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## A Combined Report on The Health and Human Services Commission

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September 1997

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# Key Points of Report

## A Combined Report on The Health and Human Services Commission

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### Overall Conclusion

The State's expectations for increased effectiveness and efficiency of service delivery in health and human services programs and activities have not yet been realized. The Health and Human Services Commission (Commission) has not effectively carried out its responsibilities as prescribed by House Bill 7, House Bill 7 amending legislation, and General Appropriations Act riders.

### Key Facts and Findings

- The Commission should develop an action plan by November 1, 1997, which will describe in detail how specific concerns noted during the review will be resolved.

The plan, at a minimum, should address the following:

- Current status of all applicable legislative requirements
  - Time line for implementation
  - List of all parties that will have responsibility for implementing each of these requirements
  - Impediments (if any) to successful implementation
  - Steps required to overcome these impediments
  - Fiscal impact for implementation of each of these requirements
- The Health and Human Services Commission has made progress in addressing operational issues raised in a prior management control review. We recommend that the Commission ensure that issues still pending are resolved effectively and within reasonable time frames.
  - All three of the selected fiscal year 1996 performance measures at the Health and Human Services Commission were certified.

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## Office of the State Auditor

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*This combined audit was conducted in accordance with Texas Government Code, Sections 321.0132 and 321.0133, as well as Section 2101.038 and the Lieutenant Governor's Budget Reform Proposal, as adopted by the Legislative Budget Board on November 18, 1991.*

## Executive Summary

The State's expectations for increased effectiveness and efficiency of service delivery in health and human services programs and activities have not yet been realized. Our review of the implementation status of requirements prescribed by the Health and Human Services Commission's (Commission) enabling legislation (House Bill 7) has raised serious questions about the Commission's ability to effectively accomplish all of its health and human services mandates.

The Commission appears to have been unable to adequately carry out its key legislative mandate: to be the lead health and human services strategic planning and budgeting agency of the State with direct responsibility for addressing health and human services goals and objectives. In addition, the Commission appears to have provided limited leadership, direction, and innovation in implementing various other legislative requirements directed at addressing the State's health and human services needs. For example, our review noted concerns in areas that relate to health and human services:

- Funds management and maximization
- Service integration
- Residential placement rate-setting
- Integrated automation (enrollment and eligibility determination systems)

Since these House Bill 7 mandates have not been accomplished, our review raises concerns regarding whether the State's resources for implementing these mandates have been expended in alignment with the goals established by the Commission's enabling legislation.

### The Commission Has Made Progress in Addressing Operational Issues Raised in A Prior Management Control Review

Commission management and staff have resolved prior issues and recommendations related to the Commission's:

- Controls and oversight of fiscal activities
- Multi-agency information system projects
- Automation systems
- Compliance with historically underutilized business guidelines
- Use of performance measures information
- Human resource management

The few remaining issues and recommendations are currently being resolved by the Commission.

### Selected Performance Measures Were Certified

All three of the selected fiscal year 1996 performance measures at the Commission were certified.

### Summary of Management's Response

The Health and Human Services Commission generally disagrees with the findings and recommendations presented in this report. See pages 25 through 51 for management's responses and State Auditor follow-up comments.

### Summary of Objectives and Scope

The objectives of this combined audit were to:

## Executive Summary

- Follow up prior State Auditor's Office work on the implementation of House Bill 7.
- Follow up issues identified in a prior management control audit (*A Review of Management Controls at the Health and Human Services Commission*, SAO Report No. 96-031, December 1995).
- Certify selected fiscal year 1996 performance measures.

The scope of this combined audit included:

- A review of Commission activities to determine whether legislative requirements prescribed by House Bill 7 and House Bill 7 amending legislation had been implemented
- A review of applicable documents and processes to assess the status of prior management control audit issues and recommendations
- Certification of three fiscal year 1996 performance measures

## Overall Comment and Recommendations

The State's expectations for the increased effectiveness and efficiency of service delivery in health and human services programs and activities are yet to be realized. The Health and Human Services Commission (Commission) has not effectively carried out its health and human services oversight responsibilities as prescribed by House Bill 7, subsequent House Bill 7 amending legislation, and General Appropriation Act riders.

### Legislative Background

The State of Texas, through House Bill 7, passed by the 72nd State Legislature, "intended" to accomplish the following for the people of Texas:

To help promote their well-being by developing a system which will increase the effectiveness and efficiency of service delivery in the State's health and human services programs and activities—as carried out by various health and human service agencies.

To accomplish this, House Bill 7 enabled the creation of an umbrella health and human services agency—the Health and Human Services Commission—and gave it broad oversight responsibilities over all the programs and activities of the State's health and human services agencies. Critical health and human services oversight responsibilities delegated to the Commission are as follows:

- ▶ Coordinated and consolidated strategic planning and budgeting
- ▶ Funds management and maximization (all sources of funds)
- ▶ Service integration
- ▶ Being the single state Medicaid entity
- ▶ Residential placement rate-setting
- ▶ Integrated automation
- ▶ Statewide needs assessment/forecasting
- ▶ Local and regional planning and coordination

The Commission's responsibilities were further expanded and clarified through requirements passed in subsequent amending legislation and General Appropriation Act riders. The critical requirements of the amending legislation related to:

- ▶ The development of a health care delivery system in an effort to restructure the delivery of Medicaid health care services (Senate Bill 10, 74th Session)
- ▶ The development of a plan for an integrated eligibility determination and service delivery system at the local and regional levels (Senate Bill 1675, 74th Session)

Many health and human services functions mandated by the Legislature are either not being fully addressed, or have not been acted upon. The unfulfilled mandates include:

- Consolidated strategic planning and budgeting
- Statewide health and human services needs assessment
- Regional/local planning and coordination
- Funds management and maximization
- Service integration
- Integrated automation
- Residential placement rate-setting

In addition, several other legislative requirements have also yet to be addressed effectively. (See Appendix 2 for a complete status inventory of the Commission's applicable legislative requirements.)

### Recommendations

We recommend that the Commission develop an action plan by November 1, 1997. The action plan should describe, in detail, how the specific concerns noted during the review will be resolved. We further recommend that this plan be submitted to all applicable oversight entities (Governor's Office, Lieutenant Governor's Office, Speaker of the House, Legislative Budget Board, State Auditor's Office, Sunset Commission, and

applicable legislative committees). At a minimum, the action plan include the following information:

- Current status of all legislative requirements
- Time line for implementation
- List of all parties that will have responsibility for implementing each of the requirements
- Impediments (if any) to successful implementation
- Steps required to overcome these impediments
- Fiscal impact of full implementation

#### The Commission's Vision and Mission

We envision the Health and Human Services Commission as an agency that is trusted and respected for its leadership, excellence and innovation in achieving an efficient and effective health and human services system for Texans.

