# TRANSITION LEGISLATIVE OVERSIGHT COMMITTEE

# Biennial Report
# December 2004

The Health and Human Services Transition Legislative Oversight Committee was created to facilitate the transfer of powers, duties, functions, programs, and activities between health and human services agencies.

**LEGISLATIVE MEMBERS**

Representative Arlene Wohlgemuth, Chair
Burleson

Representative John Davis
Clear Lake

Senator Jane Nelson
Lewisville

Senator Judith Zaffirini
Laredo

**PUBLIC MEMBERS**

Chris W. Kyker
Health and Human Services Consultant
Abilene

The Honorable Kenn S. George
Investments/Ranching
Dallas

Jacinto Juarez
Computer Science Professor
and Dean Emeritus
Laredo Community College
Laredo

# Transition Legislative Oversight Committee

## Report to the 79th Legislature

We, the members of the Transition Legislative Oversight Committee, present the following report to the 79th Legislature.

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# Overview

After 140 years of delivering health and human services to Texans in need, the state now spends more than $20 billion annually, one-third of its budget, on providing services to millions of Texans. In 2003, the delivery of health and human services involved 12 agencies with 48,000 employees operating more than 200 programs from more than 1,000 facilities and offices statewide. Occurring over many decades and without an overall plan, the health and human services agencies and programs grew into a confusing, disjointed, and redundant system.

House Bill (H.B.) 2292, passed by 78th Texas Legislature, mandated fundamental changes to create a transformed health and human services system for the 21st Century. The bill provided a vision of a coordinated system that is rational, well managed, accountable, and focused on the needs of clients. A foundation of this new system was the consolidation of health and human service agencies and a realignment of programs. The consolidated agencies created by H.B. 2292 are to function as an integrated system under the strengthened leadership of the Health and Human Services Commission (HHSC). Creating the organizational structure envisioned by H.B. 2292 as the foundation for a transformed system meant undertaking one of the most significant governmental reorganization efforts in recent U.S. history.

H.B. 2292 established the Transition Legislative Oversight Committee to oversee the consolidation and reorganization and to more broadly ensure that the multifaceted efforts to transform the health and human services system met the key objectives of improving service delivery, increasing efficiencies, and enhancing accountability. The Committee is specifically charged with facilitating the transfer of powers, duties, functions, programs, and activities between health and human services agencies as required by H.B. 2292 and providing input to the Executive Commissioner of HHSC as a statutorily required transition plan is developed and implemented. The Transition Legislative Oversight Committee is composed of seven members—two members each from the Senate (appointed by the lieutenant governor) and House of Representatives (appointed by the speaker) and three public members (appointed by the governor).

This report comes 18 months after the signing of H.B. 2292 by Governor Perry. In this time, the committee has overseen the realignment and transfer of over 46,000 employees into the new health and human services agencies.

Improvements over the past 18 months have resulted in increased efficiencies in the delivery of services, more productive working relationships with providers, and fewer barriers and greater access for clients. Notably, the changes and improvements of the past 18 months have occurred while causing minimal disruptions in service. Looking forward, these changes are perhaps most important in providing a foundation for further transformational changes in our system of health and human services.

# Activities of the Committee

The committee met in Austin on the six dates listed below to provide guidance and receive progress updates from the Health and Human Services Commission.

- September 12, 2003
- October 3, 2003
- October 21, 2003
- January 28, 2004
- June 7, 2004
- December 14, 2004
- December 20, 2004

Early in its work, the committee received invited testimony from two experts who discussed the benefits, challenges and lessons learned from their experience with managing large mergers. Mr. Jeff Rich, Chief Executive Officer of ACS, has engaged in dozens of mergers of all sizes and types in building ACS into an international company with almost $4 billion in annual revenues. Mr. David Carney, Senior Manager for Deloitte Consulting, has led numerous large merger and divestiture efforts for technology companies, including the merger of Hewlett Packard and Compaq. Key observations and advice offered by these experts included the following:

- Have a detailed integration plan.
- Focus on a quick integration—ensure operating commitments are met.
- Align and communicate organization roles and responsibilities.
- Act decisively.
- Address retention issues early and often.
- Consider the importance of culture—"humanize" the merger.
- Clearly and frequently communicate to stakeholders the implications and progress of the merger.
- Carefully monitor progress.

H.B. 2292 created the Transition Legislative Oversight Committee and assigns it the responsibility of adopting a Transition Plan to serve as a blueprint for the efforts to streamline the agency structure and transform the delivery of health and human services. The Committee held a required hearing on the draft Transition Plan in October 2003 and adopted the plan in November 2003. The key themes the Committee heard from the public regarding the transition were:

- **Consider** carefully how to organize service delivery systems based on functional needs to ensure the needs of special populations continue to be met.
- **Retain** identifiable divisions containing specialized staff with expertise needed to meet the needs of special populations.
- **Ensure** adequate time for planning and implementing the consolidation efforts.

- **Provide** ongoing opportunities for input from stakeholders throughout the transition phases.
- **Consider** the impact of potential office or state facility closures on families and clients in smaller, rural and remote communities.
- **Increase** efforts between state agencies and local communities to develop more resources and collaborative solutions for meeting the needs of Texans.
- **Ensure** that staff has the necessary expertise and training to provide client assistance regarding complex programs and requirements.
- **Identify** best practices that are occurring in the agencies and determine how they can be replicated.
- **Develop** evaluation processes to track the success of the changes that are being implemented.

# Ensuring Extensive Public Input

The Transition Legislative Oversight Committee directed HHSC to ensure public input into the development of the transition plan, the creation of the new agencies, the ongoing transformation of programs, and the development of the committee's report. Information from public input has been used throughout the transformation process.

HHSC held six public meetings across the state to receive input as the transition plan was being developed. These meetings were attended by over 1,000 persons with 344 persons providing written or verbal testimony. As noted earlier, on October 21, 2003, the Committee held the legislatively required hearing on the draft transition plan. That hearing was attended by 336 persons.

Proposed organizational structures for the four new agencies were presented to the public by HHSC at a series of open meetings in January and February 2004. Together these meetings included 1,687 attendees and 419 speakers.

HHSC also conducted a two-day workshop, held focus groups with legacy agency board chairs, and held five public meetings to ensure public input into the development of the agency councils.

HHSC continues to provide information at public meetings, through the agency website, and through a public newsletter, HHSC E-News, which has over 2,500 subscribers.

The Oversight Committee met on December 20, 2004, to receive public input on the draft committee recommendations. Over twenty people provided testimony at the hearing, and several additional people submitted written comments to the committee.

Details regarding the various forums for public input and the levels of input received are provided in Appendix 2.

# The Transition Plan

The transformation of the Texas health and human services system is guided by a transition plan required by H.B. 2292. HHSC submitted this plan to the Transition Legislative Oversight Committee on November 3, 2003. The transition plan described the organizational design of the restructured health and human services enterprise and the thorough and deliberate approach to managing the transformation. It also summarized the risk management and communication plans essential to the success of the transition. The transition plan described three overarching goals consistent with the intent of H.B. 2292.

- **A Focus on Clients and Program Delivery**: The new health and human services system is operating as an integrated organization continuously striving to improve performance and manage costs through innovation, creativity, and deployment of technology-based solutions.

- **Effective Stewardship of Public Resources**: The realignment of programs provides opportunities for more cost effective operations.

