Chapter V

Health and Human Services Commission External/Internal Assessment

The Health and Human Services Commission (HHSC or Commission) was created in 1991 by the 72nd Texas Legislature to provide the leadership and innovation necessary to administer an efficient and effective health and human services (HHS) system for Texas. The responsibilities of HHSC have grown substantially since its inception with significant authority for oversight of the entire HHS system and the consolidation and administration of several support services and programs.

The material in this chapter is arranged as follows:

- Challenges and Opportunities;
- Current Activities by Goal:
  - Service Descriptions;
  - Target Populations; and
  - Other Trends and Initiatives;
- Internal Assessment; and
- Strategic Priorities.

For consistency, the same outline is used in each of the agency chapters.

Challenges and Opportunities

The HHSC is in the midst of an unprecedented effort to design a system that will improve service delivery, have greater accountability, and achieve significant administrative savings. At the same time, the agency must remain committed to its daily operational and program mission, as well as establish timely control of new programs transferred to it with the passage of H.B. 2292. The following sections describe the key challenges HHSC faces during this significant period and the opportunities that exist for meaningful change.

Balancing Oversight and Operations

The Commission's performance and accountability expectations increased significantly with the acquisition of several major policy and program operations from the legacy HHS agencies. The Commission must effectively balance its system

leadership role with the demands of operating programs and delivering services. Major changes to aspects of the agency's organizational structure and functions impact existing workload requirements, reporting needs, management priorities, and the overall structure of the agency's budget.

The new organizational structure for HHSC delineates the system-wide leadership, oversight, and consolidated administrative services from agency operations. This new organizational structure clarifies roles and responsibilities, facilitates effective communication internally and externally, and promotes greater accountability at both the program and operations level.

The Commission revised its goals, objectives, and strategies to group strategies for the system-wide oversight and policy responsibilities, Office of the Inspector General (OIG), eligibility responsibilities, and other consolidated administrative services under a single goal, Medicaid operations under a second goal, the Children's Health Insurance Program (CHIP) under a third goal, and Family Support Services (FSS) under a fourth goal.

Consolidating Administrative Support Services

In fiscal year (FY) 2004, HHSC achieved the consolidation of the staff and budgets for several administrative services. In proceeding with these activities, the Commission continues to conduct rigorous reviews of its business operations to determine the best way to perform various administrative functions. This examination will identify areas where system changes, technology solutions, or outsourcing will result in more efficient operations, allowing HHSC to realize savings or redirect administrative funding into direct program services.

As the HHS system undergoes this major administrative consolidation, some common challenges have emerged:

- Keeping vast amounts of information and communication flowing among large numbers of employees;
- Reassigning and relocating staff, and addressing the accompanying human resources, payroll, and other administrative issues;
- Addressing the retirement exodus, replacing seasoned workers, and orienting and integrating new staff with existing staff;
- Managing major change in general and addressing worker anxiety;
- Clarifying departmental missions and organizational structures;
- Containing the costs of escalating goods and services, including data migration and integration;
- Replacing outdated IT systems; and
- Establishing a new system culture.

The Commission and the Health and Human Services Transition Legislative Oversight Committee developed the *House Bill 2292 Transition Plan* to address

these challenges. The Program Management Office implements the various tasks and milestones within the plan. With such a blueprint in place, the HHS system will have the opportunity to complete its transformation iteratively and deliberately, according to the following principles:

- Clear communication;
- Timely establishment of the system's leadership;
- Retention and recruitment of the best employees;
- Alignment and unification of the best possible system structure; and
- Adherence to a business case protocol with clear accountability.

Increasing Demand for and Costs of Medicaid/CHIP Services

The majority of HHS appropriations is associated with Medicaid and the Children's Health Insurance Program (CHIP). In April 2004, some 2.6 million Texans of all ages were enrolled in Medicaid and some 377,000 children under age 19 were enrolled in CHIP. For the state 2004-2005 biennium, Medicaid and CHIP programs [1] were appropriated a total of $30 billion in all funds,[2] representing about 76 percent of the total HHS appropriation of $39.8 billion. Thus, efforts to contain or reduce spending must include changes to Medicaid and CHIP.

For Medicaid and CHIP, Texas establishes its own eligibility standards, determines the extent of services, sets payment rates, and administers its own programs. Provisions in H.B. 2292 include many policy changes that are designed to control expenditures and maximize the use of available funding for Medicaid and CHIP, including the following steps:

- Adjusting periods of eligibility;
- Increasing CHIP client co-payments;
- Establishing a preferred drug list, with prior authorization and supplemental rebate provisions;
- Reducing provider reimbursement rates;
- Restricting eligibility for certain Medicaid client categories; and
- Narrowing the array of benefits for CHIP and certain Medicaid clients.

Even with these cost containment policy changes, a mismatch between revenue growth and Medicaid spending growth continues. Medicaid spending has grown in recent years, as Medicaid enrollment numbers and costs have increased. A serious problem facing the Medicaid program in FY 2005 is the decrease in the federal

[1] Includes Medicaid, CHIP, State Employee Children's Insurance Program, and CHIP Immigrant Health Insurance.
[2] General Appropriations Act, 78th Regular Session; includes state general revenue and Tobacco Settlement funds.

share of Medicaid spending, known as the Federal Medical Assistance Percentage (FMAP). Texas benefited from temporary federal fiscal relief for 15 months, crossing FY 2003 and FY 2004, which included an increase to the FMAP matching rate by 2.95 percent, increasing the federal share of Medicaid spending to 63.2 percent. This fiscal relief expired on June 30, 2004, returning the matching rate to 60.9 percent. As a result of these factors, Medicaid spending in Texas will increase dramatically in FY 2005.

Integrating Eligibility Determination

The state currently spends almost $700 million each year to determine eligibility for HHS programs. To improve consumer access and to conserve funding, H.B. 2292 transfers eligibility determination for CHIP, Temporary Assistance for Needy Families (TANF), Food Stamps, Medicaid, long-term care services, community-based support services, and other HHS programs to HHSC. It also directs HHSC to research the cost-effectiveness of establishing between one and four call centers to determine a participant's eligibility for HHS programs.

The proposed integrated eligibility (IE) model offers multiple communications channels for clients, including a web-enabled system to screen for potential eligibility, an online application for services, and a tool for customer service representatives to determine financial eligibility. The Texas Integrated Eligibility Redesign System (TIERS) includes many of the desired IE functions, a key consideration in designing the future system.

The Commission established a special project to meet the IE mandate. A four-phase process is being used to determine whether an IE system could reduce inefficiencies and costs associated with multiple eligibility processes, and whether call center processes and technologies could support integrated eligibility. The first two phases are complete, and the resulting business case for a call center solution is outlined in the report *Phase II, Business Case Analysis*, issued in March 2004. This report focuses on the two largest eligibility determination programs: Texas Works and Long-Term Care. These two budgets comprise about 80 percent of the total resources devoted to eligibility determination for HHS programs. The full report, available on the HHSC website, reached the following conclusions:

- It is financially feasible for Texas to operate a converged call center environment to consolidate the eligibility functions;
- A converged call center is operationally feasible, although detailed implementation planning will not be completed until the next phase of the project; and
- A request for proposals should be issued to determine whether outsourcing components of the proposed model would be cost-effective.

The third phase, which is predicated on the approval of the business case, will entail the implementation and transformation of the system. The fourth and final phase will focus on the ongoing improvement and optimization of the new system.

Strengthening Contract Management Across the System

According to the Texas Building and Procurement Commission, all the legacy HHS agencies contracted for some goods and services in FY 2003. Together, the agencies awarded a total of $735 million in these expenditures, which do not include contracts for client services. (The combined total of contracts for client services, such as legacy agencies' MHMR contracts with local MHMR authorities, would represent a much larger portion of the HHS budget as a whole).