The mission of the Health and Human Services Commission is to provide leadership and innovation needed to achieve an efficient and effective health and human services system for Texans.

In addition, to address specific concerns noted in Sections 1 through 8 of our report, we offer the following recommendations. The Commission should:

- Incorporate the "Goals" established under House Bill 7 into the consolidated strategic plan. (See Section 1.)
- Using multiple-scenario techniques, develop cost/benefit projections related to a statewide health and human services needs appraisal. This would provide the Legislature with the information to decide if funding the needs appraisal should be a state priority. In the mean time, the Commission should continue providing baseline demographic data to all health and human service agencies to assist them in their planning and budgeting. (See Section 2.)
- Increase formal participation at the agency level during the development phase of agency strategic plans and budgets. This participation should occur before strategic plans and budgets are submitted to the agencies' boards for approval. (See Section 1.)
- Develop and implement health and human services consolidated measures, as opposed to agency-specific measures. Consolidated measures would provide the State with performance data to document the progress of the cluster service system in meeting needs identified in the planning process. (See Section 1.)
- Fully implement the legislative requirement to review and comment on all rules and notices proposed by health and human service agencies. This will provide the State with assurance that agencies are acting in accordance with the goals of the consolidated strategic plan for the delivery of health and human services or will identify agency rules that may conflict with the consolidated plan. (See Section 1.)

- To improve service delivery at the local/regional level:
  - Implement a formal planning process that incorporates the priority and service needs of local/regional entities delivering health and human services. This would provide greater assurances that local/regional issues and needs will be addressed, as required by law.
  - Ensure that by September 1, 1998, all services provided by health and human service agencies through the service delivery system are organized into the uniform regional boundaries. This will further enhance statewide planning, budgeting, reporting, and monitoring.
  - Develop and implement a system for regional funds allocation based on factors developed by the Commission in conjunction with state and local health and human services agencies. This would provide a more equitable approach to the delivery of health and human services. (See Section 3.)
- Formally integrate Intermediate Care Facilities - Mental Retardation (ICF-MR) data from the long-term care plan for persons with mental retardation when making consolidated budget recommendations. This will ensure that these particular service needs are being addressed with a statewide focus. (See Section 1.)
- Formalize powers to settle interagency disputes among health and human service entities. This will assist in the effective coordination of health and human services programs and activities and will ensure compliance of all applicable entities with legislative mandates. (See Section 1.)
- Develop a formal funds management system or process for all health and human services funds, as required by law. Development of a federal funds management system would provide the Commission with the tools identified in statute as necessary for the maximization of all federal funding sources. (See Section 4.)
- Formally implement legislative requirements to review health and human service agencies' operating budgets and fund transfers. Systematic review and analysis by the Commission of agency operating budgets and fund transfers would provide the State with assurance that agency funding sources are maximized and that agency expenditures are consistent with the goals and objectives of the consolidated strategic plan. (See Section 4.)
- Conduct a comprehensive feasibility study before initiating any more service integration efforts. These studies should look at the impact on the service delivery from a physical (co-location) standpoint and from a programmatic/administrative process analysis standpoint. The Commission should also develop and implement specific administrative/programmatic measures that

can be used to assess future performance or impact of these efforts. These steps will provide the State with assurance that funds are being expended efficiently and effectively. (See Section 5.)

- Implement legislative requirements and resolve concerns noted during this review in the following areas:
  - Residential placement rate-setting (See Section 7.)
  - Performance of independent special outcome evaluations of health and human service agencies' programs and activities (See Section 8.)
  - Development of a management information system and cost accounting system for all health and human services agencies (See Section 8.)
  - Improving access to health and human services through the Transportation and Planning Office (See Section 8.)
  - Providing status reports to applicable oversight bodies on health and human service agencies' efforts to streamline and simplify the delivery of health and human services (See Section 8.)

Addressing the above will further provide the State with assurance that appropriate guidance is being provided to health and human service agencies and that legislative mandates regarding health and human services are being complied with in an efficient and effective manner.

## Consolidated Strategic Plan and Consolidated Budget Do Not Adequately Address House Bill 7 Goals or Statewide Needs

### Health and Human Services Commission

The Health and Human Services Commission (HHSC) was created in 1991. HHSC is the state agency with primary responsibility for ensuring the delivery of state health and human services in a manner which uses an integrated system to determine client eligibility, maximizing the use of federal, state, and local funds, and emphasizing coordination, flexibility and decision making at the local level . . . .

Source: Commission Strategic Plan 1997-2001 page 11

The methodology employed for creating the health and human services consolidated strategic plan and the consolidated budget, along with other planning and coordination concerns, limits the utility of the plan and the budget to the State. At present, the State has little assurance that the health and human services goals established in House Bill 7 are being achieved or that the State's health and human services needs are being addressed.

The enabling legislation for the reorganization of health and human services under the Commission

established several goals for the health and human services enterprise. The Commission has responded to the mandate for a consolidated strategic plan by addressing the goals established in the Texas Tomorrow Plan (the State's strategic plan). In several instances, Texas Tomorrow Plan goals are not the same as those established in House Bill 7. The goals from both documents are presented and paired for comparability. (See Table 1.)

The consolidated strategic plan is structured around high-level health and human services goals of the Texas Tomorrow Plan, addressing only three goals of the enabling legislation. While the additional goals appear to be worthwhile and incorporate the strategic direction of several of the health and human services agencies, the success of the health and human services consolidated plan cannot guarantee that the goals of the enabling legislation have been, or will be, addressed. Consequently, it is difficult to ascertain the success of health and human services agencies in implementing the goals established under House Bill 7.