- **Cultural Change and Accountability**: A new organizational culture is in place that values a unified health and human services system with mutual interests, common goals, and shared responsibility for client outcomes.

The plan outlined the four general phases of the consolidation efforts as required by H.B. 2292:

- Planning – to ensure a careful and deliberate approach.
- Integration – to effectively transfer staff into the new organizational structure.
- Optimization – to improve service delivery, increase efficiencies, and enhance accountability.
- Transformation – to ensure continued high quality and responsive services for Texas.

Early in the planning phase, HHSC adopted a set of guiding principles for decision-making during the reorganization. These guiding principles include:

- **Focus on service delivery.** As a result of centralization of administrative services, the new departments will focus their efforts almost exclusively on delivering services.
- **Maintain key identities.** By following an incremental process, HHSC will seek to maintain the identities of key service areas (such as blind or deaf services) to minimize any confusion among clients looking for and receiving such services.
- **Careful and deliberate.** While the effort will seek to maintain constant forward progress, HHSC leadership is approaching this reorganization with a great deal of focus on making decisions based on significant stakeholder input, analysis of best practices, and consideration of how decisions will affect all aspects of service delivery.

- **Focus on quality.** The consolidation of health and human services into HHSC and its four new departments is being managed as a **merger** of program and service delivery structures, not a takeover of one agency by another. This will ensure that the best people, the best ideas, and the best practices that exist across all agencies are identified and utilized.
- **Public input.** Throughout the reorganization process, and using various methods, HHSC will seek input and feedback from the public on how best to reorganize health and human services.
- **Incremental process.** The reorganization is not being undertaken via a single sweeping action. HHSC leadership will guide the reorganization through a series of incremental steps that accomplish reorganization while maintaining the focus on service delivery.
- **Standardization.** A significant component of the reorganization is the adoption of a consistent set of management structures and titles across the health and human services enterprise.
- **Administrative services consolidation.** Administrative services (such as human resources, purchasing, accounting, etc.) will be consolidated under HHSC, and only limited services deemed critical to supporting departmental operations will be left under the control of an individual commissioner.

# Optimizing the Performance of the System

After planning and integration phases are complete and the agency structure has been reorganized and streamlined, H.B. 2292 calls for optimizing service delivery and administrative functions to generate further cost savings, business process improvements, and improvements to service delivery. Optimization activities include efforts to:

- **Identify common customers and services** - Each department will inventory its customer base, service delivery mechanisms (e.g., direct health service provision, education services, etc.), and regional office structures.
- **Identify redundancies and savings opportunities** - Once common customers and services are inventoried, each department will then identify redundancies and opportunities for collaborative service delivery that might generate cost savings and improvements to service delivery.
- **Review and redesign business processes** - Each department will also undertake activities to review its existing business processes and identify opportunities for eliminating redundancies and streamlining operations.
- **Implement "optimized" structures and processes** - Each department will develop and implement new organization structures and new business processes that best support optimized and streamlined service delivery.

To focus optimization activities on the desired outcomes for Texas, the Commissioners of the five health and human services agencies have jointly established the following vision for the fully transformed health and human services system.

- Clients are assisted in an integrated, accessible, seamless, timely and consistent manner focused on helping them achieve their desired outcome.
- The service delivery system is responsive, accessible, reliable, focused on meeting Texans' needs and services are provided in an integrated and transparent manner between and within departments.
- The organizational structure is integrated, aligned, streamlined, and clearly communicated.
- Partners, stakeholders and providers (including taxpayers, local governments, community-based organizations, advocacy groups, and the private sector) are actively and appropriately engaged.
- Employees are rewarded in a manner that empowers them to focus on the programmatic and enterprise goals of serving the needs of Texans.

Agency commissioners have developed and are now implementing plans to optimize the performance of their agencies. HHSC will also be ensuring that the performance of the agencies as a system is optimized. Full implementation of the plans is expected to occur over a two to four year timeframe.

# Progress in Transforming Health and Human Services

The planning and integration phases of the transformation of health and human services in Texas are complete. Even more importantly, the efforts to date have created a foundation for further benefits as the agencies continue to optimize their individual performance and their performance as a system.

## Implementation of the new health and human services agency structure

Prior to H.B. 2292, the health and human services system of Texas was comprised of 12 largely independent agencies:

- Health and Human Services Commission
- Texas Department of Human Services
- Texas Department of Health
- Texas Department of Protective and Regulatory Services
- Texas Department of Mental Health and Mental Retardation
- Texas Department on Aging
- Texas Rehabilitation Commission
- Texas Commission on Alcohol and Drug Abuse
- Texas Commission for the Blind
- Texas Commission for the Deaf and Hard of Hearing
- Texas Health Care Information Council
- Interagency Council on Early Childhood Intervention

Each agency (except for HHSC) had a governing board appointed by the governor. These boards, in consultation with the Commissioner of HHSC, selected the agency director. The boards also established policies and rules for their agencies.

H.B. 2292 created a unified and focused system of five agencies led by the Texas Health and Human Services Commission. The Executive Commissioner of HHSC is appointed by the Governor and the commissioners of the four other departments are selected by HHSC's Executive Commissioner with approval by the Governor. H.B. 2292 also provides for each agency to be supported by a nine-member council appointed by the Governor, however, the Executive Commissioner of HHSC was vested with final authority for policy and rule making. Under this structure, HHSC has strengthened authority to lead the agencies in functioning as an integrated system.

As of September 1, 2004, the health and human services agency structure mandated in H.B. 2292 had been fully implemented. The date of creation, mission and high-level responsibilities of each agency in the new structure are described below.

## Health and Human Services Commission (HHSC)

H.B. 2292 vests four types of responsibility with HHSC. First, HHSC now has clarified responsibility and enhanced authority for leading and overseeing the health and human services agencies and ensuring that they function as a system. Second, HHSC has a strengthened mandate to consolidate and administer most administrative support services for the health and human services agencies. Third, HHSC now has expanded responsibilities for administering programs. Programmatic responsibilities at HHSC now include Medicaid, the Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), family violence services, refugee services, nutrition programs, and early childhood coordination programs. In addition, H.B. 2292 directs HHSC to integrate eligibility determination for many health and human services programs.

To provide assistance to HHSC in overseeing the health and human services agencies, H.B. 2292 also created the Office of Inspector General (OIG) within HHSC. The Inspector General, who is appointed by the Governor, is responsible for the investigation of fraud and abuse in the provision of health and human services and the enforcement of state law relating to the provision of those services. The office coordinates investigations, audits, and recoupment activities with other agencies, including the Office of Attorney General, and recommends policies promoting economical and efficient administration of funds and prevention of fraud and abuse.

## Department of Family and Protective Services (DFPS)

DFPS began operations February 1, 2004. DFPS consists of the programs previously administered by the Department of Protective and Regulatory Services. DFPS provides protective services to children, people with disabilities, and the elderly. The DFPS mission is to protect vulnerable people from abuse, neglect and exploitation through the Adult Protective Services, Child Protective Services, Child Care Licensing and Child Abuse Prevention and Intervention programs.

