Chapter III

Health and Human Services System External/Internal Assessment

Statewide Demographic, Economic, and Health Trends

The demographic characteristics and socioeconomic conditions of the Texas population create a unique set of circumstances within which the health and human services (HHS) system must operate. This brief discussion will address trends in age, race/ethnicity, and health status, as well as the levels of socioeconomic resources available to persons and households and the effects of these characteristics on the health and human service delivery needs of Texans. The following analysis discusses some of the predominant trends that are likely to have the most significant impact on HHS services and populations during the 2005–2009 planning period and beyond.

Overall Population Growth and Ethnic Composition

The population of Texas continues to grow more rapidly (in percentage terms) than the population of the nation, as it has done in every decade since Texas became a state. Further, the state population could continue to expand during the next 10 to 20 years, even in the absence of positive net migration, due to natural increase alone. The racial and ethnic mix is changing, as is the age of Texans. Taken together, these trends dramatically affect the delivery of health and human services, including the public health, protective, and homeland security services available to the entire population.

From 1970 to 2000, the Texas population growth rate was more than twice the national population growth rate. During that period, the state's population increased 86 percent from 11.2 to 20.9 million. Meanwhile, the national population grew by about 78.1 million, from 203.3 million in 1970 to 281.4 million in 2000, a growth rate of 38 percent. The share of the national population in Texas also increased from 5.5 percent in 1970 to 7.4 percent in 2000. In 1970, about one of every 18 people in the U.S. lived in Texas. By 2000, about one of every 13 in the U.S. lived in Texas.

With approximately 20.9 million residents, Texas currently ranks second in total population behind California, and the Texas population is projected to continue to increase in size. According to the 2000 U.S. Census and the Texas State Data Center:[1]

- Approximately 11.1 million Texans were Anglo.
- Approximately 6.7 million were Hispanic.
- Approximately 2.4 million were African American.
- Other ethnic groups, including American Indian, Asian American, and others, formed the remaining 700 thousand.
- The majority of the Hispanic population was of Mexican origin.
- From 2005 to 2009, the total population is projected to grow by 1.3 million, from 22.5 to 23.8 million, a growth rate of 6 percent.
- From 2005 to 2040, the total population is projected to grow by about 12.5 million, from 22.5 to 35 million, a growth rate of 56 percent.

In addition to overall population growth between 2005 and 2009, significant changes in population composition are expected to occur:

- The Anglo population is projected to grow from 11.3 to 11.5 million, or about one percent.
- The African American population is projected to grow from 2.6 to 2.7 million, or by about five percent.
- The Hispanic population is projected to grow from 7.8 to 8.8 million, or by about 12 percent.
- All other population groups (combined) are projected to grow from about 800 thousand to 900 thousand, or by about 14 percent.

During the 2005 to 2040 period, the percent share of the population that is Anglo is projected to decrease, from 50 percent to about 33 percent. The share of the African American population is projected to decrease from about 11 percent to about nine percent. The Hispanic share is projected to increase, from 35 percent to 53 percent. The percent share for all other population groups (combined) is projected to increase - from 4 percent in 2005 to about 6 percent in 2040.

Between 2005 and 2040, the Hispanic population is expected to grow the most in absolute terms; however, the combined population of Asian Americans, Native Americans, and other groups (excluding African Americans) is projected to experience the highest rate of growth. Both the Anglo and African American

[1] Texas State Data Center and Office of the State Demographer. Texas Population Estimates Program, San Antonio, TX: Texas State Data Center and Office of the State Demographer, Institute for Demographic and Socioeconomic Research, University of Texas at San Antonio, January 23, 2004. http://txsdc.utsa.edu/tpepp/txpopest.php (accessed June 16, 2004).

populations are projected to grow in size, although they will comprise a smaller percent of the total population. Projections for the period 2005 to 2040 include the following:

- The Anglo population will increase from 11.3 to 11.4 million, or by less than one percent.
- The African American population will increase from 2.6 to 3.3 million, or by about 27 percent.
- The Hispanic population will increase from 7.8 to 18.4 million, or by about 136 percent.
- All other population groups combined will grow from about 800 thousand to about 2 million, or by about 150 percent.

The growth rate of the non-Anglo population will present important challenges as this segment of the population often experiences conditions such as poverty and lack of access to private health insurance at higher rates compared to Anglos.

Aging and Disability

In 2000, there were about 62 children and older adults for every 100 working-age adults. By 2040, it is projected there will be 66 children and older adults for every 100 working-age adults. Compared to today, there will be fewer working-age adults to contribute their time and other resources to help meet the needs of a growing older population.

In 2006, the leading edge of the baby boom generation (those born in 1946) will turn 60. This disproportionately large population will contribute to a gradual increase in the median age of the population. In 2000, the median age in Texas was 32, but by 2020 it will be 34, and by 2040 it will be 37. The population age 65 and over will experience the highest growth rate from 2005 to 2040. The percent of older persons in the population is projected to double during this period:

- From 2005 to 2009, the population age 65 and over is projected to grow from 2.23 million to 2.45 million, a growth rate of about 10 percent.
- From 2005 to 2020, the population age 65 and over is projected to grow from 2.2 to 3.7 million, a growth rate of about 65 percent.
- From 2005 to 2040, the population age 65 and over is projected to grow from 2.2 to 6.3 million, a growth rate of about 184 percent.

The group known as the "older old," age 85 and over, is also projected to grow significantly:

- From 2005 to 2009, the population age 85 and over is projected to grow from 255,000 to almost 286,000, a growth rate of about 12 percent.
- From 2005 to 2040, the population age 85 and over is projected to grow from 255,000 to 831,000 a growth rate of about 226 percent.

The older population is also projected to become more ethnically diverse. In 2000, about 73 percent of those 65 and over were Anglo, yet by 2040 only 47 percent of the senior population will be Anglo.

Conversely, the percent of the population age 18 to 64 is projected to decrease slightly between 2005 and 2040. The same is true of the population under age 18. In 2000, 5.9 million children under age 18 comprised about 28 percent of the total population. By 2005, projections indicate that children will comprise about 27 percent of the population. The child population is projected to grow in absolute terms by 166,000 from 2005 to 2009, and by more than 700,000 between 2005 and 2020. Projections indicate that by 2009, children will represent about 26 percent (6.3 million) of the population. That number will increase to some 6.9 million, but in terms of the total population will be 25 percent of the population.

Since the older population is projected to grow at a higher rate, it is very likely that the percent of persons affected by one or more disabling conditions will increase. The population afflicted by disabling conditions includes persons who have one or more physical or mental conditions that limit their ability to successfully engage, on their own, in basic activities of daily living such as bathing, eating, getting dressed, getting in and out of bed, and taking needed medications. This population is likely to need the support of a wide variety of health and human services. Some of these services include protective and preventive services, acute health care, institutional and community-based long-term care, transportation, legal and advocacy services, assistance with home repair and home modifications, and assistance with navigating an increasingly complex social services safety net system. According to sample data taken from the 2000 census of population, about 20 percent of Texans had one or more disabling conditions. Among younger adults ages 18 through 39, 17 percent were affected. Among those ages 65 and over, however, about 47 percent were affected by one or more disabling conditions. Among persons age 85 and over, about 77 percent were affected by one or more disabling conditions.

