for investigation to the Office of Attorney General or OIG's Enforcement Division. The Compliance Division has two sections: Audit and Quality Review.

Audit

The Audit section is comprised of five business units: the Contract Audit Unit; the Hospital Audit Unit; the Managed Care Organization (MCO) Audit Unit; the Cost Report Review Unit; and Sub-Recipient Financial Review Unit.

- The Contract Audit Unit conducts audits of intermediate care facilities to ensure the proper management of residents' trust funds, audits prescription drug claims made through the Medicaid Vendor Drug program, and audits high-risk contractors within the HHS System.
- The Hospital Audit Unit audits hospital cost reports to ensure that all outpatient hospital costs charged to Medicaid are reasonable, necessary, and allowable.
- The MCO Audit Unit conducts audits of MCO plans from a financial, operational, contractual, and medical perspective. The unit reviews MCOs for financial, operational, and medical compliance. The Utilization Review (UR) nurses help as needed to ensure medical necessity of treatment and help prevent patient harm by identifying areas of non-compliance. This provides the MCO with information to correct policies, procedures, and processes to prevent patient harm.
- The Cost Report Review unit conducts audits and desk reviews (non-audit services) to ensure that certain Medicaid funded facilities are accurately reporting their service costs. These include long-term care facilities, intermediate care facilities for persons with mental illness, community care services for the aged and disabled, 24-hour child care facilities, and other state and federally funded programs. The HHSC Rate Analysis Division uses these cost reports, which show the actual cost of services provided, to determine reimbursement rates for long-term care and other facilities.
- The Sub-Recipient Financial Review unit conducts desk reviews of single audit reports, and audits of providers who contract for services with HHSC. Also housed within the Audit Section, the Quality Assurance Team ensures that Audit section personnel adhere to professional standards, including continuing professional education, as well as legal and regulatory requirements, and also ensures that an external entity performs a required peer review of the Audit section at least once every three years.

Quality Review

The Quality Review section of the Compliance Division is comprised of three business units: the Lock-In Program; Utilization Review; and Women, Infants, and Children (WIC) Vendor Monitoring.

- The Lock-In Program works to prevent the inappropriate or substandard use of medical services in the Medicaid program. The unit limits certain Medicaid recipients to designated primary care providers or pharmacies, which occurs when evidence indicates recipients have received duplicative, excessive, contraindicated, or conflicting health care services or prescription drugs.

- The Utilization Review Unit conducts nursing facility and hospital utilization reviews that verify the correct reimbursement of services provided. These reviews validate whether the facility has correctly assessed and documented the resident's needs to receive the proper reimbursement. This unit also reviews the medical necessity of the patient to reside in the nursing facility. The unit refers its findings to the Department of Aging and Disability Services to recoup overpayments and adjust underpayments. The Sanctions Division of OIG handles the medical necessity recoveries.
- The WIC Vendor Monitoring unit monitors providers of nutritional items, including grocery stores and farmers markets, to ensure they are in compliance with state and federal law, administrative rules, and the WIC Vendor Agreement. Additionally, the WIC Vendor Monitoring unit may refer suspected fraud to the United States Department of Agriculture, Office of Inspector General.

Enforcement Division

The Enforcement Division, led by the Deputy Inspector General for Enforcement, is comprised of the Medicaid Provider Integrity (MPI) Section, the General Investigations (GI) section, and the Data Analytics and Fraud Detection unit (also called the Intelligence Unit).

Medicaid Provider Integrity

The MPI section investigates allegations of fraud, waste, and abuse against Medicaid providers. If MPI determines that criminal conduct may have occurred, OIG refers the case to the Office of the Attorney General's Medicaid Fraud Control Unit for further criminal investigation. MPI may refer any allegation to the provider's licensing board for administrative action, to the federal Medicare program, or to other regulatory or law enforcement entities. MPI also has the authority to conduct its own investigations and refer its findings to the OIG Sanctions section or other appropriate enforcement or prosecution authorities. MPI also monitors the activities of Special Investigative Units (SIUs) used by managed care entities. MPI receives regular reports from these SIUs of fraud in managed care settings and has the authority to take any investigation from the SIUs in order to conduct a state investigation – particularly useful when investigating providers who belong to multiple managed care networks. MPI also reviews the managed care companies themselves.

General Investigations

The GI section investigates recipients and retailers who participate in the Supplemental Nutrition Assistance Program (SNAP). Specifically, GI investigates allegations of overpayments made to recipients in the SNAP, Temporary Assistance for Needy Families (TANF), Medicaid, Children's Health Insurance Program (CHIP), and the Women, Infants, and Children (WIC) programs. Referrals to GI primarily originate from data match clearances performed by GI staff, referrals from the Office of Eligibility Services, and from the general public, either through calls to the OIG Fraud Hotline or online complaints from OIG's website. The GI section also investigates individuals suspected of the unauthorized possession or use of an Electronic

Benefit Transfer (EBT) card. In many instances GI works these cases jointly with local, state or federal law enforcement agencies.

Data Analytics and Fraud Detection

The Data Analytics and Fraud Detection unit works closely with 21st Century Technologies (21CT), the vendor OIG has selected to provide graph pattern analysis and intelligence. Through the 21CT contract, OIG has deployed LYNXeon, a highly advanced graph pattern analysis technology that allows OIG to detect hidden relationships in cyber, intelligence, and financial transactions with the goal of identifying fraud and other aberrant practices. OIG began deploying LYNXeon in December 2012 and implementation for the initial phase of operations took place in March 2013. In less than six months of operations, this initiative has documented over $100 million in payments that are suspected to be fraudulent.

Internal Affairs Division

The Internal Affairs Division works to ensure the accountability of health and human services resources, programs, employees, and contractors by identifying misconduct, violations of the law and serious violations of policy. The Internal Affairs section is comprised of five functional units: the Vital Statistics Investigations unit, the Special Investigative Response Team, the Program Investigations unit, the Forensic Research and Analysis unit, and the State Supported Living Center and State Hospital Investigations unit. Incidents substantiated by the Internal Affairs section may result in disciplinary action, termination, counseling, or criminal prosecution.

Operations Division

Led by the Deputy Inspector General for Operations, the Operations Division is comprised of four sections: Business Operations; Technology Analysis, Development, and Support; the Center for Policy and Outreach; and the Managed Care Unit.

Business Operations

The Business Operations section is responsible for OIG's administrative functions. This section includes the Administrative Services unit, Quality and Decision Support unit, and Resource Management unit. The Administrative Services unit manages all OIG facilities. The Quality and Decision Support unit performs essential data analysis services and also assists OIG's Enforcement and Compliance divisions with determining statistically valid samples for investigations and audits. In addition, the Quality and Decision Support unit maintains the OIG Performance Measures Report System, which allows OIG management and staff to assess agency performance. The Resource Management unit houses human resources, contract management, and record management functions.

Technology Analysis, Development and Support

The Technology Analysis, Development, and Support (TADS) section directs and monitors the development, implementation, and coordination of OIG's information technology systems. TADS consists of three business units: Business Analysis and Support Services (BASS); Research, Analysis and Detection (RAD); and Third Party Liability (TPL). BASS supports OIG's automation and information technology processes, and maintains OIG's intranet. RAD monitors the utilization of Acute Care Fee for Service and Primary Care Case Management Medicaid services. In addition to helping OIG address quality-of-care issues, RAD also identifies and initiates recovery of inappropriate Medicaid payments. The RAD unit also oversees the Surveillance and Utilization Review Subsystems, or SURS, a federally required fraud detection tool, as well as overseeing the Medicaid Fraud and Detection System, a computer system that detects, identifies, and analyzes provider billing patterns.

The system sets benchmarks for what is normal based upon actual billing patterns. TPL helps to ensure that all responsible parties pay their share of recipients' expenses by redirecting claims to the liable third party, resulting in cost avoidance, or by pursuing a liable third party for claims previously paid by the Medicaid program, which results in cost recovery. This unit ensures that the state's Medicaid program is the payer of last resort, and avoids costs it otherwise would pay.

Center for Policy and Outreach

The Center for Policy and Outreach (CPO) includes the Program Integrity Research unit, the Fraud, Waste and Abuse Hotline, the Policy and Communications unit, and External Relations. The Program Integrity Research unit performs background checks on providers enrolling or re-enrolling in the Medicaid program. The Fraud, Waste, and Abuse Hotline receives allegations of fraud, waste, and abuse from the public. The Policy and Communications Unit conducts Medicaid policy analyses and develops policy recommendations, develops policies, procedures, and manuals for OIG, develops interoffice communication materials, and provides training services for OIG staff and managers, as well as providers. External Relations includes a Senior Government Relations Specialist and a Communications Coordinator who help manage OIG's external communications, analyze legislation, respond to legislative inquiries, media inquiries and open records requests, and review and edit reports.

Managed Care

The Managed Care Unit oversees HHSC's ongoing move from a fee-for-service model to managed care. The unit works closely with HHSC's Medicaid/CHIP Division and managed care organization Special Investigative Units (SIUs) to provide support and identifying provisions in the Uniform Managed Care Contract that are related to fraud, waste, and abuse. The Managed Care Unit also develops policies, procedures, and processes to coordinate focused reviews of managed care organizations.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Office of Inspector General Overall Funding

	General Revenue/GR-D	Federal	Other
G.1.1 Office of Inspector General	$11,579,171	$16,226,232	$8,275,255

Sanctions/Chief Counsel Division

	General Revenue/GR-D	Federal	Other
G.1.1 Office of Inspector General	$586,142	$586,141	0

General Revenue funding includes administrative state match for Medicaid (50 percent) with corresponding federal funds match.

Revenue-Related Authority Riders

- Art. II Section 43 relates to the appropriation of civil monetary damages and penalties.

Enforcement Division

	General Revenue/GR-D	Federal	Other
G.1.1 Office of Inspector General	$5,799,668	$6,603,624	0

General Revenue funding includes administrative state match for Medicaid (50 percent and 25 percent), SNAP (50 percent) and CHIP (28 percent) programs with corresponding federal funds with the addition of federal TANF. Some OIG expenditures are eligible for federal Medicaid administrative match rates of 75 percent for medical professionals. Enforcement actions not directly charged to SNAP, Medicaid or CHIP use a cost allocation factor charged on the number of OIG claims by HHSC program.

Revenue-Related Authority Riders

- HHSC Rider 64 authorizes provider enrollment and screening fee collections.
- Art. II Section 43 relates to the appropriation of civil monetary damages and penalties.

Appropriation and Reduction Riders

- Art. IX Section 18.32 is a contingency appropriation for Senate Bill 8.
- Art. IX Section 18.58 is a contingency appropriation for Senate Bill 1803.

Compliance Division

	General Revenue/GR-D	Federal	Other
G.1.1 Office of Inspector General	$3,016,340	$5,174,835	$3,317,434

General Revenue funding includes administrative state match for Medicaid (50 percent and 25 percent) and CHIP (28 percent) programs with corresponding federal funds. Other funds represent interagency contract funding for WIC audits charged to DSHS and the cost allocation of audit hours charged to the other HHS agency programs.

Internal Affairs Division

	General Revenue/GR-D	Federal	Other
G.1.1 Office of Inspector General	$349,048	$363,771	$2,508,135

General Revenue sources are primarily administrative matches for the Medicaid (50 percent), SNAP (50 percent) and CHIP (28 percent) programs with corresponding federal funds and the addition of federal TANF and Refugee funds. Other funds represent interagency contract funding from cost allocation billings based on the oversight factor.

Operations Division

	General Revenue/GR-D	Federal	Other
G.1.1 Office of Inspector General	$1,827,973	$3,497,861	$2,449,686

General Revenue funding includes administrative state match for the Medicaid (50 percent and 25 percent), SNAP (50 percent) and CHIP (28 percent) programs with corresponding federal funds with the addition of federal TANF and Refugee funds. Other funds represent interagency contract funding from cost allocation billings based on the oversight factor and a factor using the number of logged OIG technology support hours.

Revenue-Related Authority Riders

- Rider 64 authorizes provider enrollment and screening fee collections

Appropriation and Reduction Riders

- Rider 46 relates to funding to the Veterans Commission using PARIS data.

Provider and Programmatic Riders

- Rider 60 relates to improved detection and investigation of dental and orthodontia providers.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions. Describe the similarities and differences.

The Texas Medicaid Fraud Control Unit (MFCU) at the Office of the Attorney General conducts criminal investigations into allegations of fraud, physical abuse, and criminal neglect by healthcare providers in the Medicaid program. This unit employs investigators, auditors, and attorneys who conduct investigations and assist in the prosecution of Medicaid providers who defraud the system or abuse the elderly. The Office of Inspector General works closely with the MFCU under a Memorandum of Understanding (MOU) that is required by statute to ensure coordination of effort. As required by law and the MOU, OIG refers cases to MFCU that involve possible criminal conduct.

The Office of Attorney General's Civil Medicaid Fraud (CMF) division also participates in the MOU. The Office of Inspector General works with CMF in coordinating administrative and civil litigation against providers. The two offices also cooperate when the CMF elects to proceed with *qui tam* litigation (in which the plaintiff, a private citizen often known as a whistle blower, is entitled to a percentage of any penalty recovery) administratively as an alternate remedy to those prescribed in Human Resources Code Chapter 36.

Although the CMF and MFCU areas of OAG perform similar tasks as OIG, MFCU is limited to criminal investigations and prosecutions, while CMF is limited to civil prosecutions alone. Only OIG has the investigative capacity to review thousands of complaints annually, pursue investigations that are both civil and criminal in nature, and prosecute cases administratively. In practice, OIG, CMF, and MFCU act in a comprehensive and coordinated manner not present in other states.

The federal Health and Human Services Office of Inspector General performs similar functions as the state HHSC Office of Inspector General, though the federal office's resources are primarily directed to protecting the integrity of federally administered programs, such as Medicare.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

The Office of Inspector General, Medicaid Fraud Control Unit, and Civil Medicaid Fraud Division work together under a memorandum of understanding (MOU) that ensures cooperation in detecting, investigating, and prosecuting Medicaid fraud. Coordination activities include monthly meetings on cases being worked, and clear division of responsibilities. Within the last two years, OAG and OIG have worked cohesively to investigate and prosecute in appropriate forums any abuse of Title XIX. CMF regularly intervenes in privately filed *qui tam* actions and then elects to proceed administratively, effectively maintaining OIG's complete control of pending cases in an administrative forum. OIG also provides investigative and supporting attorney resources to CMF when OAG requests, and refers to CMF cases more appropriately pursued in state district court. Although the OAG and OIG units have regular monthly meetings and quarterly executive meetings, in practice the two agencies coordinate activities and strategies daily, subject only to ethical and legal restrictions on civil/criminal case coordination.

J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.

The Office of Inspector General routinely sends investigated cases of recipient fraud to local district and county attorneys for prosecution. OIG has contracts/inter-local agreements with local prosecutors under which compensation is provided for successful resolution of cases referred. OIG also works with the federal Centers for Medicare & Medicaid Services (CMS) to enact changes to policies and procedures made or directed at the federal level, and to ensure that Texas' fraud, waste, and abuse detection and investigation system operates within federal requirements and guidance. OIG has worked closely with CMS over the last two years to develop a full partnership, which has resulted in greatly improved coordination, cooperation, and communication.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The enforcement and compliance divisions utilize professional services boilerplate contracts. Professional services contractors include physicians, dentists, and other specialties that conduct reviews of medical records associated with investigations, audits, and hospital or nursing home reviews. Vendor contracts provide access to databases used in investigations. Local prosecuting contracts are used by county and district attorneys and provide authority to prosecute cases as a result of an investigation for fraud, waste, or abuse in the following programs: Temporary Assistance to Needy Families; Supplemental Nutrition Assistance Program; Women, Infants and Children; Food Stamps; and/or Children's Health Insurance Program.

OIG Contract expenditures: **$3,798,126.13**

Number of OIG contracts for those expenditures: **118**

1. EDS Information Services LLC

FY 2012 expenditures: $2,830,712.69
MFADS (Medicaid Fraud and Abuse Detection System): pioneering technology to detect, investigate and deter fraud, abuse and waste in the Medicaid program, and improve access to and quality of care delivered to Medicaid recipients.

2. Dr. Richard Taylor

FY 2012 expenditures: $103,934.95
Medical records review, documentation of review findings, cooperation with state agencies, written professional opinions, on-site clinical reviews, and testimony in legal proceedings.

3. Milliman

FY 2012 expenditures: $102,262.40
MCG Health, LLC for the screening criteria for Utilization Review unit retrospective inpatient hospital review. They replaced screening criteria no longer maintained by the Texas Medical Foundation.

4. Cameron County

FY 2012 expenditures: $70,560.00
Establish the terms and conditions to help defray the costs of prosecutions, as authorized by Texas Government Code section 41.004(b) in the course of the referral of cases from HHSC-OIG to the local prosecuting authority.

5. Harris County

FY 2012 expenditures: $63,796.00
Establish the terms and conditions to help defray the costs of prosecutions, as authorized by Texas Government Code section 41.004(b) in the course of the referral of cases from OIG to the local prosecuting authority.

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

OIG currently does not have statutory law enforcement authority in the area of benefit (recipient) investigations. Thus, OIG's General Investigations section does not have authority to access important databases, such as the U.S. Treasury Department's Financial Crimes Enforcement Network, NCIC (National Crime Information Center) and TCIC (Texas Crime Information Center). Equally important, OIG does not have the authority to conduct full-scale investigations of retailers OIG suspects are involved in the trafficking of Lonestar EBT cards. While OIG now has technology that can identify through electronic data analysis those retailers whose Lonestar transactions are highly indicative of illegal activity, OIG must then locate local law enforcement agencies willing to conduct joint investigations. Historically, it is rare for a SNAP/TANF/WIC trafficking investigation to have enough priority for a local law enforcement agency to dedicate resources to it. Special Agents from the United States Department of Agriculture Office of Inspector General are limited in their manpower and budgets and must target only selected retailers, leaving an enormous opportunity for fraud in EBT transactions.

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

N/A

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS − CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Texas Office for the Prevention of Developmental Disabilities
Location/Division	909 West 45th Street Austin, Texas
Contact Name	Janet Sharkis, Executive Director
Actual Expenditures, FY 2012	$353,454.22
Number of Actual FTEs as of June 1, 2013	3
Statutory Citation for Program	Human Resources Code, Title 7, Section 112.043

B. What is the objective of this program or function? Describe the major activities performed under this program.

The purpose of the Texas Office for the Prevention of Developmental Disabilities (TOPDD) is to minimize the economic and human losses in Texas caused by preventable disabilities. TOPDD is a public-private partnership overseen by an executive committee. This uniquely positions the Office to raise funds and bring state and community entities together to prevent developmental disabilities. TOPDD develops a unified, comprehensive prevention effort in Texas by engaging state agencies, private organizations, and local public entities to work for the following objectives.

- Reduce the incidence and severity of developmental disabilities.
- Establish a mechanism by which prevention activities can better be coordinated and needed prevention activities can be initiated.
- Minimize the economic and human losses in Texas caused by preventable developmental disabilities.

During the past 30 years, significant advances in research allowed for the prevention of many cases of developmental disabilities. For example, every year, the nation prevents:

- 4,000 cases of intellectual disability caused by measles encephalitis, thanks to the measles vaccine;
- 5,000 cases of intellectual disability caused by Hib diseases by using the Hib vaccine; and
- millions of cases of head injury related to increased public safety efforts such as seat belts.

Behavior is the most prevalent causes of developmental disability. Research is advancing prevention of disabilities related to behavior, such as prenatal alcohol exposure, and behaviors that lead to head injuries. TOPDD is at the forefront of addressing preventable developmental disabilities using the latest research. The Office engages leaders throughout Texas and builds on the body of national research and best practices being implemented by its counterparts throughout the country.

Texas recognized the need for a coordinated approach to seize the available and developing opportunities to prevent developmental disabilities. The Texas Legislature created TOPDD to invest in the future of the state with this need for coordination of the prevention of developmental disabilities in mind.

TOPDD's statutory requirements include increasing public awareness of preventable developmental disabilities and the development of related public policy. TOPDD centers its work on developing a coordinated approach to decreasing the incidence and severity of preventable developmental disabilities. TOPDD collaborates with other state agencies, non-governmental agencies, and individuals to plan, monitor, report, and identify opportunities to educate the public and professional communities about the prevention of targeted developmental disabilities.

TOPDD facilitates two active Task Force groups: a Fetal Alcohol Spectrum Disorders (FASD) Task Force, which is known in the community as the "FASD Collaborative," but for purposes of this report will be referred to as the FASD Task Force, as well as a Child Safety and Injury Prevention (CSIP) Task Force. The membership of TOPDD's Task Forces is extraordinarily diverse and includes professionals from the following communities: medical, judicial, mental health, legal, child advocacy, education, scientific, academic, substance abuse treatment and recovery communities, state agencies, stakeholder groups, non-profits, local governments, businesses, courts, and beyond.

TOPDD's ability to solicit and receive private and federal grant funding has allowed the Office to provide the state with a coordinated prevention effort and to collect data and identify best practices for prevention. Furthermore, these external sources of support have increased TOPDD's reach and ability to connect with stakeholders whose policies, operations, and procedures can prevent developmental disabilities and assist families and consumers who are impacted by developmental disabilities and their service providers. Raising awareness and education are primary functions of TOPDD's task forces and staff, and the statewide impact of this work has had very positive outcomes.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

The following lists TOPDD's duties, as outlined in the Office's by-laws, and describes how the agency is meeting those duties.

Educate the public and attempt to promote sound public policy.

- TOPDD organizes trainings that reach an average of 400-600 professionals annually, including lawyers, judges, medical providers, human services leaders, and children's advocates. TOPDD's efforts are enhancing knowledge of preventable disabilities, such as those caused by prenatal alcohol exposure. Last year, other organizations supported 20 workshops on FASD alone.
- TOPDD has 160 volunteer trainers who provide education at the community, regional, and state level.
- TOPDD is gaining national recognition and has presented at several national conferences. The Office has recently been invited to present a workshop on its coordinated approach to task force development and facilitation through the first international conference on FASD prevention.
- Through its state planning efforts, TOPDD has identified sound public policies that the committees of its task forces are working to implement. The Office produces two legislative reports each biennium. One is done in collaboration with the Council on Developmental Disabilities. Recently, TOPDD produced a white paper on education issues as they relate to people with developmental disabilities.
- Through its national affiliations, TOPDD identifies public policies that have proven effective and that could be implemented in Texas.

Identify, collect, and disseminate information regarding the causes, frequency of occurrence, and preventability of developmental disabilities.

- TOPDD has coordinated several projects in collaboration with a national funder to collect data which would inform prevention work. An example of such data collection efforts is the Project CHOICES initiative, in which TOPDD partnered with the Department of State Health Services (DSHS) and state-funded substance use treatment agencies to implement an intervention to prevent FASD. This data have been used locally and nationally.
- TOPDD, in collaboration with the University of Texas, conducted a needs assessment for the state on FASD.
- TOPDD tracks research and policy regarding the two most prevalent causes of preventable disabilities, fetal alcohol exposure and brain injury. The agency responds to approximately five to ten requests per month for information. These requests come from state agencies, organizations, and individual stakeholders. Some of these requests are fairly straight-forward, while others are highly complex and require extensive staff time.

Work with state agencies and other entities to develop a coordinated long range plan to effectively monitor and reduce the incidence and severity of developmental disabilities.

- TOPDD works with many different state entities in this area, including Child Protective Services (CPS), the Texas Child Fatality Review Committee, the Office of Acquired Brain Injury, and Early Childhood Intervention (ECI), to name a few. However, all of these entities would agree that there are serious gaps in the data—most children who have FASD are never diagnosed, and there are also gaps in the data related to head injuries, especially when the children are not admitted to the hospital. TOPDD is exploring how to best fill these gaps and obtain better data with its partners.
- TOPDD has conducted data collection related to specific prevention interventions for FASD to inform its work and contribute to the body of information that is being developed nationally. In addition to the value related to data collection, this work directly benefited the women who received the intervention.
- TOPDD convenes the Child Safety and Injury Prevention Task Force and the FASD Task Force. Both of these entities use data to develop plans, reduce gaps in services, and coordinate efforts to prevent developmental disabilities.

Promote and facilitate the identification, development, coordination, and delivery of needed prevention services.

- In addition to conducting its own safety events, TOPDD has provided a host of resources and materials as well as training, consultation, and information to organizations conducting safety events throughout the state.
- TOPDD serves as a catalyst and resource for the development of prevention services. TOPDD is currently working with the Department of Family and Protective Services (DFPS) to develop FASD awareness and knowledge in the CPS system. Part of the project includes an online educational training for CPS workers, in-person training on FASD by CPS workers to their colleagues, a pamphlet for potential foster parents on FASD, and a coordinated regional effort to improve the identification of children who may have an FASD in the Houston area.
- TOPDD has organized and continues to work with the medical community and state partners to better identify women who may be at risk for an alcohol exposed pregnancy, providing them with screening and brief intervention for alcohol use, and to identify children who may have an FASD, so that they may obtain appropriate intervention to prevent secondary disabilities.
- TOPDD participates in a range of efforts led by other organizations including Texas Healthy Babies, Texas Association for Infant Mental Health, Court Appointed Special Advocates (CASA), Texans Care for Children, HHSC Office of Program Coordination for Children and Youth, Hogg Foundation, ECI, Raising Texas, and Houston Area Infant and Toddler Courts.

Solicit, receive, and spend grants and donations from public, private, state and federal sources.

- TOPDD receives far more funding than it costs the state, not just for itself but for other entities as well, such as state-funded addiction treatment centers. The Office's funders do not typically support state agencies.
- TOPDD is involved with applications for several additional sources of funding and is currently awaiting responses. Cumulatively, these potential funding streams equate to $1,047,030 in support for the Office and its prevention of developmental disabilities work. These pending funding opportunities include the following.
  - An application to the Substance Abuse and Mental Health Services Administration (SAMHSA), which was prepared and submitted by DSHS. The grant was written for the implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services in Texas, which could contribute to the prevention of developmental disabilities in the state. TOPDD's role would be to provide training and technical assistance to the implementing programs. It would be a five-year grant, with TOPDD receiving $84,000 per year, for a total of $420,000.
  - TOPDD submitted an application to The Meadows Foundation to assist in ongoing statewide planning around FASD, support the work of the Task Force, and influence policy related to the prevention of developmental disabilities. This grant would directly impact TOPDD's ability to meet its statutory requirements. TOPDD previously has been funded for this work from The Meadows Foundation, which positively impacts the likelihood that the Office will be funded again. The amount that is pending is $200,437 for one year.
  - TOPDD was included in an application to the federal Maternal and Child Health Bureau (MCHB) that was submitted by Children's Research Triangle, in collaboration with NOFAS (the national network for FASD organizations). If funded, TOPDD would assist Children's Research Triangle in educating the community-based health centers about FASD. TOPDD would be funded at $24,541 per year, for a three year period, totaling $73,593.
  - TOPDD submitted an application to Northrop Grumman, which serves as the prime contractor for SAMHSA. TOPDD previously was funded by Northrop Grumman for implementation of the Project CHOICES intervention, which is an FASD prevention activity that is evidence-based. Northrop Grumman invited TOPDD to apply again for this work, making the Office the only state agency in the country offered this opportunity. TOPDD will be using its partnerships with DSHS, Specialized Female Substance Abuse Treatment agencies to do this work. If awarded the grant, TOPDD will receive a total of $353,000 for a 21-month grant period. This funding opportunity likely will be offered again in subsequent option years.

