Consolidated Budget

Fiscal Years 2008 - 2009

Health and Human Services Commission

Department of Aging and Disability Services

Department of Family and Protective Services

Department of Assistive and Rehabilitative Services

Department of State Health Services

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

October 1, 2006

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

The Honorable Rick Perry
Governor
State Capitol, Room 2S.1
Austin, Texas 78701

The Honorable David Dewhurst
Lieutenant Governor
State Capitol, Room 2E.13
Austin, Texas 78701

The Honorable Tom Craddick
Speaker of the House of Representatives
State Capitol, Room 2W.13
Austin, Texas 78701

John O'Brien, Deputy Director
Legislative Budget Board
1501 Congress Avenue, 5th Floor
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Gentlemen:

I am pleased to present the *Health and Human Services Consolidated Budget for the 2008-2009 Biennium*. The report identifies the major funding issues of the health and human services agencies and presents supporting information and data on the health and human services agency budget requests, demographics, and caseloads. Four health and human services system initiatives are also included: reduction of HHS waiting/interest lists; nurse retention/recruitment; rate considerations; and telecommunications/IT systems needs.

As directed by the Governor and Legislature, HHS agencies limited baseline requests for general revenue and general revenue-related funding to 90 percent of the sum of amounts expended in fiscal year 2006 and budgeted in fiscal year 2007 plus an amount equal to the general revenue-related allocation for the 3 percent/$50 employee pay raise in 2007. Exemptions include caseload growth in acute care Medicaid, long-term care Medicaid (except waivers), foster care, adoption subsidies, clawback, and early childhood intervention. Baseline requests held fiscal year 2006 rates flat for the 2008-2009 biennium. Medicaid costs were also held flat at the 2006 levels.

The consolidated budget was developed in conjunction with key staff from the health and human services agencies. We believe that our cooperative efforts have produced a document that will provide a high-level resource to assist with funding decisions for health and human services issues during the 80th Legislature.

We look forward to working with you in making the critical decisions needed for the future of Texas.

Sincerely,

Albert Hawkins

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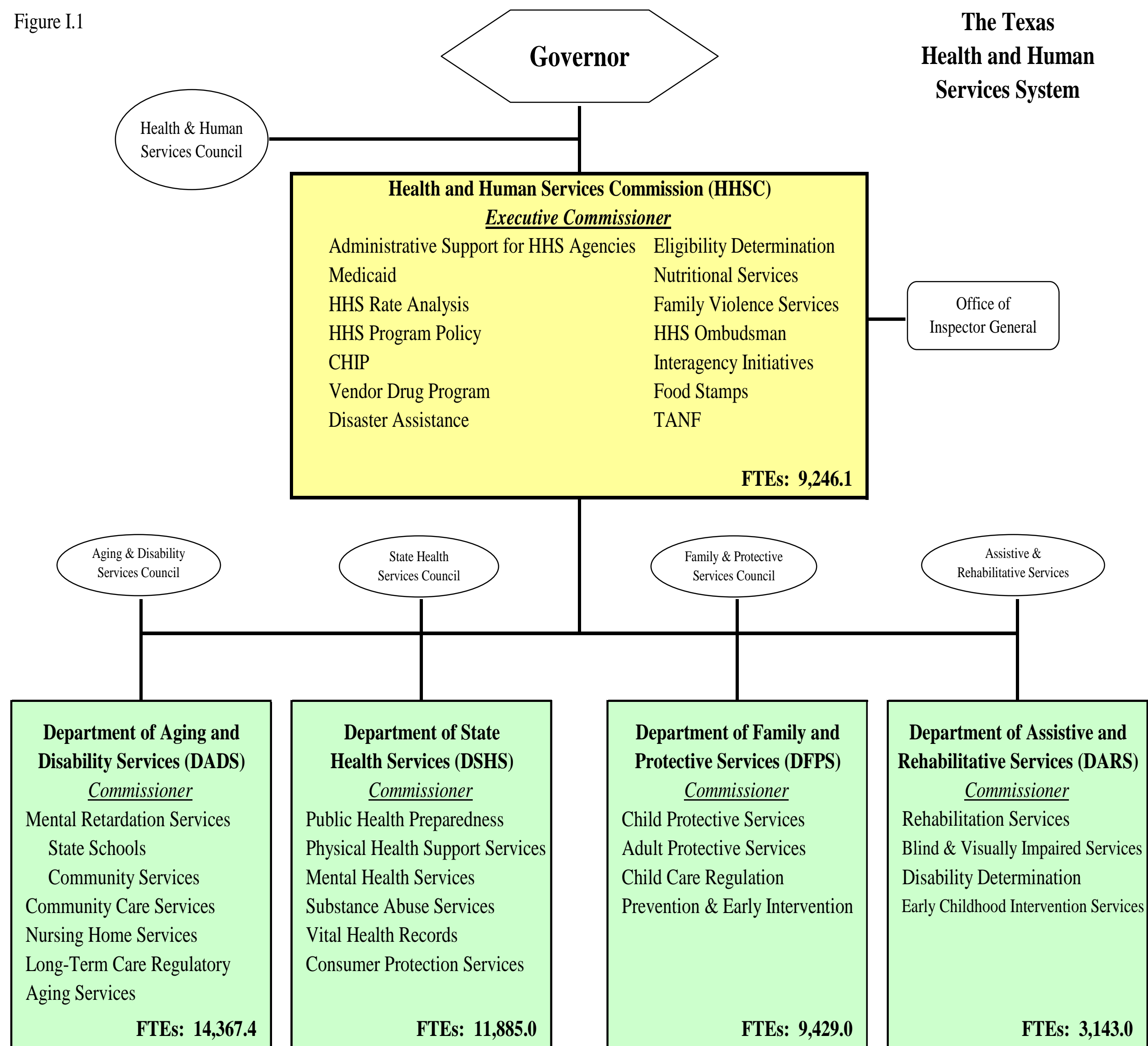
I. CONSOLIDATED BUDGET OVERVIEW

Health and Human Services System Overview

House Bill 2292 passed during the 78th Legislature set a new direction for improving the delivery of health and human services for Texas by outlining a four-phased approach to transformation.

Creation of the following agencies was designed to focus on efficiency, service delivery, and accessibility to agency resources by consumers and was successfully completed during the 2004-2005 biennium.



HHS System 2008–2009 Legislative Appropriations Request

The 2008–2009 Legislative Appropriations Request (LAR) base request combined with the exceptional items for all HHS agencies totals $58.0 billion, an increase of $9.7 billion All Funds from the 2006-2007 biennium.

Figure I.2 presents the allocation of requested funds among HHS agencies.

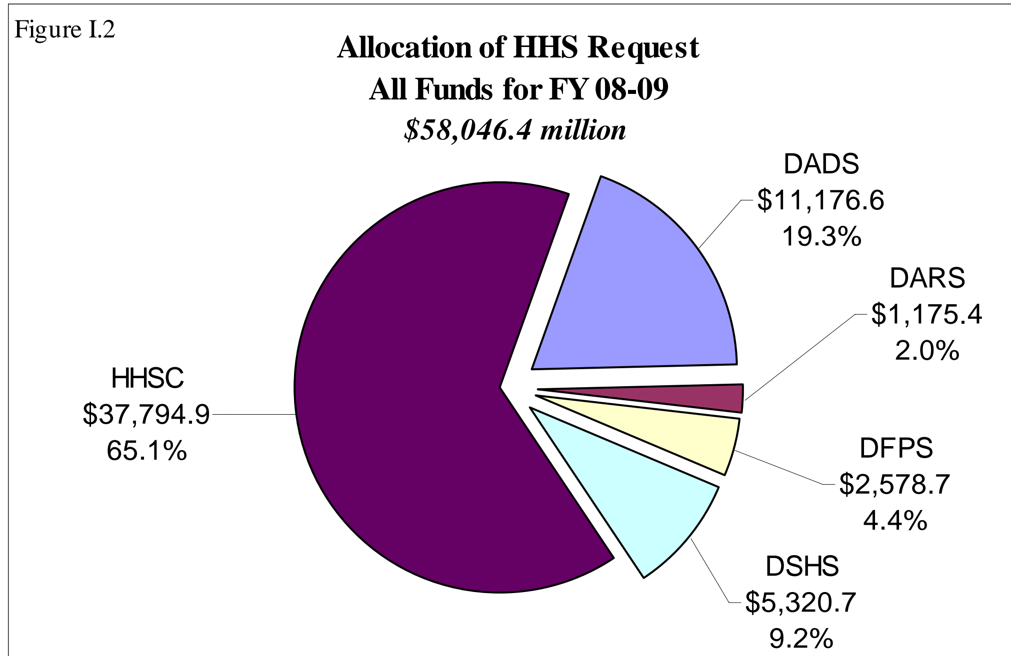
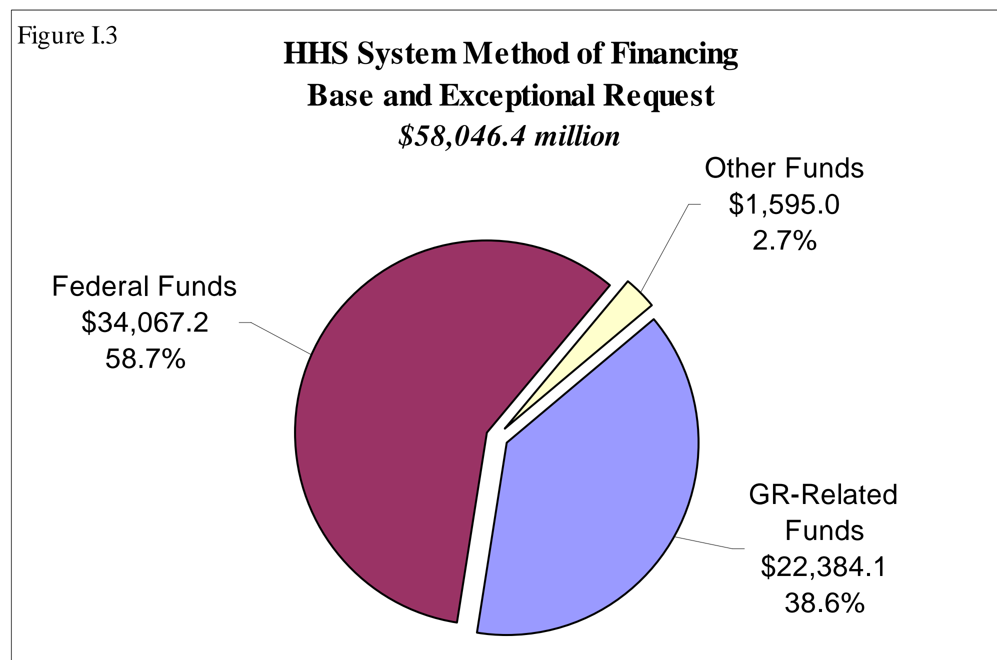
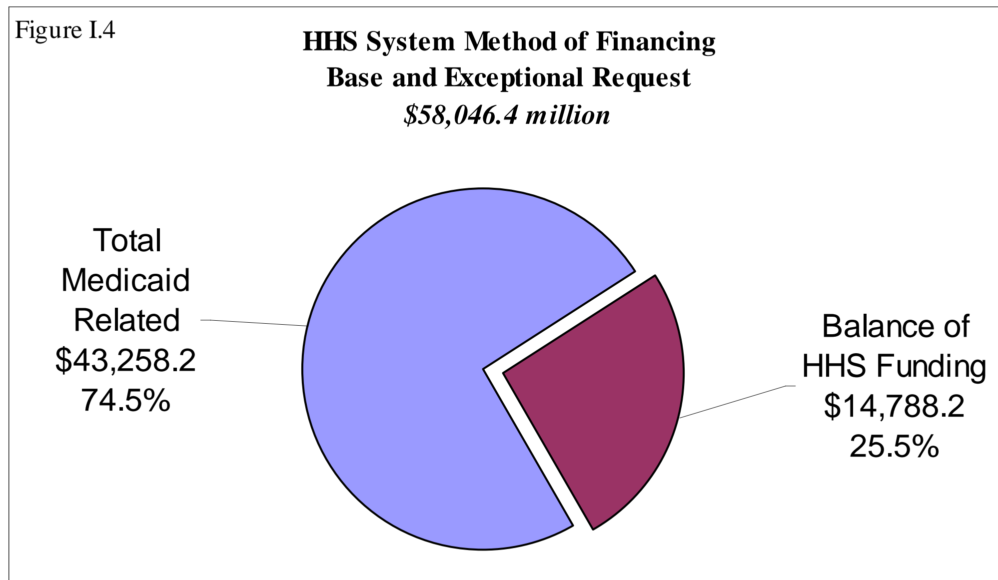


Figure I.3 presents the comparison of funding sources for the HHS System.



Exceptional items represent $8.6 billion all funds of the total 2008-2009 biennial request. The GR-related base and exceptional item request for 2008-2009 biennium totals $22.4 billion, representing a $5.1 billion increase from the 2006-2007 biennium. Total requested base and exceptional federal funds for the HHS System for the 2008-2009 biennium is $34.1 billion, representing a $5.5 billion increase over 2006-2007 biennium federal funds.

Figure I.4 presents the comparison of Medicaid to the HHS System.



As the chart indicates, Medicaid accounts for $43.3 billion, or 74.5 percent, of the total HHS funding requested in the 2008-2009 biennium. Using both state and federal funding, Texas' Medicaid program provides acute care and long term care services to millions of low income Texans each year (see Figure III.1-4 for Medicaid caseload forecasts).

Legislative Appropriation Request Guidance and Baseline Funding

Baseline Policy and HHS Assumptions

The General Revenue (GR) and GR-related base request is limited to 90 percent of the sum of the amounts expended in fiscal year 2006 and budgeted in fiscal year 2007 plus an amount equal to the GR-related allocation for the 3 percent/$50 employee pay raise in 2007. Exceptions to the 90 percent limitation include amounts necessary to maintain caseloads for federal entitlement services. The ten percent reduction in the base equals approximately $473.6 million in GR and GR-related funding across all HHS agencies for 2008-2009 biennium.

Health and Human Services

The Health and Human Services Commission's (HHSC) baseline request for GR-related funds represents a 10 percent across the board GR reduction for all programs except Medicaid client services. Medicaid caseload growth was considered entitlement for baseline request development. However, costs were required to be held flat at the fiscal year 2006 level. Medicaid caseloads are projected to increase from 2,791,482 in fiscal year 2007 to 2,877,952 in fiscal year 2008 and to 2,994,521 recipients in fiscal year 2009.

Neither the Children's Health Insurance Program (CHIP) program nor the CHIP Perinatal program is an entitlement. The Perinatal program is to be implemented for only eight months this biennium (beginning January 2007). There is no CHIP Perinatal program assumed in the 2008-2009 baseline but it is fully restored in an exceptional item request. The remaining CHIP programs are funded in the baseline request at projected caseloads at fiscal year 2008 projected costs. CHIP caseloads are projected to increase from 327,012 in fiscal year 2007 to 335,477 recipients in fiscal year 2008 and 339,037 recipients in fiscal year 2009. For additional discussion of caseloads and costs, reference Section III.

Aging and Disability Services

The Department of Aging and Disability Services' (DADS) baseline request for GR-related funds represents a 10 percent across the board GR reduction for all strategies (7 percent for Intake, Access and Services to Supports) that have GR or GR-Dedicated that are not considered entitlement services. Projected entitlement caseload growth was included in the baseline but provider rates were held flat at the fiscal year 2006 level. The long-term care entitlement caseload was projected to increase from 208,428 in fiscal year 2007 to 209,079 in fiscal year 2008 and 215,734 in fiscal year 2009.

Family and Protective Services

The Department of Family and Protective Services (DFPS) applied the directed baseline reductions to the prevention programs in order to preserve Adult Protective Services and Child Protective Services reform efforts. The 79th Legislature demonstrated support for the critical nature of DFPS' mission by providing an unprecedented increase in funding and FTEs to achieve

the improvements laid out in Senate Bill 6. By applying the 10 percent reduction to prevention services funding, there is a resulting 53.5 percent reduction in prevention programs. The restoration of this baseline funding is being requested in the agency's exceptional item 1, Restore Base Funding, DFPS' highest priority funding item. Foster Care and Adoption Subsidies caseload growth were considered entitlement in the baseline request. The Foster Care caseload is projected to grow from 20,997 in fiscal year 2007 to 22,731 in fiscal year 2008, and 24,455 in fiscal year 2009. The Adoptions Subsidies caseload is projected to grow from 22,624 in fiscal year 2007 to 24,679 in fiscal year 2008, and 26,705 in fiscal year 2009.

State Health Services

The Department of State Health Services (DSHS) applied the 10 percent reduction across all appropriation strategies. Reductions to those funds will impact the ability to provide services. DSHS reports that this reduction will affect the state's efforts to increase immunization rates and collect and analyze data for the prevention of birth defects and cancer. Programs to prevent the spread of infectious diseases, such as HIV, sexually-transmitted diseases and tuberculosis, will be compromised, resulting in increasing risks of disease and death rates. The agency's response to public health threats, such as emerging diseases, bioterrorism and natural disasters will be impacted as well as regulatory programs that safeguard Texans everyday through licensure and inspections. Clients who were receiving services in our community, mental health and substance abuse programs will find themselves on waiting lists. Reductions in mental health and substance abuse prevention and treatment programs will also affect the criminal justice system and emergency rooms across the state.

Assistive and Rehabilitative Services

The Department of Assistive and Rehabilitative Services (DARS) applied the 10 percent baseline reduction across the board, with the exception of Early Childhood Intervention which is an entitlement program and Disability Determination Services (DDS) which is 100 percent federally funded. Therefore, the focus was on administrative services, Division for the Blind, and Division for Rehabilitation. Rather than reduce Blind Children program (which was reduced 30 percent in 2003) and Independent Living Services (ILS) program which has a 9:1 match, the proposed reductions are in Vocational Rehabilitation (VR) Program for Division for Blind Services (DBS). In addition, reductions were taken in the VR program for Division for Rehabilitation Services (DRS) instead of the ILS program which has a waiting list and the Deaf & Hard of Hearing which is a targeted group for improved services.

Figure I.5

The following figure illustrates a comparison by agency of the 2008-2009 requests to the 2006-2007 appropriation, and summarizes the 2008-2009 Base Request and Exceptional Items. As directed by the LAR instructions, the DFPS requests includes $591.4 million in GR-related funds that were appropriated as Economic Stabilization Funds (ESF) during 2006-2007. However, for the comparison below, ESF is reflected as GR/GRD.

Figure I.5

Comparison of HHS Agency Baseline Request FY 2006 - 2007 and FY 2008 - 2009 *(in millions)*							
Agency	**FY 06 Expended - FY 07 Budgeted**		**FY 08-09 Baseline**		**Biennial Change**		**GR / GRD % Change**
	GR / GRD	**All Funds**	**GR / GRD**	**All Funds**	**GR / GRD**	**All Funds**	
DADS	4,009.5	10,271.3	4,080.1	10,473.2	70.6	201.9	1.76%
DARS	194.9	1,042.1	190.9	1,074.6	(4.0)	32.5	-2.04%
DFPS	827.3	2,188.3	909.0	2,312.6	81.7	124.3	9.88%
DSHS	2,417.4	5,035.6	2,177.1	4,664.2	(240.3)	(371.3)	-9.94%
HHSC	10,438.8	29,767.6	11,149.1	30,963.8	710.3	1,196.1	6.80%
Total, HHS	**$ 17,887.9**	**$ 48,304.9**	**$ 18,506.2**	**$ 49,488.4**	**$ 618.3**	**$ 1,183.5**	**3.46%**

Note: Totals may not add due to rounding. [1] Requested includes baseline and exceptional items.

HHS Agency Baseline and Exceptional Request FY 2008 - 2009 *(in millions)*						
Agency	**Baseline Request**		**Exceptional Item Request**		**Total Request**	
	GR / GRD	**All Funds**	**GR / GRD**	**All Funds**	**GR / GRD**	**All Funds**
DADS	4,080.1	10,473.2	301.8	703.4	4,381.9	11,176.6
DARS	190.9	1,074.6	23.3	100.8	214.2	1,175.4
DFPS	909.0	2,312.6	215.8	266.1	1,124.8	2,578.7
DSHS	2,177.1	4,664.2	527.0	656.5	2,704.1	5,320.7
HHSC	11,149.1	30,963.8	2,810.1	6,831.1	13,959.2	37,794.9
Total, HHS	**$ 18,506.2**	**$ 49,488.4**	**$ 3,877.9**	**$ 8,557.9**	**$ 22,384.1**	**$ 58,046.4**

Note: Totals may not add due to rounding.

HHS Agency Biennial Funding Comparison (Baseline & Exceptional Items) FY 2006 - 2007 and FY 2008 - 2009 *(in millions)*							
Agency	**FY 06 Expended - FY 07 Budgeted**		**FY 08 - 09 Requested [1]**		**Biennial Change**		**GR / GRD % Change**
	GR / GRD	**All Funds**	**GR / GRD**	**All Funds**	**GR / GRD**	**All Funds**	
DADS	4,009.5	10,271.3	4,381.9	11,176.6	372.4	905.2	9.29%
DARS	194.9	1,042.1	214.2	1,175.4	19.3	133.3	9.91%
DFPS	827.3	2,188.3	1,124.8	2,578.7	297.5	390.4	35.96%
DSHS	2,417.4	5,035.6	2,704.1	5,320.7	286.7	285.2	11.86%
HHSC	10,438.8	29,767.6	13,959.2	37,794.9	3,520.3	8,027.3	33.72%
Total, HHS	**$ 17,887.9**	**$ 48,304.9**	**$ 22,384.1**	**$ 58,046.4**	**$ 4,496.2**	**$ 9,741.4**	**25.14%**

Note: Totals may not add due to rounding. [1] Requested includes baseline and exceptional items.

Federal Medical Assistance Percentage (FMAP) and Enhanced FMAP (CHIP Match Rate)

The FMAP is the share of state Medicaid benefit costs paid for by the federal government. The formula is calculated based on a three-year average of state per capita personal income compared to the national average. The fiscal year 2008 FMAP will be published by the Department of Health and Human Services (DHHS) by November 15, 2006. The rate will be based on per capita income for calendar years 2003 through 2005. A special adjustment for states with significant numbers of hurricane Katrina evacuees are authorized by federal law and are being considered by DHHS. This adjustment is not reflected in Figure I.7.

The Enhanced FMAP (CHIP Match Rate) is calculated by taking the state's Medicaid FMAP and adding to that 30 percent of the difference between the state's FMAP and 100 percent. The CHIP enhanced FMAP is subject to a ceiling of 85 percent.

The table (Figure I.6) below details a ten year history of the Texas FMAP:

Figure I.6

Year	Type	State Fiscal Year		Federal Fiscal Year	
		State %	Federal %	State %	Federal %
2000	FMAP	38.55	61.45	38.64	61.36
	EFMAP	26.99	73.01	27.05	72.95
2001	FMAP	39.36	60.64	39.43	60.57
	EFMAP	27.55	72.45	27.60	72.40
2002	FMAP	39.80	60.20	39.83	60.17
	EFMAP	27.86	72.14	27.88	72.12
2003	FMAP	39.99	60.01	40.01	59.99
	EFMAP	28.00	72.00	28.01	71.99
2004	FMAP	39.80	60.20	39.78	60.22
	EFMAP	27.86	72.14	27.85	72.15
2005	FMAP	39.18	60.82	39.13	60.87
	EFMAP	27.43	72.57	27.39	72.61
2006	FMAP	39.32	60.68	39.34	60.66
	EFMAP	27.53	72.47	27.54	72.46
2007	FMAP	39.23	60.77	39.22	60.78
	EFMAP	27.46	72.54	27.45	72.55
2008 *Estimated*	FMAP	39.30	60.70	39.31	60.69
	EFMAP	27.51	72.49	27.52	72.48
2009 *Estimated*	FMAP	39.13	60.87	39.11	60.89
	EFMAP	27.39	72.61	27.38	72.62

EFMAP is the Enhanced Federal Medical Assistance Percentage (CHIP rate).
State Fiscal Year runs from September 1 to August 31.
Federal Fiscal Year runs from October 1 to September 30
Rates for FY 2008 – 2009 are based on FFIS Issue Brief 05-39, September 28, 2005.

Summary of HHS Agency Exceptional Item Requests

In the following table, exceptional items have been divided into several categories to highlight the types of funding needs agencies have identified for the 2008-2009 biennium. These categories represent a general prioritization of needs. However, exceptional items within each of these categories are not prioritized

The first three categories are required to maintain the current service level at state agencies. These encompass the following:

- **Restore the 10 percent General Revenue reduction ($473.6 million GR-related)** that was required of each agency based on the LAR instructions. As the section on costs savings indicates (see chapter II) HHS agencies have been vigilant in reducing both program and administrative costs in recent years and any additional reductions will hinder agencies' abilities to serve clients across the HHS System
- **Maintain Medicaid and CHIP current services and costs ($1,779.2 million GR-related).** Because the LAR instructions do not allow fiscal year 2007 costs increases to be included in the base, an exceptional item to maintain Medicaid acute care costs increases for fiscal year 2007 is requested. In addition, projected fiscal year 2008-2009 cost growth in the Medicaid and CHIP programs must be funded in order to maintain the current service level.
- **Continue FY 2006 – 2007 legislative initiatives ($175.7 million GR-related).** This category includes funding to continue major legislative initiatives, such as CPS / APS reform, increases in state mental health hospital capacity, and removal of clients from the waiting lists for community care waivers. The LAR instructions did not allow full two year funding for these efforts in fiscal year 2008-2009 baseline request.

The category related to restoring provider rate reductions that were mandated in fiscal year 2003 has been identified as a critical need because several service providers, such as medical professionals and hospitals, have been receiving reduced rates for several years. This situation has the potential to limit the number of providers willing to participate in the state's health care programs serving vulnerable Texans.

Major new initiatives have been grouped to emphasize emerging agency needs and cross agency efforts in the HHS system. For example, addressing the growing demand for mental health services and meeting the goal of maintaining the caseload per worker for CPS will require additional funding in next biennium. Likewise, cross agency efforts, such as reducing waiting lists for services and improving recruitment and retention of nurses represent growing concerns among the HHS agencies.

The group of exceptional items related critical needs for agency operations identifies priorities for staffing, information technology, equipment and transportation that will allow agencies to efficiently manage their operations statewide. Without this investment, agencies' abilities to serve clients effectively will be hampered.

The final category summarizes program expansions or enhancements that are necessary to meet the growing demand for services in several areas or fill gaps in services where there are currently unmet needs. These items have been identified by agency Councils and stakeholders as critical to building each agency's capacity to fulfill its mission.

HHS Enterprise Exceptional Item GR Request Detail

Figure I.7

Agency	Exceptional Item		GR/GRD		All Funds	GR Increase over FY 2006-07
Total Exceptional Item Request		**$**	**3,877,905,860**	**$**	**8,557,948,950**	**22.4%**
Restore 10% Reduction in Base						
DADS	Restore Base Funding		111,711,034		241,988,768	
DARS	Restore Base Funding and FTEs		12,708,976		58,084,038	
DFPS	Restore Base Funding		40,378,354		40,378,354	
DSHS	Restore Base Funding		236,150,463		294,762,523	
HHSC	Restore Base Funding		72,642,889		178,947,878	
	subtotal	**$**	**473,591,716**	**$**	**814,161,561**	2.7%
Maintain Medicaid and CHIP Current Services and Costs						
HHSC	Maintain FY07 Medicaid Costs	$	672,998,466	$	1,760,020,710	
HHSC	Maintain Medicaid Current Services and Cost Trends	$	1,091,540,018	$	2,800,066,063	
HHSC	Maintain CHIP Cost Trends and Current Services for FY09	$	14,667,544	$	44,887,509	
	subtotal	**$**	**1,779,206,028**	**$**	**4,604,974,282**	10.3%
Continue FY2006-2007 Legislative Initiatives						
DADS	Annualization of Waiver Caseload Growth		84,128,973		213,436,475	
DADS	Promoting Independence		7,803,317		19,919,531	
DFPS	Required Biennial Funding for Phased-in APS/CPS Reform Initiatives		79,576,735		95,715,240	
DFPS	Restore Loss from Method of Finance Changes		15,302,772		27,082,646	
DSHS	Required Biennial Funding for Phased in Mental Health Hospital Capacity Increase		8,589,800		8,589,800	
HHSC	Restore CHIP Perinatal Program		(19,703,069)		158,681,383	
	subtotal	**$**	**175,698,528**	**$**	**523,425,075**	1.0%
	Subtotal to Maintain Current Services	**$**	**2,428,496,272**	**$**	**5,942,560,918**	**14.0%**

Figure I.7 (continued)

Agency	Exceptional Item	GR/GRD	All Funds	GR Increase over FY 2006-07
Restore Rate Reductions from FY 2003				
DADS	Provider Rate Restorations to FY2003	10,680,736	27,236,354	
HHSC	Restore Medicaid and CHIP Rates to 2003 Levels	237,027,809	607,021,953	
DSHS	Rate Restoration	3,111,684	3,111,684	
	subtotal	**$ 250,820,229**	**$ 637,369,991**	1.5%
Major New Initiatives				
DFPS	Additional Direct Delivery Staff to Maintain Caseload Per Worker	38,743,260	44,948,042	
DFPS	Additional Purchased Client Services for Caseload Growth	10,644,080	10,742,375	
DFPS	Additional Program Support for Caseload Growth	1,387,305	1,621,873	
DADS, DARS, DSHS	Reduce HHS Waiting/Interest Lists	254,670,894	537,378,966	
DSHS	Mental Health Community Crisis Services for Children and Adults	82,336,430	82,336,430	
DADS, DSHS, HHSC	Recruit and Retain Nurses and Other Critical Shortage Professions	31,969,666	41,880,980	
HHSC	Provide Funding for Alberto N Lawsuit Settlement	107,027,375	272,942,583	
DSHS	Reduce the Spread of HIV and Tuberculosis	$ 23,235,717	$ 23,235,717	
HHSC	Improve HHS Telecommunications & IT Systems and Support	20,936,682	39,171,623	
	subtotal	**$ 570,951,410**	**$ 1,054,258,589**	3.3%
Critical Needs for Agency Operations				
DADS	Staffing for Program Oversight, Services and Support	$ 35,797,697	$ 68,092,499	
DADS	Information Technology Initiatives	$ 7,030,727	$ 14,061,454	
DADS	State School Equipment and Vehicles	$ 13,720,000	$ 13,720,000	
DADS	State School Utility and Drug Increases	$ 4,298,479	$ 13,734,810	
DADS	State School Repairs and Renovations	$ 300,000	$ 59,876,769	
DFPS	Maintain Information Technology Capabilities	$ 12,119,667	$ 12,875,266	
DFPS	Mobile Technology for Child Care Licensing Staff	$ 3,761,154	$ 4,279,866	
DSHS	Technology and Equipment for Critical Agency Functions	$ 24,874,924	$ 25,099,924	
DSHS	Replacement of Critical Client Services Transportation	$ 4,245,740	$ 4,245,740	
DSHS	Repair & Renovate Hospitals Including Equipment and Furniture Replacement	$ 7,920,763	$ 62,242,332	
DSHS	Automated Medication Dispensing System and Laboratory Information Systems	$ 7,995,870	$ 7,995,870	
HHSC	Increase Office of Inspector General Support	$ 6,557,624	$ 16,244,984	
HHSC	Support Critical Building Maintenance	$ 1,437,396	$ 1,437,396	
HHSC	Maintain Facility and Regional Infrastructure	$ 623,758	$ 623,758	
HHSC	Maintain Support of EBT Infrastructure and Implement IBC	$ 3,648,508	$ 7,533,574	
	subtotal	**$ 134,332,306**	**$ 312,064,242**	0.8%

Figure I.7 (continued) Agency	Exceptional Item		GR/GRD		All Funds	GR Increase over FY 2006-07
Program Enhancements/Expansions						
DADS	Contract Services for Guardianship	$	1,145,598	$	1,145,598	
DADS	MR Equity		22,000,000		22,000,000	
DADS	PACE Site Expansion (two new sites)	$	3,188,255	$	8,141,320	
DARS	Federal Grant Growth	$	8,763,214	$	40,904,374	
DARS	Establish New Independent Living Centers	$	1,000,000	$	1,000,000	
DARS	Increase Services at Selected Independent Living Centers	$	819,246	$	819,246	
DFPS	Relative Caregiver Caseload Growth	$	602,259	$	5,962,592	
DFPS	Increase Prevention Services	$	13,263,151	$	13,268,117	
DFPS	Establish Family Preservation Flexible Funding Program	$	-	$	9,249,500	
DSHS	Prevention, Preparedness and Emergency Response	$	15,266,435	$	15,266,435	
DSHS	Pandemic Flu Prevention and Preparation	$	1,855,747	$	1,855,747	
DSHS	Prevent/Reduce Smoking in Children and Adults		54,168,770		54,168,770	
DSHS	Recruit and Retain Critical Shortage Professionals	$	9,131,197	$	9,131,197	
DSHS	Medicaid Substance Use Disorder Initiative	$	10,245,336	$	26,043,048	
DSHS	Protection of Children - School Cafeteria Inspections, Dental Health	$	2,344,667	$	2,344,667	
DSHS	Reduce Cardiovascular Disease, Diabetes and Other Chronic Diseases /Detect Cervical Cancer Early	$	17,569,649	$	18,182,149	
DSHS	Substance Abuse Prevention and Treatment	$	15,344,972	$	15,344,972	
DSHS	Monitoring of Sexually Violent Predators	$	2,566,228	$	2,566,228	
HHSC	Maintain Compliance with Federal HIPAA Regulations	$	5,250,004	$	15,000,008	
HHSC	Expand Family Violence Services	$	2,000,000	$	2,000,000	
HHSC	Increase Coordination of Health Services	$	1,163,400	$	1,163,400	
HHSC	Implement Criminal History Checks for Health Providers	$	940,100	$	1,880,200	
HHSC	Provide State Funding for Private Urban UPL	$	54,000,000	$	137,703,057	
HHSC	Replace Non Recurring IGT	$	117,000,000	$	-	
HHSC	Provide State Funding for Hospital Financing		52,677,416		0	
HHSC	Provide State Funding for Graduate Medical Education		81,000,000		206,554,585	
	subtotal	**$**	**493,305,644**	**$**	**611,695,210**	2.9%
	Total HHS Exceptional Item Request	**$**	**3,877,905,860**	**$**	**8,557,948,950**	**22.4%**

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II. HHS Update on the Cost Containment Efforts and the Status of Consolidation

Recent History of Cost Containment Efforts and Budget Reductions

Over the past three biennia Health and Human Services agencies have endeavored to identify all opportunities for saving state resources, both through streamlining administrative functions and through program and policy changes. As a result HHS agencies have achieved approximately $1.76 billion in general revenue savings since 2002.

In the 2002-2003 biennium, the General Appropriations Act required HHS agencies to conduct a comprehensive study of business processes and reduce general revenue for administrative functions by $10 million. At the same time, specific programmatic changes in Medicaid were required to contain costs, resulting in another reduction of $205 million in agency budgets. This was followed by a directive from state leadership in fiscal year 2003 to prepare plans to reduce spending across all areas of agency operations. With the passage of H.B. 7 by the 78th Legislature, HHS budgets were reduced again by $134 million. During fiscal year 2002-2003, HHS agencies cut spending by a total of $349 million in general revenue.

Again in the 2004-2005 biennium, HHS agencies were again asked to make deep reductions in spending levels. First, agencies were required to reduce baseline budget requests by specified amounts for each agency. Second, a series of program and policy changes produced savings in the Medicaid and CHIP program. Third, the passage of H.B. 2292, consolidating HHS agencies, required significant reductions in administrative functions and challenged agencies to identify other programmatic efficiencies to reduce costs. In all, approximately $1.3 billion in general revenue was reduced in the HHS function during fiscal year 2004-2005.

In the current biennium, in addition to specified rider reductions, savings in the previous two biennia cost containment efforts have resulted in lower baseline spending across HHS agencies. For example, drug costs are not rising as rapidly due to the implementation of a preferred drug list in the Medicaid program.

Figure II.1 highlights these efforts:

Figure II.1

Major HHS Agencies Savings Initiatives since FY 2002

FY 2002 - 2003	**GR**	**FTEs**
78th Legislature, HB 7 – FY 2003 Reduction Plan	$133.9	39
77th Legislature, Business Process Study – Rider Reduction	$10.0	19
77th Legislature, Medicaid Cost Containment – Rider Reduction	$205.0	-
Subtotal	**$348.9**	**58**

FY 2004 - 2005	**GR**	**FTEs**
78th Legislature – Initial GR Reduction	$320.4	664
78th Legislature – Program Savings Included in General Appropriations Act		
Maintain 6 months continuous eligibility in Medicaid	*$282.4*	-
CHIP Policy Changes	*$144.5*	-
Preferred Drug List	*$140.0*	-
Client Transportation Transfer	*$104.3*	-
Medicaid Benefit Changes	*$43.1*	-
TANF Pay for Performance	*$29.1*	-
Other Initiatives	*$89.0*	-
Subtotal – Program Savings	*$832.4*	-
78th Legislature – HB 2292 Reductions		
Consolidation of Agencies / Administrative Reductions	*$50.4*	*671*
Programmatic Savings Reduced in Agency Budgets	*$27.6*	*1,115*
Subtotal – HB 2292 Reductions	*$78.0*	*1,786*
78th Legislature – Additional Savings Identified by HHS Agencies	$83.8	-
Subtotal	**$1,314.6**	**2,450**

FY 2006 - 2007	**GR**	**FTEs**
79th Legislature – Rider Reduction for Services to Medicaid Aged / Blind / Disabled populations	$73.0	-
79th Legislature – Rider Reduction for Multi-State Drug Purchasing Pool	$17.6	-
79th Legislature – DSHS Reductions	$6.7	52
79th Legislature – 2% FTE Reductions	-	720
Subtotal	**$97.3**	**772**

Total GR Savings: FY 2002 - 2007	**$1,760.8**	**3,280**

Consolidation Achievements

Optimization and Transformation Successes to Date

When H.B. 2292, 78th Legislature, Regular Session, 2003, was passed, the vision was to achieve a transformed system characterized by a focus on client services and needs, integrated and coordinated services, a culture of accountability and continuous improvement, innovation, achievement of results, and public input and public involvement. This transformation was to be achieved over several years through a series of phases: planning, integration, optimization, and transformation. Initially the primary focus of activity was on the consolidation of agencies and the realignment of programs. When agency consolidations were completed in September 2004, the focus of activity shifted to optimization of performance using the new agency structure as a foundation for further improvements.

Since September 2004, numerous optimization projects have been completed across the HHS System, other projects are underway, and others are still ahead. Some of these projects are massive efforts fundamentally reshaping a service or function, while others bring about incremental changes. The sections that follow highlight some of the projects and beneficial outcomes that have been achieved, as well as projects and benefits still to be completed or undertaken.

HHSC – HHSC's optimization projects address two categories of services: 1.) services provided by HHSC to all agencies of the HHS system, and 2.) administrative services that support only HHSC employees. During the 2004-2005 biennium, most administrative services supporting HHS agencies were consolidated within HHSC's System Support Services Division. Consolidation yielded immediate increases in efficiency by eliminating duplication of support activities, and it allowed for optimization of administrative functions, achieving the following benefits.

- **Consolidated Ombudsman Services –** Established one point of contact for consumer complaints, streamlined processes to decrease duplication, centralized toll-free lines and complaint tracking, and created a comprehensive communications plan to enhance customer service.
- **Facilities Management and Leasing –** Studied and optimized the print shop, mail deliver, warehouse operations, asset management, and overall space planning.
- **Enterprise Contract and Procurement Services (ECPS) –** Implemented a standardized enterprise requisition process and developed a centralized on-line supply ordering and billing system for HHS agencies. Consolidation of multiple contracts increased purchasing volume, resulting in savings while decreasing workload.
- **Civil Rights Office –** Moved forward in designing innovative processes to review and monitor program compliance. Objectives include improving access and services for persons with limited English proficiency, sensory impairments, and/or speech impairments; and providing tailored training for managers and their employees to ensure ongoing education and awareness.

- **Legal Services –** Some legal services were consolidated at HHSC, while other legal functions remained at agencies with HHSC providing guidance and coordination, as necessary.

Optimization activities planned or currently underway at HHSC reflect an intense focus on measuring and achieving high degrees of customer satisfaction in all areas of administrative services. Emphasis is on accountability, efficiency, and the careful, thorough analysis of services and alternatives. Targeted areas of optimization include enhancing contract management to further strengthen internal controls through development of risk management plans and negotiation guidelines, optimizing administrative support for HHS field offices, increased on-line training for administrative staff and customers, and increasing analysis and control of support costs including copying/printing, facilities, and telecommunications. HHSC continues to document administrative processes through employee handbooks and guidelines, and through business continuity planning.