## Department of Assistive and Rehabilitative Services (DARS)

DARS began operations March 1, 2004, with the merger of the Texas Rehabilitation Commission, Commission for the Deaf and Hard of Hearing, Interagency Council on Early Childhood Intervention and Texas Commission for the Blind. The agency's mission is to work in partnership with Texans with disabilities and families with children with developmental delays to improve the quality of their lives and to enable their full participation in society.

## Department of Aging and Disability Services (DADS)

DADS began operations September 1, 2004, through consolidation of numerous programs and activities that had been dispersed among three predecessor agencies: community mental retardation services and state school programs of the Department of Mental Health and Mental Retardation, community care and nursing home services programs of the Department of Human Services, and aging services and programs of the Texas Department on Aging, including the responsibilities and requirements associated

with the Older Americans Act. DADS' mission is to provide a comprehensive array of aging, disability and mental retardation services and supports that are easily accessed in local communities. To that end, DADS administers long-term care services and supports for older people, people with physical disabilities and people with mental retardation. DADS also licenses and regulates providers of these services through a separate division that reports directly to the Commissioner.

### Department of State Health Services (DSHS)

DSHS began operations September 1, 2004, combining the Texas Department of Health, the Commission on Alcohol and Drug Abuse, and the Texas Health Care Information Council, as well as the mental health responsibilities of the Texas Department of Mental Health and Mental Retardation. The agency's mission is to promote optimal health for individuals and communities through the provision of effective public health services, clinical services, mental health services, and substance abuse services.

## Consolidation of Administrative Functions

In addition to consolidating the health and human services system into five agencies, H.B. 2292 also mandates that the management and provision of administrative and support services be centralized at HHSC. Administrative services consolidation is intended to allow the agencies other than HHSC to focus almost exclusively on service delivery and to provide opportunities for cost savings by eliminating administrative redundancies throughout the health and human services system.

The consolidation of administrative functions began when the human resources and payroll functions for all health and human services agencies were consolidated at HHSC on June 1, 2003. All health and human services agencies also began to operate under the same human resources policies in June, 2004, a development of great importance in fostering the ability of these agencies to function as an integrated system. At this time, the following major administrative functions have been consolidated and work is continuing to optimize each of these functions:

- Human Resources Management
- Office of Civil Rights
- Planning and Evaluation
- Leasing and Facilities Management
- Procurement

In relation to legal services and information technology, specific functions that provide support that is common to all agencies were consolidated at HHSC but functions that support the unique business needs of the individual agencies were left with each agency. The centralized information technology and legal offices will also provide planning and coordination from a system perspective when appropriate.

Analysis is currently underway relating to the potential consolidation of certain financial management functions. However, a major event occurred on September 1, 2004, in relation to the financial management of the health and human services system. On that date all health and human services agencies began to use the same software system for financial management. This represents completion of a massive information technology project three years ahead of schedule with an associated cost avoidance for the state of $12.8 million. Having all five agencies use the same financial software greatly enhances the ability to gather and analyze financial information from across the health and human services system and it further reinforces the ability of the agencies to function as an integrated system.

# Benefits of Consolidation

H.B. 2292 was intended to produce benefits that would begin in the short term and increase over the longer term. Benefits in the quality, accessibility, and coordination of services were expected as the new agencies increasingly function as an integrated system with a common vision. Benefits resulting from greater efficiency would result in savings and create opportunities to redirect dollars from administrative supports into direct services.

As a result of the structural changes mandated by H.B. 2292, the HHS system is now operating as an integrated organization able to coordinate across agency lines, comprehensively investigate problems, and deploy resources from across the system to address priority needs. An example of the benefit of integrating the system was seen in the uncovering of severe problems within Adult Protective Services in El Paso. It is unlikely that those problems would have been quickly and comprehensively addressed apart from the systematic changes that were being made.

The ongoing efforts to strengthen family protective services provide a good illustration of the benefits of functioning as an integrated system to improve services. As a key component of that effort, the Office of the Inspector General (OIG) deployed its consolidated pool of audit and investigative resources to coordinate and manage an extensive review of case files at DFPS. Because the OIG was operational, the state had the ability to deal with problems that have been uncovered in both APS and CPS. Additionally, medical expertise was drawn from HHSC and DSHS to evaluate the prescribing of psychotropic medications for children in foster care.

An ongoing effort to improve contract management also illustrates the increased ability of the health and human services agencies to function as a system to improve services. The Executive Commissioner has made improving contracting practices a top priority. As part of a coordinated approach to achieving this goal an executive level Contracts Council has been created for the system. The council will pursue coordinated continuous improvements and set specific priorities for improvements from a system perspective. The consolidated enterprise procurements division at HHSC is now responsible for administrative procurements for the system and each agency has created a contracts unit to provide a central point of expertise for supporting and overseeing its contracts for client services. (The issues and recommendations section of this report contains further discussion of the need to strengthen contract management.)

The strategic realignment of programs under the new agencies is also opening the door to improvements in services and better use of resources. For example, DADS, which inherited long term care programs with three different processes and sets of locations for accessing services, will pursue the creation of integrated processes and single points of access to long term care services. DSHS is reviewing its service delivery system to identify opportunities to integrate mental health and substance abuse services, and to better link them with physical health services. In addition, DSHS has already achieved

savings by placing its laboratories under common management and by placing the South Texas Health Care System and Rio Grande State Center under common management. DARS has identified opportunities to create greater awareness of its rehabilitative services among persons who are deaf or hard of hearing. This has created the possibility of accessing additional federal funds for services for persons who are deaf or hard of hearing. DARS has also been able to allow a software tool used for its rehabilitative services clients to also benefit clients with visual impairments.

The realignment of certain programs and responsibilities at HHSC has also created a foundation for pursuing major initiatives that will both create efficiencies and improve client services. Texas currently relies on automated systems designed as far back as the 1960's to determine if people qualify for services such as Medicaid, food stamps, Temporary Assistance for Needy Families (TANF), and long-term care services. Pursuant to direction in H.B. 2292, in March of 2004, HHSC released a cost effectiveness study that laid out a new model for delivering these services. HHSC's proposed redesign of the state's eligibility determination systems would allow clients to apply for state services in person, through the Internet, over the phone, and by fax or mail. The state would establish call centers to receive and process applications, and consumers would be able to track the progress of their applications through an automated phone system. (Further discussion of the call center concept and its potential benefits is included in the Issues and Recommendations section that follows).

This realignment has had other impacts. HHSC successfully centralized the handling of TexCare referrals, referrals that were previously processed throughout the state through the Central Processing Center. The benefits of centralizing these referrals are many. A few examples are: applications received through TexCare (for children's Medicaid and CHIP) now have one single point of entry, instant access to CHIP and Medicaid information, avoidance of dual enrollment, and identification of income and assets that may not have been previously identified when these applications were being processed in two different systems. Since February 16th, when the centralization occurred, over 16,000 potential dual enrollments have been avoided--dual enrollments that would have cost the state Federal dollars.

Now, individuals are screened for eligibility for both programs and enrolled in the appropriate one. This also prevents the kind of error that results when assets reported in one program are not reported in another. For example, one family showing income of $12 thousand per year in the one system was actually making far over the income limit when an additional $30-40 thousand per year in rental income was discovered in the other system.