Develop, operate, and monitor task forces to address the prevention of specific targeted developmental disabilities.

- TOPDD has had an FASD task force since the inception of the agency. The functions of the task force have evolved over time, as has its membership. In 2011, the Office convened over 50 organizations to develop a statewide strategic plan on FASD, involving the full spectrum of both public and private human services. Over 350 individuals and agency representatives participated. Among other accomplishments, the FASD task force:
  - conducted a needs assessment in collaboration with UT Austin;
  - trained 15,000 professionals and members of the public in a single year;
  - organized the training of FASD diagnostic clinics in Houston, Dallas-Fort Worth, San Antonio, and Lubbock, thereby establishing the first clinics in the state; and
  - obtained funding to implement a brief intervention program to prevent FASD, which is called Project CHOICES, in 16 treatment centers across the state.
- The Child Safety and Injury Prevention (CSIP) Task Force is composed of leaders throughout the state, including state agency representatives, members of the medical community, and grass roots leaders. Throughout the years, much of the focus has been on bicycle safety. According to the National Safe Kids Campaign, bicycles are associated with more childhood injuries than any other consumer product besides the automobile. While more than 70 percent of children (ages 5 to 14) ride bicycles, only 5 to 25 percent of children wear helmets. By wearing a helmet, children reduce their risk of a head injury significantly.
- Initiatives of the CSIP Task Force include the following.
  - TOPDD has worked on a range of projects related to motivating families to wear bicycle helmets. In collaboration with the Texas Medical Association (TMA), the Office has distributed information and helmets to children throughout the state. TOPDD works with Texas Scottish Rite Hospital in Dallas on a safety event which attracts approximately 500 people annually. CSIP has also worked with schools and community groups to provide presentations and technical support on bicycle education and safety events.
  - TOPDD is broadening its scope related to safety and injury prevention, using the annual safety awards event to bring attention to this issue. The Office and the CSIP Task Force are exploring a wide range of potential focus areas: sports-related injuries, new technologies and their impact on safety, children who may be at high risk and underserved, such as those who have ADHD, poor impulse control, and/or other disabilities, and immigrant children and families and the importance of providing culturally appropriate messages and information.
- The task forces monitor the effectiveness of the state to prevent developmental disabilities. They are the mechanism by which the Office encourages cooperative, comprehensive planning as required by its statute.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

TOPDD was originally a completely independent agency. After the last Sunset Review, the Office was attached to what was a legacy agency and is now HHSC. As an independent agency, TOPDD was treated in a similar manner to large agencies and had obligations such as a full Sunset Review that stretched its limited resources. TOPDD is now administratively attached to HHSC and receives funding through the agency. This state investment has not only supported the work of the Office, but has also facilitated TOPDD's ability to leverage additional funds through contracts and grants.

Throughout the history of the Office, the issues that it has addressed have changed to some degree based on service gaps, prevalence data, and funds available. In its early history, TOPDD employed a more grass roots approach to its work than it presently does. This was necessary because there was little awareness about the prevention of developmental disabilities. The task forces had a large consumer/family base, and membership was more informal than it is today. Currently TOPDD uses a more formal approach to Task Force membership, which is designed to ensure that the membership is diverse and includes stakeholders from major public and nonprofit agencies. This allows TOPDD to impact policy and entire systems and to coordinate work between different systems of care.

Regardless of the specific issue areas TOPDD has addressed over the years, the work has always involved planning, needs assessment, program development, and education.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

TOPDD does not provide direct services. However, a big part of the Office's mission is to expand the capacity of other organizations to address the prevention of developmental disabilities. Any organization that is interested in building its skills in this area is encouraged to participate.

TOPDD regularly provides targeted training programs. Examples include: online training for attorneys through the Texas Bar Association; online training for Texas CASA volunteers; training to lawyers and judges through the Center for the Judiciary conference; training for medical providers in collaboration with the Texas Pediatric Society Foundation; training for early childhood providers through the Houston-area Educational Service Center (Texas Education Agency Region 4); and training for behavioral health professionals through the Behavioral Health Conference.

TOPDD uses a wide range of methods to assess its prevention efforts, including formal needs assessments, surveys, focus groups, and literature reviews. While it is difficult to compile data for each of the Office's activities because of the scope of this work, the following is a sample of the data it has compiled.

- TOPDD receives three to five training requests from other organizations per month.
- Workshop attendance typically ranges from 20 to 100 people.
- TOPDD's recent FASD training of trainers program had over 200 applicants for 150 available slots.
- Special event participation includes 500 to 1,000 people annually.
- Satisfaction surveys show 95 percent of special events participants express satisfaction.
- Pre- and post-testing show 90 percent of special events participants demonstrate increased knowledge.

The agency also implements evidence-based models and uses the data from this work to identify promising practices as well as needs which need to be addressed. The Office has implemented several brief intervention programs to prevent FASD.

- TOPDD, in collaboration with addiction treatment agencies throughout the state, implemented Project CHOICES between 2008 and 2012. Project CHOICES is an evidence-based intervention designed to reduce the risk of an alcohol-exposed pregnancy. Over 800 women participated in the intervention. Over 95 percent of the women who completed the CHOICES program reduced their risk for an alcohol-exposed pregnancy. This demonstrates the importance of the role of educating women to prevent FASD and the effectiveness of prevention efforts.
- Through a collaboration of Children's Research Triangle (in Chicago) and TOPDD, pregnant women were screened for substances in San Antonio and the Rio Grande Valley at Healthy Start sites. Nearly one third of these women screened positive for substances that can alter the brain of the fetus, with 19.4 percent using alcohol, the most dangerous drug to the brain of a fetus. Fifty percent of the women with a positive screen were using more than one drug, with alcohol use occurring in 90 percent of the pregnancies that were exposed to more than one substance prenatally. These results demonstrate the need to reach women with information about substance use and pregnancy.

National research indicates that approximately 1 in 100 children has a disability within the FASD spectrum, which is similar to the prevalence rate of Autism Spectrum Disorders (ASD) (Barr & Streissguth, 2001). The disabilities associated with prenatal alcohol exposure encompass many different domains including:

- intellectual (memory, problem solving, planning, abstract thinking);
- behavior (impulse control, executive functioning, reading social cues);
- speech and language;
- sensory processing;
- the ability to solve mathematical problems; and
- physical (major organs, hearing).

Prenatal alcohol exposure is the leading preventable cause of intellectual disabilities. Children with an FASD are at high risk for child abuse, social isolation, and suicide. They can be easy prey for negative influences. TOPDD receives many desperate emails from parents who cannot manage their child's behavior and who don't know how to negotiate the system to meet their child's complex educational needs. It is not unusual for people with an FASD to end up in the criminal justice system. Even for those with a high IQ, prenatal exposure can severely hinder their ability to anticipate the consequences of their actions. They may not understand that a suicide or murder is permanent. Or they may not be able to process or remember the instructions given to them by a court. This can lead to dire consequences for an entire community. Fortunately, FASD is preventable, and early intervention improves outcomes. TOPDD is building awareness of and commitment to preventing and addressing FASD.

Traumatic Brain Injury (TBI) is the leading cause of death and disability in children and adolescents in the United States. More than one million children sustain head injuries annually; approximately 165,000 require hospitalization (Centers for Disease and Control and Prevention [CDC], October 2011). A TBI is a blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. TBI can result when the head suddenly and violently hits an object or when an object pierces the skull and enters brain tissue. Modes of injury include motor vehicle accidents, bicycle accidents, falls, sports injuries, and child abuse. Symptoms of a TBI can be mild, moderate, or severe, depending on the extent of damage to the brain. Mild cases may result in a brief change in mental state or consciousness, while severe cases may result in extended periods of unconsciousness, coma, or even death. It is also important to note that more than 90 percent of concussions do not involve loss of consciousness; however, that does not mean that there is no long term impact on the brain, especially when multiple concussions occur.

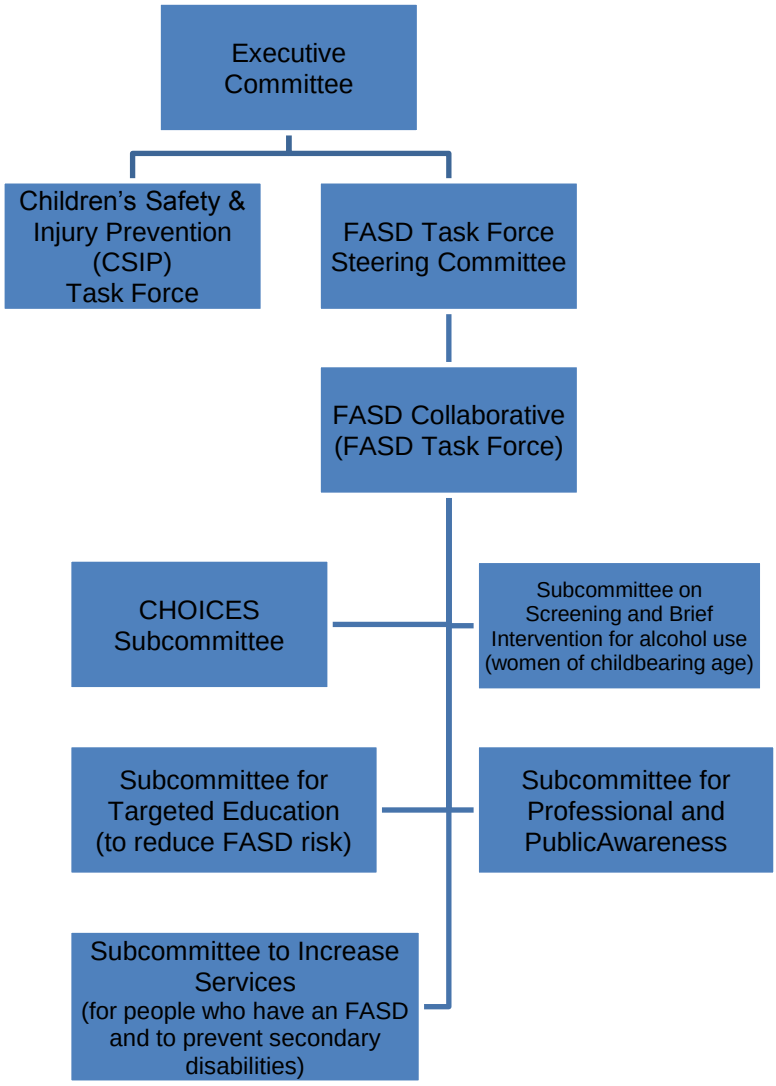
F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

TOPDD's structure includes the Executive Committee who oversees the work of the agency; two Task Forces: a CSIP Task Force, and an FASD Task Force. The FASD Task Force is overseen by an Advisory Committee (known as the Steering Committee.)

The purpose of the FASD Task Force is to implement the state plan on FASD that it developed. The FASD Task Force has subcommittees that address the goals of the FASD state plan. Ad hoc committees are also formed, as needed. They often work on either short-term projects or regional initiatives.

The organizational chart on the following page depicts TOPDD's structure.

TOPDD Organizational Chart with Task Forces



Executive Committee and Office Oversight

The Executive Committee sets the overall direction of the Office, such as the targeted areas of prevention, and uses the input of the FASD Advisory Committee and the Task Force to assess needs. The Executive Committee approves the membership of the CSIP Task Force and the FASD Task Force Steering Committee. The FASD Steering Committee approves the membership of the FASD Collaborative. The FASD Steering Committee and the Child Safety and Injury Prevention Task Force provide reports for the Executive Committee, allowing the Executive Committee to oversee activities to ensure that they are in keeping with the overall direction of the Office. The Executive Committee approves major decisions of both the FASD and CSIP Task Forces.

Budgets are project-based and not tied to an individual task force. The agency has been successful in bringing in funds for FASD work. Its child safety work has primarily been funded through the TOPDD budget rider (#54) in the General Appropriations Act. In the past ten years, TOPDD has raised funds that far exceed those provided to the Office from state appropriations. However, the funds that the Office has attracted are typically devoted to specific projects, and have almost all been for FASD work. The Executive Committee's Resource Development Committee reports at each meeting about the progress related to fundraising and the overall financial condition of the Office.

Field and Regional Services

While TOPDD does not have regional offices at this time, it does provide services at the community level. Recently, it provided FASD training of trainers programs in Houston, San Antonio, and Fort Worth. The trainers are fanning out in their communities to educate their region. TOPDD is working closely with the leadership in Houston to increase the capacity of the region to identify children with an FASD. TOPDD is specifically focused on children in care in the Houston region because of the high prevalence of FASD in this population. The Office is working with hospitals, the Infant and Toddler Court, CPS, Houston Area Partnership for FASD (a local FASD organization), The Texas Supreme Court Commission on Children and local leaders on this project. The Houston project is being led by a well-respected Judge whose influence is an important success factor. TOPDD is also providing technical assistance in the Fort Worth area to establish a local FASD effort there.

Selected Targeted Areas

TOPDD's main targets are safety and injury prevention in children and the prevention of fetal alcohol spectrum disorders. According to the Texas Traumatic Brain Injury Advisory Council report, approximately 144,000 individuals per year sustain a brain injury in Texas. Among children and youth, 3,500 children between birth and the age of 19 suffer brain injury. One third of this group suffers lifelong disabilities as a result of their brain injury. The potential impacts can include trouble with the law: five years after a brain injury, 33% of these children have justice system involvement.

Binge drinking in females is on the rise nationally and in Texas. According to the Centers for Disease Control and Prevention, one in five high school girls, and one in eight adult women binge drink. The Texas Behavioral Risk Factor Surveillance System (BRFSS) is a federally funded telephone survey conducted on a monthly basis of randomly selected adult Texans to collect data on lifestyle risk factors contributing to the leading causes of death and chronic diseases. The BRFSS is a primary source for comprehensive statewide data on preventive health practices and health risk behaviors. According to the BRFSS, 43.8 percent of women of childbearing age (18-44 years old) in Texas drink some alcohol, with 11.4 percent binge drinking. In the three months before they were pregnant, 44.3 percent of women in the survey reported binge drinking. (BRFSS, 2011)

TOPDD facilitates collaboration and cooperation around the issues related to preventable developmental disabilities. The Office's approach is to develop and build collaboratively on the knowledge and awareness around prevention of developmental disabilities and to have a larger collective impact through relationships with other agencies and non-profits. The Office intentionally creates partnerships for work with these partners to build on one another's efforts, and to have a progressively larger and more comprehensive impact on the issues.

Task Force members address preventable developmental disorders on both macro (bigger system) and micro (role/contribution of their own organization) levels to implement the overall goals of the group. This results in the delivery of services from both systems and individual organizational perspectives. The following is an example of how the Office partners with other organizations toward a collaborative large impact than could be done independently.

Texas Association for Infant Mental Health (TAIMH)

TAIMH is a statewide nonprofit organization dedicated to improving the mental health of infants. TAIMH contributions to the work of the FASD Task Force include:

- planning and facilitation of the training of trainers programs which were developed by the Task Force. TAIMH also took responsibility for organizing the registration and continuing education credits for the trainings of trainers. Additionally, they advertised and attended the events;
- organization of the annual Infant Mental Health Conference, highlighting developmental disabilities and mental health of young children;
- development/distribution of a pledge on children's mental health awareness;
- developing an online training for child care providers on preventable developmental disabilities which will reach thousands of childcare workers from throughout the state.

The impact that TOPDD and TAIMH have made collectively as a result of these combined efforts:

- FASD Training of Trainers attendees: 160. Each trainer will provide at least 2 trainings each reaching at minimum 20 people per training. Total number of people impacted by the Training of Trainers: 6,400
- 400 attendees at TAIMH annual conference
- 200 signers on pledge
- 2,000 child care providers who will be educated on FASD (projected)
- 500 members of TAIMH
- 50 members of the FASD Task Force

Total potentially impacted by TAIMH and TOPDD's collective FASD education efforts:
9,550 people

The advantage of the coordinated collaborative approach to prevention is that it results in a larger collective impact of all of the member organizations. This larger effort cannot be

compared to the individual impact of a single program, as its scope is much broader. It also provides for sustainability of the effort as individual agencies and organizations integrate the prevention of developmental disabilities in their work.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Texas Office for the Prevention of Developmental Disabilities

General Revenue:	$111,805
Federal:	$8,787
Other:	$207,722

	General Revenue/GR-D	Federal	Other
A.1.1 Enterprise Oversight & Policy	$111,805	$8,787	$207,722

The Office for the Prevention of Developmental Disabilities is funded with General Revenue, a federal grant, and other funds, which are foundation grant funding.

Funding Limitations, Transfer Authority Riders

- **Rider 7** appropriation transfers between fiscal years.

The "Other" category contains the funds TOPDD privately raised through grant moneys and donations. In a span of six years, TOPDD raised:

TOPDD's Appropriated Receipts	
Funder Name	**Amount Received**
March of Dimes	$3,000
Meadows Foundation	$94,500
Meadows Foundation	$130,000
NOFAS	$2,250
Northrop Grumman	$1,196,813*
Texas Center for the Judiciary Children's Justice Act Program	$61,130
Texas Center for the Judiciary Children's Justice Act Program	$50,000
Texas Pediatric Society Foundation	$2,000
Grand Total	**$1,484,693***

* Final figures were rounded to the nearest whole dollar

TOPDD receives state funding through a rider contained in the Health and Human Service Commission bill pattern. Historically, the amount has been $111,805, however, the funding increased to $200,000.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

TOPDD is unique because of a combination of factors. There is no other state entity that:

- addresses the primary prevention of developmental disabilities;
- uses a planning approach, acting as the convener and catalyst for change, building the capacity of systems across the state;
- raises the majority of the funds for its work independently; and
- tackles causes of disabilities that are largely connected to the behavior of individuals.

Behavior-based causes are often the most complex issues to address.

TOPDD is a well-recognized expert and organizer around FASD. The state has a comprehensive plan on FASD because of the Office. FASD is one of the leading causes of mental illness, ADHD, and intellectual disabilities. It is also associated with ADHD and other serious, life-long disabilities. As a result, FASD has a large financial impact on medical care, education, and social services in Texas. Research shows that people with preventable developmental disabilities often end up in the criminal justice system, sometimes for minor crimes, and it is common for individuals with an FASD to commit serious crimes because of their lack of impulse control and difficulty with seeing the consequences of their actions. This has a ripple effect, tearing apart families and communities, all because of a preventable disability. This is a complex issue because alcohol use is so imbedded in popular culture, and most people assume that illicit drugs are more harmful to the developing brain of an infant than alcohol, when the opposite is true. TOPDD proactively engages organizations that work across the human services spectrum to develop prevention efforts for developmental disabilities.

While there are other organizations that address disabilities, such as the Department of Assistive and Rehabilitative Services (DARS), TOPDD is unique in that it is specifically focused on developmental disabilities and their prevention. Other organizations that work on disability issues include the Governor's Committee on People with Disabilities. However, this group explores areas such as accessibility, emergency preparedness, and transportation, with a focus on adults who have disabilities, not prevention. Similarly, the Texas Council on Developmental Disabilities (TCDD) also explores areas such as transportation, employment, and developing leadership among people with disabilities, though TCDD does focus on people with developmental disabilities, not disabilities more broadly like the Governor's Committee. This is very different from TOPDD's work. However, the Office does collaborate with TCDD to write a joint legislative report which provides both prevention and service provision perspectives on people with disabilities.

The HHSC Interagency Task Force for Children with Special Needs addresses improving planning and coordination for children with special needs. TOPDD has been involved with this organization. Specifically, through TOPDD's input, it added alcohol screening and intervention for women as a priority. However, the vast majority of their work involves better treatment, not prevention of disabilities, developmental or otherwise.

The Texas Council on Children and Families has a much broader focus than TOPDD. They collaborate and leverage resources in the pursuit of delivery of services to children, youth, and families. This group has included a goal that was identified by the FASD Task Force statewide plan as one of their own priorities.

While these organizations that represent the disability community may have very different goals and perspectives related to these complex issues. The concept of "preventing disabilities" is sometimes viewed negatively by the disabilities community or as a lower priority item. This is driven by the fact that they are working with consumers who are concerned about their current needs. Preventing children in the future from having disabilities can be meaningless to the parent who is struggling to find services for the child that they already have. TOPDD seeks to actively build bridges between treatment, care issues, and prevention, and it has worked diligently with other organizations to achieve this goal, while respecting that each organization is making a unique and valuable contribution.

To maximize effectiveness, developmental disabilities must be actively prevented across systems concurrently and in a collaborative, strategic manner. Often organizations do not immediately recognize what role they can take, and few systems have a prevention orientation. TOPDD's structure is ideal to work with organizations (including other state agencies) and systems to build their effectiveness in preventing developmental disabilities. While other state agencies touch prevention, TOPDD views prevention from a very different lens, in that the focus is on preventing developmental disabilities before they occur as well as preventing secondary disabilities.

Through the work of TOPDD and its FASD Task Force, interest in FASD across Texas is increasing rapidly. The agency is currently going through an expansion to meet these growing needs and anticipates adding staff in the coming biennium to increase capacity.

The work of the Office crosses multiple systems: substance use, CPS, the judicial system, early childhood education, medical care, education, mental health, concussion research, and Medicaid policies, among others. The types of organizations that are involved are increasingly aware of the impact that they can have in preventing life-long developmental disabilities.

TOPDD's work around safety is evolving. Much of the focus has historically been on bike safety through collaborative work with hospitals and local groups. TOPDD's annual statewide safety awards bring attention to the range of efforts being made in child safety as well as the people and organizations who are leading them. Safety is an issue that can be easily overlooked, but

with evolving technology and related dangers, and with the growing awareness around sports-related concussions, the Office has a critical role to play in addressing the prevention of injuries.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

The Office has a Memorandum of Understanding (MOU) with HHSC to provide administrative support.

Each biennium, TOPDD writes a joint legislative report with the Council on Developmental Disabilities, with TOPDD focusing on the prevention aspect. TOPDD also works closely with ECI, DSHS, DFPS, The Texas Supreme Court Judicial Commission on Children and Families, and TAIMH, among others.

As discussed in item H, TOPDD works closely with many other councils and entities that have work which is related to disabilities, prevention, and children. TOPDD emphasizes prevention of developmental disabilities, which is a unique role.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

TOPDD has a unique function of coordinating awareness and other efforts around preventable developmental disabilities. The Office approaches this work by collaboration and relationship building with units of government as well as with non-profit organizations.

On a state level, TOPDD works with many other state agencies as well as county governments. These organizations provide funding, collaborate with TOPDD on projects, and partner with the Office on implementation. A small sample of the organizations the office works closely with include:

- DSHS (addiction treatment, prevention, WIC);
- CPS, on a state and county level;
- local Community Mental Health Centers;
- educational resource centers;
- hospitals such as Texas Children's and Texas Scottish-Rite;
- nonprofits such as
  - the March of Dimes and Texas Association for Infant Mental Health,
  - the Hogg Foundation,
  - the Meadows Foundation, and
  - The Arc;
- universities such as

    - University of Texas at Austin,
    - Texas State University, and
    - Texas A&M University;
- local health departments,
- Healthy Start programs,
- the Texas Pediatric Society, and
- Texans Care for Children.

On a national level, TOPDD is an affiliate of the National Organization on Fetal Alcohol Syndrome (NOFAS). NOFAS is a network of 32 organizations that are tackling FASD in their respective states. NOFAS has the pulse on national legislation and funding. It serves as a resource for its members to share best practices with one another around FASD prevention and related policy. NOFAS brings its members to a national conference each year.

TOPDD is also a member of the National Association of FASD State Coordinators (NAFSC). This organization has 30 members from throughout the country who have similar roles to TOPDD's Executive Director. This organization provides a national perspective on FASD—new issues, needs, and joint collaborative work, among others.

Additionally, TOPDD works closely with the FASD Center for Excellence (through SAMHSA under the auspices of Northrop Grumman Corporation) and the CDC, as well as the CDC's Southeast Regional Training Center on FASD. While each of these organizations has a different role, as a group they provide national resources, financial support, expertise, and training. Essentially, they help TOPDD to bring evidence-based practices, research, and nationally recognized models and approaches to Texas. SAMHSA's FASD Center for Excellence, for instance, has been a major funder of the Office, and through their support TOPDD was able to implement evidence-based models to prevent FASDs to local substance abuse treatment agencies. They also:

- provide nationally recognized speakers;
- support TOPDD staff and the Office's Executive Committee with technical assistance on issues such as FASD state planning and provision of opportunities to attend national conferences; and
- participate in important conversations.

Collectively, these national partners offer multiple opportunities for TOPDD to work with and learn from other organizations and to learn about the latest research.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

TOPDD has used subcontracts primarily as a result of its work with Northrop Grumman. Through the Office's most recent contract with Northrop Grumman, subcontracts were made for implementation of the Project CHOICES model, data collection, and follow-up interviews with clients through the subcontracted substance abuse treatment and recovery agencies. Subcontracts were also created for data analysis and evaluation (per requirements of contractor).

In Fiscal Year 2012, TOPDD had **eight** contracts totaling **$148,876**.

Top Five Contracts:

1) NTI Upstream (Data): Secure, review, and report on data collected from the sites implementing Project CHOICES – **$45,000**
2) Santa Maria Hostel : Implementation of Project CHOICES at the site and training, intervention implementation, and follow-up phase – **$36,000**
3) NTI Upstream (Evaluation) : Develop annual evaluation reports, sustainability plans, publish research data, and preparation on FASD intervention implementations from lessons learned – **$34,875**
4) Volunteers of America Inc. : Implementation of Project CHOICES at the site and training, intervention implementation, and follow-up phase – **$17,725**
5) NTI Upstream (Consultation) : Provide trainings, materials, and consultation on FASD efforts – **$8,751**

All of TOPDD's contracts are performance-based with specific requirements and deliverables and timelines.