DADS – After its creation in September 2004, DADS began shifting from the integration phase of transformation to the optimization phase to address the broader intent of H.B. 2292, which was improving efficiency, effectiveness, and integration within and among HHS departments. At DADS, optimization has resulted in benefits and opportunities. Examples of benefits attained include:

- Improved planning and implementation of the agency's receipt of 9,360 slots for interest list reduction;
- Coordinated, consistent, and direct supervision of all licensing activities within one organizational area;
- Expanded nursing facility quality of life surveys for individuals and family members in all DADS Medicaid waiver and ICF-MR/RC programs;
- Increased oversight and monitoring of regional activities within the DADS Guardianship program;
- Providing better information about the Medicaid Estate Recovery Program to consumers;
- Improved ability to plan and implement a coordinated response when a long-term care provider closes a facility; and
- Enhanced ability to coordinate a response to the implementation of the Medicare Prescription Drug Program, involving the AAAs, Mental Retardation Authorities (MRA), and DADS program staff.

For the future, DADS has identified additional opportunities emerging from the consolidated framework. These opportunities have created a foundation for future improvements within the DADS system of service delivery. Examples of identified opportunities to further improve DADS service delivery system include:

- Application of best practices in clinical quality improvement and provision of evidence-based technical assistance to nursing facilities, state schools, and other contracted facilities;
- Streamlining and standardizing the change-of-ownership processes across institutional services provider contracts to ensure requests are processed efficiently;

- Analyses of the waiver programs to determine if modifications could improve services and increase efficiencies;
- Strengthening the provider base for community services by increasing the availability and range of services provided;
- Further strengthening the state school operations management team to increase oversight of day-to-day operations and ensure facilities are using best practices;
- Reviewing policies and processes for enrollment and maintenance of the waiting/interest lists to identify opportunities for streamlining and improving the enrollment and referral processes; and
- Reduction of duplication of efforts between regulatory oversight and contract monitoring oversight.

DARS – Since its creation on March 1, 2004, DARS has undertaken numerous optimization and transformation efforts. To date, the main activities have focused on the areas of deaf and hard of hearing services, services to children and infants, contract management support and oversight, and independent living services.

To increase resources for the deaf and hard of hearing, DARS added $1.2 million for deaf and hard of hearing services by matching federal Vocational Rehabilitation (VR) funds in 2005. The Regional Specialist Program was expanded from 11 contractors to 22. A Hard of Hearing Specialist program was developed by funding seven contracted specialists across the state. A state coordinator for the deaf was hired to provide training, program coordination among divisions, staff development, and outreach and education.

A grant from the Health Resources and Services Administration (HRSA) to the Division for Early Childhood Intervention (ECI) enabled DARS to improve outreach to families, begin intervention services as early as possible, and assist families in planning for future services for their child. ECI has also combined financial and staff resources with the Division for Blind Services (DBS) to provide comprehensive services for children who are blind or visually impaired. Cross-training has enabled both divisions to fully understand the variety of services available through each program.

DARS has improved and expanded contract management support and oversight to all program areas. This expansion helped improved contractor/provider performance in delivering services. To reduce complexity regarding contracts, DARS standardized contract terms, conditions, and performance requirements.

By increasing reimbursements from the Social Security Administration (SSA), DARS increased funding to the Independent Living Services (ILS) Program. This was done by removing the reimbursement function from service delivery divisions and centralizing it under financial services, which improved the ability to claim reimbursements from SSA for successfully employing SSI and SSDI recipients.

DARS is also focusing on opportunities for future improvements. To align and standardize consumer purchasing processes, two consumer case management systems were consolidated. The Transition Services program, in the Division for Rehabilitation Services, is being expanded

by re-deploying 100 existing FTEs to serve students with significant disabilities transitioning from school to work. In addition, DARS is improving vocational rehabilitation counselors' skills in providing job development and employment assistance services. Recognizing the importance of collaboration with workforce partners around the state, DARS is strengthening its relationship with the Texas Workforce Investment Council (TWIC) and the Texas Workforce Commission (TWC).

DFPS – Optimization efforts at DFPS have been incorporated into a broad agency renewal effort affecting every aspect of daily operations. In response, to HHSC reform recommendations and S.B. 6, 79th Legislature, Regular Session, 2005, DFPS is in the process of reforming itself, to find new and better ways to protect the unprotected. Hundreds of improvements are in the works, affecting every aspect of the agency. These changes will strengthen investigations, improve management and accountability, reduce caseloads, support quality casework, prevent maltreatment, and build community partnerships. Highlights are:

Medical Services
S.B. 6 directs HHSC to develop a statewide healthcare delivery model for children in foster care, to provide accessible, coordinated, comprehensive, and continuous healthcare for each child in care. Foster children served through the model also will benefit from a health passport, which will include their Medicaid medical history, to ensure portability of timely medical information and ready availability of comprehensive health information to healthcare providers, DFPS staff, caregivers, courts, and youth.

Outsourcing Case Management and Substitute Care Services
A key aspect of S.B. 6 pertains to the outsourcing of case management and substitute care services for children in DFPS legal conservatorship. This effort is aimed at improving outcomes for children and enabling DFPS to increase its focus on protective and preventive services for Texas' most vulnerable children and families. The outsourcing of these services provides a significant opportunity for DFPS to address many of the service delivery issues identified in HHSC's reform recommendations.

Workforce Expansion and Enhancements
The 79th Legislature, Regular Session, 2005, also focused on bringing worker caseloads to a reasonable level. DFPS was given an additional 2,500 positions to strengthen work units throughout the state, and all investigative caseworkers and supervisors were given a salary supplement as a way of retaining existing staff and attracting new workers. Training for CPS caseworkers was increased from 6 weeks to 12 weeks, and the curriculum was revamped. These changes were seen as key to achieving manageable caseloads and providing quality casework for children and families.

DSHS – H. B. 2292 encouraged the use of new and existing technology to improve service delivery. The Electronic Benefits Transfer (EBT) smart card for the Women, Infants, and Children (WIC) program is an excellent example of success. The card is easier and more flexible for both clients and vendors to use, and it is efficient for the State. DSHS piloted the EBT smart card in El Paso beginning in June 2004 and expanded to Grayson County in October

2005 and Collin County in February 2006. Statewide implementation is phasing in during summer, 2006.

DSHS has created an opportunity for the Family and Community Health Services (FCHS) and the Mental Health and Substance Abuse (MH/SA) Services programs to improve service delivery. In collaboration with Texas Tech University and other partners, Title V and MH/SA programs jointly funded a pilot study to evaluate the practicality of behavioral health screening, assessment, treatment and/or referral of adolescents in selected primary care settings. The objective is early identification and treatment of adolescent mental health and/or substance abuse risks and disorders. Five pilot sites will be selected and will include different types of primary and preventive health providers. A report of preliminary findings from the pilot study should be released by end of January 2007.

FCHS and MH/SA Services are also collaborating on a Substance Abuse and Birth Outcomes charter project. The objective is to develop a best-practice protocol for screening for substance abuse among pregnant women, particularly in WIC and other FCHS service programs, and improving a referral process into SA treatment centers and/or collocating SA-funded outreach, screening, assessment, and referral resources at WIC offices. A report on this should be completed by summer, 2006.

Establishing a Common Regional Framework and Consolidating Regional Support Services

More than 75 percent of HHS employees work outside of Austin, in approximately 1,200 facilities across the state. An integrated regional structure for delivering health and human services offers the opportunity to improve both the quality of services and the cost-effectiveness of delivering them. Consolidating administrative staff and combining office operational expenses are expected to reduce lease payments, utility services, administrative service contracts, phone systems and lines, postage accounts, and the need for leased office equipment and bulk office supplies.

An initial step in consolidating administrative services was to standardize the HHS regions. Before the 12 agencies were merged by H.B. 2292, they used a variety of regional boundaries. Some agencies, such as the Commission on Alcohol and Drug Abuse, used regional boundaries consistent with the existing 11 HHS boundaries. Other agencies, such as the Department of Health, used a modified HHS regional map that combined some of the 11 HHS regions. Still other agencies, such as the Rehabilitation Commission and the Department on Aging, used regional boundaries that were inconsistent with HHS boundaries.

To better provide administrative services at the regional level, 10 HHS regions were adapted from the prior 11-region concept, with Regions 2 and 9 combined. Each region currently has a Regional Administrative Service Center. Administrative services will be delivered at the regional level by the Regional Administrative Service Center via an integrated service delivery system supporting all HHS agencies. This approach, in addition to providing administrative efficiencies, will reduce the effort program staff must expend on support and administrative

functions. Standardized policies and procedures for administrative contracts will be developed for the HHS System, rather than for individual agencies.

Regional administrative functions currently include facility management and leasing, facility operations, asset management, administrative contract management, budget, purchase requests, payments, receivables, and health and safety. Regional administrative services are currently provided on a consolidated basis to the regional and field offices of HHSC, DADS, and DFPS. Beginning in fiscal year 2007, DARS and DSHS will begin receiving these services.

Integrated Eligibility and Enrollment (IEE)

Integrated Eligibility and Enrollment (IEE) encompasses all aspects of program management, such as offering self-sufficiency opportunities; providing multiple channels for people to apply for benefits including face-to-face at offices and home visits, fax, internet and telephone; determining eligibility for Temporary Assistance to Needy Families (TANF), Food Stamps, Medicaid, Long Term Care, Children's Health Insurance Program (CHIP) and Refugee services; enrolling CHIP and Medicaid clients in managed care; issuing benefits through electronic benefit cards or letters; finger imaging and other accountability measures; Healthy Marriage projects; Food Stamp, CHIP and Medicaid outreach; nutrition education; providing information and referral services through the 2-1-1 Texas Information Referral Network; ombudsman services; maintaining the Texas Integrated Eligibility Redesign System (TIERS), automated application; and policy, training, contract oversight, operational oversight, data integrity, and quality assurance and quality control supportive activities for these functions. The eligibility determination process is being transformed from a non-integrated paper-based process using 1970s technology to a system featuring multiple access channels, document imaging and electronic case files, a web-based automated system using up-to-date programming and architecture, and shared work flow between state and contractor staff housed in call centers and local HHSC benefits offices.

In June 2005, HHSC signed a contract covering three functions – maintenance of the TIERS, enrollment broker for CHIP and Medicaid managed care, and integrated eligibility services, including call centers to help state workers process Medicaid, Food Stamps, and TANF eligibility and benefit determinations. The integrated eligibility portion of the contract also moved CHIP eligibility and benefits processing from a previous vendor to the new contractor.

- November 2005 - The TIERS maintenance and enrollment broker functions were transitioned.
- December 2005 - Statewide CHIP eligibility determination transitioned from the previous vendor to the new contractor.
- January 2006 – Processing of new Children's Medicaid applications was transitioned to the new contractor.
- January 2006 – The integrated eligibility pilot was implemented for Travis and Hays counties for Food Stamps, Medicaid and TANF.

HHSC remains committed that this modernized approach to determining eligibility for services will create a system that works better, costs less and provides clients options in accessing assistance. At this time, no additional rollouts are planned until modifications can be applied. New estimates of savings cannot be made until details and dates of new rollouts are determined. Therefore, the HHSC budget request assumes the status quo of implemented operations.

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III. ELEMENTS DRIVING FUNDING NEEDS OF HHS PROGRAMS

Some of the major factors affecting the demand for HHS services include the economy and demographic trends which can affect the caseload in various programs.

Economic Outlook

As of September 2006, both the national and the state economy are strong. The last time the national economy experienced negative growth was in the third quarter of 2001. Since then, and through June 2006, the national economy has grown for 19 consecutive quarters. The performance of the Texas economy has been improving also, especially during the last 2 years. Like in the nation as a whole, total employment levels are at historically high levels, and the rate of unemployment has been steadily declining.

In July 2004, the rate of unemployment was 6 percent, but by July 2006 the rate had declined to 5.2 percent. From July 2004 to July 2006, the estimated population of persons officially classified as unemployed by the Texas Workforce Commission declined from 664,000 to 601,000, which translates into a 10 percent reduction in the number of unemployed. However, in spite of the strengthening of the economy and improved job market conditions, in July 2006, a lower percentage of working-age Texans were employed in comparison to July 2000 (73 percent versus 77 percent). In addition, compared to the U.S. as a whole, the state continues to have a relatively high poverty rate, a lower median household income, and a relatively low rate of employer-based health insurance coverage.

In spite of the strengthening of the economy and improved job market conditions, a lower percentage of working-age Texans were employed in July 2006 in comparison to July 2000 (73 percent versus 77 percent). In addition, compared to the U.S. as a whole, the state continues to boast a relatively high poverty rate, a lower median household income, and a relatively low rate of employer-based health insurance coverage.

As long as the population continues to grow, and as long as a relatively high percentage of the population is uninsured and living below the poverty level, the demand for health and human services is likely to remain strong.

Forecast for Selected Texas Key Indicators

The forecast for the indicators cited below is based on the Spring 2006 Economic Forecast published by the Texas Comptroller of Public Accounts.

Growth of the Economy. The economy is forecasted to expand at a rate of 3.2 percent per year during the fiscal year 2008-2009 period.

- **Rate of Unemployment.** The rate of unemployment is forecasted to average 4.8 percent per year during the fiscal year 2008-2009 period.

- **General Price Inflation.** The general rate of inflation is forecasted to remain relatively low, averaging 1.8 percent per year during the fiscal year 2008-2009 period.

- **Per Capita Personal Income.** For fiscal year 2006, per capita personal income is forecasted at $33,600. Not adjusted for inflation, per capita personal income is forecasted to increase to $36,600 in fiscal year 2008 and to $38,100 in fiscal year 2009.

- **Prime Interest Rate.** For fiscal year 2006, the rate is forecasted to average 7.6 percent. The rate is forecasted to average 7.5 percent during fiscal year 2008 and 7.9 percent during fiscal year 2009.

Needs of Hurricane Katrina Evacuees

Hurricane Katrina made landfall on the Gulf Coast on August 29, 2005. According to the Federal Emergency Management Agency (FEMA), it was the most destructive and costly natural disaster in U.S. history. Katrina is also responsible for causing the largest population displacement in U.S. history as a result of a natural disaster.

The amount of damage caused by the storm in the city of New Orleans and along the Mississippi Gulf Coast was of catastrophic proportions, resulting in the evacuation of hundreds of thousands of residents from the most severely damaged areas. A large number of evacuees came to Texas in the aftermath of Katrina. Texans and Texas-based organizations responded to the plight of the evacuees by providing urgently needed resources and services such as housing/shelter, food, clothing, transportation, health care and other human services.

The Texas Health and Human Services System has played an instrumental role in assisting a large number of evacuees with their human and health care needs. By September 2005, for example, HHSC had already extended food stamp benefits to approximately 62,000 evacuees. Through May 2006, more than 59,000 evacuees had received Medicaid services. The current estimate for the value of Medicaid services provided to evacuees is $58.3 million.

Responding to the concerns of citizens, elected officials, and other civic and government organizations, HHSC contracted with the Gallup organization in March 2006 to conduct a large-scale survey of Katrina evacuees to collect information about their demographic and socioeconomic characteristics, health and human services needs, and their plans for the future. A total of 6,415 evacuee households participated in the survey. The results from the survey were published by HHSC in August 2006 [1].

The results of the HHSC-Gallup survey indicate that as of May-June 2006 an estimated 251,000 evacuees remained in Texas. The data from the survey suggest that due to the lower socio-economic status and skewed demographics of most of the evacuee households (for example, a relatively high percent of the evacuee households with children are headed by a single-parent), the level of need for health and human services among them is high.
The survey found that as of May-June 2006:

- Only 41 percent of adult evacuees in the job market had jobs.
- 41 percent of households made less than $500 in monthly income.
- 54 percent of evacuee households were receiving federal housing subsidies.
- 39 percent of evacuee households were receiving food stamps.
- 32 percent of evacuee households were receiving unemployment benefits.
- About 50 percent of evacuee households reported their children were covered by Medicaid or the Children's Health Insurance Program.
- Children comprised 39 percent of the evacuees.

[1] Hurricane Katrina Evacuees in Texas. Texas Health and Human Services Commission. Epidemiology Team. Strategic Decision Support. Financial Services Division. August 2006.

- Women comprised 60 percent of the adults.
- 63 percent of adult evacuees were 18-44; only 8 percent are 65 or older.
- 83 percent of the adult evacuees have a high school education or better.
- 19 percent are college graduates.
- Half of survey respondents expected to be living in Texas a year after the survey, and 40 percent expected to remain in the state at least two years.

The 251,000 evacuees that remained in the state as of May-June 2006 represented approximately one percent of the State's total population during that period.

The long-term demographic and social impact of the evacuee population will depend to a large extent on the number that settles in Texas permanently. The results from the HHSC-Gallup survey indicate that a relatively high percentage of evacuee households expect to remain in the state during the next year.

According to the State Demographer for Texas, Dr. Steve Murdock, even if most of the evacuees were to settle in Texas permanently, they are not likely to cause a significant long-term shift in terms of total population growth trends for the state as a whole. However, the demographic and social impact on some local areas, in particular on areas that are still hosting a significant number of evacuees, could be more noticeable [2].

The permanent settlement in Texas of a large number of Katrina evacuees could have a more significant impact on the HHS system, especially during the short term, considering the high level of need in that population already documented by the HHSC-Gallup survey. Given these circumstances, it is expected that, while many evacuees plan to leave the state or foresee improvements in their financial situation in the next 2 years, a significant number of the evacuees that remain in the state are likely to seek services and support from HHS agencies in order to meet pressing human and health care needs.

[2] Coming to Texas. By Dr. Steve Murdock. Tierra Grande. Publication of the Real Estate Center at Texas A&M University. Vol. 13, No. 1. January 2006.

Impact of Demographics and Demand for Services

Texas' HHS system will feel the additional pressure resulting from growth in the total population and from other demographic trends and events such as the gradual aging of the population, the disproportionate growth rates of the non-Anglo population, and the influx of evacuees from other Gulf Coast states due to the destruction caused by hurricane Katrina in the summer of 2005. Even without accounting for the potential long-term demographic impact of the evacuees that do not return to their home states, the state's population is projected to experience significant growth between 2006 and 2009. During that period, the state's total population is projected to grow by 1.4 million, from 23.5 million in 2006 to 24.9 million in 2009. Programs that target the population as a whole such as those related to public health, prevention and protective services will be to be impacted by the overall growth of the population.

In 2006, there are 2.3 million Texans age 65 or older. Between 2006 and 2009, this group is projected to grow at a faster rate than the population as a whole. During this period, the 65 and older group is projected to grow by about 9 percent, from 2.3 million in 2006 to 2.5 million in 2009. In contrast, the projected growth rate for the population as a whole over the same period is 6 percent. Since the incidence of disability is higher among the elderly, the growth of this segment of the population could exert additional pressure on long-term care programs that meet the needs of persons with disabilities and/or chronic illness.

The projected disproportionate growth rate for the non-Anglo population is expected to impact the HHS system as the incidence of conditions such as poverty and lack of private health insurance is higher among non-Anglos. Between 2006 and 2009, the percent share of the total population that is non-Anglo is projected to increase, from 51 percent in 2006 to 54 percent in 2009. This could possibly result in greater demand for certain means-tested services, such as Medicaid, CHIP, TANF, and Food Stamps. It may also increase the demand for primary health care services.

Caseloads and Cost

Medicaid caseloads are projected to average over 3.0 million recipients in fiscal year 2009, with an average of 1.87 million in the children's risk groups (non-disabled children aged 0-18, and TANF recipients through age 18). The caseload shown in fiscal year 2007-2009 for both Medicaid and CHIP is the caseload with CHIP perinatal clients removed from the Medicaid caseload and reflected in CHIP. CHIP caseload is projected to average approximately 440,000 in fiscal year 2009.

Figure III.1

Medicaid Acute Care Caseload

Premium Strategy Risk Group	FY2006	FY2007	FY2008	FY2009
Aged & Medicare Related	328,883	334,145	339,157	344,244
Disabled and Blind	290,204	312,518	332,565	353,669
TANF Child	255,173	266,860	280,416	294,465
TANF Adult	55,581	55,616	55,966	56,201
Pregnant Women	123,586	128,380	134,125	140,128
Newborns	157,053	169,483	181,663	194,745
Expansion Children	716,545	718,923	751,087	783,406
Federal Mandate Children	796,595	789,155	814,921	841,683
Medically Needy	46,649	45,333	47,321	49,396
Risk Group Total	**2,770,268**	**2,820,413**	**2,937,221**	**3,057,937**
Medicaid Children	**1,925,365**	**1,944,421**	**2,028,087**	**2,114,299**

Notes:

Expansion Children and Total Children reflect the removal of clients expected to be in the CHIP Perinatal program

Caseload is reported as average monthly recipients (recipient months)

Source: 200606_LAR2

Figure III.2

CHIP Caseload

Group	FY2006	FY2007	FY2008	FY2009
Federally Funded	286,655	303,205	311,053	314,354
Perinatal (Federally Funded)		70,193	95,480	101,977
Legal Permanent Residents	14,958	15,828	16,238	16,411
TRS Eligible	7,559	7,979	8,186	8,272
Group Total, no Perinates	**309,172**	**327,012**	**335,477**	**339,037**
Group Total, with Perinates	**309,172**	**397,205**	**430,957**	**441,014**

Notes:

Caseload is reported as average monthly recipients

Figure III.3

Long Term Care Caseload

Group	FY2006	FY2007	FY2008	FY2009
Residential LTC	80,942	82,081	82,953	83,809
Promoting Independence	4,927	5,417	6,027	6,448
Community Care				
Entitlement - Base	128,834	120,930	120,099	125,477
Entitlement Base + Exceptional (PACE Expansion)			120,177	125,703
Non-Entitlement - Base	41,437	45,507	36,340	36,340
Non-Entitlement - Base + Exceptional			45,097	45,277

Notes:

Residential includes: *Nursing Facility, Skilled Nursing Facility, Hospice, ICF/MR and State Schools*

Community Care Entitlement includes: *Primary Home Care, Community Attendant Services, Day Activity and Health Services*

Community Care Non-Entitlement includes: *Community Based Alternatives, Community Living Assistance and Support Services, Medically Dependent Children Recipients, Program for All-Inclusive Care for the Elderly*, Texas Home Living, Home and Community Based Services, Deaf-Blind Waiver, Consolidated Waiver*

Figure III.4

Other HHS Caseloads

Agency/Program	FY2006	FY2007	FY2008	FY2009
Department of Family & Protective Services				
Foster Care	19,025	20,994	22,728	24,451
Adoption Subsidies	20,368	22,624	24,679	26,705
Department of Rehabilitative Services				
Early Childhood Intervention	46,067	50,741	55,661	59,280
Health and Human Services Commission				
Temporary Assistance to Needy Families	189,287	189,300	196,802	205,082

Notes:

Foster Care caseload is reported as average daily clients

Adoption Subsidy and TANF caseloads are average monthly clients

ECI caseload is a unique client count across the fiscal year

In forecasting the Medicaid program for the LAR, the base forecast held costs at the fiscal year 2006 level, and the base caseload includes Medicaid clients who will become part of the CHIP Perinatal program. As part of the exceptional items requested, cost growth was projected first through the end of the current biennium, then through the end of the 2008-2009 biennium. Caseload was adjusted in both the CHIP and Medicaid programs for the impact of CHIP Perinatal, where a child born to a mother receiving only emergency Medicaid services is CHIP eligible prior to birth, with a 12-month continuous eligibility in CHIP (thus placing the child in CHIP rather than Medicaid for the first 6-9 months of life, to take advantage of a higher federal matching percentage). Both caseload and cost trends are determined by time-series analyses of

historical data, with consideration of external factors such as policy impacts (for example, the CHIP perinatal program.

Residential long-term care caseloads are projected to reach approximately 90,000 clients by fiscal year 2009, an increase of approximately 1.5 percent each year of the biennium. Foster care and adoption subsidy caseloads are both projected to increase each year of the 2008-2009 biennium, with a daily average of just over 24,000 children in paid foster care in 2009. Early childhood intervention caseload increases by 9.7 percent in fiscal year 2008 and 6.5 percent in fiscal year 2009, in part due to the impact of the new federal CAPTA requirements. Temporary Assistance to Needy Families is projected to slowly increase, however the impact of the Deficit Reduction Act and TANF Reauthorization may mitigate these slight increases.

Revenue and Federal Funds Enhancement Initiatives

This section summarizes Quality Assurance Fees, Upper Payment Limit initiatives that are active and pending, HHS funds flowing to Independent School Districts, and other federal funds maximization activities. The CHIP Perinate coverage authorized by the 79th Legislature is also highlighted.

Quality Assurance Fees in Texas

A Quality Assurance Fee (QAF) is a health care-related tax described under Title 42 of the Code of Federal Regulations (CFR), §433.68. QAFs are used by a number of states to access additional federal matching funds for health care programs without increasing General Revenue Fund expenditures. A state may receive, without a reduction in Federal Fund Participation (FFP), health care-related taxes if all of the following criteria are met:

- The taxes are broad-based (imposed on all providers in the same class, e.g., hospitals, nursing facilities, ICF/MRs, etc.);
- The taxes are uniformly imposed throughout a jurisdiction (the tax rate is the same for everyone in the class); and
- The tax program does not violate the hold harmless provisions (that some providers will pay full health care-related taxes and not receive anything in return).

The broad-based and uniformity requirements may be waived if certain conditions are met, primarily that the tax is “generally redistributive” and that the hold harmless provisions are not violated. The health care-related tax cannot produce revenues greater than 6 percent of the revenues (gross receipts) received by the taxpaying class in the aggregate.

The 77th Legislature (2001) through the passage of H.B. 1839 amended the Texas Health and Safety Code (Chapter 252, Subchapter H) to impose a QAF on each licensed private Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) provider as well as any ICF/MR facility owned by a community mental health and mental retardation center. This fee took effect during state fiscal year 2002.

The 78th Legislature (2003) through the passage of H.B. 7 and H.B. 2292 amended the Texas Health and Safety Code (Chapter 252, Subchapter H) to also include state schools in the list of ICF/MR facilities required to pay the quality assurance fee. This fee took affect during state fiscal year 2003.

The fee imposed on the ICF/MR providers was 5.5 percent of the facilities’ total annual gross receipts during fiscal year 2002-2003. That percentage was increased to 6 percent of the facilities total annual gross receipts during fiscal year 2004-2005. As shown on the table below, approximately $291.3 million has been collected and paid into the state QAF fund since fiscal year 2002, with $58.2 million anticipated in fiscal year 2007.

Figure III.5

DADS Quality Assurance Fees (QAF)							
General Revenue Dedicated (GR-D) Funds Increase ($ in millions)							
	FY02	**FY03**	**FY04**	**FY05**	**FY06**	**FY07**	**FY02-07 Total**
Community Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) QAF	$20.4	$21.9	$23.4	$22.3	$20.6	$21.5	$130.1
State School QAF		$28.0	$30.5	$31.6	$34.4	$36.7	$161.2
Total	**$20.4**	**$49.9**	**$53.9**	**$53.9**	**$55.0**	**$58.2**	**$291.3**
Note: These are the amounts collected and paid in to the state GR-D QAF Fund 5080 and vary from amounts appropriated. QAF is a method of finance in the DADS base budget.							

Quality Assurance Fees in Other States

States use provider taxes to generate state and federal funds to support their Medicaid programs in a number of ways. Some states devote all the new resources to support their overall Medicaid budgets. Others use the funds to finance specific provider rate increases. In other cases, the funds help address overall state budget shortfalls. Several states implemented and plan to implement increases or new provider taxes to generate revenue in fiscal year 2005 and fiscal year 2006 (Figure III.6)).

At the beginning of fiscal year 2005, a total of 35 states had one or more provider taxes in place. Among those taxes already in place, the most common were assessments on nursing homes, ICF/MR, hospitals, and MCOs. In 16 states, taxes or assessments applied to more than one category of provider tax. In fiscal year 2005, a total of 21 states increased or imposed new provider assessments or taxes. One state, West Virginia, reduced all of its three different existing provider taxes (for physicians, other practitioners and emergency ambulance services) in a plan to phase them out over a five-year period.

For fiscal year 2006, 24 states are increasing or imposing one or more new provider assessments or taxes. States most frequently planned new taxes on MCOs and nursing homes for fiscal year 2006. Three states reduced a total of five different existing provider taxes: Two of these were nursing homes and the three additional are the aforementioned taxes being phased out in West Virginia.

These increases in provider taxes are occurring in the context of proposals contained in the President's budget for Medicaid that would re-define and limit acceptable Medicaid provider taxes for fiscal year 2006 and beyond. The executive budget proposals would reduce the maximum allowable provider tax rate from 6 percent to 3 percent. In addition, an acceptable managed care organization (MCO) tax would be applied to all MCOs in a state, not just those providing services to Medicaid beneficiaries (as is allowed under current law).[3]

[3] Current federal law at Section 1903(w)(7)(A)(viii) of the Social Security Act specifies that health care services that can be taxed include "Services of a Medicaid managed care organization with a contract under section 1903(m)."

Figure III.6

Actions on Provider Taxes and Assessments in FY 2005 and FY 2006								
Provider Type	In Place Prior to 2005	New FY 2005	Tax Increased FY 2005	Tax Decreased FY 2005	New FY 2006	Tax Increased FY 2006	Tax Decreased FY 2006	Total FY 2006
Nursing Home	23	5	6	0	4	9	2	32
ICF/MR	12	5	2	0	2	1	0	19
Hospital	12	2	3	0	2	5	0	17
MCO	6	3	1	0	6	0	0	15
Pharmacy	3	0	0	0	1	0	0	4
Home Health	2	0	0	0	0	0	2	2
Practitioner	2	0	0	2	0	0	2	2
Other	1	2	0	1	1	0	1	4

Upper Payment Limit (UPL) Initiatives

The UPL is the federal limit on Medicaid payments to a group of hospitals and is determined under Federal regulations as a reasonable estimate of the amount that would be paid for the Medicaid services or similar services using Medicare payment principles. Supplemental payments are made to certain hospitals to make up the difference between what Medicaid actually paid for their Medicaid clients and what Medicare would have paid for the same services.

As shown on the table below, Texas has six active UPLs and three UPLs pending CMS state plan amendment approval. Active UPLs have generated $3.1 billion in federal funding since fiscal year 2002. In fiscal year 2007, active UPLs are expected to generate approximately $831.4 million in federal funding. UPLs pending Centers for Medicare and Medicaid (CMS) approval would generate an additional $277.3 million in fiscal year 2007. For further details on Active and Pending UPLs, see Appendix F.

Figure III.7

Upper Payment Limit (UPL) Programs: Active and Pending, FY 2002-2007 Federal Funds ($ in millions)	FY02	FY03	FY04	FY05	FY06	FY07	FY02-07 Total
Active UPL Programs							
Large Urban Public Hospital UPL*	$169.7	$216.8	$409.6	$429.7	$400.0	$400.8	$2,026.6
State-Owned Hospital UPL*			28.2	39.2	39.2	39.2	146
Rural Hospital UPL*	14.0	21.0	29.0	41.9	45.5	45.6	197
Urban Non-Public (High-Volume Payments to Private Hospitals)*				52.5	-	-	52.5
Regional UPL for Private Hospitals					152.8	121.5	274.3
Statewide UPL for Private Hospitals*					177.6	224.3	401.9
Subtotal	***$183.7***	***$237.8***	***$466.8***	***$563.3***	***$815.1***	***$831.4***	***$3,098.1***
UPL Programs Pending CMS approval							
State Hospital Physician UPL						231.9	231.9
Tarrant County Physician UPL						6.7	6.7
Children's Hospital UPL						38.7	38.7
Subtotal	-	-	-	-	-	***$277.3***	***$277.3***
Total	**$183.7**	**$237.8**	**$466.8**	**$563.3**	**$815.1**	**$1,108.7**	**$3,375.4**

*These UPL amounts are shown based on date of service (program year); the other UPL amounts reflect date of payment (cash basis).

Impact of STAR+Plus Expansion on Federal UPL Revenue and Retroactive Claiming of Federal Funds Under UPL and Disproportionate Share Hospitals (DSH)

UPL payments are not allowed by federal regulations under capitated managed care arrangements, such as the STAR+Plus program. However, managed care offers the best tool for controlling rising Medicaid costs. To avoid a reduction in supplemental UPL payments to hospitals, the state developed an alternative STAR+Plus model that carves out hospital related costs and payments. These costs and payments continue to be paid by the state, maintaining the hospital supplemental UPL payments.

HHSC developed a comprehensive plan to maximize federal funding available to Texas hospitals. On February 11, 2005, HHSC identified $103.6 million in retroactive claims for UPL, DSH, and Graduate Medical Education (GME). The actual amount claimed was $314.5 million. (See table below for further details).

Figure III.8

Maximizing Federal Funding for Local Hospitals		
Type of Adjustment	**Estimate Provided 2/11/05 ($ in millions)**	**Actual**
FY2004-2005 Retroactive UPL Claims and Increase DSH Limit to local public hospitals to 175% of hospitals' cost	59.0	241.9
Retroactive GME claims for Parkland Hospital	44.6	72.6
Total	**$103.6**	**$314.5**

Fiscal year 2004-2005 Retroactive UPL Claims – HHSC staff determined that services provided to Medicaid clients under Primary Care Case Management (PCCM) programs could be included in the determination of a hospital's Upper Payment Limit (UPL) supplemental payments. The addition of these clients greatly enhanced the amount of UPL payments to Texas hospitals with high Medicaid utilization.

Increase DSH limit to local public hospitals to 175 percent of hospital costs – for state fiscal year 2004 and 2005, HHSC staff determined that UPL payments could be maximized utilizing a formula that multiplied the actual DSH limit of each hospital by 1.75. Since the DSH limit is a limiting factor for UPL payments, this enhanced the amount of UPL payments to Texas hospitals with high Medicaid utilization.

Retroactive GME claims for Parkland Hospital – payment of retroactive federal funds related to claims for Graduate Medical Education (GME) costs for fiscal years 1999 through 2001. These funds were paid as part of a Compromise and Settlement Agreement between HHSC and Parkland Hospital.

HHS Funds Provided to Independent School District's (ISDs)

The HHS system provides funding to ISDs through a number of programs. As shown on the table following, the HHS system provided a total of $57.2 million to ISDs in fiscal year 2005 and $64.7 million in fiscal year 2006. The majority of funds are provided through the School Health and Related Services (SHARS) and Medicaid Administrative Claiming (MAC) programs (also see SHARS in chapter IV).

In fiscal year 2006, approximately $55.0 million in federal funding was provided through SHARS and in fiscal year 2005, approximately $8.0 million was provided through MAC. SHARS is a Medicaid program administered jointly between the TEA and HHSC. Using existing state and local special education appropriations as state matching funds, local school districts obtain Medicaid reimbursement for certain health and rehabilitation related services provided to special education students. MAC provides school districts with the ability to receive reimbursement for certain outreach and case management activities. The outreach services may be to a student or their family and for activities that include coordinating, referring, or assisting the student/family in accessing needed medical/health or mental care services.

In fiscal year 2006, DARS provided approximately $7.4 million in funding to ISDs for services provided to infants and toddlers under the age of three who have a developmental delay, a medically diagnosed condition that has a high probability of resulting in a delay or who exhibit atypical development.

In fiscal year 2006 DSHS provided approximately $2.0 million in funding to ISDs for Abstinence Education, School Health, and Family Support for the Children with Special Health Care Needs (CSHCN) program.

Figure III.9

HHS Funds Provided to School Districts: FY 2005 and 2006							
		2005			2006		
Agency	**Program**	**GR**	**Federal**	**Total**	**GR**	**Federal**	**Total**
HHSC	School Health and Related Services (SHARS)[1]	-	40,912,830	40,912,830	0	55,350,104	55,350,104
HHSC	Medicaid Administrative Claiming (MAC)[2]	-	7,397,553	7,397,553	0	-	-
Subtotal, HHSC		**$0**	**$48,310,383**	**$48,310,383**	**$0**	**$55,350,104**	**$55,350,104**
DARS[3]	IDEA Part B	-	356,040	356,040	-	348,928	348,928
DARS[3]	IDEA Part C	-	962,040	962,040	-	1,721,935	1,721,935
DARS[3]	Developmental Rehab. Svcs.	-	1,528,507	1,528,507	-	1,150,091	1,150,091
DARS[3]	MAC	-	229,778	229,778	-	256,157	256,157
DARS[3]	TANF	-	1,262,951	1,262,951	-	1,143,786	1,143,786
DARS[3,4]	State Funds	2,910,686	-	2,910,686	2,791,660	-	2,791,660
Subtotal, DARS		**$2,910,686**	**$4,339,316**	**$7,250,002**	**$2,791,660**	**$4,620,898**	**$7,412,557**
DSHS	Adol. Forensic Program Administrator	25,770	-	25,770	-	-	-
DSHS	Abstinence	73,008	769,000	842,008	71,360	1,296,706	1,368,066
DSHS	CSHCN Family Support	10,000	-	10,000	10,000	-	10,000
DSHS	School Health	-	697,917	697,917	-	602,028	602,028
DSHS	Bioterrorism	-	22,000	22,000	-	-	-
Subtotal, DSHS		**$108,778**	**$1,488,917**	**$1,597,695**	**$81,360**	**$1,898,734**	**$1,980,094**
Grand Total		**$3,019,464**	**$54,138,616**	**$57,158,080**	**$2,873,020**	**$61,869,736**	**$64,742,756**

[1] Claims paid during state fiscal years 2004, 2005, and 2006.

[2] Claims paid for months of service in federal fiscal years 2004, 2005, and 2006. As of the end of the third quarter of FY2006, HHSC has received no FFY06 MAC claims.

[3] Claims paid based on appropriation years 2004, 2005, and 2006. FY2006 amounts are estimated. Five school districts are ECI providers and receive these funds: Dallas, Garland, Katy, Lubbock, and Silsbee.

[4] This is the amount of general revenue funds DARS provides to the five school districts mentioned above.

Federal Funds Maximization Activities

In addition to monitoring federal funding information and working with the HHSC Washington-based federal liaison staff and Office of State and Federal Relations on pending federal legislation, HHSC has sought to increase federal funding for health care expenditures with specific revenue maximization projects working with an outside consultant and HHS departments. As highlighted below, completed revenue maximization projects have generated approximately $138 million in additional federal funds. Additionally, an Upper Payment Limit (UPL) initiative is pending CMS state plan amendment approval and would generate approximately $232 million in federal funds during fiscal year 2007 including retroactive amounts, and approximately $68 million in federal funds annually thereafter. Underway at the Department of State Health Services (DSHS) are two initiatives expected to generate approximately $800,000 in federal funds for retroactive claims. In October, HHSC will issue a Request for Proposals (RFP) to again procure revenue maximization consulting services. The funds generated by initiative as shown below cover multiple years in some cases.

TANF Delinking Revenue Claiming ($20.4 million)

This project identified additional costs that qualified for reimbursement through a special Medicaid eligibility allocation. The initiative is complete and Texas has drawn all of the funds available.

Developmental Rehabilitation Services ($4.2 million)

This project identified retroactive Medicaid claims related to the Developmental Rehabilitation Services state plan amendment for Early Childhood Intervention services.

School Health and Related Services (SHARS) ($44.2 million)

- Retroactive corrections were made to direct service and transportation rates for SHARS and direct service and transportation rates were developed for fiscal year 2004 and fiscal year 2005.
- The requirement that the referral for SHARS speech therapy must be provided by a physician was eliminated. This increased SHARS units of service by also allowing the referral to be provided by a licensed speech-language pathologist.

State-Owned Hospital Upper Payment Limit ($69.1 million) *(Also see UPL Initiatives Section and Appendix F for further details)*

Supplemental reimbursement amounts were paid to state-operated hospitals up to applicable limits, increasing overall reimbursements.

State Hospital Physician Upper Payment Limit (pending CMS approval) *(Also see UPL Initiatives Section and Appendix F for further details)*

Additional reimbursements would flow to physician practice plans associated with state-operated hospitals. This state plan amendment is pending CMS approval.

Projects currently underway at the Department of State Health Services

- Review state laboratory claims to ensure that Texas is receiving full reimbursement.
- Review claims for flu and pneumococcal vaccinations to seniors to ensure that Texas is receiving full reimbursement

<u>Health Coverage Initiatives Authorized by the 79th Legislature</u>

Children's Health Insurance Program (CHIP) Perinate Coverage

Senate Bill 1, 79th Legislature, Regular Session, 2005, Rider 70, authorized HHSC to expend funds to provide unborn children with health benefit coverage under CHIP. The result is a new CHIP Perinatal benefit that will begin January 1, 2007. The program will extend coverage for 12

months to the unborn children of non-Medicaid eligible women, and cover children born under the program at higher CHIP FMAP rates. This benefit will allow pregnant women who are ineligible for Medicaid due to income or immigration status to receive prenatal care, and will provide CHIP benefits to the newborn upon delivery for the duration of the coverage period. Members receiving the CHIP Perinatal benefit are exempt from the 90-day waiting period, the asset test and all cost sharing, including enrollment fees and co-pays, for their coverage period.