Poverty and Economic Indicators

The continued uncertainty of the Texas and U.S. economies is a key concern for the HHS agencies. An economic downturn traditionally leads to an increased demand for social services, with a simultaneous decrease in the financial resources available to address the increased demand. In 2002, an estimated 3.4 million people in Texas

lived in families with incomes below the federal poverty guidelines.[2] The U.S. Census defined the average poverty threshold for a family of four in 2002 as $18,392 in annual income, $14,348 for a family of three, $11,756 for a family of two, and $9,183 for unrelated individuals.[3]

Although the poverty rate in 2002 for the entire population was nearly 16 percent, for children under 18 the poverty rate was about 22 percent. The rate of poverty also varies by race and ethnicity. For Anglos, the rate was seven percent; but African American and Hispanic poverty rates were significantly higher: 19 and 25 percent, respectively.

The rate of poverty for children also varies by race and ethnicity, with rates being higher for non-Anglo children. In 2002, the rate of poverty for Anglo children was about 8 percent, but for African American and Hispanic children the rate of poverty was 23 and 34 percent, respectively.

For the population as a whole, 39 percent had incomes below 200 percent of poverty. There is variance according to race and ethnicity. In 2002, 22 percent of Anglos had incomes below 200 percent of poverty, compared with 44 percent of African Americans and 59 percent of Hispanics.

State economic forecasters are guardedly optimistic about current and future trends in the Texas economy. While leading economic indices are slow to improve, renewed growth is now predicted. The Texas Comptroller of Public Accounts' sales tax revenue receipts for February 2004 totaled more than $1.26 billion, an increase of 6.2 percent compared to February 2003. This increase indicates that the Texas economic recovery is gaining momentum. The latest economic data predicts that the Texas economy will outpace the nation through 2005.

While the Texas economy appears to be improving, the number of non-farm jobs in Texas has changed little during the past three years. During the 1990s, Texas' job count increased by nearly 20,000 every month, an average annual increase of 2.9 percent over the decade. In July 2003 there were 9,424,000 non-farm jobs in Texas, the same number of non-farm jobs as the summer of 2000. [4] Job gains for the second half of 2003 were very small. The average employment for the fourth quarter of 2003 is still 86,500 fewer jobs than in December 2000.[5]

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[2] U.S. Census Bureau, "March Current Population Survey," 2003 Annual Social and Economic Supplement.
[3] U.S. Census Bureau, "Poverty 2003" http://www.census.gov/hhes/poverty/threshld/thresh03.html (accessed June 16, 2004)
[4] Texas Workforce Commission, "Texas and U.S. Unemployment Rates," http://www.twc.state.tx.us/customers/rpm/rpmsub3.html (accessed June 16, 2004)
[5] Texas Comptroller of Public Accounts, "Texas Economic Update-Summer 2003," http://www.cpa.state.tx.us/ecodata/teusum03 (accessed June 16, 2004)

Further, Texas employment grew at a rate of approximately three percent per year throughout the 1990s, but slowed dramatically in 2000 and reached a low of -1.07 percent in 2002 as depicted in Figure 3.1. In the spring of 2004, the State Comptroller predicted that job growth would level out at an annual increase of approximately two percent per year for the remainder of the decade.

Figure 3.1.
Annual Percentage Change in Texas Non-Farm Employment:
State Fiscal Years 1990-2003 Actual, 2004-2010 Projected

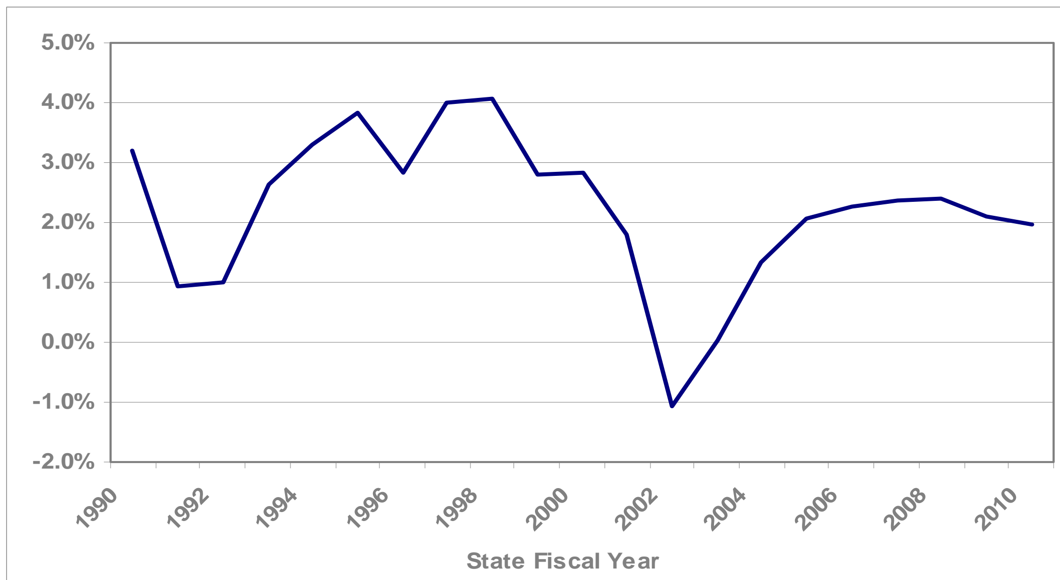

Figure 3.1: Texas Comptroller of Public Accounts, Spring 2004 Economic Forecast; HHSC Center for Strategic Decision Support.

Unemployment in Texas, as the rest of the nation, increased significantly as illustrated in Figure 3.2. Data from the Texas Workforce Commission, Texas Comptroller of Public Accounts, and the Congressional Budget Office indicate that unemployment in Texas and in the rest of the nation will gradually decrease and stabilize during the next few years.