The Commission has taken several steps to ensure accountability, best value, and maximum outcomes in contracting for services. An internal workgroup with representation from all the HHS contracting agencies has been created to identify ways to reduce or eliminate duplication of effort and to ensure continuity of processes. A second workgroup is examining the administrative burden experienced by nonprofit organizations that are contracting with HHS agencies and ways to decrease these burdens.

Efforts to make improvements in contract administration will include a review of audit findings from both the State Auditor's Office and HHS Internal Audit, and a review of other government reports and recommendations. Staff will conduct interviews to identify agency best practices processes needed enterprise-wide. The Commission will establish minimum standards for roles and responsibilities of contract managers/monitors and for grant management, as well as standardized databases.

Plans also include cross-agency coordination with internal and external entities to determine their current efforts regarding contract management. These include the HHS Legal Office, the Office of the Inspector General, the Commission and departmental program management offices, the Comptroller of Public Accounts, the Attorney General's Office, and agencies outside the enterprise, such as the Texas Department of Transportation, Texas Department of Housing and Community Affairs, and the Texas Workforce Commission.

Current Activities: Services, Target Populations, Trends, and Initiatives by Goal

HHSC Goal 1: Health and Human Services System

HHSC will improve the effectiveness and efficiency of the delivery of health and human services in Texas through the oversight and coordination of a prompt, accurate, and comprehensive service delivery system.

Health and Human Services Oversight and Transition

As 12 agencies reorganize to create four departments under the direction of the Health and Human Services Commission, the oversight and administrative services roles of the Commission are critical to the success of the realigned system. The goal of the transformation is to create an integrated, effective, and accessible HHS enterprise that protects public health and brings high-quality services and support to Texans in need.

To this end, HHSC will continue to administer the following interagency initiatives:

- Guardianship Alliance of Texas;
- Community Resource Coordination Groups;
- Texas Integrated Funding Initiative; and
- Substance Abuse and Mental Health Services Administration grant.

Office of Inspector General

To ensure client and provider accountability, H.B. 2292 created an independent Office of Inspector General (OIG) in HHSC, to be responsible for oversight of HHS activities. The OIG uses compliance and enforcement activities to identify and reduce waste, abuse, and fraud, and to improve efficiency and effectiveness in the HHS system, including provider and recipient activities.

In January 2004, the OIG began consolidated operations with more than 500 staff transferred from the legacy agencies. In the following months, the OIG staff worked with Central Project Management Office (CPMO) consultants to optimize the business organization and processes, communicating change management strategies to maximize efficiency and effectiveness. On September 1, 2004, the new OIG structure will be in place. The OIG fulfills its responsibility through the following activities:

- Providing education, technical assistance, and training to ensure responsible use of resources;
- Researching, detecting, and identifying episodes of waste, abuse, and/or fraud;
- Investigating episodes of waste, abuse, and/or fraud and monitoring cases internally, with appropriate referral to outside agencies for further action; and

- Issuing sanctions and performing corrective actions against program providers and/or clients as appropriate.

The OIG uses several automated systems to perform its duties, including the following projects or initiatives:

- **Diagnosis-Related Groups Validation Project**—under which a vendor contracts to review a subset of hospital inpatient claims, to validate diagnosis assignments, so billing errors may be identified and erroneous payments recovered;
- **TeamMate**—auditing software using a relational database engine which enables users to quickly access information of interest;
- **Fleeing Felons Data Match**—a cooperative initiative with the Federal Bureau of Investigation and the Texas Department of Public Safety; and
- **Missing and Exploited Children Data Match**—a cooperative initiative with the National Center for Missing and Exploited Children.

Consolidated System Support

Under H.B. 2292, HHSC assumed responsibility to plan and implement an efficient and effective centralized system of support services for HHS agencies. In FY 2004, the major focus was on consolidating the functions of human resources, civil rights, purchasing, facilities management, and strategic planning and evaluation.

Human Resources

The human resources (HR) function from each HHS agency was consolidated and moved to HHSC. A centralized HR organizational structure was established, allowing managers and supervisors to provide consistent policies, practices, and services across the enterprise. The HHS enterprise now has the following standardized elements:

- A standardized HR Policy Manual with standardized forms;
- An HR web site;
- A single Workforce Plan including standardized recruitment and retention strategies;
- A common method of job audit review;
- A uniform performance management program and complaint investigation procedure; and
- Combined administrative training delivery for major training programs.

A common technology solution, the Health and Human Services Administrative Systems (HHSAS), is used by each agency for HR, payroll, and time and labor production activities. The consolidated system provides new efficiencies in position control management, providing employee information, processing payroll, and time and labor transactions, tracking administrative training, standardizing workforce

reports, and improving ad hoc reporting capabilities. The HHSAS production system is targeted for implementation on September 1, 2004.

Civil Rights

The Civil Rights Office assists HHSC in maintaining a work environment free of discrimination, harassment, or intimidation and in providing services to clients in a non-discriminatory manner by using resources that previously provided support to 60 percent of the system. Such efficiency in operation will be accomplished through the maximum use of technology (e.g., computer/Internet based training, teleconferencing, videoconferencing), streamlined civil rights processes (e.g., use of program embedded processes for compliance reviews), and placing resources closer to customers (employees and clients).

The Civil Rights Office performs these six functions in providing civil rights support to HHSC and consolidated agencies:

- Subject matter expertise;
- Investigation/Dispute resolution;
- Compliance with civil rights laws;
- Accessibility;
- Training; and
- Reporting and trend analysis.

The Civil Rights Office provides civil rights support to about 45,000 employees, 7 million program applicants and consumers, and thousands of HHSC contractors and other entities that agencies use for service delivery.

Purchasing

Purchasing employees at HHS agencies were consolidated to a single Purchasing Division at HHSC on October 1, 2003. The optimization of purchasing functions is in progress, with significant reductions in staffing levels already achieved through retirements and attrition. In cooperation with providers and provider associations, HHSC continues to implement strategies to support and streamline purchasing of goods and services for clients. Other areas of savings include pharmaceuticals, office supplies, and equipment maintenance.

Facilities Management

The HHSC Facility Management Division (FMD) will consolidate two critical administrative support functions from the HHS agencies: Facility Leasing (FL) and Facility Management (FM). The FL staff was consolidated to HHSC effective June 1, 2004, with the FM staff and other administrative support services to be transferred later in the summer.

The legislature directed the Texas Building and Procurement Commission (TBPC) to reduce leased office space and achieve cost savings as part of an overall cost-

saving strategy. The HHS agencies currently expend nearly $66 million per year to lease nearly six million square feet of space for offices throughout the state. The FMD will be the primary program area for the coordination of lease contract transactions with the TBPC and its outsourced, private-sector contractor, Scribcor Texas, for all contract lease and space allocation functions.

The FMD will coordinate the approval and consolidation of lease contract space impacted by the reorganization efforts. Consolidating client eligibility and establishing call centers will reduce HHS agency needs for leased space and achieve significant cost savings. Since HHS agencies constitute nearly 54 percent of all TBPC leased space, the HHS consolidation and reorganization will contribute significantly in reducing state expenditures for leased space.

Consolidated Information Technology Support

The HHS Enterprise Information Technology (IT) Division has been developed to provide oversight and direction for the creation of an integrated solution for delivering information resources to health and human service agencies that:

- Establishes enterprise IT policies and standards;
- Efficiently and effectively provides IT support to all HHS staff;
- Provides innovative solutions for delivery of services to HHS clients; and
- Develops strategies to optimize the provision of IT services.