TOPDD has not experienced any contracting problems.

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

In terms of its own statutes, TOPDD only recommends statutory changes related to outdated information. For instance, the statute should indicate that TOPDD is administratively attached to HHSC.

TOPDD would like clarification about its ability to advocate and put forward a legislative agenda. When TOPDD was an independent agency, it was very active in legislative issues, especially around helmets and bike safety. However, since TOPDD is part of HHSC, it is unclear what the guidelines are around this.

On a big-picture perspective, HHSC is the umbrella agency that includes a host of human services agencies, and because TOPDD touches on so many issues across the different human service agencies, the concept of the Office being placed in HHSC makes sense. The merger that created HHSC is in some ways still in progress because for so many years, each agency worked independently. As HHSC continues to develop its role as the umbrella, lead agency, TOPDD's ability to work across agencies will be enhanced.

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

One of the unique aspects of TOPDD is that it functions as a public-private partnership. Through the Executive Committees, it obtains the oversight of leaders with diverse leadership positions. TOPDD's task forces also include leaders from across the state that work in tandem to address preventable disabilities. This structure enables TOPDD to infuse the prevention of developmental disabilities across systems of care.

Another unique aspect of TOPDD is that it is expected to raise funds beyond what the Rider amount provides. What comes with this reality is that by design, the availability of outside funds (contracts, grants, etc.) would drive the work of the Office. It is noteworthy that TOPDD's ability to raise more funds for FASD in comparison to child safety and injury prevention has led to a much greater emphasis on FASD.

Member	Appointed By	Term
Garnett, Richard, Ph.D. (Chair)	Speaker of the House	2/1/2011 - 20/1/2017
Giardino, Angelo, M.D.	Lieutenant Governor	2/1/2011 - 20/1/2017
Givens, Ashley	Governor	2/1/2011 - 20/1/2017
Kiper, Valerie, DNP, MSN, RN, NEA-BC	Governor	2/1/2011 - 20/1/2017
Jackson, Jim	Speaker of the House	2/1/2011 - 20/1/2017

Roberts-Scott, Joan	Lieutenant Governor	2/1/2011 - 20/1/2017
Sokol, Marian, Ph.D., MPH	Governor	2/1/2011 - 20/1/2017
Tijerina, Mary, Ph.D., MSSW	Lieutenant Governor	2/1/2011 - 20/1/2017
Truitt, Vicki	Speaker of the House	2/1/2011 - 20/1/2017

TOPDD's public-private partnership model provides it with the clout of the state, which is extremely important in organizing task forces and collaborative efforts. Its role as a convener, planner, and facilitator on a high level is facilitated by its status as a state agency. This model also facilitates fundraising. These factors allow the agency to be flexible and to make quick decisions.

- TOPDD has three staff. The volunteer base of influential leaders is the foundation for the work of the Office. The Office provides education to hundreds of professionals on FASD. It implements evidence-based strategies, brings national resources to the state (financial and otherwise), and is the well-recognized convener around developmental disabilities to identify needs and resources and organize effective systems of care.
- TOPDD's funding has a major impact on its direction and the projects it undertakes. As a result, it cannot simultaneously address all issues that may be worthy of focus.
- The Office needs to be dynamic and to adapt to new opportunities as they arise. TOPDD must stay on the cutting edge of prevention, a very dynamic field. TOPDD has a position which allows it to respond to emerging challenges without the delay that might otherwise be expected.

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:
- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VII. GUIDE TO AGENCY PROGRAMS – CONTINUED

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Interagency Task Force for Children with Special Needs
Location/Division	1106 Clayton Lane, Austin, Texas/HPCS
Contact Name	Sherry Broberg, Acting Director
Actual Expenditures, FY 2012	Funding is included in OPCCY Expenditures
Number of Actual FTEs as of June 1, 2013	Staffing is included in OPCCY FTEs
Statutory Citation for Program	Senate Bill 1824, 81st Legislature, Regular Session, 2009

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Legislature established the Task Force for Children with Special Needs (Task Force) for the purpose of improving the coordination, quality and efficiency of services for children with special needs. The task force is charged with developing a comprehensive five-year strategic plan to address the needs of children with chronic illnesses, intellectual or other developmental disabilities or serious mental illness. Specifically, the Legislature charged the Task Force with the following duties.

- Coordinate with federal agencies to compile a list of opportunities to increase flexible funding for services for children with special needs, including alternative funding sources and service delivery options.
- Conduct a review of state agency policies and procedures related to service delivery for children with special needs.
- Perform a needs assessment, including public hearings to identify service delivery gaps, system entry points, and service obstacles.
- Develop a five-year plan to improve the coordination, quality, and efficiency of services for children with special needs.

Although the Task Force does not receive a direct appropriation and HHSC supports its activities through the Office of Program Coordination for Children and Youth under the Health Policy and Clinical Services division, the Task Force does have a separate Sunset date. As such, HHSC provided additional details related to the Task Force's creation, organization, and functions.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

Starting September 2009 through January 2011, the Task Force formed eight subcommittees that were assigned specific topics to deliver recommendations that served the basis for the Task Force Five Year Plan. The subcommittees were chaired by Task Force members and included 122 family and stakeholder members. Public hearings plus testimony from families and stakeholders guided the Task Force to produce a stakeholder survey and develop the final recommendations for a Five-Year Plan to improve the delivery and quality of services for children with special needs.

The Task Force identified in the Five-Year Plan as its highest priority, the 'Empowered and Informed Families' recommendation to address stakeholders' and families' frustration over not being able to find accurate, up to date, easily accessible and easy to find relevant information and resources. To address this priority, in June 2012, with Task Force guidance, state agencies found funds to complete a statewide formative assessment that involved parents, professionals, state staff and other stakeholders, to evaluate the need, structure and design of a potential web site to address the stakeholder needs.

In response to the assessment report findings, the Task Force began work to find funding for, develop, and implement the website as its top priority. State agency staff coordinated efforts to procure funding and initiate the web site project. This project will provide a well branded, independent website that will be the single portal for families of children, youth and young adults with special needs to access information and resources. It will bring together state, private and community resource and support information. The vision is to provide efficient, relevant and dynamic information that can be used by families, professional, agency staff and 211. Families who have access to clear, accessible information are better able to make informed decisions, secure early appropriate treatment and services and thereby potentially mitigate the intensity of long term state services. If accurate information is available that assists families in making good choices it may result in less pressure on the state system.

The second priority elected by the Task Force to implement from the Five Year Plan, is to address Crisis Prevention and Intervention. This project to develop a plan, began in November 2012 with a subcommittee comprised of cross agency staff from each of the Task Force agencies, Task Force members, parents, a state wide parent organization, Family Based Alternative representatives and a faith-based organization. The subcommittee is charged with creating a set of specific project recommendations for implementation across agencies. An interim report is due by August 31, 2013 with a final report by December 31, 2013.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

The Interagency Task Force for Children with Special Needs began operations in September 2009 and its Five Year Plan was published in October of 2011. The report can be found at: www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/TaskForce.shtml

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The Task Force affects children younger than 22 years of age diagnosed with a chronic illness, intellectual or other developmental disability, or serious mental illness and is designed to improve the coordination, quality, and efficiency of services for children with such special needs.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.

Organizationally, the Task Force is managed by the Office for Program Coordination for Children and Youth (OPCCY) Director who reports to Deputy Commissioner for Health Policy and Clinical Services. Overseen by the Governor's Office, the Task Force includes representation from the 10 agencies that work on behalf of the special needs population, four legislators, and three parents or consumer advocates and a representative from a local mental health or mental retardation authority, also known as Community Mental Health Centers that provide services to a specific geographic area of the state, called the local service area. A complete list of the Task Force members in provided below in section N.

A staff member from OPCCY supports the Task Force. The OPCCY Director is appointed by legislation as the Task Force interagency coordinator. Meetings are held on a quarterly basis, more often as necessary, to seek public input. Status updates are provided biennially to the Governor's office and the Legislature. Timelines were established and developed for the initial work to produce the Five Year Plan. Subsequent project work is being guided by the timelines.

The Task Force's top priority, the website, is in the development stage with an early 2015 completion anticipated. The Centers for Medicare & Medicaid Services is funding the project with federal Balancing Incentive Payment monies.

The second priority is implementation of a Crisis Prevention and Intervention plan and this work is being done concurrently with the web project development. A subcommittee has been working to research and produce recommendations to the Task Force by December 2013.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Expenditures related to the Task Force are absorbed by the Office of Program Coordination for Children and Youth budget.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.

The Task Force is the only interagency organization that brings together all child serving agencies, legislators, stakeholders and families to focus on this population and their needs. The Task Force is charged with not only identifying improvements to the system on a cross agency level, but also implementing them.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

The Task Force interacts with many other councils and organizations to enhance and leverage its work. The HHSC family member representative is also a member of the Children's Policy Council. The two groups, the Council and the Task Force, coordinate and support each other's work through standing agenda reports, coordination of legislative recommendations and technical assistance. A similar coordination exists with the Council on Children and Families. The Task Force web and crisis intervention plan projects involve staff from all agencies, external stakeholders, consumers and other agencies. Projects are designed in some cases to leverage and coordinate work, for example, a Texas Education Agency grant to develop information for families of young children requires coordination with the Task Force website project team.

J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.

The OPCCY staff are coordinating with the HHSC Information Technology (IT) division the website project. Since the building of the website is considered a major IT project, the HHSC IT Quality Assurance Team is following procedures required by the Department of Information Resources to ensure adherence to quality and project management compliance standards. The website is federally funds under the Affordable Care Act, therefore, OPCCY staff are also coordinating with the Centers for Medicare & Medicaid regional office.

K. If contracted expenditures are made through this program please provide:

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

Suma-Orchard Vendor: June - October 2012 – The Task Force directed the state agency to contract services for a Formative Assessment to evaluate the scope of need and relevance for a website for children with special needs, identify the structure necessary to meet the needs of the population and to identify the types of tools and relevant information. Participants included parents, professionals, state agency leadership and external stakeholders.

Expenditures for FY 2012: **$100,000**

Ensuring Accountability for Funding and Performance:
The deliverable report contained detailed information of the focus group findings that resulted in 17 recommendations, a national listing of resource websites, an inventory and recommendation of/for tools, website technical specifications and cost projections. The contractor provided HHSC with all documentation for the focus groups preparation and delivery, frequent and extensive communication, and a final comprehensive report.

Current Contracting Problems: None

L. Provide information on any grants awarded by the program.

N/A

M. What statutory changes could be made to assist this program in performing its functions? Explain.

The Task Force is an unfunded mandate. OPCCY has been successful in securing funding for the website and project management for the Crisis Prevention subcommittee. Going forward, a

reliable funding source is necessary to continue the level of success the Task Force has achieved. Additionally, the membership of the Task Force should be re-evaluated in light of the scope of the work for the special needs population. It is recommended that leadership representation from DSHS children's Mental Health and the Texas Work Force Commission be included.

N. Provide any additional information needed to gain a preliminary understanding of the program or function.

Below is a listing of the Task Force for Children with Special Needs membership.

AGENCY MEMBERS	
Kay Ghahremani, State Medicaid Director HHSC – Medicaid/CHIP Division 4900 N. Lamar Blvd., Mail Code H600 Austin, TX 78751 (512) 491-1339 kay.ghahremani@hhsc.state.tx.us	**Evelyn Delgado**, Assistant Commissioner DSHS – Family and Community Health Services Division 1100 W 49th Street, M362 – Mail Code 1920 Austin, TX 78756 (512) 458-7321 Evelyn.Delgado@dshs.state.tx.us
Kim Wedel, Assistant Commissioner DARS – Early Childhood Intervention Services 4900 North Lamar Blvd., MC3029 Austin, TX 78751 (512) 424-6751 kim.wedel@dars.state.tx.us	**Jennifer Sims**, *Deputy Director* DFPS 701 W. 51st Street, MC: E-654 Austin, TX 78751 (512) 438-4814 jennifer.sims@dfps.state.tx.us
Tracy Levins, Director of Collaborative Initiatives Texas Juvenile Justice Department 11209 Metric Boulevard Austin, TX 78758 (512) 490-7130 Tracy.levins@tjjd.texas.gov	**Barbara J. Madrigal**, Assistant Commissioner DARS – Division for Blind Services 4800 North Lamar, MC 1418 Austin, TX 78756 (512) 377-0602 Barbara.Madrigal@dars.state.tx.us
Chris Adams, *Director* DADS – Center for Policy & Innovation 701 W. 51st Street, MC W619 Austin, TX 78751 (512) 438-3518 Chris.adams@dads.state.tx.us	**B.J. Wagner**, Assistant Commissioner Texas Department of Criminal Justice Texas Correctional Office on Offenders with Medical or Mental Impairments 8610 Shoal Creek Blvd. Austin, TX 78757 (512) 465-5165 benniejo.wagner@tdcj.state.tx.us

Cindy Swain, Ph.D., Manager of Special Education Support Services Division of Federal and State Education Policy Texas Education Agency 1701 N. Congress Ave. Austin, TX 78701 (512) 463-9414 cindy.swain@tea.state.tx.us	**Linda Brooke**, Director External Affairs, Policy & Education Services Texas Juvenile Justice Department 11209 Metric Boulevard Austin, TX 78758 (512) 490-7130 linda.brooke@tjjd.texas.gov
PUBLIC and LEGISLATIVE MEMBERS	
The Honorable Jane Nelson, *State Senator* State Capitol, Room 1E.5 Austin, TX 78701 (512) 463-0112 – Austin Office (817) 424-3446 – District Office Staff Contact Stephanie Blackburn Senate Committee on Health and Human Services 201 E. 14th Street, Room 420 Austin, TX 78701 (512) 463-0360 stephanie.blackburn@senate.state.tx.us	**The Honorable Eddie Lucio, Jr.**, *State Senator* State Capitol, Room 3E.18 Austin, TX 78701 (512) 463-0127 – Austin Office (956) 548-0227 – District Office Staff Contact Sara Gonzalez Texas State Senate P.O. Box 12068 Austin, TX 78711 (512) 463-0127 Sara.gonzalez@senate.state.tx.us
The Honorable Eddie Lucio, III, *State Representative* State Capitol Extension, Room E1.318 Austin, TX 78701 (512) 463-0606 – Austin Office (956) 361-2795 – District Office Staff Contact: Houston Tower State Capitol Extension, Room E2.802 Austin, TX 78768 (512) 463-060	**The Honorable John Davis**, *State Representative* State Capitol, Room 4S.4 Austin, TX 78701 (512) 463-0734 – Austin Office (281) 333-1350 – Houston Office Staff Contact: Rachel Deason State Capitol, Room 4S.4 Austin, TX 78701 (512) 463-0734
Terry Crocker, Chief Executive Officer Tropical Texas Behavioral Health 1901 S. 24th Edinburg, TX 78549 (956) 289-7260 tcrocker@TTBH.org MHA representative appointed by Governor	**Tammy Toll,** Public Member 3913 Martingale Dr Plano, TX 75023 (214) 289-1942 tammytoll@tx.rr.com Public member appointed by TYC

Donna McCamant, Public Member 3803 Rockledge Drive Austin, TX 78731 (512) 794-8024 dmccamant@austin.rr.com Public member appointed by TEA	**John Cissik,** Public Member 3600 Cherry Blossom Lane McKinney, TX 75070 940/898-2901 jcissik@yahoo.com Public member appointed by HHSC
PROJECT COORDINATION AND LEADERSHIP	
Vacant, Policy Analyst Office of the Governor P.O. Box 12428 Austin, TX 78711 (512) 463-1778 Governor's designee	**Sherry Broberg** Office of Program Coordination for Children & Youth *Interim Director* and Task Force for Children with Special Needs *Director* HHSC 1106 Clayton Lane, Suite 225E Austin, TX 78723 (512) 420-2852 Terry.Beattie@hhsc.state.tx.us
HHSC PROJECT STAFF	
Ina Savage Texas Health and Human Services Commission P.O. Box 13247, MC 1214 Austin, TX 78711 (512) 420-2857 Ina.Savage@hhsc.state.tx.us	

O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

N/A

P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

N/A

VIII. STATUTORY AUTHORITY AND RECENT LEGISLATION

A. Fill in the following chart, 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 FY 2009 – 2013, or earlier significant Attorney General opinions, that affect your agency's operations.

Under section 531.0055 of the Government Code, HHSC is responsible for oversight of the HHS System agencies. The following list of statutes, regulations, and Attorney General Opinions includes governing authority for the programs directly administered or operated by HHSC. It does not include governing authority for the programs administered or operated by the other HHS System agencies under HHSC's oversight; that authority is included in the agencies' Self-Evaluation Reports.

Health and Human Services Commission **Exhibit 12: Statutes/Attorney General Opinions**	
Federal Statutes	
Citation/Title	**Authority/Impact on Agency**
42 U.S.C. §§1396–1 to 1396w–5	Title XIX of the Social Security Act establishes the Medical Assistance Program, commonly known as Medicaid. Medicaid is a jointly funded state–federal healthcare program that serves eligible individuals, including children, pregnant women, and elderly individuals who meet income and resource requirements. These statutes define eligibility criteria, the range of services that can be offered through the Medicaid program, and general terms and conditions for federal matching funds. HHSC administers the Texas Medicaid Program according to a State plan for medical assistance approved by the Centers for Medicare & Medicaid Services (CMS). In addition, HHSC operates several Medicaid waiver programs under Social Security Act § 1915, 42 U.S.C. § 1396n, and Social Security Act § 1115, 42 U.S.C. § 1315. Social Security Act § 1902(gg), 42 U.S.C. § 1396a(gg), requires states to maintain Medicaid eligibility standards, methods, and procedures

Health and Human Services Commission Exhibit 12: Statutes/Attorney General Opinions	
Federal Statutes	
Citation/Title	**Authority/Impact on Agency**
	until a state health benefit exchange established under the Patient Protection and Affordable Care Act (PPACA) is operational.
42 C.F.R. Parts 430–456	These federal rules, promulgated by CMS, outline the responsibilities of a State Medicaid Agency in administering a state Medicaid program. Within these federal rules and its state statutory authority, HHSC determines eligibility standards, types and range of services, payment levels for services, and administrative and operating procedures for the Texas Medicaid Program. 42 C.F.R. Part 438 addresses managed care. 42 C.F.R. Part 455 sets forth requirements for a State fraud detection and investigation program and for disclosure of information on ownership control.
42 U.S.C. §§ 1301 to 1320e–2	Title XI of the Social Security Act, 42 U.S.C. §§ 1301–1320e–2, establishes general provisions for federal programs created by the Act, including Medicaid. Under Social Security Act § 1115, 42 U.S.C. § 1315, the Secretary of Health and Human Services may approve "demonstration projects" that are likely to help promote the objectives of Medicaid and 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 programs. Under this authority and related state statutory authority, HHSC operates a demonstration project entitled the "Texas Healthcare Transformation and Quality Improvement Program." 42 U.S.C. §§ 1320a–7 to 1320a–7k address fraud and abuse in federal and state healthcare programs; establish civil and criminal penalties for violations; and outline circumstances under

Health and Human Services Commission Exhibit 12: Statutes/Attorney General Opinions	
Federal Statutes	
Citation/Title	**Authority/Impact on Agency**
	which individuals may, or must, be excluded from state and federal healthcare programs. In conjunction with other agencies, including the Texas Attorney General's Office, the Office of the Inspector General at HHSC investigates fraud, waste, and abuse in the Texas Medicaid Program, including violations of federal law.
42 C.F.R. Part 1001	These federal rules specify bases upon which individuals and entities may, or in some cases must, be excluded from participation in Medicare, Medicaid, and all other federal healthcare programs.
42 C.F.R. Part 1002	These federal rules specify certain bases upon which individuals and entities may, or in some cases must, be excluded from participation in the Medicaid program. These regulations specifically address the authority of State agencies to exclude on their own initiative, regardless of whether the federal Office of Inspector General (OIG) has excluded an individual or entity under part 1001 of this chapter. These regulations also delineate the States' obligation to inform the OIG of certain Medicaid-related convictions.
42 C.F.R. Part 1003	These federal rules impose civil monetary penalties for violations of certain federal laws, including Medicaid.
42 C.F.R. Part 495	This part provides for incentive payments to Medicaid providers for adopting, implementing, or upgrading certified EHR technology, or for meaningful use of such technology. This part also provides enhanced Federal financial participation (FFP) to States to administer these incentive payments.
42 U.S.C. §§ 1382–1382j 20 C.F.R. Part 416	When resolving Medicaid eligibility matters not specifically addressed in Medicaid law and policy, HHSC will refer to federal law related to the

Health and Human Services Commission Exhibit 12: Statutes/Attorney General Opinions	
Federal Statutes	
Citation/Title	**Authority/Impact on Agency**
	Supplemental Security Income (SSI) Program, as well as related policy guidance.
42 U.S.C. § 1395eee 42 U.S.C. § 1396d(a)(26) 42 U.S.C. § 1396u-4 42 C.F.R. Part 460	These provisions address the State option under Medicaid to provide for Medicaid payments to, and coverage of benefits under, the Program for All-Inclusive Care of the Elderly (PACE).
42 U.S.C. § 1395z 42 U.S.C. § 1395aa 42 U.S.C. § 1395bb 42 U.S.C. § 1396a 42 U.S.C. § 1396b 42 U.S.C. § 1396r 42 C.F.R. Parts 482–498	Under Social Security Act § 1902, 42 U.S.C. § 1396a, the state plan for medical assistance must provide that a state health agency, or other appropriate medical agency, is responsible for establishing and maintaining health standards for public and private institutions in which Medicaid beneficiaries receive services. Through a formula grant for State Survey Certification of Healthcare Providers and Suppliers under Title XIX, funds are made available to States for the purpose of inspecting providers and suppliers of healthcare services, to ensure mandatory adherence to Medicaid health and safety standards and conditions. Funds support or reimburse State Staff for performing survey activities and for State administration of the program. Social Security Act § 1919, 42 U.S.C. § 1396r, establishes requirements for nursing facilities. 42 C.F.R. Part 483 establishes requirements for long term care facilities; standards for training nurse-aides and for evaluating their competency; regulations regarding intermediate care facility services in facilities for individuals with intellectual disabilities or persons with related conditions; regulations regarding preadmission screening and review of individuals with an intellectual disability or a mental illness; and resident assessment instruments. Under 42 U.S.C. §§ 1395z and 1395aa, the Secretary of HHS may enter into an agreement

Health and Human Services Commission Exhibit 12: Statutes/Attorney General Opinions	
Federal Statutes	
Citation/Title	**Authority/Impact on Agency**
	with a state health agency to assist in certification of hospitals, skilled nursing facilities, rural health clinics, comprehensive outpatient rehabilitation facilities, ambulatory surgical centers, home health agencies, and hospice programs. Title 42, Chapter IV, Subchapter G, of the Code of Federal Regulations establishes conditions of participation for providers in the Medicare and Medicaid program, and provide for the use of state survey agencies that determine compliance with these conditions. The Texas Department of State Health Services (DSHS) and Texas Department of Aging and Disability Services (DADS) act as state survey agencies.
42 C.F.R. Part 1007	This part establishes State Medicaid Fraud Control Units, separate from the State Medicaid Agency.
42 U.S.C. §§ 1397aa–1397mm 42 C.F.R. Part 457	Title XXI of the Social Security Act, 42 U.S.C. §§ 1397aa–1397mm, establishes the Children's Health Insurance Program (CHIP), a state–federal matching funds program providing health insurance coverage to low-income children and pregnant women who are not eligible for Medicaid. HHSC administers CHIP according to a state plan approved by CMS.
42 U.S.C. §§ 601–619 45 C.F.R. Parts 235, 260–284	Title IV-A of the Social Security Act establishes the block grant program for Temporary Assistance for Needy Families (TANF). Created by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWOR), TANF increases state's flexibility in designing programs to (1) provide assistance to families with needy children so that children can be cared for in their own homes; (2) reduce dependency by promoting job preparation, work, and marriage; (3) reduce and prevent out-of-wedlock pregnancies; and (4) encourages the formation

Health and Human Services Commission Exhibit 12: Statutes/Attorney General Opinions	
Federal Statutes	
Citation/Title	**Authority/Impact on Agency**
	and maintenance of two-parent families. With a TANF block grant, HHSC provides financial help to low-income children and the parents or relatives who live with them. Monthly cash payments help pay for basic living needs. 45 C.F.R. Part 235 applies to state plans for financial assistance under Title IV-A of the Social Security Act. 45 C.F.R. Parts 260–284 address the structure and administration of state TANF programs. 45 C.F.R. § 235.110 requires a state agency to establish methods and standards to identify fraud in the TANF program and to refer suspected fraud to appropriate law enforcement officials.
7 U.S.C. §§ 2011–2036a	This chapter establishes the Supplemental Nutrition Assistance Program (SNAP), commonly known as the Food Stamp Program. The program alleviates hunger and malnutrition by increasing the food purchasing power of low-income households. As the state public assistance agency responsible for administering SNAP, HHSC certifies applicant households and issues electronic benefit transfer (EBT) cards.
7 C.F.R. Parts 271–280 and 282–283	These federal rules relate to SNAP and the food distribution program. 7 C.F.R. Part 272 discusses nutrition education and outreach. 7 C.F.R. § 273.16(a)(1) directs that "state agency shall be responsible for investigating any case of alleged intentional program violation." 7 C.F.R. § 273.18 requires the state agency to establish and collect claims against recipients when benefits are overpaid or when recipients intentionally violate SNAP rules by trafficking benefits.
8 U.S.C. §§ 1521–1524 45 C.F.R. Part 400	These provisions authorize programs for domestic resettlement of and assistance to refugees. Through this program, the federal Office of Refugee Resettlement approves grants

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	to states for programs that facilitate refugee employment and achievement of self-sufficiency. HHSC works with the federal government and local non-profit organizations to help refugees with asylum status and victims of severe forms of human trafficking. Services include cash, medical assistance, interpretation and translation services, job training, English language training, education, and cultural orientation services.
42 U.S.C. §§ 10401–10420 45 C.F.R. Part 1370	The Family Violence Prevention and Services Act, 42 U.S.C. §§ 10401–10420, assists states in efforts to (1) increase public awareness about, and primary and secondary prevention of family violence, domestic violence, and dating violence; and (2) provide immediate shelter and supportive services for victims of family violence, domestic violence, or dating violence, and their dependents. The Act also provides for technical assistance and training relating to family violence, domestic violence, dating violence programs, and the national domestic violence hotline. With federal funding from this Act, HHSC operates the Family Violence Program. The program provides emergency shelter and support services to victims of family violence and their children, educates the public, and provides training and prevention support to various agencies.
42 U.S.C. § 5174 44 C.F.R. Part 206	In accordance with this section, the President, in consultation with the governor of a State, may provide financial assistance; and, if necessary, direct services, to individuals and households in the State who, as a direct result of a major disaster, have necessary expenses and serious needs. This assistance is only for cases in which the individuals and households are unable to meet such expenses or needs through other