IV. FEDERAL FUNDS

For the 2008-2009 biennium, the legislative appropriations base request and exceptional items include $34 billion in federal funds or 59 percent of the total requested appropriations. Issues such as a decline in the Federal Medical Assistance Percentage (FMAP), formula and program changes that may occur in the reauthorization of major grants such as the Ryan White Care Act (HIV/AIDS), as well as significant funding changes in federal appropriations levels or regulatory changes can impact the state's ability to continue or improve services to clients.

Federal Budget Outlook

Continuing Resolution and Impact

The federal fiscal year 2007 federal budget, which begins October 1, 2006, has not been finalized for health and human services; the federal government is expected to operate under a continuing resolution until after the November election. Generally, continuing resolutions have provided a continuation of the previous year's funding except for entitlement programs. More recently, efforts have been made to reduce funding below current levels in order to expedite passage of final appropriations. Regardless, a long term continuation of prior year's funding does place pressure on programs such as the AIDS Drug Assistance Program (ADAP) which has experienced significant annual federal growth.

Outlook for Appropriations

Concern about federal deficit projections and the growth in entitlement programs is expected to result in action to tighten federal expenditures in both discretionary and entitlement programs during the fiscal year 2007-2009 time period. In addition, policy considerations may shift federal spending priorities from broad-based state-oriented programs, such as the Preventive Health and Health Services Block Grant and the Social Services Block Grant, to targeted federal concerns such as national defense or preparation for a pandemic event. Congress and the Administration are also considering adding a state-local matching funds provision for the ongoing expenses of some homeland security expenses, including bioterrorism. The Administration also has indicated it will seek legislation that will introduce a 20 percent State match for Federal nutrition services and administrative spending to begin in FY 2008 for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Federal Regulatory Process/Administration proposals

In addition to the uncertainty of congressional budget action, regulatory action by federal agencies can impact the federal budget. The Department of Health and Human Services has proposed in its fiscal year 2007 budget to implement several Administration proposals and policies which could shift Medicaid costs to the states or reduce overall federal payments. Key among these Medicaid proposals for Texas are limitations on payments to government providers (including local government-owned hospitals and state-owned teaching hospitals); reduction in provider taxes used as state matching funds from 6 percent to 3 percent; other restrictions on the

use of upper payment limits or intergovernmental transfers and stricter policies in what may be considered Targeted Case Management, Rehabilitation Services and School Based services.

The Administration is also reportedly seeking legislation to introduce a 20 percent State match for the WIC Nutrition Services and Administrative (NSA) grant in 2008. If implemented, significant costs for WIC nutrition services would shift to the State. WIC is currently one of the few Federal programs that do not require State-matching funds for administrative purposes. According to the National WIC Association, this proposal could possibly move in two directions were it to receive active consideration from Congress, requiring states to either appropriate 20 percent of their required NSA funding for them to receive the remaining 80 percent of their NSA grant from the federal government or to forego the 20 percent if no match was provided. A 20 percent state match in Texas, using fiscal year 2006 funding as an example, would be close to $30 million dollars under the first scenario. The proposal would not be effective until fiscal year 2008 so that states are provided adequate notification to allow their legislatures to appropriate funds.

Deficit Reduction Act (DRA)

The Deficit Reduction Act (DRA) of 2005 was signed into law February 8, 2006. This Act reduces mandatory (entitlement) federal spending in Medicaid (and other programs) through changes in program requirements set by federal law. The DRA reduces direct federal spending by $39 billion for the five-year period of 2006-2010. Net changes in Medicaid, SCHIP, and Katrina funding for that period are $4.74 billion or 12 percent of the total reductions.[4] Changes in TANF and Child Welfare total ($344 million and $813 million, respectively) represent about 3 percent of the total reduction.

DRA Medicaid Impact Nationally

Medicaid reductions in direct spending are in five major categories which account for $10.5 billion in reductions over the five-year period from 2006 through 2010. The table below lists the reduction categories and identifies what percent each category constitutes of the total net reductions in those categories.

Figure IV.1

Category	Reductions in Billions 2006 - 2010	Percent of Total Medicaid Reductions
Drugs	- $3.855	37%
Assets	- 2.364	23%
Fraud, Waste & Abuse	- .294	3%
Cost-Sharing and Benefits	- 3.160	30%
State Financing (changes in funding Targeted Case Management; Restrictions on Managed Care Organization Provider Taxes)	- .830	8%
Total	**- $10.503**	**100%**

At the federal level, changes in drug reimbursements and policies, cost sharing and benefit flexibility, and in asset policy for long term care eligibility account for nearly 90 percent of the estimated reductions in federal Medicaid expenditures.

DRA Texas Impact

The Deficit Reduction Act is expected to have a significantly different impact in Texas, with the most significant effects in the loss of federal entitlement funding for child welfare services, and estimated state savings related to long term care eligibility and asset policy changes. Changes in asset policy could result in savings for Long Term Care services and costs will also be incurred due to automation changes.

[4] Source: Congressional Budget Office Cost Estimate, January 27, 2005. S. 1932 Deficit Reduction Act of 2005. Note that Medicaid net funding was reduced by $6.90 billion; while Katrina funding increased by $2.14 billion and SCHIP increased by $20 million for a net reduction of $4.74 billion.

Relative to child welfare services, one significant impact was the loss of federal Medicaid Targeted Case Management (TCM) reimbursement estimated at $154.7 million for the 2006-2007 biennium. A portion of this Medicaid TCM loss was funded with additional Title IV-E claiming and the remaining shortfall was funded with general revenue by the 79th Legislature. Another significant impact was an unanticipated provision that prohibited Title IV-E claiming for children in unlicensed placements resulting in a shortfall of $39.2 million for the 2006-2007 biennium which was funded by transfers from HHSC. For more details on DFPS budget impact, see Child Welfare Funding Impact in the Current Issues section following.

Depending on how broadly the TCM provision is interpreted, there are ten additional programs at DFPS, Department of Assistive and Rehabilitative Services (DARS), Department of State Health Services (DSHS) and the Department of Aging and Disability Services (DADS) that were identified as either targeted case management or case management services provided as part of a home and community based waiver package that could be at risk.

Changes in the maximum amount that states can pay for drugs (the federal upper limit or FUL) have the potential for significant state savings.[5] Nationally, increased flexibility in cost sharing and in benefit requirements is expected to reduce federal spending by about $1.2 billion over five years. Changes will increase the amount of cost-sharing that can be required and will allow states to choose to require premiums for some groups. The law also allows states to permit providers to require cost sharing payments as a condition of providing services for some groups, and allows states to deny Medicaid eligibility to certain groups that fail to pay required premiums.

These cost sharing options are limited in Texas to a very narrow population since Texas has a limited number of clients in those groups and seeking those services subject to cost-sharing. Many eligibility groups and services continue to be excluded. Co-pays can be required for any client who uses non-preferred drugs, and for emergency room visits for non-emergent conditions – but only if alternative access is guaranteed and other conditions are met.

Benefit flexibility provisions allow states to provide a benefit package that is smaller than the standard Medicaid packages for certain non-mandatory populations. In Texas, federal exemptions would limit that option largely to children. However, states are required to continue providing Early Periodic Screening, Diagnosis and Treatment (EPSDT) services to Medicaid enrollees under 19; in essence eliminating a basic benefit option for children.

DRA-required changes to the Medicaid program include:

- New certification of citizenship requirements for Medicaid eligibility; effective July 1, 2006.
- Reductions in pharmacy upper payment limits; new rebates, and improved regulation of generics;
- Reform of asset transfer rules for Medicaid eligibility making it more difficult to transfer assets at less than market value and qualify for Medicaid
- Fraud waste and abuse provisions including enhancing third party reimbursement

[5] These are currently being reviewed.

- Reductions in Medicaid coverage for Targeted Case Management

DRA optional programs, grants and pilots that states may choose to pursue include the following:

- Long-term care partnerships.
- State Plan option for expanded home and community-based services.
- Cost-sharing and benefit flexibility options
- Medicaid transformation grants.
- Health opportunity accounts pilots.
- Money follows the person grants.
- Coverage for disabled children up to 300 percent FPL to purchase Medicaid.

Additional detail is provided below on some of the key provisions of the DRA that affect Texas.

FMAP

The Deficit Reduction Act recognized the need for alleviating any adverse impact to states hosting a significant number of Katrina evacuees and provided for an adjustment to the FMAP calculation. This adjustment is necessary to correct the mismatch between the 2005 population count that occurred before the hurricane hit and the 2005 personal income data that will include income attributable to the evacuees. Because Hurricane Katrina resulted in population migrations among states that were not included in the July population count, host states may be measured as having increased per capita income in calendar year 2005. Should additional adjustments be made to the per capita income or population data assumed in the FMAP calculation, the FMAP for Texas would change above the amount assumed in the 2008-2009 LAR. Once the final fiscal year 2008 FMAP is published, updated information will be provided to executive and legislative budget staff.

Child Welfare Funding Impact

The DRA Targeted Case Management (TCM) provision makes Medicaid the payor of last resort if case management services are reimbursable from other federal funding sources, and alters the TCM definition to exclude provision of direct services. This DRA provision significantly impacts DFPS' ability to fund a portion of Child Protective Services (CPS) case management with Medicaid. Federal rules were scheduled to be published in July 2006 on how broadly the DRA TCM provision will be interpreted. These rules have not been published, and until they are, the HHS system is assuming a narrow interpretation of the provision by eliminating, for budget purposes, Medicaid TCM reimbursement for the CPS Out-of-Home Foster Care population. DFPS has continued to draw Medicaid TCM funds, but due to the likely possibility that these claims would be disallowed, funds claimed beginning January 2006 are being held off-budget until federal guidance is provided, or direction is received from state leadership.

The DRA also prohibits Title IV-E administrative claiming for children in unlicensed placements effective January 2006. In Texas, this type of placement only includes relative homes. This provision was not anticipated and appropriated funding for fiscal year 2006-2007 assumed these children could be included in the population ratio for Title IV-E reimbursement. By excluding children in relative placements from the population ratio, the DRA caused the ratio to drop from 67 percent to 51 percent, reducing the amount of Title IV-E that can be claimed, thereby increasing the agency's GR need which was resolved by transfers from HHSC.

The continued claiming of Medicaid TCM from September 2005 to December 2005 helped offset the loss of Title IV-E, and HHSC provided additional funds to DFPS for the remaining Title IV-E shortfall for the 2006-2007 biennium. However, since Medicaid TCM funds are not being assumed for fiscal year 2008-2009, there is a $10.8 million shortfall in DFPS' base request that is reflected in DFPS Exceptional Item #3 - Restore Loss of Funds from Method of Financing Changes. This exceptional item also includes an additional funding shortfall beyond the DRA impact.

Transitional Medicaid Assistance

The 1988 Family Support Act (FSA) required states to offer Medicaid coverage for up to 12 months to families who lost their Aid to Families with Dependent Children (AFDC) eligibility due to increased earnings. Twelve months coverage was set to expire after December, 2005. However, the Deficit Reduction Act extended 12 months coverage through December, 2006.

Transitional Medicaid Assistance (TMA) was created to assist former welfare recipients by providing transitional Medicaid coverage after they enter the workforce. Welfare recipients may enter low-wage jobs that do not offer health insurance or that offer insurance that is unaffordable to individuals transitioning off TANF. Since not having access to affordable health insurance is a potential disincentive for seeking employment, states were required to provide at least four and up to nine months of transitional Medicaid benefits for qualifying individuals.

If 12 months transitional coverage is not extended beyond 12/06 the anticipated effects are:

- individuals who lose Medicaid would have only four months of transitional Medicaid, rather than the 12 months currently provided. This will reduce coverage and member months; and
- additional administrative costs related to eligibility system changes. In Texas, the change would likely be implemented so that individuals who lose Medicaid coverage after 12/06 would receive only four months transitional Medicaid; while those who lost prior to that date would keep their 12 months. Administratively, Texas would have to maintain systems for each of these two groups until all the 12 month-eligibles lose coverage. As of December 2005, there were 77,267 individuals on transitional Medicaid coverage.

TANF/Work Requirements

The DRA maintained TANF federal work participation rate standards but revised the caseload reduction credit calculation. The two work standards require 50 percent of all families and 90 percent of two-parent families to meet work participation. Texas was able to meet the standards in previous years because of significant caseload reduction credits. The revised caseload reduction calculation gives states credit for caseload declines that occur from fiscal year 2005 forward.

The work participation rate denominator (the number of TANF families that include a work eligible adult or minor head of household) has been expanded to include non-recipient parents living with a child receiving TANF and families in TANF MOE separate state programs. Federal penalties will be assessed for failure to meet federal work participation requirements. The non-adjusted State Family Assistance Grant (SFAG) for fiscal year 2006 is $538.9 million. The federal penalty for failure to meet the all families rate is five percent of the SFAG, increased by two percent for each consecutive year to a maximum of 21 percent. The penalty for failure to meet the two-parent rate is five percent of the SFAG multiplied by the percentage of the state's caseload that are two-parents.

A federal participation rate penalty results not only in the loss of TANF federal funds but the state is required to expend state funds in an amount equal to the penalty amount. In addition, the TANF MOE requirement will be 80 percent, rather than 75 percent of the historical state expenditures under the former Aid to Families with Dependent children (AFDC) program in fiscal year 1994. The potential total penalty for failure to meet participation requirements for fiscal year 2008 is $70.4 million.

Other Current Federal Issues

In addition to the requirements and options in the DRA, other federal action affecting Texas includes:

Medicaid Reform

Beyond responding to federal requirements and initiatives that affect HHS agencies, Texas also has the option to create significant reform in its single largest program through Medicaid Reform. While the DRA does offer some states additional flexibility to tailor programs through State Plan Amendments, in Texas, many of these new options have little applicability. For example, we already cover community based services for most populations at higher incomes than allowed in the DRA SPA options; most of our covered populations are exempted from DRA-allowed cost-sharing and the basic benefit package options; and we already have a Money Follows the Person program similar to the DRA initiative.

States with less DRA flexibility can still pursue the existing 1115 demonstration waiver option to implement Medicaid reform. States including Florida, California, Massachusetts and Iowa have developed significant Medicaid reform plans using waiver authority negotiated with the Centers for Medicare and Medicaid Services (CMS). Key themes for reform include efforts to maintain federal funding through Intergovernmental Transfers (IGT), Disproportionate Share Hospital (DSH) payments, and Upper Payment Limit (UPL) payments; creation of Low Income Pools (LIPs) or Safety Net Care Pools (SNCPs) funded by IGTs to provide healthcare for the uninsured; coverage expansions, managed care expansions; tailored benefit plans; and increased consumer directed care, responsibility and rewards. Perhaps the most innovative trend with the most capacity to alter use of federal funding through IGTs is the development of LIPs and SNCPs.

Florida is moving towards enrolling almost 100 percent of Medicaid beneficiaries into managed care by the end of 2010. Because the managed care expansion eliminates the state's ability to provide Upper Payment Limit disbursements to hospitals, the state created a Low-Income Pool. The pool will distribute payments to providers for delivering health care services to the un- and underinsured. California also created a Safety Net Care Pool to pay for care delivered to the un- and underinsured as part of its 1115 waiver. While Iowa did not create a pool for the uninsured and underinsured under its 1115 waiver, the state did expand eligibility for previously uninsured populations to receive limited services at two public hospitals. The state also eliminated its use of Intergovernmental Transfers as part of its hospital financing agreement with CMS.

Medicaid Long Term Care

The National Governors Association's (NGA) Medicaid working group has taken a lead in advocating for additional reforms that would improve long-term care services for seniors. Citing Medicaid as the nation's largest payer of long-term care services, funding approximately 50 percent of all long-term care spending and nearly two-thirds of the costs for all nursing home residents, the NGA working group believes that further reforms are necessary to ensure the

sustainability of the Medicaid program. Further, they state that Medicaid cannot continue to afford to be the predominant provider of long-term coverage for seniors. In a letter to the Medicaid Commission, the Governors urged reforms including increased coordination between the Medicare and Medicaid programs since Medicaid funds many services for beneficiaries who are eligible for both programs. The governors built upon earlier recommendations – many of which were enacted in the Deficit Reduction Act (DRA) of 2005—calling for a "combination of policies to slow the growth of Medicaid long-term care costs." Policies to slow the growth of Medicaid long-term care costs that the Governors believe should be considered include federal, employer-based, personal, familial, and community-based proposals both within and outside of Medicaid. Additionally, governors believe certain reforms should be made outside of the Medicaid program to identify other means for funding these services, including expanding incentives for purchasing long-term care insurance. The governors urged the Commission to include these recommendations in its final report to Congress due on December 31, 2006.

Child Abuse Prevention and Treatment Act (CAPTA) Implementation

In 2003, Congress amended CAPTA to require state child protective services agencies refer children under the age of three who are involved in substantiated cases of abuse and/or neglect to state early intervention services agencies. A similar provision was added to the Individuals with Disabilities Education Act (IDEA) during reauthorization of IDEA in 2004. There was no additional federal funding authorized to implement either the CAPTA or IDEA requirements.

HHSC has worked with DARS and the Department of Family and Protective Services (DFPS) to develop a process for complying with the requirements of CAPTA. This process will result in additional screenings, eligibility determinations, comprehensive services, and follow-along services for the Early Childhood Intervention program and a need for increased funding. In fiscal year 2007, the Department of Assistive and Rehabilitative Services can absorb the costs of CAPTA compliance with IDEA Part C funds, appropriated GR within DARS, and Medicaid. During the 2008-2009 biennium, DARS estimates that compliance with CAPTA will require a total of $25.9 million ($7.8 million in IDEA Part C funds, $9.4 million in Medicaid funding, and $8.7 million in additional GR Match for Medicaid).

Children's Health Insurance Program (CHIP)

Over 18 states expect to face federal funding shortfalls for their CHIP programs in federal fiscal year 2007. In the past, sufficient funds have been available to eliminate shortfalls of a small number of states by using "expiring funds" from other states, from additional federal appropriations or a combination of the two. In fiscal year 2007, the current redistribution process is not expected to yield sufficient funds for states expecting CHIP shortfalls, and Congress may not be willing to appropriate the additional funds necessary. The Administration proposed in its budget request that changes be made to the current provision which gives states three years to spend each annual allocation. The result would be to redistribute funds that some states, including Texas, plan to spend in subsequent years. In addition, the Children's Health Insurance Program statutory provisions expire October 30, 2007. The formula for distributing

funds between states is expected to be re-evaluated at that time, unless significant new federal funds are made available. Adoption of either (or both) of these provisions or a change in the enhanced match rate for CHIP would reduce the amount of federal funds available for this program. Congress may not resolve these issues until after the Regular Session of the Texas Legislature concludes.

International Classification of Diseases (ICD-10) Project

New initiatives are being proposed at a national level that will continue to improve health care claim technology and medical information. Along with these efforts is the proposal to implement the International Classification of Diseases 10th Revision, Clinical Modification (ICD-10-CM). Most health care claim systems require a medical diagnosis for a patient and those diagnosis codes are currently provided through use of ICD-9. The implementation of these new medical diagnosis and inpatient procedural coding methods will require changes to information technology systems throughout the state. Texas Medicaid must be able to accept these new codes by the mandated date, anticipated to be October 2010. While there are additional smaller requirements that will be implemented during the biennium, such as new file formats and additional claim data, ICD-10 is the most critical and costly.

National Provider Identifier (NPI) Project

The HIPAA National Provider Identifier (NPI) regulations were published January 23, 2004. The NPI is a federally generated number required for all medical providers. Medical providers must apply for an NPI and use that number for claims processing with all payers. The provider number is one of the most critical pieces of information submitted on a claim. It is used to set payment rates, validate service levels, eliminate duplicate claims, write payments, investigate fraud and abuse, and set future rates. Texas Medicaid is preparing to be compliant with this requirement by May 23, 2007.

Agencies Operating Without Public Assistance Cost Allocation Plans (PACAPs)

Effective September 1, 2004, the Health and Human Services Commission (HHSC) and the Department of Family and Protective Services (DFPS) are operating under unapproved Public Assistance Cost Allocation Plans (PACAP). Both HHSC and DFPS have submitted PACAPs to the federal Division of Cost Allocation (DCA) as required by federal regulations. We have received an initial request for additional information and clarification on the DFPS PACAP submission and have replied to that request. With respect to the HHSC PACAP submission, we have received no formal response to date from DCA. If DCA disagrees with any of the methodologies as submitted in these two PACAPs, financial adjustments to previously submitted federal claims may be required. This could cause a shift in the amount of state dollars needed.

It should be noted that DCA has made HHSC responsible for the approval of the PACAP prepared by the Department of Aging and Disability Services (DADS). While HHSC has

approved the DADS PACAP, comments from DCA on the HHSC submission may also cause the DADS PACAP to need revisions, and may result in financial adjustments to be needed at DADS. Adjustments could cause a shift in the amount of state dollars needed.

Medicaid State Plan Amendment Review Process/Federal Audit and Deferrals

Texas currently has numerous state plan amendments pending CMS approval. CMS appears to be applying restrictive interpretations of previously approved Medicaid State Plan Amendments. Additionally, a national trend has emerged in which CMS is allocating more resources to review many aspects of state Medicaid operations for cost-containment opportunities and increased efficiencies. CMS is increasing efforts to reduce allowable federal reimbursement and assuring that payments to public providers are tied directly to actual costs. Highlighted below are two examples of programs in Texas currently under discussion with CMS: School Health and Related Services (SHARS) and Developmental Rehabilitation Services (DRS). Information about a deferral at DFPS is also included.

School Health and Related Services (SHARS)

SHARS is a Medicaid program administered jointly between the TEA and HHSC. Using existing state and local special education appropriations as state matching funds, local school districts obtain Medicaid reimbursement for certain health and rehabilitation related services provided to qualified special education students. From state fiscal year 2003 through state fiscal year 2005, the average federal portion of Medicaid payments to SHARS providers were over $50 million annually.

CMS is attempting to make school based Medicaid programs consistent from state to state. As a result, CMS is requiring that Texas make major revisions to the SHARS state plan amendment including the following:

- a consolidated statewide time study, based on the Random Moment Time Study (RMTS) method, for Medicaid Administrative Claiming (MAC) and cost reconciliation/cost settlement purposes;
- a revised certification of funds process whereby public providers certify not only the state share of Medicaid payments but both the state and federal shares;
- a revision in the types of providers that can be reimbursed for delivering SHARS and the definition of each service;
- implementation of district specific interim rates; and,
- a revised reimbursement methodology, including approval of a cost report to be completed annually by providers, cost report instructions, allowable costs to be included on the cost report, and processes for the reconciliation, review and settlement of interim payments to actual allowable costs.

As a result of these changes, Texas school districts will likely experience a reduction in reimbursement rates. HHSC has submitted a state plan amendment and has worked aggressively to reach an agreement. To date, negotiations with CMS continue.

Developmental Rehabilitation Services (DRS)

CMS began deferring a portion of ECI/DRS funds January 18, 2006 due to concerns with the ECI/DRS reimbursement rate and the rate methodology developed by Maximus in 2002. So far, CMS has deferred $5.2 million (approximately $1.7 million per quarter) and Texas is negotiating a prospective change without retroactive penalty. While there is no guarantee that CMS will not ultimately move to a disallowance of these funds, HHSC is proposing that CMS release the deferral once broader concerns over payment and rate-setting methodologies for public providers are addressed. In order to pursue this strategy, Texas will need to continue the ECI deferral process until broader concerns are resolved.

Department of Family and Protective Services Deferral

CMS deferred approximately $29.5 million in Federal Medicaid reimbursement for Quarter 2 of 2006. These costs represent the entire CMS claim for DFPS for that quarter. CMS stated in their deferral letter that the deferral was based on issues raised by the HHS Division of Cost Allocation and referenced the fact that DFPS did not have an approved Public Assistance Cost Allocation Plan (PACAP) in place. DFPS has submitted a PACAP but DCA has not yet approved it.

V. *ENTERPRISE INITIATIVES*

Provider Rate Considerations

The rate table in Appendix B.2. illustrates the cost of providing increases in the rates paid to providers in order to appropriately reflect changes in costs incurred by providers that care for HHS clients. Without this funding, continued rising costs incurred by providers will erode the quality of services provided and could result in access problems for clients.

In general, most Medicaid programs have not had a rate increase in six to seven years (as of September 1, 2006) with a few programs not experiencing a rate adjustment in over 10 years. In addition, most of these programs were subject to a rate reduction effective September 1, 2003 (1.1 percent for community long-term care programs, 1.75 percent for long-term care institutional care programs, and 2.5 percent for acute care programs and 5 percent for hospitals). As of September 1, 2005, only certain long-term care programs have seen these reductions restored. The Nursing Facility and Hospice Program was the only service to receive a rate increase in fiscal year 2006. The agency specific Legislative Appropriations Requests include exceptional items for restoration of these rate reductions (where appropriate), however these rate restorations will not be sufficient to cover the increased costs of these programs. Reference Appendix B.1. for information regarding rate histories.

Since 2000 the Medical Price Index has increased 27 percent, an average of 4.5 percent a year. With rates held flat or reduced in most programs over these years and into the current biennium, the rates for these programs are not keeping pace with routine inflation, much less medical inflation.

Long-Term Care

Currently, long-term care providers are finding it difficult to attract and retain reliable attendants and nurses with the appropriate skills to provide the standard of care required by state and federal regulations. Rate increases for community care providers are conservative in that they only provide for general inflation increases for attendant wages and no other wage adjustments. Rate increases for nursing facilities are needed to mitigate some of the impact of the conversion from the Texas Index for Level of Payment (TILE), Texas based case mix payment system, to the Resource Utilization Group (RUG), national based case mix payment system developed by the Centers for Medicare and Medicaid. Data from nursing facility provider's fiscal year 2004 cost reports show the average. Medicaid payment per day was $96.11, whereas the average private pay resident per day was $103.14 and the average Medicare resident per day was $280.66. A comparison of Nursing Facility Medicaid rates to Medicare rates and estimated private pay amounts is detailed in Figure V.1.

Figure V.1

Comparison of Nursing Facility Rates

Procedure Description	Average Medicaid Fee	Average Private Pay	% Medicaid to Average Private Pay
Nursing Facility	$96.11	$103.14	93.18%

Physician / Medicare Payments

According to a report by Peter Cunningham and Jessica May entitled "Medicaid Patients Increasingly Concentrated Among Physicians,"[6] a national report on physician Medicaid payments, identifies national trends in four physician surveys conducted between 1996 and 2005. The major findings of the report indicate that physician Medicaid participation is down slightly and that Medicaid patients are more concentrated with fewer physicians. Trends like these can result in limited access for Medicaid clients. Rate increases for physicians would promote access to care for Medicaid clients that would likely erode without the increase. The study also documents that physician care has shifted to larger provider groups and institutional settings (from solo or small group practices) and the physicians in large metropolitan areas are less likely to accept new Medicaid patients than physicians in rural areas. Among physicians not accepting new Medicaid patients in 2004-2005, 84 percent cited low payment as a reason, 70 percent cited high administrative burdens, and 65 percent cited slow reimbursement. A comparison of select physician Medicaid rates to Medicare rates and estimated private pay amounts is detailed below.

Figure V.2

Comparison of Select Physician Fees

Procedure Description	Current Medicaid Rate	2006 Medicare Nonfacility Rate	Medicaid as % of Medicare	Estimated Private Payer	Medicaid as % of Private Payer
New Patient Office Visit	$47.07	$97.02	48.52%	$107.28	43.82%
Established Patient Office Visit	$28.78	$54.68	52.64%	$59.17	48.64%
Circumcision	$49.48	$241.89	20.46%	$569.51	8.69%
Vaginal Delivery with postpartum care	$692.74	$933.90	74.18%	$1,832.70	37.80%
Cesarean Delivery with postpartum care	$706.87	$1,112.78	63.52%	$2,187.59	32.31%
Eye Exam	$35.63	$67.18	53.03%	$101.07	62.33%
Colonoscopy	$148.93	$384.66	38.72%	$914.43	24.66%
New patient under 1 year	$70.00	$103.84	67.41%	Not Available	Not Available

[6] Center for Studying Health Systems Changes, Washington, D.C., August 2006, Tracking Report Number 16

Hospital Rates

The standard dollar amount (SDA) has not been increased since 2002. The increase in the SDA done in 2002 was based on inflating and rebasing 2000 hospital claims data. Since 2002 the SDA has actually been decreased by five percent due to legislative action. This reduced level of Medicaid funding has resulted in an increased amount of hospital cost not being met by the Medicaid reimbursement rate. This reimbursement shortfall results in hospitals using DSH funding to cover these costs and not be used for the cost of uncompensated care. In addition to the DSH hospitals have had to utilize the UPL program to access increase federal funding. DSH and UPL are funding through Inter-governmental Transfers (IGTs). The level of IGTs has now reached the point where IGTs represent 42 percent of the state cost of hospital acute care.

Riders 60 (Medicaid Provider Reimbursement, General Appropriations Act, 79th Legislature, Regular Session, 2005) directed the HHSC to review different methods for developing and modifying hospital rates. Rider 61 of the same Legislative session sought recommendations on standardizing of the reporting of uncompensated care. HHSC has secured the services of consultant in researching the hospital funding issue and providing options for consideration by HHSC. In their research Deloitte has interviewed various entities impacted or involved in the determination of hospital rates and will report findings to the Hospital Rate Workgroup for discussion. The results of this process will be a report to the 80th Legislature with recommendations for standardizing hospital's uncompensated care amounts and recommendations for changes in the hospital reimbursement rate methodology.

Ambulance Fees

Rates for ambulances are also falling behind as illustrated in the comparison chart of select ambulance fees in Figure V.3.

Figure V.3

Comparison of Select Ambulance Fees

Procedure Description	Current Medicaid Fee	Medicaid Average Payment	2006 Medicare Urban Average Payment	% Medicaid to 2006 Medicare Urban Average	2006 Medicare Rural Average Payment	% Medicaid to 2006 Medicare Rural Average
Ground mileage, per statute mile - ground ambulance	$3.30		$6.05	54.55%	$6.11	54.01%
Ambulance service, basic life support, nonemergency transport (BLS) - ground ambulance		$53.26	$198.17	26.88%	$200.13	26.61%
Fixed wing air mileage, per statute mile - air ambulance	$16.24		$7.18	226.18%	$10.76	150.93%
Rotary wing air mileage, per status mile - air ambulance	$16.24		$19.14	84.85%	$28.71	56.57%

Vendor Drug Dispensing Fees

The Medicaid dispensing fee paid to Texas pharmacies has not been increased since 1997 despite an increase in operating costs. The average blended (generic and brand name) dispensing fee for 2007 is estimated to be $6.72. The incremental cost of a $1 increase in the dispensing fee per prescription is contained in Appendix B1. Most states use a single, flat rate dispensing fee. These fees are administratively simple and are more easily understood by pharmacy providers. Consideration might be given to changing from the current pharmacy dispensing fee formula to a single, flat fee. Of potential importance to pharmacies beginning in 2007 are provisions contained in the Deficit Reduction Act of 2005 (DRA). These provisions will revise the formula used by states for setting federal upper payment limit (FUL) prices for multiple-source (generic) drugs dispensed in the Medicaid program. It has been estimated that approximately 52 percent of all Medicaid prescriptions are currently being filled with generic drugs. It is expected that this DRA change will reduce reimbursement to pharmacy providers for the cost of drugs. Information from the Centers for Medicare and Medicaid Services (CMS) is pending so an estimate of the fiscal impact cannot yet be fully calculated and is not included in the consolidated budget.

Foster Care Rates

Adequate funding for foster care reimbursement rates is essential to recruiting and retaining quality foster care providers and thus ensuring appropriate capacity of foster care placements so that all children in foster care are provided the best care in the least restrictive setting. The rate increase for foster care in Appendix B.2. represents an across-the-board inflation adjustment to the current rates to account for increased costs impacting these providers and foster families.

Other Rates

In addition, as HHSC has implemented changes in some programs to move from cost based reimbursement methodologies to prospective unit rate methodologies (with no retrospective settlement), more providers are required to contain costs below the prospective unit rates they are paid in order to make any profit. While prospective unit rates are good at containing costs to reasonable levels, when they are not adjusted periodically to account for cost changes and inflation, providers must reduce the quality and/or quantity of the services they provide in order to remain financially viable. Severe cost containment can lead to diminished quality of care and access to care.

Reduce HHS Waiting / Interest Lists

Background – HHS Waiting / Interest Lists

The 79th Legislature, Regular Session, 2005, made a major new funding commitment in S.B. 1, the General Appropriations Act.

A $377 million increase (All Funds) will provide services for almost 12,000 Texans currently on interest lists for services. This effort is part of a long-term plan to eliminate the interest lists for services that help Texans live more independently, receive mental health treatment and care for children with chronic medical conditions.
In many cases interest lists will be eliminated or reduced:

- At DARS, the new funding will eliminate current interest lists for Comprehensive Rehabilitative Services and Independent Living Services.
- The funding will eliminate the interest list for the Deaf Blind with Multiple Disabilities waiver at DADS.
- The funding will reduce DADS interest lists by 10 percent for long-term care community programs, including community based alternatives, home and community based services, community living assistance and support service and medically dependent children programs.
- DSHS will be able to reduce waiting lists for Adult Community Mental Health, Child and Adolescent Community Mental Health, and Children with Special Health Care Needs.

By the end of the 2006-2007 biennium, interests lists for all affected programs are expected to be reduced by a total of 11,986 clients. Of these clients, an estimated 9,360 additional persons will receive services through DADS programs. By the end of fiscal year 2006, new interests lists slots filled from the November, 2004 interest/waiting lists is in excess of 50 percent of the target.

Interest List Improvements to Date

- DADS is currently posting to the DADS website, a monthly Interest List Report, identifying the number of individuals on the list (Figure V.4) and the percentage of individuals who have been on the list for varying time periods (Figure V.5). This report also specifically shows the numbers of individuals that have been removed from the interest list due to the Interest List Reduction funding received during the last legislative session.

- DADS is now generating a monthly report, which identifies unduplicated individuals currently on the interest list.

- DADS is currently sending confirmation letters or packets to individuals who wish to be on the interest list or who are currently on the interest list. This letter or packet is utilized to confirm their registration and requires them to notify DADS if they have any changes to the information regarding the individual or if they determine they no longer wish to remain on the interest list.

- DADS is currently able to identify the number of individuals on the HCS interest list who are under 22 years old, residing in a facility.

- DADS is currently contacting individuals on the interest list, at least annually, to ensure they desire to remain on the interest list.

- DADS has instituted a quarterly manual process to match the MERP death file to the Interest List and remove individuals who are identified as deceased. As of the May 2006, manual run, 1,420 individuals on the interest lists were identified as deceased. Once this information has been fully verified the individuals will be removed from the interest list.

- DSHS is currently generating a monthly report identifying adults and children waiting for all community mental health services and those who are under-served due to resource limitations.

- DSHS generates a monthly report to identify the rate of contact for individuals waiting for all community mental health services to assess if there has been any changes in the individuals condition that would warrant reprioritization for services.

- DSHS generates a monthly report to identify individuals who are under-served due to resource limitations. This report also produces a list of clients who need to be prioritized because of an increased likelihood of psychiatric crisis and/or hospitalization.

- DSHS also generates a monthly report on the number of individuals who have been removed from the wait list since the last legislative session. In all, 1,325 individuals were removed from the waiting list from September 2005 to July 2006, with 120 individuals removed from the wait list on average per month.

- Each month, DSHS reviews the CSHCN client data and prepares a waiting list report of unduplicated clients who are determined eligible for the program but are not receiving health care benefits.

- DSHS provides case management services to those clients on the waiting list to help identify alternative resources for health care.

- Under Rider 63, DSHS reports the finding that funds are available to remove clients from waiting list to the Governor and LBB at least 15 days prior to adding clients from the waiting list to the program to begin receiving health care benefits. Since the creation of the waiting list, DSHS has removed seven groups of children, so that they could receive ongoing benefits.

Further improvements in progress or planned:

Programming modifications for the Community Services Interest List (CSIL) and the Client Assignment and Registration (CARE) systems are planned to achieve the following:

- Reporting of the number of individuals on more than one list.
- Reporting of the number of individuals under the age of 22 residing in a facility.
- Reporting of the number of individuals whose names were removed from the list at annual contact or any time while waiting for services.
- Reporting of the number of individuals who, when their names came up for an offer of service were not enrolled (declined a slot).
- Reporting of the number of individuals who asked to return to the interest list after declining or failing to qualify for services.
- Reporting of the number of individuals who are receiving other DADS services.
- Automating the Medicaid Estate Recovery Program (MERP) death file match to the Interest List.

Figure V.4

Monthly Interest List Report	CBA	CLASS	DBMD	MDCP	HSC	TOTAL
Number of Clients on IL LAR Submission (November 2004	66,787	13,453	18	8,604	26,698	115,560
Total Released / Removed from IL	35,958	3,083	34	1,796	2,780	43,651
o *Enrolled*	*6,771*	*392*	*5*	*121*	*1,261*	*8,550*
o *In the pipeline*	*5,635*	*1,988*	*16*	*685*	*953*	*9,277*
o *Denied / Declined*	*23,552*	*703*	*13*	*990*	*566*	*25,824*
Net Remaining from LAR Submission	30,829	10,370	- 16	6,808	23,918	71,909
Percent Reduction from LAR Submission	53.8%	22.9%	188.9%	20.9%	10.4%	37.8%
Added to IL since LAR Submission	13,022	4,754	32	3,242	6,194	27,244
Current IL – July 31, 2006	43,851	15,124	16	10,050	30,112	99,153
New Percentage Change from LAR Submission	- 34.3%	12.4%	- 11.1%	16.8%	12.8%	- 14.2%

Figure V.5

Time on List	CBA	CLASS	DBMD	MDCP	HCS
0 – 1 Years	51.8%	21.0%	62.5%	24.4%	18.1%
1 – 2 Years	26.6%	18.3%	37.5%	23.4%	15.1%
2 – 3 Years	12.5%	18.7%	0.0%	23.7%	14.6%
3 – 4 Years	9.0%	18.6%	0.0%	22.2%	13.3%
4 – 5 Years	0.0%	11.8%	0.0%	6.3%	12.6%
5 Years +	0.0%	11.7%	0.0%	0.0%	26.2%
Average Time on List (in years)					
November 2004	1.5	2.9	1.4	2.0	3.3
July 31, 2006	1.2	2.7	0.8	2.1	3.4

Reduce Current HHS Waiting / Interest Lists

The Health and Human Services Commission supports funding waiver slots in all community-based services programs. HHSC included two exceptional item requests to continue the effort to reduce/eliminate programs with waiting or interest lists at the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services (DARS) and the Department of State Health Services (DSHS). These two items would serve 27,764 individuals by end of fiscal year 2009 and cost $255 million General Revenue for the biennium.

Reduce for Demographic Growth – HHSC is requesting $56 million General Revenue to keep pace with population growth in programs with waiting/interest lists. Of the amount requested, approximately $29 million would serve 4,609 individuals from the interest lists at DADS for home and community-based waivers, non-Medicaid services, and the In-Home and Family Support program. The community-based waivers include Community Based Alternatives (CBA), Community Living Assistance and Support Services (CLASS), Medically Dependent Children Program (MDCP), Deaf-Blind with Multiple Disabled Waiver (DBMD), and the Consolidated Waiver Program. The Consolidate Waiver Program draws from interest/waiting lists of five waiver programs: CBA, MDCP, HCS, DBMD, and CLASS.