During the Planning phase, the following IT assets and resources were identified across the HHS system:

- 816 Applications and Databases;
- 750 Information Technology Contracts; and
- 1,400 Information Technology Employees and Contractors.

In addition, a survey was conducted to identify IT hardware and facility assets across the HHS enterprise.
The IT consolidation is currently in the Integration Phase, and an enterprise Chief Information Officer is now in place. The organizational structure will include the HHS Enterprise IT Division and an Information Resources Department providing operational support for each of the new agencies. The implementation of this structure will be completed in September of 2004.

Optimization strategies under review include common technologies which are not unique to an agency's functions, such as help desk services and data center/server management. Managing these services at an enterprise level will maximize economies of scale and leverage IT investments across the HHS system.

Strategic Planning and Evaluation

The strategic planning and evaluation functions and staff from the legacy agencies were consolidated at HHSC in January 2004. The new consolidated division was structured to include a research team, a demography team, a program performance and evaluation team, a data management team, and a strategic planning unit that includes planning teams to work within HHSC and with each of the new departments.

In May 2004, as part of a larger reorganization at HHSC, the division name was changed to the Center for Strategic Decision Support (Center), and its director reports directly to the Chief of Staff. The name change reflects a focus on providing information, analysis, planning, and evaluation services to the HHS leadership and the system as a whole to promote decisions based on current, consistent, and accurate data.

The Center will lead the HHS system in the use of new business intelligence software that enables users to identify the key business questions required of the data set. The data warehouse is then developed to answer those questions. This represents a major shift in the way information is handled, away from compiling and maintaining massive amounts of data to the development of more streamlined, effective data sets that respond appropriately to specific questions.

This consolidation of planning, evaluation, and other analytical services provides a significant opportunity for integrated planning and performance systems, focusing system efforts on common strategic goals, and encouraging decision-making consistent with the mission and goals of the HHS system.

Ombudsman/Consumer Affairs

Under H.B. 2292, HHSC assumed responsibility for a consolidated HHS ombudsman function. Consolidating customer services functions will improve efficiency gains through the following efforts:

- The centralized point of contact for consumer concerns increases accountability to the consumer and eliminates duplication of effort.
- A large pool of staff resources from agencies allows availability of a diverse knowledge base, especially through cross training.

The Office of the Ombudsman has gone through several phases of transition. The Planning Phase is complete, and the Integration Phase is nearly complete, with the following activities: determining role and scope of the Office of the Ombudsman; business case planning; identification of staffing levels to support the consolidated functions; and creation of policies and procedures to monitor consumer issues to resolution. The Optimization Phase, including implementation, fine-turning processes for greater efficiency, and streamlining of consolidated customer service functions, is scheduled for completion by September 30, 2004.

Consumer Support Systems

Texas Council for Developmental Disabilities

The Texas Council for Developmental Disabilities (TCDD) is a 30-member board dedicated to ensuring that all Texans with developmental disabilities—about 344,300 individuals—have the opportunity to be independent, productive, and valued members of their communities. Using a variety of methods, the TCDD works to ensure that the service delivery system provides comprehensive services and supports that meet people's needs, are easy to access, and are cost-effective. The council also works to improve understanding of disability issues.

Prior to the passage of H.B. 2292, the Texas Rehabilitation Commission (TRC) provided administrative support to the TCDD. Federal law specifies that an agency supporting the TCDD may not also serve people with developmental disabilities. A grandfather clause allowed TRC to serve the TCDD, but that clause does not extend to DARS. Thus, responsibility for the TCDD has been transferred to HHSC.

Texas Information and Referral Network and the 2-1-1 Telephone System

The Texas Information and Referral Network (TIRN) was designated by the 75th Legislature as the HHSC program responsible for the development, coordination, and implementation of a statewide information and referral network. A major component of this effort has been the implementation of the state's 2-1-1 telephone system, which is a single, statewide number that consumers can dial for information about community resources. After receiving approval from the Federal Communications Commission for the abbreviated dialing code, TIRN developed the network platform, provided the necessary telephony, and began operations. To date, 2-1-1 is available in all areas of the state except El Paso, which was scheduled to be operational in summer 2004.

In 2003, through a decentralized system of 25 private partnerships, the Texas 2-1-1 system handled over 1.1 million calls for general information and referral, with over 80 percent of the calls answered within 60 seconds. In an effort to provide easy access to information while maximizing the state's investment, staff is exploring ways to integrate 2-1-1 with all other consumer avenues to information. Using advanced technologies to enable voice communication over the Internet, TIRN will continue these efforts and will provide overall coordination and oversight of the Texas 2-1-1 system.

Eligibility Determination

Eligibility determination for many HHS programs is currently performed in 382 separate field offices. There are 1,011 workers performing eligibility determination in other community locations, such as hospitals. The legacy DHS, which was responsible for determining eligibility for Food Stamps, TANF, Medicaid, long-term care services, and community-based services, has more than 7,000 eligibility staff

across the state. This staff determines, or supports the determination of, an applicant's eligibility for services, certifies the applicant's benefits, and re-certifies benefits to ensure an applicant's eligibility for services. Eligibility staff at DHS performs more than 13 million case actions annually.

With the passage of H.B. 2292, HHSC is responsible for centralizing eligibility determination across health and human services and creating an Eligibility Services division within HHSC.

Departments under the Commission's umbrella perform eligibility determination for multiple programs. The functions involved in both centralizing and conducting eligibility determination for HHS programs will apply to consumers seeking to participate in the following programs:

- Children's Health Insurance Program;
- Temporary Assistance for Needy Families;
- Medicaid;
- Food Stamps and Special Nutrition Programs;
- Community-based support services for long-term care services (financial);
- Long-term care services (financial); and
- Other HHS programs.

Eligibility determination for additional programs will be considered for transfer to the Commission as allowed by federal law, as part of Phase II of the consolidation and integration of eligibility services. It should be noted that the functional aspects of long-term care eligibility determination will remain with DADS due to the need for specialized staff to determine the need for supports and services.

HHSC Goal 2: Medicaid[3]

HHSC will administer the state Medicaid system efficiently and effectively, using a comprehensive approach to integrate Medicaid client health services with other direct service delivery programs.

Medicaid

Service Description

Medicaid is a means-tested entitlement program financed jointly by the state and federal governments and administered by the states. In April 2004, about one in nine Texans relied on Medicaid for health insurance or long-term care services. As such, the Medicaid program is the state's largest HHS program. Medicaid pays for basic health care (physician services, inpatient, outpatient, pharmacy, lab, and x-ray services). It also covers long-term care services for the aged and recipients with disabilities.

The federal share of the jointly financed program is determined based on average state per capita income compared to the U.S. average. This is known as the Federal Medical Assistance Percentage (FMAP). In Texas, the FMAP for federal fiscal years (FFY) 2003 and 2004 is 63.2 percent federal and 36.8 percent state, as a result of temporary federal fiscal relief to assist states with the fiscal crises facing them in 2003. On July 1, 2004 the FMAP will revert to its standard rate of 60.9 percent.

Target Population

Medicaid serves primarily low-income families, children, related caretakers of dependent children, pregnant women, older persons, and people with disabilities. Initially, the program was only available to people receiving cash assistance (TANF) or Supplemental Security Income (SSI). During the late 1980s and early 1990s, Congress expanded program eligibility to include a broader range of people (older persons, people with disabilities, children, and pregnant women). Under federal direction, Medicaid eligibility is no longer linked to the receipt of cash assistance.