Figure 3.2.
Texas and U.S. Seasonally Adjusted Unemployment Rates: State Fiscal Years 1990-2003 Actual, 2004-2010 Projected

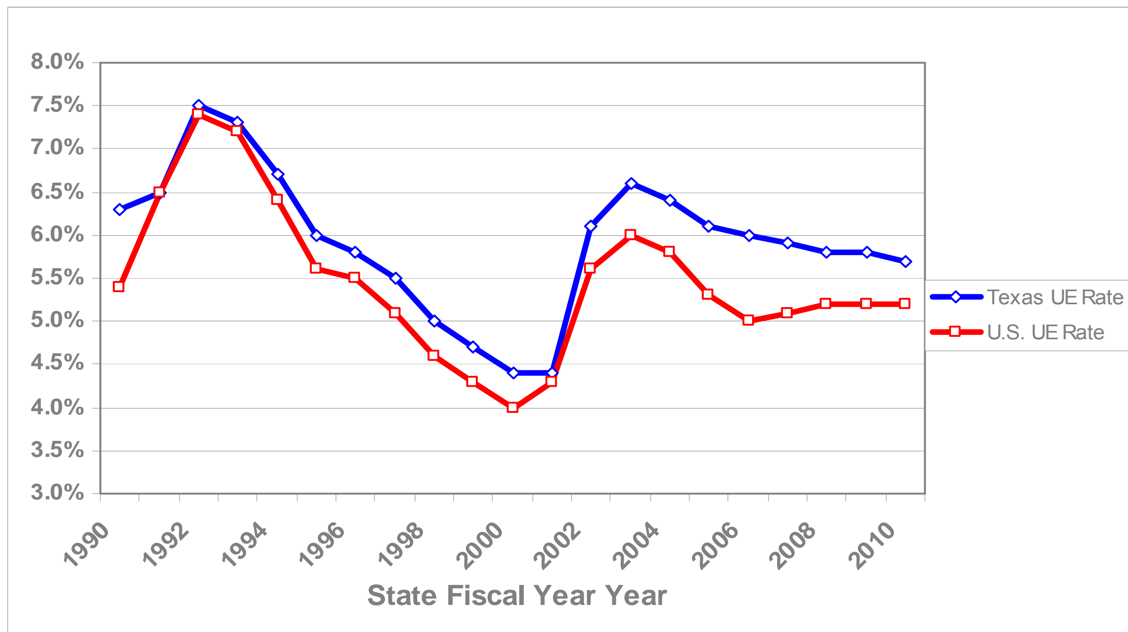

Figure 3.2: Texas Comptroller of Public Accounts, Spring 2004 Forecast; U.S. Congressional Budget Office, January 2004 Projections; HHSC Center for Strategic Decision Support.

The seasonally adjusted monthly unemployment rate in Texas for January 2004 was 6.3 percent, whereas the national unemployment rate was 5.6 percent. Figure 3.2 illustrates seasonally adjusted annual unemployment rates from 1990 to a projected rate for 2010.[6] Current projections show that the unemployment rate for Texas during fiscal year (FY) 2004 is expected to average 6.4 percent and then slowly decline to 5.7 percent by 2010.[7]

As the economy returns to pre-recession employment levels, jobs continue to shift from high-wage to low-wage industries. In Texas, from the end of the recession through November 2003, the average wage for a job in a growing industry was $31,663 annually, compared with an annual salary of $48,751 for a job in a contracting industry.[8] As the economy shifts to lower wage jobs, job growth and creation is also shifting away from industries that are more likely to provide health

[6] Texas Workforce Commission, "Texas and U.S. Unemployment Rates," http://www.twc.state.tx.us/customers/rpm/rpmsub3.html (accessed June 17, 2004)
[7] Texas Comptroller of Public Accounts, "Spring 2003 State Economic Forecast," http://www.cpa.state.tx.us/ecodata/fcst03spr (accessed June 17, 2004)
[8] Economic Policy Institute, "Economic Snapshots," January 21, 2004, http://www.epinet.org/webfeatures/snapshots/archive/2004/0121/snap20040121_wage_diff_table.pdf (accessed June 17, 2004)

coverage to their workers to industries that are less likely to provide health coverage, an issue discussed in the next section.

Health Insurance Status[9]

Low-income individuals and families not covered by private health insurance are likely to turn to state or local government to meet their health care needs. In 2002, about 62 percent of Texans under age 65—and for whom their income status was known—had private health insurance. For the entire population under age 65, rates of private coverage varied according to race and ethnicity, with 79 percent Anglo, 59 percent African American, and 43 percent Hispanic.

However, across all race/ethnic groups, people with incomes below 200 percent of poverty were less likely to have private insurance. Within the below-200 percent of poverty group, non-Anglos had lower rates of private insurance than Anglos (46 percent), compared to African Americans at 37 percent, and Hispanics at 21 percent.

Of those whose income exceeds 200 percent of poverty, disparities also exist in the rate of private insurance coverage. In 2002, rates of private coverage varied according to race and ethnicity as follows: Anglos at 87 percent, African Americans at 75 percent, and Hispanics at 68 percent.

The State of Texas plays an important role in providing health insurance coverage for low-income children. In March 2004, about 2.1 million low-income children under age 19 were enrolled in Medicaid and the Children's Health Insurance Program (CHIP). These children represent about one-third of all the children in the State. The rate of private coverage varies according to race/ethnicity. In 2002, the rate of private coverage for Anglo children was about 78 percent, but for African American and Hispanic children the rates were 58 and 36 percent, respectively. The demand for state-funded health care services is likely to increase or decrease depending on economic factors, particularly unemployment and poverty rates, as well as the health factors, discussed below.[10]

Health Risk Factors[11]

Medicaid and CHIP represent 76 percent of the total $38.9 billion health and human services budget. Clearly, the state's efforts at education and prevention of prevalent health problems and investments in improved public health overall have the potential

[9] U.S. Department of Commerce. U.S. Census Bureau. March 2003 Current Population Survey (CPS) for Texas.
[10] Enrollment analysis by HHSC Center for Strategic Decision Support, from Monthly Enrollment Files.
[11] TDH, Health of Texans 2002: Texas State Strategic Health Plan, Part I, Executive Summary, September 2002.

to decrease the costs of providing health and human services in Texas. This section considers the health factors in this equation: infant mortality and low birth weight, chronic disease, infectious disease, and behavioral health risks.

Infant Mortality and Low Birth Weight

The infant mortality rate (IMR) historically serves as an important indicator of the overall health of the community and is a composite indicator of the quality of and access to medical care for pregnant women and infants. The IMR is the ratio of deaths to infants less than one year of age per 1,000 live births. The overall IMR in Texas in 2000 was 5.7 per 1,000 live births. The Texas IMR declined 20 percent between 1990 and 1999 from 8.0 to 6.2 per 1,000 live births. From 1989 to 2000, African American infants on average died at a rate twice that of all other infants born in the state. The African American infant mortality rate in 2000 was 11.4 per 1,000 live births, followed by Hispanics at 5.3, and Anglos at 4.8.

Low birth weight, defined as a weight of less than 2,500 grams at birth, places infants at an increased risk for adverse health outcomes, including death. In 2000, 7.4 percent of Texas newborns had a low birth weight. The percentage of African American infants was almost twice that of Anglo infants (6.6 percent), or Hispanic infants (6.8 percent). Mothers over 40 years of age and teen mothers are most likely to have low birth weight babies.

Disease Trends: Chronic Disease

Chronic conditions are the major cause of illness, disability, and death in Texas. Chronic diseases are generally characterized by multiple risk factors, a long latency period, a prolonged course of illness, non-contagious origin, functional impairment or disability, and low curability. Claiming the lives of more than 101,000 Texans every year, these diseases are responsible for seven of every 10 deaths.