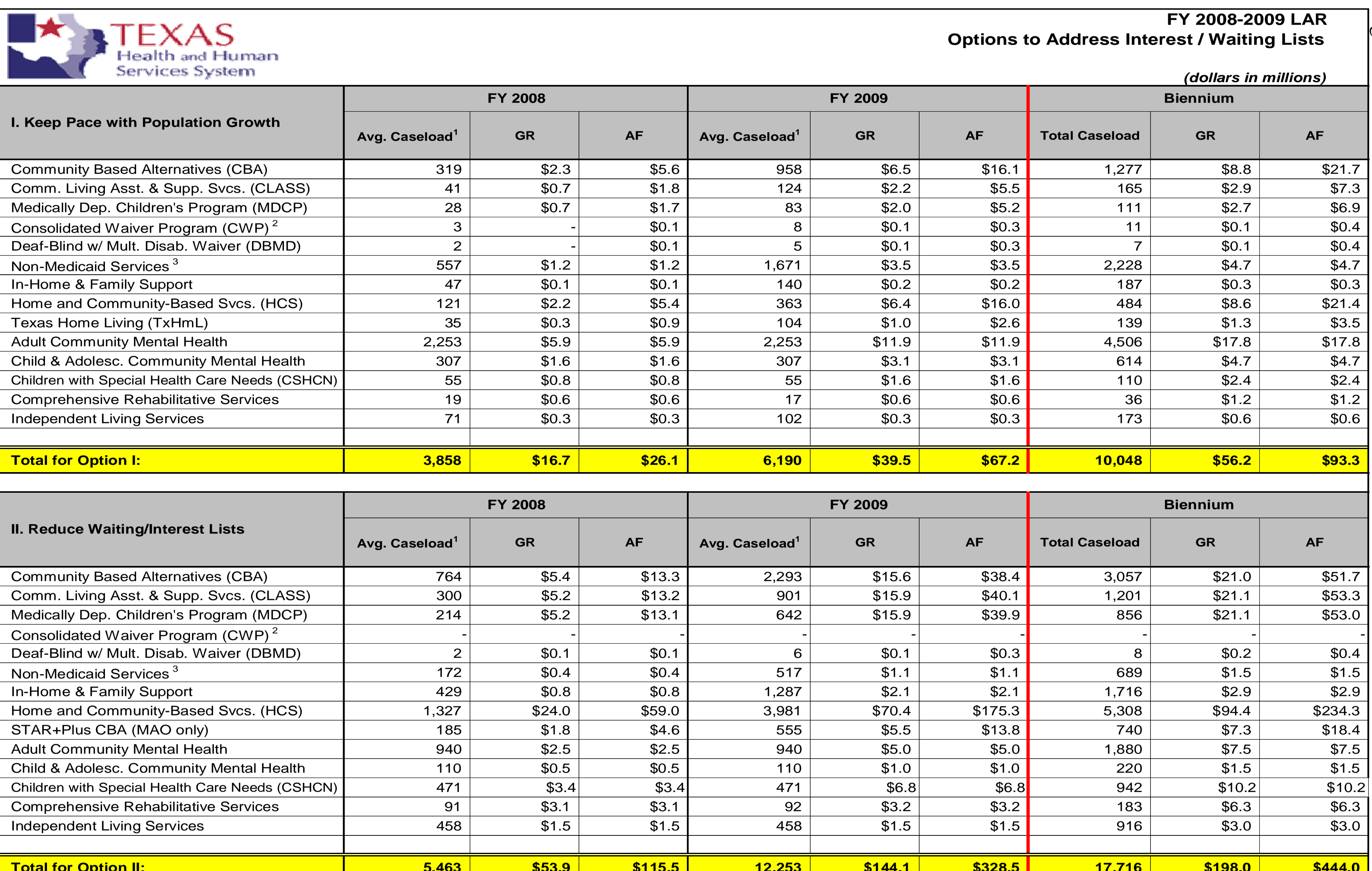
Approximately $25 million General Revenue is requested for DSHS to remove 5,230 individuals from the waiting lists for Adult Community Mental Health, Child and Adolescent Community Mental Health, and Children with Special Health Care Needs (CSHCN). For DARS, approximately $2 million General Revenue is being requested to remove 209 individuals from the waiting list for Comprehensive Rehabilitative Services and Independent Living Services.

Reduce/Eliminate HHS Waiting/Interest Lists - HHSC is requesting approximately $198 million General Revenue to reduce/eliminate current waiting/interest lists. For DADS, approximately $170 million General Revenue (almost 86 percent of the request) would remove 13,575 individuals from interest lists (a 20 percent reduction) for home and community-based

waivers, non-Medicaid services, and the In-Home and Family Support program. For DSHS, approximately $19 million General Revenue would remove 3,042 individuals from the waiting lists for Adult Community Mental Health, Child and Adolescent Community Mental Health, and Children with Special Health Care Needs (CSHCN). For DARS, approximately $9 million General Revenue is requested to remove 1,099 individuals from the waiting list for Comprehensive Rehabilitative Services and Independent Living Services. When combined with the Reduce for Demographic Growth exceptional item, the waiting lists at DSHS and DARS are completely eliminated during the 2008-2009 biennium.

Appendix C contains additional detail on the amount of funding being requested and the applicable waiting/interest lists at DADS, DSHS, and DARS for the Reduce for Demographic Growth and the Reduce/Eliminate Waiting/Interest Lists Exceptional Items.

Figure V.6



TEXAS Health and Human Services System

FY 2008-2009 LAR
Options to Address Interest / Waiting Lists

(dollars in millions)

I. Keep Pace with Population Growth	FY 2008			FY 2009			Biennium		
	Avg. Caseload[1]	GR	AF	Avg. Caseload[1]	GR	AF	Total Caseload	GR	AF
Community Based Alternatives (CBA)	319	$2.3	$5.6	958	$6.5	$16.1	1,277	$8.8	$21.7
Comm. Living Asst. & Supp. Svcs. (CLASS)	41	$0.7	$1.8	124	$2.2	$5.5	165	$2.9	$7.3
Medically Dep. Children's Program (MDCP)	28	$0.7	$1.7	83	$2.0	$5.2	111	$2.7	$6.9
Consolidated Waiver Program (CWP)[2]	3	-	$0.1	8	$0.1	$0.3	11	$0.1	$0.4
Deaf-Blind w/ Mult. Disab. Waiver (DBMD)	2	-	$0.1	5	$0.1	$0.3	7	$0.1	$0.4
Non-Medicaid Services[3]	557	$1.2	$1.2	1,671	$3.5	$3.5	2,228	$4.7	$4.7
In-Home & Family Support	47	$0.1	$0.1	140	$0.2	$0.2	187	$0.3	$0.3
Home and Community-Based Svcs. (HCS)	121	$2.2	$5.4	363	$6.4	$16.0	484	$8.6	$21.4
Texas Home Living (TxHmL)	35	$0.3	$0.9	104	$1.0	$2.6	139	$1.3	$3.5
Adult Community Mental Health	2,253	$5.9	$5.9	2,253	$11.9	$11.9	4,506	$17.8	$17.8
Child & Adolesc. Community Mental Health	307	$1.6	$1.6	307	$3.1	$3.1	614	$4.7	$4.7
Children with Special Health Care Needs (CSHCN)	55	$0.8	$0.8	55	$1.6	$1.6	110	$2.4	$2.4
Comprehensive Rehabilitative Services	19	$0.6	$0.6	17	$0.6	$0.6	36	$1.2	$1.2
Independent Living Services	71	$0.3	$0.3	102	$0.3	$0.3	173	$0.6	$0.6
Total for Option I:	**3,858**	**$16.7**	**$26.1**	**6,190**	**$39.5**	**$67.2**	**10,048**	**$56.2**	**$93.3**

II. Reduce Waiting/Interest Lists	FY 2008			FY 2009			Biennium		
	Avg. Caseload[1]	GR	AF	Avg. Caseload[1]	GR	AF	Total Caseload	GR	AF
Community Based Alternatives (CBA)	764	$5.4	$13.3	2,293	$15.6	$38.4	3,057	$21.0	$51.7
Comm. Living Asst. & Supp. Svcs. (CLASS)	300	$5.2	$13.2	901	$15.9	$40.1	1,201	$21.1	$53.3
Medically Dep. Children's Program (MDCP)	214	$5.2	$13.1	642	$15.9	$39.9	856	$21.1	$53.0
Consolidated Waiver Program (CWP)[2]	-	-	-	-	-	-	-	-	-
Deaf-Blind w/ Mult. Disab. Waiver (DBMD)	2	$0.1	$0.1	6	$0.1	$0.3	8	$0.2	$0.4
Non-Medicaid Services[3]	172	$0.4	$0.4	517	$1.1	$1.1	689	$1.5	$1.5
In-Home & Family Support	429	$0.8	$0.8	1,287	$2.1	$2.1	1,716	$2.9	$2.9
Home and Community-Based Svcs. (HCS)	1,327	$24.0	$59.0	3,981	$70.4	$175.3	5,308	$94.4	$234.3
STAR+Plus CBA (MAO only)	185	$1.8	$4.6	555	$5.5	$13.8	740	$7.3	$18.4
Adult Community Mental Health	940	$2.5	$2.5	940	$5.0	$5.0	1,880	$7.5	$7.5
Child & Adolesc. Community Mental Health	110	$0.5	$0.5	110	$1.0	$1.0	220	$1.5	$1.5
Children with Special Health Care Needs (CSHCN)	471	$3.4	$3.4	471	$6.8	$6.8	942	$10.2	$10.2
Comprehensive Rehabilitative Services	91	$3.1	$3.1	92	$3.2	$3.2	183	$6.3	$6.3
Independent Living Services	458	$1.5	$1.5	458	$1.5	$1.5	916	$3.0	$3.0
Total for Option II:	**5,463**	**$53.9**	**$115.5**	**12,253**	**$144.1**	**$328.5**	**17,716**	**$198.0**	**$444.0**

[1] Average Caseload is an average monthly figure except for Adult Community Mental Health, Child and Adolescent Community Mental Health, Children with Special Health Care Needs, Comprehensive Rehabilitative Services, and Independent Living Services, for which Average Caseload is an annual figure.

[2] CWP draws from waiting/interest lists of five waiver programs: CBA, MDCP, HCS, DBMD, and CLASS.

[3] Non-Medicaid Services include these Title XX and GR funded services: Family Care, Home Delivered Meals, Emergency Response, Adult Foster Care, Special Svcs. for Persons with Disabilities, Residential Care, Client Managed Attendant Care, and Title XX Day Activity & Health Services (DAHS).

Nurse Retention / Recruitment

The competition for qualified nursing staff throughout the state has a direct impact on HHS agencies' operations. Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) account for approximately 2,800 staff positions at DADS, DSHS and HHSC in several areas critical to client services, such as state hospitals, state schools, and long term care regulation. High turnover and vacancy rates in these positions have the potential to diminish the quality of nursing services throughout the HHS System. As the table below indicates, turnover for nurses in HHS agencies averaged 27 percent for RNs and 31 percent for LVN in fiscal year 2005, with similar turnover rates continuing in fiscal year 2006. This level of turnover is well above the statewide average of 17 percent (10 percent without involuntary termination), according to the State Auditor's Office data. In addition, vacancy rates continue to be high in this area. Currently, the overall vacancy rate is 17 percent for RNs and 10 percent for LVNs.

Figure V.7

Nurse Turnover & Vacant Rates by Agency & Program Area	Total Positions	Vacancy Rate	FY 2005 Turnover Rate	Average Salaries
DADS State Schools				
RN	277	10.9%	28.0%	$43,067
LVN	550	15.5%	24.9%	$29,600
DADS Regulatory Services				
RN	56	12.5%	23.0%	$46,042
Subtotal - DADS				
RN	633	10.1%	29.9%	$44,382
LVN	550	15.5%	24.9%	$29,600
DSHS State Hospitals				
RN	857	17.4%	34.3%	$45,277
LVN	479	11.9%	25.4%	$29,573
DSHS Regional Offices				
RN	139	24.5%	26.0%	$40,931
LVN	23	4.3%	28.6%	$26,212
DSHS Central Office				
RN	81	27.2%	36.5%	$46,887
LVN	10	10.0%	37.5%	$26,212
Subtotal – DSHS				
RN	1,077	19.1%	33.4%	$44,836
LVN	512	11.5%	25.8%	$29,350
HHSC Office of Inspector General				
RN	61	21.3%	27.7%	$48,593
Total HHS Agencies				
RN	1,771	16.8%	30.6%	$44,926
LVN	1,062	10.4%	26.6%	$29,346

The high turnover and vacancy rates experienced in this area not only affects the quality of client services but also increases costs related to recruitment, training, and loss of productivity associated with frequently hiring new employees.

One key factor contributing to the high turnover rate is the disparity between state salaries and private sector salaries for nurses. On average HHS agencies pay RNs $44,926 and LVNs $29,346 annually. U.S. Bureau of Labor Statistics data from 2004 cite an average statewide salary for RNs of $53,935 and $34,259 for LVNs, indicating that state nursing jobs lag the private sector by approximately 15 percent. More recent information pulled from the Salary.com website shows an even greater difference between private sector and state nursing positions.

The exceptional item included in the HHSC LAR addresses this critical issue by requesting funding to reduce the salary disparity between the private and public sector nurses and to provide incentives for nurses to continue employment in state agencies for longer periods of time. These recommendations were developed by a workgroup of key staff involved in the recruitment and retention of nurses from the affected agencies.

The total request for nurse recruitment and retention is $41.9 million for the biennium, with $32 million coming from General Revenue. The exceptional item consist of the following two components.

1. Increase in nurse salaries in the following key program areas in HHS agencies by an average of 15 percent.
    - DSHS – State Hospitals, Regional and Central Office
    - DADS – State Schools, Regulatory Services, Access and Intake
    - HHSC – Office of Inspector General

    General Revenue related to this request totals $23.4 million for the biennium. This request would be implemented using a reallocation of nurse position classifications that will be requested through the State Auditor's Office.

2. Fund educational incentives, including a stipend program, reimbursement for licensure renewal and funding for mandatory continuing education. General Revenue related to this request totals $8.6 million for the biennium.

    - Stipend program for 50 LVNs, 50 Associate RNs, 4 bachelor RNs, and 4 Master level RNs each year. This program would cost $7,989,660 in general revenue for the biennium. An Enterprise Nurse Education Advisory Council would be responsible for selecting potential candidates for the program. Individuals selected would receive a stipend for tuition, fees, and books, while drawing a state salary. The LVN and Associate RN program would be based on community college tuition rates. The Bachelor RN and Master RN would be based on state college tuition rates. Participants would be required to successfully complete coursework

and commit to state service for a specified time period. Additional FTE authority would be required for these stipend positions.

- Reimbursement for continuing education and license renewal assumes a flat amount of $150 a year for all RNs and LVNs for a total biennial amount of $580,840. This mirrors the policy currently in place for DADS regulatory nursing staff. LVNs and RNs pay $67.00 every two years for license renewal. The remaining funds, $233 for the biennium, would be used to meet continuing education requirements.

Telecommunications / IT Systems Needs

The Health and Human Services Commission Enterprise Information Technology strives to provide leadership and direction to achieve an efficient and effective health and human services system for Texans. This technology initiative implements several HHS enterprise projects to improve security, telecommunications and information technology systems to accomplish that goal.

While expenditures are required at this time to move these initiatives forward, over the long term, these investments will benefit the state through

- Reduced maintenance of existing hardware and software,
- Reduced need to maintain multiple systems with similar functionality,
- Protection of vital health and human services information assets against unauthorized access or disclosure, while assuring the availability, integrity, authenticity, and confidentiality of this information,
- Increased productivity through enhanced sharing of data and systems capabilities, and
- Better decision making through more timely, complete, secure and accurate data availability.

Through interagency collaboration with a variety of business and technical stakeholders, these initiatives (and the funding requested for them) will support all five health and human services agencies. The six projects are:

Enterprise Information Management (Data Warehouse) for HHS Business Planning, Monitoring and Governance

The Health and Human Services (HHS) Enterprise IT (EIT) Division seeks to design and implement an Enterprise-class Information Management Solution (Enterprise Data Warehouse) that provides a single source of reliable information across the agency's operations to support business user requirements. By using the Enterprise Data Warehouse as the foundation for integrating related program data and for conducting advanced data analysis, HHS will enhance the ability to interpret patterns and gain insights into outcomes; put another way, determine what has happened and why, and more importantly, what will happen in the future.

The major programs at HHS that use large databases have developed significant information system capabilities in executing and monitoring their programs. Unfortunately, a large amount of the data is replicated across multiple systems creating inefficiencies and unnecessary expense. While HHS has instituted a decision support program at an executive level to provide cross-program performance analysis and trends, the size of this effort needs to be significantly enhanced to address continued service demands and cost reduction requirements.

Based on benchmarks from other states that have implemented an Enterprise Management solution, the financial return on investment (ROI) is significant. To validate the ROI, HHS released an RFI. The responses confirmed the market analysis that was conducted by IDC, an industry research firm's report (*The Financial Impact of Analytics*, December 2002), on the

benefits of analytics and data warehousing which included industry surveys on ROI from such projects. The results from that survey showed that 46 percent of the organizations generated ROI of 100 percent or less, 54 percent generated ROI of more than 100 percent (including 20 percent who reported ROI in excess of 1,000 percent).

Several HHS agencies around the country have identified similar challenges and have instituted successful Information Management and Business Intelligence Programs. New York, which annually processes and analyzes $41billion in claims for 3.5 million clients, has developed one of the largest HHS information management (Data Warehouse) capabilities. Since its inception a year ago, the program has documented $66 million in savings from productivity improvements, fraud and abuse identification, identification of dual benefit issuance and reduction in administrative costs.

The Enterprise Data Warehouse project will implement the critical tools necessary to help HHS improve its delivery of health care services, determine which programs are most effective, detect fraud and abuse, reduce overall costs to taxpayers, and predict the state's health care needs and priorities in the years to come.

HHS Enterprise Telecommunications Strategy

Telecommunications systems across the HHS agencies represent the major delivery mechanism for communication with clients and the provision of administrative services. Numerous client services are provided through telephone contact such as eligibility determination for Medicaid and other family services, abuse and neglect hotlines for children and the elderly, access to mental health and substance abuse services, access to long term care services for the elderly and mentally retarded, and hearings and general information on available services that use telecommunications as a core delivery component across the state. Core systems in the Winters Complex and other HHS locations are beyond the end of life cycle and the various platforms in place throughout the HHS system are not interoperable. In some cases, equipment is failing; in others, additional capacity may be needed. There are both short-term and long-term opportunities to improve stability and service offerings through a system-wide approach to strategic planning for telecommunications.

Identity Management

The Identity Management initiative will improve access to, and security of, HHS information resources. This includes a streamlined and automated process for user provisioning and a standardized method for identity management and access control, along with development tools to quickly enable applications to use this functionality. This would increase asset and data security, address common Enterprise security issues, and reduce associated costs by centralizing and standardizing processes. It builds capability to proactively manage information security and application access.

Recent audits of HHS agencies, both external and internal, have had findings regarding access management issues with information systems. Findings have included issues with user provisioning and de-provisioning, and consistent implementation of password policies. With the

implementation of the Identity Management solution, the HHS Enterprise would benefit in several areas including:

- Increased user productivity through the implementation of single sign-on and self-service functionality. A recent Gartner study indicates that self-service password reset can reduce help desk call volume up to 35 percent.
- Reduced operating costs through improved user life cycle management, user provisioning, and automation of administrative activities
- Reduced security risks and improved compliance with HHSS Enterprise Information Security Standards and Guidelines, and State and Federal regulations, including the State's security standards in 1 § TAC 202 and the Federal Information Security Management Act
- Reduce the point-to-point integration and maintenance cost by creating Enterprise Directory as the central point of information on all HHS users and enable data synchronization for new hires and employee terminations between the constituent systems.
- Control of access to enterprise-class applications such as Integrated Eligibility, Messaging/Collaboration and AccessHR.

The preferred solution is to implement an Enterprise Directory that would be used to house the user and identity-related data and the security policies. The Enterprise Directory will help authenticate users and control the access rights to the various applications in the enterprise. The Enterprise Directory will also help institute consistent mechanisms to synchronize data across multiple data repositories scattered across the enterprise, in a seamless manner. This will result in the standardization of data synchronization mechanisms leading to greater efficiencies and cost savings. The creation of an Enterprise Directory would result in increased security, which will help to provide authorized access to users in a timely manner, and more effectively control unauthorized access.

Information Technology (IT) Security Services Capability

HHSC, in collaboration with DIR, proposes an enterprise-wide IT Security Services Capability (ITSSC) to serve all HHS agencies. This initiative will include the following functions, which are currently not institutionalized within the enterprise:

- Identification of all IT assets, including ownership of these assets,
- Risk Assessment,
- Internal Security Vulnerability Scanning,
- Intrusion Detection,
- Patch Management, and
- Computer Incident Tracking, Analysis and Response.

Since the consolidation of HHS agencies in September 2004, there have been numerous information security events that have undermined public confidence in HHS, drastically impacted worker productivity, wasted labor hours, and exposed an insufficient information security posture. A series of computer network attacks in 2005 covertly installed programs that allowed unauthorized users to control HHS computers remotely (i.e., Robot or BOT malware) and is estimated to have cost the enterprise more than $2 million to correct.

DIR's collected security data illustrates the large number of potential security events at the HHS agencies. DIR security assessments involving the five HHS agencies during 2006 resulted in the identification of significant high-risk vulnerabilities requiring immediate remediation. Additionally, between September 2004 and March 2006, there were over 600,000 security incidents involving these agencies, which resulted in 7,000 hours of system downtime at a cost of close to $1 million. Malicious code was identified over 46,000 times on HHS's internal network. There were over 3.3 million attempts to transmit viruses to HHS IT resources.

With the ITSSC in place, HHS agencies will have the tools needed to detect internal security vulnerabilities and correct them before they can be exploited. In addition, HHS will have the tools to efficiently and effectively test and apply software patches to all desktop computers, to ensure the highest levels of operating system security. This initiative would help the HHS Enterprise move toward compliance with:

- The Centers for Medicare and Medicaid Services (CMS) policy for the Information Security Program dated May 2005 (Document Number: CMS-CIO-POL-SEC02) section 4.1.1.5, states that appropriate vulnerability assessment tools and techniques shall be implemented and selected personnel shall be trained in their use and maintenance.
- HB3112 Sec. 2059.056, from the 79th Legislative Session, states, “Network security management for that state agency or entity regarding internal threats remains the responsibility of that state agency or entity”.
- HHSS Enterprise Information Security Standards and Guidelines, and State and Federal regulations, including the State’s security standards in 1 § TAC 202, the Health Insurance Portability and Accessibility Act (HIPAA) and the Federal Information Security Management Act (FISMA).
- State, federal, and private industry best practices including 2005 State Strategic Plan for Information Resources Management, The National Strategy to Secure Cyberspace, National Institute of Standards and Technology (NIST) Computer Security Division (CSD) publications, and the International Organization for Standardization (ISO) 17799 Code of practice for information security management,

The Enterprise ITSSC initiative will introduce standardized security processes that are not being carried out on a consistent basis. Currently, security on most systems is a “best effort” of the system owners and those who manage them, under the guidance of each agency Information Security Officer. This initiative will formalize the validation and verification of system security. This would increase asset and data security, address common Enterprise security issues, and reduce associated costs by centralizing and standardizing processes. It also puts information security into a more proactive and preventative versus reactive mode.

Business operations will benefit by having increased assurances that their information systems and data are secure. It will also lead to reduced computer system downtime, time spent notifying clients, and possible financial penalties that would occur in the event of a security breach.

Messaging & Collaboration

HHS currently operates five independent Email systems with limited integration between them. Additionally, email systems for two of the five agencies are no longer supported by the vendor due to their age. Due to capital and funding restrictions it has not been possible for the agencies to operate Email systems that are consistently maintained and available. Gaps exist in security protections that reduce the overall security of all HHS agencies. HHS requires a solution that is financially viable, consistently available, secure, and avoids the requirement of capital authority to develop, implement, and operate.

The replacement system must achieve important objectives for HHS including:

- Increased collaboration to support the consolidation of the agencies,
- Reduced costs by leveraging economies of scale,
- Commodity pricing with cost predictability,
- Improved service levels, reliability, and security, and
- Compliance with the HHS IT architecture.

Through achieving these objectives, we anticipate that opportunities for collaboration between HHS staff will increase, IT staff will be able to focus more on agency and program priorities, the availability and performance levels of our email system will improve, and we will be better able to predict costs for this service in response to volume changes.

HHS examined three options to determine which could achieve our goals:

- Each of the five HHS agencies operating existing individual email systems. Two of five agencies must upgrade email systems that are no longer supported by the vendor. Operating five separate systems does not take advantage of economies of scale, does not support consolidation and collaboration, cannot provide SLA assurance, cannot provide predictable pricing for scaling, and relies on capital authority that may not be available in the mid to long-term.

- In-house development and implementation of a consolidated email solution for HHS. More costly than the Messaging and Collaboration solution, cannot provide SLA assurance, cannot provide predictable pricing for scaling, and relies on capital authority that may not be available in the mid to long-term.

- Competitive procurement of email services for all five HHS agencies – Messaging and Collaboration.

Analysis of the options clearly demonstrates that the Messaging and Collaboration solution is the only alternative that achieves the objectives that were established at the onset of the project:

- Improved Collaboration – Messaging and Collaboration provides a Global Address List and shared calendars for all HHS employees with additional opportunities for expanded collaboration through optional features. Independent email solutions could not provide this level of collaboration.

- Economies of Scale – solution leverages full volumes of HHS plus other Texas state agencies and potentially other government customers.
- Commodity Pricing – solution provides consistent pricing and the ability to scale volume up or down with volume cost adjustments made on a monthly basis. This produces cost stability that cannot be replicated by an HHS in-house solution.
- No Capital Expenditure – this is the only solution that eliminates the need for ongoing capital authority through acquisition of Email as a service.
- Service and Reliability – contract provides measurable service level requirements backed by IBM 24x7 operations, disaster recovery, and greatly improved security solutions. SLAs result in financial credits if performance is not met. An HHS solution cannot effectively provide 24x7 operations at a reasonable price or back performance requirements with financial incentives.
- Enterprise Architecture – Application Service Provider model complies with HHS Services Oriented Architecture and Identity Management strategies.

The Business Case financial analysis demonstrates that the project can be delivered within a cost structure that is favorable for HHS. Compared against the in-house solution model, the Messaging and Collaboration solution will avoid $14M in costs that would be required to develop, implement, and operate a system that is compliant with the technical requirements of the system. However, even at the higher cost, the in-house solution could not meet all of the project objectives.

Developer Tools

HHSC would acquire software licenses for application development staff use in developing web-based applications in a Service-Oriented Architecture environment.

Proposed Revisions to Article II Special Provisions

Figure V.8

Agency Code:	Agency Name:	Prepared By:	Date:	Request Level:
	Special Provisions Relating to All Health and Human Service Agencies	Thomas M. Suehs	10/01/06	Base

Page Number In 2006-2007 GAA	Current Rider Language	Proposed Rider Language
II - 92	**Sec. 2. Night Shift and Weekend Differential.** a. Clinical and Support Personnel. The Department of State Health Services and the Department of Aging and Disability Services are authorized to pay an additional night shift salary differential not to exceed 15 percent of the monthly pay rate to personnel who work the 3 p.m. to 11 p.m. or the 11 p.m. to 7 a.m. shift or its equivalent. A weekend shift salary differential not to exceed 5 percent of the monthly pay rate may be paid to persons who work weekend shifts. The evening or night shift salary differential may be paid in addition to the weekend shift salary differential for persons working weekend, evening, or night shifts. b. Data Processing Personnel. The Department of State Health Services, the Department of Aging and Disability Services, the Department of Family and Protective Services, the Health and Human Services Commission, and the Health and Human Services Consolidated Print Shop may pay an evening or night shift salary differential not to exceed 15 percent of the monthly pay rate to personnel in data processing or printing operations who work the 3:00 p.m. to 11:00 p.m. shift or 11:00 p.m. to 7:00 a.m. shift, or their equivalents. A weekend shift salary differential not to exceed 5 percent of the monthly pay rate may be paid to persons who work weekend shifts. The evening or night shift salary differential may be paid in addition to the weekend shift salary differential for persons working weekend, evening, or night shifts.	The Department of Family and Protective Services is proposing the following addition to this rider. c. Statewide Intake Personnel. The Department of Family and Protective Services is authorized to pay an evening or night shift salary differential not to exceed 15 percent of the monthly pay rate to Statewide Intake personnel who work the 3:00 p.m. to 11:00 p.m. shift or 11:00 p.m. to 7:00 a.m. shift, or their equivalents. A weekend shift salary differential not to exceed 5 percent of the monthly pay rate may be paid to persons who work weekend shifts. The evening or night shift salary differential may be paid in addition to the weekend shift salary differential for persons working weekend, evening, or night shifts. Justification: The ability to retain workers in non-standard shifts means there are more tenured workers, which reduces errors and helps ensure better quality of reports of abuse, neglect and exploitation.

Figure V.8 (continued)

Page Number In 2006-2007 GAA	Current Rider Language	Proposed Rider Language
		Currently, employees working the night shift are significantly less tenured. For example, 11.5 percent of day shift employees have less than one year of tenure, while 26 percent of employees working night and weekends have less than one year. • Typically more serious types of allegations are reported after-hours. Priority 1 calls comprised a higher percentage compared to those received on the day shift (35.3 percent versus 29.0 percent). • During fiscal year 2006, one hundred percent of the longest delay times during each 24-hour period occurred at night, the time period of 7:00 pm to 7:00 am. Of these, the very longest delays occurred on the weekend. • Having less turnover will also reduce the average hold time, which provides for faster handling of calls and processing to the field.

Figure V.8 (continued)

Page Number In 2006-2007 GAA	Current Rider Language	Proposed Rider Language
II – 96	**Sec. 14. Payment for Compensatory Time**. It is expressly provided that the Department of State Health Services and the Department of Aging and Disability Services, to the extent permitted by law, may pay FLSA exempt and FLSA non-exempt employees of state mental health and mental retardation facilities on a straight-time basis for work on a holiday or for regular compensatory time hours when the taking of regular compensatory time off would be disruptive to normal business functions.	The HHS System is proposing the following modification to this rider. **Sec. 14. Payment for Compensatory Time**. It is expressly provided that the Department of State Health Services and the Department of Aging and Disability Services, to the extent permitted by law, may pay FLSA exempt and FLSA non-exempt employees of state mental health and mental retardation facilities on a straight-time basis for work on a holiday or for regular compensatory time hours when the taking of regular compensatory time off would be disruptive to normal business functions. In addition, any health and human service agency, with the explicit approval of the Health and Human Services Executive Commissioner, to the extent permitted by law, may pay FLSA exempt and FLSA non-exempt employees required to provide support during a federal or state declared disaster on a straight-time basis for work on a holiday or for regular compensatory time hours when the taking of regular compensatory time off would disruptive to normal business functions. Justification: As the health and human services agencies faced the challenges of providing services during the relief efforts for Hurricane Katrina and Rita evacuees, hhs employees were deployed in a variety of settings to provide emergency assistance. The expansion of this rider to all hhs agencies will allow payment of compensatory time only during times of a federal or state declared disaster.

Figure V.8 (continued)

Page Number In 2006-2007 GAA	Current Rider Language	Proposed Rider Language
II – 106	**Sec. 29. Funding Equity Among Local Mental Health and Mental Retardation Authorities**. It is the intent of the Legislature that the Department of State Health Services and the Department of Aging and Disability Services shall implement a long-term plan to achieve equity in state funding allocations among local mental health and mental retardation authorities. The plan shall be implemented from fiscal years 2006-2013. The goal of the plan shall be to achieve equity to the greatest extent possible by fiscal year 2013, however, any funding reductions to a local authority for the purpose of achieving equity may not exceed 5 percent of allocated general revenue in a fiscal year. The plan shall also provide for improving funding equity to be a priority in distributing any new state or federal funds that may become available for allocation to community centers. In assessing the equity of funding the departments may use alternatives other than basing equity calculations solely on the total population served by each local authority. Additional factors, such as incidence of poverty, may be considered if they help to provide a better estimate of the need for state funded mental health or mental retardation services in the areas served by each local authority. The departments shall submit the long-term equity plan to the Office of the Governor and the Legislative Budget Board by December 31, 2005. The departments shall include in legislative appropriations requests a table showing how implementation of the equity plan will affect projected allocations to community centers at the baseline current services funding level.	The HHS System is proposing the following deletion to this rider. ~~The departments shall submit the long-term equity plan to the Office of the Governor and the Legislative Budget Board by December 31, 2005. The departments shall include in legislative appropriations requests a table showing how implementation of the equity plan will affect projected allocations to community centers at the baseline current funding level.~~ Justification: The requested revision deletes the reporting requirement that is no longer required.

Figure V.8 (continued)

Page Number In 2006-2007 GAA	Current Rider Language	Proposed Rider Language
II – 110	**Sec. 49. Appropriation Reduction for the Provision of Services to the Medicaid Aged/Blind/Disabled Population.** Appropriations to the Health and Human Services Commission made elsewhere in this Act are hereby reduced by $36,500,000 in General Revenue Match for Medicaid and an estimated $56,350,000 in Federal Funds for fiscal year 2006, and by $73,000,000 in General Revenue Match for Medicaid, and an estimated $111,700,000 in Federal Funds for fiscal year 2007. In order to achieve the level of savings anticipated by this provision, it is the intent of the Legislature that the Commission utilize cost-effective models to better manage the care of the aged/blind/disabled Medicaid population including primary care case management (PCCM), HMO carve-out, or integrated care management (ICM). It is specifically provided, however, that funds appropriated for the provision of services to the Medicaid aged/blind/disabled population may not be expended to expand the use of any capitated managed care model which would eliminate existing federal matching payments to local public hospitals under federal upper payment limit (UPL) regulations. The implementation or expansion of managed care models is further subject to the following provisions: a. The Commission shall develop an equitable allocation of the appropriation reductions made herein to each of the service delivery areas listed below and shall establish an appropriate share of the savings target to each managed care organization in that service delivery area-Bexar, Dallas, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis.	The Health and Human Services Commission is proposing the deletion to this rider since it relates to appropriations for the 2006-07 biennium.

Figure V.8 (continued)

Page Number In 2006-2007 GAA	Current Rider Language	Proposed Rider Language
II – 110	**Sec. 49. Appropriation Reduction for the Provision of Services to the Medicaid Aged/Blind/Disabled Population (Continued)** b. As authorized by law, the Commission shall develop an Integrated Care Management model for the provision of medical and health care services to the aged/blind/disabled population in the Dallas service delivery area. Subject to competitive procurement requirements and any necessary federal approval, the Commission shall implement the model by September 1, 2006 or as soon thereafter as practicable. Not later than August 1, 2006, the Commission shall establish an actuarial estimate of the savings expected to be achieved by the ICM model. To the extent necessary, the Commission is directed to adjust payments to hospitals, physicians, and home health providers in the service delivery area to ensure that the savings target is achieved. c. In any service delivery area where a capitated managed care model for the aged/blind/disabled population is utilized (HMO carve-out), not later than August 1, 2006 the Commission shall establish an actuarial estimate of the apportioned share of savings expected to be achieved by each managed care organization. To the extent necessary, the Commission is directed to adjust payments for administration, risk, and profit to ensure that the savings target is achieved. d. The Commission may utilize the Primary Care Case Management model for the aged/blind/disabled population in a service delivery area only if the actuarial estimate of savings achieves the savings target for that area.	~~**Sec. 49. Appropriation Reduction for the Provision of Services to the Medicaid Aged/Blind/Disabled Population.** Appropriations to the Health and Human Services Commission made elsewhere in this Act are hereby reduced by $36,500,000 in General Revenue Match for Medicaid and an estimated $56,350,000 in Federal Funds for fiscal year 2006, and by $73,000,000 in General Revenue Match for Medicaid, and an estimated $111,700,000 in Federal Funds for fiscal year 2007. In order to achieve the level of savings anticipated by this provision, it is the intent of the Legislature that the Commission utilize cost-effective models to better manage the care of the aged/blind/disabled Medicaid population including primary care case management (PCCM), HMO carve-out, or integrated care management (ICM).~~ ~~It is specifically provided, however, that funds appropriated for the provision of services to the Medicaid aged/blind/disabled population may not be expended to expand the use of any capitated managed care model which would eliminate existing federal matching payments to local public hospitals under federal upper payment limit (UPL) regulations. The implementation or expansion of managed care models is further subject to the following provisions:~~

Figure V.8 (continued)

Page Number In 2006-2007 GAA	Current Rider Language	Proposed Rider Language
	e. It is the intent of the Legislature that the Commission consult with public hospital officials and appropriate county officials in each service delivery area in determining the managed care model to be utilized in that area. f. Contingent upon federal approval of any necessary waiver changes, the Commission may expend funds appropriated to the provision of services to the Medicaid aged/blind/disabled population to convert the Harris County STAR+PLUS model to an HMO carve-out model as soon as practicable. g. Medicaid funds appropriated to the Department of Aging and Disability Services and the Health and Human Services Commission may be transferred between the agencies during the 2006-07 biennium to support the implementation of models of care under sections (b), (c), and (d). The Commission shall notify the Legislative Budget Board and the Governor of the amounts to be transferred for this purpose. The notification shall indicate the impact to performance measures at both agencies. The Commission shall provide a final notification update November 1, 2006 on amounts to be transferred and the impact to performance measures.	~~a. The Commission shall develop an equitable allocation of the appropriation reductions made herein to each of the service delivery areas listed below and shall establish an appropriate share of the savings target to each managed care organization in that service delivery area Bexar, Dallas, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis.~~ ~~b. As authorized by law, the Commission shall develop an Integrated Care Management model for the provision of medical and health care services to the aged/blind/disabled population in the Dallas service delivery area. Subject to competitive procurement requirements and any necessary federal approval, the Commission shall implement the model by September 1, 2006 or as soon thereafter as practicable. Not later than August 1, 2006, the Commission shall establish an actuarial estimate of the savings expected to be achieved by the ICM model. To the extent necessary, the Commission is directed to adjust payments to hospitals, physicians, and home health providers in the service delivery area to ensure that the savings target is achieved.~~ ~~c. In any service delivery area where a capitated managed care model for the aged/blind/disabled population is utilized (HMO carve-out), not later than August 1, 2006 the Commission shall establish an actuarial estimate of the apportioned share of savings expected to be achieved by each managed care organization. To the extent necessary, the Commission is directed to adjust payments for~~

Figure V.8 (continued)

Page Number In 2006-2007 GAA	Current Rider Language	Proposed Rider Language
		~~administration, risk, and profit to ensure that the savings target is achieved population in a service delivery area only if the actuarial estimate of savings achieves the savings target for that area.~~ ~~d. The Commission may utilize the Primary Care Case Management model for the aged/blind/disabled~~ ~~e. It is the intent of the Legislature that the Commission consult with public hospital officials and appropriate county officials in each service delivery area in determining the managed care model to be utilized in that area.~~ f~~. Contingent upon federal approval of any necessary waiver changes, the Commission may expend funds appropriated to the provision of services to the Medicaid aged/blind/disabled population to convert the Harris County STAR+PLUS model to an HMO carve-out model as soon as practicable.~~ ~~g. Medicaid funds appropriated to the Department of Aging and Disability Services and the Health and Human Services Commission may be transferred between the agencies during the 2006-07 biennium to support the implementation of models of care under sections (b), (c), and (d). The Commission shall notify the Legislative Budget Board and the Governor of the amounts to be transferred for this purpose. The notification shall indicate the impact to performance measures at both agencies. The Commission shall provide a final notification update November 1, 2006 on amounts to be transferred and the impact to performance measures.~~

Figure V.8 (continued)

Page Number In 2006-2007 GAA	Current Rider Language	Proposed Rider Language
II – 111	**Sec. 50. Alternatives to Abortion**. From funds appropriated in Strategy B.1.3, Family Planning Services, Department of State Health Services, $2,500,000 each year of TANF federal funds initially designated to be converted to the Title XX Social Services Block Grant is transferred to the Health and Human Services Commission to be expended as TANF federal funds through grant or contract. The Health and Human Services Commission shall expend these funds, consistent with federal and state law, to implement a statewide program for women seeking alternatives to abortion focused on pregnancy support services that promote childbirth	The Health and Human Services Commission proposes deletion of this rider because there is a specific strategy appropriation for this program. ~~**Sec. 50. Alternatives to Abortion**. From funds appropriated in Strategy B.1.3, Family Planning Services, Department of State Health Services, $2,500,000 each year of TANF federal funds initially designated to be converted to the Title XX Social Services Block Grant is transferred to the Health and Human Services Commission to be expended as TANF federal funds through grant or contract. The Health and Human Services Commission shall expend these funds, consistent with federal and state law, to implement a statewide program for women seeking alternatives to abortion focused on pregnancy support services that promote childbirth.~~

Figure V.8 (continued)

Page Number In 2006-2007 GAA	Current Rider Language	Proposed Rider Language
II – 111	**Sec. 52. Transfers of Funds for Consolidated Support Services**. The Health and Human Services Commission (HHSC) is authorized to return funding at the Commission to the appropriate HHS agency for support functions and programs consolidated at the Commission. HHSC shall notify the Legislative Budget Board, Governor, and the Comptroller prior to making the transfers. a. Funds related to consolidated programs and support services shall be returned to 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). These funds will be matched with available federal funds and expended under interagency memoranda between HHSC and each agency. b. Transfer limitations elsewhere in this Act do not apply to this provision. c. By July 1 preceding the start of each fiscal year, the agencies of Article II shall provide a report by strategy that reduces funding at HHSC and increases funding by the same amount at DADS, DARS, DFPS, and DSHS. d. The transfers shall be made prior to the start of the fiscal year. e. The loss of funds at HHSC shall be replaced by increased interagency contracts in the method of finance. f. This transfer shall not result in a change in total funding in Article II.	The HHSC proposes the following revision of this rider. **Transfers of Funds for Consolidated Support Services.** The Health and Human Services Commission (HHSC) is authorized to return any funding at the Commission to the appropriate HHS agency for support functions and programs consolidated at the Commission or funding requested on behalf of another HHS agency. HHSC shall notify the Legislative Budget Board, Governor, and the Comptroller prior to making the transfers. a.) Funds related to consolidated programs and support services shall be returned to the Department of Aging and Disability Services (DADS), the Rehabilitative Services (DARS), the Department of Family and Protective Services (DFPS), and the Department of State Health Services (DSHS). These funds will be matched with available federal funds and expended under interagency memoranda between HHSC and each agency. b.) Transfer limitations elsewhere in this Act do not apply to this provision. c.) By July 1 preceding the start of each fiscal year, the agencies of Article II shall provide a report by strategy that reduces funding at HHSC and increases funding by the same amount at DADS, DARS, DFPS, and DSHS. d.) The transfer shall be made prior to the start of fiscal year.