Table 1

Health and Human Services Goals (Mandated by House Bill 7) Compared to Health and Human Services Consolidated Strategic Plan	
House Bill 7 Goals	Consolidated Health and Human Services Strategic Plan Goals
<ul style="list-style-type: none"> <li>• <b>Goal 1:</b> Maximize federal funds through the efficient use of available state and local resources.</li> <li>• <b>Goal 2:</b> Provide a system that delivers prompt, comprehensive, effective services to the people of this State.</li> <li>• <b>Goal 3:</b> Promote the health of the people of this State.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Goal V:</b> Provide an efficient, effective, responsive and accessible health and human services system.</li> <li>• <b>Goal II:</b> Promote and protect the health of the people of Texas.</li> </ul>

Health and Human Services Goals (Mandated by House Bill 7) Compared to Health and Human Services Consolidated Strategic Plan	
House Bill 7 Goals	Consolidated Health and Human Services Strategic Plan Goals
<ul style="list-style-type: none"> <li>• <b>Goal 4:</b> Foster the development of responsible, productive, and self-sufficient citizens.</li> <li>• <b>Goal 5:</b> Provide needed resources and services to the people of this State when they cannot provide or care for themselves.</li> <li>• <b>Goal 6:</b> Protect the physical and emotional safety of all the people of this State.</li> <li>• <b>Goal 7:</b> Improve the coordination and delivery of children's services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Goal I:</b> Foster the development of responsible, productive and independent Texans.</li> <li>• <b>Goal III:</b> Provide effective and appropriate long-term care services to elderly and disabled Texans allowing them to live as independently as possible, within a continuum of care ranging from in-home and community services to institutional care.</li> <li>• <b>Goal IV:</b> Promote an accessible, efficient, and effective service delivery system that informs people with disabilities of choices and options available to them leading to employment of choice, participation in their communities, and living as independently as possible.</li> <li>• <b>Goal VI:</b> Foster a coordinated, accessible, and efficient eligibility determination process and service delivery system for the people of Texas.</li> </ul>

In addition, the consolidated strategic plan and the consolidated budget, as they have been developed to date, do not appear to address the State's health and human services needs. Instead, they appear to address the programmatic/service needs of each individual health and human service agency. This approach appears to be driven more by individual agency budget considerations than by identified statewide health and human services needs, thereby limiting the State's ability to respond effectively to an ever-changing environment. (See Section 2.)

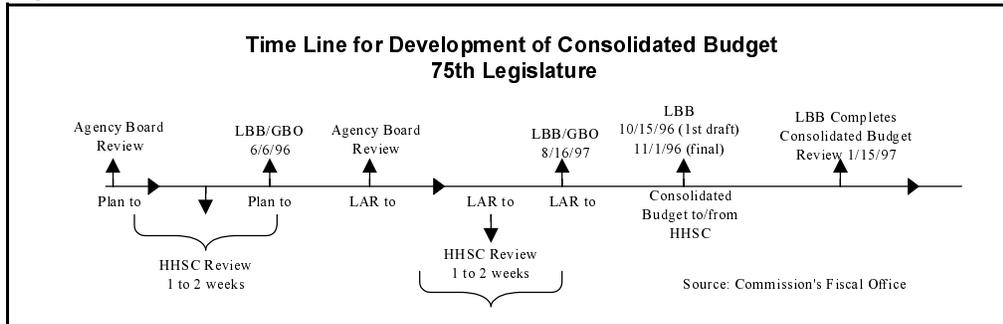
The plan and budget's usefulness or impact is further compromised by the following planning and coordination concerns noted during our review:

- The time frame for the Commission to review and comment on health and human services agencies' plans and budgets is inadequate. The law specifies that the Commission establish the time frames for agency submission of strategic plans and Legislative Appropriation Requests (LARs) to the Commission by health and human service agencies. It further provides that the Commission review and comment on agency strategic plans and budgets prior to their final submission to the appropriate bodies. This is to ensure

consistency between health and human service agency plans/budgets with the health and human services consolidated plan/budget. The time frames for review and comment that the Commission has allowed for itself

(approximately one to two weeks) have been very compressed. These compressed time frames provide the Commission with little option except to concur with the agency document(s). (See Figure 1 for

Figure 1



a time line of the consolidated budget process.)

- The basis upon which the coordinated plan for health and human services is built is flawed, focusing on state agency current services and ignoring regional variation and local need. House Bill 869 (74th Legislature) requires the Commission to develop a method for providing local input through the identification of local governmental entities that provide health and human services. The focus is to involve regions, counties, and municipalities responsible for the provision of health and human services in identifying strategic priorities and needs. In conjunction with these entities, the Commissioner is charged with developing a coordinated plan for the delivery of health and human services. The Commission has never identified these local governmental entities or formally developed these partnerships. The result is a plan/budget that cannot guarantee local health and human service needs and priorities are addressed. (See Section 3.)
- The present consolidated budget, through the clustering of like services, has provided the Legislature with an approach that is an improvement over previous efforts. However, it is unclear how success at the agency strategy level will contribute to a success in health and human services clusters statewide.

The present consolidated budget is built on a concept of six clusters, or areas of emphasis: Family Services, Health, Long Term Care, Rehabilitation, Coordination/Eligibility Determination, and Administration. Existing agency strategies and measures are grouped into the appropriate cluster.

Though a significant improvement, the cluster budget uses existing agency-specific measures to measure the effect of the service system. No uniform

measures exist to measure the effect of the cluster or to understand precisely how each agency strategy contributes to the success of the cluster effort.

Furthermore, the budget evolving from the plan is agency-focused and also fails to include local needs and priorities. In addition, though a monumental undertaking, the budget appears to have been of limited use to the Appropriations and Finance Committees of the Legislature in making decisions. This appears related, in part, to the timing of the submission of the agency-developed budgets to the Commission and the subsequent submission to the appropriate bodies for consideration.

- The plan on long-term care for persons with mental retardation (long-term plan) is not included in making consolidated budget estimations or projections. House Bill 1510, 74th Legislature, requires that the Commission submit the proposed long-term plan as part of the health and human services consolidated budget recommendations.

Our review noted that the Commission submitted the proposed long-term plan as part of the consolidated budget recommendations. (See Appendix C of the Health and Human Services Consolidated Budget Request.) However, the Commission did not integrate the long-term plan's ICF-MR (Intermediate Care Facilities - Mental Retardation) data in making the consolidated budget recommendations. The Commission hopes to capture that data indirectly through the budget recommendations of each applicable agency (the Department of Mental Health and Mental Retardation, the Rehabilitation Commission, and the Department of Human Services). The impact of this condition appears to be that, while the planning needs of each of the individual agencies may be addressed, the health and human services planning and budgeting needs of the State may not be adequately addressed.

The Commission is making progress in the development of a plan for service in the area of long-term care. House Bill 2698, 74th Legislature, requires the Commission, in conjunction with appropriate state agencies, to develop a plan for long-term care that will ease access to the service delivery system. The plan is presently in the draft phase and is projected to be finalized and released during fiscal year 1997.