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	means. HHSC's Disaster Assistance Program provides money or assistance to those whose property has been damaged or destroyed in a federally declared disaster.
45 C.F.R. Part 92	This part establishes uniform administrative rules for Federal grants and cooperative agreements; and sub-awards to State, local and Indian tribal governments. 45 C.F.R. § 92.42 addresses record retention.
45 C.F.R. Part 16	This part contains requirements and procedures applicable to certain disputes arising under programs administered by the United States Department of Health and Human Services (HHS). This part provides for appeal from written final decisions through the Departmental Appeals Board (DAB). As stated in 42 C.F.R. § 434.78, HHSC may request reconsideration of a disallowance of federal financial participation (FFP) related to the Texas Medicaid Program using these appeal procedures. These appeal procedures are also applicable to discretionary grant disputes, such as those related to 1115 waivers.
45 C.F.R. Part 74	This part establishes uniform administrative requirements governing sub-grants or other sub-awards awarded under HHS grants and agreements administered by State, local and Indian Tribal governments.
45 C.F.R. Parts 80, 84, 91	These provisions prohibit discrimination on the basis of race, color, national origin, handicap, and age, in programs and activities receiving or benefiting from federal financial assistance through HHS.
42 U.S.C. § 1786 7 C.F.R. Part 246	42 U.S.C. § 1786 establishes the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). This federal grant

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	program provides food, nutrition education, and referrals to health and other social services to low-income pregnant, postpartum, and breastfeeding women, and infants and children up to age 5 who are at nutrition risk. As required by Social Security Act § 1902(a)(11), 42 U.S.C. § 1396a(a)(11), HHSC provides for timely coordination between the WIC program, which is operated by the Department of State Health Services (DSHS), and the Texas Medicaid Program.
42 U.S.C. §§ 1397–1397h	Title XX, Subtitle A, of the Social Security Act establishes block grants to the states for social services. These grants may be used to fund the following services: child care services; protective services for children and adults; services for children and adults in foster care; services related to the management and maintenance of the home; day care services for adults; transportation services; family planning services; training and related services; employment services; information, referral, and counseling services; the preparation and delivery of meals; and health support services and appropriate combinations of services designed to meet the special needs of children, the elderly, the blind, persons with a disability, persons with emotional disturbances, and persons with substance use disorders. HHSC coordinates and oversees this block grant and related services provided by HHSC and other health and human services agencies.
42 U.S.C. § 300u-6	The U.S. Department of Health and Human Services, Office of Minority Health, operates the State Partnership Grant Program to Improve Minority Health. HHSC uses this grant to address significant disparities in heart disease, stroke,

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	and obesity within minority populations.
42 U.S.C. § 711	This PPACA provision establishes Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs. With a formula grant, Texas is implementing an evidence-based home visiting program in seven communities across the state. The program will contribute to the development of a comprehensive early childhood system that promotes maternal, infant, and early childhood health, safety, and development; and strong parent-child relationships in these communities.
Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4108, 124 Stat. 119, 561 (2010)	This PPACA provision authorizes Medicaid Incentives for Prevention of Chronic Disease. These grants fund a comprehensive, evidence-based, widely available, and easily accessible program, proposed by the State and approved by the Secretary of HHS, that is designed and uniquely suited to address the needs of Medicaid beneficiaries and has demonstrated success in helping individuals achieve one or more of the following: (1) ceasing use of tobacco products; (2) controlling or reducing their weight; (3) lowering their cholesterol; (4) lowering their blood pressure; and (5) avoiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition.
42 U.S.C §§ 5106–5106a	These statutes establish Children's Justice Grants to States. With these grants, states develop, establish, and operate programs designed to improve the child-protection system. These programs improve screening, forensic diagnosis, and health and developmental evaluations of children who have been subjects of substantiated cases of child abuse or neglect. The grant facilitates training opportunities for state and local governmental entities and community service providers.

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42 U.S.C. § 300jj-33	This provision establishes State Grants to Promote Health Information Technology. These grants facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards. With funding authorized by 42 U.S.C. § 300jj-33, HHSC administers a local health information exchange (HIE) grant program that partially funds planning, development, and operations of local and regional HIE networks.
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Government Code Chapter 531	Chapter 531 creates the Health and Human Services Commission and sets out its duties and authority. The chapter also contains provisions regarding the administration of the Medicaid program, the financial assistance program (TANF), Medicaid and financial assistance fraud, and provisions related to most Health and Human Services Commission programs. Chapter 531 comprises Subchapters A through W.
Government Code Chapter 531, Subchapter A	Subchapter A contains general provisions and sets out the organization of HHSC. The subchapter creates the office of EC of the Commission, who is appointed by the Governor with the advice and consent of the senate; and confers on that office broad authority to implement various health and human services programs at HHSC and to oversee the operational implementation of other health and human services programs by the other four HHS agencies created by law, DADS, DARS, DFPS, and

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	DSHS. Section 531.0055 sets out the EC's broad authority. Additionally, the EC is required to adopt rules to implement HHS programs on behalf of all the HHS agencies and to appoint, with the approval of the Governor, the Commissioner of each HHS agency. HHSC is directed to directly operate the following HHS programs: the medical assistance program under Chapter 32, Human Resources Code (Medicaid); the two child health programs under Chapters 62 (CHIP) and 63, Health and Safety Code; the nutrition assistance program under Chapter 31, Human Resources Code (SNAP); the financial assistance program under Chapter 33, Human Resources Code (TANF); long-term care services, as defined by Section 22.0011, Human Resources Code determining eligibility); and community-based support services, as identified by Section 531.02481 of Government Code (determining eligibility). The EC has operational authority and responsibility for the programs administered by the other HHS agencies.
Government Code Chapter 531, Subchapter B	Subchapter B sets out the powers and duties of HHSC. The subchapter outlines detailed powers and duties regarding the operation of the state Medicaid program, including provisions governing the implementation of a managed care model for the provision of medical assistance, the child health plan program established by Chapter 62, Health and Safety Code, and the TANF program established by Chapter 31, Human Resources Code. The Commission is required to adopt a Medicaid Bill of Rights, setting out the responsibilities and rights of each recipient of medical assistance. At

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	the same time, the Commission is directed to provide support and information services to a person enrolled in or applying for Medicaid coverage who experiences barriers to receiving healthcare services. The Commission is directed to administer and operate the medical transportation program. The Commissioner is required to develop a coordinated, six-year strategic plan for health and human services in this state and must update the plan biennially. The Commission is directed to operate the vendor drug program and the Medicaid Drug Utilization Review program.
Government Code Chapter 531, Subchapter C	Subchapter C creates the Office of Inspector General in HHSC, who investigates fraud, waste, abuse, and overcharges in Medicaid and in other health and human services. The inspector general is appointed by the Governor with the advice and consent of the senate. The subchapter sets out detailed provisions governing inspector general investigations and administrative hearings. The inspector general is required to coordinate certain investigations with and to assist the Office of Attorney General in certain investigations. The subchapter creates the Medicaid and Public Assistance Fraud Oversight Task Force, which advises and assists the Commission and the Commission's office of inspector general in improving the efficiency of fraud investigations and collections. The subchapter also includes provisions governing the investigation of fraud, waste, and abuse by managed care organizations in the provision of Medicaid.

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	The subchapter also confers authority on the HHSC-OIG to investigate fraud in the financial assistance program (TANF).
Government Code Chapter 531, Subchapter D	Subchapter D creates the Guardianship Advisory Board. The board advises the Commission and the Department of Aging and Disability Services with regard to the creation of a statewide guardianship program and the development of a proposal for a statewide guardianship program. Additionally, the board reviews and comments on the guardianship policies of all health and human services agencies and recommends changes to the policies the advisory board considers necessary or advisable.
Government Code Chapter 531, Subchapter D-1	Subchapter D–1 governs permanency planning for children below the age of 22. HHSC and each appropriate health and human services agency is required to develop procedures to ensure that a permanency plan is developed for each child who resides in an institution in the state on a temporary or long-term basis or with respect to whom the Commission or appropriate health and human services agency is notified in advance that institutional care is sought.
Government Code Chapter 531, Subchapter E	Subchapter E governs health and human services legislative oversight and provides that the standing or other committees of the house of representatives and the senate that have jurisdiction over the Health and Human Services Commission and other agencies relating to implementation of Chapter 531 must monitor the Commission's implementation of Section 531.0055 and the Commission's other duties in consolidating and integrating health and human services to ensure implementation consistent with law. Additionally, the committees are directed to recommend adjustments to the

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	implementation of Section 531.0055 and the Commission's other duties in consolidating and integrating health and human services. Finally, the committees are required to review the rulemaking process used by the Commission, including the Commission's plan for obtaining public input.
Government Code Chapter 531, Subchapter F	Subchapter F governs integrated enrollment services and requires HHSC, subject to the approval of the Governor and the Legislative Budget Board, to develop and implement a plan for the integration of services and functions relating to eligibility determination and service delivery by health and human services agencies, the Texas Workforce Commission, and other agencies.
Government Code Chapter 531, Subchapter G-1	Subchapter G–1 governs developing local mental healthcare systems for certain children and requires HHSC to form a consortium to develop criteria for and implement the expansion of the Texas Integrated Funding Initiative pilot project; and to develop local mental healthcare systems in communities for minors who are receiving residential mental health services or who are at risk of residential placement to receive mental health services.
Government Code Chapter 531, Subchapter H	Subchapter H creates the Office of Early Childhood Coordination within HHSC and directs the office to create and implement a statewide strategic plan for the delivery of health and human services to children younger than six years of age. The goals of the office are to promote community support for parents of all children younger than six years of age through an integrated state and local-level decision-making process and provide for the seamless delivery of health and human services to all children

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	younger than six years of age to ensure that all children are prepared to succeed in school.
Government Code Chapter 531, Subchapter I	Subchapter I governs a state prescription drug program and requires HHSC to develop and implement a state prescription drug program that operates in the same manner as the vendor drug program operates in providing prescription drug benefits to recipients of medical assistance under Chapter 32, Human Resources Code. The subchapter lists those persons who would be eligible for prescription drug benefits under the program.
Government Code Chapter 531, Subchapter J	Subchapter J governs the provision of information about patient assistance programs, which refers to a program offered by a pharmaceutical company under which the company provides a drug to persons in need of assistance at no charge or at a substantially reduced cost. The subchapter requires each pharmaceutical company that does business in this state and that offers a patient assistance program to inform the Commission of the existence of the program, the eligibility requirements for the program, the drugs covered by the program, and information such as a telephone number used for applying for the program.
Government Code Chapter 531, Subchapter J-1	Subchapter J–1 requires HHSC to develop and implement a program designed to assist domestic victims, including victims who are children, in accessing necessary services.
Government Code Chapter 531, Subchapter K	Subchapter K creates the Health and Human Services Council to assist the EC in developing rules and policies for the Commission.
Government Code Chapter 531, Subchapter L	Subchapter L governs the service provision for certain children with multiagency needs. The

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	subchapter requires the consortium that oversees the Texas Integrated Funding Initiative to prepare a report of recommendations, based on an evaluation developed by each community resource coordination group regarding the provision of systems of care services in the community served. The consortium is directed to create a summary report based on the evaluations in the reports submitted to the consortium by community resource coordination groups. The consortium'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.
Government Code Chapter 531, Subchapter N	Subchapter N directs the EC to seek a federal waiver governing the provision of health care in accordance with very detailed instructions set out in statute regarding the nature of the waiver. Subject to approval of the waiver, the Texas health opportunity pool trust fund is created as a trust fund outside the state treasury to be held by the comptroller and administered by the Commission as trustee on behalf of residents of this state who do not have private health benefits coverage and healthcare providers providing uncompensated care to those persons.
Government Code Chapter 531, Subchapter O	Subchapter O uncompensated hospital care and directs the EC to adopt rules providing for a standard definition of "uncompensated hospital care", a methodology to be used by hospitals in this state to compute the cost of that care that incorporates the standard set of adjustments set out in the subchapter, and procedures to be used by those hospitals to report the cost of that care

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	to the Commission and to analyze that cost.
Government Code Chapter 531, Subchapter Q	Subchapter Q directs the EC to establish the Nurse–Family Partnership Competitive Grant Program to award grants for the implementation of nurse-family partnership programs, the expansion of existing programs, and for the operation of those programs for a period of not less than two years.
Government Code Chapter 531, Subchapter R	Subchapter R requires the Executive Commissioner (EC) to establish the Advisory Committee on Qualifications for Healthcare Translators and Interpreters, which directed to establish and recommend qualifications for healthcare interpreters and healthcare translators.
Government Code Chapter 531, Subchapter S	Subchapter S governs the Community-based Navigator Program. The subchapter provides that, if the EC determines that a statewide community-based navigator program can be established and operated using existing resources and, without disrupting other Commission functions, the Commission should establish a statewide community-based navigator program. The Commission is direct to train and certify as navigators volunteers and other representatives of faith- and community-based organizations to assist individuals applying or seeking to apply online for public assistance benefits through the Texas Integrated Eligibility Redesign System (TIERS) or any other electronic eligibility system that is linked to or made a part of that system.
Government Code Chapter 531, Subchapter T	Subchapter T creates the Council on Children and Families. The council is established to coordinate the state's health, education, and human services systems to ensure that children and

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	families have access to needed services; and to improve coordination and efficiency in state agencies, advisory councils on issues affecting children, and local levels of service. Additionally, the council is required to prioritize and mobilize resources for children, to facilitate an integrated approach to providing services for children and youth; and to promote the sharing of information regarding children and their families among state agencies.
Government Code Chapter 531, Subchapter U	Subchapter U governs the creation of a mortality review system for certain individuals with developmental disabilities.
Government Code Chapter 531, Subchapter V	Subchapter V directs HHSC to develop an electronic health information exchange system to improve the quality, safety, and efficiency of healthcare services provided under the child health plan and Medicaid programs. The subchapter creates an advisory committee to make recommendations regarding the system and sets out detailed requirements governing the development of such a system.
Government Code Chapter 531, Subchapter W	Subchapter W creates a Task Force to Address the Relationship Between Domestic Violence and Child Abuse and Neglect, which is directed to develop policy recommendations for addressing the relationship between family violence, and child abuse and neglect; and to develop comprehensive statewide best practices guidelines for both child protective services and family violence shelter centers. The subchapter expires September 1, 2013. Subchapter W governs adverse licensing, listing, or registration decisions made by HHS agencies. The subchapter requires each health and human services agency that regulates a person who is required to have a license for certain regulated

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	occupations to maintain a record of each application for a license, including a renewal license or a license that does not expire; a listing or registration that is denied by the agency under the law authorizing the agency to regulate the person; and each license, listing, or registration that is revoked, suspended, or terminated by the agency under the applicable law.
Government Code Chapter 533	Chapter 533 governs the implementation of the Medicaid Managed Care Program. The chapter sets out detailed provisions regarding the implementation of a managed care delivery model, as opposed to a fee-for-service delivery model, for the Medicaid program, including the services that must be delivered to recipients the provisions that must be included in contracts for services between managed care organizations and HHSC. The chapter also requires the creation of regional Medicaid managed care advisory committees and outlines the committees' powers and duties. Additionally, the chapter requires the creation of a state-wide Medicaid managed care advisory committee and outlines its powers and duties. Finally, the chapter delineates principals of an integrated care management model for Medicaid managed care and directs the Commission by rule to develop such a model. The EC is authorized to create a state-wide integrated care management advisory committee to assist in the development and implementation of an integrated care management model.
Government Code Chapter 535	Chapter 535 governs the provision of human services and other social services through faith-based and community-based organizations. The chapter requires certain listed agencies,

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	including HHSC and the HHS agencies, to each appoint a liaison to work with faith-based and community-based organizations to encourage and facilitate such organizations in providing healthcare and social services. Additionally, the chapter creates a "Renewing our Communities" account in the General Revenue fund, with money deposited to the account designated for awarding grants to further the purposes of the chapter.
Government Code Chapter 536	Chapter 536 requires the creation of the Medicaid and CHIP quality-based payment advisory committee for the purpose of: (a) developing reimbursement systems used to compensate physicians or other healthcare providers under those programs that reward the provision of high-quality, cost-effective health care, and quality performance and quality-of-care outcomes with respect to healthcare services; and (b) establishing standards and benchmarks for quality performance, quality-of-care outcomes, efficiency, and accountability by managed care organizations and physicians and other healthcare providers. The Commission, in consultation with the advisory committee, is required to create quality-based outcome and process measures that promote the provision of efficient, quality health care; and that can be used in the child health plan and Medicaid programs to implement quality-based payments for acute and long-term care services across all delivery models and payment systems, including fee-for-service and managed care payment systems.
Government Code Chapter 537	Chapter 537 directs the EC to seek federal approval for the Medicaid Reform Waiver and details the objectives the Waiver must achieve.

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Health and Safety Code Chapter 32	Under authority conferred by Chapter 32, DSHS created the Texas Women's Health Program, which is funded with money appropriated to HHSC. HHSC by contract administers the program.
Health and Safety Code Chapter 62	Chapter 62 is the state enabling legislation for the federal children's health insurance program (CHIP), Title XXI of the Social Security Act (42 U.S.C. Sections 1397aa et seq.). The program is a federal/state program, with the state providing funds to drawn down federal matching funds. The chapter confers administration of the program to HHSC, and requires HHSC to develop a state-designed child health plan program to obtain health benefits coverage for children in low-income families. The chapter sets out eligibility standards for children seeking coverage and cost-sharing requirements for recipients. The chapter also sets out detailed provisions that govern the benefits of plans and the conduct of healthcare providers.
Health and Safety Code Chapter 63	Chapter 63 governs the provision of health benefits to the children of undocumented immigrants, as permitted by federal law (8 U.S.C. Sections 1641 et seq.), who are not eligible for healthcare benefits provided by either the child health plan program established under Chapter 62, Health and Safety Code, or the medical assistance program established under Chapter 32, Human Resources Code. HHSC is directed to develop and implement a program to provide healthcare benefits to qualifying children. The program is entirely state-funded; the state receives no federal matching funds.

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Health and Safety Code Chapter 104	Chapter 104 creates the Statewide Health Coordinating Council, which includes as a member the EC. In accordance with rules adopted by the Council, DSHS is directed to develop a statewide health plan every six years. DSHS is required to submit the plan to HHSC for review and comment before it submits the plan to the Governor. HHSC is directed to adopt rules setting out procedures for the collection of data that DSHS will follow in preparation of the plan.
Health and Safety Code Chapter 107A	Chapter 107A requires the EC to maintain the Center for the Elimination of Disproportionality and Disparities, which is directed to work with various public and private sector entities in an effort to decrease or eliminate health and health access disparities among racial, multicultural, disadvantaged, ethnic, and regional populations. The primary duties of the Center involve the dissemination of information, coordinating conferences and training activities, pursuing and administering grants, and publicizing information regarding health disparities.
Health and Safety Code Chapter 260	Chapter 260 requires the EC to adopt model standards for the operation of boarding home facilities. Counties and municipalities are authorized require local boarding home facilities to comply with the model standards.
Human Resources Code Chapter 22	Chapter 22 confers on the EC the power and duties conferred by earlier enacted legislation on the board of the department of human services and the Commissioner of the department. The chapter provides that, notwithstanding any other provision of law, the department may extend the scope of its programs to the extent

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	necessary to ensure that federal matching funds are available, if the department determines that the extension of scope is feasible and within the limits of appropriated funds. Additionally, the chapter provides that, if the department determines that a provision of state welfare law conflicts with a provision of federal law, the department may promulgate policies rules necessary to allow the state to receive and expend federal matching funds to the fullest extent possible in accordance with the federal statutes, the provisions of this title, the state constitution, and within the limits of appropriated funds. The chapter also authorizes the department to conduct research and demonstration projects that will assist in promoting the purposes of the department's assistance programs. The department may conduct the projects independently or in cooperation with a public or private agency.
Human Resources Code Chapter 23	Chapter 23 sets forth administrative procedures for suspension of a person's driver's or recreational license if that person has failed to reimburse the HHSC for SNAP or TANF overpayments.
Human Resources Code Chapter 31	Chapter 31 directs the executive Commission to implement the federal/state program governing the provision of financial assistance and services to families with dependent children (TANF). Subchapter A sets out detailed eligibility requirements, including a requirement that an adult recipient sign and comply with a responsibility agreement. Subchapter B contains provisions governing the administration of the financial assistance

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	program, including outlining processes for submitting an application for assistance, procedures for applying a denial of assistance, and limitations on the use of financial assistance. Subchapter C governs limitations on the amount of financial assistance that may be awarded.
Human Resources Code Chapter 32	Chapter 32 governs the medical assistance program commonly known as Medicaid. Subchapter A sets out general provisions and definitions for terms and phrases in the chapter. Subchapter B sets out very detailed provisions governing eligibility and the administration of the program. Subchapter C requires the EC to establish and administer an electronic, searchable, and Internet-based database of all participating providers in the medical assistance program. Subchapter E authorizes the EC, to the extent allowed by federal law, to adopt rules allowing HHSC to permit, facilitate, and implement the use of health information technology for the medical assistance program to allow for electronic communication among the Commission, the operating agencies, and participating providers. Subchapter F creates the partnership for long-term care program, which is administered as part of the medical assistance program by HHSC with the assistance of the Texas Department of Insurance. The program is required to be consistent with provisions governing the expansion of a state long-term care partnership program established under the federal Deficit Reduction Act of 2005.
Human Resources Code Chapter 33	This chapter covers Nutritional Assistance, including Food Stamps (SNAP), Commodity

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	Distribution, the Child and Adult Care Food Program, and the Summer Food Service Program. Subchapter A sets out very detailed provisions governing the administration of the programs. Subchapter B contains provisions designed to more efficiently administer SNAP, including the provision of application assistance, using technology to promote efficiency and fraud prevention; and implementing workforce management improvements.
Human Resources Code Chapter 34	Chapter 34 covers temporary assistance and related support services, which is not a component of the financial assistance program (TANF) under Chapter 31. HHSC and the Texas Workforce Commission, with the participation of local workforce development boards, is directed to jointly develop and implement a state program of temporary assistance and related support services that is distinct from the financial assistance program authorized by Chapter 31. Temporary assistance and related support services may be provided under the state program only to two-parent families or persons residing in minimum service counties, as defined by the Texas Workforce Commission. Temporary assistance and related support services provided under the state program may not be funded with federal money provided to the state for the financial assistance program authorized by Chapter 31.
Human Resources Code Chapter 35	Chapter 5 governs the state's program for providing subsidies for support services for persons with disabilities. The chapter directs HHSC to adopt rules to implement and administer the chapter, including: (1) procedures and guidelines for determining eligibility standards relating to financial

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	qualifications and the need for services, and for determining eligibility criteria for selecting clients to receive assistance; (2) standards and procedures for approving qualified programs and support services; (3) procedures for conducting a periodic review of clients; (4) procedures and guidelines for determining when assistance duplicates other support programs or results in excessive support to a client; (5) reasonable payment rates for qualified programs and support services under this chapter; and (6) a copayment system.
Insurance Code Chapter 843	Chapter 843 sets out provisions governing health maintenance organizations. Many, but not all of the provisions of the chapter, affect the MCOs with which HHSC contracts.
Insurance Code Chapter 847	Chapter 847 governs healthcare quality assurance and contains provisions relating to presumed compliance with certain statutory and regulatory requirements.
Insurance Code Chapter 1207	Chapter 1207 sets forth provisions related to enrollment of medical assistance recipients and children eligible for the state child health plan.
Occupations Code Chapter 102	This chapter governs the solicitation of patients by licensed healthcare providers.

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GA-0777 (2010)	Construes section 17.10(b) (2) of the 2010-2011 General Appropriations Act, which provides for a transfer of funds to the Texas Rail Relocation and Improvement Fund if appropriations to a State Highway Fund had been reduced to fund other agencies. The opinion concludes that "[i]t is unclear whether a court would conclude" that the transfer of funds to the Health and Human Services Commission in the 2008-2009 General Appropriations Act, and the absence of such transfer in the 2010-2011 General Appropriations Act, represents a "gain" for purposes of the section 17.10(b)(2) calculation.
GA-0844 (2011)	Concludes that federal law does not preempt 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.)
GA-0845 (2011)	Confirms HHSC's authority to define by rule the term "affiliate," if the definition is consistent with 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.)
GA-0889 (2011)	Concludes that the Medicaid and Public Assistance Fraud Oversight Task Force, created under Government Code section 531.107 to advise and assist HHSC and HHSC's Office of Inspector General in improving the efficiency of fraud investigations and collections, is not subject to Government Code chapter 2110; which, among other things, provides for

Health and Human Services Commission Exhibit 12: Statutes/Attorney General Opinions	
Attorney General Opinions	
Citation/Title	**Authority/Impact on Agency**
	reimbursement of advisory committee members limits the duration of advisory committees.
GA-0947 (2012)	Applies to HHSC to the extent it uses SOAH. If the State Office of Administrative Hearings assesses its fee for a contested case hearing to the party that does not prevail in the hearing, it should bill the non-governmental party if the state agency prevails. If the non-governmental party prevails, SOAH should bill the state agency if the agency is not one of those listed in Rider 7c of SOAH's 2012-13 appropriation. HHSC is not listed in Rider 7c. (Note: Rider 7c has been carried forward into the 2014-15 appropriations act.)
GA-0983 (2013)	Concludes that, to the extent that 1 TAC 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 Human Resources Code section 32.050(c) and is unenforceable.
GA-1004 (2013)	Concludes that Government Code section 813.202 likely authorizes the Employees Retirement System to require the payment of interest to establish service credit of an employee who has been reinstated after wrongful termination. It is then for HHSC to determine, in the first instance, the manner in which it will pay interest to the Employees Retirement System to establish service credit for an employee who is reinstated after wrongful termination. (Note: The Legislature amended section 813.202(c) in 2013 to provide specifically for the payment of state contribution for interest.)