Figure V.8 (continued)

Page Number In 2006-2007 GAA	Current Rider Language	Proposed Rider Language
		e.) The loss of funds at HHSC shall be replaced by increased interagency contracts in the method of finance when services are to be billed. f.) This transfer shall not result in a change in total funding in Article II. Justification: The requested revisions would allow HHSC to redistribute any funding appropriated for enterprise purposes to the other HHS agencies in instances when the funding remains appropriated to HHSC but is expended at another agency.

Proposed Revisions to Article IX, Sec. 3.05

Figure V.9

Agency Code:	Agency Name:	Prepared By:	Date:	Request Level:
	Article IX, Sec. 3.05	Albert Hawkins	10/01/06	Base

Page Number In 2006-2007 GAA	Current Rider Language	Proposed Rider Language
IX - 20	**Sec. 3.05. Scheduled Exempt Positions** (a) Except for the positions listed under Subsection (b)(3), a position listed following an agency's appropriation in the agency's "Schedule of Exempt Positions" shall receive compensation at a rate not to exceed the amount indicated in that agency's "Schedule of Exempt Positions." (b) (1) Notwithstanding the rate listed in an agency's "Schedule of Exempt Positions," a position listed in Subsection (b)(3) may receive compensation at a rate set by the Governor in an amount not to exceed the "Maximum Salary" but not less than the "Minimum Salary" for the appropriate group listed in Subsection (b)(2). (2) an exempt position listed in Subsection (b)(3) for which the term "Group," followed by an Arabic numeral, is indicated, may receive compensation at a rate within the range indicated below for the respective salary group indicated. **Scheduled Exempt Position Salary Rates**	

Group	Minimum Salary	Maximum Salary
1	$ 45,816	$ 70,788
2	54,228	83,784
3	64,200	99,192
4	76,068	117,516
5	90,060	139,140
6	106,692	189,000

Figure V.9 (continued)

Page Number In 2006-2007 GAA	Current Rider Language	Proposed Rider Language
	(3) Agency / Position / Salary Group (1) Fire Fighter's Pension Comm. — Comm. — Group 1; (2) Secretary of State — Sec. of State — Group 4; (3) Office of State-Fed. Relations — Ex. Director — Group 3; (4) Health & Human Serv. Comm. — Comm. — Group 6; (5) Texas Education Agency — Comm. — Group 6; (6) Adjutant General's Dept. — Adj. Gen. — Group 4; (7) Dept. Criminal Justice — Presiding Officer, Board of Pardons — Group 3; (8) Dept. Criminal Justice — Par. Bd. Mem.(6) — Group 3; (9) Comm. On Envir. Quality — Comm. (3) — Group 5; (10) Dept. of Housing and Community Affairs — Ex. Director — Group 4; (11) Workforce Commission — Comm. (3) — Group 4; (12) State Office of Admin. Hear. — Chief Admin. Law Judge — Group 3; (13) Dept. of Insurance — Comm. — Group 6; (14) Office of Public Ins. Council — Public Counsel — Group 3; (15) Public Utility Commission — Comm. (3) — Group 4; (16) Office of Pub. Utility Council — Public Counsel — Group 3; (17) Bond Review Board — Ex. Director — Group 3 (c) In addition to all other requirements, any salary increase from appropriated funds within the limits provided by this section and salary increases within the limit established under an agency's bill patter, must be: (1) in writing; (2) signed by the presiding officer of the governing board; (3) submitted to the Governor, the Legislative Budget Board and the Comptroller; (4) approved by the governing board in a public meeting.	The Health and Human Services Commission is proposing the following addition to this rider. (3) Agency / Position / Salary Group (18) Dept. of Aging & Disability Services Commissioner — Group 6 (19) Dep. of Assistive & Rehabilitative Services Commissioner — Group 6 (20) Dept. of Protective & Family Services Commissioner — Group 6 (21) Dept. of State Health Services Commissioner — Group 6

Figure V.9 (continued)

Page Number In 2006-2007 GAA	Current Rider Language	Proposed Rider Language
	(d) (1) Each title listed in an “Schedule of Exempt Positions” following an agency’s appropriation authorizes one position for the agency unless the title is followed by an Arabic numeral indicating the number of positions authorized or unless the title is followed by “(UL)” which authorizes an unlimited number of positions for such position title. (2) The number of authorized positions for a title listed in a “Schedule of Exempt Positions” may be exceeded only: (A) for the purpose of hiring a replacement in a key management position as certified by the chief administrator of the agency; (B) if the current incumbent of the position has formally resigned or otherwise announced irrevocable plans to vacate the position; (C) for a period of time not to exceed the equivalent of one month’s salary per fiscal year per termination incumbent (excluding time spent on the payroll for the purpose of exhausting accrued annual leave or state compensatory time); and (D) if exceptions are reported as prescribed for payroll reporting procedures	

Figure V.9 (continued)

<table>
<tr><th>Page Number In 2006-2007 GAA</th><th>Current Rider Language</th><th>Proposed Rider Language</th></tr>
<tr><td></td><td>(e) Notwithstanding the rate listed in the agency’s “Schedule of Exempt Positions,” a position listed in this subsection shall receive compensation at the rate and within the group provided below.

Scheduled Exempt Position Salary Rates

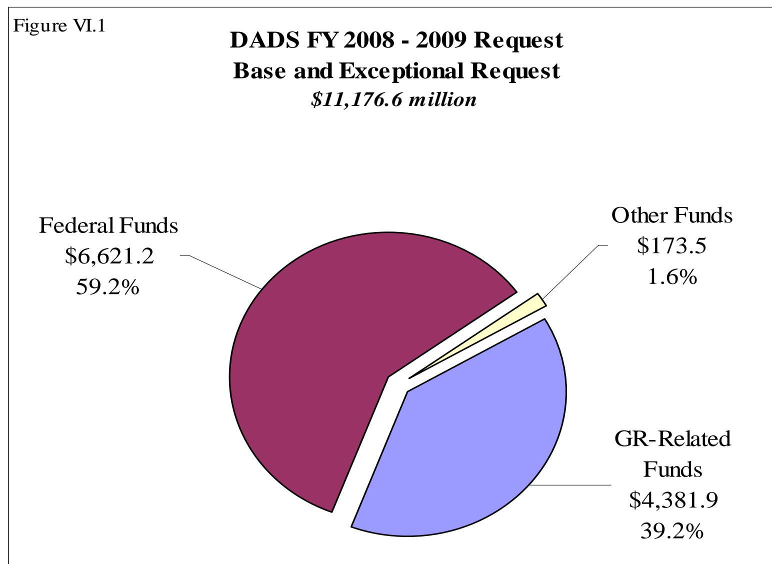
Position | Salary Group | Rate
(1) Attorney General | Group 6 | $125,000;
(2) Comptroller of Public Accounts | Group 6 | $125,000;
(3) Commissioner of Agriculture | Group 6 | $125,000;
(4) Land Commissioner | Group 6 | $125,000;
(5) Railroad Commissioner (3) | Group 6 | $125,000.</td><td></td></tr>
</table>

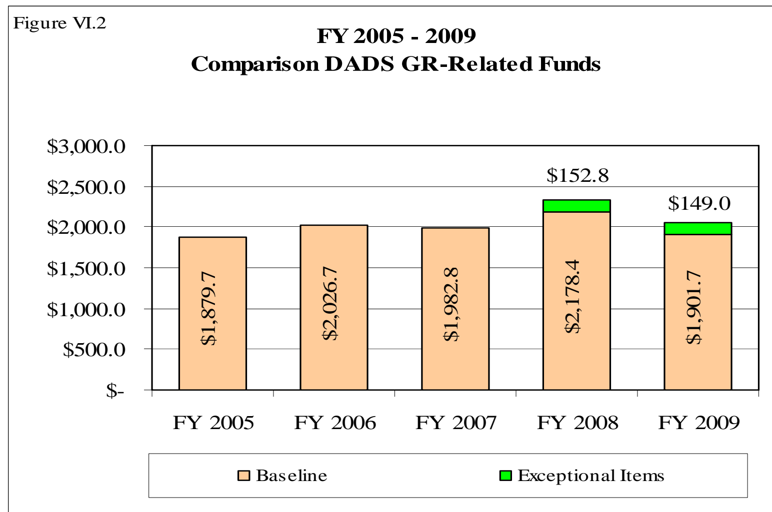
VI. AGENCY BUDGET REQUEST SUMMARIES

Department of Aging and Disability Services (DADS)

General Functions

The Department of Aging and Disability Services (DADS), created by HB 2292, 78th Legislature, Regular Session (2003), is the agency responsible for long term services and supports to individuals who are aging or have a disability. The department administers programs for community care through various programs such as Medicaid 1915 (c) home and community based waivers, community attendant, primary home care, and day activity services, for institutional care such as Nursing Facilities and ICF-MRs, and other community services to individuals who are aging or have a disability (cognitive and physical). Additionally, DADS provides regulatory services related to these programs.





DADS' mission is "to provide a comprehensive array of aging and disability services, supports, and opportunities that are easily accessed in local communities." To that end, DADS is a functional organization, which requires each division to work internally across agency divisions as well as externally within the HHS Enterprise and with our stakeholders. This functionality provides numerous opportunities to simplify and improve how services are provided, received, and regulated with a goal of enhancing the quality of life for individuals and improving the system of care that will serve all of us as we age, and those of us who may experience a disability.

Summary of Budget Request

The "Baseline" request totals $10.5 billion in all funds over the biennium, with 4.1 billion being GR related. This is an increase of over $201.9 million in all funds from our 2006-2007 amount of $10.3 billion. The GR-related base and exceptional item request for 2008-2009 is $4.4 billion.

Base Request

DADS base level request includes a state fund increase of approximately $70.6 million or approximately 1.8 percent over the projected expenditures for 2006-2007 biennium.

The DADS LAR was prepared in accordance with the instructions received from the Legislative Budget Board and Governor's Office. The 2008-2009 DADS base appropriations request will provide long-term supports and services to an estimated 279,300 individuals in Texas. There are two factors that affect the fiscal year 2008-2009 base appropriations request that will reduce the number of individuals that will be served in 2008-2009 from the ending fiscal year 2007 amount.

First, the LAR instructions limited an agency's base request for GR-related funds to 90 percent of the sum of amounts expended in fiscal year 2006 and budgeted in fiscal year 2007. Additional guidance was given that allowed DADS to exclude entitled Medicaid services from the required base reduction as well as maintaining projected fiscal year 2008-2009 caseload levels at fiscal year 2006 costs for entitled Medicaid services. This resulted in a reduction of 5,735 consumers served and 298 FTEs.

Second, during 2006-2007 DADS was appropriated funds to provide Medicaid waiver services to approximately 9,360 persons residing on agency interest lists. These funds were appropriated to support a "roll-out" of waiver slots over the course of the biennium, so the number of persons served at the end of fiscal year 2007 will be higher than the average number of persons served for the 2006-2007 biennium. However, DADS was required to build its 2008-2009 appropriations request for Waiver services based on the average expenditure level for 2006-2007 expenditures, rather than maintaining the number of persons served at the end of fiscal year 2007. This averaging requirement resulted in a reduction of 4,588 Waiver consumers served from the end of fiscal year 2007.

Exceptional Items

There are of two types of exceptional items in the DADS request: first, to restore the department to its 2006-2007 service levels and second, to address significant needs for the future.
Note: All figures below are biennial.

Restore to the fiscal year 2006-2007 service levels ($206.5 million GR; $ 482.7 million AF)

- The 2008-2009 GR funds were reduced by 10 percent from the 2006-2007 non-entitlement GR. This equated to a $111.7 million GR reduction ($242.0 million All Funds)
- DADS received $97.9 million GR increase in 2006-2007 to reduce Interest Lists by ten percent this biennium, serving 9,360 new consumers. ($84.1 million GR; $213.4 million AF) because waiver programs are not an entitlement, only half of this increase is included in the base request.

- Rate Restoration to fiscal year 2003 - This request restores these provider rates to their fiscal year 2003 levels. ($10.7 million GR; $27.2 million AF)

Address Future Needs ($95.3 million GR; $220.7 million AF)

- Promoting Independence requests funds to move 240 persons from large community ICF-MRs and 120 children aging out of foster care to the Home and Community-Based Services (HCS) waiver program by the end of fiscal year 2009. ($7.8 million GR; $20.0 million AF)
- DADS is requesting 682.8 FTEs over the biennium for Program Oversight, Services, and Support. This exceptional item impacts programs that are critical for DADS to adequately serve individuals who are aging and who may have a disability. These programs include Guardianship, Functional Eligibility, Regulatory, Contract Management, and Program Oversight. ($35.8 million GR; $68.0 million AF)
- Information Technology Initiatives requests several critical automation infrastructure needs at DADS. DADS will also be included in a number of HHS Enterprise technology requests. ($7.0 million GR; $14.1 million)
- DADS has three exceptional items to address infrastructure needs at State Schools. The items cover Equipment and Vehicles, Utility and Drug Increases, and Repairs and Renovations. ($18.3 million GR; $87.3 million AF)
- Guardianship requests funding to meet 50 percent of the projected caseload increases for Guardianship services with community contractors. ($1.1 million GR; $1.1 million AF)
- MR Equity - This item requests funds for the biennium to increase allocations to Mental Retardation Authorities (MRAs) that are currently funded below the mean as compared to all MRAs operating across the State. ($22.0 million GR; $22.0 million AF)
- PACE Site Expansion — This exceptional item requests funds to add two additional Program of All-Inclusive Care for the Elderly (PACE) sites. These two additional sites would serve an additional 222 individuals in this program by the end of fiscal year 2009. ($3.2 million GR; $8.1 million AF)

DADS is also included in four Enterprise Requests that are included in HHSC's LAR and the HHS Consolidated Budget. The first of these is the continuation of the DADS Interest List reductions from 2006-2007. The second item pertains to rate increases for providers and direct care staff. The third item is Nurse Retention and Recruitment. The fourth is telecommunications.

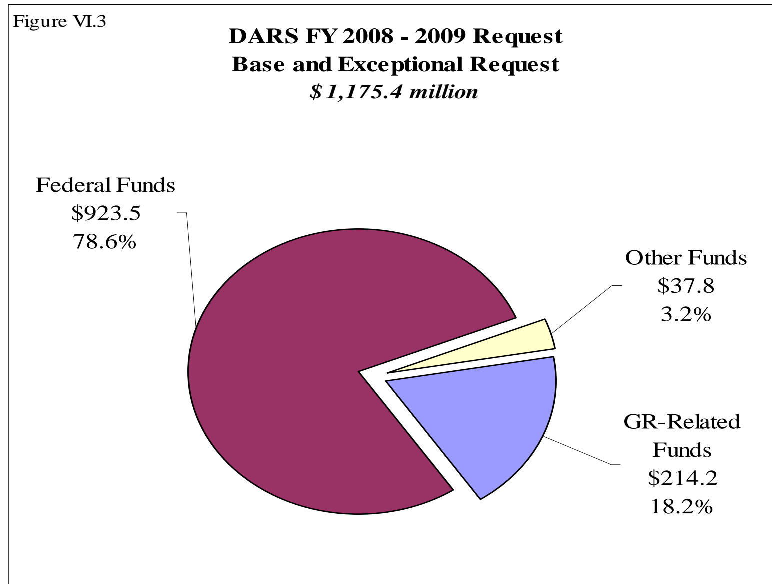
The DADS Legislative Appropriations Request can be found online at:
http://cfoweb.bdm.dhs.state.tx.us/2008_09_lar.htm

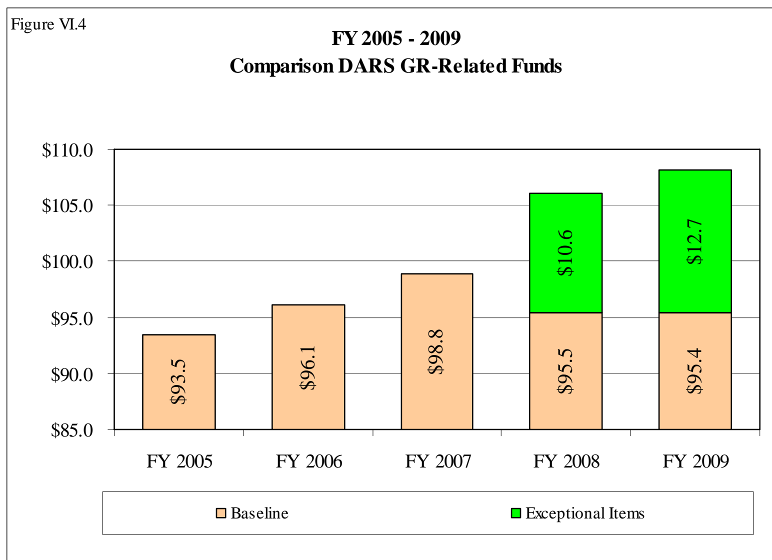
Department of Assistive and Rehabilitative Services (DARS)

General Functions

DARS administers programs that:

- Assist Texans with disabilities to find or retain employment
- Prepare children with disabilities and developmental delays age 0-3 to meet educational and developmental goals
- Help Texans with disabilities to live independently in their communities
- Help survivors of traumatic brain and spinal cord injuries to regain functionality and independence
- Make disability determinations for Texans who apply for Social Security Disability Insurance and/or Supplemental Security Income





Summary of Budget Request

The 2008-2009 LAR base and exceptional items total nearly $1.2 billion, All Funds over the 2006-2007 biennium. This increase is base request is nearly $1.1 billion, and exceptional items total almost $101 million, all funds. The GR-related base and exceptional item request for 2008-2009 of $214.2 million represents a 9.9 percent increase over 2006-2007. Federal and other funds requested have increased by 13.5 percent over 2006-2007 levels for a total of $961 million in 2008-2009.

Exceptional Items

- Restoration of 2008-2009 Baseline General Revenue to 2006-2007 Levels

In addition to restoring important GR funding to select program and administrative strategies, approval of this request would enable the agency to avoid a dollar-for-dollar reduction in federal VR funds for failing to meet the required Maintenance of Effort (MOE) in the VR program.

- Non-Federal Match for the Vocational Rehabilitation (VR) Federal Grant

DARS estimates 3.5 percent annual growth in the federal VR grant available for match at a ratio of nearly $4 federal for every $1 state. Adequate state funding for Vocational Rehabilitation will help Texas avoid a waiting list for services and allow us to continue to serve all eligible disabled applicants.

- Funding for Two New Centers for Independent Living (CILs)

Centers for Independent Living (CILs) are community-based non-residential organizations that provide independent living skills training, individual and systems advocacy, peer counseling and information and referral services to people with significant disabilities. Currently there are 21 CILs in Texas and, at the request of advocacy groups, DARS is seeking additional funding to expand and strengthen this existing network.

- Additional General Revenue to Bring All CILs to an Operating Funding Level of $250,000 Annually

This request is consistent with a study conducted by Independent Living Research Utilization, (ILRU), in Houston, which found that it costs approximately $250,000 to establish a Center for Independent Living. Currently, there are 10 Texas CILs that are operating below the $250,000 level.

- Disability Determination Services (DDS)

DARS is requesting 162.5 full-time equivalent (FTE) positions in 2008-2009 LAR for the DDS program, which determines disability for the Social Security Administration. These FTEs are 100 percent federally-funded.

- The Health and Human Services Commission will include an exceptional request in its LAR on behalf of DARS to fund waiting lists during the biennium.

<u>Comprehensive Rehabilitation Services (CRS) Waiting List</u>

The CRS program help persons with spinal cord and brain injuries receive intensive therapies to increase independence. DARS estimates $7.5 million will be needed during the ’08-’09 biennium to serve all consumers on the CRS waiting list.

Independent Living Services (ILS) Waiting List

The ILS program provides goods or services such as wheelchairs, ramps, adaptive equipment and daily independent living skills training to increase the independence of Texans with significant disabilities. DARS estimates $3.6 million will be needed during the 2008-2009 biennium to serve all consumers on the ILS waiting list.

The full Legislative Appropriations Request for DARS can be found at:
http://www.dars.state.tx.us/reports/financial.shtml

Department of Family and Protective Services (DFPS)

General Functions

The Department of Family and Protective Services (DFPS) is charged with protecting children, the elderly, and people with disabilities from abuse, neglect, and exploitation, and regulating all child-care operations and child-placing agencies. The agency is also charged with managing community-based programs that prevent child abuse and neglect and juvenile delinquency. The agency's services are provided through its Adult Protective Services (APS), Child Protective Services (CPS), Child Care Licensing (CCL), and Prevention and Early Intervention (PEI) programs. By the end of fiscal year 2007, over 9,500 DFPS employees across the state will be working to protect the physical safety and emotional well-being of the most vulnerable citizens of Texas.

Agency Reform

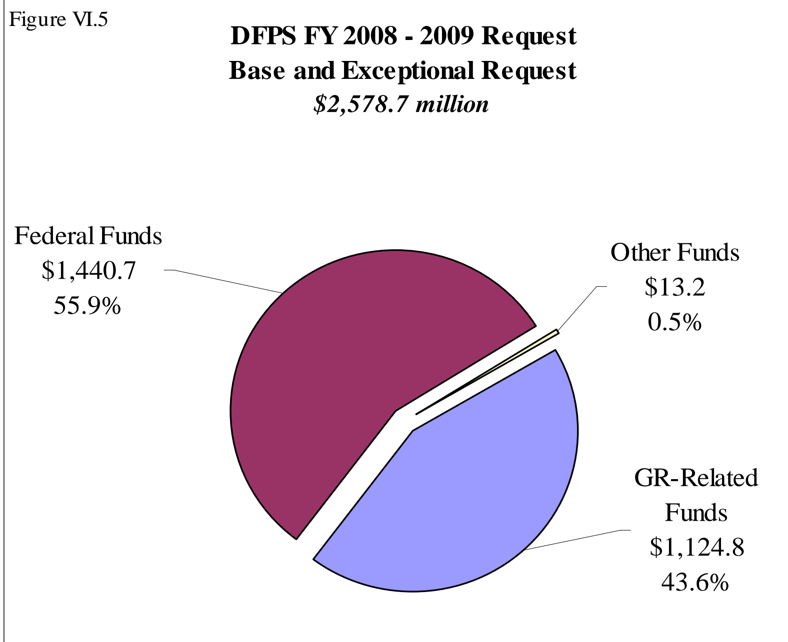
Senate Bill 6, passed by the 79th Texas Legislature and signed by Governor Rick Perry, laid the groundwork for comprehensive reform of child and adult protective services in Texas. Resources and direction were put in place to transform the programs charged with protecting children and people who are elderly or have disabilities from abuse, neglect, and exploitation. In the first year since Senate Bill 6 came into effect, these sweeping reforms have yielded tremendous improvement in the services that protect the most vulnerable Texans.

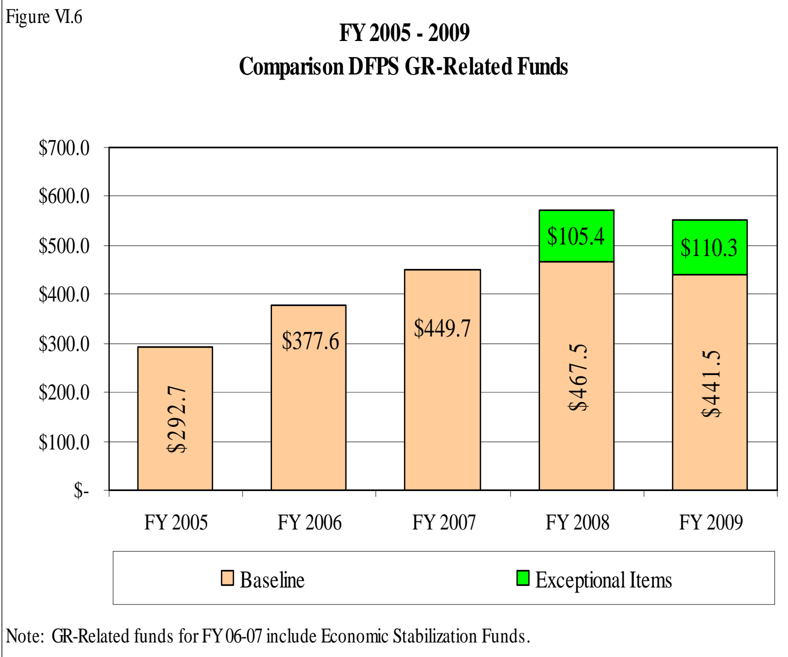
Since the legislation's passage DFPS has hired more than 1,900 new protective services staff, and in CPS, functional units were created for direct delivery stages of service. Training for caseworkers was strengthened, risk assessments were improved, and technological innovations were deployed to enhance casework in the field.

The Senate Bill 6 180-Day Progress Report, dated September 1, 2006, provides a more detailed report of the concrete progress that DFPS has made in implementing Senate Bill 6.

Summary of Budget Request

The 2008-2009 LAR base and exceptional items total $2.6 billion, a 17.8 percent increase in All Funds over the 2006-2007 biennium. The base request totals $2.3 billion and exceptional items total $266.1 million.





The GR-related base and exceptional item request for 2008-2009 of $1.1 billion represents a 36.0 percent increase over 2006-2007. Federal and other funds requested have increased by 6.8 percent from 2006-2007 levels for a total of $1.5 billion in 2008-2009.

As directed by the LAR instructions, amounts appropriated out of the Economic Stabilization Fund in 2006-2007 were requested as General Revenue for the 2008-2009 biennium.

Exceptional Items

The agency has three exceptional items totaling $163.2 million to restore dollars already appropriated or FTEs already authorized.

- One item restores the required general revenue base reduction to non-entitlement services that the agency applied to the prevention programs resulting in a 53.5 percent reduction in prevention services funding. This item totals $40.4 million.
- Two items restore the loss of appropriated FTEs in the agency's base request. One of these items requests $95.7 million to fund the annualized cost of the phased-in APS and CPS Reform initiatives and prevent a reduction of 1,150 direct delivery FTEs. The other item requests $27.1 million to restore the loss of federal entitlement funds due to method of financing changes and prevent a reduction of 325 direct delivery FTEs.

The agency proposes five separate exceptional items totaling $76.2 million to maintain current services by addressing caseload growth and agency infrastructure issues.

- There are three exceptional items related to maintaining current caseloads in CPS and Statewide Intake. These items total $57.3 million and propose 503 new FTEs in fiscal year 2008 and an additional 47 in fiscal year 2009. These items request the additional direct delivery staff necessary to maintain projected fiscal year 2007 caseloads per worker, as well as the associated support staff and purchased client services.
- One item requests $6.0 million to address caseload growth in the Relative and Other Designated Caregiver monetary assistance program.
- The agency is requesting an exceptional item to address aging IT infrastructure that includes upgrades to Microsoft server and desktop operating systems, Microsoft Office software, circuits, routers, and printers. This item totals $12.9 million.

Finally, the agency proposes three exceptional items considered as mission critical enhancements totaling $26.8 million.

- Funding for prevention services is being enhanced in an exceptional item that would provide a 10 percent increase for the Services to At Risk Youth program, provide two new sites for the Community Youth Development program, 3-4 new contracted programs for evidence-based at-risk prevention services, and new funding for community-based at-risk family services called for in S.B. 6. This item is for $13.3 million and 5 FTEs.
- Federal TANF funding is being requested to implement a Family Preservation Flexible Funding pilot program in seven CPS disproportionality sites to offset certain poverty-related factors to help keep families intact. This item totals $9.2 million.
- Efficiency and effectiveness will be enhanced with tablet PCs for the monitoring staff in the Child Care Licensing program and for the Child Care Licensing day care investigators. This request is for $4.3 million.

Other Issues

- Outsourcing of CPS Case Management and Substitute Care: In April 2006 DFPS announced that Region 8 (San Antonio area) would be the first region to outsource case management and substitute care services. The agency issued a request for proposal for an independent administrator to manage and oversee the outsourced services. The timeline for this procurement will not allow the agency to know the budgetary impact of outsourcing until the final contract is executed, anticipated to be January 2007. At that time, a new exceptional item may be presented to the Legislature for the purpose of funding any additional cost of outsourcing for 2008-2009.

- Enhanced Family Preservation Pilot: DFPS is seeking a new rider to request the authority to transfer funds from foster care to a new pilot program where CPS staff would work to divert children from foster care. This new pilot would utilize small capped caseloads to allow concentrated services to the family, time-limited cases with follow-up services, and the provision of non-traditional services to give families what they most need to maintain or establish the stability of their families.

The DFPS Legislative Appropriations Request can be found online at:
http://www.dfps.state.tx.us/About/Financial_and_Budget_Information/2008_09_LAR.asp

Department of State Health Services (DSHS)

General Functions

The Texas Department of State Health Services (DSHS) was officially launched on September 1, 2004, combining the legacy functions of the Department of Health, the Commission on Alcohol and Drug Abuse, the mental health component of the Department of Mental Health and Mental Retardation and the Texas Health Care Information Council. The agency's mission is to promote optimal health for individuals and communities and to provide effective public health, clinical services, mental health, and substance abuse services to Texans. DSHS fulfills its mission through a complex array of programs and services that fall into four general areas.

- **Preparedness and Prevention Services.** The range of activities related to this function includes improving the state's capacity to respond to bioterrorism threats, maintaining vital records and health registries, immunizing Texas children, addressing the health needs of specific groups such as children with special health care needs and kidney health patients, and operating a laboratory for health-related testing statewide.

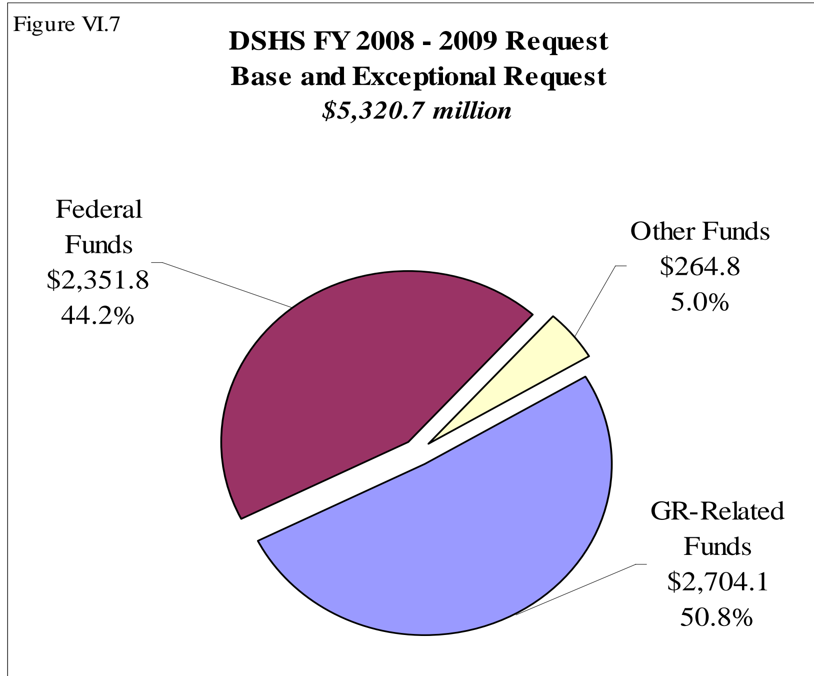
- **Community Health Services.** Services provided in this area cover primary care and indigent health services, WIC nutrition services, women and children's health services, family planning services, community based mental health and substance abuse services as well as tobacco education and enforcement activities.

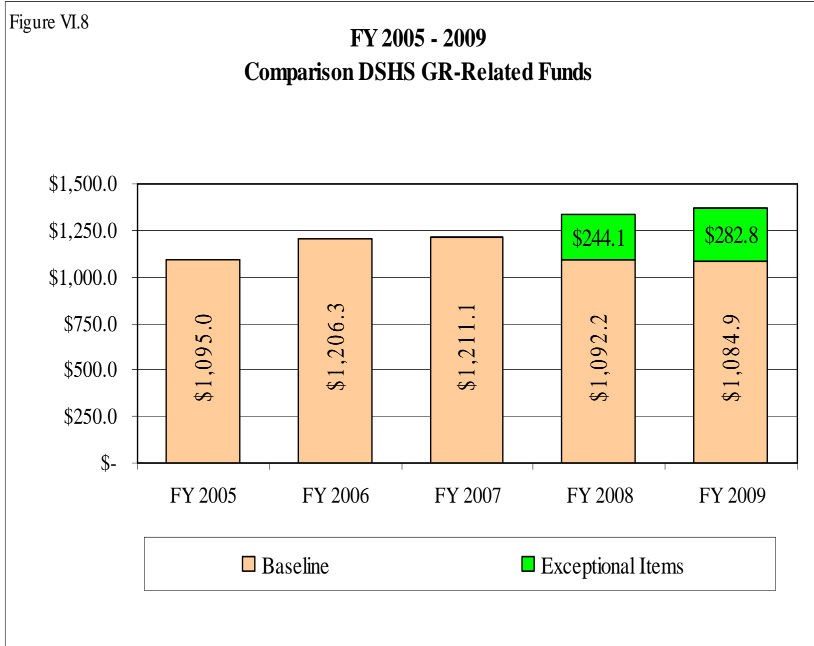
- **Hospital Facilities Management and Services.** DSHS is responsible for operating the state's mental health hospitals, the Texas Center for Infectious Diseases and the South Texas Health Care System.

- **Consumer Protection.** DSHS is the state authority for enforcing consumer health protection in areas such as food and drug safety, environmental health and radiation control. The Department is also responsible for licensing health care professionals and facilities.

Summary of Budget Request

The 2008-2009 LAR base and exceptional items total $5.3 billion, a 0.5 percent increase in All Funds over the 2006-2007 biennium. The base request totals $4.7 billion, and exceptional items total $656.5 million. The GR- related base and exceptional item request for 2008-2009 of $2.7 billion represents a 10.7 percent increase over 2006-2007. Federal and other funds requested have remained constant from 2006-2007 levels for a total of $2.6 billion in 2008-2009.





Exceptional Items

To restore the 10 percent reduction in GR to the base, DSHS is requesting $236.2 million. The ten percent reduction was taken agency and affects services to clients agency-wide.

Other exceptional items can be categorized into two areas, direct services and agency operations. Direct services includes HIV and Tuberculosis medications and services, mental health crisis services, local public health, pandemic flu prevention, tobacco prevention and cessation, cardiovascular and diabetes prevention, and treatment for substance abuse.

Agency operations includes critical needs such as the information technology, repairs and renovations for state hospitals, salary increases for critical classifications as well as a residency program to improve retention and recruitment.

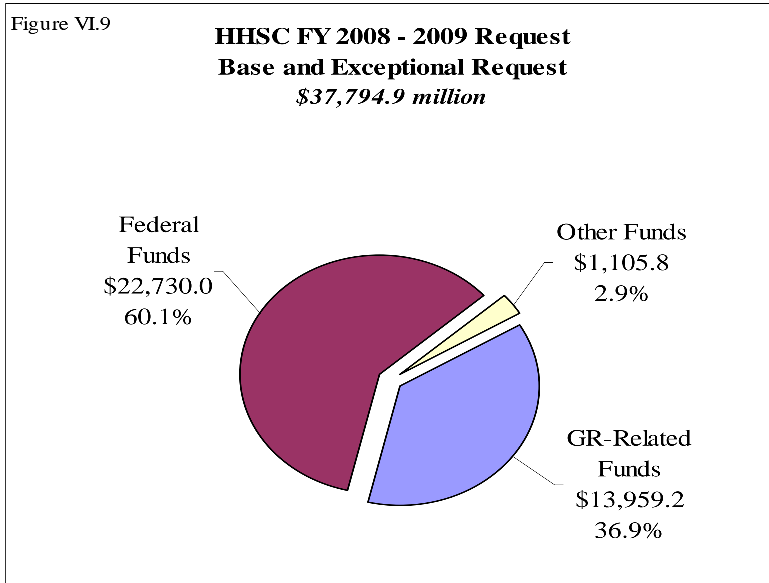
The DSHS Legislative Appropriations Request can be found online at: http://www.dshs.state.tx.us/budget/lar.

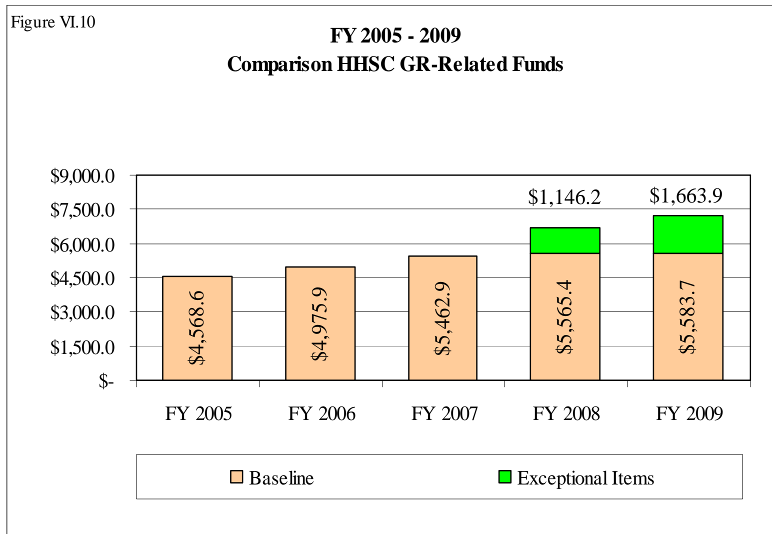
Health and Human Services Commission (HHSC)

General Functions

The Health and Human Services Commission (HHSC) was created in 1992 to coordinate and improve the delivery of health and human services across Texas. During its 15-year history, HHSC has increased its oversight role of health and human services programs and consolidated functions to a major transformation that is now two-years old.

In addition to operating the health and human services system in Texas, HHSC is responsible for program administration of Medicaid, Children's Health Insurance Program (CHIP), Disaster Assistance, Temporary Assistance for Needy Families, Food Stamps, Special Nutrition Programs, Family Violence and Refugee programs. Thus, HHSC has responsibilities as a leadership, operational, and oversight agency. The agency is accountable to Texans for ensuring that the consolidated Health and Human Services (HHS) agencies provide quality services as efficiently and effectively as possible.





Summary of Budget Request

The 2008-2009 LAR base and exceptional items total $37.8 billion, a 27.0 percent increase in All Funds over the 2006-2007 biennium. The base request totals $31.0 billion, and exceptional items total $6.8 billion. The GR-related base and exceptional item request for fiscal year 2008-2009 of $14.0 billion represents a 33.7 percent increase over 2006-2007. Federal and other funds requested have increased by 23.3 percent from 2006-2007 levels for a total of $23.8 billion in 2008-2009.

Exceptional Items

In addition to the base request, HHSC is seeking funding for 23 exceptional items totaling almost $2.8 billion in GR, of which approximately $1.9 billion, or 67.2 percent, is needed to maintain current services in Medicaid, CHIP, TANF and other agency programs and administration.