These improvements also support the coordination necessary for changes in enrollment criteria such as the income and asset verification to the CHIP program under HB 2292. While CHIP has experienced a significant decline in enrollment with the introduction of tighter income and asset verification provisions, 38 percent of the reduction in CHIP enrollment was due to parents failing to complete the renewal process. Some of this decline is undoubtedly due to a self-determination that they did not meet eligibility

requirements. This was similar to the drastic reduction in enrollment in Food Stamps and AFDC (now TANF) after the introduction of an electronic benefits transfer card known in Texas as the Lone Star Card.

# ISSUES AND RECOMMENDATIONS

H.B. 2292 sought to bring about major savings, efficiencies and improvements in services through streamlining of the agency structure and through policy changes in a number of health and human services programs. The Committee has identified a number of opportunities to achieve further progress in transforming our system of health and human services through additional statutory changes. Those opportunities and the needed legislative actions are described below.

## Flexibility in Funding

Ensuring that the health and human services agencies function as an integrated system was a key goal embodied in H.B. 2292. The bill included several measures to bring this about including creation of the streamlined agency structure, and strengthening the authority of the HHSC Executive Commissioner to lead the system. The added responsibility and enhanced authority given to the Executive Commissioner needs to be complemented by now providing the Executive Commissioner with enhanced authority to manage the funds and full-time employees (FTEs) appropriated to the agencies for which the Executive Commissioner is ultimately responsible.

**The Transition Legislative Oversight Committee recommends that the Legislature provide the Executive Commissioner of the Health and Human Services Commission System with additional flexibility in relation to transferability of funds and in relation to the restrictions in the capital budget rider**. The extent to which the Executive Commissioner can transfer funds between the agencies in the health and human services system has changed little from the era before H.B. 2292 when these agencies largely functioned independently. Additional flexibility will also provide the Commissioner with an important additional tool for timely problem solving and responding to the needs of the public.

The capital budget rider in the appropriations bill has not been adjusted to enable the health and human services agencies to function as an integrated system. The HHSC Executive Commissioner needs to have additional latitude for solving problems by being able to transfer capital authority across agencies or to vary from the specific provisions of the capital budget riders of the health and human services agencies. Providing carefully considered transferability and flexibility with respect to capital authority, with notification requirements as appropriate, will aid in solving problems. It will also allow the Executive Commissioner latitude in utilizing capital investments to modernize the

business practices and processes of the agencies and to continue to gain efficiencies in operations.

## Fraud Prevention

H.B. 2292 required HHSC to conduct a front-end Medicaid fraud reduction pilot program to address provider fraud and appropriate cases of third party and recipient fraud. This program was to include the following:

- Participant smart cards and biometric readers that reside at the point of contact with Medicaid providers, recipients, participating pharmacies, hospitals, and appropriate third-party participants. Fingerprint images collected as part of the program shall only be placed on the smart card.
- A secure finger-imaging system.
- A monitoring system.

Four vendors, utilizing different technology approaches have operated the pilot in six counties of the state since March 2004.

The pilot indicates that biometric technology can deter fraud, abuse and waste, in five specific areas:

- Billing for services not rendered – the technology used in the pilot demonstrates the presence of the authorized eligible patient at the provider's office on a specific date and time;
- Up-coding of services – the technology provides a record of attendance and time of appointment, allowing the state to identify billing for services that are known to take longer than the time spent in the office by the patient;
- Card swapping – the use of a biometric within the card limits the service to a specific patient, eliminating recipient card swapping fraud;
- Services to unauthorized, ineligible patients – the use of a biometric, and the ability to obtain real-time eligibility verification limits services to authorized, eligible patients;
- Third party fraud – the monitoring system within the pilot allows the state to compare the check-in records with claims filed on behalf of a provider, eliminating the potential for a third-party biller to submit bills for services not rendered or services rendered to ineligible patients.

In addition to deterring fraud, abuse, or waste in these areas, the pilot technology also expedites patient check-in and verification of eligibility. The pilot has also demonstrated the opportunity to increase efficiencies and reduce expenditures by consolidating multiple forms of identification or benefit issuance cards used by HHS beneficiaries into a Universal Services Card. At a minimum, Lone Star EBT Card, Medical ID form, and WIC EBT Card may be consolidated into the Universal Services Card. Other services used by HHSC beneficiaries, such as medical

transportation, child-support payments, and vendor drugs, may also be combined with the Universal Services Card.

**The Transition Legislative Oversight Committee recommends that the Legislature build on the promise of the pilot initiative authorized by H.B. 2292 by enacting legislation to accomplish the following:**

- Provide authorization and appropriate approval mechanisms for HHSC to expand the use of front-end fraud reduction methods statewide if indicated by the results of an assessment of the pilot and remove statutory time limitations that were applicable to the pilot initiative.
- Provide authorization for HHSC to assess the feasibility and cost-effectiveness of using a Universal Services Card or another method of consolidating recipient identification and benefits issuance to replace multiple forms and cards used by various health and human services programs. The universal card or consolidated method may:
  - Incorporate a biometric identifier to enable authentication at point of service and reduce fraud potential.
  - Use real-time electronic eligibility verification for Medicaid and other health and human services programs.

**The recommended changes would:**

- Reduce costs to the state for production of multiple forms of identification and electronic benefits transfer cards. Card replacement costs would also be reduced.
- Allow the state to implement a common point-of-service platform, increasing acceptance by providers who must now maintain separate platforms for Medicaid and other health and human services programs.
- Support the integrated eligibility concept through a standardized services card for multiple service applications.
- Improve processing and reduce costs for providers of health and human services and the state, allowing for real time electronic eligibility verification.
- Improve the integrity of health and human services programs, including Medicaid, by preventing fraud or abuse at the earliest possible point.

HHSC will analyze pilot results and make recommendations in the final report due to the legislature on February 1, 2005.

## Quality Assurance For Long Term Care Facilities

**The Transition Legislative Oversight Committee recommends that the Legislature enact legislation to extend the Quality Assurance Fee for Intermediate Care Facilities for the Mentally Retarded (ICFsMR) and State Schools, and establish a Quality Assurance Fee for Nursing Facilities. The Committee further recommends that the revenues generated from providers and the additional matching federal funds be used to support the quality of care provided in ICFsMR, State Schools and Nursing Facilities.**

In 2001, the 77th Legislature enacted a Quality Assurance Fee for privately run ICFsMR. In 2003, the 78th Legislature extended the Quality Assurance Fee to include State Schools. This fee has proven successful in increasing reimbursements, while ultimately helping to improve the quality of care for residents of these facilities. Unless continued by the 79th Legislature, this fee (which is intended to improve the quality of care for ICFMR and State School residents) will expire on September 1, 2005.

There have been a number of nursing homes in severe financial trouble in recent years. In 2001, one in four nursing homes was in bankruptcy. As our state's population ages and the nursing home population grows, the need for high quality nursing care has never been higher. The state must work to ensure this vital service is available to those who need it in coming years as the demographic trends for the increase in the elderly population are staggering.

Medicaid patients comprise 72% of nursing home patients. Therefore, nursing homes are for the most part dependent on the state's reimbursement rate for their financial well-being.

Recently, in testimony to the Select Committee on Long Term Care, an HHSC representative testified that Texas is under-funding the nursing home reimbursement rate by $21.00 per day. Combined with the skyrocketing rates of medical malpractice insurance these facilities must pay, this creates an unsustainable gap for most nursing homes. An industry that has already suffered heavy financial losses is poised for greater losses if action is not taken.