B. B. Provide a summary of recent legislation regarding your agency by filling in the chart below or attaching information already available in an agency-developed format. Briefly summarize the key provisions. For bills that did not pass, 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.

Health and Human Services Commission Exhibit 13: 83rd Legislative Session Chart		
Legislation Enacted – 83rd Legislative Session		
H.B. 12	Flynn	Bill requires agencies to post information on their websites regarding salary supplements to all employees and salary information for senior staff.
H.B. 15	Kolkhorst	Bill requires HHSC, DSHS, and an appointed Perinatal Advisory Council to work together to develop a process for the designation of levels of neonatal and maternal care at hospitals. The EC must appoint the Council by December 1, 2013, and the Council must submit a report by September 1, 2015.
H.B. 16	Flynn	Bill requires agencies to post their internal audit plan and annual internal audit report on their website.
H.B. 194	Farias	Bill adds disabled veterans to the HUB definition.
H.B. 243	Menendez	Bill allows a community center to sell real property without approval from HHS agencies if it was acquired with private funds.
H.B. 367	Martinez	Bill protects the confidentiality of information and records of constituents who submit casework to legislators or the Lt. Governor when it is disclosed to an agency.
H.B. 595 Section 1 only	Kolkhorst	Bill extends HHSC's control of the formulary / Preferred Drug List (PDL) until August 31, 2018.
H.B. 617	Rodriguez, E.	Bill directs TEA to work with HHSC to develop a web-based transition and employment guide for students enrolled in special education programs as they exit the school system, by September 1, 2014.
H.B. 634	Farias	Bill requires TDCJ to utilize data from the Public Assistance Reporting Information System (PARIS) match system to investigate and verify the veteran status of each inmate.

Health and Human Services Commission Exhibit 13: 83rd Legislative Session Chart		
Legislation Enacted – 83rd Legislative Session		
H.B. 808	Zerwas	Bill authorizes licensed psychologists to delegate tests and services to a psychologist with a temporary or provisional license or with new licensure that does not allow eligibility for managed care panels.
H.B. 970	Rodriguez, E.	Bill requires HHSC to revise existing rules regarding cottage food preparation by January 1, 2014.
H.B. 1023	Burkett	Bill requires a report of recommendations regarding mental health workforce shortages by September 1, 2014.
H.B. 1025 Section 24	Pitts	Section appropriates $137.8 million from Account 5111 (Trauma Facility and EMS) to DSHS for the purposes of entering into an IAC with HHSC to use the funds for the non-federal share of the DSH program for FY 2013.
H.B. 1128	Herrero	Bill requires agencies with more than 1,500 employees to allow employees to submit cost savings ideas online and allow the public to vote on them.
H.B. 1382	Simpson	Bill allows HHSC to adopt rules for temperature requirements for food sold at, prepared on-site at, or transported to or from, a farmers' market by December 1, 2013.
H.B. 1392	King, S.	Bill requires HHSC to adopt rules regarding DSHS response to inquiries regarding food regulation and to periodically evaluate DSHS food safety rules.
H.B. 1487	Harper-Brown	Bill requires agencies that award grants of greater than $25,000 to post the purpose of the grant on their website.
H.B. 1605	Davis, S.	Bill establishes a pilot program in Harris County to create pregnancy medical homes that will provide coordinated, evidence-based maternity care management to women enrolled in Medicaid managed care. A report is due by January 1, 2015.
H.B. 1632	Fletcher	Bill protects identifying information of peace officers, including date of birth, address, and phone numbers.
H.B. 1738	Naishtat	Bill requires HHSC to adopt rules prescribing the manner in which a person is informed of the rights of persons apprehended, detained, or transported for emergency detention.

Health and Human Services Commission Exhibit 13: 83rd Legislative Session Chart		
Legislation Enacted – 83rd Legislative Session		
H.B. 1960	Cortez	Bill requires HHSC to adopt rules allowing an individual to be eligible for emergency medical services personnel certification through reciprocity if they have successfully completed training through the military by January 1, 2014.
H.B. 1965	Harper-Brown	Bill adds HHSC to the Contract Advisory Team (CAT); it requires the CAT to make recommendations on contracts over $10 million and develop new policies and procedures to improve state agency contracting.
H.B. 2020	Crownover	Bill allows agencies to offer financial incentives and provide on-site clinic or pharmacy services in their wellness programs.
H.B. 2414	Button	Bill allows a member of a governmental body to participate remotely in an Open Meeting via videoconference call if the video and audio feed of the member is broadcast live at the meeting.
H.B. 2550	Patrick	Bill requires the Texas Higher Education Coordinating Board to create a Residency Physician Expansion Grant Program to encourage creation of new GME slots, and requires HHSC to verify eligibility and seek Medicaid matching funds.
H.B. 2562	Farias	Requires the HHSC, DADS, the Texas Veterans Commission, and the Veterans Land Board to prepare a report by October 1 of each year regarding usage of the Public Assistance Reporting Information System in identifying and obtaining US Department of Veterans Affairs benefits for those receiving Medicaid and other public benefits.
H.B. 2620	Collier	Bill requires the EC to appoint a Task Force on Domestic Violence and the task force to submit a report by September 1, 2015.
H.B. 2673	Price	Bill changes the types of entities HHSC may contract with to conduct mortality review activities and expands the programs that must undergo mortality reviews to include all 1915(c) waivers serving individuals with intellectual or developmental disabilities. It also requires contractors of DADS, DSHS, or HHSC to undergo background checks if they will be in contact with individuals served in SSLCs.
H.B. 2873	Harper-Brown	Bill requires the Contract Advisory Team (HHSC is a member) to identify the types of procurements that post a low risk of loss to the state and develop a model contract management process for use with these.

Health and Human Services Commission Exhibit 13: 83rd Legislative Session Chart		
Legislation Enacted – 83rd Legislative Session		
H.B. 3093	Elkins	Bill directs DIR to develop contracting standards for agency purchase of information resources technologies.
H.B. 3116	Cook	Bill requires agencies to include purchasing in their enterprise resource planning systems (CAPPS for the HHS agencies) and provide reimbursement to the Comptroller for those services.
H.B. 3196	Price	Bill requires HHSC to adopt rules staggering nursing facility Alzheimer's certification periods and allows HHSC to adopt rules requiring an applicant for nursing facility Medicaid to provide a performance bond.
H.B. 3285	Davis, Y.	Bill requires HHSC to adopt rules requiring facilities reporting healthcare associated infections to DSHS to include if the patient died as a result of the infection.
H.B. 3556	Kolkhorst	The bill would add additional licensure requirements for emergency medical services (EMS) providers. The bill states the Commissioner may suspend, revoke, or deny an EMS provider license in cases of fraud or criminal conviction. The bill also requires Medicaid EMS providers to provide HHSC a $50,000 surety bond as a condition of enrollment.
H.B. 3648	Harper-Brown	Bill requires substantial compliance to contracts before material changes can be made, and requires agencies to only contract with nonresident bidders in situations where their bids are lower than a resident bidder by the amount that would be required in the nonresident bidder's state to get a comparable contract.
H.B. 3793	Coleman	Bill creates new requirements for counties, including changing county obligation requirements to provide healthcare services.
S.B. 7	Nelson	Bill requires all Medicaid eligible populations with intellectual or developmental disabilities to receive acute care services in a managed care model and seeks to integrate acute and long-term care services. The bill also expands STAR+PLUS to new populations, provides attendant and habilitation services for eligible individuals with disabilities, mandates children with disabilities into the STAR Kids managed care model, and addresses quality-based payments.
S.B. 8 Data Analysis Unit and Article IX Sec	Nelson	Section direct establishment of a data analysis division. Rider appropriates $452K and 21.6 FTEs in 2014, and $446K and 34.1 FTEs in 2015.

Health and Human Services Commission Exhibit 13: 83rd Legislative Session Chart		
Legislation Enacted – 83rd Legislative Session		
18.32		
S.B. 8 Medical Transportation	Nelson	Sections require an MOU with DMV and DPS to obtain eligibility information for Medical Transportation Program clients; mandate delivery of MTP through a managed care model by September 1, 2014; and clarify legislative intent on transport of minors.
S.B. 8 Ambulance and EMS Studies	Nelson	By January 1, 2014, sections require reviews of laws and policies related to use of nonemergency ambulance, licensure of nonemergency transport, and delegation of health care to EMS personnel.
S.B. 8 Prior Authorization	Nelson	Sections direct a review of PA processes and require a study of standard PAs by December 31, 2014.
S.B. 8 OIG Sections and Article IX Sec 18.32	Nelson	Sections require OIG employment of a maximum of five peace officers; require revocation of a provider's enrollment based on federal debarmen; establish the beginning date of a mandatory ineligibility period resulting from a false claims lawsuit; and require a report regarding SNAP investigations by September 1, 2014. Rider appropriates $796K in 2014 and $1.5M in 2015.
S.B. 33	Zaffirini	Bill requires HHSC to adopt rules regarding monitoring SSLC residents with electronic video or audio devices.
S.B. 34	Zaffirini	Bill adds the right to refuse psychoactive medication to the list of rights of the client under the Persons with Mental Retardation Act. While not directed by the bill, DADS will need to develop rules for HHSC to adopt.
S.B. 44	Zaffirini	Bill requires EC to review findings of a DFPS and DSHS study on ways to prevent families from relinquishing custody of a child to DFPS in order to get mental healthcare services. It also adds a related requirement to the Council on Children and Families duties.
S.B. 45	Zaffirini	Bill directs HHSC or DADS to provide employment assistance and supported employment to participants in Medicaid waiver programs.
S.B. 50	Zaffirini	Bill revises the membership of the Children's Policy Council, increases its to include mental health services for children with

Health and Human Services Commission Exhibit 13: 83rd Legislative Session Chart		
Legislation Enacted – 83rd Legislative Session		
		disabilities.
S.B. 58 Sections 1-2 And 4-5	Nelson	Bill requires integration of Medicaid behavioral health services through existing Medicaid managed care entities, except in the NorthSTAR service area.
S.B. 58 Sections 3,6, And 7 And DSHS Rider 58	Nelson	Sections require DSHS, in collaboration with HHSC, to establish maintain a public reporting system of performance and outcome measures for all state-funded or operated mental health and substance abuse services; and submit a feasibility study of maintaining the reporting system by December 1, 2014.
S.B. 59	Nelson	Bill modifies or repeals 14 of the 24 HHS agency reports recommended for repeal by the HHS agencies because they were redundant or obsolete.
S.B. 126	Nelson	Bill requires DSHS to establish and maintain a mental health and substance abuse treatment public reporting system with performance and outcome measures.
S.B. 152 Sections 1-2, 4-8, 10-12	Nelson	Sections require HHSC to adopt rules regarding training requirements for DSHS staff employed at state hospitals by December 1, 2013.
S.B. 152 Sections 3 and 9	Nelson	Sections require OIG to employ peace officers to assist law enforcement in the investigation of an alleged criminal offense involving a patient of a state hospital by May 1, 2014; and require a summary report of each investigation on an annual basis.
S.B. 171	West	Bill directs DPS to establish a workgroup of Emergency Management Council members (HHSC is a member) to determine if a uniform application form for assistance following a disaster can be developed. A report from the workgroup is due by September 1, 2014.
S.B. 176	Carona	Bill requires consulting services contracts to include a provision that allows the state to distribute any report produced under the contract and post it on the web.
S.B. 279	Watson	Bill requires agencies that post high-value data sets on their website to provide DIR with a brief description of the data set and a link to it.

Health and Human Services Commission Exhibit 13: 83rd Legislative Session Chart		
Legislation Enacted – 83rd Legislative Session		
S.B. 329	Huffman	Bill requires HHSC to adopt rules changing the age limit for using a tanning facility's tanning device from 16.5 years old and older to 18 years old and older.
S.B. 348 HHSC Rider 66	Schwertner	Bill requires HHSC to establish a utilization review process for STAR+PLUS MCOs and submit a report by December 1 of each year.
S.B. 360	Watson	Bill requires HHSC to adopt rules prohibiting the use of carbon monoxide chambers as a means for euthanizing a dog or cat in an animal shelter by December 1, 2013.
S.B. 365	Carona	Bill requires issuers of managed care plans to create an expedited credentialing process for podiatrists and therapeutic optometrists who have recently joined a medical practice with an established managed care plan contract.
S.B. 406	Nelson	Bill allows advanced practice registered nurses (APRNs) and physician assistants (PAs) prescriptive authority over medications and DME/supplies.
S.B. 421	Zaffirini	Bill creates local coordinated systems of care for children and youth with serious mental health needs, and defines the membership and duties of a state consortium to oversee these efforts. A report is due by November 1, 2014.
S.B. 426	Nelson	Bill requires HHSC to develop a strategic plan and outcome indicators for home visiting programs for at-risk pregnant women and families with children under the age of six.
S.B. 443	Birdwell	Bill requires agencies to allow employees who are reserve law enforcement officers to have no more than 5 days leave of absence, per year, without a dedication in salary to attend required continuing education.
S.B. 492	Lucio	Bill creates a licensing category for a nonresidential prescribed pediatric extended care centers.
S.B. 495	Huffman	Bill allows HHSC to adopt rules relating to a new Maternal Mortality and Morbidity Task Force, which will be administered by DSHS. While there is no due date for the rules in the bill, the Task Force must be appointed by December 1, 2013.
S.B. 632	Carona	Bill prohibits insurers from limiting the fees that optometrists and therapeutic optometrists may charge for services not covered under a health plan.

Health and Human Services Commission Exhibit 13: 83rd Legislative Session Chart		
Legislation Enacted – 83rd Legislative Session		
S.B. 651	Rodriguez	Bill requires HHSC to adopt rules to add the option for a notary public to acknowledge signature of a medical power of attorney form by October 1, 2013.
S.B. 746	Nelson	Bill increases the scope of liability for conspirators; decreases the requirements a whistleblower must satisfy to be considered an original source; and expands retaliation protection to associates of employees, contractors, and their agents.
S.B. 822	Schwertner	Bill requires TDI registration and disclosure for entities that contract with healthcare providers, including MCOs' delegated network subcontractors.
S.B. 984	Ellis	Bill allows a public meeting via videoconference call if the presiding member is physically present at one location of the meeting that is open to the public.
S.B. 1057 DSHS Riders 75 and 76	Nelson	Bill requires HHSC to adopt rules regarding individuals applying for DSHS that must attest they do not have access to private health insurance coverage. It also requires HHSC to seek a federal waiver as soon as possible.
S.B. 1106	Schwertner	Bill requires MCOs to have a provider appeals process to dispute the maximum allowable costs and processes.
S.B. 1150	Hinojosa	Bill requires a provider protection plan to reduce provider administrative burdens on providers to be included in MCO contracts.
S.B. 1175	Deuell	If found to be cost effect, bill creates a volunteer program for the reuse of durable medical equipment provided to Medicaid recipients.
S.B. 1216	Eltife	Bill requires TDI to create a single form for requesting prior authorization for healthcare or medical services.
S.B. 1226	Zaffirini	Bill requires HHSC, TEA, and TWC to jointly adopt; and implement an employment-first policy, including appointment of an Employment First Task Force by the EC by January 1, 2014. A report is due by Sept. 1, 2014.
S.B. 1297	Watson	Bill allows written electronic communication exchanged between two members of a governmental body about public business or public policy to be shared without constituting a meeting.

Health and Human Services Commission Exhibit 13: 83rd Legislative Session Chart		
Legislation Enacted – 83rd Legislative Session		
S.B. 1368	Davis, W.	Bill requires contracts with nongovernmental vendors involving the exchange or creation of public information to allow for public access of that information.
S.B. 1401	Carona	Bill mandates that a qualified lab will be considered eligible to serve as in-state provider for all HHS programs that involve diagnostic lab services if it, or its affiliated corporate entities, employ at least 1,000 persons in Texas.
S.B. 1459	Duncan	Bill makes various changes to the state employee retirement and insurance programs, including requiring agencies to contribute 0.5 percent of their payroll to the retirement system.
S.B. 1542 HHSC Rider 85	Van de Putte	Bill creates Medicaid Quality Improvement process to solicit suggestions for clinical initiatives to improve the quality and cost-effectiveness of the Medicaid program; and directs HHSC to report on two initiatives (treatment of severe sepsis and blood-based allergy testing for asthma patients) by January 1, 2014. Rider directs a report on health outcomes related to sepsis by September 1, 2014.
S.B. 1681	Zaffirini	Bill requires the Contract Advisory Team (HHSC is a member) to establish a training program for state contracting staff and to make recommendations on contracts over $10 million.
S.B. 1803 Article IX Sec 18.58	Huffman	Bill links existing OIG intake integrity review evaluations to new requirements for preliminary investigations of fraud allegations, including a 90-day deadline on all cases. It also establishes different appeal processes available for recoupment proceedings depending on the amount at issue.
S.B. 1836 HHSC Rider 70	Deuell	Bill allows applicants for birth, marriage, and divorce records to voluntarily contribute to HHSC's Home Visiting program; and establishes the Texas Home Visiting Program trust fund.
S.B. 1842	Deuell	Bill requires HHSC to adopt rules relating to face-to-face evaluations of a facility residents after use of restraint and seclusion by January 1, 2014.
S.B. 1892	Garcia	Bill adds the Office of Acquired Brain Injury to the Coordinating Council for Veterans Services, which already includes an HHSC representative.

Health and Human Services Commission Exhibit 13: 83rd Legislative Session Chart		
Legislation Not Passed – 83rd Legislative Session		
H.B. 58	Burnam	Bill deletes in its entirety Section 32.024(c-1), Human Resources Code, which currently requires DSHS to ensure that money spent for purposes of the demonstration project for women's healthcare services under the former Section 32.0248, Human Resources Code, or a similar successor program is not used to perform or promote elective abortions, or to contract with entities that perform or promote elective abortions or affiliate with entities that perform or promote elective abortions. The deletion of the subsection would have the effect of lifting the prohibition on the DSHS-run program.
H.B. 161 H.B. 1244	Larson king, Ken	Requires adult applicants, excluding applicants applying solely on behalf of a child, to submit to a drug test as a condition of eligibility for Temporary Assistance for Needy Families (TANF).
H.B. 249	Laubenberg	Requires, with good cause, drug screening and drug testing for minor parent heads of household and all adult applicants and recipients, including applicants applying solely on behalf of a child. The denial of an individual because of a drug test failure does not affect the individual's child or family eligibility for TANF. The individual must designate a protective payee to receive benefits on behalf of the individual's child or family.
H.B. 499	Hernandez Luna	Bill increases the income eligibility limit for the Children's Health Insurance Program (CHIP) to 300 percent of the federal poverty level (FPL) and requires HHSC to implement a CHIP Buy-In program for households with net family income above 300 percent of the FPL.
H.B. 587 H.B. 1072 S.B. 879 H.B. 1141	Burnam Allen, Alma Ellis Naishtat	Bill prohibits HHSC from denying SNAP benefits to other household members if the primary wage earner fails to comply with SNAP Employment and Training requirements. In addition, H.B. 587 and H.B. 1141 also remove the lifetime SNAP disqualification penalty for individuals with drug-related felony convictions.
H.B. 948	King, Susan	Bill requires HHSC to request approval for two separate, five-year waivers to restrict and incentivize SNAP purchases; encourage SNAP retailers to promote purchases of healthy foods and discourage purchases of foods with minimal nutritional value in advertising; and to report on its efforts. The bill also requires HHSC to develop rules to appropriately stop or reduce SNAP benefits when a child is removed from a household by DFPS or court order.

Health and Human Services Commission Exhibit 13: 83rd Legislative Session Chart		
Legislation Not Passed – 83rd Legislative Session		
H.B. 1381 S.B. 450	Martinez Hinojosa	Bill prohibits the delivery of prescription drug benefits through Medicaid managed care organizations (MCOs), returning the delivery of prescription drug benefits to the Vendor Drug Program (VDP) under a Fee for Service (FFS) model.
H.B. 1582	Riddle	Bill requires random substance use screening for Temporary Assistance for Needy Families (TANF) applicants and recipients, and drug testing with good cause. The bill also requires TANF applicants to sign an affidavit attesting that they are not and will not use a controlled substance or marijuana while receiving TANF. A violation of the affidavit is a class B misdemeanor.
H.B. 1709	Farrar	Bill requires HHSC to immediately seek federal funds through a Section 1115 waiver to establish a program identical to the former Medicaid Women's Health Program if HHSC should cease to operate the Texas Women's Health Program (TWHP) in response to a court ruling that the administrative rules precluding affiliates of elective abortion providers from the program are unconstitutional or otherwise unenforceable.
H.B. 2070	Cortez	Bill requires HHSC to provide continuous Medicaid eligibility for children under age 19 and for persons age 65 and older for a period of 12 months, without additional review and regardless of changes in income or resources.
H.B. 2161	Gonzalez, Mary	Bill lowers the eligibility age for the Texas Women's Health Program from 18 to 15.
H.B. 2428	Martinez	Bill prohibits HHSC from delivering dental services for Medicaid and CHIP through a managed care model in Cameron and Hidalgo Counties.
H.B. 3171	Bohac	Bill would require drug screening and drug testing, when there is good cause to suspect drug use, for minor parent heads of household and all adult applicants and recipients, including applicants applying solely on behalf of a child.
H.B. 3631	Canales	Bill requires HHSC to expunge unused SNAP benefits 90 days after issuance.
H.B. 3715 S.B. 1528	Guerra Hinojosa	Bill would require HHSC, in consultation with DSHS, to: 1) conduct a study of the effects of the ACA on Medicaid reimbursements and DSH payments to hospitals in Texas; and 2) develop proposals designed to provide long-term funding solutions related to Medicaid

Health and Human Services Commission Exhibit 13: 83rd Legislative Session Chart		
Legislation Not Passed – 83rd Legislative Session		
		for hospitals.
H.B. 3734	Coleman	Bill would increase the income eligibility limit for the Children's Health Insurance Program (CHIP) to 300 percent of the federal poverty level (FPL); create new asset standards; and require HHSC to implement a CHIP Buy-In program for households with net family income above 300 percent FPL, but below 400 percent FPL. The bill would require 12 months of continuous coverage for clients in CHIP and SNAP. Additionally, this bill would require increased outreach and application assistance; and implementation of application processing standards for Medicaid, CHIP, TANF, and SNAP benefits.
S.B. 11	Nelson	As filed, the bill requires, with good cause, drug screening and drug testing for minor parent heads of household and all adult applicants and recipients, including applicants applying solely on behalf of a child. The bill also changes TANF work requirements, codifies the allowable uses of TANF, establishes a 36-month state time limit, applies Personal Responsibility Agreement requirements to non-recipient parents, and requires a TANF assistance voucher study. The provisions related to TANF work requirements were removed in the Senate committee substitute.
S.B. 191	Birdwell	Bill requires TANF recipients to present photo identification to verify identity before making a cash withdrawal from an electronic benefit transfer (EBT) account. The bill also requires the name of the recipient and any authorized person, if applicable, to be printed on the EBT card.

Affordable Care Act

In addition to the bills listed above, the following bills specifically related to the Affordable Care Act (ACA), also failed to pass during the 83rd Legislative Session. The listing groups these ACA-related bills by category.

Exchange

S.B. 84 by Ellis

- Establishes the Texas Health Insurance Exchange (Exchange).

- Amends the Insurance Code related to coverage for emergency care and preventive services, cost sharing, eligible dependents under a health plan, pre-existing conditions, and prohibitions on rescinding coverage.

SJR 8 by Ellis

- Proposes an amendment to the Texas Constitution to expand Medicaid to all individuals for whom federal matching funds are available under the Affordable Care Act (ACA).
- Requires submission of the constitutional amendment to voters at the November 5, 2013, election.
- Will not take effect If the constitutional amendment is not approved by the voters.
- Companion: HJR 91 by Coleman.

H.B. 1002 by Eric Johnson

- Establishes a Texas Health Insurance Exchange (Exchange) as authorized under the Affordable Care Act (ACA) to create a marketplace for individuals and small employers to purchase health insurance.
- Requires eligibility for the federal tax credits (also known as subsidies) to be fully integrated into HHSC's eligibility system modernization efforts.
- Calls for utilizing the Texas Exchange in place of the Federally Facilitated Exchange.

H.B. 3185 by Laubenberg

- Prohibits the state or local entity from implementing, establishing, or maintaining an exchange.

Expansion - Statewide

S.B. 455 by Rodriquez

- Requires the state to expand Medicaid to individuals who apply for assistance and for whom there are federal matching funds available per the Affordable Care Act (ACA).
- Codifies federal eligibility determination mandates (i.e. MAGI, elimination of assets tests, etc.).

S.B. 880 by Ellis

- Requires the state to expand Medicaid to individuals who apply for assistance and for whom there are federal matching funds available per the Affordable Care Act (ACA).
- Companions: H.B. 593 (Naishtat), H.B. 999 (Eric Johnson).

S.B. 1232 by West

- Requires the state to expand Medicaid to individuals who apply for assistance and for whom there are federal matching funds available per the Affordable Care Act (ACA).

- Requires the state to cease expansion if FMAP falls below the percentage provided per the ACA.
- Includes cost-sharing requirements for the expansion population.
- Requires HHSC to report to the legislature on the effects of expansion.

S.B. 1378 by Ellis

- Appropriates $50.4 million GR from the rainy day fund for Medicaid expansion.
- Is similar to H.B. 3346 by Eddie Rodriquez.

S.B. 1816 by Rodriquez

- Requires the state to expand Medicaid to individuals who apply for assistance and for whom there are federal matching funds available per the Affordable Care Act (ACA).
- Mandates that, in the 8 largest counties, expansion is funded with local IGT or QAF.
- Mandates that funding for other counties is through GR.

H.B. 593 by Naishtat

- Requires the state to expand Medicaid to individuals who apply for assistance and for whom there are federal matching funds available per the Affordable Care Act (ACA).
- Companions: S.B. 880 (Ellis), H.B. 999 (Eric Johnson).

H.B. 880 by Eric Johnson

- Requires the state to expand Medicaid to individuals who apply for assistance and for whom there are federal matching funds available per the Affordable Care Act (ACA).
- Companions: S.B. 880 (Ellis), H.B. 593 (Naishtat).

H.B. 2950 by Justin Rodriquez

- Is similar to S.B. 1232 by West, but sets the FMAP reduction threshold at 90 percent and does not include cost-sharing requirements.

H.B. 3122 by Rep. Lucio, H.B. 3266 by McClendon, H.B. 3376 by Sylvester Turner, H.B. 3487 by Villareal, H.B. 3700 by Marquez, H.B. 3806 by Giddings

- Is similar to S.B. 1232 by West, except this bill specifies incentives and strategies (expanded managed care, HIPP, etc) that HHSC can include in cost-sharing requirements.