- The Commission has never formalized powers given to it by the Legislature to settle interagency disputes. The Legislature provided the Commission with the power to arbitrate disputes and render decisions related to interagency disputes. Disputes between agencies related to service delivery authority and related issues are to be addressed by the Commission. However, the Commission has not formally developed and implemented a process to address this issue.

This power would be important as the Commission sets about coordinating the service delivery system for the State. Under the new scenario related to the

development of an integrated eligibility system for service delivery, re-engineering and scope of agency service will become issues. Thus, disagreements among affected parties are likely. Policies or procedures related to dispute resolution would provide the Commission with the framework to finalize unresolved issues. Furthermore, given the Commission's enhanced role in servicing Medicaid fraud detection, the development and implementation of a formal dispute resolution process would be prudent.

During our review, we noted a situation that illustrates the types of issues that would benefit from a more direct role of the Commission in resolving disputes among entities delivering health and human services: The Commission has been unable to implement Subsection 11 of Senate Bill 1675, 74th Legislature, due to disagreements among the parties involved. The requirement mandates that the Commission expand its existing integrated eligibility program to include Harris County Hospital District (HCHD) and The University of Texas Medical Branch at Galveston (UTMB-G). However, due to unresolved disputes among the parties involved (HCHD, UTMB-G, and Department of Human Services) no conclusive agreement has been reached to date. In addition, other requirements impacted by this issue have also not been implemented.

- The Commission is not reviewing all health and human service agency rules to ensure consistency in health and human services service delivery. In order for a service system to be effective, the policies and rules under which services are provided should be reviewed for consistency with a service strategic plan. House Bill 7, 72nd Legislature, provides the Commission with the authority to review and comment on all rules proposed by health and human services agencies for their respective board's approval. Presently, it appears that only Medicaid rules are consistently reviewed by the Commission. Failure to review all proposed rules does not allow the Commission the latitude to be certain that the proposed rules are consistent with its consolidated strategic plan and that the rules will not jeopardize receipt of federal funds. The Commission reports that with only review and comment capability, and no enforcement capability, the impact of any review would not be fully effective. While this may be an issue, it has not been tested because of inactivity on the part of the Commission related to rule and policy review.

Finally, the effect of weaknesses in the Commission's planning and coordination may have contributed to the State's relative lack of coordination and preparedness related to Federal Welfare Reform and the receipt of related block grant funding. Two particular areas of need related to Federal Welfare Reform are:

- The development of a coordinated and integrated plan for service delivery in order to provide assurances that the State will meet the federal requirements for continued maximum participation

- A plan to address the needs of individuals who have been eligible for public assistance in the past, but under new federal law will no longer be eligible

To date, no coordinated plan for addressing Federal Welfare Reform presently exists.

Section 2:

## Lack of a Comprehensive Statewide Needs Assessment Restricts the State's Ability to Effectively and Efficiently Plan for the Future

Our review found that the Commission has experienced difficulty in addressing the legislative requirement to develop an information base for the identification of service needs through a statewide comprehensive needs assessment. The Commission was given authority to develop this information base was also given and explicit authority for implementation and enforcement in House Bill 7, 72nd Legislature, and in Senate Bill 1675, 74th Legislature.

**The External Environment:** Perhaps the one constant in health and human services today is the notion of change. Increasing demands for services, shrinking resource bases, and greater expectation for services all combine to form a dynamic environment significantly impacting health and human services in Texas.

Source: Commission Strategic Plan 1997-2001 page 5.

A statewide comprehensive needs assessment is necessary for effective consolidated planning and budgeting. The current caseload forecasting/needs assessment information compiled by the Commission is not based on any comprehensive statewide health and human services needs study. The Commission and the health and human services agencies rely heavily on historical caseload data to develop projections for future health and human services needs. Consequently, this lack of a comprehensive analysis in planning for the State's health and human services diminishes the State's ability to predict future service needs.

It is quite possible that the development of a statewide needs appraisal would have significant cost. However, to date, the Commission has neither implemented this requirement nor has it formally identified costs that would be incurred in implementing it.

In addition, legislative requirements that authorize the Commission to conduct a statewide needs appraisal also provide for the sharing of data related to needs assessment with health and human services agencies. While the Commission has not implemented the statewide needs appraisal option, it has provided agencies with baseline demographic data for use in planning. However, the Commission reports that it will no longer provide this data to agencies. This raises an additional concern regarding policy and budgetary leadership and coordination. Since planning and budgeting are agency-driven and conducted without the benefit of local input, the impact of the Commission as a coordinating body is significantly reduced. In fact, the present system appears to be similar to the service delivery system in place prior to House Bill 7.



## The Commission Has Not Identified the Priorities or Addressed the Strategic Planning and Funding Needs of Local Service Providers

The Commission has not adequately addressed the health and human services priorities and strategic planning needs of governmental entities that coordinate the delivery of health and human services in different regions, counties, and municipalities in the State. These entities have not been identified by the Commission. In addition, these entities have not been formally included in the consolidated health and human services strategic planning process.

While uniform boundaries for health and human service delivery areas have been established, the boundaries have not been enforced. The enabling legislation of the Commission and the health and human services enterprise anticipated the use of uniform health and human services boundaries. The uniform boundaries divide the State into 11 regions for the purposes of service delivery, funds allocation, and performance reporting. However, our review found that health and human services agencies do not all allocate funding and services based on the boundaries established by the Commission. Coordination of service delivery and local considerations may be hampered by the failure to adhere to service boundaries.

Furthermore, fund distribution across health and human services regions may not be addressing regional needs. The Commission has not developed a formula for distribution of funds across health and human services regions of the State. House Bill 7, 72nd Legislature, directs the Commission to develop a formula for the distribution of funds within the 11 identified regions of the State. Senate Bill 1675, 74th Legislature, requires the Commission to review and comment on agency formulas based on identified need factors. Need factors described in statute include “client base, population, and economic and geographic factors.”

Senate Bill 1675 oversight responsibility has been delegated informally to the health and human services agencies with no monitoring by the Commission. Feedback obtained from the applicable agencies for their health and human services regional fund distribution methods indicates that this requirement appears not to be met effectively by all of them. Consequently, little assurance exists that need factors such as client base, population, economy, and geography are being included in determining distribution of funds across health and human services regions, as required by statute.

Under a process of funds distribution that is agency-specific and decentralized, the interactive effects and economies achievable under a consolidated system are weakened.