To address this problem, many states have adopted nursing home assessments, which allow them to take advantage of a matching program available through the Federal government. Funds generated through the nursing home assessment would qualify as state match if certain conditions were met. Entering the 79th Legislature, the state has another opportunity to increase the amount of federal money it receives in meeting the growing need for long term care services, which provides health care services, rather than just insurance, for Texas most vulnerable population - nursing home residents.

Such a program is not unprecedented in Texas. In 2001, the 77th Legislature adopted legislation establishing a program for private and nonprofit providers of intermediate care facilities for persons with mental retardation (ICF-MR). Revenues were intended for supporting rate increases for the ICF-MR and waiver providers of community based services for persons with mental retardation. In 2003, the 78th Legislature extended the application of the program to state operated facilities for persons with mental retardation. The revenues generated in this instance were used to support the operations of the state schools.

The increased Medicaid reimbursement rate will alleviate the growing financial pressures on nursing homes and allow them to address many deficiencies, all of which will improve the quality of care for all patients, such as: reducing staff turnover through increased wages and improved benefits, allowing nursing homes to make capitol improvements to facilities, and increasing the number of qualified direct care staff who provide nursing services to residents. At the same time, increased funding will mitigate further nursing home bankruptcies as a result of insufficient Medicaid reimbursement.

## Enhance Pharmaceutical and Therapeutics Committee Practices

**The Transition Legislative Oversight Committee recommends that HHSC ensure that, as appropriate, the basis for recommendations of the Texas Pharmaceutical and Therapeutics Committee is communicated to drug manufacturers and that an appeals process allow reconsideration of a committee recommendation in the event new and relevant information becomes available.**

The Pharmaceutical and Therapeutics Committee (P&T)was mandated by HB 2292 to develop recommendations for preferred drugs lists adopted by the Health and Human Services Commission (HHSC). Texas Government Code, Section 531.074 requires the appointment of committee members by the Governor. The committee consists of six physicians and five pharmacists actively participating in the Medicaid program. The committee has been effective in ensuring access for Texans in need to appropriate and effectual pharmaceuticals.

In developing its recommendations the committee considers the clinical efficacy, safety, cost-effectiveness and any program benefit associated with a drug product. The Committee's by-laws state that the Committee shall maintain the confidentiality of information used in considering their recommendations that is deemed confidential by law. Current practice is to discuss the merits of including or excluding pharmaceuticals from the preferred drug list in a confidential work session. Pharmaceutical manufacturers view this practice with some concern since the decision of this group may have a fiscal impact on their company. A particular concern of company officials is that decisions may be made by the committee on data that is misinterpreted or misapplied. A process which more fully discloses the rationale and basis for P&T committee recommendations and a better defined procedure to seek reconsideration would establish an appropriate means for a manufacturer to provide relevant, clarifying information.

## Ensure Consistency in the Prior Authorization of Pharmaceuticals

**The Transition Legislative Oversight Committee recommends that HHSC should modify procedures and scheduling to limit the period of time between the availability of a new pharmaceutical product and the consideration of that product by the P&T committee.**

HB 2292 requires HHSC to establish procedures that ensure that a prior authorization requirement is not imposed for a drug before it has been considered at a meeting of the

Pharmaceutical and Therapeutics Committee (PTC). This requirement was originally intended to ensure that the process would not unnecessarily delay the availability of a drug while under consideration by the PTC. The result has been a number of drugs that are prescribed and paid for by Medicaid but which are more expensive than the preferred products in the class. Further, the non-evaluated drug does not receive a supplemental rebate. In addition, the investment in marketing and distributing a drug before the PTC reviews it leads to more prior authorization costs if the PTC recommends and HHSC decides that the product should be non-preferred.

H.B. 2292 Section 2.13(e)(2) provides the means for drug manufacturers to have the opportunity to get their products on the preferred drug list quickly, as it requires that HHSC schedule a review for new products at its next quarterly meeting of the P&T Committee.

## Continuing Education Requirements for Respiratory Care Practitioners

**The Transition Legislative Oversight Committee recommends that Chapter 614 of the Texas Occupations Code should be amended to reestablish continuing education requirements of not less than six or more than 12 hours annually for licensed respiratory care practitioners.**

Respiratory Care Practitioners are required by Chapter 614 of the Texas Occupations Code to be licensed and they must receive a specified number of continuing education hours over the term of the license. Prior to the passage of HB 2292. the term of license was for one year and practitioners were required to receive not less than six or more than 12 continuing education hours over the term of the license. HB 2292 amended Subchapter B, Chapter 12, Health and Safety Code to standardize the term of any license issued by a health and human service agency to two years. This action inadvertently reduced the continuing education hours required of respiratory care practitioners by half.

## Access to Investigative Information

**The Transition Legislative Oversight Committee recommends that Section 531.1021 of the Texas Government Code be amended to ensure that the public has access to basic information relating to closed investigations of fraud and abuse conducted by the OIG.**

HB 2292 provided the authority for the OIG to investigate fraud, waste and abuse in the health and human services agencies. A major part of this authority is the ability to gather relevant information, including the ability to subpoena as provided in Texas Government Code Section 531.1021. Information collected by the OIG needs to be kept confidential during the investigative process to ensure that the investigation is not inadvertently compromised. However, once a determination is made whether fraud, waste or abuse has occurred and any resulting enforcement action is taken, there is a strong public interest in knowing some of the basic details of results of the investigation, such as the identity of the alleged perpetrator of fraud, the amount of public funds in issue, and the OIG's

disposition of the matter. Currently, the law does not sufficiently distinguish between the confidentiality of information related to active investigations and information related to closed investigation. This results in holding some information confidential that is of interest to the public and that does not need to be confidential.

## Reinstatement of Certain Advisory Councils

The reorganization required by H.B. 2292 created an agency council for each new agency to serve as a primary means of obtaining public input, specialized expertise and diverse perspectives to assist in shaping policy. In reorienting the public input mechanisms to focus on the agency councils H.B. 2292 also sought to streamline advisory mechanisms by abolishing the multitude of advisory committees that had developed over the years. The advisory committees that were retained were in general committees that required by federal law or related to certification, licensing, or regulation of entities providing health and human services.

**The Transition Legislative Oversight Committee recommends that, in order to enhance services to school children, the School Health Advisory Committee should be reconstituted and that it should be a collaborative effort between DSHS, the Texas Education Agency, and the Texas Department of Agriculture.** The School Health Advisory Committee (SHAC) was originally appointed by the Board of Health in 2000 to advise the board in delivery of school health services. SHAC advised the board on development of a model to compiling basic information about school health services in the state and on relevant issues based on the data collected. The committee was comprised of 2 physicians providing services to school age children, 2 registered nurses or physician assistants providing school health services, 6 consumer members including parents of school-aged children and at least 1 parent of a special needs child, 2 school administrators, and 4 members representing organizations and/or agencies involved with health of school children.

**The Transition Legislative Oversight Committee also recommends that Indigent Health Care Advisory Council be reinstated as advisory committee to DSHS.** Section 22.009 of the Human Resources Code originally established the Indigent Health Care Advisory Council at the Texas Department of Human Services (DHS) in October 1989. In 1993 when the County Indigent Health Care Program was transferred from DHS to the Texas Department of Health the committee was also transferred. The purpose of the committee served as a sounding board for policy development pertaining to indigent healthcare issues. The committee was comprised of 11 members consisting of four consumer and seven other representatives appointed by the Board of Health.