H.B. 3346 by Eddie Rodriquez

- Appropriates $50.4 million GR from the rainy day fund for Medicaid expansion.
- Is similar to S.B. 1378 by Ellis.

H.B. 3722 by Martinez-Fischer

- ARTICLE 2 - requires the state to expand Medicaid to individuals who apply for assistance and for whom there are federal matching funds available per the Affordable Care Act (ACA).

HJR 91

- Proposes an amendment to the Texas Constitution to expand Medicaid to all individuals for whom federal matching funds are available under the Affordable Care Act (ACA).
- The constitutional amendment would be submitted to voters at the November 5, 2013, election.
- If the constitutional amendment is not approved by the voters, the amendment does not take effect.
- Companion: SJR 8 by Ellis.

Expansion – Local Option

H.B. 59 by Burnam

- Allows local entities (counties, hospital districts) to apply directly to the federal government to expand Medicaid contingent on their ability to provide local tax funds for the state share of the match.

H.B. 1001 by Eric Johnson

- Requires HHSC to seek a waiver to allow certain counties on their request to expand Medicaid eligibility under the federal Affordable Care Act and work with the county to implement a county Medicaid expansion.
- Only applies to a county that has a population of 2.2 million or more and is adjacent to a county with a population of more than 600,000; and, in which, more than 5,000 physicians are practicing medicine.

Individual Mandate

SJR 5 by Campbell

- Prohibits the state from imposing, collecting, enforcing, or effectuating a penalty or sanction for failing to purchase health insurance coverage.
- Companions: HJR 48 (White), HJR 59 (Creighton).

H.B. 3709 by Bell

- "Health Freedom Act."

HJR 48 by White

- Prohibits the state from imposing, collecting, enforcing, or effectuating a penalty or sanction for failing to purchase health insurance coverage.
- Companion: SJR 5 (Campbell), HJR 59 (Creighton).

HJR 59 by Creighton

- Prohibits the state from imposing, collecting, enforcing, or effectuating a penalty or sanction for failing to purchase health insurance coverage.
- Companion: SJR 5 (Campbell), HJR 48 (White).

HJR 109 by Laubenberg

- Prohibits enforcement of the individual mandate.

IX. MAJOR ISSUES − Health and Human Services (HHS) System

Brief Description of Issue

Issue 1: Are there additional avenues to further integrate the HHS System?

Discussion

The HHS System consolidation is the most considerable reorganization effort in state history. House Bill 2292 envisioned a unified Health and Human Services System, consolidating functions and streamlining service delivery, while giving HHSC and its Executive Commissioner broad oversight authority. As part of this measure, the bill charged HHSC with delivering administrative functions, such as human resources, civil rights, and support services for field office locations. Adding to these initial consolidation efforts, HHSC now oversees all contracting and procurement and many IT initiatives. Beyond day-to-day operations, the Executive Commissioner has final rulemaking authority for all program areas within the HHS System.

Although the spirit of a consolidated HHS System has been realized, nearly 10 years post-consolidation, several steps to reaching full integration remain.

The following are examples of areas that could realize additional efficiencies through further System integration:

- streamlined rate analysis,
- streamlined rulemaking,
- uniform definitions in statutes and rules, and
- increased data sharing.

Possible Solutions and Impact

- **Streamlined rate analysis.** Should HHSC have broad authority to set all rates across the HHS System? Currently HHSC sets rates for Medicaid-related programs; however the respective department administering the non-Medicaid program establishes rates. A centralized rate setting office would better ensure consistent rates among different program areas and also ensure a uniform approach to receiving stakeholder input.
- **Streamlined rulemaking.** Should HHSC and the Executive Commissioner be authorized to transfer program functions, and related rulemaking authority, from one HHS agency to another when such transfers will improve effectiveness or efficiency? For example, as discussed in section IV. Policymaking Structure of the Self-Evaluation Report, rule changes originate within the respective department; receive several layers of review, including the commissioner and advisory council; and are then forwarded to HHSC for review by a senior-

level policy advisor and finally the Executive Commissioner. While the Executive Commissioner has broad rule and policymaking authority, HHSC does not have legal authority to operate all programs.

- **Uniform definitions in statutes and rules.** Should statute be re-codified to address outdated terms, references, and definitions? Inconsistent terms and definitions cause confusion both within the HHS System and for outside stakeholders.
- **Increased data sharing.** Should statute direct broad information-sharing, allowing easy transfer of information within departments and increased accessibility to the public? All program areas would benefit from such a change. For example, regulatory divisions at DADS, DSHS, and DFPS would be able to see if certain individuals hold multiple licenses in their respective programs, connecting compliance histories and other enforcement information.

IX. MAJOR ISSUES CONTINUED − HHS System

Brief Description of Issue

Issue 2: Should all Medicaid-related programs be administered by one department within the HHS System?

Discussion

Each state must designate a single state Medicaid agency, in accordance with the Social Security Act, Sec. 1902(a)(5), that is accountable to the federal government for administration of the state's Medicaid program. In Texas, HHSC is the single state Medicaid agency responsible for operating, and in some instances, for supervising the administration of the Medicaid program. HHSC has authority over federal funds received by other agencies under its control and is required to monitor and ensure effective use of these funds (Texas Government Code, Sec. 531.028). HHSC is the primary federal point of contact for Medicaid-funded programs and performs the following functions.

- Establishes Medicaid policy direction.
- Determines financial eligibility.
- Administers the Medicaid State Plan.
- Operates the state's acute care, vendor drug, and managed care programs, and the Texas Healthcare Transformation and Quality Improvement 1115 Waiver.
- Approves Medicaid rules and reimbursement rates.
- Provides oversight of state agencies operating Medicaid programs.

When first established, HHSC included a small policy unit charged with directing the big-picture strategy for the Texas Medicaid program, which, previous to consolidation, was housed among many different legacy agencies. Over time, it became increasingly apparent that consolidation of at least some of the Medicaid program operations into HHSC would give the Executive Commissioner more control of this program with its sizeable and growing portion of the state budget.

HHSC delegates the operation of some Medicaid-funded programs to other agencies in the HHS Enterprise.

The Department of Aging and Disability Services (DADS) administers the following long-term services and supports for the Medicaid program.

- Medicaid waiver programs (authorized by section 1915(c) of the Social Security Act) allowing Texas to waive certain program requirements to establish alternative, community-based services for individuals with certain conditions. These services are delivered through Medicaid 1915(c) waivers:

  - Community-Based Alternatives (CBA),
  - Community Living Assistance and Support Services (CLASS),
  - Medically Dependent Children Program (MDCP),
  - Deaf-Blind with Multiple Disabilities (DBMD),
  - Home and Community-Based Services (HCS), and
  - Texas Home Living (TxHmL).
- State entitlement programs funded by Medicaid: Primary Home Care, Community Attendant Services, and Day Activity Health Services.
- Nursing facilities program providing institutional care to Medicaid recipients whose medical condition regularly requires skilled care and for individuals who have a medical necessity and meet certain requirements.
- Intermediate care facilities for individuals with intellectual disabilities or related conditions (ICF/IID).

The Department of State Health Services (DSHS) administers:

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program (known in Texas as Texas Health Steps);
- case management for pregnant women and children;
- select functions of the personal care services benefit;
- targeted case management and rehabilitative services for people with mental illness;
- NorthSTAR managed care program, which integrates Medicaid-funded and public, non-Medicaid funded mental health and chemical dependency services; and
- Youth Empowerment Services (YES) waiver (a 1915c waiver), which provides community-based services for children and young adults with severe emotional disturbances.

The Department of Assistive and Rehabilitative Services (DARS) administers:

- Early Childhood Intervention Program, and
- case management services for children who are blind or visually impaired.

The current Medicaid program structure sometimes requires families to access services through multiple systems which can be frustrating and confusing. The current structure can also result in duplication of services, including multiple case managers or accessing services that are not coordinated (such as attendant services, nursing services, and waiver benefits).

Managed care offers the opportunity to integrate the full spectrum of acute and long-term services and supports. Services carved into managed care include acute Medicaid services; some long-term services; dental care for children and young adults; pharmacy benefits; services and supports for individuals in state conservatorship; and behavioral health services.

Senate Bill 7 and S.B. 58, 83rd Legislature, Regular Session, 2013, will result in further expansion of Medicaid managed care, including children receiving Supplemental Security Income, individuals in nursing facilities, individuals with intellectual and developmental disabilities, and

additional behavioral supports. The expected impact of this legislation is by 2020, almost all community-based, Medicaid-funded services will be operated by HHSC. Most will be supported through a system of managed care organizations.

C. Possible Solutions and Impact

HHSC is carrying out the initiatives required by S.B. 7 and S.B. 58, to transition various waivers, nursing facility services, and other State Plan home and community-based services into managed care and under the full operational authority of HHSC. Programs slated for transition have far-reaching impacts on individuals, so the transition will be staged to ensure continuity of services. Since some programs will not be fully integrated into managed care until 2020, it may be appropriate to consider how program operations can be streamlined during the interim period.

HHSC could evaluate the impact of transitioning additional Medicaid-funded programs into managed care or at least under HHSC's operational authority. HHSC could achieve additional administrative efficiencies through streamlined program financing, diminished interagency contracting, less complicated oversight activities through more centralized operations, reduced CMS requirements concerning the Medicaid agency's oversight role, and increased consistency in the definitions and rates paid for similar services.

IX. MAJOR ISSUES CONTINUED − HHS System

Brief Description of Issue

Issue 3: Should programs supporting individuals with Intellectual and Developmental Disabilities (IDD) be administered by one department within the HHS System?

Discussion

People with Intellectual and Developmental Disabilities (IDD) who also have behavioral health needs experience challenges accessing behavioral health services because the IDD system and mental health system are located in different agencies.

The Department of State Health Services (DSHS) administers mental health and substance abuse (MHSA) services through local mental health authorities (LMHAs) for all persons regardless of Medicaid eligibility. The Department of Aging and Disability Services (DADS) administers the waiver programs that provide long-term services and supports (LTSS) to Medicaid-eligible persons. While overseen by HHSC, these agencies operate the MHSA and LTSS systems independently from each other. Currently, someone who receives LTSS through the DADS system who also needs MHSA services would have to qualify separately for these services through the system operated by DSHS.

Possible Solutions and Impact

Beginning September 1, 2014, HHSC will provide targeted mental health case management and rehabilitation services to individuals enrolled in Medicaid through the Medicaid managed care plans, as required by S.B. 58, 83rd Legislature, Regular Session, 2013.

Senate Bill 7, also passed this last Session, requires HHSC to also provide LTSS to persons enrolled in Medicaid through managed care plans beginning September 1, 2015 (and going through September 2020). Through these major policy changes, there are opportunities to improve the coordination of mental health and IDD services. With the carve-in of both behavioral health services and LTSS into managed care, these programs will be administered under HHSC and managed care contract requirements can be put in place to require better coordination of the provision of these services when an individual is eligible for both.

IX. MAJOR ISSUES CONTINUED − HHS System

Brief Description of Issue

Issue 4: Are there opportunities to address gaps in waiver coordination throughout the HHS System?

Discussion

The Health and Human Services Commission (HHSC), as the single state Medicaid agency, oversees Medicaid waivers but does not provide the administration of most of these waivers. The six 1915(c) waivers operated by the Department of Aging and Disability Services (DADS) include:

- Community-based Alternatives,
- Community Living Assistance and Support Services,
- Medically Dependent Children Program,
- Deaf-Blind with Multiple Disabilities,
- Home and Community-based Services, and
- Texas Home Living.

In addition, the Department of State Health Services (DSHS) administers the following waivers:

- Youth Empowerment Services, a 1915(c) waiver, and
- NorthSTAR, a 1915(b) waiver.

In its oversight role, HHSC ensures waivers operate in accordance with applicable federal regulations and waiver provisions. HHSC staff approve waiver language, proposed rules, ensures compliance with federal guidance, and monitors consistency in policy across waivers. HHSC serves as the single point-of-contact with the federal Centers for Medicare & Medicaid Services (CMS) and directs and negotiates interactions with CMS.

Senate Bill 7, 83rd Legislature, Regular Session, 2013, requires the transition over time of most of DADS waiver programs into HHSC's managed care programs. Smooth transition will require thorough analysis of policy and operations considerations.

Senate Bill 7, directs the transition of waivers for individuals with intellectual and developmental disabilities and contains grandfathering provisions for individuals currently enrolled in the 1915(c) waivers. As a result, individuals enrolled in 1915(c) waiver programs will be permitted to remain in the program for long-term services and supports, but will access acute care through the STAR+PLUS program. HHSC will continue to oversee multiple waiver programs and must provide effective coordination and program operations. Issues to consider across waiver programs include contract management and monitoring, policy development

processes, budget development, legal support, communication between HHSC and operating agencies both internally and with federal partners, stakeholder coordination, and operational decision-making authority in related to managed care transition dates.

Possible Solutions and Impact

Senate Bill 7 and S.B. 58, will likely provide additional efficiencies relating to administration and oversight of Medicaid services and supports as waivers are carved into managed care. While HHSC has extensive statutory authority over the operating agencies, it may be appropriate to consider additional language specifying HHSC's responsibility to assess waiver program operations and implement process improvements. This could be accomplished through an amendment to Texas Government Code, Section 531.021(b), which currently lists HHSC's responsibilities for administration of the Medicaid program.

IX. MAJOR ISSUES CONTINUED − HHS System

Brief Description of Issue

Issue 5: Should separate agencies have oversight of State Hospitals and State Supported Living Centers?

Discussion

Background

House Bill 2292, 78th Legislature, Regular Session, 2003, authorized the reorganization of the Texas Health and Human Services (HHS) agencies by reducing the number of agencies to five. Before this reorganization, TDMHMR provided the oversight of the State Hospitals and State Supported Living Centers (SSLCs). House Bill 2292 moved the operations of the State Hospitals into the Department of State Health Services (DSHS) and operations of the SSLCs into the Department of Aging and Disability Services (DADS). State Hospitals provide inpatient psychiatric services to individuals with mental illness, while SSLCs provide campus-based residential services and supports for people with intellectual and developmental disabilities.

Both types of facilities employ many types of healthcare providers, including physicians, psychiatrics, nurses, psychologists, social workers, nutritionists, chaplains, pharmacists, direct support staff, food service workers, maintenance staff, and habilitation therapists. Both types of facilities are also involved in maintaining large campuses, managing fleet operations, construction, risk management, computer systems, and other support services.

Also, each agency operates forensic facilities, serving individuals who have been committed through the criminal justice system. This has created confusion with local judges and courts, who don't always understand the difference in the nature of the commitments and which department oversees the commitment.

Cooperative Projects

Given the similar nature of facility management at DADS and DSHS, there are many instances where the two departments work together to increase efficiency and operational expertise. Currently, the Health and Human Services Facility Support Services (FSS) division provides centralized management and administrative support for the 24 DADS SSLCs and DSHS State Hospitals across Texas. The support services provided by FSS have streamlined day-to-day business operations at both DADS and DSHS and allowed the facilities to focus on caring for the clients. Current support services provided by FSS include:

- competency training and development,
- computer aided facility management,
- fleet operations,
- facility support performance indicators,

- facility support services oversight,
- laundry and environmental services,
- maintenance and construction,
- nutrition and food service,
- real estate management,
- risk management, and
- supply services.

In addition to the support services provided by FSS, DADS and DSHS have also developed several key relationships designed to increase facility efficiency. Specifically, the Austin SSLC provides all food for the Austin State Hospital and the San Antonio State Hospital provides most support services for the San Antonio SSLC.

However, these relationships and projects require the departments and HHSC to coordinate on a regular basis.

Identified Inefficiencies

While FSS provides many valuable services to DADS and DSHS, the following is a list of additional inefficiencies which exist between the two departments.

- Duplicative administrative functions exist in both agencies.
- Recruitment and retention of professional service providers often lead to both DADS and DSHS competing for limited professional staff such as physicians, psychologists and psychiatrists.
- Delayed transfer process of individuals between SSLCs and State Hospitals causes:
    - delays in needed services;
    - disrupted coordination of care between SSLCs and State Hospitals; and
    - unnecessary costs for Local Authorities (LA).
- Ineffective exchange of health information between DSHS State Hospitals and DADS SSLCs.
- Cross-agency coordination is required for certain facilities management functions.

Possible Solutions and Impact

Consolidating facility operations into one agency would streamline facility management and increase efficiencies. As both departments already have significant functions outside of facility management, this function could be moved to a single entity that focuses solely on the operations of these state facilities. This entity could be housed either within or outside the HHS System. The benefit of this structure would not only result in streamlined focus for both DADS and DSHS, but could also provide increased oversight of such state-operated health facilities.

Positive Impacts

- Efficiencies in administrative overhead and reduced duplication of functions.
- Allows for cooperative recruitment and retention of professional staff.

- Expedites the transfer process of individuals between SSLCs and State Hospitals.
- Expands the Electronic Health Record system to improve technology and information sharing between the agencies.
- Increases forensic expertise level and reduces confusion with judges/courts.
- Reduces costs by eliminating duplicative expenses and increasing cooperative buying power.
- Strategic decisions regarding facility properties, capital construction legislative requests and prioritization of those requests, and potential repurposing of facilities as SSLCs continue to downsize in population will be improved.

Negative Impacts

- Stakeholders may object to the alignment of facilities into one agency due to the functional alignment of current HHS agencies.

IX. MAJOR ISSUES − Health and Human Services Commission (HHSC)

Brief Description of Issue

Issue 1: Should eligibility criteria for Medicaid Buy-In Denials based on mental illness be revised?

Discussion

The Balanced Budget Act of 1997 enacted an optional Medicaid group to create a work incentive program. This program assists individuals with disabilities in maximizing their employability, with the goal to become economically self-sufficient, and ultimately less dependent on state and federal benefits programs. In response to this congressional mandate, the 79th Legislature passed S.B. 566 creating a Medicaid Buy-in Program for working persons with disabilities, which the Health and Human Services Commission (HHSC) fully implemented in September 2006 The MBI program allows eligible individuals to have income within certain limits without losing their Medicaid benefits.

MBI requires enrollees to pay monthly premiums for the Medicaid coverage. Since its inception and despite considerable efforts by agency staff and interested stakeholders, enrollment remains low, with only 262 active participants. Estimates indicate an increased average monthly caseload of 52 individuals in FY 2014 under a more equitable premium structure; 81 additional average monthly caseload for FY 2015; 112 average monthly in FY 2016; 117 average monthly in FY 2017; and 122 average monthly in FY 2018. These estimates assume a 50 percent take-up rate in year one, 75 percent in year two, and 100 percent in following years.

Staff completed a review of the program and identified the program's current premium structure as one of the contributing factors to its low enrollment. The premium structure discourages enrollment for individuals who wish to decrease or eliminate their dependence on disability benefits such as SSI and SSDI, by setting a higher premium for participants with unearned income. In most states, such individuals comprise the majority of MBI participants. In Texas, two people with the same disability, medical needs, and income can pay significantly different premiums depending on the source of their income. Under the current premium structure, a participant with unearned income such as SSI or SSDI may pay a maximum of $500 per month; a person without unearned income will pay a maximum of $40 per month.

Another contributing factor to low program enrollment is the current disability determination process for the MBI program. Under the current process, few individuals with chronic mental illness are eligible to participate in the program even though their ability to maintain employment is unlikely without ongoing therapies, medication, or other accommodations in the workplace.

In May 2011, the Executive Commissioner established a MBI Oversight Workgroup that meets monthly to revise the current premium structure and eliminate such disincentives.

Premium Structure

Currently the MBI program has two separate premium structures. The premium calculation for individuals with no unearned income, such as Supplemental Security Income (SSI) or Social Security Disability Income (SSDI), is based on a portion of earned income in relation to percentages of the federal poverty level (FPL).

Premium calculations for individuals with unearned and earned income are based on all unearned income above the federal benefit rate (FBR), plus a portion of earned income in relation to percentages of the FPL. The FBR is the maximum monthly SSI payment an individual can receive, and is currently $710 a month for 2013. In the month of December 2012 alone, slightly more than half of the individuals enrolled in MBI did not pay any monthly premium under the current premium structure, resulting in lost revenue for the State.

The existing premium structure sets a higher premium level for participants with unearned income, which is a disincentive for individuals who desire to reduce their dependence on disability benefits. In most states, such individuals comprise the majority of MBI participants. In Texas, two people with the same disability, medical needs, and income can pay significantly different premiums depending on the source of their income. The participant with unearned and earned income may pay a maximum of $500 in a monthly premium; the person without unearned income will pay a maximum of $40.

For example, under the current Texas MBI premium structure, if a person has unearned income (which could be SSI, SSDI, railroad benefits, etc.), they pay all of the unearned income above FBR. If the person receives $1,200/month in SSDI, they would pay ($1,200 - $710) $490 of their SSDI check towards an MBI premium (this calculation does not count the amount they would pay in earned income toward their premium).

Disability Determination Process

To be eligible for the Texas MBI Program, a person must meet the definition of disability by the Social Security Administration used to determine SSI eligibility, except that the requirement that the person be unable to engage in any substantial gainful activity does not apply. Unfortunately, determining disability without this requirement is difficult. States have struggled in their attempts to determine which parts of disability determination apply so that meeting the inability to engage in substantial gainful activity analysis is not required. The Centers for Medicare & Medicaid Services does not provide sufficient guidance to clarify the issue.

C. Possible Solutions and Impact

Revise the premium structure to be based on income regardless of the source of the income − a change that more equitably distributes premium payments across all MBI program enrollees. This change would require some individuals who currently do not pay a premium to pay a premium, but it would decrease the amount of premium others pay. Revising the premium structure to one that is more equitable would also eliminate disincentives for individuals with unearned and earned income, and would allow those who currently do not pay to take personal responsibility for their health coverage.

Several options exist to change the current disability determination process and allow individuals with chronic mental illness who are employed to participate in the MBI program, if they meet all other criteria. Based on other state MBI programs, there are ways the Texas program can interpret the disability determination guidelines to increase the likelihood that certain individuals with mental illness can be determined eligible.

- Increase and enhance training requirements of disability determination staff that review MBI applications and make eligibility determinations.
- Require training on MBI program and disability determination of medical professionals that review appeals of denied applications to the MBI program.

The impact of these proposals will increase state revenue through premium payments, promote personal responsibility of individuals on Medicaid, and provide opportunities for individuals with disabilities to enter the workforce and maintain competitive and gainful employment without losing their health coverage.

IX. MAJOR ISSUES CONTINUED − HHSC

Brief Description of Issue

Issue 2: Should managed care organizations assist with Medicaid eligibility maintenance and continuity of care?

Discussion

HHSC encourages contracted Medicaid managed care organizations (MCOs) to contact members and offer assistance with Medicaid eligibility renewals. HHSC allows this informal arrangement as long as the individual is an existing MCO member, and promotes this activity to support continuity of care. However, assistance with Medicaid eligibility renewals is not contractually required of the MCOs.

For various reasons, members may lose Medicaid eligibility which results in MCO changes. MCOs currently do not have access to their members' Medicaid eligibility renewal or end dates. To address concerns related to continuity of care, HHSC implemented an automatic reenrollment process into the same MCO (if available) for members who are dis-enrolled due to temporary ineligibility for Medicaid. Texas' waiver agreement with the Centers for Medicare & Medicaid Services (CMS) defines a temporary loss of eligibility as a period of six months or less.

HHSC implemented the automatic reenrollment process because the eligibility file from HHSC to the MCOs does not include the member's recertification date. MCOs do not know when a members' renewal is due. To identify members who may be scheduled for renewal, some MCOs have developed internal notification systems. However, these notification systems are inaccurate because they are based on when the MCO learned of the member, not the member's actual eligibility date.

As Medicaid managed care is expanded to cover more vulnerable populations (e.g., individuals residing in nursing facilities and children with disabilities), maintaining members' Medicaid eligibility and enrollment becomes critical. Loss of coverage (even temporary) affects Medicaid managed care members, many whom have complex medical needs and can have significant negative impacts on continuity of care. This is especially true for members receiving Medicaid waiver services who are only eligible for Medicaid because of the waiver, and who would otherwise not qualify for services.

Possible Solutions and Impact

To improve continuity of care, HHSC is exploring the following options.

- Developing additional information to inform MCOs when members' eligibility is scheduled for renewal or ends.
- Issuing policy clarifications to the MCOs clearly defining activities to help members maintain Medicaid eligibility.
- Adding new contract requirements.
- Dedicating existing state resources to help maintain continuity of care.

HHSC will make system changes to the eligibility file sent to the MCOs to add the Medicaid eligibility renewal date. In addition, HHSC will amend its managed care contracts to address Medicaid eligibility renewal assistance.

IX. MAJOR ISSUES CONTINUED − HHSC

Brief Description of Issue

Issue 3: How can the provider enrollment process be strengthened?

Discussion

Multiple Health and Human Services program areas and agencies have responsibilities for provider enrollment. Enrollment activities also include coordination with Office of the Inspector General (OIG).

The following table outlines the entities responsible for provider enrollment.

	Texas Medicaid and Health Care Partnership (TMHP)	HHSC Vendor Drug Program (VDP)	Department of Aging and Disability Services (DADS)	Managed Care
Medicaid Acute Care Providers	√			√ *(credentialing)*
Medicaid Pharmacies		√		√ *(credentialing)*
Medicaid Long-term Care Providers	√		√	√ *(credentialing)*
Medical Transportation Providers	√			
Early Childhood Intervention (ECI) provider enrollment	√			√ *(credentialing)*
CHIP Providers		√		√ *(full enrollment)*

Note: TMHP also enrolls providers participating in the Kidney Health program, Children with Special Health Care Needs program, and certain safety net programs. The Vendor Drug Program also enrolls providers participating in the Kidney Health program and Children with Special Health Care Needs programs.

In March 2011, the Affordable Care Act (ACA), Section 6401, mandated new provider screening and enrollment requirements for providers and suppliers enrolling in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). States are permitted to use Medicare's or other states' screening to confirm a provider has met the federal requirements.

In general, ACA federal regulations require states to do the following.

- Enroll providers based on a federally designated risk level. The risk level consists of three categories: high, medium and low.
- Revalidate/rescreen enrollment of all providers every five years.
- Terminate or deny enrollment if a provider (or any person with 5 percent or greater ownership interest) has been convicted of a criminal offense or as been terminated by Medicare, or another state's Medicaid or CHIP program.
- Conduct unannounced pre and post provider site visits for moderate and high-risk providers.
- Conduct criminal background checks and finger printing for high-risk providers including persons with 5 percent or greater ownership interest.
- Conduct federal database checks at various federally mandated frequencies on an ongoing basis.
- Require all national provider identifier (NPI) be included for enrollment and claims payment. Collect an application fee prior to enrollment with the exception of:
    - Physicians and non-physician practitioners; or
    - Providers who are enrolled in Medicare or another state's Medicaid or CHIP program and have already paid an enrollment fee.