## The State Has Limited Assurance That All Health and Human Services Funds Are Properly Managed and That All Funding Sources Are Maximized

While the Commission appears to have devoted resources to the maximization and management of Medicaid dollars, the Commission cannot provide assurance that it is maximizing all of the health and human services funding sources. House Bill 7, 72nd Legislature, requires that the Commission establish a federal health and human services funds management system in order to manage and maximize funds that come to Texas for the delivery of health and human services.

Our review found that no formal health and human services funds maximization system appears to be in place at the Commission. Consequently, the State may not be using available health and human services funds efficiently and may not be maximizing all federal funding sources.

The Commission has no process in place for systematically reviewing and commenting on agency operating budgets or transfers. The review and comment process is critical to effective funds management and maximization. Through allowable transfers, agencies have the authority to move funding sources between strategies as provided in the General Appropriations Act. Senate Bill 1675, 74th Legislature, provides the Commission with the authority to review operating budgets and transfers between strategies.

Since the Commission has the responsibility for funds management and maximization, it would benefit the Commission to review all operating budgets and fund transfers made by health and human service agencies. These reviews would help ensure that the budgets and transfers maximize health and human services funding and address goals and objectives of the consolidated strategic plan as well as the goals of its enabling legislation.

Inadequate monitoring by the Commission of agency operating plans and budget transfers among strategies also raises concerns about the continued utility of the consolidated strategic plan and budget.

Significant difficulties related to non-Medicaid federal funding sources have developed recently. These difficulties may have their origin in the informal system for federal funds management. These difficulties include the following:

- In a report to the 75th Legislature, the Legislative Budget Board reported over-expenditures in Title V funding by the Texas Department of Health, resulting in an over-commitment of federal resources. In order to continue the level of service provided under the over-commitment, the Legislature had to provide additional state dollars.

- The Legislative Budget Board also identified that, due to lack of full participation, the State may not be accessing all the Supplemental Nutrition Program for Women, Infants and Children (WIC). Approximately \$31.2 million worth of federal program funds were returned by the state in fiscal year 1996.

A management system, as identified in statute, may have been able to either control for the changing funds demand, or at the very least, would have provided the State leadership with advance notice of the issues.

Section 5:

## The Service Integration Initiative May Not Adequately Address Service Delivery Needs, and Its Impact on Service Delivery Is Unknown

The current effort to enhance health and human services co-location is not based on any comprehensive feasibility study of health and human service delivery needs. Health and human services agencies are being primarily co-located based on their physical space needs, and not based on their program/activity needs for the services they deliver. Consequently, the State has no assurance that any benefit has been gained or will be gained in health and human services service delivery from the current co-location effort.

### Health And Human Services Commission

Health and Human Services Commission has several administrative and oversight functions. These duties include setting the overall direction for the health and human services system, and acting as a single state agency for Medicaid. The commission also serves as a lead on health and human services initiatives.

Source: Commission Strategic Plan 1997-2001 page 11

Goal 2 of House Bill 7 and Goal 5 of the Consolidated Plan provide for a responsive and accessible health and human services system. Under House Bill 7, this was to be accomplished, in part through co-location of agencies and services. In this way, ease of access would be coupled with economies that could be gained through shared resources.

In addition, the physical co-location effort has only been achieved for health and human services agencies' central offices and a few selected pilot sites. The effort is essentially on hold for other sites until the impact on staffing changes from the development of the integrated eligibility system can be determined.

With the advent of changing technology, physical proximity is becoming a less essential service integration tool for improving service delivery. Instead, improvements in programmatic/administrative processes are becoming more important. Thus, co-location efforts should ensure that decision-making processes take all factors into account, including space needs, program/activity needs, and technological change.

Section 6:

## Initiatives for Enhancing Service Delivery Through Integrated Eligibility Determination and Enrollment Processes Have Not Been Fully Realized

In an effort to enhance health and human service delivery, significant state resources have been expended on integrated enrollment and eligibility determination systems and processes. However, to date, none of the initiatives taken have been fully implemented across health and human service agencies. Due to a lack of an effectiveness analysis, serious questions remain as to the impact these efforts have had (or will have) on health and human services service delivery. (See Table 2 for a description of major initiatives.)

Table 2

Major Initiatives to Integrate Enrollment and Eligibility Determination Processes and Their Current Status		
Initiative	Description	Status/Comment
Integrated Data Base Network (IDBN)	The IDBN is an automated system which provides an index of the clients of Texas health and human service agencies. This index provides clients' participation status in programs administered by the health and human service agencies and also provides access to selected detailed client data stored in existing agency data bases. Approximately 80 percent of the current health and human services client population is represented in the IDBN.	PENDING. Although implemented at the Department of Human Services, the Texas Department of Health, the Department of Mental Health and Mental Retardation, and the Texas Rehabilitation Commission, IDBN is still in the pilot stage. Further implementation of IDBN appears to have been put on hold pending the development of an integrated eligibility determination system.
Texas Eligibility Screening System (TESS)	TESS is an automated system which screens for potential eligibility of individuals for programs administered by health and human service agencies. TESS is a potential eligibility screening (who may be eligible) system, and NOT an eligibility determination (decides whether a client qualifies for services) system.	PENDING. Full implementation only at the Department of Human Services and the Texas Department of Health. Projected Time line for full implementation for TESS is unknown, but will be absorbed into the proposed integrated eligibility determination system.

Talbe 2 (concluded)

Major Initiatives to Integrate Enrollment and Eligibility Determination Processes and Their Current Status		
Initiative	Description	Status/Comment
Texas Integrated Eligibility System (TIES)	TIES is a potential eligibility determination system and will also have the ability to enroll individuals in health and human services or programs.	PENDING. The Commission developed and submitted a proposed planning document to applicable federal agencies for review and comment. Initial federal feedback has been received. However, feedback provided by the federal entities has raised some issues regarding TIES planning and implementation. At present, it is unknown what definitive actions will be taken by the State Legislature and the Commission to address pending issues related to this project. Per Commission management, if one assumes that work will begin in fiscal year 1998, then best possible estimates for TIES' full implementation is around fiscal years 2001-2002.

Section 7:

## Inadequate Oversight and Coordination Problems May Still Persist in Residential Placement Rate-Setting

House Bill 7, 72nd Legislature, provides that the Commission review and comment on issues related to rate setting. Section 17, Special Provisions of Article II, General Appropriations Act, 74th Legislature, provided for the setting of a maximum rate above which agencies could not spend. The rider also provided for the establishment of a uniform application and submission of cost reports according to procedures established by the Commission.