## Children's Health Insurance Program (CHIP)

**The Committee makes the following recommendations regarding CHIP to ensure that it is meeting the needs of Texas children:**

**Maintain the six month continuous eligibility interval allowed by H.B. 2292**

H.B. 2292 reduced the period of continuous eligibility for the CHIP program from one year to an interval of 6 months until September 1, 2005, at which time the interval of 12 months must be re-established. Since the need for CHIP services may change as the children's or parents' economic conditions improve, the shorter eligibility interval helps ensure that only those who maintain eligibility for services are covered. The renewal process is uncomplicated and convenient and does not serve as a barrier to those who qualify for the services.

**Maintain the asset requirement**

CHIP is designed to serve children who are not eligible to receive Medicaid but whose family still finds health insurance unaffordable. An asset requirement assures the state is meeting its policy objective of providing coverage for those most in need and ensuring the responsible use of public funds. The concept of an asset limit is not new. In fact, for some time, Texas has implemented an asset requirement for Medicaid, Food Stamps, and other government assistance programs.

The asset requirement was developed to ensure that families that are unable to afford health insurance coverage receive CHIP coverage, and to screen out families with the means to pay for their children's health insurance coverage. It is important to note that the asset requirement applies only to families with incomes above 150% Federal Poverty Level (in 2004, this was $28,275 for a family of four) who are applying for or renewing CHIP coverage. Under the policy, families can own one vehicle with a value of $15,000, and it does not count as an asset. In addition, the vehicle is excluded altogether if it is used primarily for work purposes or if it is modified to provide transportation for a household member with a disability. Families with incomes above 150% of FPL with cash in excess of $5,000 are not eligible for CHIP. However, retirement accounts, scholarship funds and real property, such as a home are not counted as an asset.

The asset test has been effective in ensuring that assistance is provided to those who are most in need. Since implementing the assets test, the Health and Human Services Commission has denied CHIP eligibility to families who owned expensive vehicles. For example, a new CHIP application was denied due to the assets test for a family consisting of one adult and one child that owned three vehicles, including a 2004 Jeep Cherokee. The value of these vehicles after the allowable deductions outlined above totaled nearly $50,000. In another case, a family of four, two adults and two children, were denied CHIP under the assets policy because they owned a 2004 Suburban and a 2003 Expedition. Families have also been denied reenrollment in the program who owned 2004 Dodge Durangos, 2004 Suburbans, a 2003 Lexus, a 2004 Lexus, a 2004 Nissan Pathfinder, and 2004 Cadillac. Recently, HHSC denied CHIP enrollment to a household of 4 after verifying a monthly income of $5,004.64 and 3 IRA accounts with a total value of $158,713.11. The client had initially reported earnings of $1,550.00 monthly. In another case, a family of four that had initially reported yearly income of less than $12,000 was denied enrollment after it was discovered they had failed to report rental income of approximately $40,000 per year.

The concern has been raised that the asset test triggered a drop in enrollment among people who really met eligibility criteria. However, the drop in renewals was more likely because parents understood they could not meet the asset test.

Much attention has been given to the decline in CHIP enrollment following the implementation of an assets test for those making above 150% of FPL. However, this reduction is similar to the 1995 reduction in food stamps enrollment following the rollout of the Lone Star Card, another anti-fraud measure. In the two years following the introduction of the card, food stamp enrollment declined nearly 32%. This year, 38% of the initial decline in CHIP enrollment was due to enrollees who did not complete the enrollment process.

Referencing the decline in food stamp enrollment, former Comptroller John Sharp, who spearheaded the implementation of the Lone Star Card, said, "What happened was, either we were cleaning up the rolls, or there were people who weren't on there to get the food stamps in the first place." When it was discovered that an average of 8,000 children per month were enrolled in two taxpayer-provided insurance programs – CHIP and Medicaid - from December 2003 to May 2004, one must assume that the same pattern could be applied to the decline in CHIP enrollment.

**Restore benefits related to vision, eyeglasses and dental services**

The lack of coverage related to vision, eyeglasses and dental services produces an undesirable hardship on working families who cannot afford these services. The legislature should restore these benefits to the CHIP program on an added coverage basis with a sliding scale.

**Increase co-payments and link them directly to service benefits**

Co-payments at the point of service (i.e., doctors office, hospital visit, etc.) and monthly premiums are intended to discourage employers and other persons from electing to discontinue offering coverage for children under employee or other group health benefit plans and discourage individuals with access to adequate health benefit plan coverage, other than coverage under the child health plan, from electing not to obtain or to discontinue that coverage for a child. Current copayment levels do not appear large enough to achieve this objective, even though total cost sharing (co-pays and premiums) may be at the federal maximum allowable level for certain families.

**Require an enrollment fee in lieu of a monthly premium**

H.B. 2292 added Section 32.064 to the Human Resources Code to require recipients of medical assistance to share the cost of medical assistance, including provisions requiring recipients to pay an enrollment fee. The cost-sharing provisions adopted may be determined based on the maximum level authorized under federal law and applied to income levels in a manner that minimizes administrative costs.

Preliminary results from a study on disenrollment patterns for fiscal year 2004 by The Institute for Child Health Policy (ICHP) showed that even though about 81.4 percent of

families believe the premium charged is about the right amount and most families rarely or never had difficulty paying premiums, about a third of families sometimes felt that paying the premium was a waste of money since their child is healthy and did not need medical care very often. Further, about 14 percent of families surveyed indicated they disenrolled from the program either due to non-payment of the premium or the family was dissatisfied with the premium. In addition, about 3 percent of the families did not complete the renewal forms because they did not have enough funds to cover the premium/renewal fee.

Preliminary results from a more focused study by ICHP during February through March 2004 showed that even though about 69 percent of families thought that a premium of $15 per month was about the right amount to pay for health insurance, about 58 percent of families thought it would be difficult to pay this amount almost every month or every couple of months. Further, even though families clearly valued health insurance for their children, about 25 percent indicated they would not be able to keep their children enrolled in CHIP due to the new monthly premiums and more than 50 percent indicated they would have trouble paying their premium.

Replacing monthly premiums with a single enrollment fee would ensure that all CHIP recipients have shared in the cost of their insurance over the course of their enrollment in the program. It would also reduce the administrative costs associated with the monthly processing of premiums. .

## Call Centers Implementation

**The Committee recommends that HHSC proceed with the implementation of Integrated Eligibility and Enrollment, including the use of call centers. It is further recommended that the 79th Legislature reallocate the savings generated to support direct service needs in health and human services**

Texas currently spends almost $700 million a year on a system designed in the 1960s to determine if people qualify for Medicaid, food stamps, Temporary Assistance for Needy Families (TANF) and long-term care services. House Bill 2292, passed by the 78th Texas Legislature, directs HHSC to evaluate whether call centers are cost effective and, if so, to determine whether state workers or private-sector employees should staff them. Study results showed that state-operated call centers would generate savings of nearly $400 million over the next five years. Privately operated call centers offer the potential for substantially greater savings.

However, the biggest advantage of this shift is the heightened level of service it will give to clients applying for services. An HHSC review of the current system found that applicants often had to make multiple office visits to determine if they qualified for services. HHSC's integrated eligibility project will incorporate modern business processes and new technology to become more efficient and provide consumers with more options, streamline the application process and allow consumers to choose the application method that is most convenient for them.