In 2000, four of the five leading causes of death were chronic diseases, including diseases of the heart, cancer, stroke, and chronic lower respiratory diseases. Other chronic diseases among the top leading causes of death in Texas include diabetes, Alzheimer’s disease, and chronic liver disease and cirrhosis. Many chronic diseases, such as diabetes and cancer affect older persons more often and/or more seriously than other age groups.

Disease Trends: Infectious Diseases

Bacteria, viruses, or other microorganisms cause infectious diseases. Many of the infections plaguing Texans have common modes of transmission that relate to behaviors. Approximately 87 percent of the top 10 reported infectious diseases are

sexually transmitted. Sharing contaminated needles also can spread infectious diseases, including hepatitis and human immunodeficiency virus (HIV).

At the end of 2001, 68,327 Texans had been diagnosed with HIV or acquired immune deficiency syndrome (AIDS), 36,309 of whom were still living. The rate of reported HIV cases among African Americans in 2001 was more than five times higher that the rate for Anglos, and the 2001 AIDS rate among African Americans was more than five times higher than the rate for Anglos, and nearly four times the rate for Hispanics.

Tuberculosis, or TB, is a bacterial disease that primarily infects the lungs and is transmitted from one person to another by inhalation of droplet nuclei containing the bacteria. In 2001, there were 1,643 cases of TB reported in Texas. Of those, 84 percent were reported in minorities, with 57 percent in Hispanics, 30 percent in African Americans, and 13 percent in Asians. Foreign-born persons accounted for 43 percent of TB cases in Texas for this time period, an increase from 26 percent in 1995. Additionally, high TB rates in the Mexican states that border Texas contribute to a higher rate for TB in the Texas counties near the Texas border, as compared with the rest of the state. In 2001, 14 border counties had a TB rate of 12.8 cases per 100,000, which is 1.6 times higher than the statewide TB rate of 7.9. Many people cross the border daily, providing ample opportunity for TB to spread from one person to another.

Behavioral Health Risks

In Texas, each of the seven leading causes of death can be linked to one or more significant behavioral risk factors. Three risk behaviors are the major contributors to cardiovascular disease and cancer: tobacco use, poor nutrition, and physical inactivity.

Tobacco use, including cigarette smoking and the use of other tobacco products, takes an enormous toll, killing an estimated 24,000 Texans each year:

- More than one in five Texas adults currently smoke.
- Both nationally and in Texas, among adults, Anglos are more likely to smoke than African Americans and Hispanics, males are more likely to smoke than females, and young adults are more likely to smoke than older adults.
- In 2001, 10 percent of middle school students and 25 percent of high school students smoked cigarettes on at least one of the 30 days preceding the survey.
- Anglo and Hispanic high school students were more likely to smoke than African Americans, and in middle school Hispanics were much more likely to smoke than Anglos and African Americans.
- Tobacco costs the state of Texas more than $10 billion annually, or $499 for every person in the state, including medical care costs and lost productivity.

Being overweight and obese, together with poor diet and physical inactivity, are the second leading cause of preventable mortality and morbidity in the U.S. These factors account for nearly 300,000 deaths annually, along with economic costs that rival those attributed to smoking:

- Nearly one in four adult Texans is considered obese, while six of every 10 are at an unhealthy weight (overweight or obese).
- Statistically, Texans are more likely to be obese than the national median.
- Both nationally and in Texas the rate of adult obesity nearly doubled between 1990 and 2000.
- Texas Hispanics are significantly more likely than Hispanics nationally to be obese (31 percent versus 22 percent). In Texas, the highest rate of adult obesity is found among Hispanics.
- Nearly seven in 10 adult men in Texas are overweight or obese, compared with half of all adult women.

Of particular concern is the growing problem of overweight youth whose unhealthy lifestyle patterns are established in the formative years and are likely to continue into adulthood:

- About 14 percent of Texas high school students were overweight or obese, as compared to 10.5 percent of high school students nationally.
- Overall male students (19.4 percent) were significantly more likely than female students (8.7 percent) to be overweight or obese. This significant gender gap was identified for Anglo and Hispanic students, as well as students in all grade subpopulations and age groups.
- Overall, African American (17.3 percent) and Hispanic (17.6 percent) students were significantly more likely than Anglo students (10.6 percent) to be overweight or obese. Anglo female students (5.3 percent) were significantly less likely than African American female students (15.1 percent) and Hispanic female students (10.8 percent) to be overweight or obese.

Physical activity, even moderate amounts of regular physical activity, has been shown to produce significant health benefits:

- In 2000, Texas adults were slightly more likely to report no physical activity in the past month than the national median.
- Texas Hispanics performed particularly poorly on this indicator, both relative to other racial/ethnic groups within the state and compared to the national median, as nearly four of 10 Texas Hispanics reported no physical activity.
- Women were more likely than men to report no physical activity during the past month, both in Texas and the nation.
- Texans ages 18–44 years were more likely to report no physical activity than the national median. Among those over age 45, differences between Texas and the U.S. were not statistically significant.

Alcohol abuse is an underlying factor in a wide range of heath problems, based on the results of the *Texas School Survey of Substance Use Among Students: Grades 7-12*:[12]

- In 2000, the economic cost of alcohol abuse was $16.4 billion, a total that includes health care expenditures, lost productivity, motor vehicle crashes, crime, and other costs.
- Texans are more likely than residents of other states to abuse alcohol.
- Alcohol continues to be the most widely used substance among secondary school students in Texas. In 2002, 71 percent of these students reported they had ever used alcohol, and 35 percent reported past-month alcohol use.
- Alcohol was the easiest substance for secondary students to obtain; the major sources for youth to obtain alcoholic beverages were from parties and friends.

Illicit drug use is costly to the individual, the family, and to society:[13]

- Economic cost of illegal drugs in 2000 in Texas was $9.5 billion.
- About 75 percent of all prisoners are involved with alcohol or drugs, either abusing or dependent, arrested for drug or alcohol offenses, or under the influence when the crime is committed.
- Only 47 percent of secondary school students were drug-free from all substances including alcohol during the last school year.
- In 2003, 25 percent of all adults served in the Texas public mental health system were diagnosed with a co-occurring substance abuse disorder.

Prevailing disparities in unemployment, poverty, private insurance coverage, disabilities, and health problems along racial and ethnic lines call for strategic policies that effectively address these trends. As Texas and the nation face increasing costs associated with health care and the root causes of poverty, projections such as these allow policy makers to target limited resources where they will be most useful.

Challenges and Opportunities in the HHS System

As a populous and geographically expansive state with a large poverty population and major health issues, Texas faces unique challenges in delivering an interconnected array of health and human services. House Bill 2292, 78th Legislature, Regular Session, 2003, addresses these challenges.