The Commission was providing the oversight related to rate setting established under Section 15 as of an August 1994 review of statutory compliance with requirements of House Bill 7 conducted by the State Auditor's Office. However, a more in-depth study conducted by our Office during fiscal year 1995 noted the following:

**Weaknesses in the Rate-Setting and Levels of Care System Could Affect the Quality of Children's Care** - There is a need for more oversight and coordination over the State's level of care system for residential care. Our review noted problems with the processes used to set reimbursement rates for children's residential care and with the levels of care system. . . .

**There Is A Need to Review the Levels of Care System Tools and Improve Coordination and Information Sharing** - The [levels of care] definitions have not been reviewed since they were originally approved

by the Health and Human Services Coordinating Council in 1989. . . . some agency personnel also expressed concern about the standard application form that is required by Article V, Section 74 of the General Appropriations Act. . . . There is a need for better coordination and information sharing between state and local agencies who use the levels of care system. Our review found that one state agency and two of the five counties we visited were using the Health and Human Services Commission's ceilings as their primary rates. They were not aware that they could use lower rates . . .

Furthermore, the report acknowledged the fact that "The [Health and Human Services Coordinating] Council's responsibility to maintain the levels of care was not specifically passed to another agency when it was dissolved." The report recommended that the Commission take initiative in resolving the oversight and coordination concerns raised since the Commission has primary responsibility for coordinating the delivery of human services, which include children's residential care (*A Review of Rate-Setting For Children's Residential Care*, SAO Report No. 95-022, November 1994).

In our present review, we noted that the Commission is no longer in full compliance with either of the aforementioned requirements. As indicated in Section 1 of the report, the Commission is not reviewing all agency rules for consistency and compliance, and the Commission has delegated the responsibility of the rider to the agencies with no monitoring to ensure compliance. Thus, the possibility exists that the conditions raised in the State Auditor's Office report may persist.

Section 8:

## Several Other Legislative Requirements Have Not Yet Been Effectively Addressed

During the course of our review, we concluded that several other legislative requirements have yet to be addressed effectively. These requirements include the following:

- Plan and implement Medicaid/managed care reform initiatives. The requirement of Senate Bill 10, 74th Legislature—the development of a health care delivery system in an effort to restructure the delivery of Medicaid health care services—has not been implemented. Implementation of this requirement requires approval by the federal oversight agency. The original waiver (Form 1115) was amended and resubmitted as requested by the Federal Government. No decision has been made as yet on the re-submission.
- Perform independent special outcome evaluations. Subsection 14 (a) (8), House Bill 7, 72nd Legislature, requires the Commission to perform periodic performance or effectiveness reviews of health and human service agencies' programs and activities. This particular requirement would appear to be an extremely valuable tool for the Commission since it allows the Commission to

monitor the effectiveness of health and human service agencies in implementing legislative mandates and to assess compliance with the consolidated plan/budget. However, to date, the Commission has not adequately used this tool, and as such no meaningful evaluation has been conducted by the Commission.

- Establish a management information system (MIS) and a cost accounting system (CAS). Subsection 14, House Bill 7, 72nd Legislature, mandates that the Commission develop these systems for all health and human service agencies to ensure compatibility with the State's financial systems. The Commission is still in the planning stage for this requirement. It is not known when full implementation will be accomplished.
- Improve access to health and human services through the Transportation and Planning Office. House Bill 1510, 73rd Legislature, and House Bill 2891, 74th Legislature, require that the Commission assess the feasibility of using the Transportation and Planning Office to enhance service delivery through means such as mobile clinics. To date, this issue is unresolved, and no formal plan of action has been developed.
- Provide status reports on delivery of services to appropriate oversight authorities. Section 8, Senate Bill 1675, 74th Legislature, mandates that the Commissioner of the Health and Human Services Commission adopt rules relating to reports required for assessing the efforts of health and human service agencies to streamline and simplify the delivery of services. To date, no such rules have been promulgated by the Commission. The required quarterly reports on efforts to enhance service delivery have not been submitted by the health and human service agencies to their governing bodies. Subsequently, no required semi-annual reports have been submitted by the Commission to applicable entities, such as the Governor's Office, the Lieutenant Governor's Office, the Legislative Budget Board, the Office of the Comptroller of Public Accounts, the Office of the Speaker of the House, and appropriate legislative committees.
- Accomplish majority of service delivery tasks by established legislative deadlines. Based on observations made by our Office in this review, it would appear that the Commission has either not met many established time lines or appears to be far from realizing them:
  - Section 1.16, House Bill 7, 72nd Legislature: "Not later than 9/1/95, the commissioner of health and human services shall complete the reorganization of the delivery system for health and human services in accordance with the goals stated in Section 2, Article 4413(502)."
  - Section 12, Senate Bill 1675, 74th Legislature: "Not later than September 1, 1996, the Health and Human Services Commission, subject to the availability of funds to the commission and the health

and human service agencies, shall have completed the development and substantial implementation of a plan for an integrated eligibility determination and service delivery system at the local and regional levels. . . .”

- Section 13, Senate Bill 1675, 74th Legislature: “Not later than September 1, 1997, the Health and Human Services Commission shall develop, using existing state, local, and private resources, an integrated approach to the health and human service delivery system that includes a cost-effective one-stop or service center method of delivery to a client. The commission shall determine the feasibility of using hospitals, schools, mental health and mental retardation centers, health clinics . . . and other appropriate locations to achieve this integrated approach. . . . This section expires September 1, 1997.”

## Follow-Up Review of Prior Management Control Issues

The Commission's management and staff have made progress in resolving issues and recommendations related to the Commission's controls and oversight of fiscal activities, multi-agency information system projects, automation systems, compliance with HUB guidelines, utilization of performance measures information, and human resource management.

With few exceptions, the issues noted in our report *A Review of Management Controls at the Health and Human Services Commission* (SAO Report No. 96-031, December 1995) have been addressed. The remaining issues and recommendations regarding fiscal monitoring of agency grants and contracts, post-implementation review of the Integrated Data Base Network pilot project, and operational policies and procedures are currently being resolved by the Commission.

(See Appendix 3 for a detailed list of prior audit issues and their current status.)

### Recommendation:

The Commission needs to ensure that prior management control audit issues still pending be resolved effectively and within reasonable time frames.