The strength of the new model is its flexibility for the consumer. A primary advantage of the proposed system is improved access to state services for working Texans, for people who lack transportation or live in remote areas, and for others who have difficulty traveling. In a recent news article about the shift to call centers (Selby, Gardner. "Welfare changes are 'stressful,' but also 'awesome'." San Antonio Express News 05 July 2004,) many clients recognized the advantages of the shift, saying, "It will make the whole process a lot easier," and "awesome, you won't have to wait so long."

Key components of the proposed system include: using the 2-1-1 system to provide general information and referrals to state and community resources; making automated screening tools available over the phone and through the Internet; maintaining sufficient field offices and maintaining staff in more than 200 hospitals to allow consumers to apply for services in person and get additional help and information; allowing consumers to access the system through convenient access points, such as schools, libraries and community organizations; using mobile offices to expand access in rural areas; establishing up to four call centers in Texas to accept and process applications.

It is important to emphasize that clients will still have to option to apply for services in local offices. Offices will be located so that consumers would travel no more than 5 miles for services in urban areas, 15 miles in suburban areas, and 30 miles in rural areas. In addition, mobile offices will help expand services in rural areas, and HHSC will continue to maintain offices in 211 hospitals across the state.

Other states have adopted similar models of eligibility determination and have had great success. In Pennsylvania, a web-based system receives more than half of its applications outside of normal business hours, and an Idaho system is most heavily used on Sundays. These results show this is a system that will be valued and used by clients.

We can provide better government at a better price by allowing Texans to apply for the services they need in the way that is most convenient for them. It's a commonsense approach that is long overdue.

This change will generate, at a minimum, nearly $400 million in savings for the state and will greatly enhance the accessibility of services for those applying for health and human services benefits. The potential for greater savings exists through outsourcing the operation of call centers. Vendor proposals are currently under evaluation.

## Strengthening Contract Oversight

**The Transition Legislative Oversight Committee recommends that HHSC should develop and implement a comprehensive, risk-based strategy to strengthen state oversight capabilities throughout the contracting process. The comprehensive plan should ensure, where appropriate, uniform standards for HHS agencies, consistent practices and requirements and sharing of information and resources among HHS agencies and programs. The HHSC should also advise the 79th Legislature of**

**budget or statutory actions to improve contract management, oversight and enforcement.**

Health and human services agencies spend more than $14 billion per year to procure goods and services and millions of Texans receive services each year from providers under contract to health and human services agencies. Strong contract management is vital to client services and accountability for the system's resources. Strengthening contract management is a top priority for this committee and for the health and human services system.

HHSC is taking active steps to improve contract management, including the formation of the Enterprise Contract and Procurement Division in October 2003 to direct and manage all administrative procurements (purchasing and contracting) for health and human services agencies. While contracting for client services remains the responsibility of each agency because of the specialized knowledge required, contracting for client services is also a major focus of these improvement efforts.

HHSC has mandated that all contracts, including contracts for services, contain clear performance standards and enforcement provisions. Currently, each health and human services agency monitors these contracts and relies upon limited resources ensure that the quality, level and cost of services complies with contractual expectations. The committee believes that these efforts would be strengthened by establishing clearer direction, focusing oversight resources based on contract risk, and enforcing contract provisions.

## Local Service Delivery

**The Transition Legislative Oversight Committee recommends that the Legislature reorganize the delivery of local services to reflect the changes mandated by HB 2292 and fully realize the advantages of the new state structure.**

With the large number of local authorities and overlapping regional structures, the current system of local service delivery presents many challenges. There are inconsistencies in service delivery, a lack of accountability, and potential conflicts of interest for authorities, who often function as the administrator and provider of services. Local reorganization will provide an opportunity to address these shortcomings, as well as identify and correct any existing gaps in services and create a local service delivery system that acknowledges the needs and resources of each local community.

Local reorganization should apply a consistent structure to local authorities. Aging and Disabled Authorities (ADA) and Behavioral Health Authorities (BHA) should be developed, each contracting with their appropriate new state agency to provide services more effectively at the local level.

Such change will ensure greater client accessibility. It will also allow for greater coordination of care and a continuum of services, improving health outcomes. Any apparent conflict of interest will be removed, since the new authorities will no longer be able to provide services.

Local reorganization should also restructure the various regions in the state. This will require the development of more consistent regions to more accurately facilitate regional planning, effective accountability mechanisms, and sharing of local resources. These regions should combine communities with similar needs and provide for more effective service delivery.

# Appendix I-Transition Legislative Oversight Committee Members

The Health and Human Services Transition Legislative Oversight Committee was created to facilitate the transfer of powers, duties, functions, programs, and activities between health and human services agencies. The committee provides input to the Executive Commissioner of the Health and Human Services Commission (HHSC) regarding those transfers as the transition plan is developed and the transfers move forward.

## LEGISLATIVE MEMBERS

**Representative Arlene Wohlgemuth, Chair**
**Burleson**
Rep. Arlene Wohlgemuth took office in 1994 and represents District 58. She is a homemaker and has been a flight instructor for 30 years. She previously served as chair of the House Appropriations Subcommittee on Health and Human Services. She also serves on the Human Services Committee, the Select Committee on Health Care Expenditures, and as vice-chair of the Calendars Committee. She has been named to the GalleryWatch and Texas Monthly Top Ten Best Legislators List.

**Representative John Davis**
**Clear Lake**
Rep. John Davis took office in 1998. He is the past President of Oates Industries, an industrial roofing company. He now serves as an independent manufacturer representative for RPM, a roof and wall restoration company. He is currently serving as Chair for the House Appropriations Subcommittee on Health and Human Services and is Chairman of Budget and Oversight for the State Affairs Committee. House Speaker Tom Craddick appointed Davis to serve as State Chairman for the American Legislative Exchange Council, the nation's largest bipartisan organization of state legislators.

**Senator Jane Nelson**
**Lewisville**
Sen. Jane Nelson took office in 1992 after two terms on the State Board of Education. She is a former teacher and is known for her work in education. Sen. Nelson serves as chair of the Senate Health and Human Services Committee, the Sunset Advisory Commission and the Senate Workgroup on Education Reform. She is a key lawmaker on health care policy and a strong advocate for Texas patients.

**Senator Judith Zaffirini**
**Laredo**
Senator Judith Zaffirini represents the 21st Senatorial District. She is a communications specialist and educator. Zaffirini served three consecutive terms as chair of the Senate Health and Human Services Committee, five terms as a member of the Appropriations Conference Committee, five terms on the Senate Committee on Finance and eight consecutive terms on the Senate Committee on Education. In 2003, Lt. Gov. David Dewhurst appointed her vice chair of the Senate Finance Committee and to the Legislative Budget Board, the Senate Committees on Education, Health and Human Services and International Relations and Trade and to the Appropriations Conference Committee, the Joint Interim Committee on Higher Education and the Legislative Oversight Committee on Higher Education.