During the strategic planning process, each HHS agency reviewed its major challenges and opportunities. Every agency identified major workforce challenges

[12] TCADA, "Texas School Survey of Substance Use Among Students: Grades 7-12," 2002.
[13] TCADA, "Toward a Drug-Free Texas," January 2003.

associated with retirements, turnover, and shortages in specific job titles. The HHS Enterprise Workforce Plan (Appendix E) presents a system-wide plan for addressing these issues.

Other challenges and opportunities common to the HHS system are discussed below. Challenges and opportunities specific to a particular agency are discussed in that agency's chapter.

Ensuring Stakeholder Input in the H.B. 2292 Environment

House Bill 2292 established five agency councils to advise the Commission and the four departments on HHS policy and operations. These councils replace the governing boards of the legacy agencies. The bill also created a Transition Legislative Oversight Committee to facilitate the transfer of various programs among the four departments and HHSC. The committee held public hearings on the Transition Plan and continues to monitor implementation progress.

The Governor will appoint nine-member councils for HHSC and each of the departments being created under the legislation. The purpose of the new councils is to provide public review and input on the impact of agency operations, polices and rules on the delivery of services to constituents. The councils, which must meet at least quarterly, are:

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

The Commission has been working with advocacy and stakeholder groups to define the roles and responsibilities of the five agency councils. The Commission sponsored a workshop to develop a framework for the policies and procedures that will guide the new councils. Key discussions at the workshop included guiding principles, scope of council responsibilities in agency management and operations, councils' legislative responsibilities, standard operating procedures, subcommittee recommendations, and cross-agency rulemaking. The workshop recommended the following Guiding Principles:

- Stakeholder Inclusion in Council Functions;
- Leadership/Decision-Making;
- Focus on Consumer Needs;
- Stewardship; and
- Business Operations.

HHSC conducted five public meetings to receive public comment on the proposed guiding principles and standard operating procedures for the new agency councils mandated in H.B. 2292. The workshop results are being considered by HHSC in defining the roles of the councils.

Another method of ensuring stakeholder input was holding public hearings on the departments' proposed organizational structures before the agency structures were finalized. Almost 1,700 people attended the hearings, with 419 providing public comments. As a result, agencies made key changes to the structure, including structural changes to ensure consumers have a mechanism for providing input into the transformation and agency decisions regarding service delivery and policies.

Section 2.06 of H.B. 2292 requires HHSC to conduct a public hearing to solicit public comment prior to establishing the first call center to determine eligibility for certain public assistance and public health programs. Twelve such hearings were held in April and May 2004. Numerous public hearings and meetings are continuing, as well, on Medicaid/CHIP managed care and various program changes.

Although H.B. 2292 changed the structures through which stakeholder organizations and public input are received, the HHS agencies will continue to solicit stakeholder input throughout the transformation of the new departments and as new service delivery improvements are identified.

Increased Demand for Services, Limited Resources, and Rising Costs

The demand for HHS services is growing steadily, in direct proportion to the state's population growth or, in some cases, at an even greater rate. Additionally, as HHSC continues to streamline eligibility processes and provide continuous coverage for children, the number of persons receiving benefits each month increases.

Moreover, the economic downturn over the past four years has caused an increase in caseloads and costs associated with caring for more people as they become eligible for Medicaid. Increasing pharmaceutical costs have affected a Medicaid budget already experiencing a 10 percent increase in expenditures.

As each of these factors began to converge throughout 2003, Texas, like other states across the nation, faced a serious budget crisis. In an effort to close the budget gaps, Texas lawmakers made cuts in many areas of state government, to achieve greater efficiency and cost savings.

Even with reductions, the HHS budget remains the second-largest in state government, after education. As expected, the majority of HHS appropriations is associated with the Medicaid and CHIP programs. In April 2004, Medicaid was

serving approximately 2.6 million recipients, while CHIP was serving about 377,000 children under the age of 19.

To conserve funds, HHSC and the HHS legacy agencies spent much of FY 2003 and FY 2004 consolidating and streamlining administrative services. At the same time, in accordance with H.B. 2292, the HHS system began the complex task of transforming itself from 12 agencies to four service delivery agencies and the Commission.

Aging of the Population

As noted in the section above on Statewide Demographic, Economic, and Health Trends, the population of Texas is aging, resulting in certain trends that have a significant impact on the state's delivery of health and human services. These demands are already evident in the strategic planning efforts of several HHS agencies.

The HHSC State Medicaid Office cites the aging population as a key factor in the increased demand for and rising costs of this program. Older persons frequently enroll in Medicaid to cover the costs of long-term care services, which are often more costly than acute care services. In federal fiscal year (FFY) 2002, persons ages 65 and over accounted for nine percent of Medicaid enrollees that received services, but the cost for the services they received represented 27 percent of all funds spent on services by the program. The growing aging population will thus continue as a major contributor to the fiscal challenges for Medicaid (See Chapter V, Challenges and Opportunities.).

The HHSC and the HHS agencies must expand efforts to address other specific trends and issues as well, such as the lack of prescription drug coverage for a large number of older Texans (31 percent), and the increasing prevalence of obesity and diabetes in the older population. There is also a significant lack of access to health care services for older Hispanics living along the Texas-Mexico border. Other issues cited by the Texas Department of Aging and Disability Services include the:

- Increasing numbers of persons who are placed in the role of providing informal care giving for older persons;
- Growing number of children who are being cared for by grandparents (currently nearly eight percent);
- Lack of sufficient guardianship and alternatives to guardianship services;
- Growing number of older persons suffering from abuse and/or neglect, both at home and in unlicensed, unregulated assisted living facilities; and
- Aging of Texas baby boomers, placing an increased demand on independent living services and affecting other areas of the socio-economic sector (See Chapter VII, Challenges and Opportunities.).

The aging of the Texas population provides several opportunities for the HHS system to re-focus specific programs and initiatives, such as providing substance abuse prevention for older adults, conveying the importance of financial planning, strengthening public health outreach, and other efforts. For example, the Texas Department of Family and Protective Services recognizes the impact of an aging Texas as it seeks to improve its Adult Protective Services programs.

Finally, the aging of the population provides an important impetus for HHSC to provide system leadership as it realigns the delivery of both short-term and long-term services and supports for Texans of all ages.

Implementing New Program Policies in a Changing Environment

In addition to carrying out the major restructuring actitivities laid out in Article 1 of H.B. 2292, Article 2 details more than 200 program policy changes that the HHS system must implement. The provisions in Article 2 involve numerous agency programs and services. Many are designed to achieve cost savings, efficiencies, and a streamlined system of service delivery across all agencies.

Significant policy changes mandated by Article 2 of H.B. 2292 will challenge the HHS system's resources and workforce. Many aspects of the new system's structure and functioning will be affected, including the following:

- Continued focus on client needs and program delivery;
- Management of existing and new workload requirements;
- Expedient and effective implementation of the new program changes;
- Maintenance of current reporting requirements along with project (transition) management tracking;
- Balancing of management priorities regarding policies and programs;
- Continued adherence to existing state and federal requirements; and
- Restructuring of the system budget while maintaining effective stewardship of public resources.