Exceptional items can be categorized in five main areas:

- **Maintain Current Services** – ($1.94 billion GR)
  Includes six items related to restoring the 10 percent general revenue reduction in the base request and funding cost increases in the Medicaid and CHIP program and complying with the Alberto N lawsuit.
- **Restore Provider Rates** – ($237.0 million GR)
  Restores reductions made in the 2004-2005 biennium in Medicaid and CHIP rates for health care providers.
- **Improve Systems and Services** - ($21.6 million GR)
  Includes eight items covering an array of operational and service needs, such as compliance with HIPAA regulations, expansion of family violence services, improved coordination of certain health activities and increases in Office of Inspector General staff as well as conducting extensive background checks on new Medicaid providers. Three other initiatives would support existing systems, facilities and infrastructure including the Electronic Benefits Transfer systems and implementing the Integrated Benefit Card statewide.
- **Provide Medicaid Financing for Hospitals** – ($304.7 million GR)
  Includes four items to improve Medicaid financing for hospitals across the state that would replace certain intergovernmental transfers with state funding, re-establish state funding for graduate medical education payments, and fund a private urban hospital upper payment limit program.
- **Implement Enterprise Initiatives** – ($307.6 million GR)
  Includes four items that support the following efforts across HHS agencies:
  - Reducing Waiting/Interest Lists(2 exceptional items)
  - Improving HHS Telecommunications and IT Systems and Security
  - Increase Nurse Recruitment and Retention

The HHSC Legislative Appropriations Request can be found online at http://www.hhsc.state.tx.us/LAR-2008-2009/index.html

VII. APPENDICES

A. Texas Economic / Demographic Outlook

I. Economic Outlook

As of September 2006, both the national and the state economy are strong. The last time the national economy experienced negative growth was in the third quarter of 2001. Since then, and through June 2006, the national economy has grown for 19 consecutive quarters.

A number of factors such as relatively low interest rates, robust consumer and business spending, and increased productivity levels have contributed to sustain economic growth during the last 2 years. And even though interest rates and the price of oil and other commodities are higher today compared to 2 years ago, the economy continues to expand, although at a slower pace, as both consumers and business continue to spend on a variety of goods and services.

The performance of the Texas economy has also been improving during the last 2 years. Like in the nation as a whole, total employment levels are at historically high levels, and the rate of unemployment has been steadily declining. The July 2004 unemployment rate was 6 percent; in contrast, the July 2006 rate was 5.2 percent. The estimated number of persons officially classified as unemployed by the Texas Workforce Commission declined from 664,000 to 601,000 from July 2004 to July 2006. This translates into a 10 percent reduction in the number of unemployed.

In spite of the strengthening of the economy and improved job market conditions, a lower percentage of working-age Texans were employed in July 2006 in comparison to July 2000 (73 percent versus 77 percent). In addition, compared to the U.S. as a whole, the state continues to have a relatively high poverty rate, a lower median household income, and a relatively low rate of employer-based health insurance coverage.

As long as the population continues to grow, and as long as a relatively high percentage of the population is uninsured and living below the poverty level, the demand for health and human services is likely to remain strong.

Forecast for Selected Texas Key Indicators

The forecast for the indicators cited below is based on the Spring 2006 Economic Forecast published by the Texas Comptroller of Public Accounts.

Growth of the Economy. The economy is forecasted to expand at a rate of 3.2 percent per year during the state fiscal year 2008-2009 period.

- **Rate of Unemployment.** The rate of unemployment is forecasted to average 4.8 percent per year during the state fiscal year 2008-2009 period.

- **General Price Inflation.** The general rate of inflation is forecasted to remain relatively low, averaging 1.8 percent per year during the state fiscal year 2008-2009 period.

  Per Capita Personal Income. For state fiscal year 2006, per capita personal income is forecasted at $33,600. Not adjusted for inflation, per capita personal income is forecasted to increase to $36,600 in state fiscal year 2008 and to $38,100 in state fiscal year 2009.

- **Prime Interest Rate.** For state fiscal year 2006, the rate is forecasted to average 7.6 percent. The rate is forecasted to average 7.5 percent during state fiscal year 2008 and 7.9 percent during state fiscal year 2009.

II. Texas Demographic / Socioeconomic Outlook

General Overview

Texas' population is projected to grow in size and to change in terms of age and race/ethnic makeup.

Growth in the total population is likely to have an impact on the HHS system. Certain programs in areas related to public health and protective services, for example, may be impacted by total population growth. Based on a total of 67,000 completed investigations, in state fiscal year 2005 the rate of completed investigations involving alleged cases of elderly abuse and neglect per 1,000 Texans age 65 or older was 28.8. If that rate were to remain unchanged in the future, by state fiscal year 2040 the number of completed APS investigations could be approaching the 214,000 mark. Thus, just due to growth in the total population age 65 or older, the number of completed investigations could more than triple by the year 2040.

The disproportionate growth rate of the 65 and older and the non-Anglo groups could also have an impact on the HHS system. For example, the rate of disability and chronic illness is higher among persons 65 and older, while the rate of poverty and uninsured is higher among non-Anglos. The growth in the population of persons age 65 or older could exert additional pressure on long-term care programs that meet the needs of persons with disabilities and/or chronic illness. The disproportionate increase in the number of non-Anglo persons could possibly result in greater demand for certain means-tested services, such as Medicaid, CHIP, TANF, and Food Stamps.

Growth in Total Population

Between 1990 and 2000, the State's population grew at a rate of 24 percent; growing by 4 million, from 16.9 million in 1990 to 20.9 million in 2000. Without factoring-in the demographic impact resulting from the influx of evacuees from neighboring Gulf Coast states in the aftermath of hurricane Katrina, the population is estimated to have grown by 2.6 million between 2000 and 2006, from 20.9 million in 2000 to 23.5 million in 2006. Between 2006 and 2040, the population is projected to grow by 22 million. It is projected that by the year 2040 the population will reach the 45.4 million mark.

Figure VII.A.1

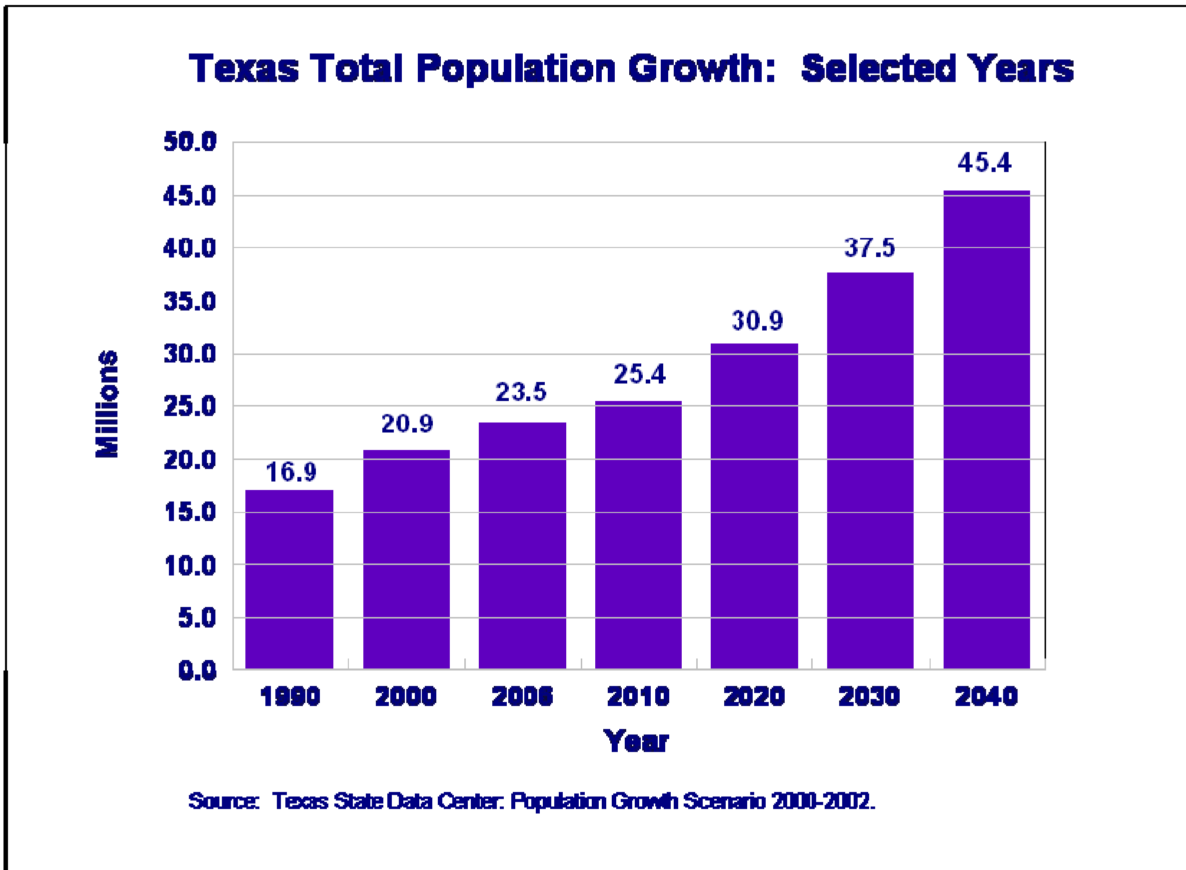
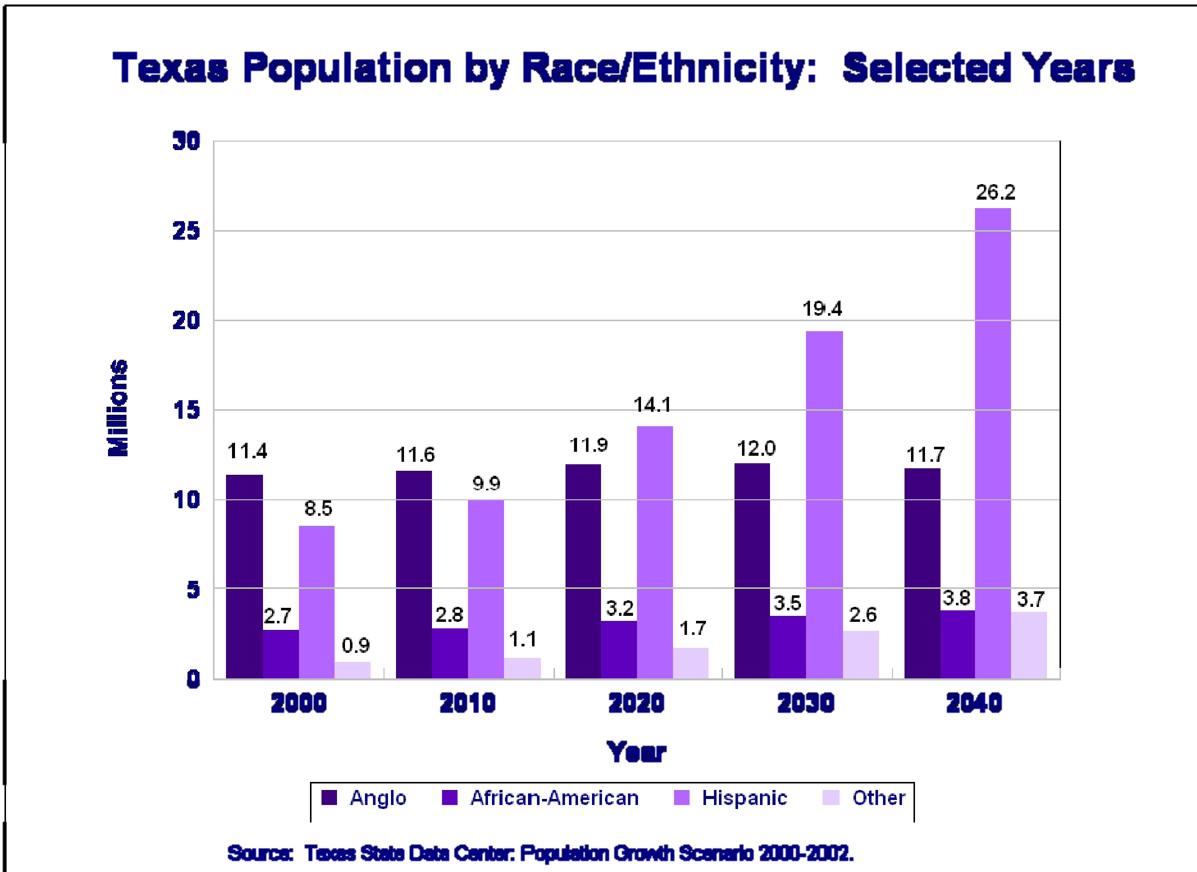


Figure VII.A.2



Projected Changes in Race / Ethnic Composition

Texas is projected to become a minority-majority state. In 2000 Anglos accounted for about 11.1 million or 53 percent of the total population. But Anglos are projected to comprise less than 50 percent of the Texas population in 2006. By the year 2040, they are projected to comprise 26 percent of the population.

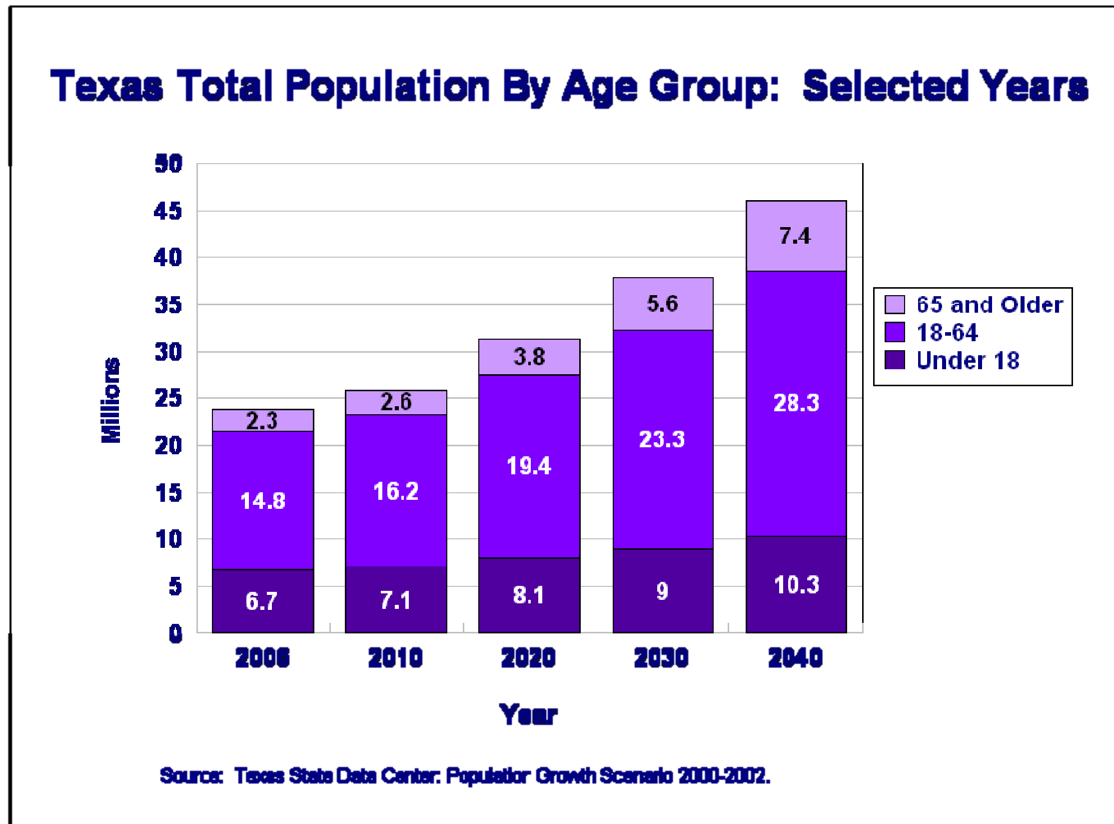
Sometime between 2015 and 2020 Hispanics are projected to overtake Anglos as the single largest ethnic group in the State. Hispanics accounted for 6.7 million or 32 percent of the State's population in 2000. By 2040, Hispanics are projected to comprise 58 percent of the population.

The size of the African-American population is projected to increase; however, this group will see its percent share of the total population drop, from 12 percent in 2000 to 8 percent in 2040.

Projected Changes in Age Composition

All the major age cohorts: children under 18; adults ages 18-64; and adults ages 65 and older, are expected to experience population growth over the short and long-term futures. Between 2006 and 2010, the population of children under 18 is projected to grow by 0.3 million; the population of adults ages 18-64 is expected to grow by about 1.4 million; and the population of adults ages 65 and older is expected to grow by about 2 million.

Figure VII.A.3

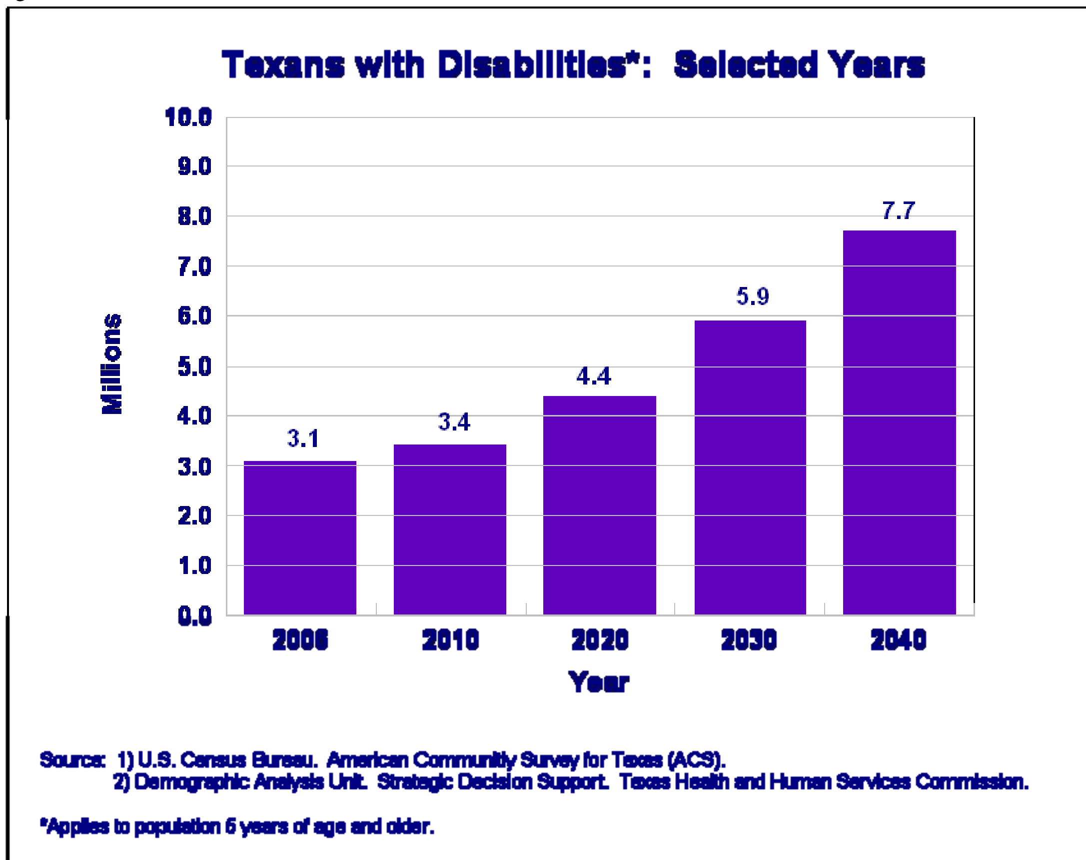


Over the long term, children under 18 are projected to account for a smaller share of the total population. Their share is expected to decrease to 26 percent by 2010, down from 28 percent in 2000. Their share will decline to 21 percent by 2040. Meanwhile, the 65 and older group is projected to account for a larger share of the population. This group will see its percent share grow from 10 percent in 2006 to 16 percent in 2040. Growth in the percent of the population that is 65 and older will start accelerating after the year 2011, the year when the leading edge of the baby boom generation turns 65.

The aging of the population is expected to cause growth in the population of persons with disabilities. This population includes persons who have physical and/or mental conditions that limit their ability to perform, on their own -- and without the assistance of others or of special equipment and/or medications -- basic activities of daily living. These activities include things such as bathing, eating, communicating, toileting and transferring. The size of the population with disabilities could more than double between 2006 and 2040.

The projection for the disability population presented in Figure VII.A.4 could materialize if current rates of disability were to hold steady over time. But if there were to be a reduction in age-specific disability rates, due to advances in health care, for example, the population with disabilities may grow at a slower rate.

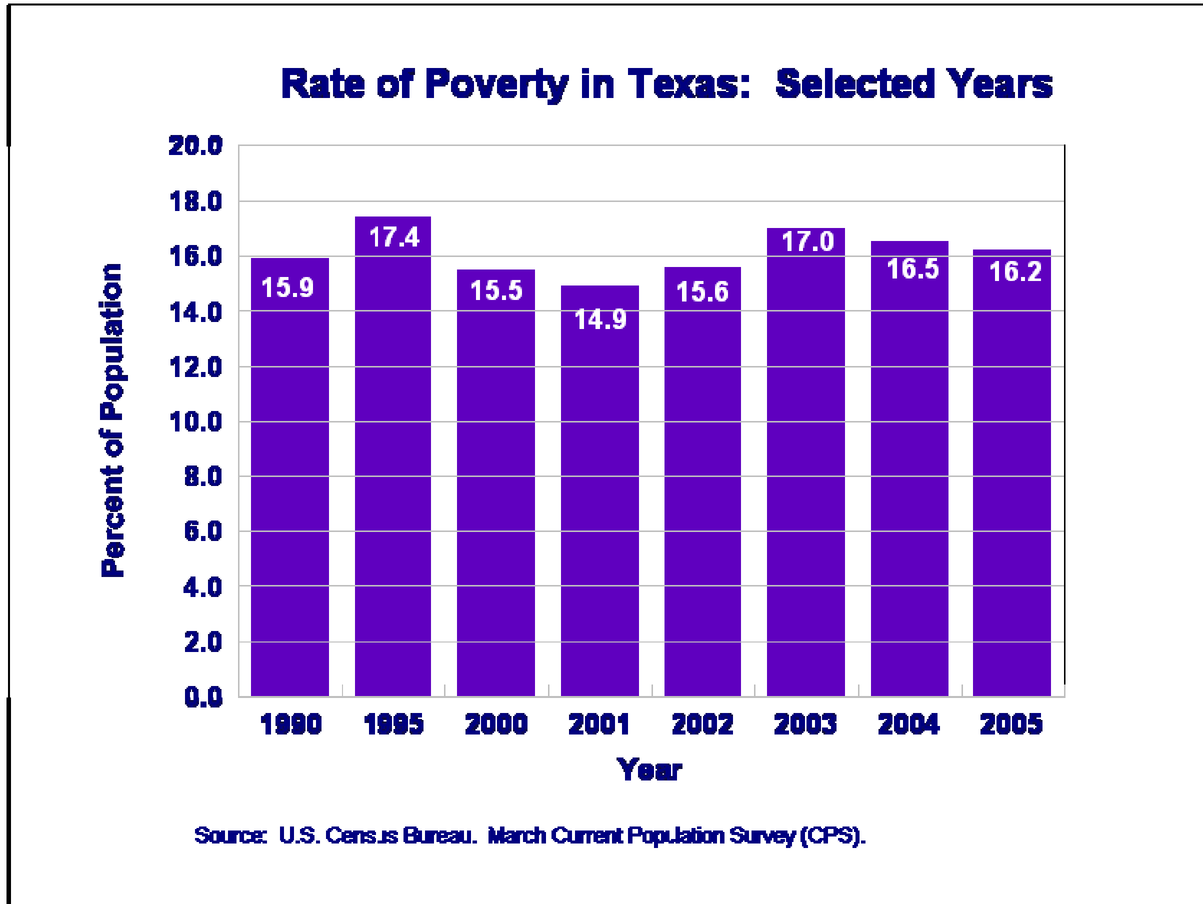
Figure VII.A.4



Poverty Population

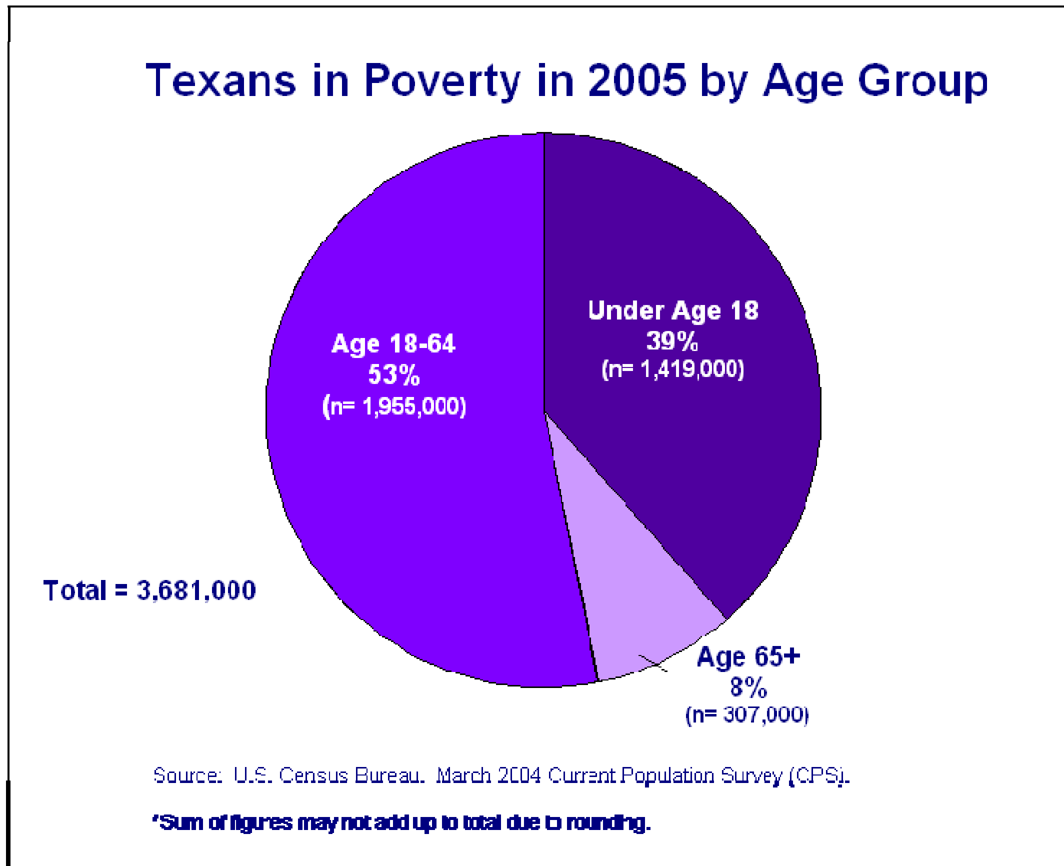
As in the other states, the rate of poverty in Texas has fluctuated in recent years. The rate has been impacted by both 'boom' and 'bust' economic cycles. For example, during the economic expansion of the late 1990's, and through the first half of 2001, the rate of poverty in Texas declined; from 17.4 percent in 1995 to 14.9 percent in 2001. Conversely, after the end of that economic expansion cycle, the rate of poverty rose again, peaking at 17 percent in 2003. As a result of the economic expansion of the last 2 years, the rate of poverty has declined again, although very slightly. In 2005, 16.2 percent of Texans lived in households/families with incomes below the federal poverty level (FPL).

Figure VII.A.5



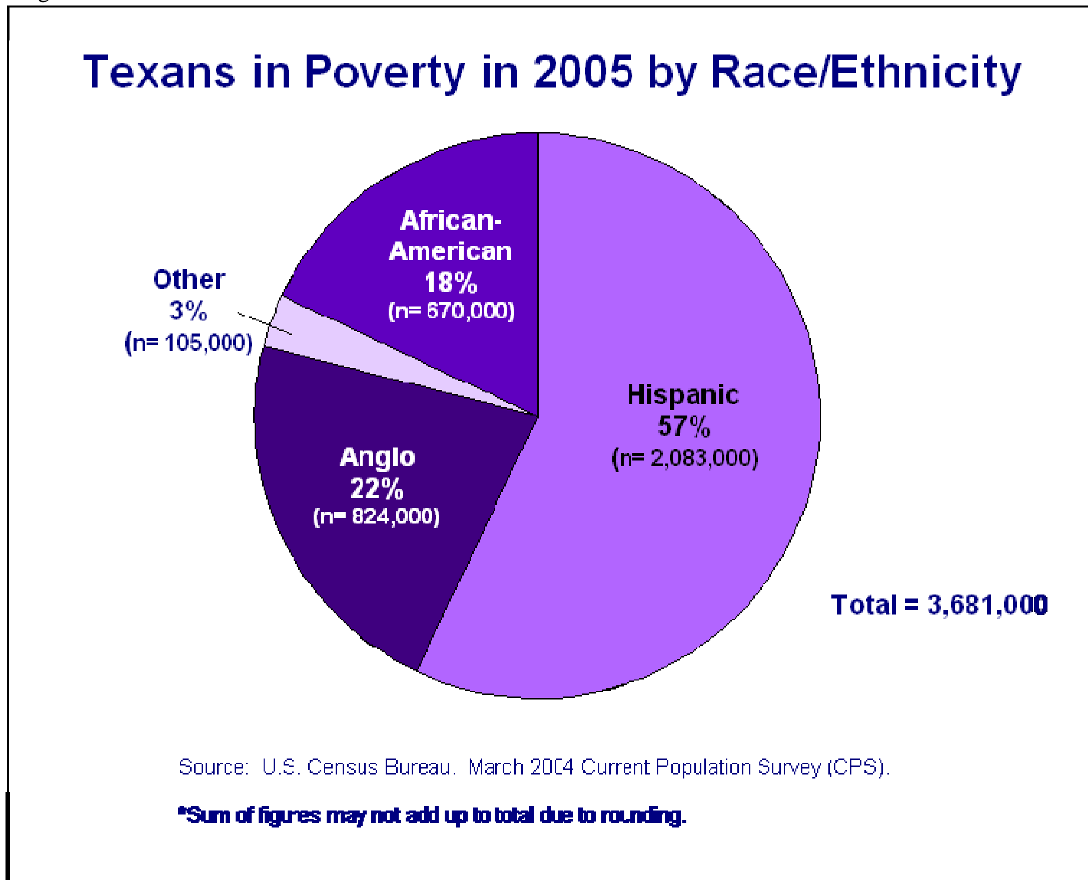
The most recent U.S. Census Bureau data on poverty (see Figure VII.A.6), indicate that poverty is not evenly distributed across all the major age groups. In 2005, children under age 18 comprised 29 percent of the total population, but they accounted for 41 percent of the poverty population.

Figure VII.A.6



In addition, the data indicate that poverty is not evenly distributed across all the major race/ethnic groups. In 2005, Hispanics and African-Americans, combined, comprised 48 percent of the total population; however, they accounted for 75 percent of the poverty population.

Figure VII.A.7



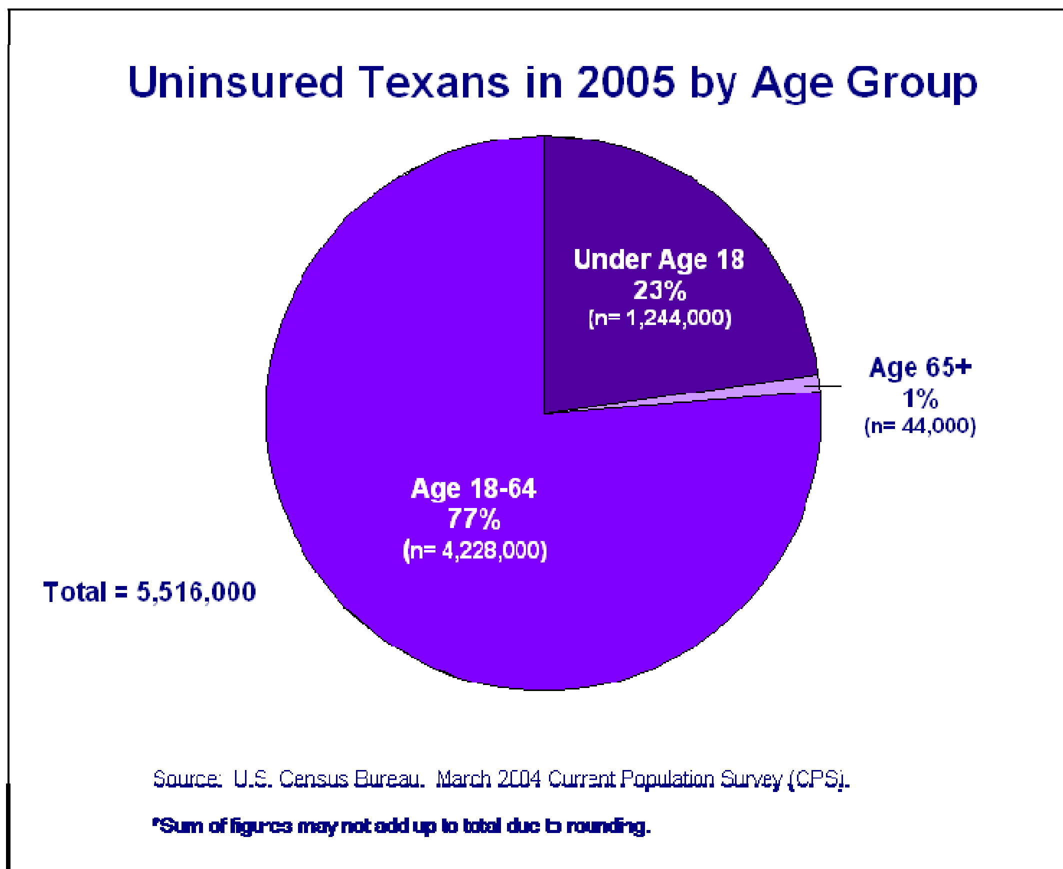
Uninsured Population

In recent years, Texas has experienced high rates of uninsured. There have been minor year-to-year fluctuations in the rate of uninsured during the last decade; however, the percent of uninsured in the State has consistently remained above the national average.

Estimates derived from U.S. Census Bureau data indicate that 5.5 million (24 percent of Texans) did not have health insurance in 2005. An estimated 1.2 million children under age 18 (19 percent) did not have health insurance in 2005. Children under 18 represented 23 percent of the 5.5 million without health insurance.

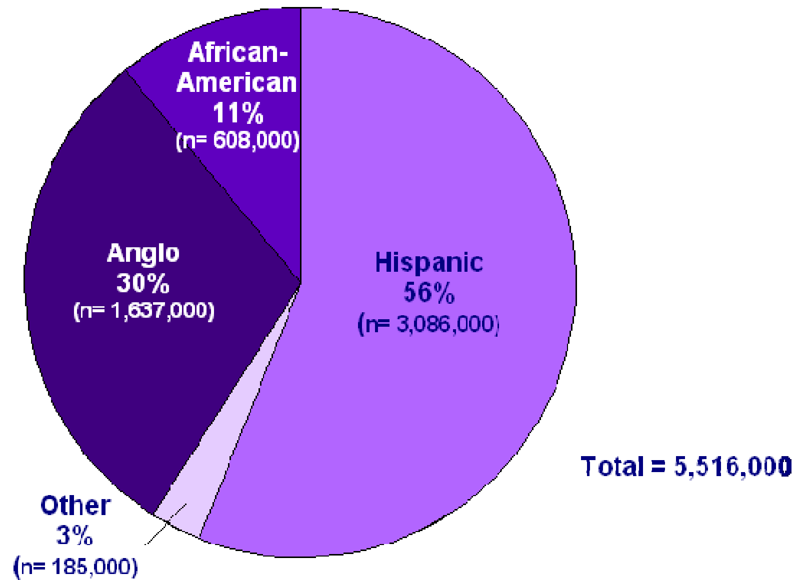
In 2005, 30 percent of adults under age 65 did not have health insurance.

Figure VII.A.8



The data for 2005 also indicate that the percent without insurance varies significantly on the basis of race/ethnicity. In 2005, African-Americans and Hispanics comprised 48 percent of the total population; however, they accounted for 67 percent of the uninsured.

Figure VII.A.9



III. Demographic Outlook Summary

If current demographic and socio-economic trends hold steady, in coming years agencies and programs within the HHS System are likely to experience additional demands for services. This will be due to growth in the general population, but also due to the growth in key at-risk populations such as the aged and disabled, the lower-income and the poor, and the health care indigent/uninsured, among others.