## PUBLIC MEMBERS

**Chris W. Kyker**
**Health and Human Services Consultant**
**Abilene**
Chris Kyker is a self-employed organization and development consultant, with an extensive record of public service and community involvement that includes a focus on health and human services. She has served as a member of the Advisory Council for the University of Texas School of Social Work. She has also served as the founding Executive Director of the Texas Department on Aging, prior to which she served as the Director of the West Central Texas Area Agency on Aging and the Abilene Mental Health Association. As a member of the Texas Silver-Haired Legislature she has served as chair of the Human Services Committee, and is currently serving her second term as Speaker. She also serves or has served on numerous public and community boards and committees, including the Alternatives to Guardianship board, HHSC Consumer Task Force and Committee on Texas Long Term Care Access, the board of World Wide Youth Camps, and the board of Abilene Meals on Wheels Plus. Her contributions include service on various boards and councils of Abilene Christian University, from which she received her undergraduate and graduate degrees and where she served as a Speech and Theatre Director and lecturer. She has been involved in leadership roles in various professional associations and has received numerous public service awards.

**The Honorable Kenn S. George**
**Investments/Ranching**
**Dallas**
Kenn George is a former two-term state representative from District 108 in Dallas. Previously, he has served as a general partner in River Acquisitions, a commercial real estate corporation; past chairman and CEO of Ameristat, Inc., one of the largest private ambulance providers in Texas; and past chairman and CEO of EPIC Healthcare Group. He was appointed Assistant Secretary of the U.S. and Foreign Commercial Service of the International Trade Administration at the U.S. Department of Commerce by President

Reagan. George has served on the boards of the Dallas County Hospital District, Dallas Area Rapid Transit and the Texas Youth Commission, and is an active participant in the Boy Scouts of America, where he has three sons who are Eagle Scouts.

**Jacinto Juarez**
**Computer science professor and dean emeritus**
**Laredo Community College**
**Laredo**
Jacinto Juarez is a computer science professor and dean emeritus at Laredo Community College. He is a member of the United States Census Bureau's Race and Ethnic Advisory Committee, vice chairman of the Hispanic Populations Committee and vice president of the Rio Grande International Study Center. He is a board member of the Webb County Cooperative Extension Service and chairman of the Family Community Sciences Committee. Juarez is a past member of the Texas Healthcare Information Council, past president of the Laredo Community College Faculty Senate and previously served on the Statewide Health Coordinating Council. A graduate of Texas A&M University at College Station, Juarez received a master's degree from Texas A&M University at Kingsville and a doctorate from Texas A&M University at Commerce.

**EX-OFFICIO MEMBER**

**Albert Hawkins**
**Executive Commissioner**
**Austin**
Executive Commissioner Albert Hawkins is the chief executive responsible for leading and guiding the operations of the health and human services agencies in Texas. Prior to his appointment by the governor as HHSC Commissioner, Hawkins' career included the following positions: Assistant to President George W. Bush and Secretary to the Cabinet, Deputy Campaign Manager for the Bush-Cheney Presidential Campaign, State Budget Director for Governor Bush, and Deputy Director of the Texas Legislative Budget Board. Hawkins holds a Master of Public Affairs and a Bachelor of Arts from the University of Texas at Austin.

# Appendix II-Overview of Public Input

The Transition Legislative Oversight Committee directed HHSC to ensure public input into the development of the transition plan, the creation of the agencies, and in the ongoing transformation of programs. Information from public input has been used throughout the transformation to improve services to Texans in need.

## Public Meetings on The Development Of The H.B. 2292 Transition Plan

Six public meetings on a draft transition plan were held by HHSC across the state attended by over 1,000 people with 344 providing written or verbal testimony.

| Location | Date | Number of Attendees | Number Providing Testimony |
|---|---|---|---|
| Fort Worth | September 15, 2003 | 299 | 75 |
| Lubbock | September 16, 2003 | 112 | 17 |
| Tyler | September 19, 2003 | 120 | 19 |
| Harlingen | September 22, 2003 | 199 | 65 |
| Houston | September 23, 2003 | 204 | 131 |
| El Paso | September 25, 2003 | 110 | 37 |

A video produced by HHSC on the transformation was presented at each public meeting. It included an overview of H.B. 2292 and its goals, a description of the new agency structure, and the process for the development of the transition plan. Specific feedback was requested in five key areas:

- **Timing** - What needs to happen first, and next?
- **Improvements** - Where or how can we improve when merging agencies?
- **Savings** - What changes will help improve services?
- **Priorities** - What is important to clients, providers, and taxpayers?
- **Risks** - What challenges do we face, where should special care be taken and why?

Issues raised at these meetings were presented to the Committee and addressed in the final transition plan as appropriate.

## Public Hearing On The H.B. 2292 Transition Plan

The Committee took public testimony at a public hearing in Austin required by H.B. 2292 that was held on October 21, 2003. The hearing was attended by 336 people with written and/or verbal testimony provided by 39 individuals representing a wide array of organizations.

Numerous organizations offered assistance to the Transition Legislative Oversight Committee as the details of the plan were developed.

## Public Meetings on The New Agency Structures

Proposed organizational structures for the four new agencies were presented to the public at a series of open meetings in January and February 2004. DADS and DSHS held joint meetings since many mental and mental retardation programs of interest to the public may have been included in the design of either of these agencies. Together the meetings included 1,687 attendees and 419 speakers.

| New Agency | Meeting Location | Meeting Date | Number of Attendees | Number of Speakers | Number of written comments (letters, written testimony, & web pages) |
|---|---|---|---|---|---|
| DFPS | Austin | January 2004 | 83 | 9 | 2 |
| DARS | Dallas, El Paso, Harlingen, Houston and Tyler | January 2004 | 572 | 110 | 7 |
| DADS | Austin, Harlingen, Houston, and El Paso | January & February 2004 | 543 | 182 | 135 |
| DSHS | Austin, Harlingen, Houston, and El Paso | January & February 2004 | 489 | 118 | 47 |
| | | Total | 1,687 | 419 | 191 |

## Public Meetings Regarding Agency Councils

HHSC held a workshop February 19-20, 2004 to gain public input regarding the role and process of the new agency councils. A total of 170 stakeholder groups were invited as well as the 10 legacy agency board chairs. A total of 82 individuals from a wide variety of stakeholder groups across the state attended.

HHSC also held two focus groups to discuss the role and function of the new agency councils. A focus group held February 25, 2004 brought together the legacy agency board liaisons. A second focus group held March 23, 2004 brought together seven of the board chairs from the legacy agencies to discuss the agency councils with Executive Commissioner Hawkins.

HHSC held five public meetings for public input regarding about the agency council roles and responsibilities, including their role in the rule making process.

| City | Date | Attendees | Speakers |
|---|---|---|---|

| City | Date | Attendees | Speakers |
|---|---|---|---|
| Austin | 3/4/04 | 17 | 3 |
| El Paso | 3/8/04 | 34 | 11 |
| Fort Worth | 3/15/04 | 42 | 17 |
| Houston | 3/16/04 | 54 | 11 |
| McAllen | 3/17/04 | 20 | 4 |

## Continuing Communications

In addition to the many public meetings, the health and human services agencies have continued to provide the public up to date information at conferences, stakeholder meetings, and through other ongoing interaction with the public. In addition, HHSC communication strategies to support the transformation include the HHSC E-News with over 2,500 subscribers and employee updates and web sites kept up to date with information about the consolidation efforts. There have been more than 1,000,000 hits to its public Internet site on the implementation of H.B. 2292.