The HHSC is using a project management approach to oversee and monitor the consolidation, in accordance with H.B. 2292. The Central Program Management Office (CPMO) assists HHSC leadership in planning, facilitating, and overseeing the portfolio of projects that will achieve the consolidation of the HHS departments and the streamlining of administrative support services. Each new department also established a Departmental Program Management Office (DPMO) that works closely with the HHSC CPMO on transition activities.

The CPMO has developed a framework for implementing the transition. This framework encompasses two broad classes of activities: operations and

transformation. Operations activities are those that focus on delivering services, or supporting the delivery of services, to clients. Transformation activities include consolidation and optimization, each discussed below.

Consolidation activities are those which merge a commonly defined system (i.e., a function) currently operating in multiple management structures into a new unified management structure. This may involve combining a single function operating in multiple agencies into a unified function, such as procurement. It may involve combining multiple functions into a unified function, such as integrated eligibility. Finally, it may involve the creation of an oversight function that provides standards and facilitates coordination of similar functions located across the other agencies.

Optimization activities are those aimed at significantly improving service delivery or enhancing efficiencies in that delivery. These activities should result in measurable, or at least demonstrable, outcomes such as decreased delay or interruption in service, ease of access, cost savings, cost avoidance, or reduced administrative burden. These outcomes may focus on different constituencies including clients, providers, and staff. All these activities directly contribute to the need for ensuring that resources are appropriately focused on serving Texans.

Ensuring Provider Availability and Effective Regulation

Ensuring an adequate number of providers to serve Texas' HHS populations is an ongoing challenge. Providers cite the following reasons for the shortage: low reimbursement rates, high costs of operations, administrative complexity of serving the state's clients, the lack of qualified workers, and the relatively low level of funding for staff training and salaries.

Service providers are in particularly short supply for the 16.5 percent of the state's population living in rural areas. In these regions, high levels of need result from poverty and rural economic decline, limited employment and training opportunities, and insufficient transportation and support systems for families and youth. Addressing providers' needs related to training and salary levels would support recruitment and retention efforts in these areas of the state.

Service provider availability is also affected by the difficulty in accurately forecasting caseloads. The timing for setting the state's general appropriations and other factors may cause projections to become unstable over a two-year period despite the use of sophisticated, scientific, and statistical methods to project caseloads. The resulting budgeted levels may be either too high or too low. In a large program such as Medicaid/CHIP, even a small error can be fiscally significant and impact providers' ability to plan for efficient service delivery. The recent consolidation of the forecasting function at HHSC has the potential to result in more timely information and data exchange, and improved business processes.

Underlying these issues is the state's responsibility to regulate providers, inspect facilities, and ensure program integrity, sanctioning those who do not meet standards, and ensuring overall compliance with state and federal law and regulation. In the area of long-term care, there have been major initiatives to educate and build understanding with providers. A parallel effort focuses on providing quality information and better education for consumers to encourage good choices of providers. In addition, regulatory standards and procedures have been more rigorously and consistently applied. These initiatives have potential applicability across the HHS agencies.

Maximizing Federal Funds in a Consolidated Structure

The HHS function makes up about one-third of Texas government spending. No other function of Texas state government relies as heavily on federal funds as the HHS system. Federal funds account for approximately 58 percent of the total HHS appropriations. The largest single source of federal funds in the system is the Medicaid program funded by Title XIX of the Social Security Act, followed by Food Stamps and Temporary Assistance for Needy Families (TANF). The legacy HHS agencies included 103 different sources of federal funds in their appropriation requests for the state 2004-2005 biennium. Nineteen of these funds represent over 99 percent of all federal HHS funds. Additionally, much of the HHS system general revenue is dedicated to either maintenance of effort[14] or matching federal funding sources.

Effective management of federal funds continues to be a day-to-day function of each of the HHS agencies. Every HHS agency budget decision involves management of one or more federal funding sources. Receiving and spending federal funds are complex tasks and will become even more complex as the demand on both state and federal resources continues to increase, and as the HHS system consolidates its budget structure. Use of federal funds entails significant responsibilities for managing many compliance requirements. Moreover, several major federal programs were either recently reauthorized or will be in the near future, which often brings change to programs and services.

Effective management of federal HHS funding is critical for three reasons: 1) the state relies very heavily on this funding source, 2) HHS programs depend on each other for success, and 3) the considerable changes in the current HHS environment increase the risk of management problems. Provisions of H.B. 2292 require greater integration of the federal HHS funding process. Organizational changes require the HHS system to develop a new federal cost allocation process, which will allow the system to identify how best to align availabile federal funds with funding needs.

[14] "Maintenance of effort" is a federal requirement preventing states from decreasing funds for identified services below a certain level.

The need to integrate the diverse network of funding sources into a seamless service delivery system adds further challenges. Greater integration of the federal funds process also will prevent changes in one agency's funding policies from affecting another agency's resources. Using multiple federal funding sources supports the HHS system both by increasing the pool of funds available to the system and by increasing the financing flexibility. When a given service is an allowable expense under more than one federal funding source, these options add both flexibility and complexity to financing of the service.

Developing an Integrated Regional Structure

With a myriad of existing regional boundaries among the agencies, developing an integrated regional structure offers the opportunity to improve service delivery and maximize resources. Currently, all five HHS agencies administer programs and deliver services at the local level using a variety of geographic boundaries. Several of the agencies use regional boundaries consistent with the 11 HHS regions, such as the legacy agency TCADA and the DFPS. Others use a modified HHS regional map that combines some of the 11 HHS regions, such as the legacy agency TDH, which provides services in eight public health regions. Some agencies use regional boundaries unlike the HHS regions, such as the legacy agency TRC, which has five regions and the legacy agency TDoA, which delivers services through contracts with 28 area agencies on aging throughout the state. Table 3.1 below describes an overview of the respective geographic boundaries by HHS legacy agency, prior to H.B. 2992.

Table 3.1.
Service Boundaries by Legacy HHS Agency.

LEGACY AGENCY	SERVICE BOUNDARY
HHSC	11 HHS regions (some HHSC staff co-located with other HHS agencies; grants and special initiatives in select regions through contracts)
TCADA	11 HHS regions (contract for services)
TCB	12 regions with 29 district offices; and a rehabilitation center in Austin
TDoA	28 Area Agencies on Aging regional boundaries (contract for services)
TDH	8 public health regional offices serving the 11 HHS

LEGACY AGENCY	SERVICE BOUNDARY
	regions, along with 64 autonomous local heath departments providing services to local communities
DHS	10 administrative regions with 400 local offices
TCDHH	11 HHS regions (contract for services)
PRS	5 districts with 239 field offices; centralized administrative office in Austin; districts combine 11 HHS regional service areas
MHMR	*Mental Health*: 10 State Mental Health Facilities (SMHFs) and 40 Local Mental Health Authorities (LMHAs) in 7 regions *Mental Retardation*: 41 local community MR authorities; 13 state mental retardation facilities; contract services with private providers throughout the state
TRC	5 regions with 130 regional and field offices
ECI	11 HHS regions (contract for services)

Table 3.1: HHSC Center for Strategic Decision Support, 2004.