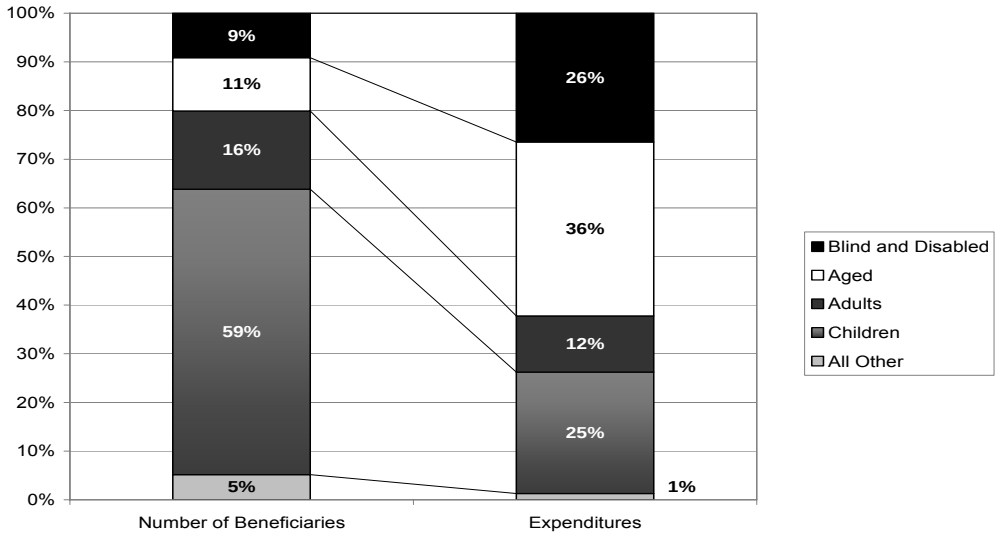
As a demographic sector, children comprise the majority of Medicaid recipients but account for a relatively small portion of the expenditures. By contrast, the aged and people with disabilities make up just 20 percent of recipients, but account for 62 percent of Texas Medicaid spending on direct health care services. Figure 5.1 illustrates the percentage of the Medicaid population by category and the portion of the Medicaid budget spent on them in FFY 2003.

[3] Information for this section of the HHS Strategic Plan was extracted from various data sources, such as Texas's Medicaid Statistical Information Systems (MSIS) and monthly program data files tracked and maintained by the HHSC Center for Strategic Decision Support.

Texas covers a limited number of optional groups under Medicaid, such as the medically needy. The Medically Needy Program is not a cash assistance program like TANF. Rather, the Medically Needy Program provides Medicaid benefits to: (1) individuals and families who may be eligible for TANF but have chosen not to participate in that program, or (2) individuals whose income exceeds Medicaid eligibility limits, but who do not have the resources required to meet their medical expenses. Those eligible for Medically Needy services are allowed to spend-down their incomes to gain Medicaid eligibility. The Medically Needy Program is not available to older or disabled persons. Texas covers pregnant minors and infants up to 185 percent of the federal poverty level and adult pregnant women up to 158 percent of the federal poverty level.

From a programmatic standpoint, the largest portion of the Medicaid population is composed of women and children. As of April 2004, about 56 percent of the Medicaid population was female, and 67 percent was under age 19. These groups are more likely to meet the eligibility criteria established by TANF, which provides them with automatic Medicaid eligibility. Medicaid eligibility is determined first, and eligibility for other programs is determined subsequently.

Figure 5.1.
Texas Medicaid Beneficiaries and Expenditures for FFY 2003



NOTES:
(1) Most beneficiaries included in the category of 'All Other' are recipients of long-term care.
(2) Children are included the 'Blind/Disabled' category.

Figure 5.1: Texas Medicaid Program: Medicaid Statistical Information System (MSIS), 2004.

The Social Security Administration determines eligibility for Supplemental Security Income (SSI), the federal program that provides direct financial payments to low-income older persons, blind people, and people with other disabilities. All SSI

recipients in Texas are also categorically eligible for Medicaid and automatically receive Medicaid upon SSI determination. The Department of Assistive and Rehabilitative Services is the disability determination agent for the Social Security Administration in Texas.

Disability

As of April 2004, about 14 percent of the children and adults receiving Texas Medicaid services became eligible because of a disability. However, this figure understates the actual frequency of disabling conditions among Texans in the Medicaid program, because many people over age 65 also have a disability. Almost one-third of aged clients receive care in a nursing home, and tens of thousands receive home and community-based services to help with disabling conditions.

Gender

Texas Medicaid recipients are disproportionately female, for several reasons:

- The poverty rate in 2002 was higher among females (17 percent versus 14 percent for males);
- Women live longer, on average, and the rate of poverty among women ages 65 and over is higher than among their male counterparts (16 percent versus 14 percent in 2002);
- TANF-related coverage targets poor single-parent families, which in Texas are usually female-headed (87 percent in February 2004). Female-headed single-parent families in Texas have higher poverty rates than their male-headed counterparts (44 percent versus 15 percent in 2004); and
- Medicaid covers eligible low-income women for pregnancy-related services.

Age

As of April 2004, children and older persons made up 81 percent of the program enrollees. Children under age 19 comprise 67 percent or 1,715,000 of the 2,558,000 persons enrolled in the program.

Ethnicity

Hispanics represent the largest proportion of Medicaid enrollees, comprising 52 percent of all enrollees, followed by Anglos (26 percent), and then African Americans (19 percent). In 2004, the state's composition according to race/ethnicity was as follows: 51 percent Anglos, 12 percent African American, and 34 percent Hispanic. All other groups comprise the remainder.

HHSC Goal 2 Trends and Initiatives

The number of Texans participating in the Medicaid program has increased significantly during the last four years. From 1999 to 2003, the yearly average growth rate in total enrollment was about 10 percent. Figure 5.2 shows the number of Medicaid enrollees as of the month of December for selected calendar years. In December 2003, total point-in-time, unduplicated enrollment was about 784,000 higher compared to December 1999.

Figure 5.2.
Texas Medicaid Enrollment (in December of Calendar Years)

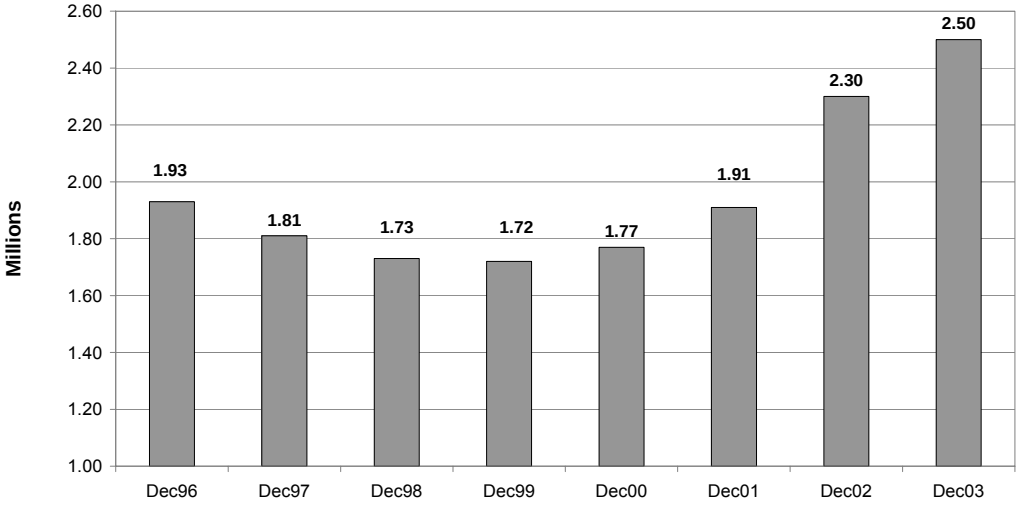


Figure 5.2: HHSC Center for Strategic Decision Support, 2004.