In addition to ACA enrollment requirements, all managed care providers must be enrolled through HHSC prior to being credentialed by a health plan. Providers who offer multiple services (e.g.., pharmacies that also provide durable medical equipment) may be subject to multiple provider application, enrollment, and credentialing requirements.

Although the current provider enrollment process is (in some areas) coordinated by several HHS agencies, OIG, and TMHP, the current system is not flexible enough to easily add new provider types not typically recognized or provider types that do not typically enroll in Medicare (e.g. pharmacies).

Possible Solutions and Impact

Pursuant to new federal provider enrollment requirements and recent state law, HHSC is updating the provider enrollment process to streamline provider enrollment, reduce enrollment timeframes, make the process more user-friendly for providers and standardize enrollment processes. HHSC is exploring opportunities to reduce duplication and centralize provider enrollment systems.

The Centers for Medicare & Medicaid Services (CMS) continues to provide ACA guidance to states. Federal guidance has not been finalized. As further federal guidance is provided, a need for state statutory changes may be identified.

The following activities are either under development or under consideration as possible solutions to streamline and strengthen the provider enrollment process.

Activities in Progress

Redesign provider enrollment processes to centralize and streamline provider enrollment activities.

- HHSC is evaluating operational considerations and impacts for development of one streamlined provider enrollment application and a new provider enrollment system for all Medicaid program areas and agencies.
- Consolidate enrollment activities.
- Modify the provider application form.
- Enhance coordination activities to reduce enrollment timeframes.

Current managed care provider credentialing and re-credentialing requirements are as follows.

- HHSC's managed care contracts require the MCOs' Medicaid and CHIP credentialing processes to be consistent with recognized MCO industry and Texas Department of Insurance (TDI) standards.
- HHSC's managed care contracts establish timelines for completing credentialing processes and entering newly-credentialed providers into the MCOs' claims processing systems.
- Senate Bill 1150, 83rd Legislature, Regular Session, 2013, requires MCOs to comply with HHSC's provider protection plan, including requirements for prompt credentialing. HHSC will establish a workgroup to develop standardized credentialing applications and requirements.

Future Improvement Considerations

- Enhancement to the Provider On-line Portal.
- Establish a workgroup to identify issues and solution improvements.
- Develop a process for more timely and accurate provider information (currently self-reported) through coordination with MCO provider information.
- Explore opportunities to enhance system capability to support the addition of new provider types or modification of existing provider types.

IX. MAJOR ISSUES CONTINUED − HHSC

Brief Description of Issue

Issue 4: Do gaps exist in managed care delivery and HHSC's relationship with managed care organizations?

Discussion

HHSC continues to improve and enhance contract monitoring and oversight of managed care organizations' (MCO) delivery systems. The Medicaid/CHIP Division Program Operations area provides MCO oversight and contract monitoring. HHSC hired additional staff for contract management functions and restructured the area to facilitate better identification of MCO activities. HHSC is subject to increased federal oversight through the monitoring requirements of the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver and must report on managed care service delivery on a regular basis.

Challenges exist including meeting aggressive timelines for federal approvals necessary to implement legislation or other directives and providing MCOs sufficient lead time to implement and operationalize new business expectations. Staff work to improve internal processes and shift the focus from fee for service process to managed care so MCOs have sufficient time to implement new policies.

The Medicaid/CHIP Division works with an external quality review organization (ERQO) to monitor the quality of MCO benefits and services. A recently developed web portal, various quality-of-care reports, and a performance based program reward and penalize plans based on certain quality measures. HHSC and the EQRO are able to provide quality information about to help plans improve care for Medicaid members.

HHSC strives to achieve financial integrity and transparency of MCO financial reporting. Various MCO business models, which include different financial and operational motivations, business practices, and infrastructure, are all important as HHSC strives to confirm MCO financial statements are fully transparent. HHSC employs the experience rebate process to recover excess profits generated by the MCOs. The effectiveness of the experience rebate process depends upon the reliability and accuracy of the MCOs' self-reported data.

Possible Solutions and Impact

As more services and programs are carved into managed care, there is a need for more staff to continue MCO contract management improvements and communication. Implementation of utilization review by HHSC, as directed in S.B. 348, 83rd Legislature, will provide additional

oversight for MCO service assessment and delivery in STAR+PLUS. The transition of the DADS STAR+PLUS Support Unit to HHSC will increase Program Operations' abilities to provide ongoing and additional monitoring of MCO activities.

Staff are working to improve coordination between HHSC, EQRO, and the MCOs to better incorporate the EQRO reports and data into the contract monitoring process.

To achieve the highest level of financial integrity of MCO reporting, Program Operations employs a variety of tools and methods:

- stringent cost allowability and transparency requirements;
- a robust financial reconciliation and validation process;
- a three-part audit program using two outside contractors;
- a functional survey of the MCOs; and
- the use of encounter data to validate MCO paid claims.

Program Operations cooperates with federal agencies regarding MCO compliance with Medicaid program integrity issues. This area develops required contract amendments and oversees MCO compliance with federal requirements. Program Operations also identifies any need to revise policies or business practices due to recent and proposed changes to national financial reporting practices and principles.

IX. MAJOR ISSUES CONTINUED − HHSC

Brief Description of Issue

Issue 5: Should the State revise its approach to obtaining durable medical equipment?

Discussion

Currently, HHSC and the Medicaid program purchase outright (pay up-front) only new durable medical equipment (DME), regardless of cost. Once purchased, even the most expensive items are considered the property of the patient. Often, these items are only used for a relatively brief period of time due to changes in the patient's medical condition making that particular DME no longer the appropriate item; the DME not performing for the patient as expected; the patient's residence changing so that the item is no longer necessary (e.g., moved to long-term care); or the patient expiring. In these situations, the value of the DME is not realized by either the patient or the Medicaid program. The patient and or the family is then burdened with having to store or dispose of these unnecessary or unused items, often selling them. Millions of dollars are lost each year due to the unnecessary cash purchasing of expensive, non-customized DME with a limited future.

Most of the purchased DME devices, such as the $25,000 hospital beds, are not customized but are off-the-shelf and not tailored for a specific patient. Such items could be recycled and used by other patients. In the commercial world, similar equipment is rented, sometimes indefinitely, and sometimes until a cumulative purchase price has been reached, at which time ownership changes hands.

Possible Solutions and Impact

Allowing or mandating lease-to-own for all new or used DME greater than $1,000, for example, would help the State avoid unnecessary expenditures and avoid paying up-front for expensive DME items which may turn out to have only a very short period of use. This change could also move HHSC toward solving the issue of "ownership" as presented in S.B. 1175, 83rd Legislature, Regular Session, 2013. The DME companies would likely benefit by this arrangement because any item returned before the purchase price has been reached could then be reused, re-leased, or re-rented by them, as they would retain ownership.

Under this scenario, HHSC and Medicaid would stop purchasing non-customized, new, expensive DME costing greater than a specified amount, and put all this DME on a lease-to-own contract. Once the purchase price plus some additional percent for maintaining the equipment has been reached, the equipment would be considered purchased by HHSC and a maintenance agreement would kick in going forward.

Once purchased, the State could retain "ownership" or ownership could pass to the patients, as it does now. If the equipment is owned by the State and it is no longer needed or used by the patient, then the state would retrieve the equipment, clean, and store it until reissued to another Medicaid patient. Prior to "purchase," if the equipment is no longer needed by the patient, ownership would revert back to the DME company. Patients expecting ownership might be unhappy if the State retained ownership and the State would be responsible for housing DME retrieved from patients' homes. However, financial savings could occur for both the State and the DME providers.

Alternatively, all non-customized, expensive DME could be purchased directly from the manufacturer, at wholesale, either outright or on a scheduled payment plan − a common practice with commercial carriers. Under this scenario, the manufacturer would be responsible for delivery, set-up, and on-going maintenance (probably via local subcontractors). This type of arrangement could include not only DME, but also on-going or continuous supplies, including everything from internal feeding formulas to diapers and nebulizer sets. Such items would likely be purchased directly from the manufacturers and manufacturers could bid their product prices to be put on a state "Preferred Supplies List" (similar to the State's Preferred Drug List). As such, the State would pay discounted, wholesale prices.

IX. MAJOR ISSUES CONTINUED − HHSC

Brief Description of Issue

Issue 6: Is the health information exchange providing beneficial outcomes?

Discussion

The exchange of health information has a direct and positive impact on the quality-of-care delivered to Medicaid clients and enhancing the Health and Human Services' (HHSC) oversight and monitoring functions. The electronic exchange of Medicaid client histories can be accomplished through health information exchanges (HIE). HHSC is a key player in HIE development in Texas. The data exchanged will be obtained from clinicians' electronic health records (EHR) systems, laboratories, and public health registries.

Since 2011, more than 6,200 eligible professionals and 285 eligible hospitals received Medicaid incentive funds to adopt, implement, or upgrade to certified EHR technology (CEHRT). Ideally, HHSC should have access to clients' electronic data maintained in the Medicaid providers' EHRs. This clinical information will allow the state to combine this information with other data sources to formulate a more complete picture of Texas Medicaid clients' health.

Texas does not have a fully operational statewide health information exchange. The infrastructure for the secure exchange of standards-based electronic health records among authorized organizations, providers and patients is being implemented. With initial funding from the Office of the National Coordinator, HHSC contracted with the Texas Health Services Authority (THSA) and 12 local HIEs throughout the state to establish the HIE infrastructure. Several of the local HIEs funded by HHSC are already operational, but limited, and others will be coming online in the near future. As a pilot project, HHSC successfully exchanged medication information with two local HIEs, as required by H.B. 1218, 81st Legislature, Regular Session, 2009. The impact of this data on the quality of care of clients was not part of this pilot.

HHSC is developing a clinical gateway to collect data, especially clinical data, from the EHRs for Medicaid clients. The Medicaid Clinical Gateway will interface with statewide HIEs based on THSA standards and protocols based on nationally recognized standards. Medicaid providers who receive EHR incentives attest to meaningful use of CEHRT and clinical quality measures outlined by the Centers for Medicare & Medicaid Services. These measures must be provided to HHSC by the ENR recipients as part of their state attestation they are using CEHRT in a meaningful way. Eligible professionals and hospitals can opt to report key public health measures, such as immunization records, electronically via the HIEs. Public health reporting is a key component to the HIEs.

While HIE technology and standards are progressing, legal and policy framework for the HIEs requires additional work. The following are two examples of legal and policy issues.

- Maintaining privacy and security of electronic personal health information (ePHI) presents a deployment barrier to an HIE framework in Texas. The Health Insurance Portability and Accountability Act (HIPPA) allows sharing ePHI, except for psychotherapy notes, without patient consent between covered entities (a healthcare provider, a health plan, or a healthcare clearinghouse) for treatment, payment, and operations. However, other federal and state laws have more stringent data privacy protections. Navigating through this framework poses a huge challenge. The challenges of authenticating the parties requesting the sharing of this information are substantial.
- The ability for state agencies to share health information to improve the quality of healthcare provided to Medicaid clients is difficult with the current regulatory framework. Agencies need to share information with Medicaid providers and facilitate transition of care to clients who seek treatment elsewhere. Senate Bill 7, 83rd Legislature, Regular Session, 2013, begins to address this challenge. However, additional statutory barriers still exist, such as the inability of sharing much of the DSHS public health information.

The 83rd Legislature, 2013, passed bills that accelerate the implementation of the HIE framework (S.B. 1643, 83rd Legislature, Regular Session, 2013), which enables providers to access controlled substance prescription information. Other proposed HIE related bills did not pass. Some of these bills include:

- House Bill 2939, 83rd Legislature, Regular Session, 2013, directed all communication and information system used by HHSC is interoperable with each other, based on nationally recognized interoperability standards. This bill would have allowed the state to begin exchanging information with each other and other entities.
- Amendments to S.B. 7, 83rd Legislature, Regular Session, 2013, clarified DSHS statutes enabling access to certain public health information.

Possible Solutions and Impact

- Work with HHSC Legal for an interpretation of Government Code, Section 531.024, (amended by S.B. 7, 83rd Legislature, Regular Session, 2013), regarding statutory barriers to fully implement HIEs.
- Convene a HHS System-level workgroup for formulating policy for the electronic sharing of data. The workgroup needs to address a uniform way for the state to manage patient consent to share their health information.
- Facilitate public health reporting through the HIEs.
- Consider obtaining clinical records from Medicaid providers through contract amendments.

IX. MAJOR ISSUES CONTINUED − HHSC

Brief Description of Issue

Issue 7: Does a more effective method exist to operate the Texas Women's Health Program efficiently under its new structure?

Discussion

The Medicaid Women's Health Program (WHP), funded through a Section 1115(a), Social Security Act, research and demonstration waiver, ended on December 31, 2012. Pursuant to the 2012-13 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, Health and Human Services Commission, Rider 62), HHSC sought renewal of the demonstration waiver authorizing WHP. The program is subject to Human Resources Code § 32.024(c-1), as added by the 82nd Legislature, First Called Session, 2011, where affiliates of abortion providers are prohibited from participating in WHP. Due to the limitation on participating providers, the Centers for Medicare & Medicaid Services indicated to HHSC that the Section 1115 (a) research and demonstration waiver would not be renewed. To serve WHP clients with continued access to family planning services, the fully state-funded Texas Women's Health Program (TWHP) was created and implemented on January 1, 2013.

HHSC has limited authority to administer healthcare services other than Medicaid. TWHP was established within the Department of State Health Services (DSHS) under state law to administer Primary Healthcare Program services. DSHS contracted with HHSC through an interagency contract to administer the day-to-day operations of the TWHP. Other family planning services in the HHS Enterprise are provided through Medicaid or administered by DSHS.

TWHP uses many of the day-to-day operations of its predecessor program, including client eligibility requirements, provider billing processes, and provider certification processes. TWHP provides the same services as its predecessor program plus treatment for certain sexually transmitted infections diagnosed during family planning health screenings. Similar to the predecessor program, TWHP provides limited benefits to clients, so when a provider identifies other medical issues, the provider must refer a client to another provider who can assist them. Prior to fiscal year 2013, DSHS family planning contractors provides additional wrap services to WHP clients pursuant to the 2010-11 General Appropriations Act, S.B. 1, 81st Legislature, Regular Session, 2009 (Article II, Department of State Health Services, Rider 66), and with the Primary Health Care expansion, the Medicaid/CHIP Division is working with DSHS to provide wrap services once again.

To maintain client access to qualified providers, HHSC developed an active client referral process prior to the implementation of TWHP. HHSC expanded the scope of the client and

provider call centers to assist clients in locating a provider. Clients were directed to the call center if they needed assistance finding a provider. To date, the call center has found a provider for every client that requested assistance in locating a provider. HHSC created the TexasWomensHealth.org website to further assist clients in locating a provider.

Possible Solutions and Impact

The ability to contract with DSHS through an interagency contract enabled HHSC to operate TWHP. As noted, other family planning services continue to be administered by DSHS. However, the HHS System could evaluate if efficiencies can be achieved by transitioning additional TWHP operational authority to DSHS. TWHP does not receive federal Medicaid funding and DSHS has policy and medical staff that support other family planning programs and develop standards of care that act as a guide for family planning providers. This change could enhance efficiencies through centralizing family planning operations.

X. OTHER CONTACTS

Health and Human Services Commission Exhibit 14: Contacts			
INTEREST GROUPS			
Group or Association Name/ Contact Person	**Address**	**Telephone**	**E-mail Address (if available)**
AARP/ Amanda Fredricksen, Director of Advocacy	98 San Jacinto Blvd. Suite 750 Austin, TX 78701	(512) 391-9299	afredriksen@aarp.org
ADAPT/ Bob Kafka, Organizer	1640 E. 2nd Street, # A Austin, TX 78702	(512) 442-0252	bob.adapt@sbcglobal.net
Arc of Texas/ Amy Mizcles, Director of Government Affairs	8001 Centre Park Dr. Austin, TX 78754	(512) 454-6694 ext. 7736	amizcles@thearcoftexas.org
Casey Family Programs/ Carolyne Rodriguez, Senior Director, Strategic Consulting	5201 E. Riverside Dr. Austin, TX 78741	(512) 892-5890	Not disclosed.
Center for Public Policy Priorities/ Anne Dunkelberg, Associate Director	7020 Easy Wind Dr. #200 Austin, TX 78752	(512) 320-0222	dunkelberg@cppp.org
Coalition of Texans with Disabilities/ Dennis Borel, Executive Director	316 W. 12th Street Suite 405 Austin, TX 78701	(512) 478-3366	dborel@txdisabilities.org
Daughters of Charity/ J.T. Dwyer	1018 W. 31st Street Austin, TX 78705	(512) 533-4770	jtdwyer@seton.org
Disability Rights Texas/ Susan Murphee, Senior Policy Specialist	2222 W. Braker Lane Austin, TX 78758	(512) 454-4816	smurphee@brtx.org
Hogg Foundation for Mental Health/ Colleen Horton, Policy Program Officer	3001 Lake Austin Blvd. Austin, TX 78703	(512) 471-5041	colleen.horton@austin.utexas.edu
March of Dimes/ Morgan Sanders, State Director of Public Affairs	11044 Research Blvd Suite A-210 Austin, TX, 78759	(512) 568-3449	slucas@marchofdimes.com

INTEREST GROUPS			
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Mental Health America of Texas/ Gyl Switzer, Public Policy Director	1210 San Antonio Street, Suite 200 Austin, TX 78701	(512) 454-3706	gyl@mhatexas.org
NAMI Texas/ Kent Reynolds, Executive Director	Fountain Park Plaza III 2800 S. IH-35 Suite 140 Austin, TX 78704	(512) 693-2000	executivedirector@namitexas.org
Texans Care for Children/ Lauren Dimitry, Policy Coordinator	811 Trinity Street, Suite A Austin, TX 78701	(512) 473-2274	ldimitry@txchildren.org
Texas Alliance for Life/ Joe Pojman, Executive Director	8000 Centre Park Dr. Suite 380 Austin, TX 78754	(512) 477-1244	joe@texasallianceforlife.org
Texas CASA/ Andrea Sparks, Director of Public Affairs	1501 W. Anderson Lane, Suite B-2 Austin, TX 78757	(512) 473-2627	asparks@texascasa.org
Texas Conservative Coalition/ Brent Connett, Policy Analyst	919 Congress Avenue Austin, TX 78701	(512) 474-1798	brent@txcc.org
Texas Council on Family Violence/ Aaron Setliff, Director of Policy	P.O. Box 161810 Austin, Texas 78716	(512) 794-1133	asetliff@tcfv.org
Texas E-Health Alliance/ Nora Belcher, Executive Director	815-A Brazos Street PMB 233 Austin, TX 78701	(512) 536-1340	nora@txeha.org
Texas Food Bank Network/ JC Dwyer, Senior Director of Policy and Communications	2001 Beach Street # 630 Fort Worth, TX 76103	(817) 531-3663	jcdwyer@tfbn.org
Texas HIV/AIDS Coalition/ Randall Ellis, Chair	1415 California Street Houston, TX 77006	(832) 202-4722	rellis@legacycommunityhealth.org
Texas Hunger Initiative/ Jeremy Everett	School of Social Work Baylor University, One Bear Place - Suite #97120 Waco, TX 76798-7120	(254) 710-3704	jeremy.everett@baylor.edu
Texas Impact/ Bee Moorhead, Executive Director	200 E. 30th Street Austin, TX 78705	(512) 472-3903	bee@texasimpact.org

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Texas Public Policy Foundation/ Arlene Wohlgemuth, Executive Director	900 Congress Avenue Suite 400 Austin, TX 78701	(512) 472-2700	arlene@texaspolicy.com
Texas Right to Life/ John Seago, Legislative Director	9800 Centre Parkway, Suite 200 Houston, TX 77036	(713) 782-5433	JSeago@TexasRightToLife.com
Texas Senior Advocacy Coalition/ David Thomason, Chair	2205 Hancock Drive Austin, TX 78756	(512) 467-2242	david@tahsa.org
Texas Silver Haired Legislature/ Carlos Higgins, Chair, Legislative Action Committee	10712 Fountainbleu Circle Austin, TX 78750	(512) 258-3564	carlostx@sbcglobal.net
TexProtects/ Madeline McClure, Executive Director	2904 Floyd Street Suite C2 Dallas, TX 75204	(214) 442-1674	madeline@texprotects.org

INTERAGENCY, STATE, OR NATIONAL ASSOCIATIONS			
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Childrens Hospital Association of Texas/ Bryan Sperry, President	823 Congress Avenue Suite 1500 Austin, TX 78701	(512) 320-0910	bryansperry@childhealthtx.org
Coalition for Nurses in Advanced Practice/ Jennifer Fontana, Executive Director	P.O. Box 86 Cedar Park, TX 78630	(512) 694-8346	jennifer@cnaptexas.org
National Association of Social Workers - Texas Chapter/ Susan Milam, Director of GR	810 W. 11th Street Austin, TX 78701-2010	(512) 474-1454	smilam@naswtx.org
OneStar Foundation/ Elizabeth Darling, CEO	9011 Mountain Ridge Drive, Suite 100 Austin, TX 78759	(512) 287-2000	liz@onestarfoundation.org
Teaching Hospitals of Texas/ Chris Yanas, Vice President, Operations & Advocacy	1005 Congress Avenue Suite 830 Austin, TX 78701	(512) 476-1497	chris@thotonline.org
Texas Academy of Family Physicians/ Tom Banning, CEO/Executive VP	12012 Technology Blvd., Suite 200 Austin, TX 78727	(512) 329-8666 ext. 22	tbanning@tafp.org
Texas Academy of Physician Assistants/ Lisa Jackson, Executive Director	401 W. 15th Street Austin, TX 78701-1680	(512) 370-1537	lisa.jackson@texmed.org
Texas Ambulance Association/ GK Sprinkle, Public Policy Consultant	2801 Winston Court Austin, TX 78731	(512) 458-1888	gksprinkle@gmail.com
Texas Ambulatory Surgery Center Society/ Tony German, Executive Director	401 W. 15th Street Austin, TX 78701	(512) 535-2325	tony@texasascsociety.org
Texas Association for Home Care and Hospice/ Rachel Hammon, Executive Director	3737 Executive Center Drive, Ste. 268 Austin, TX 78731	(512) 338-9293	Rachel@tahch.org
Texas Association of Community Health Centers / Jose Camacho, Executive Director	5900 Southwest Parkway, Bldg. 3 Austin, TX 78735	(512) 329-5959	jcamacho@tachc.org
Texas Association of Health Plans/ David Gonzales, CEO & Executive	1001 Congress Avenue, Suite 300	(512) 476-2091	dgonzales@tahp.org

INTERAGENCY, STATE, OR NATIONAL ASSOCIATIONS			
Group or Association Name/ Contact Person	**Address**	**Telephone**	**E-mail Address (if available)**
Director	Austin, TX 78701		
Leading Age Texas/ Alyse Migliaro, Director of Public Policy	2205 Hancock Drive Austin, TX 78756	(512) 467-2242	alyse@leadingagetexas.org
Texas Association of Obstetricians and Gynecologists/ Mignon McGarry, Legislative Consultant	504 W. 14th Street Austin, TX, 78701	(512) 708-9053	mignon@mignonm.com
Texas Association of Orthotists and Prosthetists / Brandon Aghamalian, Legislative Consultant	823 Congress Avenue, Suite 1200 Austin, TX, 78701	(512) 637-6020	taopstaff@gmail.com
Texas Council of Community Centers/ Susanne Elrod, Associate Director - Developmental Disability	8140 N. Mopac Expwy. Westpark Building 3 Suite 240 Austin, TX 78759	(512) 794-9268	selrod@txcouncil.com
Texas Dental Associatio / Susan Ross, Consultant	1946 S. IH 35 Suite 400 Austin, TX 78704	(512) 443-3675	jcalvert@tda.org
Texas Federation of Drug Stores/ Brad Shields, Lobbyist	504 W. 12th Street Austin, TX 78701	(512) 472-8261	jstorm@txretailers.org
Texas Health Care Association/ Tim Graves, President & CEO	P.O. Box 4554 Austin, TX 78765	(512) 458-1257	tgraves@txhca.org
Texas Hospital Association/ Dan Stultz, President & CEO	1108 Lavaca Street Suite 700 Austin, TX 78701-2180	(512) 465-1000	dstultz@tha.org
Texas Medical Association/ Darren Whitehurst, VP - Advocacy	401 W. 15 Street Austin, TX 78701	(512) 370-1300	dan.finch@texmed.org
Texas Nurses Association/ Ellarene Sanders, Interim Executive Director	8501 N. MoPac Expy. Suite 400 Austin, TX 78759-8396	(512) 452-0645	esanders@texasnurses.org
Texas Occupational Therapy Association/ Mary Hennigan, Executive Director	1106 Clayton Lane Suite 516W Austin, TX 78723	(512) 454-8682	mary@tota.org
Texas Ophthalmological Association/	401 W. 15th Street	(512)	exec@texaseyes.org

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Texas Optometric Association/ BJ Avery, Executive Director	1104 West Avenue Austin, TX 78701	(512) 707-2020	bj@txeyedoctors.com
Texas Organization of Rural & Community Hospitals/ David Pearson, President & CEO	P.O. Box 203878 Austin, TX 78720-3878	(512) 873-0045	dpearson@torchnet.org
Texas Orthopedic Association/ Bobby Hillert, Executive Director	401 W. 15th St Suite 820 Austin, TX 78701	(512) 370-1505	bhillert@toa.org
Texas Pediatric Society/ Mary Greene-Noble, Executive Director	401 W. 15th Street Suite 682 Austin, TX 78701	(512) 370-1506	mary.greene-noble@txpeds.org
Texas Pharmacy Association/ Joe DaSilva, Director of Public Affairs	6207 Bee Caves Road Suite 120 Austin, TX 78746	(512) 836-8350	jdasilva@texaspharmacy.org
Texas Pharmacy Business Council/ Michael Wright, Executive Director	1001 Congress Avenue Suite 250 Austin, TX 78701	(512) 992-1219	mwright@TxRxCouncil.org
Texas Physical Therapy Association/ Paul Hardin, Executive Director	900 Congress Avenue Suite 410 Austin, TX 78701	(512) 477-1818	paul@tpta.org
Texas Psychological Association/ David White, Executive Director	1464 E. Whitestone Blvd., Suite 401 Cedar Park, TX 78613	(512) 528-8400	tpa_dwhite@att.net
Texas Society of Anesthesiologists/ N. Martin Giesecke, President	401 W. 15th Street Suite 990 Austin, TX 78701-1665	(512) 370-1659	chris@tsa.org
Texas Society for Clinical Social Work/ Carolyn King, President	1635 N.E. Loop 410 Suite 901 San Antonio, TX 78209	(210) 829-0134	cmklcsw@hotmail.com
Texas Society of Pathologists/ Jill Sutton, Executive Director	401 W. 15th Street Austin, TX 78701-1680	(512) 370-1510	jill.sutton@texmed.org