Creating a more standardized structure also offers some unique challenges, and to address these challenges a new interagency workgroup called the Regional Structure Steering Committee has been formed. The Committee is charged with designing an integrated model for supporting HHS administrative services for all regions, while also examining opportunities for the future integration of services. In the summer of 2004, the workgroup is expected to propose:

- The geographic boundaries for administrative services and proposed locations of regional headquarter and local field offices;
- A list of administrative functions that can be consolidated and performed at regional locations; and,
- Sample models of functional organizational designs.

The Committee identified the following challenges related to the effort to better align regional administration and services:

- Business and contractual obligations, such as leases, telephone systems, and other technologies may require extensive negotiation to restructure;
- Computer systems may need major changes in order to become compatible;
- Budget constraints, restrictions on funding sources, or indirect cost allocations may impact the ability to purchase the various components needed for supporting the infrastructure in each region; and
- Statutory requirements for specific programs and functions may impact co-location and other aspects of integrating administrative services.

Moreover, current proposals to outsource centralized functions such as human resources and purchasing will need to be considered in the implementation of the new regional structure.

Despite these challenges, a more consistent integrated structure poses significant opportunities to achieve cost savings, such as lower administrative overhead, and improved customer access to HHS services. One example of how this may be achieved is through the co-location of agency offices. The new structure also has the potential to offer more efficient contracting methods by reducing the number of contracts, points of contact, and billing activities between the state and its contractors (See also Chapter V, Strengthening Contracting Management Across the System.).

Realizing Efficiencies through Technology Integration

Advances in technology continue to provide new opportunities for HHS departments. Computers and telecommunications technology, both data and voice, provide new possibilities to improve administration of services. Medical and adaptive technologies are changing the types of available services, and the Internet has created new ways of conducting business. The HHS system must carefully integrate technology across the agencies and ensure that the new technology provides rapid access to accurate information, conducts electronic transactions, and integrates business processes, without regard to organizational boundaries.

As in private sector organizations, the technology deployed by state agencies must be refreshed periodically. Texas telecommunications infrastructure consists of the hardware and software connecting people to information and to each other. The legislative direction for technology in the state is to provide electronic access to information about state programs and services for all Texans. To provide this access, HHS IT must have the capability to handle current and increasing demands. Technology integration needs to address the ability of the HHS agencies and their public and private partners to stay abreast of technological advances, analyze

usefulness and stability of current systems, and deploy improvements in an effective and efficient manner.

In H.B. 2292, the IT function is consolidated into HHSC. This consolidation will ease the integration and consolidation of technology across the HHS agencies. Some IT infrastructure and personnel will remain in the departments to support program operations and core technologies that represent integrated systems reaching across the HHS system. The HHS system will continue to integrate and consolidate technology across the HHS agencies in the following areas.

Health and Human Services Administrative System

The Health and Human Services Administrative System (HHSAS) is an integrated system designed to support the consolidation of administrative tasks and reduce the cost of operating administrative systems. The HHSAS allows agencies to do the following activities:

- Conduct electronic transactions and integrate business processes across organization boundaries in a secure environment;
- Share common data and best practices across HHS agencies; and
- Produce and access information in a real-time environment.

The development of HHSAS has required systemwide coordination to consolidate agencies' business systems and operations to ensure uniform and consistent implementation.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted by Congress to reform the health care insurance market and to simplify health care administrative processes. This process is being accomplished by standardizing the electronic transmission of many administrative and financial transactions and protecting electronic health information. The HHSC has established a HIPAA Program Management Office to coordinate HIPAA implementation activities and to make HHS agency IT systems compliant with HIPAA standards.

Texas Integrated Eligiblity Redesign System

The Texas Integrated Eligibility Redesign System (TIERS) is a multi-year project to create a state-of-the-art eligibility determination system for HHS programs. This project provides eligibility workers with a single, integrated system for use in delivering food stamp benefits, cash assistance, and medical and long-term care services to Texans in need. It will support data sharing with 20 state agencies. In addition, TIERS is expected to improve customer service, expand access to services, provide a more efficient system for workers, and enhance fraud protection tools. As TIERS is implemented, clients and workers will complete less paperwork,

because once a family's information is provided, the same information will not have to be provided again. The technology will better adapt to changes in policy or law. TIERS will serve as the backbone of the Integrated Eligibility Project.

State Legislative and Policy Changes

In addition to the structural changes addressed in Article 1 of H.B. 2292, significant policy changes contained in Article 2 also impact continuing operations of every HHS agency. Many of the cost savings, however, come from changes to the CHIP and Medicaid program. The following highlights several of the major provisions, which are also discussed in greater detail in the appropriate section.

Call Centers

The HHSC is directed to establish from one to four call centers, if cost-effective, for determining, certifying, and recertifying eligibility for CHIP, TANF, Medicaid, Food Stamps, long-term care services, community-based support services, and other HHS programs. The Commission will contract with one to four private entities for the operation of a call center unless determined that it would not be cost-effective. Each call center must be located in Texas, but a call center in another state that processes overflow calls is not prohibited.

Children's Health Insurance Program and Medicaid

Preferred Drug List

This provision requires HHSC to establish a Preferred Drug List (PDL) for the Medicaid/CHIP Vendor Drug Program. The Commission may establish PDLs for community health centers, state mental health hospitals, foster children, and any other state program administered by the Commission or an HHS agency. The PDL may contain only drugs for which supplemental rebates have been negotiated. In addition, H.B. 2292 established the Pharmaceutical and Therapeutics Committee to make recommendations to HHSC about the contents of the PDL. The PDL must be available to consumers on the Internet.

Medicaid Managed Care

The HHSC is required to provide medical assistance for acute care through the most cost-effective model of Medicaid managed care. The cost-effectiveness calculation must take into account administrative costs, local market factors, and premium tax revenues the state will gain from the model of managed care pursued. Fee-for-service (traditional) Medicaid is allowed if Medicaid Managed Care is found not to be cost-effective.

Health Insurance Premium Payment

The Texas Medicaid program has the option to pay a Medicaid-eligible employee's share of the employer-sponsored coverage when it is cost-effective to do so. Legislative changes in 2001 allow a similar payment for CHIP eligible employees. The HHSC is directed to consolidate these programs and outsource this function, if it is cost-effective.

Eligibility Levels

This provision of CHIP establishes eligibility levels for children under age 19 at or below 200 percent of the federal poverty level (FPL) for gross family income for health benefits coverage, subject to the availability of appropriated money. Changes in eligibility income from gross family to net family income, effectively reduces the program's upper income limit. The HHSC is also authorized to establish standards regarding the amount and types of allowable assets for a family whose gross family income is above 150 percent of FPL.