Research also shows that the number of Texans potentially eligible to receive Medicaid benefits is expected to continue growing. By 2007, the average monthly number of people eligible for Medicaid is expected to rise to 1,141,859—an increase of 76 percent since 1998. This growth is listed by categories of the eligible population, not including those qualified through TANF:

- The number of qualified pregnant women at or below 185 percent of poverty, not TANF eligible, will grow from 135,207 in 2003 to 143,157 in 2007—a 5.9 percent increase.
- The number of infants at or below 185 percent of poverty, not TANF eligible, will grow from 128,691 in 2003 to 134,974 in 2007—a 4.9 percent increase.
- The number of children ages 1-5 at or below 133 percent of poverty, not TANF eligible, will grow from 369,928 in 2003 to 389,872 in 2007—a 5.4 percent increase.

- The number of poor children ages 6-18, not TANF eligible, will increase from 556,493 in 2003 to 600,264 in 2007—a 7.9 percent increase.

Medicaid Managed Care

Texas Medicaid currently operates managed care in eight service delivery areas of the state. As of April 2004, the number of Medicaid managed care enrollees had grown to over 1.34 million[4] or over one-half of the state's Medicaid population. The early managed care programs concentrated on enrolling non-disabled, low-income families, and children and pregnant women into managed care. However, current Medicaid managed care programs have been expanded to serve certain disabled populations, and new pilot programs have been created to serve Medicaid recipients with more complex needs. In 1998, STAR+PLUS, a managed care pilot in the Houston area, began integrating acute and long-term care services for the aged and people with disabilities.

Medicaid managed care was implemented in the Dallas and El Paso service delivery areas in 1999. In 1999 in the Dallas service area, the HHSC and legacy agencies Texas Commission on Alcohol and Drug Abuse and Department of Mental Health and Mental Retardation, implemented a pilot for behavioral health and substance abuse services, called NorthSTAR. NorthSTAR was designed to create a more coordinated and flexible behavioral health care system.

Medicaid Fraud Prevention Pilot

As mandated by H.B. 2292, HHSC is conducting Medicaid integrity pilots in six counties of the state. The goals of the pilots are to reduce fraud cases arising from authentication fraud; reduce total amount of Medicaid expenditures; and reduce the number of fraudulent participants. The pilot systems use identification cards and biometric readers to authenticate the person receiving services.

This pilot is an important first step toward the HHSC vision of a single card supported by an integrated eligibility system, where HHS recipients have a common card for all programs, enabling positive identification, automated eligibility determination, and an electronic billing process.

The objective of the Medicaid fraud prevention pilot is to collect information regarding the use of biometric technology to reduce losses to the Medicaid program arising from authentication fraud or abuse, use of services by unauthorized persons, as well as billing for services not rendered.

[4] HHSC, "Texas Enrollment Broker Enrollment Report," April 2004. Includes STAR, STAR+PLUS, and NorthSTAR Medicaid. http://www.hhsc.state.tx.us/medicaid/mc/about/reports/confirmed_eligibles_report.html. (accessed June 16, 2004)

Medicaid Estate Recovery Program

House Bill 2292 required HHSC to implement a Medicaid Estate Recovery Program as required by federal law in the Omnibus Budget Reconciliation Act of 1993. This federal law requires states to recover the costs of Medicaid coverage for certain long-term care services after the death of Medicaid recipients age 55 years and over.

The program's proposed rules were published in April 2004, and a public hearing was held in late May. The proposed rules and an amendment to the Medicaid State Plan were submitted to the Centers for Medicare and Medicaid Services (CMS) for initial review in May 2004. The program's expected effective date is September 1, 2004.

HHSC Goal 3: Texas Children's Health Insurance Program

HHSC will ensure health insurance coverage for eligible children in Texas.

Children's Health Insurance Program

Service Description

The federal Balanced Budget Act of 1997 established the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. In response to this legislation, Texas developed the TexCare Partnership to raise awareness of the children's health insurance options available, and to help Texas families obtain and utilize affordable coverage for their uninsured children (ages 0-19). The partnership is comprised of various vendors with whom HHSC contracts to deliver program benefits and services. Vendors include Affiliated Computer Services, the health plans, and the community-based organizations. The TexCare Partnership offers two separate programs with benefits packages covering a full range of services, including regular checkups, immunizations, prescription drugs, lab tests, X-rays, hospital visits, and other services.

Target Population

The program assists families who have incomes too high to qualify for Medicaid yet cannot afford private health insurance. The federal CHIP provides matching grants to states for health insurance coverage for children in families with incomes below 200 percent of the federal poverty level (FPL).

HHSC Goal 3 Trends and Initiatives

Future trends for CHIP are difficult to project, as recent policy changes are in the early stages of implementation. Based on current data received for FY 2004, HHSC predicts the average enrollment level throughout the year will be just over 406,000,

and will be about 345,000 in 2005. The policy requiring more frequent eligibility reviews has not discouraged families from submitting renewals. While the caseload has declined by about 130,000 between September 2003 and April 2004, the caseload will not decline to levels assumed in the General Appropriations Act for the 2004-2005 biennium.

Assets Test Policy

House Bill 2292 authorized HHSC to establish eligibility standards for CHIP regarding the type and dollar value of allowable assets for a family whose gross family income is above 150 percent of the FPL. In general, the policy change will mean that to qualify for CHIP, households with gross incomes above 150 percent of the FPL must own $5,000 or less in assets. Assets are defined as the sum of countable liquid assets and excess vehicle value for countable vehicles. Real property, such as a home, is not countable as an asset. The assets test applies only to new or renewing applicants.

Vendor Drug Program and Pharmaceuticals Bulk Purchasing

The Commission provides prescriptions statewide to Medicaid, Kidney Health, and CHIP recipients, as well as consumers of the Children with Special Health Care Needs program. Staff assists providers with information pertaining to the online status of paid and rejected claims, client eligibility inquiries, and general information regarding the Vendor Drug Program's policies and procedures.

Additionally, the Interagency Council on Pharmaceuticals Bulk Purchasing continues to develop purchasing procedures and options for HHS agencies to follow. State law requires manufacturers and wholesale distributors of pharmaceuticals in Texas to report purchase prices of the drugs to the council. By coordinating the purchasing efforts of the HHS agencies, Texas can negotiate lower prices on drugs by purchasing in bulk.

HHSC Goal 4: Encourage Self-Sufficiency

HHSC will encourage and promote self-sufficiency, safety, and long-term independence for families.

The services discussed under this section transferred to HHSC under H.B. 2292.

Temporary Assistance for Needy Families

Service Description

Under H.B. 2292, HHSC assumed responsibility for the Temporary Assistance for Needy Families (TANF) program, which provides temporary financial assistance to families with needy children who are deprived of financial support because of the absence or disability of one or both parents. Two-parent households can receive

assistance through the TANF State Program (TANF-SP), if the family meets income and resource criteria. Assistance is typically provided on a monthly basis, but it may be provided as a one time per year emergency cash assistance payment of $1,000, if the family meets crisis criteria.

Target Population

The TANF population in Texas is composed predominately of African-American or Hispanic women with the following characteristics.

- Are on average 30 years of age;
- Have one or two children under age 11;
- Are unemployed and have no other income;
- Receive a TANF grant of $217 or less;
- Receive TANF for less than 12 continuous months; and
- Dropped out of school between the 8th and 11th grades and have no job training.