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## Performance Measures Certification

All of the selected fiscal year 1996 performance measures at the commission were certified:

Fiscal Year 1996 Performance Measures Certification Health and Human Services Commission			
Description	Classification	Results	Certification
Number of Interagency Administrative Support Initiatives	Outcome	11	Certified
HUB Compliance for Health and Human Service Agencies	Outcome	18.7	Certified
Number of Interagency Projects	Output	4	Certified

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## Management's Response



July 25, 1997

Mr. Lawrence F. Alwin  
State Auditor  
P.O. Box 12067  
Austin, Texas 78711-2067

Dear Mr. Alwin:

Attached please find a copy of the Health and Human Services Commission's management response to the State Auditor's Office draft audit of HHSC dated August 1997. The draft departs from the customary audit report in ways that complicated the preparation of our response.

The draft report has made it necessary for us simply to address the issues raised in the audit point by point. If you have any questions, please call me or Marina Henderson, Executive Deputy Commissioner.

Sincerely,

Michael D. McKinney, MD

MM/hw

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## Executive Summary of Management's Response

Auditor's note:

The section numbers in this formatted report are different from those in the unformatted draft version to which the Commission responded. Current section numbers are included in brackets.

*HHSC management finds the SAO report format unconventional and its editorial comments unusual. Our response is designed to provide a clear focus on relevant issues and to clarify the functions, methods and operations of the Commission in carrying out its legislated duties.*

*Our response consists of three parts: the executive summary, a general management response, and specific responses to each item on the SAO matrices. We have organized our general management response according to these issues: service integration and co-location; local planning and governance; integrated eligibility; budget and planning functions; and rules, policies and procedures.*

### **General Comments**

*HHSC offers the following general comments:*

- *The SAO report intersperses general recommendations within its essay format. Many of the recommendations do not appear to be supported by adequate audit findings. Others represent the formulation of policy which is properly within the discretion of the legislature or the agency.*
- *The SAO report contains numerous inaccurate statements and conclusions, perhaps based on incomplete understanding of HHSC's operations and accomplishments, eg. inconsistencies in SAO interpretation of Commission enforcement powers.*
- *HHSC will aggressively implement appropriate corrective action in those areas where the audit findings are complete and correct.*
- *All HHSC performance measures have been met, as reported by the SAO.*
- *Many of the statutes which govern HHSC's numerous and complex functions were enacted subsequent to HB7. This additional legislation was not adequately considered in the SAO report.*
- *Pursuant to statute, HHSC prioritizes, in a work plan, its many complex functions and the limited resources available to perform those functions. That work plan is submitted to the Legislature. SAO comments do not consider that work plan.*

## ***HHSC Statutory Accomplishments***

*By any objective standards, the Commission has made significant progress in recent years. HHSC notes that the following accomplishments are not mentioned in the SAO report:*

- *Recovery of \$7 million in FY97 by HHSC's Medicaid Provider Sanctions;*
- *Successful co-location of HHS agencies evidenced by co-location in 51.1% of statewide sites and involvement of co-location in 45.6% of lease requests;*
- *Timely development and submission of required HHS strategic plans and consolidated HHS budgets;*
- *Design and piloting of service integration tools, e.g., eligibility screening and integrated data base systems which will be included in a statewide integrated service delivery system;*
- *Establishment of local Community Resource Coordination Group (CRCG) teams statewide to develop service plans for children with complex needs who require services from multiple agencies (funded by HHS agencies through interagency contracts);*
- *Establishment of Information & Referral Centers statewide;*
- *Implementation of a managed care system of delivery for Medicaid services.*
- *Development and implementation of a number of one-stop service center models;*
- *Development and implementation of transportation brokerage models to coordinate and reduce duplication among the various transportation resources;*
- *Development and implementation of local sites to serve children with developmental disabilities and their families which are focused on permanency planning to keep children at home in their families and communities;*
- *Development and implementation of sites to serve children who have high-cost mental health service needs through pooled funding from various agencies and funding sources; and*
- *Thorough analysis of client confidentiality issues and implementation of methods to address confidentiality as needed.*

## **Conclusion**

*In preparing this management response, the Commission's analysis shows that many of HHSC's specific legislative tasks have been accomplished. Many others are in progress. A few have been delegated to other agencies. Some have been replaced by more recent legislation. Some are assigned a low priority in the HHSC work plan. Overall, HHSC disagrees with the general audit conclusions, and affirms its continued and successful work to achieve new and ongoing legislative mandates.*

## **State Auditor's Follow-Up Comment**

Our review was limited to assessing the implementation status of requirements mandated under House Bill 7 and legislation that amended the mandates of House Bill 7. Based on our review of the information provided by the Commission, we believe that a significant number of the mandates tested have not been completely accomplished. As a result, it is our conclusion that the Commission has not been able to accomplish all of its health and human services mandates.

The scope of this project was communicated to the Commission during the entrance conference and during periodic briefings with Commission management.

## **Management's Response**

*HHSC management finds the SAO report unusual in its format and in its editorial content. Many of the auditor's recommendations are not supported by adequate findings. Others represent the formulation of policy which is properly done at the discretion of the legislature or the agency. Therefore, our response has been prepared as follows.*

*We appreciate the recognition that all performance measures have been met in Report Segment 3: Performance Measures Certification. HHSC staff has been working hard to improve the effectiveness and efficiency of the State's health and human services delivery system. We also appreciate other constructive comments made in the State Auditor's report and will aggressively implement corrective action on those issues as appropriate. However, many of the findings and resultant recommendations were not based on a complete understanding of the facts.*

*The audit's misleading conclusions may be the result of the auditor's emphasis on HB 7. The SAO did not adequately consider the many subsequent statutes that currently guide HHSC activities. Therefore the auditor's conclusions about the Commission's effectiveness are based on a partial and incomplete review of HHSC enabling legislation. We think the auditor's limited understanding of how the Commission operates explains why the report fails to recognize HHSC's accomplishments. In addition, a somewhat puzzling aspect of this report is the auditor's depiction of the*

requirements of HB 7 and the authority it grants the Commission particularly in light of their recognition of the bill's limitations published in an earlier report.

An SAO report dated April 8, 1993 entitled House Bill 7: Creating the Department of Protective and Regulatory Services, assessed HB 7 as follows:

*“The implementation of House Bill 7, 72<sup>nd</sup> Legislature, has been impeded for a variety of reasons. The bill did not grant any enforcement authority to the Health and Human Services Commission. This has prevented the Commission from making decisions or issuing directives to the agencies under its umbrella of authority. Instead, the Commission has had to rely on a time-consuming process of negotiation and consensus building with each agency.”*

On page 4 of the same report, the SAO goes on to state:

*“House Bill 7 was passed during the First Called Session . . . Therefore the Legislature had only 30 days to consider the contents of the bill. . . This short time frame may have prevented further consideration of details that would have made the bill easier to implement.”*

*The current report assumes the existence of enforcement powers that the earlier report explicitly noted were not delegated to the Commission. We find these inconsistencies disturbing and significant.*

## State Auditor's Follow-Up Comment

A significant number of the enforcement authority questions have been addressed by the Legislature in House Bill 7 amending legislation and General Appropriation Act riders passed subsequent to the issuance of this 1993 report.