B1. Rate Schedule – Cost of 1 Percent Rate Increase

Figure VII.B1

Rate Histories and Rate Change Impacts

KEY - A - Access based; B - Based on rates from other Medicaid programs
BR - Blue Ribbon File of Claims Data
CD - Percent of claims data - trend to FY 08/09
CR - Cost Reports used for prospective rate - trend to FY 08/09
CS - Cost Reports used for interim rate and cost settlement - trend to FY 08/09
T - Trending from current rate to FY 08/09
M - Based on Medicare rates; PA - Pro forma analysis

Program by Budget Agency	Date of Last Rate Increase (other than rate restoration)	Percent of Last Rate Increase (other than rate restoration)	Percent of Rate Reduction FY03-04	Percent of Rate Reduction Restored	Method of Determining Rate Change	Incremental Cost of 1 Percent Rate Increase			
						2008		2009	
						AF	GR	AF	GR
DADS									
Access and Intake - Mental Retardation Service Coordination	SFY 2002	2.00%	1.75%	0.00%	CS	0	0	0	0
Community Attendant Services	9/1/2000	1.20%	1.10%	1.10%	CR	3,742,208	1,470,688	4,056,264	1,587,216
Community Based Alternatives	9/1/2000	2.20%	1.10%	1.10%	CR	3,727,036	1,464,725	3,727,036	1,458,389
Community Living Assistance and Support Services	9/1/2002	0.04%	1.10%	0.00%	CR	1,283,740	504,510	1,291,456	505,347
Consolidated Waiver Program	9/1/2000	2.20%	1.10%	1.10%	B	39,317	15,452	39,317	15,385
Day Activity and Health Services - Title XIX	9/1/2002	1.30%	1.10%	1.10%	CR	979,600	384,983	1,013,306	396,507
Deaf-Blind Multiple Disabilities	9/1/2002	0.04%	1.10%	1.10%	B	72,493	28,490	72,493	28,366
Home and Community-based Services	9/1/1998 - all services; 9/1/2001 - services with direct care level staff and foster care	9/1/1998 - 1.25%; 9/1/2001 - various from decrease of 4.4% to increase of 3.23%	1.10%	0.00%	CR	4,816,216	1,892,773	4,816,216	1,884,585
Hospice Payments (NF Related Only)	1/1/2006	11.75%	1.75%	1.75%	B	1,673,358	657,630	1,821,998	712,948
Intermediate Care Facilities - Mental Retardation	9/1/2001 and 11/1/2001	varied between 10% and 13% total increase	1.75%	0.00%	CR	3,426,271	1,346,525	3,426,271	1,340,700

Figure VII.B1 (continued)

Program by Budget Agency	Date of Last Rate Increase (other than rate restoration)	Percent of Last Rate Increase (other than rate restoration)	Percent of Rate Reduction FY03-04	Percent of Rate Reduction Restored	Method of Determining Rate Change	Incremental Cost of 1 Percent Rate Increase			
						2008		2009	
						AF	GR	AF	GR
DADS (continued)									
Medically Dependent Children Program	1998	NA	1.10%	1.10%	B	391,805	153,979	391,805	153,313
MR State Schools Services	9/1/2005	7.50%	0.00%	0.00%	CS	Increased Operating Costs Included in DADS LAR			
Non-Medicaid Services - Title XX	9/1/2000	various	0.00%	0.00%	CR	736,760	736,760	736,760	736,760
Nursing Facility	1/1/2006	11.75%	1.75%	1.75%	CR	22,521,880	8,851,099	22,465,540	8,790,766
Primary Home Care	9/1/2000	1.20%	1.10%	1.10%	CR	3,896,804	1,531,444	3,993,880	1,562,805
Program of All-inclusive Care for the Elderly	1/1/2006	various	NA	NA	CD	293,387	115,301	293,387	114,802
Promoting Independence Services	9/1/2000	various	1.10%	1.10%	B	903,458	355,059	966,552	378,212
Texas Home Living Waiver	3/1/2004 rates based on HCS	0.00%	0.00%	0.00%	B	119,976	47,150	119,976	46,946
Total DADS						**48,624,309**	**19,556,567**	**49,232,257**	**19,713,048**
DARS									
ECI - Case Mgmt.	FY 2000	0.00%	0.00%	0.00%	CR	0	0	0	0
ECI - Development Rehab Svcs.	4/4/2003	63.00%	0.00%	0.00%	CR	0	0	0	0
Total DARS						**0**	**0**	**0**	**0**
DFPS									
24-Hr. Residential Child Care (Foster Care)	9/1/2005	2.78%	0.00%	0.00%	CR	4,398,424	1,615,197 See note 1	4,703,686	1,734,683 See note 2
Total DFPS						**4,398,424**	**1,615,197**	**4,703,686**	**1,734,683**

Figure VII.B1 (continued)

Program by Budget Agency	Date of Last Rate Increase (other than rate restoration)	Percent of Last Rate Increase (other than rate restoration)	Percent of Rate Reduction FY03-04	Percent of Rate Reduction Restored	Method of Determining Rate Change	Incremental Cost of 1 Percent Rate Increase			
						2008		2009	
						AF	GR	AF	GR
DSHS									
Children with Special Health Care Needs (CSHCN) - Outpatient Hospital	NA	NA	0.00%	0.00%	B	32,319	32,319	44,058	44,058
CSHCN - Ambulance Services	9/1/1999	1.50%	2.50%	0.00%	B	909	909	1,676	1,676
CSHCN - ASCs/HASCs	9/1/1995	Changed to Fee Schedule	0.00%	0.00%	B	2,155	2,155	2,558	2,558
CSHCN - Dental Services	FY 2001	13.50%	2.50%	0.00%	B	4,307	4,307	5,211	5,211
CSHCN - Drugs/Biological Fees	FY 2000	-2.80%	0.00%	0.00%	B	97,037	97,037	111,437	111,437
CSHCN - Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS)	FY 2003	Varies	0.00%	0.00%	B	30,643	30,643	36,252	36,252
CSHCN - Home Health Agencies (Therapies)	11/1/2002	Change to Statewide Visit Rate	2.50%	0.00%	B	54	54	64	64
CSHCN - Inpatient Hospital - SDA Inflation Only	9/1/2001	13.87%	5.00%	0.00%	B	131,040	131,040	168,331	168,331
CSHCN - Inpatient Hospital Rebasing	9/1/2001	13.87%	5.00%	0.00%	B	131,040	131,040	174,097	174,097
CSHCN - Meals, Transportation, Lodging	NA	NA	2.50%	0.00%	Cost	13,514	13,514	15,446	15,446
CSHCN - Physician/ Professional Services	9/1/1999	1.50%	2.50%	0.00%	B	55,126	55,126	60,638	60,638
CSHCN - Private Duty Nursing	9/15/1993	32.00%	2.50%	0.00%	B	5,173	5,173	9,681	9,681
Family Planning - DMEPOS	FY 2003	Varies	0.00%	0.00%	B	3,644	3,644	4,072	4,072
Family Planning - Drugs/Biologicals	FY 2000	-2.80%	0.00%	0.00%	B	65,088	65,088	67,626	67,626

Figure VII.B1 (continued)

Program by Budget Agency	Date of Last Rate Increase (other than rate restoration)	Percent of Last Rate Increase (other than rate restoration)	Percent of Rate Reduction FY03-04	Percent of Rate Reduction Restored	Method of Determining Rate Change	Incremental Cost of 1 Percent Rate Increase			
						2008		2009	
						AF	GR	AF	GR
DSHS (continued)									
Family Planning - FQHCs	Provider FYE 2006	Medicare Economic Index (MEI) or MEI+1.5%	0.00%	0.00%	B	12,563	12,563	13,605	13,605
Family Planning - Maternity Service Clinics	9/1/1999	1.50%	2.50%	0.00%	B	25,098	25,098	39,819	39,819
Family Planning - Outpatient Hospital	NA	NA	2.50%	0.00%	B	904	904	962	962
Family Planning - Physician Services	9/1/1999	1.50%	2.50%	0.00%	B	483,558	483,558	502,417	502,417
Family Planning - RHCs	Provider FYE 2006	Medicare Economic Index (MEI) or MEI+1.5%	0.00%	0.00%	B	213	213	231	231
Institutions for Mental Disease	9/1/2002	5.35%	0.00%	0.00%	CR	42,861	16,844	43,132	16,877
Maternal and Child Health - Genetics	9/1/1999	1.50%	0.00%	0.00%	B	14,152	14,152	18,236	18,236
Maternal and Child Health - Physician Services	9/1/1999	1.50%	2.50%	0.00%	B	130,636	130,636	143,700	143,700
MH Rehabilitative Services	8/31/2004	Converted to Program Resiliancy and Disease Management	1.75%	0.00%	CS	35,952	14,129	37,457	14,657
MH Targeted Case Management	8/31/2004	Converted to Program Resiliancy and Disease Management	0.00%	0.00%	CS	116,879	45,934	125,896	49,263
NorthSTAR -- Medicaid Clinical Laboratory Fees - Independent Laboratories	FY 2002	NA	2.50%	0.00%	C	1,616	635	2,144	839

Figure VII.B1 (continued)

Program by Budget Agency	Date of Last Rate Increase (other than rate restoration)	Percent of Last Rate Increase (other than rate restoration)	Percent of Rate Reduction FY03-04	Percent of Rate Reduction Restored	Method of Determining Rate Change	Incremental Cost of 1 Percent Rate Increase			
						2008		2009	
						AF	GR	AF	GR
DSHS (continued)									
NorthSTAR -- Medicaid Inpatient Hospital -- Inflation only	9/1/2001	13.87%	5.00%	0.00%	BR	92,066	36,182	95,104	37,214
NorthSTAR -- Medicaid Inpatient Hospital -- Rebasing	9/1/2001	13.87%	5.00%	0.00%	BR	92,066	36,182	95,104	37,214
NorthSTAR -- MH Rehabilitative Services	8/31/2004	Converted to Program Resiliancy and Disease Management	0.00%	0.00%	CS	207,937	81,719	216,641	84,772
NorthSTAR -- MH Targeted Case Management	8/31/2004	Converted to Program Resiliancy and Disease Management	0.00%	0.00%	CS	57,225	22,489	61,639	24,120
NorthStar - Physician/ Professional Services	9/1/1999	1.50%	2.50%	0.00%	B	85,567	33,628	85,567	33,482
Total DSHS						**1,971,341**	**1,526,914**	**2,182,804**	**1,718,557**

Program by Budget Agency	Date of Last Rate Increase (other than rate restoration)	Percent of Last Rate Increase (other than rate restoration)	Percent of Rate Reduction FY03-04	Percent of Rate Reduction Restored	Method of Determining Rate Change	2008 AF	2008 GR	2009 AF	2009 GR
HHSC									
Ambulance Services	9/1/1999	1.50%	2.50%	0.00%	M	737,136	289,694	765,884	299,691
Ambulatory Surgical Center/Hospital Ambulatory Surgical Center	9/1/1995	Changed to Fee Schedule	2.50%	0.00%	M	2,857,569	1,123,025	2,918,825	1,142,136
Birthing Centers	9/1/1992	Changed to Fee Schedule	2.50%	0.00%	CD	5,355	2,105	5,578	2,183
Children & Pregnant Women - Case Management	1/1/1998	NA	2.50%	0.00%	B	16,330	6,418	17,465	6,834
CHIP (including perinate)	9/1/2006	10.70%	2.50%	0.00%	T	7,036,211	2,150,239	7,812,845	2,360,757

Figure VII.B1 (continued)

Program by Budget Agency	Date of Last Rate Increase (other than rate restoration)	Percent of Last Rate Increase (other than rate restoration)	Percent of Rate Reduction FY03-04	Percent of Rate Reduction Restored	Method of Determining Rate Change	Incremental Cost of 1 Percent Rate Increase			
						2008		2009	
						AF	GR	AF	GR
HHSC (continued)									
CHIP Dental	5/1/2006	New Contract	NA	NA	T	464,166	127,692	469,092	130,126
Clinical Lab. Fees - DSHS Lab - EPSDT	4/1/2006	28.00%	0.00%	0.00%	CS	4,739	1,863	6,199	2,426
Clinical Lab. Fees - DSHS Lab Newborn Screening	4/1/2006	6.00%	0.00%	0.00%	CS	1,667	655	1,808	708
Clinical Lab. Fees - Independent Labs.	FY 2002	NA	2.50%	0.00%	CD	1,227,628	482,458	1,628,821	637,358
Dental Services - THSteps - CCP	FY 2001	13.50%	2.50%	0.00%	A,CD	5,235,539	2,057,567	5,759,093	2,253,533
Drugs/Biological Fees	FY 2000	-2.80%	0.00%	0.00%	A,CD	714,490	280,794	725,524	283,898
Durable Medical Equipment, Prosthetics, Orthotics, Supplies	FY 2003	Various	0.00%	0.00%	CD	2,319,725	911,652	2,908,312	1,138,022
Federally Qualified Health Centers	Provider FYE 2006	Medicare Economic Index (MEI) or MEI+1.5%	0.00%	0.00%	CS	1,266,858	497,875	1,281,025	501,265
Genetic Services	9/1/1999	1.50%	2.50%	0.00%	CD	37,059	14,564	43,411	16,987
Home Health Services	11/1/2002	Change to Statewide Visit Rate	2.50%	0.00%	A,CD	1,280,356	503,180	1,391,321	544,424
Inpatient Hospital - SDA Inflation Only	9/1/2001	13.87%	5.00%	0.00%	BR	49,195,197	19,333,713	50,818,639	19,885,333
Inpatient Hospital - SDA Rebasing	9/1/2001	13.87%	5.00%	0.00%	BR	40,112,610	15,764,256	41,436,326	16,214,034
Maternity Centers	9/1/1999	1.50%	2.50%	0.00%	M	3,565	1,401	5,291	2,070
Outpatient Hospital	NA	NA	2.50%	0.00%	CD	4,771,181	1,875,074	5,177,059	2,025,783
Personal Care Services / THSteps-CCP	New service to begin 09/01/07 (Alberto N.)		0.00%	0.00%	B	817,833	321,408	836,622	327,370
Physician & Professional Services	9/1/1999	1.50%	2.50%	0.00%	CD	22,486,940	8,837,367	23,363,933	9,142,307

Figure VII.B1 (continued)

Program by Budget Agency	Date of Last Rate Increase (other than rate restoration)	Percent of Last Rate Increase (other than rate restoration)	Percent of Rate Reduction FY03-04	Percent of Rate Reduction Restored	Method of Determining Rate Change	Incremental Cost of 1 Percent Rate Increase			
						2008		2009	
						AF	GR	AF	GR
HHSC (continued)									
Private Duty Nursing/THSteps - CCP	9/15/1993	32.00%	2.50%	0.00%	B	1,552,201	610,015	1,957,593	766,006
Renal Dialysis Facilities	9/1/1999	NA	2.50%	0.00%	CD	296,111	116,372	298,285	116,719
Rural Health Clinics	FYE 2006	Medicare Economic Index (MEI) or MEI+1.5%	0.00%	0.00%	CD	1,269,298	498,834	1,292,505	505,757
STAR+PLUS -- Community Based Alternatives	9/1/2000	2.20%	1.10%	1.10%	B	1,902,274	747,594	2,061,432	806,638
STAR+PLUS -- Day Activity and Health Services	9/1/2002	1.30%	1.10%	1.10%	B	38,988	15,322	42,250	16,532
STAR+PLUS -- Primary Home Care	9/1/2000	1.20%	1.10%	1.10%	B	5,531,535	2,173,893	5,994,341	2,345,586
TB Clinics	9/1/1996	NA	0.00%	0.00%	CD	948	373	998	390
Total HHSC						**151,183,509**	**58,745,402**	**159,020,476**	**61,474,873**
Vendor Drug Dispensing Fees	FY 1997	15.82%	2.50%	0.00%	PA	The incremental cost of a $1 increase in the dispensing fee per prescription dispensed for FY 2008 is $27,485,420 and for FY 2009 is $28,759,622 All Funds. The impact of this increase is not included in the totals shown above for HHSC or below for HHS.			
Total HHS						**206,177,582**	**81,444,080**	**215,139,223**	**84,641,162**

note 1 $ 10,938,648 If TANF funding is available, up to $4,494,010 of this amount is eligible for TANF funding the remaining $6,444,638 must be GR

note 2 $ 11,669,020 If TANF funding is available, up to $4,801,735 of this amount is eligible for TANF funding the remaining $6,867,285 must be GR

B2. Rate Schedule – Rate Increase Based on Current Review of Costs

Figure VII.B2

Program by Budget Agency	Percentage Rate Change		Estimated Cost of Rate Change				Estimated Biennial Cost of Rate Change	
	2008	2009	2008		2009			
			AF	GR	AF	GR	AF	GR
DADS								
Access and Intake - Mental Retardation Service Coordination	0.00%	0.00%	0	0	0	0	0	0
Community Attendant Services	15.24%	15.24%	57,031,244	22,413,279	61,817,465	24,189,174	118,848,709	46,602,453
Community Based Alternatives	16.90%	16.90%	62,986,913	24,753,857	62,986,913	24,646,779	125,973,826	49,400,636
Community Living Assistance and Support Services	11.30%	11.30%	14,506,258	5,700,959	14,593,450	5,710,417	29,099,708	11,411,376
Consolidated Waiver Program	10.40%	10.40%	408,897	160,697	408,897	160,001	817,794	320,698
Day Activity and Health Services - Title XIX	5.00%	5.00%	4,898,002	1,924,915	5,066,531	1,982,534	9,964,533	3,907,448
Deaf-Blind Multiple Disabilities	10.50%	10.50%	761,174	299,141	761,174	297,847	1,522,348	596,989
Home and Community-based Services	9.56%	9.56%	46,028,580	18,093,835	46,028,580	18,001,778	92,057,160	36,095,613
Hospice Payments (NF Related Only)	19.38%	19.38%	32,429,672	12,744,861	35,310,327	13,816,931	67,739,999	26,561,792
Intermediate Care Facilities - Mental Retardation	21.59%	21.59%	73,957,024	29,065,110	73,957,024	28,939,383	147,914,048	58,004,494
Medically Dependent Children Program	29.90%	29.90%	11,714,960	4,603,979	11,714,960	4,584,064	23,429,920	9,188,043

Figure VII.B2 (continued)

Program by Budget Agency	Percentage Rate Change		Estimated Cost of Rate Change				Estimated Biennial Cost of Rate Change	
	2008	2009	2008		2009			
			AF	GR	AF	GR	AF	GR
DADS(continued)								
MR State Schools Services	Increased Operating Costs Included in DADS LAR							
Non-Medicaid Services - Title XX	16.74%	16.74%	12,333,368	12,333,368	12,333,368	12,333,368	24,666,736	24,666,736
Nursing Facility	19.38%	19.38%	436,474,039	171,534,297	435,382,162	170,365,040	871,856,201	341,899,337
Primary Home Care	15.33%	15.33%	59,737,999	23,477,034	61,226,180	23,957,804	120,964,179	47,434,838
Program of All-inclusive Care for the Elderly	4.45%	4.45%	1,305,571	513,089	1,305,571	510,870	2,611,142	1,023,959
Promoting Independence Services	17.31%	17.31%	15,638,864	6,146,074	16,731,012	6,546,845	32,369,876	12,692,919
Texas Home Living Waiver	27.12%	27.12%	3,252,465	1,278,544	3,252,465	1,272,039	6,504,930	2,550,583
Total DADS			**833,465,030**	**335,043,039**	**842,876,079**	**337,314,875**	**1,676,341,109**	**672,357,914**

Program by Budget Agency	2008	2009	2008 AF	2008 GR	2009 AF	2009 GR	Biennial AF	Biennial GR
DARS								
ECI - Case Mgmt.	0.00%	0.00%	0	0	0	0	0	0
ECI - Development Rehab Svcs.	0.00%	0.00%	0	0	0	0	0	0
Total DARS			**0**	**0**	**0**	**0**	**0**	**0**

Program by Budget Agency	2008	2009	2008 AF	2008 GR	2009 AF	2009 GR	Biennial AF	Biennial GR
DFPS								
24-Hr. Residential Child Care (Foster Care)	3.99%	3.99%	17,549,710	6,444,638	18,767,707	6,921,387	36,317,417	13,366,025 See note 3
Total DFPS			**17,549,710**	**6,444,638**	**18,767,707**	**6,921,387**	**36,317,417**	**13,366,025**

Figure VII.B2 (continued)

Program by Budget Agency	Percentage Rate Change		Estimated Cost of Rate Change				Estimated Biennial Cost of Rate Change	
	2008	2009	2008		2009			
			AF	GR	AF	GR	AF	GR
DSHS								
Children with Special Health Care Needs (CSHCN) - Outpatient Hospital	23.93%	23.93%	773,394	773,394	1,054,314	1,054,314	1,827,708	1,827,708
CSHCN - Ambulance Services	167.68%	167.68%	152,364	152,364	281,032	281,032	433,396	433,396
CSHCN - ASCs/HASCs	7.95%	7.95%	17,129	17,129	20,340	20,340	37,469	37,469
CSHCN - Dental Services	10.00%	10.00%	43,068	43,068	52,113	52,113	95,181	95,181
CSHCN - Drugs/Biological Fees	4.40%	4.40%	426,962	426,962	490,323	490,323	917,285	917,285
CSHCN - Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS)	7.55%	7.55%	231,356	231,356	273,705	273,705	505,061	505,061
CSHCN - Home Health Agencies (Therapies)	8.41%	8.41%	450	450	537	537	987	987
CSHCN - Inpatient Hospital - SDA Inflation Only	16.78%	16.78%	2,198,851	2,198,851	2,824,600	2,824,600	5,023,451	5,023,451
CSHCN - Inpatient Hospital Rebasing	20.78%	20.78%	2,723,011	2,723,011	3,617,738	3,617,738	6,340,749	6,340,749
CSHCN - Meals, Transportation, Lodging	3.90%	3.90%	52,706	52,706	60,238	60,238	112,944	112,944

Figure VII.B2 (continued)

Program by Budget Agency	Percentage Rate Change		Estimated Cost of Rate Change				Estimated Biennial Cost of Rate Change	
	2008	2009	2008		2009			
			AF	GR	AF	GR	AF	GR
DSHS (continued)								
CSHCN - Physician/ Professional Services	2.50%	5.00%	137,814	137,814	303,190	303,190	441,004	441,004
CSHCN - Private Duty Nursing	70.15%	70.15%	362,864	362,864	679,154	679,154	1,042,018	1,042,018
Family Planning - DMEPOS	7.55%	7.55%	27,510	27,510	30,741	30,741	58,251	58,251
Family Planning - Drugs/Biologicals	645.71%	645.71%	42,027,843	42,027,843	43,666,929	43,666,929	85,694,772	85,694,772
Family Planning - FQHCs	4.23%	4.23%	53,143	53,143	57,551	57,551	110,694	110,694
Family Planning - Maternity Service Clinics	52.70%	52.70%	1,322,655	1,322,655	2,098,462	2,098,462	3,421,117	3,421,117
Family Planning - Outpatient Hospital	23.93%	23.93%	21,634	21,634	23,016	23,016	44,650	44,650
Family Planning - Physician Services	2.50%	5.00%	1,208,895	1,208,895	2,512,084	2,512,084	3,720,979	3,720,979
Family Planning - RHCs	4.23%	4.23%	902	902	977	977	1,879	1,879
Institutions for Mental Disease	10.06%	10.06%	431,184	169,455	433,906	169,788	865,090	339,243
Maternal and Child Health - Genetics	17.14%	17.14%	242,570	242,570	312,561	312,561	555,131	555,131

Figure VII.B2 (continued)

Program by Budget Agency	Percentage Rate Change		Estimated Cost of Rate Change				Estimated Biennial Cost of Rate Change	
	2008	2009	2008		2009			
			AF	GR	AF	GR	AF	GR
DSHS (continued)								
Maternal and Child Health - Physician Services	2.50%	5.00%	326,590	326,590	718,499	718,499	1,045,089	1,045,089
MH Rehabilitative Services	0.93%	0.93%	334,357	131,402	348,353	136,311	682,710	267,713
MH Targeted Case Management	106.17%	106.17%	12,409,064	4,876,762	13,366,409	5,230,276	25,775,473	10,107,038
NorthSTAR -- Medicaid Clinical Laboratory Fees - Independent Laboratories	15.80%	15.80%	25,532	10,034	33,876	13,256	59,407	23,289
NorthSTAR -- Medicaid Inpatient Hospital -- Inflation only	16.78%	16.78%	1,544,867	607,133	1,595,847	624,455	3,140,714	1,231,588
NorthSTAR -- Medicaid Inpatient Hospital -- Rebasing	20.78%	20.78%	1,913,131	751,860	1,976,264	773,312	3,889,395	1,525,172
NorthSTAR -- MH Rehabilitative Services	0.93%	0.93%	193,381	75,999	201,476	78,838	394,858	154,837
NorthSTAR -- MH Targeted Case Management	106.17%	106.17%	6,075,539	2,387,687	6,544,260	2,560,769	12,619,800	4,948,456
NorthStar - Physician/ Professional Services	2.50%	5.00%	213,918	84,070	427,836	167,412	641,754	251,482
Total DSHS			**75,492,684**	**61,446,113**	**84,006,331**	**68,832,519**	**159,499,015**	**130,278,633**

Figure VII.B2 (continued)

Program by Budget Agency	Percentage Rate Change		Estimated Cost of Rate Change				Estimated Biennial Cost of Rate Change	
	2008	2009	2008		2009			
			AF	GR	AF	GR	AF	GR
HHSC								
Ambulance Services	167.68%	167.68%	123,602,962	48,575,964	128,423,477	50,252,107	252,026,439	98,828,071
Ambulatory Surgical Center/Hospital Ambulatory Surgical Center	7.95%	7.95%	22,717,673	8,928,046	23,204,658	9,079,983	45,922,331	18,008,028
Birthing Centers	18.75%	18.75%	100,415	39,463	104,581	40,923	204,996	80,386
Children & Pregnant Women - Case Management	60.99%	60.99%	995,982	391,421	1,065,203	416,814	2,061,185	808,235
CHIP (including perinate)	Trend	Trend						
CHIP Dental								
Clinical Lab. Fees - DSHS Lab - EPSDT	30.08%	30.08%	142,559	56,026	186,468	72,965	329,027	128,991
Clinical Lab. Fees - DSHS Lab Newborn Screening	8.48%	8.48%	14,137	5,556	15,336	6,001	29,473	11,557
Clinical Lab. Fees - Independent Labs.	15.80%	15.80%	19,396,519	7,622,832	25,735,371	10,070,251	45,131,890	17,693,083
Dental Services - THSteps - CCP	10.00%	10.00%	52,355,388	20,575,667	57,590,927	22,535,330	109,946,315	43,110,997
Drugs/Biological Fees	4.40%	4.40%	3,143,754	1,235,495	3,192,307	1,249,150	6,336,061	2,484,645
Durable Medical Equipment, Prosthetics, Orthotics, Supplies	7.55%	7.55%	17,513,920	6,882,971	21,957,754	8,592,069	39,471,674	15,475,040
Federally Qualified Health Centers	4.23%	4.23%	5,358,811	2,106,013	5,418,735	2,120,351	10,777,546	4,226,364
Genetic Svcs.	17.14%	17.14%	635,189	249,629	744,060	291,151	1,379,249	540,780

Figure VII.B2 (continued)

Program by Budget Agency	Percentage Rate Change		Estimated Cost of Rate Change				Estimated Biennial Cost of Rate Change	
	2008	2009	2008		2009			
			AF	GR	AF	GR	AF	GR
HHSC (continued)								
Home Health Services	8.41%	8.41%	10,767,793	4,231,743	11,701,009	4,578,605	22,468,802	8,810,347
Inpatient Hospital - SDA Inflation Only	16.78%	16.78%	825,495,412	324,419,697	852,736,761	333,675,894	1,678,232,172	658,095,591
Inpatient Hospital - SDA Rebasing	20.78%	20.78%	833,540,040	327,581,236	861,046,861	336,927,637	1,694,586,900	664,508,872
Maternity Centers	52.70%	52.70%	187,870	73,833	278,827	109,105	466,697	182,938
Outpatient Hospital	23.93%	23.93%	114,174,354	44,870,521	123,887,020	48,476,991	238,061,374	93,347,512
Personal Care Services / THSteps-CCP	46.05%	46.05%	37,661,211	14,800,856	38,526,444	15,075,398	76,187,655	29,876,253
Physician & Professional Services	2.50%	5.00%	56,217,350	22,093,419	116,819,667	45,711,536	173,037,017	67,804,954
Private Duty Nursing/THSteps - CCP	70.15%	70.15%	108,886,884	42,792,545	137,325,117	53,735,318	246,212,001	96,527,864
Renal Dialysis Facilities	6.01%	6.01%	1,779,628	699,394	1,792,693	701,481	3,572,321	1,400,875
Rural Health Clinics	4.23%	4.23%	5,369,130	2,110,068	5,467,295	2,139,353	10,836,425	4,249,421
STAR+PLUS -- Community Based Alternatives	16.90%	16.90%	32,148,437	12,634,336	34,838,195	13,632,186	66,986,632	26,266,522
STAR+PLUS -- Day Activity and Health Services	5.00%	5.00%	597,687	234,891	647,694	253,443	1,245,381	488,334
STAR+PLUS -- Primary Home Care	15.33%	15.33%	27,657,675	10,869,466	29,971,705	11,727,928	57,629,379	22,597,394
TB Clinics	3.51%	3.51%	3,327	1,308	3,502	1,370	6,829	2,678
Total HHSC			**2,300,464,107**	**904,082,394**	**2,482,681,667**	**971,473,336**	**4,783,145,774**	**1,875,555,730**

Vendor Drug Dispensing Fees	The incremental cost of a $1 increase in the dispensing fee per prescription dispensed for FY 2008 is $27,485,420 and for FY 2009 is $28,759,622. The impact of this increase is not included in the totals shown below above for HHSC or below for HHS.

Total HHS			**3,210,036,307**	**1,300,355,713**	**3,411,396,560**	**1,377,925,220**	**6,621,432,867**	**2,678,280,934**

note 3 If TANF funding is available, up to $2,328,647 of this amount is eligible for TANF funding the remaining $3,335,417 must be General Revenue

B3. Rate Schedule – Comparison of Select Physician Fees

Figure VII.B3

Comparison of Select Physician Fees

Procedure Description	Current Medicaid Rate	2006 Medicare Nonfacility Rate	Medicaid as % of Medicare	Estimated Private Payer	Medicaid as % of Private Payer
New Patient Office Visit	$47.07	$97.02	48.52%	$107.28	43.82%
Established Patient Office Visit	$28.78	$54.68	52.64%	$59.17	48.64%
Circumcision	$49.48	$241.89	20.46%	$569.51	8.69%
Vaginal Delivery with postpartum care	$692.74	$933.90	74.18%	$1,832.70	37.80%
Cesarean Delivery with postpartum care	$706.87	$1,112.78	63.52%	$2,187.59	32.31%
Eye Exam	$35.63	$67.18	53.03%	$101.07	62.33%
Femoral (leg, above knee) Fracture	$946.48	$1,115.05	84.88%	$2,227.45	42.49%
Coronary Artery Bypass	$1,647.74	$1,933.53	85.22%	$3,748.95	42.85%
Upper GI Endoscopy	$207.84	$334.26	62.18%	$703.65	28.80%
Colonoscopy	$148.93	$384.66	38.72%	$914.43	24.66%
First Vaccine Administration	$5.00	$10.99	45.50%	$9.37	53.36%
New patient under 1 year	$70.00	$103.84	67.41%	Not Available	Not Available
New patient 1-4 years	$70.00	$111.80	62.61%	Not Available	Not Available
New patient 5-11 years	$70.00	$109.52	63.92%	Not Available	Not Available
New patient 12-17 years	$70.00	$119.00	58.82%	Not Available	Not Available
Established patient under 1	$70.00	$78.83	88.80%	Not Available	Not Available
Established patient 1-4	$70.00	$88.30	79.28%	Not Available	Not Available
Established patient 5-11	$70.00	$87.16	80.31%	Not Available	Not Available
Established patient 12-17	$70.00	$96.26	72.72%	Not Available	Not Available

B4. Rate Schedule – Comparison of Select Ambulance Fees

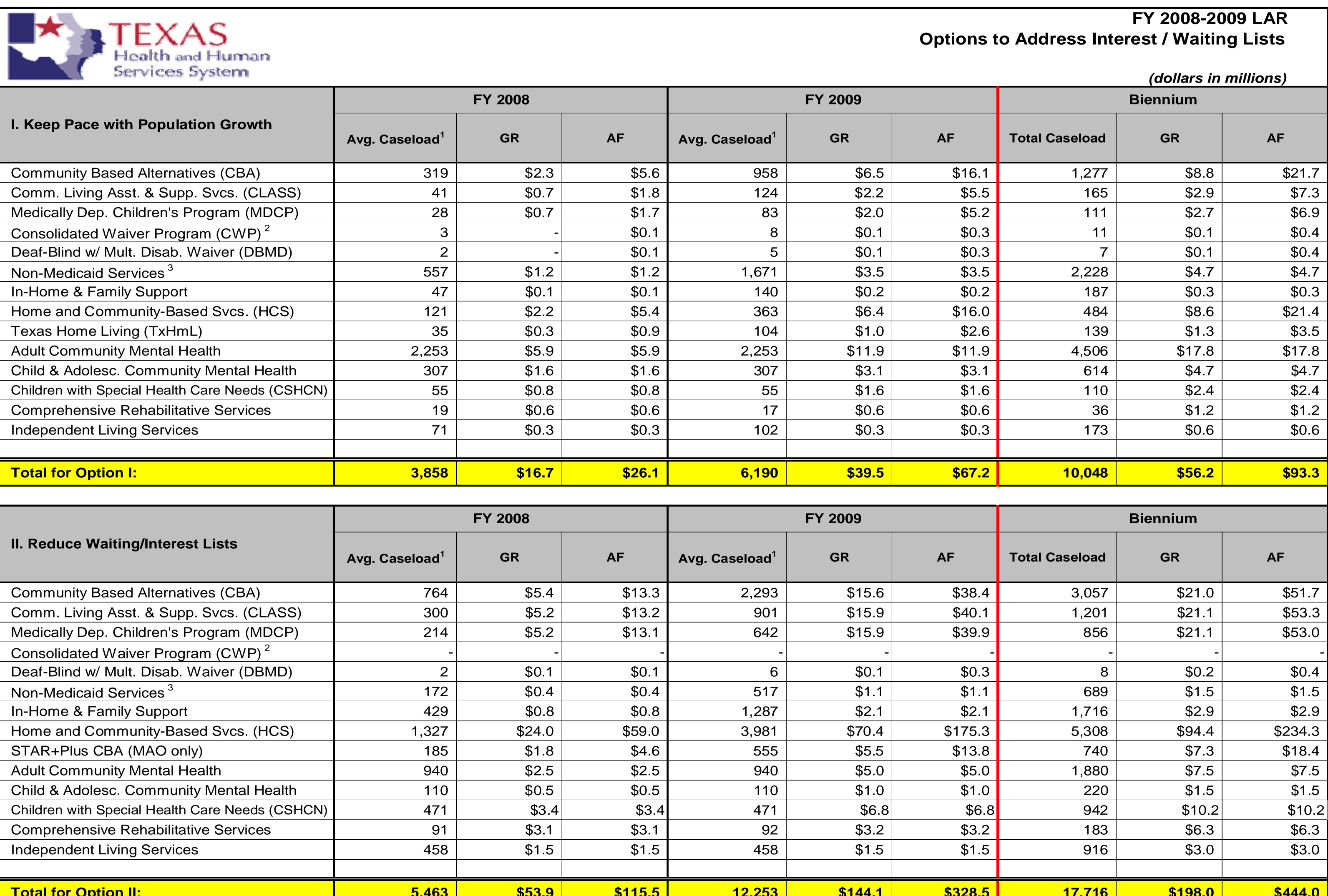
Figure VII.B4

Comparison of Select Ambulance Fees

Procedure Description	Current Medicaid Fee	Medicaid Average Payment	2006 Medicare Urban Average Payment	% Medicaid to 2006 Medicare Urban Average	2006 Medicare Rural Average Payment	% Medicaid to 2006 Medicare Rural Average
Ground mileage, per statute mile - ground ambulance	$3.30		$6.05	54.55%	$6.11	54.01%
Ambulance service, basic life support, nonemergency transport (BLS) - ground ambulance		$53.26	$198.17	26.88%	$200.13	26.61%
Ambulance service, basic life support, emergency transport (BLS - emergency) - ground ambulance		$116.36	$317.08	36.70%	$320.21	36.34%
Ambulance service, conventional air services, transport, one way (fixed wing) - air ambulance	$1,140.08		$2,489.18	45.80%	$3,733.76	30.53%
Ambulance service, conventional air services, transport, one way (rotary wing) - air ambulance	$609.00		$2,894.03	21.04%	$4,341.04	14.03%
Fixed wing air mileage, per statute mile - air ambulance	$16.24		$7.18	226.18%	$10.76	150.93%
Rotary wing air mileage, per status mile - air ambulance	$16.24		$19.14	84.85%	$28.71	56.57%

C. Waiting / Interest List Detail

Figure VII.C1



FY 2008-2009 LAR
Options to Address Interest / Waiting Lists

(dollars in millions)

I. Keep Pace with Population Growth	FY 2008			FY 2009			Biennium		
	Avg. Caseload[1]	GR	AF	Avg. Caseload[1]	GR	AF	Total Caseload	GR	AF
Community Based Alternatives (CBA)	319	$2.3	$5.6	958	$6.5	$16.1	1,277	$8.8	$21.7
Comm. Living Asst. & Supp. Svcs. (CLASS)	41	$0.7	$1.8	124	$2.2	$5.5	165	$2.9	$7.3
Medically Dep. Children's Program (MDCP)	28	$0.7	$1.7	83	$2.0	$5.2	111	$2.7	$6.9
Consolidated Waiver Program (CWP)[2]	3	-	$0.1	8	$0.1	$0.3	11	$0.1	$0.4
Deaf-Blind w/ Mult. Disab. Waiver (DBMD)	2	-	$0.1	5	$0.1	$0.3	7	$0.1	$0.4
Non-Medicaid Services[3]	557	$1.2	$1.2	1,671	$3.5	$3.5	2,228	$4.7	$4.7
In-Home & Family Support	47	$0.1	$0.1	140	$0.2	$0.2	187	$0.3	$0.3
Home and Community-Based Svcs. (HCS)	121	$2.2	$5.4	363	$6.4	$16.0	484	$8.6	$21.4
Texas Home Living (TxHmL)	35	$0.3	$0.9	104	$1.0	$2.6	139	$1.3	$3.5
Adult Community Mental Health	2,253	$5.9	$5.9	2,253	$11.9	$11.9	4,506	$17.8	$17.8
Child & Adolesc. Community Mental Health	307	$1.6	$1.6	307	$3.1	$3.1	614	$4.7	$4.7
Children with Special Health Care Needs (CSHCN)	55	$0.8	$0.8	55	$1.6	$1.6	110	$2.4	$2.4
Comprehensive Rehabilitative Services	19	$0.6	$0.6	17	$0.6	$0.6	36	$1.2	$1.2
Independent Living Services	71	$0.3	$0.3	102	$0.3	$0.3	173	$0.6	$0.6
Total for Option I:	**3,858**	**$16.7**	**$26.1**	**6,190**	**$39.5**	**$67.2**	**10,048**	**$56.2**	**$93.3**

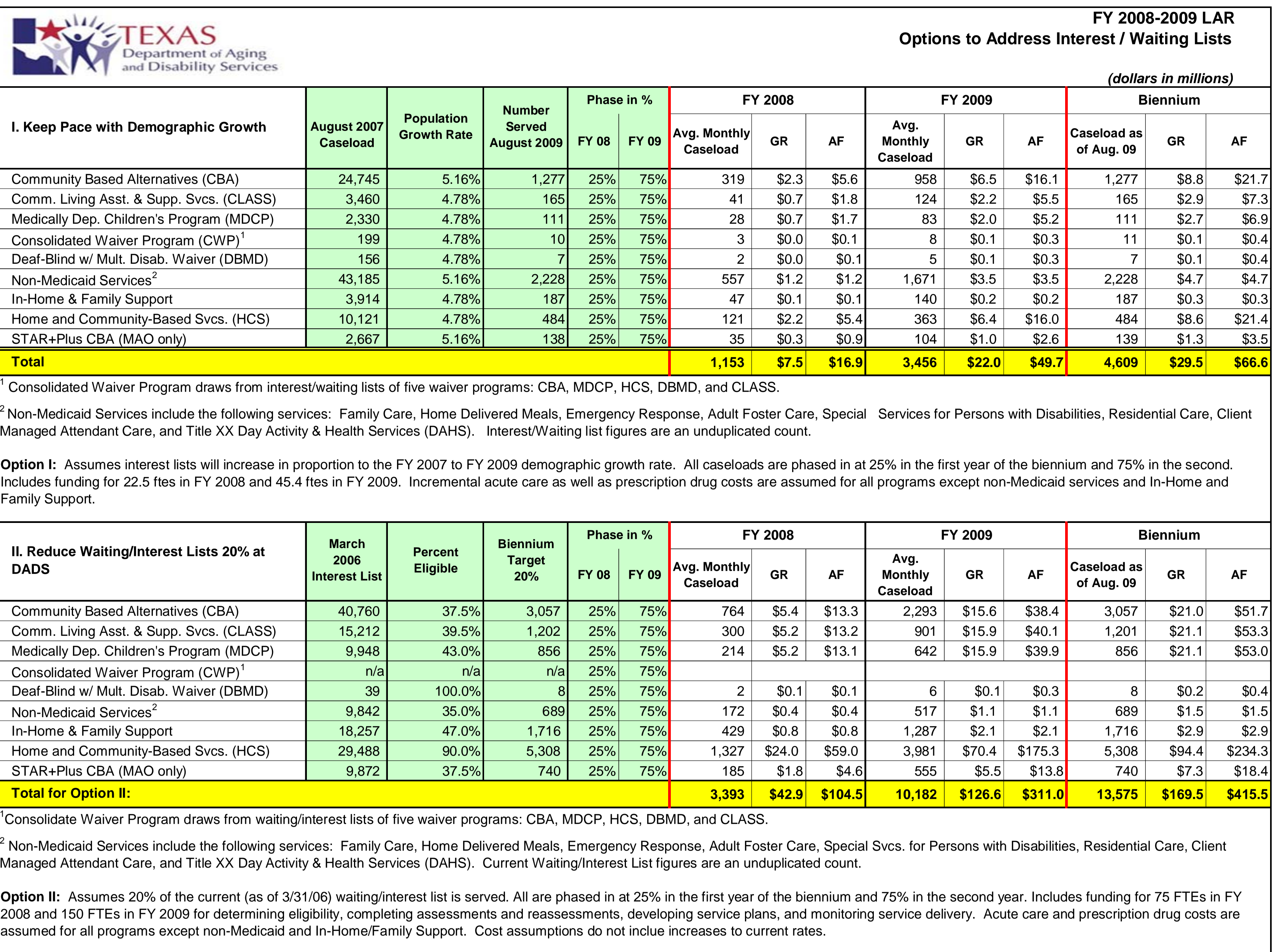
II. Reduce Waiting/Interest Lists	FY 2008			FY 2009			Biennium		
	Avg. Caseload[1]	GR	AF	Avg. Caseload[1]	GR	AF	Total Caseload	GR	AF
Community Based Alternatives (CBA)	764	$5.4	$13.3	2,293	$15.6	$38.4	3,057	$21.0	$51.7
Comm. Living Asst. & Supp. Svcs. (CLASS)	300	$5.2	$13.2	901	$15.9	$40.1	1,201	$21.1	$53.3
Medically Dep. Children's Program (MDCP)	214	$5.2	$13.1	642	$15.9	$39.9	856	$21.1	$53.0
Consolidated Waiver Program (CWP)[2]	-	-	-	-	-	-	-	-	-
Deaf-Blind w/ Mult. Disab. Waiver (DBMD)	2	$0.1	$0.1	6	$0.1	$0.3	8	$0.2	$0.4
Non-Medicaid Services[3]	172	$0.4	$0.4	517	$1.1	$1.1	689	$1.5	$1.5
In-Home & Family Support	429	$0.8	$0.8	1,287	$2.1	$2.1	1,716	$2.9	$2.9
Home and Community-Based Svcs. (HCS)	1,327	$24.0	$59.0	3,981	$70.4	$175.3	5,308	$94.4	$234.3
STAR+Plus CBA (MAO only)	185	$1.8	$4.6	555	$5.5	$13.8	740	$7.3	$18.4
Adult Community Mental Health	940	$2.5	$2.5	940	$5.0	$5.0	1,880	$7.5	$7.5
Child & Adolesc. Community Mental Health	110	$0.5	$0.5	110	$1.0	$1.0	220	$1.5	$1.5
Children with Special Health Care Needs (CSHCN)	471	$3.4	$3.4	471	$6.8	$6.8	942	$10.2	$10.2
Comprehensive Rehabilitative Services	91	$3.1	$3.1	92	$3.2	$3.2	183	$6.3	$6.3
Independent Living Services	458	$1.5	$1.5	458	$1.5	$1.5	916	$3.0	$3.0
Total for Option II:	**5,463**	**$53.9**	**$115.5**	**12,253**	**$144.1**	**$328.5**	**17,716**	**$198.0**	**$444.0**

[1] Average Caseload is an average monthly figure except for Adult Community Mental Health, Child and Adolescent Community Mental Health, Children with Special Health Care Needs, Comprehensive Rehabilitative Services, and Independent Living Services, for which Average Caseload is an annual figure.