The primary welfare reform initiative within the TANF program is Texas Works, which encourages people who apply for or receive TANF benefits to find jobs. Every adult who comes to a local office to apply for TANF benefits receives clear messages regarding personal responsibility, time-limited benefits, and the requirement to work toward self-sufficiency. A TANF recipient or potential recipient also faces self-sufficiency issues including lack of affordable day care and reliable transportation when attempting to enter the labor market. The Texas Works program refers applicants to the Texas Workforce Commission, in accordance with current law, for employment and job training services. Texas Works staff also works with clients to:

- Identify ways to help working clients and former clients retain employment and advance toward a career;
- Act as advocates for needed community services, such as child care and transportation;
- Promote and advocate for community collaboration to identify, develop, and expand resources needed to promote independence;
- Promote transitional Medicaid and child-care services for those who qualify;

- Contact employers to follow up on employment leads; and
- Follow up with working clients and former clients to support their continued employment and career progress.

The average monthly TANF grant amount in Texas was $61.06 per consumer in FY 2004. At the current payment level, with the value of food stamps and Medicaid added, the average TANF child lives in a home with an income equal to 75 percent of the federal poverty level.

The TANF caseload declined almost 57 percent from its high point in January 1994 to August 1999. During this period, significant program changes were implemented following the passage of the federal Personal Responsibility and Work Reconciliation Act in 1996 and H.B. 1863, 74th Legislature, 1995. However, the TANF caseload increased 7.5 percent from 128,369 cases in FY 2001 to 137,976 cases in FY 2003. In FY 2004, the TANF caseload declined about 20 percent from FY 2003 due to implementation of full family sanctions and pay for performance requirements. The average monthly TANF caseload is estimated to be 111,029 cases in FY 2004. The TANF caseload for FY 2009 is projected to be 100,174 cases, 31.9 percent lower than the FY 2003 caseload, but only 9.8 percent lower than the FY 2004 caseload.

In addition to these projections, it is likely that many more Texans are eligible for TANF benefits but are not currently receiving assistance. Percent of need met was 34.9 percent in FY 2003. Those at risk of needing TANF will grow from 1,055,132 in FY 2003 to 1,160,123 in FY 2009 for an increase of 10.0 percent—approximately 2 percent per year.

Food Stamps

Service Description

The nutrition assistance program, or Food Stamps, is a federally funded entitlement program that helps low-income families buy nutritious food from local retailers. Food stamp benefits are 100 percent federally funded and administrative costs are 50 percent federally funded.

Target Population

Food insecurity, not always having access to enough food to meet basic needs, is a concern for many low-income Texans. The United States Department of Agriculture (USDA) estimates that 14.8 percent of Texans experience food insecurity (with or without hunger), and that 4.1 percent of Texans experience food insecurity with hunger.[5]

[5] Mark Nord, Margaret Andrews, and Steven Carlson, "Household Food Security in the United States," 2002, Food Assistance and Nutrition Research Report No. FANRR35, October 2003, p. 19.

Like TANF, the Food Stamp program in Texas has experienced dramatic changes in its caseload over the past decade. The average number of households served by the food stamp program each month increased by more than 110 percent, from 492,168 in FY 1988 to a peak of 1,033,995 in FY 1994. Food stamp households then decreased by more than 50 percent to 503,784 by FY 2000, when 68 percent of those potentially eligible for nutritional assistance did not receive food stamps. Outreach efforts began in January 2000, and the Simplified Nutrition Assistance Program (SNAP) for older SSI participants began in October 2001, adding about 60,000 people to the Food Stamp program. As a result, the percent of those potentially eligible who did not receive services dropped from 68 to 63 percent from FY 2000 to FY 2003.

In addition to a shift in the number of families receiving food stamps, the average monthly benefit allotment has increased from $74.08 per person in FY 2001 to $80.32 per person in FY 2003.

Current projections indicate that the number of potentially eligible households will grow from 1,939,454 in FY 2003 to 2,117,261 in FY 2009, an increase of 9.2 percent. Households receiving food stamps are projected to increase by a total of 39 percent in the next six years—from 720,548 in FY 2003 to 1,097,016 in FY 2009, an average growth rate of about 8 percent per year.

Special Nutrition Programs

Special Nutrition Programs (SNP) include a number of USDA Child Nutrition and Commodity Distribution Programs that are closely aligned with programs administered by the Texas Department of Agriculture (TDA). A strong relationship exists between SNP and TDA, and both agencies have similar stakeholders, federal rules and regulations, and objectives. HHSC intends to transfer the Special Nutrition Programs to the TDA as soon as interagency agreements are in place and a transition plan can be enacted.

Service Description

The Special Nutrition Programs include six child and adult nutrition programs and three food distribution programs providing cash reimbursements and commodities to improve participants' nutrition. Special Nutrition Programs costs and administrative responsibilities are 100 percent federally funded except for the Texas Commodity Assistance Program, for which the state shares administrative costs, and the Summer Food Service Program, which received state funding for FY 2004 to supplement meal reimbursement for program sponsors.

The child and adult nutrition programs enable private, non-profit, and governmental organizations to establish or improve a food service component as part of the child and adult care or educational services they provide. Programs include the:

- Summer Food Service Program;
- Child and Adult Care Food Program;
- National School Lunch and School Breakfast Programs; and
- Special Milk Program.

In FY 2003, these programs collectively served more than 158 million meals to children and adults throughout Texas.[6] The number of people served through these programs will likely increase in the next few years. By FY 2009, Special Nutrition Programs expect to pay contractors the following for service provision:

- $22.3 million to the Summer Food Service Program to feed an average of 216,475 people daily;
- $212.7 million to the Child and Adult Care Food Program to feed an average of 265,507 children and adults daily; and
- $16.1 million to National School Lunch, School Breakfast, and Special Milk Programs, to serve an average of 47,181 children daily.

Food distribution programs provide donated commodities from the USDA directly to individuals, public and private school districts, and other governmental organizations, to improve participants' diets and to sustain agriculture through price support and removal of food surpluses:

- During FY 2003, the Food Distribution Program distributed 100 million pounds of USDA-donated commodities valued at $82.3 million to 1,335 agencies, primarily school districts, serving an average of 2,344,444 people daily.
- The Texas Commodity Assistance Program (TEXCAP) distributed 41.1 million pounds of USDA-donated commodities valued at $34.0 million to 3,754,910 Texas households during FY 2003.
- The Commodity Supplemental Food Program (CSFP) serves a caseload of approximately 13,000 women, infants, children, and older persons. In FY 2003, the CSFP distributed 2.9 million pounds of USDA-donated commodities valued at $1.7 million.

Target Population

The target populations of these programs include:

- Children ages 12 years or under and migrant children ages 15 years or under who are enrolled in private, nonprofit licensed child care centers, family day homes, or for profit child care centers in which 25 percent or more of enrolled

[6] Accumulated total from Special Nutrition Programs, Program Facts Webpage: http://www.dhs.state.tx.us/programs/snp/pgm_facts.html (accessed May 11, 2004).

children receive Title XX benefits, or are eligible to receive free or reduced-price meals according to the National School Lunch Act;

- Children ages 12 years or under and migrant children ages 15 years or under who reside in emergency shelters with their parent(s) or guardian(s);
- Children ages 18 years or under who attend At-Risk After School Snack Programs;
- Functionally impaired adults or persons ages 60 years and over receiving care in private, nonprofit adult day care centers, and for profit adult day care centers in which at least 25 percent of the enrolled adults receive Title XIX or Title XX benefits;
- Geographic areas where at least 50 percent of children are eligible for free or reduced-price meals under the National School Lunch Program, or at specific service sites where at least 50 percent of the enrolled children are eligible for free or reduced-price meals under the National School Lunch Program; and
- Pregnant, postpartum, or breast-feeding women, infants, children ages five and under who do not participate in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

Refugee Assistance

Service Description

The Commission administers the Refugee Assistance program, which is 100 percent federally funded by the Office of Refugee Resettlement, U.S. Department of Health and Human Services. The program helps people eligible for refugee services to become self-sufficient as quickly as possible after arriving in the United States.