Continuous Coverage

Individuals are eligible for CHIP for 12 months following the date of eligibility determination or until the individual's 19th birthday, whichever is sooner. Continuous eligibility may be established at an interval of 6 months beginning immediately and ending September 1, 2005 at which time an interval of 12 months will be re-established.

Prescription Limitations

This provision authorizes HHSC to limit CHIP children to four outpatient brand-name prescriptions per month and no more than a 34-day supply of a brand-name prescription at any one time if cost-effective. This provision allows HHSC to grant exceptions in consultation with a doctor and/or a nurse.

Cost-Sharing

This provision ensures that families with higher levels of income are required to pay progressively higher percentages of the cost of the plan. Cost sharing may be based on the federal maximum allowable amounts in a manner that minimizes administrative costs.

Ninety-Day Waiting Period

The CHIP may include co-payments and other provisions intended to discourage employers from discontinuing benefits for children, and to discourage individuals from choosing CHIP when they have other adequate health plan coverage. This provision imposes a new, 90-day waiting period for CHIP coverage to take effect.

Cost-Sharing for Medicaid Recipients

The HHSC must adopt provisions requiring recipients of Medicaid to share the cost of medical assistance to the extent allowed under federal law. Provisions include requiring a recipient to pay an enrollment fee (not currently allowed under federal law), a deductible, coinsurance, or a portion of the plan premium. All provisions adopted will be on a sliding scale.

Transfer of Medical Transportation Program

The DSHS and HHSC now contract with the Texas Department of Transportation (TXDoT) for the provision of transportation services for eligible clients through the Medical Transportation Program (MTP). This contractual arrangement requires TXDoT to assume all MTP responsibilities and permits TXDoT to contract with any public or private transportation broker.

Temporary Assistance for Needy Families

Healthy Marriage Development Program

If federal funds are available, once Congressional reauthorization of the TANF program is complete and if reauthorization includes provisions for healthy marriage programs, HHSC must develop rules to create a Healthy Marriage Development program for Temporary Assistance for Needy Families (TANF) consumers. The program must promote and provide the following courses:

- Premarital counseling (including anger resolution, family violence prevention, communication, honoring your spouse, and managing a budget);
- Physical fitness and active lifestyles (including cooking, nutrition on a budget, and abstinence for all unmarried persons); and
- Parenting skills.

Temporary Exclusion of a New Spouse’s Income

If a TANF parent marries, the new spouse’s income will be disregarded for six months, if it does not exceed 200 percent of the poverty income level.

Resource Limits and Exclusions

This provision changes the TANF eligibility requirements to exclude certain assets when assessing the applicant's available resources. The new rule excludes $1,000 for the applicant's household, including a household with a person with a disability or a person age 60 and over. It also excludes the fair market value of the applicant's ownership interest in a vehicle up to $4,650 for the TANF State Program to make it the same as the regular TANF cash assistance program. This section applies to a

person receiving financial assistance on or after the effective date of the Act, regardless of the date on which eligibility for financial assistance was determined.

Pay for Performance

This provision strengthens the requirement that each TANF recipient sign a personal responsibility agreement (PRA). If it is determined that a person is not cooperating, rather than complying with the requirements of their PRA, a sanction will immediately terminate the total amount of their TANF grant for the person, and additionally for their family, until the person meets the requirements of their agreement or one month, whichever is longer. During this time, medical assistance may be denied to individuals ages 19 years and over if the non-cooperation involved the work requirement or child support. An individual who fails to comply with their PRA for two consecutive months becomes ineligible for TANF. The individual may reapply, but must meet the requirements of their PRA for one month before receiving their first TANF check.

Family Cost Share for Early Childhood Intervention Services

The Department of Assistive and Rehabilitative Services has the authority to establish a system of payments by families of children receiving early childhood intervention services, including a schedule of sliding fees. The system of fees must be consistent with the federal Individuals with Disabilities Education Act (IDEA).

Texas Border Health Foundation

The Texas Border Health Foundation is a non-profit corporation created under the authority of H.B. 2292. Its purpose is to identify and seek partners to help maintain or increase the existing levels of financing of health programs and activities along the Texas-Mexico border. The Department of State Health Services (DSHS) will ensure that the foundation operates independently of any state agency or political subdivision. It will raise funds from other foundations, governmental entities, and the private sector.

Contracts for Community-Based Mental Health and Mental Retardation Services

The legacy Department of Mental Health and Mental Retardation (TDMHMR) contracts with community centers, which are designated by TDMHMR as Local Mental Health and Mental Retardation Authorities (LMHMRAs) to ensure the delivery of community-based mental health and mental retardation services for adults and children. The transfer of all powers, duties, functions, programs and activities from TDMHMR by H.B. 2292 to the authority of two separate departments will affect the

management of the LMHMRA performance contracts. This separation of state-level mental health and mental retardation results in the moving the mental retardation services to the Department of Aging and Disability Services (DADS) and the mental health services to the DSHS.

The LMHMRA contracting process is also affected by an amendment to Section 533.035, Health and Safety Code, through H.B. 2292, which specifies that in assembling a network of service providers, a LMHMRA may serve as a provider of services only as a provider of last resort. This means that the LMHMRA may only provide services when demonstrating to the state authority that it has made every reasonable attempt to solicit the development of an available and appropriate provider base that is sufficient to meet the needs of consumers in its service area, and there is no willing provider of the relevant services in the authority's service area.

Finally, performance contracts with local mental health authorities (LMHAs) must incorporate disease management practices. Disease management is an approach to service delivery and management that affects the benefit package and financing methodology for community mental health services. Through this approach, services offered by LMHAs must be ongoing, match the needs of the individual, focused on a process of recovery, and guided by both evidenced-based protocols and a strength-based model of service.

Modernization of Bioterrorism Law

The statutory powers of the Governor, the Commissioner of Health, and a health authority are expanded to allow the state and local governments to more quickly and more efficiently respond to public health emergencies. The Governor and the Commissioner of Health have the authority to declare a public health disaster. In addition, the authority of the Commissioner of Health, as stated in Section 81.003 of the Health and Safety Code, has been expanded. The expansion includes permitting the Commissioner of Health to require additional communicable disease reports or reports of other health conditions from providers and to impose an area quarantine upon suspicion of disease. In addition, a health authority or his or her designee may continue to investigate the existence of a communicable disease within the boundaries of the health authority’s jurisdiction to determine the nature and extent of the disease as well as to formulate and evaluate the control measures used to protect the public’s health. Under separate law, the Commissioner of Health or health authority may also declare an area quarantine to address the introduction of other environmental toxic agents, such as radioactive or hazardous substances.

Reports on Customer Service

Each of the HHS legacy agencies conducted some form of customer survey or assessment process to obtain feedback on their performance from the customer's perspective. On June 1, 2004, individual agencies submitted their respective *Reports on Customer Service* to the Legislative Budget Board and the Governor's Office of Budget, Planning and Policy. HHSC will review individual agency reports and consider a consistent approach in developing future reports.