[2] CWP draws from waiting/interest lists of five waiver programs: CBA, MDCP, HCS, DBMD, and CLASS.

[3] Non-Medicaid Services include these Title XX and GR funded services: Family Care, Home Delivered Meals, Emergency Response, Adult Foster Care, Special Svcs. for Persons with Disabilities, Residential Care, Client Managed Attendant Care, and Title XX Day Activity & Health Services (DAHS).

Figure VII.C1 (continued)



FY 2008-2009 LAR
Options to Address Interest / Waiting Lists

TEXAS Department of Aging and Disability Services

(dollars in millions)

I. Keep Pace with Demographic Growth	August 2007 Caseload	Population Growth Rate	Number Served August 2009	Phase in %		FY 2008			FY 2009			Biennium		
				FY 08	FY 09	Avg. Monthly Caseload	GR	AF	Avg. Monthly Caseload	GR	AF	Caseload as of Aug. 09	GR	AF
Community Based Alternatives (CBA)	24,745	5.16%	1,277	25%	75%	319	$2.3	$5.6	958	$6.5	$16.1	1,277	$8.8	$21.7
Comm. Living Asst. & Supp. Svcs. (CLASS)	3,460	4.78%	165	25%	75%	41	$0.7	$1.8	124	$2.2	$5.5	165	$2.9	$7.3
Medically Dep. Children's Program (MDCP)	2,330	4.78%	111	25%	75%	28	$0.7	$1.7	83	$2.0	$5.2	111	$2.7	$6.9
Consolidated Waiver Program (CWP)[1]	199	4.78%	10	25%	75%	3	$0.0	$0.1	8	$0.1	$0.3	11	$0.1	$0.4
Deaf-Blind w/ Mult. Disab. Waiver (DBMD)	156	4.78%	7	25%	75%	2	$0.0	$0.1	5	$0.1	$0.3	7	$0.1	$0.4
Non-Medicaid Services[2]	43,185	5.16%	2,228	25%	75%	557	$1.2	$1.2	1,671	$3.5	$3.5	2,228	$4.7	$4.7
In-Home & Family Support	3,914	4.78%	187	25%	75%	47	$0.1	$0.1	140	$0.2	$0.2	187	$0.3	$0.3
Home and Community-Based Svcs. (HCS)	10,121	4.78%	484	25%	75%	121	$2.2	$5.4	363	$6.4	$16.0	484	$8.6	$21.4
STAR+Plus CBA (MAO only)	2,667	5.16%	138	25%	75%	35	$0.3	$0.9	104	$1.0	$2.6	139	$1.3	$3.5
Total						**1,153**	**$7.5**	**$16.9**	**3,456**	**$22.0**	**$49.7**	**4,609**	**$29.5**	**$66.6**

[1] Consolidated Waiver Program draws from interest/waiting lists of five waiver programs: CBA, MDCP, HCS, DBMD, and CLASS.

[2] Non-Medicaid Services include the following services: Family Care, Home Delivered Meals, Emergency Response, Adult Foster Care, Special Services for Persons with Disabilities, Residential Care, Client Managed Attendant Care, and Title XX Day Activity & Health Services (DAHS). Interest/Waiting list figures are an unduplicated count.

Option I: Assumes interest lists will increase in proportion to the FY 2007 to FY 2009 demographic growth rate. All caseloads are phased in at 25% in the first year of the biennium and 75% in the second. Includes funding for 22.5 ftes in FY 2008 and 45.4 ftes in FY 2009. Incremental acute care as well as prescription drug costs are assumed for all programs except non-Medicaid services and In-Home and Family Support.

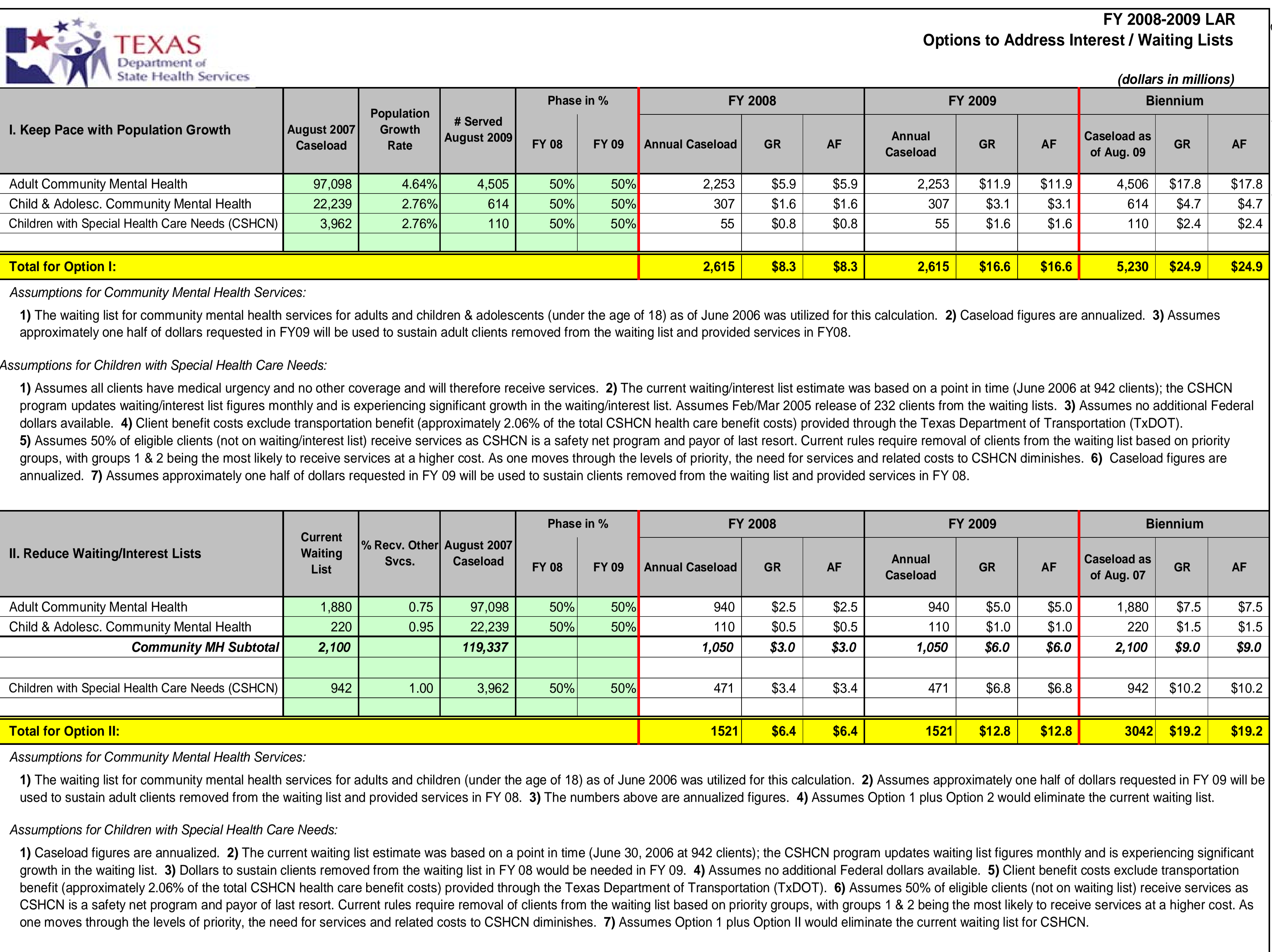
II. Reduce Waiting/Interest Lists 20% at DADS	March 2006 Interest List	Percent Eligible	Biennium Target 20%	Phase in %		FY 2008			FY 2009			Biennium		
				FY 08	FY 09	Avg. Monthly Caseload	GR	AF	Avg. Monthly Caseload	GR	AF	Caseload as of Aug. 09	GR	AF
Community Based Alternatives (CBA)	40,760	37.5%	3,057	25%	75%	764	$5.4	$13.3	2,293	$15.6	$38.4	3,057	$21.0	$51.7
Comm. Living Asst. & Supp. Svcs. (CLASS)	15,212	39.5%	1,202	25%	75%	300	$5.2	$13.2	901	$15.9	$40.1	1,201	$21.1	$53.3
Medically Dep. Children's Program (MDCP)	9,948	43.0%	856	25%	75%	214	$5.2	$13.1	642	$15.9	$39.9	856	$21.1	$53.0
Consolidated Waiver Program (CWP)[1]	n/a	n/a	n/a	25%	75%									
Deaf-Blind w/ Mult. Disab. Waiver (DBMD)	39	100.0%	8	25%	75%	2	$0.1	$0.1	6	$0.1	$0.3	8	$0.2	$0.4
Non-Medicaid Services[2]	9,842	35.0%	689	25%	75%	172	$0.4	$0.4	517	$1.1	$1.1	689	$1.5	$1.5
In-Home & Family Support	18,257	47.0%	1,716	25%	75%	429	$0.8	$0.8	1,287	$2.1	$2.1	1,716	$2.9	$2.9
Home and Community-Based Svcs. (HCS)	29,488	90.0%	5,308	25%	75%	1,327	$24.0	$59.0	3,981	$70.4	$175.3	5,308	$94.4	$234.3
STAR+Plus CBA (MAO only)	9,872	37.5%	740	25%	75%	185	$1.8	$4.6	555	$5.5	$13.8	740	$7.3	$18.4
Total for Option II:						**3,393**	**$42.9**	**$104.5**	**10,182**	**$126.6**	**$311.0**	**13,575**	**$169.5**	**$415.5**

[1]Consolidate Waiver Program draws from waiting/interest lists of five waiver programs: CBA, MDCP, HCS, DBMD, and CLASS.

[2] Non-Medicaid Services include the following services: Family Care, Home Delivered Meals, Emergency Response, Adult Foster Care, Special Svcs. for Persons with Disabilities, Residential Care, Client Managed Attendant Care, and Title XX Day Activity & Health Services (DAHS). Current Waiting/Interest List figures are an unduplicated count.

Option II: Assumes 20% of the current (as of 3/31/06) waiting/interest list is served. All are phased in at 25% in the first year of the biennium and 75% in the second year. Includes funding for 75 FTEs in FY 2008 and 150 FTEs in FY 2009 for determining eligibility, completing assessments and reassessments, developing service plans, and monitoring service delivery. Acute care and prescription drug costs are assumed for all programs except non-Medicaid and In-Home/Family Support. Cost assumptions do not inclue increases to current rates.

Figure VII.C1 (continued)



TEXAS Department of State Health Services

FY 2008-2009 LAR
Options to Address Interest / Waiting Lists

(dollars in millions)

I. Keep Pace with Population Growth	August 2007 Caseload	Population Growth Rate	# Served August 2009	Phase in %		FY 2008			FY 2009			Biennium		
				FY 08	FY 09	Annual Caseload	GR	AF	Annual Caseload	GR	AF	Caseload as of Aug. 09	GR	AF
Adult Community Mental Health	97,098	4.64%	4,505	50%	50%	2,253	$5.9	$5.9	2,253	$11.9	$11.9	4,506	$17.8	$17.8
Child & Adolesc. Community Mental Health	22,239	2.76%	614	50%	50%	307	$1.6	$1.6	307	$3.1	$3.1	614	$4.7	$4.7
Children with Special Health Care Needs (CSHCN)	3,962	2.76%	110	50%	50%	55	$0.8	$0.8	55	$1.6	$1.6	110	$2.4	$2.4
Total for Option I:						**2,615**	**$8.3**	**$8.3**	**2,615**	**$16.6**	**$16.6**	**5,230**	**$24.9**	**$24.9**

Assumptions for Community Mental Health Services:

1) The waiting list for community mental health services for adults and children & adolescents (under the age of 18) as of June 2006 was utilized for this calculation. **2)** Caseload figures are annualized. **3)** Assumes approximately one half of dollars requested in FY09 will be used to sustain adult clients removed from the waiting list and provided services in FY08.

Assumptions for Children with Special Health Care Needs:

1) Assumes all clients have medical urgency and no other coverage and will therefore receive services. **2)** The current waiting/interest list estimate was based on a point in time (June 2006 at 942 clients); the CSHCN program updates waiting/interest list figures monthly and is experiencing significant growth in the waiting/interest list. Assumes Feb/Mar 2005 release of 232 clients from the waiting lists. **3)** Assumes no additional Federal dollars available. **4)** Client benefit costs exclude transportation benefit (approximately 2.06% of the total CSHCN health care benefit costs) provided through the Texas Department of Transportation (TxDOT).
5) Assumes 50% of eligible clients (not on waiting/interest list) receive services as CSHCN is a safety net program and payor of last resort. Current rules require removal of clients from the waiting list based on priority groups, with groups 1 & 2 being the most likely to receive services at a higher cost. As one moves through the levels of priority, the need for services and related costs to CSHCN diminishes. **6)** Caseload figures are annualized. **7)** Assumes approximately one half of dollars requested in FY 09 will be used to sustain clients removed from the waiting list and provided services in FY 08.

II. Reduce Waiting/Interest Lists	Current Waiting List	% Recv. Other Svcs.	August 2007 Caseload	Phase in %		FY 2008			FY 2009			Biennium		
				FY 08	FY 09	Annual Caseload	GR	AF	Annual Caseload	GR	AF	Caseload as of Aug. 07	GR	AF
Adult Community Mental Health	1,880	0.75	97,098	50%	50%	940	$2.5	$2.5	940	$5.0	$5.0	1,880	$7.5	$7.5
Child & Adolesc. Community Mental Health	220	0.95	22,239	50%	50%	110	$0.5	$0.5	110	$1.0	$1.0	220	$1.5	$1.5
Community MH Subtotal	***2,100***		***119,337***			***1,050***	***$3.0***	***$3.0***	***1,050***	***$6.0***	***$6.0***	***2,100***	***$9.0***	***$9.0***
Children with Special Health Care Needs (CSHCN)	942	1.00	3,962	50%	50%	471	$3.4	$3.4	471	$6.8	$6.8	942	$10.2	$10.2
Total for Option II:						**1521**	**$6.4**	**$6.4**	**1521**	**$12.8**	**$12.8**	**3042**	**$19.2**	**$19.2**

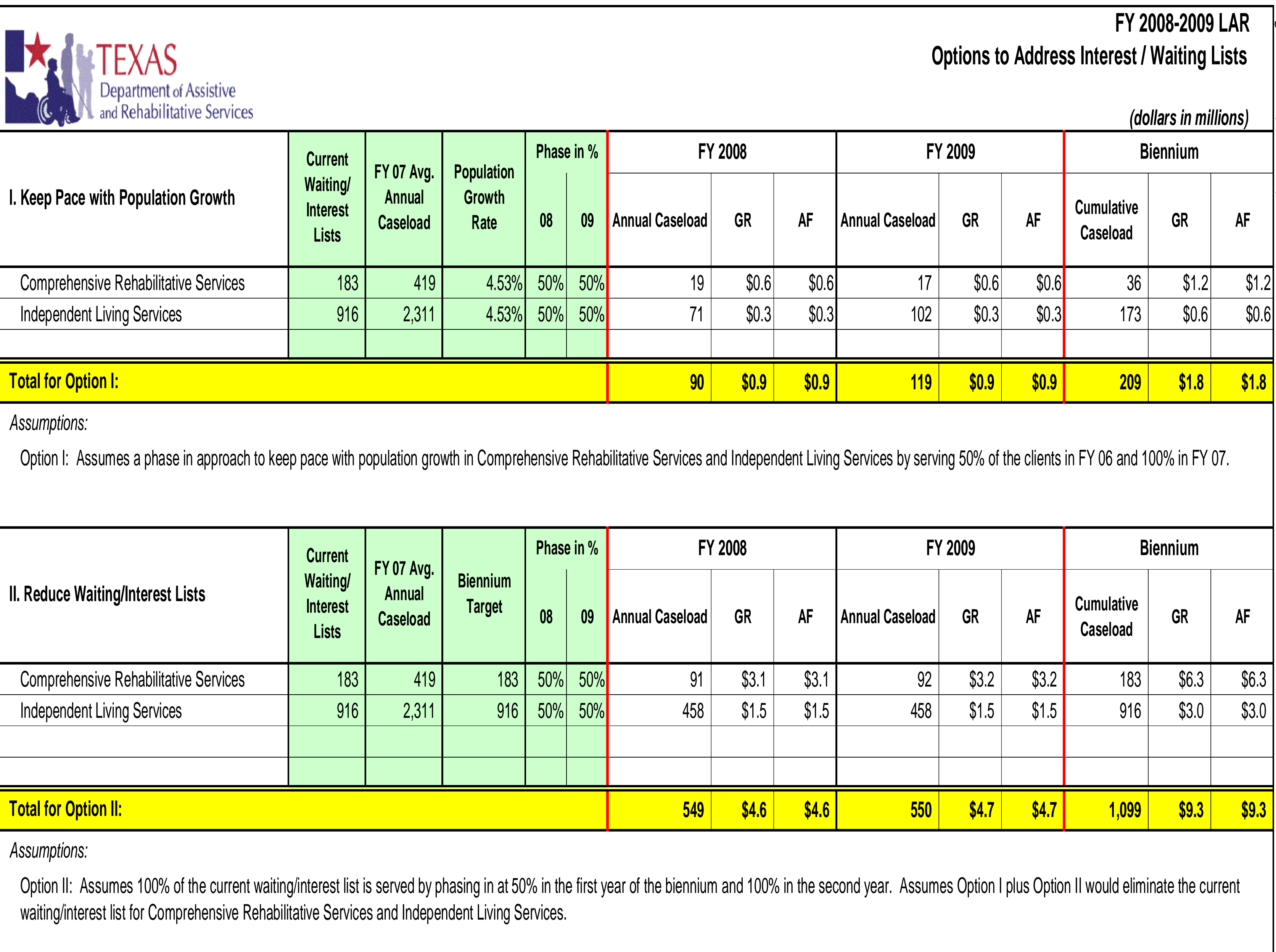
Assumptions for Community Mental Health Services:

1) The waiting list for community mental health services for adults and children (under the age of 18) as of June 2006 was utilized for this calculation. **2)** Assumes approximately one half of dollars requested in FY 09 will be used to sustain adult clients removed from the waiting list and provided services in FY 08. **3)** The numbers above are annualized figures. **4)** Assumes Option 1 plus Option 2 would eliminate the current waiting list.

Assumptions for Children with Special Health Care Needs:

1) Caseload figures are annualized. **2)** The current waiting list estimate was based on a point in time (June 30, 2006 at 942 clients); the CSHCN program updates waiting list figures monthly and is experiencing significant growth in the waiting list. **3)** Dollars to sustain clients removed from the waiting list in FY 08 would be needed in FY 09. **4)** Assumes no additional Federal dollars available. **5)** Client benefit costs exclude transportation benefit (approximately 2.06% of the total CSHCN health care benefit costs) provided through the Texas Department of Transportation (TxDOT). **6)** Assumes 50% of eligible clients (not on waiting list) receive services as CSHCN is a safety net program and payor of last resort. Current rules require removal of clients from the waiting list based on priority groups, with groups 1 & 2 being the most likely to receive services at a higher cost. As one moves through the levels of priority, the need for services and related costs to CSHCN diminishes. **7)** Assumes Option 1 plus Option II would eliminate the current waiting list for CSHCN.

Figure VII.C1 (continued)



TEXAS Department of Assistive and Rehabilitative Services

FY 2008-2009 LAR

Options to Address Interest / Waiting Lists

(dollars in millions)

I. Keep Pace with Population Growth	Current Waiting/ Interest Lists	FY 07 Avg. Annual Caseload	Population Growth Rate	Phase in %		FY 2008			FY 2009			Biennium		
				08	09	Annual Caseload	GR	AF	Annual Caseload	GR	AF	Cumulative Caseload	GR	AF
Comprehensive Rehabilitative Services	183	419	4.53%	50%	50%	19	$0.6	$0.6	17	$0.6	$0.6	36	$1.2	$1.2
Independent Living Services	916	2,311	4.53%	50%	50%	71	$0.3	$0.3	102	$0.3	$0.3	173	$0.6	$0.6
Total for Option I:						**90**	**$0.9**	**$0.9**	**119**	**$0.9**	**$0.9**	**209**	**$1.8**	**$1.8**

Assumptions:

Option I: Assumes a phase in approach to keep pace with population growth in Comprehensive Rehabilitative Services and Independent Living Services by serving 50% of the clients in FY 06 and 100% in FY 07.

II. Reduce Waiting/Interest Lists	Current Waiting/ Interest Lists	FY 07 Avg. Annual Caseload	Biennium Target	Phase in %		FY 2008			FY 2009			Biennium		
				08	09	Annual Caseload	GR	AF	Annual Caseload	GR	AF	Cumulative Caseload	GR	AF
Comprehensive Rehabilitative Services	183	419	183	50%	50%	91	$3.1	$3.1	92	$3.2	$3.2	183	$6.3	$6.3
Independent Living Services	916	2,311	916	50%	50%	458	$1.5	$1.5	458	$1.5	$1.5	916	$3.0	$3.0
Total for Option II:						**549**	**$4.6**	**$4.6**	**550**	**$4.7**	**$4.7**	**1,099**	**$9.3**	**$9.3**

Assumptions:

Option II: Assumes 100% of the current waiting/interest list is served by phasing in at 50% in the first year of the biennium and 100% in the second year. Assumes Option I plus Option II would eliminate the current waiting/interest list for Comprehensive Rehabilitative Services and Independent Living Services.

D. Promoting Independence

Background

The Americans with Disabilities Act (ADA):

Section 35.130(d), Title II of the Americans with Disabilities Act, the Congress of the United States instructed the U.S. Attorney General to issue regulations implementing Title II's discrimination proscriptions, and one such regulation, known as the "integration regulation", requires a "public entity to administer programs in the most integrated setting appropriate to the needs of qualified individuals with disabilities".

Under the ADA, states are obliged to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modification would fundamentally alter the nature of the service, program or activity."

U.S. Supreme Court Olmstead Decision and Texas' Promoting Independence Plan and Initiative:

The Olmstead Decision upheld Title II of the Americans with Disabilities Act (ADA), Section 35.130(d), and allowed that individuals living in institutions must be provided community care when the following conditions are met:

- State's treatment professionals determine that such placement is appropriate;
- Affected persons do not oppose such treatment; and
- Placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state supported disability services.

Governor's Executive Order GWB 99-2

In September 1999, Executive Order GWB 99-2 issued by then Governor George W. Bush ordered HHSC to conduct a comprehensive review of all services and support systems available to people with disabilities in Texas ensuring the involvement of consumers, advocates, providers, and relevant agency representatives in this review. The Order also stated that the review shall focus on identifying affected populations, improving the flow of information about supports in the community, and removing barriers that impede opportunities for community placement.

Governor's Executive Order RP-13

In April 2002, Governor Rick Perry issued a new Executive Order, RP–13, related to improving community-based alternatives for people with disabilities. This order directs HHSC to continue its development and implementation of the state's Promoting Independence Initiative and Plan, including revising it on a regular basis. Additionally, the Governor's Executive Order highlights the need for housing, workforce, and permanency planning efforts. RP-13 also includes the direction that HHSC shall work with TDMHMR to develop a selected essential services waiver, with existing general revenue and direct cost savings at serving individuals waiting for home and community-based services.

Pursuant to Executive Order RP-13, HHSC continues to enlist the participation of families, consumers, advocates, providers and relevant agency representatives in a comprehensive review of all services and support systems available to persons with disabilities. The original Texas Promoting Independence Plan was completed in January 2001, was updated in 2002, and will be updated again in December 2004.

Promoting Independence Plan

The Promoting Independence Plan articulates a value base that serves as the framework for future system improvements:

- People should be well informed about their program options, including community-based programs, and allowed the opportunity to make choices among affordable services and supports.
- Families' desire to care for their children with disabilities at home should be recognized and encouraged by the state.
- Services and supports should be built around a shared responsibility among families, state and local government, the private sector, and community-based organizations, including faith-based organizations.
- Programs should be flexible, designed to encourage and facilitate integration into the community, accommodating the needs of individuals;
- Programs should foster hope, dignity, respect and independence for the individual.

The Texas Promoting Independence Plan and Initiative also includes specific requirements to provide community options for persons within the Olmstead population who are served in large community Intermediate Care Facilities for the Mentally Retarded (ICF/MRs), state mental retardation facilities (state schools), state mental health facilities (state hospitals) and nursing facilities who are appropriate for and desire community alternatives.

Legislation Related to Promoting Independence

As a direct result of the State's Promoting Independence Initiative and Plan, the Texas Legislature passed legislation with specific direction to the state as follows:

S.B.367: Task Force on Appropriate Care Settings for Persons with Disabilities. This legislation expanded the state's efforts to include individuals with mental illness who had three or more hospitalizations within a 180-day period as individuals at "imminent risk" for institutionalization who are waiting for services. The bill required pilots by the Texas Department of Human Services to relocate individuals from nursing facilities to the community. The bill continued the Promoting Independence Plan requiring it to be updated December 1 of each even-numbered year (77th Legislature, Regular Session, 2001).

S.B. 368: This bill emphasizes and provides direction to HHSC and all HHSA's regarding the implementation of permanency planning efforts. The bill also requires that HHSC provide oversight and monitoring to all agency CEO's who

are approving permanency plans, and placements of children in institutions beyond six months. The bill also directed HHSC to develop a pilot project for alternative family based options for children in institutions (77th Legislature, Regular Session, 2001).

H.B 1867: This bill codifies DADS' "money follows the person" policy created Riders 37 (77th Legislature, Regular Session, 2001) and 28 (78th Legislature, Regular Session, 2003). H.B. 1867 allows individuals residing in nursing facilities to access community-based services without being placed on an interest list (79th Legislature, Regular Session, 2005).

SB 40: Strengthens the permanency planning activities for children residing in state institutions. This bill includes, among its mandates, the elimination of the potential conflict of interest by requiring that permanency planning activities be conducted by a third party who is not the provider of service (79th Legislature, Regular Session, 2005).

SB 626: This bill would allow certain individuals to receive services in the community up to a cost of 133.3 percent of the cost of services in an institution (79th Legislature, Regular Session, 2005).

HB 2579: Provides certain mandates relating to procedures which ensure the involvement of parents or guardians of children placed in certain institutions (79th Legislature, Regular Session, 2005).

78th Legislative Session Riders

Rider 46: It is the intent of the Legislature, to provide opportunities for children (under the age of 22) residing in community intermediate care facilities for the mentally retarded to transition to families during the 2006-07 biennium. To facilitate such transitions when requested by parent/guardian, funding for up to 50 children residing in community intermediate care facilities for the mentally retarded may be transferred from the ICF/MR strategy to Community Care Services Strategies to cover the cost of the shift in services. The Executive Commissioner may develop rules that would allow decertification of the ICF/MR beds upon such transition to prevent additional costs being incurred.

Rider 54: CPS Reform Plan. Out of funds appropriated in Strategy A.3.2, Home and Community-Based Services, $1,182,270 in General Revenue Funds, and the associated federal funds, are set aside each fiscal year for children aging out of Foster Care.

The Health and Human Services Commission oversees the Promoting Independence initiative and delegates the daily management of this initiative to the Department of Aging and Disability Services (DADS). DADS has an exceptional item request to provide Home and Community Based Services Waiver (HCS) slots for two distinct populations. This item requests funding to

move 240 persons from large community Intermediate Care Facilities for the Mentally Retarded (ICF-MR) to HCS waiver services. These slots would be phased in by the end of fiscal year 2009. This request would keep DADS in compliance with the State's commitment to place individuals currently residing in large ICF/MR institutions into a more integrated setting within 12 months of notification. The funding is for the HCS costs for these individuals (ICF/MRs retain their funded beds).

The second population targeted in this exceptional item are the children aging out of foster care. Funding is being requested to provide HCS foster care or residential services for 120 individuals (age 18 and above) whose Child and Protective Services Conservatorship is ending. These slots will be phased in by the end of fiscal year 2009 and provide much needed stability to those individuals who are aging out of the CPS system, yet still require follow along and services.

E. Long Term Care Plan

The Texas Health and Human Services Commission (HHSC), pursuant to Section 533.062 of the Texas Health and Safety Code (see Appendix A), approves this proposed Long Term Care Plan for People with Mental Retardation and Related Conditions. Section 533.062 requires the plan to be developed biennially and adjusted following legislative action on appropriations for long term care services. HHSC publishes the plan to reflect the legislative appropriations request for the proposed number of intermediate care facilities for individuals with mental retardation (ICF/MR) beds licensed or approved as meeting license requirements, and the proposed capacity of the home and community-based services waiver program for persons with mental retardation or a related condition. As required by Section 533.062 of the Texas Health and Safety Code, the numbers appearing in the tables below are consistent with the projected amounts to be requested by HHSC in the consolidated health and human services budget. Effective September 1, 2004, the Texas Department of Aging and Disability Services (DADS) operates all of the programs included in this report.

The report includes information on the following programs:

- The Intermediate Care Facilities for Persons with Mental Retardation or a Related Condition Program (ICF-MR/RC);
- The Home and Community-based Services for Persons with Mental Retardation Waiver Program (HCS);
- The Texas Home Living Waiver Program (TxHmL);
- The Community Living Assistance and Support Services Program (CLASS);
- The Deaf-Blind with Multiple Disabilities Waiver Program (DB/MD); and
- The Consolidated Waiver Program (CWP).

The World Health Organization (WHO) estimated that the overall prevalence of mental retardation is between 1 percent and 3 percent and that mild mental retardation is much more common than severe mental retardation, accounting for 65 to 75 percent of all persons with mental retardation. The total population of Texas is expected to grow from 22.8 million in 2006 to an estimated 24.2 million in 2010. The priority population of persons with mental retardation is forecast to grow from 93,083 in 2006 to 98,615 in 2010.

Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR)

This is a Medicaid funded program that provides services to people with mental retardation and related conditions in residential settings of four or more beds with 24-hour supervision. These services are provided in two settings: state-mental retardation facilities and community facilities.

State Mental Retardation Facilities

State mental retardation facilities provide services to people with mental retardation admitted to eleven state schools and two state centers. State schools are located in Abilene, Austin, Brenham, Corpus Christi, Denton, Lubbock, Lufkin, Mexia, Richmond, San Angelo, and San Antonio. The two state centers, in El Paso and Rio Grande, also provide campus-based mental retardation services. The development of community alternatives is expected to result in decreased demand for state schools. The size and rate of this trend will be a function of the availability of community resources, the capability of the community services infrastructure to expand, and individual choice of services.

Proposed ICF/MR Bed Capacity[7] for State Mental Retardation Facilities	
FY2008	FY2009
4,869	4,869

Community Facilities

Community facilities, as the name implies, provide services to people with mental retardation in community settings. Both public and private providers operate these facilities. The public providers are local mental retardation authorities.

Proposed ICF/MR Bed Capacity[8] for Community Facilities	
FY2008	FY2009
7,019	7,019

Waiver Programs

Section 1915(c) of the Social Security Act provides, that upon federal approval, states may "waive" some federal Medicaid requirements to provide an array of support services in the community as an alternative to institutional care. Medicaid expenses for people in waiver programs cannot exceed, in the aggregate, Medicaid expenses for institutional services for people with similar needs. A major expansion of the waiver programs was funded by the 79th Legislature.

[7] Capacity in this reference means total beds.
[8] Capacity in this reference means anticipated average number of persons served per month.

The Home and Community-based Services for Persons with Mental Retardation Waiver Program (HCS)

The HCS program is for persons with mental retardation and provides individualized service and supports for individuals living in their family home, their own home, in a foster/companion care setting or in a residence with no more than four individuals who receive services.

Proposed HCS Capacity[9]	
FY2008	FY2009
13,726	16,560

The Texas Home Living Waiver Program (TxHmL)

The Texas Home Living Program (TxHmL) provides community services for people with mental retardation. Selected essential services and supports are provided for people so they can continue to live with their families or in their own homes.

Proposed TxHmL Capacity[9]	
FY2008	FY2009
2,163	2,163

The Community Living Assistance and Support Services (CLASS) Program

CLASS provides home and community-based services to individuals with related conditions as a cost-effective alternative to ICF/MR/RC institutional placement. People with related conditions have a qualifying disability, other than mental retardation, that originated before age 22 and affects their ability to function in daily life.

Appropriated CLASS Capacity[9]	
FY2008	FY2009
3,760	4,361

[9] Capacity in this reference means anticipated average number of persons served in the program each month.

Medicaid Waiver Program for People who are Deaf-Blind with Multiple Disabilities (DB/MD)

DB/MD provides home and community-based services for people who are deaf-blind with multiple disabilities. As an alternative to institutional care, the program focuses on increasing opportunities for individuals to communicate and interact with their environment.

Proposed DB-MB Capacity[9]	
FY2008	FY2009
158	162

The Consolidated Waiver Program (CWP)

CWP is a pilot waiver. The purpose of the pilot is to test the feasibility of consolidating five of the state's other Section 1915(c) Medicaid waiver programs. The program is limited to Bexar County, and serves individuals who will qualify for nursing facility or for ICF/MR/RC level of care I or VIII.

Proposed CWP Capacity[3]	
FY2008	FY2009
199	199

Health and Safety Code §533.062

Plan on Long-Term Care Facilities for Persons with Mental Retardation

(a) The department shall biennially develop a proposed plan on long-term care for persons with mental retardation.

(b) The proposed plan must specify the capacity of the HCS waiver program for persons with mental retardation and the number and levels of new ICF/MR beds to be authorized in each region. In developing the proposed plan, the department shall consider: (1) the needs of the population to be served; (2) projected appropriation amounts for the biennium; and (3) requirements of applicable federal law.

(c) Each proposed plan shall cover the subsequent fiscal biennium. The department shall conduct a public hearing on the proposed plan. Not later than July 1 of each even-numbered year, the department shall submit the plan to the Health and Human Services Commission for approval.

(d) The Health and Human Services Commission may modify the proposed plan as necessary before its final approval. In determining the appropriate number of ICF/MR facilities for persons with a related condition, the department and the Health and Human Services Commission shall consult with the Texas Department of Human Services.

(e) The Health and Human Services Commission shall submit the proposed plan as part of the consolidated health and human services budget recommendation required under Section 13, Article 4413(502).

(f) After legislative action on the appropriation for long-term care for persons with mental retardation, the Health and Human Services Commission shall adjust the plan to ensure that the ICF/MR beds licensed or approved as meeting license requirements and the capacity of the HCS waiver program are within appropriated funding amounts.

(g) After any necessary adjustments, the Health and Human Services Commission shall approve the final biennial plan and publish the plan in the Texas Register.

(h) The department may submit proposed amendments to the plan to the Health and Human Services Commission.

(i) In this section, "HCS waiver program" means services under the state Medicaid home and community-based services waiver program for persons with mental retardation adopted in accordance with 42 U.S.C. Section 1396n(c).

Definitions

Mental Retardation is defined by 40 Texas Administrative Code (TAC) §5.153 as:

Consistent with THSC, §591.003, significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Related Condition is defined by 40 TAC §5.153 as:

As defined in the Code of Federal Regulations (CFR), Title 42, 435.1009, a severe and chronic disability that:

(A) is attributable to:

(i) cerebral palsy or epilepsy; or

(ii) any other condition, other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for persons with mental retardation;

(B) is manifested before the person reaches the age of 22;

(C) is likely to continue indefinitely; and

(D) results in substantial functional limitation in three or more of the following areas of major life activity:

(i) self-care;
(ii) understanding and use of language;
(iii) learning;
(iv) mobility;
(v) self-direction; and
(vi) capacity for independent living.

Mental Retardation Priority Population

The priority population for mental retardation services consists of individuals who meet one or more of the following descriptions:

- Persons with mental retardation as defined by Texas Health Safety Code §591.003;
- Persons with pervasive developmental disorders, as defined in the current edition of the Diagnostic and Statistical Manual, including autism;
- Persons with related conditions who are eligible for services in Medicaid programs including the ICF/MR and Medicaid waiver programs;
- Nursing facility residents who are eligible for specialized services for mental retardation or a related condition pursuant to §1919(e)(7) of the Social Security Act; or
- Children who are eligible for services through the Early Childhood Intervention Interagency Council.

F. Upper Payment Limit (UPL) Programs

Active UPL Programs

Large Urban Public Hospitals (effective SFY 2001)

Supplemental payments are made for inpatient and outpatient hospital services provided by a publicly-owned hospital or hospital affiliated with a hospital district in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Midland, Tarrant, Travis, Potter, and Randall counties. This UPL program makes supplemental payments to 11 of the largest public hospitals in Texas. This UPL program became effective on July 6, 2001.

SFY 2006: $659.4 AF; $400.0 Federal
SFY 2007: $659.4 AF; $400.8 Federal

State Hospital UPL (effective SFY 2004)

Supplemental payments are made for inpatient hospital services provided by state government-owned or operated hospitals. To qualify for a supplemental payment, the hospital must be owned or operated by the state of Texas. This UPL program became effective on December 13, 2003.

SFY 2006: $65.2 AF; $39.2 Federal
SFY 2007: $65.2 AF; $39.2 Federal

Rural Hospital UPL (effective SFY 2002)

Supplemental payments are made for inpatient hospital services provided by approximately 118 rural hospitals that are either publicly owned or affiliated with a local governmental entity. For purposes of this program, "rural hospital" means a hospital affiliated with a city, county, hospital authority, or hospital district located in a county of less than 100,000 population based on the most recent federal decennial census. This UPL program became effective on January 1, 2002.

SFY 2006: $75.1 AF; $45.5 Federal
SFY 2007: $75.1 AF; $45.6 Federal

Regional UPL for Private Hospitals (effective SFY 2005)

This is the UPL program that was created as a result of the recently approved SPA TX-05-001. It is the private hospital UPL for Bexar, Montgomery, Webb, Hidalgo, Potter, Maverick, Travis, Randall, Midland and Potter counties. This SPA has an effective date of June 10, 2005.

SFY 2006: $251.7 AF; $152.8 Federal (includes retroactive amounts)
SFY 2007: $200.4 AF; $121.5 Federal

High-Volume Payments to Private Hospitals (effective SFY 2006)

High-volume payments not exceeding $26.4 million shall be allocated in proportion to uncompensated care loss for eligible hospitals participating in the current year DSH program. Eligible hospitals are defined as non-state owned or operated, non-public, hospitals located in urban counties. The state share for this UPL program comes from General Revenue instead of Intergovernmental Transfers (IGT's). This program became effective on September 1, 2005.

SFY 2005: $86.3 AF; $52.5 Federal (includes retroactive amounts)
SFY 2006: $26.4 AF; $16.0 Federal
SFY 2007: $26.4 AF; $16.0 Federal

> ***Note:*** For state fiscal year 2005, the language in the State Plan allowed HHSC to pay $86.3 million to these hospitals, instead of $26.4 million. There were 2 separate calculations that year. One referred to as "high volume" payments and the other referred to as "cost containment". The cost containment portion was removed from the State Plan with SPA TX-05-012, while the high volume portion remains unchanged.

Pending UPL State Plan Amendments

Statewide UPL for Private Hospitals (SPA TX-05-011) (if approved, effective SFY 2006)

This would create a statewide UPL program for private hospitals. This SPA has an effective date of November 12, 2005. HHSC received a request for additional information from CMS on March 21, 2006, which we responded to on June 30, 2006. The only issue remaining is revising the actual SPA language, which was submitted to CMS in August 2006.

SFY 2006: $292.8 AF; $177.6 Federal (includes retroactive amounts)
SFY 2007: $369.8 AF; $224.3 Federal

State Physician Practice Plan UPL (SPA TX-04-010) (if approved, effective SFY 2004)

This would create a physician UPL for practitioners employed by state academic health systems, specifically hospitals that are part of the systems of the University of Texas, Texas Tech University, and the University of North Texas. This SPA has an effective date of May 11, 2004.

SFY 2007: $270.3 AF; $164.0 Federal (includes retroactive amounts)
SFY 2008: $111.9 AF; $68.0 Federal

Tarrant County Physician UPL (SPA TX-04-029) (if approved, effective SFY 2005)

This would create a physician UPL for practitioners employed by Tarrant County. This SPA has an effective date of November 26, 2004.
SFY 2007: $11.1 AF; $6.7 Federal (includes retroactive amounts)
SFY 2008: $6.0 AF; $3.7 Federal

Children's Hospital UPL (SPA TX-06-021) (if approved, effective SFY 2007)

This would result in UPL payments to certain in-state children's hospitals for the 2006-2007 biennium. The state share for this UPL program comes from GR. Amounts shown below are for the biennium. 2006-2007 biennium. This SPA is set to have an effective date of September 1, 2006.

SFY 2007: $63.7 AF; $38.7 Federal (includes retroactive amounts)
SFY 2008: $31.9 AF; $19.4 Federal

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