Through contracts with service providers in FY 2003, 6,328 refugees in Texas received social services, including employment services, English language instruction, health and emergency services, and other discretionary grants. In addition, a monthly average of 760 refugees received financial and medical benefits. Expenditures for refugee services in state fiscal year 2003 were approximately $18.8 million.

Target Population

The target population for refugee services includes three groups of people: refugees meeting federal refugee regulations, asylees, and trafficking victims. People granted asylum are eligible for refugee benefits and services from the date that asylum was granted. Victims of severe forms of trafficking and their immediate family members who have received a certification or eligibility letter from the Office of Refugee Resettlement are eligible from the date of the certification letter.

Texas is likely to remain among the top five states in refugee resettlement, along with California, New York, Florida, and Washington. However, it is difficult to project

the number of future refugee arrivals. The Department of Homeland Security and the Department of State have increased national security measures, which may decrease refugee arrivals, and international country conditions fluctuate unpredictably. Refugee arrivals will likely continue to represent Near East/South Asia, Latin America, Europe, East Asia, Africa, and the former Soviet Union.

Disaster Assistance

The Texas Disaster Act of 1975, in conjunction with the federal Disaster Relief Act, authorizes financial grants to individuals with serious needs and necessary expenses associated with events declared disasters by the President. Additional services include identifying, obtaining, and delivering available food, water, and ice supplies for mass care shelters and bulk distribution centers. The Individual and Family Grant Program provided more than $206 million to assist more than 87,000 families affected by floods, hurricanes and tornadoes since 1974. During the past 26 years, Texas has averaged two disaster declarations per year.

Family Violence Program

Service Description

The Family Violence Program (FVP) works to end family violence by supporting community-based services for victims of domestic violence and their families. The FVP funds Family Violence Centers to provide core emergency services, such as a 24-hour shelter and crisis hotline, access to emergency medical care and transportation, intervention services, legal assistance, training and employment information, educational arrangements for children, and referrals to existing community services. Special nonresidential projects help unserved and underserved victims of family violence with services specific to the needs of the community. Other transitional supports needed by victims include affordable childcare, transitional housing, permanent housing, legal resources, and transportation. Community-based family violence organizations collaborate to help victims locate resources, as available, to establish their independence from violence.

Target Population

One of every four American women reports that she has experienced physical or sexual assault by a husband or boyfriend at some point in her life. In 2002, Texas law enforcement agencies received 183,440 reports of domestic violence. The Texas Department of Public Safety reported that 117 women were killed by an intimate partner in 2002.

During FY 2003, an estimated 913,404 women were battered in Texas. In that same time period, programs funded by FVP reported serving 45,997 women, meeting only five percent of the estimated need in that time period. A victim is defined as an adult member of a family or household who is subjected to an act of family violence, or a

member of the household of the adult previously described, other than the member of the household who commits the act of family violence.

Guardianship Program

Service Description

With input from the Guardianship Advisory Board, and in close partnership with the Department of Family and Protective Services (DFPS), the Commission annually submits a statewide plan to ensure that incapacitated individuals in the state who need guardianships or other protective measures receive that assistance. To this end, HHSC supports the Guardianship Alliance of Texas, a consortium of guardianship programs around the state, some of which are also partially funded by the Commission. The HHSC also contracts with the Texas Alternatives to Guardianship Program, which focuses on expanding volunteer-based money management services around the state.

For years, DFPS' Adult Protective Services (APS) program has also operated a guardianship program for its clients deemed incapacitated. In a recent move to consolidate the guardianship programs within both HHSC and APS, administration of the latter will be transferred to, and become a part of, the overall HHSC program in September 2004.

Guardianship services offered to APS clients allow court-appointed people or entities to have full or limited authority over the person and/or estate of a mentally incapacitated person. Depending upon the powers granted by the court, guardianship might involve a range of responsibilities, such as managing estates, making medical decisions, and arranging for residential care. In FY 2003, there were 722 guardianship cases in the state of Texas. The section below focuses specifically on guardianship services provided to clients who are served through the APS system.

Target Population

Formally the authority of DFPS/APS, HHSC will now have the right to seek guardianship over two discreet classes of people: incapacitated children aging out of Child Protective Services (CPS) conservatorship, and incapacitated adults whom DFPS determines to be in a state of abuse, neglect, and/or exploitation. Increasingly, courts and other entities seek to appoint HHSC as guardian for other people who are incapacitated without suitable family, even if they are not at risk of abuse, neglect, and/or exploitation. Of the 722 guardianship cases in 2003, 62

percent were female, and 38 percent were male. Age groups were represented as follows:

- 30 percent of those clients were 18-33 years of age;
- 10 percent were 34-49 years of age;
- 12 percent were 50-64 years of age;
- 24 percent were 65-81 years; and
- 23 percent were 82 years of age and over.[7]

Ethnic groups were represented in guardianship cases as follows in 2003:

- 54 percent Anglo;
- 22 percent African American;
- 16 percent Hispanic;
- Less than one percent Native American;
- Less than one percent Asian; and
- 8 percent were listed as "Other."[8]

In FY 2004, guardianship cases are projected to increase by 3.1 percent compared to FY 2003 totals, and in FY 2005, they are expected to increase by 3.4 percent compared to FY 2004 totals.

HHSC Goal 4 Trends and Initiatives

Electronic Benefits Transfer

Consolidation efforts within HHSC will provide opportunities to capitalize on adding programs to the Electronic Benefits Transfer (EBT) Program managed by Lone Star Technology in the Office of Family Support Services. This is consistent with the goals outlined in the Texas Electronic Services Delivery Final Report (January 2001) by the Comptroller of Public Accounts.

Farm-to-School Pilot Program

The USDA and the U.S. Department of Defense are working with the TDA and HHSC Special Nutrition Programs to bring local produce to school districts. The pilot currently operates in three areas: Dallas-Ft. Worth, Houston, and the Lower Rio Grande Valley. The initiative supports small farmers by providing a ready market for their crops, and it provides fresh, nutritious ingredients for school meals, helping to combat the ever-growing child obesity epidemic. Healthy meals support children's health, behavior, school attendance, and ability to learn.

[7] Total figures may not equal 100 percent, due to rounding.
[8] Total figures may not equal 100 percent, due to rounding.

Expanding After-School Snack Programs for At-Risk Children

The USDA has made available to states two new programs to provide healthy snacks to children who are in activities or child care after school. The programs operate as extensions of either the National School Lunch Program or the Child and Adult Care Food Program. They operate during the school year and target low income children. Their purpose is to prevent juvenile delinquency by providing educational or enrichment activities in an organized, supervised setting. They operate in schools, child care centers, and recreational centers. The USDA is expanding the program to include suppers in some states, as children in these programs often go without a meal until breakfast at school the next morning. The programs support the general health of school age children, assist working mothers with child care, and deter juvenile delinquency.

Trends in Refugee Assistance

The impact of the September 11, 2001 terrorist attacks and the inclusion of new populations eligible for services under refugee funding not only changed the landscape of refugee resettlement, but also created new challenges for service providers. Due to a temporary suspension of refugee arrivals and implementation of new overseas security measures, refugee arrivals between the end of FY 2001 and FY 2003 were at an all-time low. Refugee arrivals in FY 2004 are slowly returning to levels common before September 11, 2001, and according to national data, Texas remains among the top five states in numbers of refugee resettlement. Texas anticipates final funding for FY 2004 to be level with FY 2003 as federal allocations for the program are based on three-year arrival patterns. Staff is working with the federal Office of Refugee Resettlement to ensure adequate funding for the administration of the Refugee Cash and Medical Services. Staff is also working with the service provider network to identify additional funding sources to meet the needs of the increasing numbers of refugee arrivals.