INTERAGENCY, STATE, OR NATIONAL ASSOCIATIONS			
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Texas Speech-Language-Hearing Association/ Larry Higdon, Director of Legislation	P.O. Box 7922 Horseshoe Bay, TX 78657-7922	(830) 265-0828	lwhtsha@gmail.com
Texas Transit Association/ Beth Corbett, Executive Director	106 East 6th Street Suite 900 Austin, TX 78701	(512) 478-8883	beth@texastransit.org
Texas Transplantation Society/ Laurie Reece, Executive Director	P.O. Box 202194 Austin, TX 78720	(512) 961-6532	Not disclosed.
United Ways of Texas/ Karen Johnson, President & CEO	701 Brazos Street Suite 500 Austin, TX 78701	(512) 478-6601	Karen.Johnson@uwtexas.org
Women's Health and Family Planning Association of Texas/ Fran Hagerty, CEO	700 Lavaca Street Suite 1420 Austin, TX 78701	(512) 448-4857	fran.hagerty@whfpt.org

LIASONS AT OTHER STATE AGENCIES			
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Comptroller of Public Accounts/ Martin Hubert, Deputy Comptroller	P.O. Box 13528 Austin, TX, 78711-3528	(512) 463-4600	Martin.hubert@cpa.state.tx.us
Office of the Attorney General/ Daniel Hodge, First Assistant AG and Chief of Staff	P.O. Box 12548 Austin, TX, 78711-2548	(512) 463-2191	Daniel.hodge@texasattorneygeneral.gov
Texas Department of Criminal Justice/ Brad Livingston, Executive Director	P.O. Box 13084 Austin, TX, 78711-3084	(936) 437-2101	exec.director@tdcj.state.tx.us
Texas Education Agency/ Michael Williams, Commissioner	1701 N. Congress Avenue Austin, TX 78701-1494	(512) 463-9734	Commissioner@tea.state.tx.us
Texas Division of Emergency Management/ Chief W. Nim Kidd	P.O. Box 4087 Austin, TX 78773-0220	(512) 424-2208	Nim.Kidd@dps.texas.gov
Texas Employees Retirement System/ Ann Bishop, Executive Director	P.O. Box 13207 Austin, TX 78711-3207	(512) 867-7711	ann.bishop@ers.state.tx.us
Texas Facilities Commission/ Terry Keel, Executive Director	P.O. Box 13047 Austin, TX 78711-3047	(512) 463-3446	Terry.keel@tfc.state.tx.us
Texas Higher Education Coordinating Board/ Linda Battles, Associate Commissioner	P.O. Box 12788 Austin, TX, 78711-2788	(512) 427-6101	Linda.battles@thecb.state.tx.us
Texas Department of Housing and Community Affairs/ Tim Irvine, Executive Director	P.O. Box 13941 Austin, TX 78711-3941	(512) 475-3800	tim.irvine@tdhca.state.tx.us
Texas Department of Information Resources/ Karen Robinson, Chief Information Officer	P.O. Box 13564 Austin, TX 78711-3564	(512) 475-4700	karen.robinson@dir.texas.gov
Texas Department of Insurance/ Katrina Daniel	P.O. Box 149104 Austin, TX 78711-9104	(512) 463-6169	Katrina.Daniel@tdi.texas.gov

LIASONS AT OTHER STATE AGENCIES			
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Texas Board of Nursing/ Kathy Ship, Executive Director	333 Guadalupe Street Suite 3-460 Austin, TX 78701	(512) 305-7400	kathy.thomas@bne.texas.gov
Texas Department of Public Safety/ Steven McCraw, Director	P.O. Box 4087 Austin, TX 78773-0001	(512) 424-2000	steven.mccraw@dps.texas.gov
Texas Department of Transportation/ Phil Wilson, Executive Director	125 E. 11th Street Austin, TX 78701-2483	(512) 463-8585	phil.wilson@txdot.gov
Texas Veterans Commission/ Thomas Palladino, Executive Director	P.O. Box 12277 Austin, TX 78711-2277	(512) 463-6564	executiveoffice@tvc.texas.gov
Texas Workforce Commission/ Larry Temple, Executive Director	101 E. 15th Street Austin, TX 78778	(512) 463-2222	Larry.temple@twc.state.tx.us

XI. ADDITIONAL INFORMATION

A. Texas Government Code, Sec. 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 report that 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 in place. If the list is longer than one page, please include it as an attachment.

HHSC completes more than 100 statutorily required reports. Due its length, the list is included as an attachment to the Self-Evaluation Report.

B. Has the agency implemented statutory requirements to ensure the use of "first person respectful language"? Please explain and include any statutory provisions that prohibits these changes.

Section 531.0227 of the Government Code requires the Executive Commissioner to ensure that HHSC and the HHS System agencies "use the terms and phrases listed as preferred under the person first respectful language initiative in Chapter 392 [of the Government Code] when proposing, adopting, or amending the commission's or agency's rules, reference materials, publications, and electronic media." Section 531.0227 was effective September 1, 2011.

This statutory directive has been implemented at HHSC, both through the Executive Commissioner's instructions to HHSC and the HHS System agencies and through HHSC's own work developing or revising agency materials. Specific examples include the following.

Guidance Memorandum

The Executive Commissioner issued Health and Human Services (HHS) Guidance Memorandum GM-12-002, *Person First Respectful Language in Communications*, in December 2011. In it, the Executive Commissioner directs each agency to use appropriate person first terms and phrases when proposing, adopting, or amending agency rules, reference materials, publications, and electronic media. Executive management at HHSC and the HHS System agencies was notified directly of GM-12-002. In addition, the release of GM-12-002 was featured in *The Connection*, the HHS System newsletter available to staff at HHSC and the HHS System agencies. GM-12-002 was last updated in January 2013.

Communications to Staff

The Connection highlighted the legislation underlying section 531.0227 – House Bill 1481, 82nd Legislature, Regular Session, 2011 – and noted efforts of DADS and other agencies to encourage person first respectful language. A second article noted the passage of H.B. 1481 and the new

requirements for HHSC and the HHS System agencies.

Rule Review

Staff uses rule drafting guidelines that include a specific reference to H.B. 1481 and examples of person first respectful language. As HHSC develops new rules or proposes to amend existing rules, the originating program and legal staff review to ensure the use of preferred terms.

HHS Style Guide

HHSC's Communications staff updated the *HHS Style Guide for Consumer Materials* to include instructions on the use of person first respectful language. The style guide is intended to ensure consistency in the materials written for consumers of HHS services by the agency or contractors providing those services. Medicaid managed care organizations, for example, are required by HHSC's Uniform Managed Care Manual to use the style guide in writing marketing or other materials for their members.

HHSC has not encountered any statutory prohibition on using person first respectful language.

C. Fill in the following chart detailing information on complaints regarding your agency. Do not include complaints received against people or entities you regulate. The chart headings may be changed if needed to better reflect your agency's practices.

Health and Human Services Commission
Exhibit 15: Complaints Against the Agency — Fiscal Years 2011 and 2012

	FY 2011	FY 2012
Number of complaints received	34,649	23,286
Number of complaints resolved	34,647	23,263
Number of complaints dropped/found to be without merit	See Note*	17,788
Number of complaints pending from prior years	171	173
Average time period for resolution of a complaint	1 Business Day	2 Business Days

Notes:

* **Number of complaints dropped/found to be without merit –** The Office of the Ombudsman (OO) addressed all complaints received and did not identify complaints as dropped or found to be without merit. Effective September 1, 2011 (FY 2012), the OO enhanced its database to track the following categories.

- **Substantiated** - Research clearly indicates agency policy or agency expectations were violated.
- **Unsubstantiated -** Research clearly indicates agency policy or agency expectations were **not** violated.
- **Unable to Substantiate -** Research does not clearly indicate if agency policy or agency expectations were violated.

D. Fill in the following chart detailing your agency's Historically Underutilized Business (HUB) purchases.

Health and Human Services Commission Exhibit 16: Purchases from HUBs FISCAL YEAR 2010					
Category	**Total $ Spent**	**Total HUB $ Spent**	**Percent**	**Agency Goal ***	**Statewide Goal**
Heavy Construction	$896.00	$0	0.00%	11.9%	11.9%
Building Construction	$9,811.00	$408.00	4.16%	26.1%	26.1%
Special Trade	$2,782,572.00	$433,069.00	15.56%	57.2%	57.2%
Professional Services	$4,593,419.00	$159,960.00	3.48%	20.0%	20.0%
Other Services	$632,262,406.00	$98,372,758.00	15.55%	33.0%	33.0%
Commodities	$75,055,526.00	$18,080,205.00	24.08%	12.6%	12.6%
TOTAL	$714,704,630.00	$117,046,400.00	16.30%		

FISCAL YEAR 2011					
Category	**Total $ Spent**	**Total HUB $ Spent**	**Percent**	**Agency Goal**	**Statewide Goal**
Heavy Construction	$400.00	$0	0.00%	11.9%	11.9%
Building Construction	$6,820.00	$0	0.00%	26.1%	26.1%
Special Trade	$3,161,847.00	$687,394.00	21.74%	57.2%	57.2%
Professional Services	$3,899,745.00	$0	0%	20.0%	20.0%
Other Services	$624,524,275.00	$112,828,270.00	18.07%	33.0%	33.0%
Commodities	$78,782,839.00	$25,170,665.00	31.95%	12.6%	12.6%
TOTAL	$710,375,926.00	$138,686,329.00	19.52%		

FISCAL YEAR 2012					
Category	**Total $ Spent**	**Total HUB $ Spent**	**Percent**	**Agency Goal**	**Statewide Goal**
Heavy Construction	$0	$0	0.00%	0.00%	11.2%
Building Construction	$0	$0	0.00%	0.00%	21.1%
Special Trade	$2,913,068.00	$266,349.00	9.14%	28.9%	32.7%
Professional Services	$2,098,063.00	$327,810.00	15.62%	23.6%	23.6%

Other Services	$704,177,042.00	$166,846,608.00	23.69%	24.6%	24.6%
Commodities	$60,927,474.00	$15,105,553.00	24.79%	21.0%	21.0%
TOTAL	$770,115,647.00	$182,546,320.00	23.70%		

* If your goals are agency-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 20.13)

House Bill 3560, 80th Legislature, Regular Session, 2009, amended Texas Government Code 2161.123, requiring state agencies to establish goals for contracting with HUBs in each procurement category based on scheduled fiscal year expenditures and the availability of HUBs in each category, as determined by the Texas Comptroller of Public Accounts (CPA) statewide HUB rules. H.B. 3560 also directed the Texas State Auditor's Office (SAO) to consider the agency goals when conducting a HUB compliance audit. The SAO determined that state agencies must engage in their own internal goal-setting deliberations to establish HUB contracting goals that align with the agency's operational needs.

As directed by CPA staff, each HHS HUB Office reviews the past five years of its agency expenditure data to determine the appropriate agency goal for contracting with HUBs in each procurement category. In addition, each agency requested fiscal-year contracting activities forecasting for each procurement category with input from various agency programs/divisions.

E. Does your agency have a HUB policy? How does your agency address performance shortfalls related to the policy? (Texas Government Code, Sec. 2161.003; TAC Title 34, Part 1, rule 20.15b)

Yes, HHSC has a policy on the use of Historically Underutilized Businesses (HUBs). HHSC adopted the Comptroller of Public Accounts (CPA) HUB rules by reference in TAC §392.100. The policy mandates that HHSC shall make a good faith effort to utilize HUBs or minority businesses in contracts for construction, services, and commodities; and to encourage the use of HUBs by implementing these policies through race-, ethnic-, and gender-neutral means.

HHSC is committed to promoting full and equal business opportunities for all businesses in state contracting in accordance with the following six goals for HUB participation:

(1) 11.9 percent for heavy construction other than building contracts;
(2) 26.1 percent for all building construction, including general contractors and operative builders' contracts;
(3) 57.2 percent for all special trade construction contracts;
(4) 20 percent for professional services contracts;
(5) 33 percent for all other services contracts; and
(6) 12.6 percent for commodities contracts.

HHSC's policy on the utilization of HUBs is related 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 shall 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.

In order to address performance shortfalls, HHSC monitors its contracts on a monthly basis to determine the level of HUB and minority participation. HHSC strives to eliminate shortfalls by analyzing the expenditures and payments made to its vendors, improve the expertise of HHSC program/division staff in evaluating contract opportunities for HUBs or minority firms, and assist each Program/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 statewide;
- hosting internal HUB forums providing HUBs the opportunity to give business presentations to agency management, purchasing, and agency HUB staff;
- identifying and developing opportunities for HUBs;
- sponsoring and assisting in the development of mentor-protégé relationships with Prime Contractors and HUBs;
- recruiting new HUBs/minority vendors for potential contracting opportunities in the procurement categories where there has been minimal 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 regarding state procurement procedures;
- assisting and soliciting minority firms for current and new contract opportunities;
- assisting HUBs with the certification and re-certification process for the Statewide HUB Program; and
- encouraging HUBs to register on the CPA's Centralized Master Bidders List (CMBL).

F. 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, Sec. 2161.252; TAC Title 34, Part 1, rule 20.14)

Yes, HHSC has an established process to ensure consideration is given to HUB goals when HHSC enters into a contract with an expected value of $100,000 or more. HHSC makes a determination whether or not subcontracting opportunities are probable under the contract

before HHSC solicits 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 division/program staff to administer comprehensive HUB subcontracting plans that include:

- providing an overview of the HUB subcontracting plan requirements during the vendor conference;
- evaluating proposal/bid responses for compliance;
- hosting post award meetings with the selected vendor which details the contractor performance expectations related to fulfilling the HUB requirements of the contract; and
- monitoring 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 will be used, then the vendor will be required to demonstrate what effort was made to solicit a certified HUB subcontractor. HHSC encourages vendors to utilize 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 of their selection process.

In addition to the above efforts, the Enterprise Contracts and Procurement Services (ECPS, Purchasing Section) assist in making a good faith effort to ensure HUBs are included in the procurement solicitation processes.

G. For agencies with biennial appropriations exceeding $10 million, answer the following HUB questions.

	Response / Agency Contact
1. Do you have a HUB coordinator? (Texas Government Code, Sec. 2161.062; TAC Title 34, Part 1, rule 20.26)	HHSC HUB Coordinator: Robert Hall, Director of Contract and Administration 4405 N. Lamar Blvd, Bldg. #1 Austin, Texas 78756

	Phone: (512) 206-5526 Fax: (512) 206-4605 Robert.Hall@hhsc.state.tx.us
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, Sec. 2161.066; TAC Title 34, Part 1, rule 20.27)	Yes, the HHSC and HHS agencies conduct a HUB forum on a monthly basis where HUB vendors are invited to attend and give a presentation regarding their products, staff, and core capabilities. We also discuss potential contracting opportunities with the vendors. HHSC invites procurement, program, HUB staff, and related decision-makers to attend these forums.
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, Sec. 2161.065; TAC Title 34, Part 1, rule 20.28)	Yes, the HHSC has a Mentor-Protégé Program. HHSC sponsored eight separate mentor-protégé agreements. Several of the HUB protégés have benefited from the agreements by receiving contracts directly from HHSC or indirectly through subcontracting opportunities.

H. Fill in the chart below detailing your agency's Equal Employment Opportunity (EEO) statistics.

Health and Human Services Commission
Exhibit 17: Equal Employment Opportunity Statistics

FISCAL YEAR 2009

Job Category	Total Positions	Minority Workforce Percentages					
		Black		Hispanic		Female	
		Agency	Civilian Labor Force %	Agency	Civilian Labor Force %	Agency	Civilian Labor Force %
Officials/Administration	416	19.2%	7.5%	17.3%	21.1%	58.4%	37.5%
Professional	8,147	27.8%	9.7%	36.5%	18.8%	78.2%	53.3%
Technical	317	17.4%	13.9%	53.9%	27.7%	73.8%	53.9%
Administrative Support	2,404	27.9%	12.7%	46.2%	31.9%	87.7%	67.1%
Service Maintenance	161	24.8%	14.1%	24.8%	49.9%	73.3%	39.1%
Skilled Craft	0	0%	6.6%	0%	46.3%	0%	6.0%

FISCAL YEAR 2010							
Job Category	Total Positions	Minority Workforce Percentages					
		Black		Hispanic		Female	
		Agency	Civilian Labor Force %	Agency	Civilian Labor Force %	Agency	Civilian Labor Force %
Officials/Administration	440	19.3%	7.5%	19.1%	21.1%	58.0%	37.5%
Professional	8,756	28.9%	9.7%	36.1%	18.8%	78.5%	53.3%
Technical	313	17.6%	13.9%	55.9%	27.7%	75.1%	53.9%
Administrative Support	2,475	27.4%	12.7%	46.5%	31.9%	87.8%	67.1%
Service/Maintenance	160	25.0%	14.1%	23.1%	49.9%	70.6%	39.1%
Skilled Craft	0	0%	6.6%	0%	46.3%	0%	6.0%

FISCAL YEAR 2011							
Job Category	Total Positions	Minority Workforce Percentages					
		Black		Hispanic		Female	
		Agency	Civilian Labor Force %	Agency	Civilian Labor Force %	Agency	Civilian Labor Force %
Officials/Administration	437	19.2%	8.99%	20.6%	19.5%	60.0%	39.4%
Professional	8,754	28.3%	11.33%	37.4%	17.4%	78.3%	59.14%
Technical	329	18.5%	14.16%	53.8%	21.63%	75.4%	41.47%
Administrative Support	2,362	27.3%	13.57%	46.1%	30.53%	88.4%	65.52%
Service/Maintenance	146	24.7%	14.68%	25.3%	48.18%	69.9%	40.79%
Skilled Craft	0	0%	6.35%	0%	47.44%	0%	4.19%

Source Data: Fiscal Year 2009 from Human Resources/PeopleSoft 08/31/2009, Fiscal Year 2010 from Human Resources/PeopleSoft 08/31/2010, and Fiscal Year 2011 from Human Resources/PeopleSoft 08/31/2011.
Note 1: The Service/Maintenance category includes three distinct occupational categories: Service/Maintenance, Para-Professionals, and Protective Services. Protective Service Workers and Para-Professionals are no longer reported as separate groups. Please submit the combined Service/Maintenance category totals, if available.
Note 2: Civilian Labor Force Figures from Texas Workforce Commission.

I. Does your agency have an equal employment opportunity policy? How does your agency address performance shortfalls related to the policy?

HHS agencies promote equal employment opportunity (EEO) through programs and policies designed to achieve employment without regard to race, color, religion, sex, national origin,

age, disability, or veteran status (referred to as protected class).

HHS EEO policy consists of the following objectives.

- Provide equal employment and promotional opportunities to all qualified persons, regardless of protected class.
- Provide civil rights information to employees regarding personnel policies, complaint procedures, and other conditions of employment affecting employees.
- Provide an internal complaint procedure for the processing of employment discrimination complaints.
- Prohibit policies, practices, or procedures that adversely impact a particular individual or group of people due to protected class status.
- Provide training to employees and managers on civil rights and equal employment legislation, policies, and procedures.

To implement this policy, HHS agencies:

- recruit, hire, train, and promote persons without regard to protected class;
- make employment decisions furthering the principle of equal employment opportunity; and
- ensure that personnel actions are administered without regard to protected class.

The Civil Rights Office conducts a workforce analysis for each agency once during the state biennium. If the analysis discloses underutilization for any agency, that agency must prepare a Recruitment Plan (RP).

Overall responsibility for implementation of the RP rests with the Executive Commissioner for Health and Human Services or designee. The Civil Rights Director is delegated the authority for implementation of the program.

HHS agencies are equal opportunity employers. HHS agencies recruit, hire, train, and promote the most qualified persons without regard to protected class. Management staff is accountable for compliance with equal opportunity policies and responsible for program support and personal leadership in establishing, maintaining, and carrying out the equal opportunity program.

Agency RPs are designed to be consistent with policies and guidelines outlined in federal and state regulations and guidelines. RPs are modified when there are substantial changes in the workforce or organization.

RPs are public records and may be viewed at the Civil Rights Office. HHS agencies send copies of their RPs to appropriate agencies of the U. S. government and the state of Texas, and to interested local groups, upon request.

XII. AGENCY COMMENTS

The passage of House Bill 2292, in 2003, established a clear directive to transform the State's approach to the delivery of health and human services, with a particular focus on addressing the following issues.

- Access to services for individuals with complex health needs that required assistance from multiple agencies.
- Lack of integrated health and human services programs and agency policies.
- Redundant and/or inefficient administrative structures.
- Blurred lines of accountability.

Through the enactment of H.B. 2292, 12 stand-alone agencies were consolidated into an integrated system of four new departments under the leadership of the Texas Health and Human Services Commission (HHSC).

Today, nearly a decade post-consolidation, a coordinated HHS System services exists. Although continued improvements may be needed in areas, progress on addressing the issues originally identified can be seen in a myriad of ways, as highlighted by the following examples.

- **Improved Service Quality and Accessibility.** Integrated programs result in improved community health. For example, the Department of State Health Services (DSHS) developed a single agency focus on physical and behavioral health issues emphasizing multi-program collaboration to improve efficiency and enhance services. Also, through a collaborative effort, HHSC and DSHS promote the benefits of the Women's Health Program and DADS, DFPS, and DSHS continue to work together to improve services in HHS-operated facilities, such as State Supported Living Centers and State Hospitals.

  Integrating service delivery among physical and behavioral health providers improves outcomes. As a means to guide current and future planning and decision making, DSHS, in conjunction with external stakeholder efforts, developed a comprehensive approach to service integration by linking behavioral and physical health services. DSHS actively encourages the use of primary health care provision as a site for early screening and diagnosis of behavioral health problems.

  Meeting the demand for services is a perennial challenge facing the HHS System. Although waiting and interest lists for programs and services remains long, the ability to consolidate funding requests to address waiting lists and to request those funds as HHS System priorities has resulted in unprecedented levels of new funding to address interest lists, especially for waiver services.

  Managing long-term care services through one agency, the Department of Aging and Disability Services (DADS), leads to greater flexibility for individuals and families seeking services. For instance, previously some individuals rose to the top of a waiting list for one program, only to learn that another agency's waiver program was more appropriate for their needs than the waiver service for which they had originally applied. Unfortunately, sometimes that meant that the client would have to start over at the bottom of another

program's list. DADS now identifies, provides services and/or places the person on the most appropriate waiver list for meeting their needs.

Better alignment of guardianship responsibilities protects the public. The transfer of guardianship responsibilities to DADS reinforced the Department of Family and Protective Services' (DFPS) primary role of investigating and serving adults in need of protection. DADS' expertise with long-term services and support programs for persons who are older and for adults with disabilities made it the appropriate agency for assuming guardianship responsibilities. Transferring this program removed any appearance of conflict of interest for DFPS staff in assessing and providing services for individuals in need of guardianship. As a result of coordinated DADS and DFPS efforts, the transfer of the guardianship program was completed with no disruption in services to individuals served.

- **Strengthening Children's Services.** An integrated system allows for a comprehensive approach to improve children's health care. Three divisions within DSHS, along with the regional Education Services Centers, combined efforts and resources to promote a coordinated approach to improving children's physical and behavioral health. The comprehensive approach includes coordinated school health, obesity prevention, suicide prevention, mental health awareness, diabetes prevention and care, and abstinence education activities. In 2008, DFPS worked with HHSC to launch STAR Health, the Medicaid managed care plan for children in foster care. Under contract with HHSC, STAR Health coordinated oversight of psychotropic medication utilization and use of psychotropic medications decreased. Additionally, the Health Passport was developed as an electronic health information system that provides information about prescribed psychotropic medications and is used as a primary source for the Psychotropic Medications Utilization Review process.

  Interagency efforts reduce psychotropic medications use for foster children. Soon after the consolidation of HHS agencies, concerns arose about possible overuse of psychotropic medications with the foster care population. DFPS and DSHS worked together using the services of a child psychiatrist to assess prescribing practices, develop prescribing guidelines, and recommend a process for ongoing clinical reviews of the use of psychotropic medications in the treatment of children in foster care.

  Consolidation leads to enhanced support for Early Childhood Intervention (ECI). Before consolidation, ECI, as a small stand-alone agency, struggled with addressing specialized tasks such as assessing the implications of rules and setting rates. Now, as a division within DARS and the integrated HHS System, ECI receives valuable support on such matters as rules, rates, and state Medicaid plan amendments.

- **Efficient and Effective Service Delivery.** Unifying web support for blind and rehabilitation services replaced two redundant legacy agency systems, and reduces the technical support, need for modifications, and costs for hardware, software, and related maintenance. Using a single system also enhances consistency among programs, because program changes and modifications will now be applied to only one application, rather than the prior multiple applications. Eliminating the redundant rules of DARS legacy agencies resulted in the

elimination of more than 100 redundant or unnecessary administrative rules from the legacy agencies.

Consolidated pharmaceutical purchasing for the DSHS Pharmacy Branch, DSHS state hospitals, and DADS state schools saves millions of dollars annually in medication and medical supplies costs. Also, consolidated support services for such facilities save millions in personnel, operations, and supply costs for both DADS and DSHS.

- **Improving Information Accessibility Across the HHS System.** Coordinating long-term care licensing and regulatory activities yields coordinated, consistent, and direct oversight. Responsibility for long-term services and supports previously was split among DADS' three legacy agencies. The services and supports provided by the three agencies served various client populations. Many of the same regulatory issues were encountered for these services and supports. The agencies often addressed these issues in different ways and with limited coordination.
- **Adopting More Cost-Effective Business Practices.** House Bill 2292 assigned HHSC responsibility for delivering administrative services for the HHS System. Examples include centralized HR services, civil rights, and support services for regional offices. These improvements saved millions in overhead costs and resulted in consistent policies, practices, and services.