Initiatives to maximize resources and improve services include the following:

- Maintaining an effective public/private Refugee Cash Assistance program;
- Designing and implementing a new web-based Refugee Data Center;
- Internal and external assessment of program activities, available resources, and strategies to maximize federal funding through a coordinated and integrated approach with refugee service providers;
- Outreach, training, and development of statewide resources on new populations including trafficking victims and Somali Bantu refugees; and
- Establishing and implementing two Unaccompanied Refugee Minor programs through the United States Catholic Conference of Bishops in Houston and the Lutheran Immigration and Refugee Services in Dallas.

The Commission will continue the successes of the Refugee Assistance program and will ensure eligible consumers have access to services, programs, and benefits in a timely manner.

Trends in Family Violence and Services

A number of trends continue to change the face of family violence service provision in Texas. The complexities of victims' needs—including transitional housing, affordable childcare, and immigration issues—have resulted in a trend of women staying in shelter for longer periods of time. Many urban areas have waiting lists and lack the array of specialized services needed in their communities. Additionally, reductions in federal funding and diminishing private donations have limited program success. In Texas, 85 counties have inadequate access to core emergency services for victims of domestic violence. Recent research has confirmed that the needs of certain populations, such as people of color, immigrants, people who are older, and people with disabilities, including mental illness are not consistently met. These underserved populations often need unique services, particularly non-residential services, more specialized than those developed and provided by mainstream domestic violence programs.

Initiatives to maximize resources and improve services include the following:

- Planned program growth—with funding for expansion of services in a manner that best utilizes scarce resources, including nonresidential services;
- Supporting the continuation of services to underserved populations;
- Continued collaboration with other agencies on initiatives and services for victims of domestic violence;
- Involving family violence experts in planning healthy marriage promotion initiatives or activities; and
- Conducting a statewide survey to update the statistical data on the incidence of domestic violence in Texas.

HHSC Internal Assessment

This section represents an evaluation of the key internal factors that influence HHSC. Below is a discussion of the agency's internal processes and operations, and its perceived strengths and challenges.

HHSC Internal Processes

With the enactment of H.B. 2292 and the consolidation of numerous new functions and staff, the Commission's internal processes have undergone dramatic changes. Acquiring significant new policy and program operation responsibilities along with expanded leadership and oversight roles has required the agency to streamline and formalize many processes, including, but not limited to the:

- Hiring, transfer, alignment, and location of thousands of staff;
- Management of the flow of internal and external communications;

- Solicitation and management of stakeholder input; and
- Construction of business cases for key functions, including contracting with, and conducting transactions with several large vendors.

The Commission continues to rely on the guidance of the H.B. 2292 Transition Legislative Oversight Committee to facilitate the transfer and optimization of various programs among the four departments and HHSC. In addition, a Transformation Steering Committee consisting of a group of senior leaders from the health and human services enterprise is providing tactical guidance to the transformation effort and to new HHS departments.

The Central Project Management Office (CPMO) assists the departments and HHSC with planning and facilitating 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.

Finally, a Health and Human Services Council will be appointed to provide input to the Commission on overall system leadership, decision-making and business operations.

HHSC Internal Operations

The Commission has implemented its high-level organizational structure (Executive Commissioner, Deputy Commissioners, Assistant Commissioners, and Departmental Division levels) in a manner consistent with the conceptual outline in the *H.B. 2292 Transition Plan*. Several new operational features have been added to the Commission's structure as well, including the new divisions of Administrative Support Services, Office of Communications, and Office of the Inspector General. In addition, to coordinate the high volume of requests, decisions, correspondence, and reports requiring his action, the Executive Commissioner created the Office of the Executive Clerk.

In preparation for implementing H.B. 2292 requirements, HHSC conducted a functional review of its own internal operations and those of the HHS agencies. The results of this effort illustrated that the agencies lacked a consistent management structure. With the H.B. 2292 mandate to consolidate both existing agencies and administrative support activities, it was determined that the focus of each of the four new agencies would be on service delivery. The Commission outlined a standardized program and operational structure for each of the agencies that support this focus and also includes policy and program support components.

The HHSC assumed responsibility for administrative services for the HHS system. Each administrative service will be streamlined, simplified, and standardized to generate cost savings and efficiency improvements.

Administrative services functions will also be evaluated to determine whether service delivery can be improved and/or enhanced in a more cost effective way by private contractors.

HHSC Internal Strengths and Challenges

The Commission must continue to address the impact of major changes on its employees, particularly in the area of effective communications, where numerous staff must be kept informed across many systems and locations. The Commission also faces a loss of subject matter experts resulting from retirements and functional reorganization. In the midst of these changes, staff in all areas of HHS must also adapt to new ways of doing business, and HHSC must accommodate its changing role as an agency.

As discussed earlier in this chapter, balancing system oversight and program operations is a significant undertaking. Managing this balance will continue to challenge HHSC as it aligns the resources needed for planning and implementing improvements to the service system. Even so, HHSC has an unprecedented opportunity to draw upon the work accomplished so far in the areas of integrated service delivery and technology, such as single points of entry, uniform intake and referral processes, and on-line screening for eligibility. Using more efficient tools and techniques, meaningful changes can be made to the overall system that may result in better client services.

Managing a complex variety of funding sources is another important internal challenge for the Commission. As various components of the HHS system are transformed, HHSC will be the key agency to ensure that the system continues to maximize state and federal funding streams (see Chapter III, HHS System External/Internal Assessment). Although management of federal funds continues to be a day-to-day function of each of the HHS agencies, HHSC must provide the leadership in developing a federal cost allocation process, while ensuring that state general revenue is appropriately dedicated to maintenance of effort or matching federal funding requirements.

One of it greatest strengths is the Commission's talented and knowledgeable workforce, staff who come from all areas of the HHS system, creating an extensive pool of expertise and experience. The Commission can use this important resource to identify best practices that can be applied to the design of the new system.

In its effort to use a business approach in the transformation of the HHS system, the Commission has involved outside consultants from the private sector to help bring new ideas, expertise, and approaches. It was with the help of these consultants

that HHSC implemented the CPMO, whose first mission was to break the transformation effort into manageable tasks and create a variety of project plans, with measures of accountability built into each. The CPMO also created a task order process that provides quick access to outside resources when creative solutions are needed.

As it continues to provide the leadership needed for a major transformation of the HHS system, HHSC remains committed to a sound internal operational structure that:

- Focuses on service delivery;
- Maintains key service identities to minimize confusion among customers;
- Makes decisions based on significant stakeholder input and analysis of best practices;
- Focuses on quality; and
- Implements all new processes incrementally.

HHSC Strategic Priorities

The following priorities express the emphasis that HHSC will employ to meet agency goals and fulfill the agency mission:

- HHSC will institute a new level of accountability and an outcome-based culture throughout the HHS system to ensure effective stewardship of public resources.
- HHSC will proceed with the project to integrate eligibility determination across HHS programs in order to improve access to services and reduce the cost of eligibility services.
- HHSC will continue the systematic expansion of managed care and vendor drug initiatives to improve the quality of services and reduce the cost of service delivery.
- HHSC will complete the consolidation of administrative and support services to realize savings and redirect savings into direct service delivery.
- HHSC will institute a comprehensive business intelligence system that will support management decision-making and performance measurement within the HHS system.
- HHSC will establish effective fraud prevention and ombudsman functions to ensure equity to all stakeholder groups.
- HHSC will strengthen contract oversight and monitoring to ensure both quality in client services and results, and the appropriate, efficient use of public dollars.