## Management's Response, continued

*The following are general comments in response to the SAO report. They are expanded responses to the elements of Matrices 1, 2 and 4 [Appendices 2 and 3], as well as, the body of the report. Significant differences exist between many of SAO's conclusions and the facts of HHSC operations and accomplishments.*

*Though not apparent from the SAO report format and presentation, the report focuses on a limited number of issues: Service Integration and Co-Location; Local Planning and Governance; Integrated Eligibility; Budget and Planning Functions; and Rules, Policies and Procedures. Our response is organized according to these issues.*

## ***Service Integration and Co-Location***

***Section 1, General Comments regarding service integration*** [Executive Summary]- *We disagree with the audit conclusion. The audit report fails to acknowledge much of the real and substantial progress made in service integration. HHSC has worked toward service integration with limited staff and financial resources. Since there is a need to maintain vital services to the people of Texas while at the same time trying to streamline and integrate the service delivery system, only a small percentage of HHS agencies' resources can be devoted to systems change without jeopardizing the safety and welfare of many Texans. HHSC has obtained federal and private foundation funding to carry out the many tasks associated with service integration, and has accomplished much given the resource limits. Some of the major service integration accomplishments include:*

- *Establishment of local Community Resource Coordination Group (CRCG) teams statewide to develop service plans for children with complex needs which require services from multiple agencies (funded by HHS agencies through interagency contracts);*
- *Establishment of I&R Centers statewide (funded by federal grant);*
- *Development and implementation of a number of one-stop service center models;*
- *Development and implementation of transportation brokerage models to coordinate and reduce duplication among the varied transportation resources (funded largely by federal grant);*
- *Development and implementation of an action plan to address statewide client transportation issues;*
- *Development and implementation of local sites to serve children with developmental disabilities and their families which are focused on permanency planning to keep children at home in their families and communities (funded by a federal grant);*
- *Development and implementation of sites to serve children who have high-cost mental health service needs through pooled funding from various agencies and funding sources (funded by foundation grant and interagency contract);*
- *Draft of a state Long Term Care Plan;*
- *Development and submission of a state Service Integration Plan;*
- *Establishment of a statewide Location Database to track co-location, submission of annual co-location reports, and facilitation of increases in co-location among agencies;*
- *Design and implementation of a plan for an automated information and referral system (funded by a federal grant);*
- *Annual reports and recommendations on services to children with disabilities including implementation of multiple recommendations to coordinate and improve these services;*
- *Development and implementation of IDBN and TESS which have evolved to be included in a statewide integrated enrollment system (partly funded by a foundation grant);*

- Establishment of Regional Interagency Councils statewide.

**Overall Comment - “service integration (co-location)” and Section 1-E: “The Service Integration Initiative May not Adequately Address Health and Human Services Service Delivery Needs. In addition, the Service Integration Initiative’s Impact on Health and Human Service Delivery is Unknown** [Executive Summary and Section 5].

*We disagree with the audit conclusions. The SAO apparently does not fully understand this issue. Section 1-E [Section 5] seems to equate “the service integration initiative” and “co-location.” The service integration initiative is actually multifaceted and includes CRCGs, I&R, Transportation, Children with Disabilities, Long Term Care, Children’s Services, Financing Strategies, Case Management, Service Delivery Best Practices, etc.*

*Service integration and co-location are not synonymous. Co-location is one tool that may be used to achieve service integration. Service integration involves much more than physical, or even technological, proximity. Service integration is a process which includes co-location, common information systems, and agency consolidation; but these are only potential tools in an ongoing, dynamic process. Service integration can be defined as a process to plan, provide and evaluate services, using agreed upon principles, and standards of performance across existing programs and services. Ultimately, it should be defined by the client receiving the most appropriate service, at the right time, with measurable outcomes and cost efficiencies. HHSC, in partnership with the HHS agencies, has made considerable progress in developing some of the tools of service integration, and continues its leadership role in developing tools, models and best practices which further the broad goals for service integration as established in HB7.*

*While HHSC has only limited authority to enforce compliance with service integration activities, HHSC has found the agencies willing and helpful in cooperative service integration initiatives. Service integration is not the development of projects to achieve better coordination, but rather an ongoing focus on how we provide services.*

**Overall Comments contain the statement - “prior to initiating any more service integration efforts conduct a comprehensive feasibility study—i.e., one that looks at impact on service delivery from a physical (co-location) standpoint and from a programmatic/business process analysis standpoint. Also, develop and implement specific administrative/programmatic measures that can be used to assess future performance or impact of these efforts. These steps will provide the state with the assurance that funds are being expended efficiently and effectively;”** [Recommendation, page 5] *We disagree with audit conclusions. Initial baseline data on co-location was collected by HHSC in 1992 to assess the potential for co-location. As part of this data collection effort, regions were also asked to submit overall co-location plans. HHS agencies currently provide data on all locations statewide to HHSC every quarter. HHSC also tracks, on a quarterly basis, the number of new lease and lease renewal requests which result*

*in co-location. Health and human services agencies have made significant progress in co-location since May, 1993 with from 34% to 52% of lease requests involving co-location each year. Statewide, 649 (51.1%) out of 1271 sites are co-located.*

*A process is in place to assess the feasibility of co-location on a case-by-case basis. For each new lease or lease renewal request, agency leasing personnel must assess co-location possibilities and record the information on the Co-Location Worksheet which is sent to HHSC and GSC. Both spatial and programmatic needs are examined during this process. HHSC uses the information provided on this form to approve/disapprove the lease request. Without HHSC approval, GSC does not proceed with the lease. The exception is that GSC does process emergency leases without HHSC approval. The emergency lease process is determined and governed by GSC. GSC is willing for HHSC to approve emergency leases; however, after consulting with GSC staff, it seems that to review emergency leases is not a good use of HHSC staff time, since these are leases that must be processed quickly due to the circumstances that GSC defines as an emergency. Some emergency leases do involve co-location.*

*The meaning of “conducting a comprehensive feasibility study at this time prior to initiating any more service integration efforts” needs clarification. (See comments regarding the differences in co-location and service integration.) Co-location is a tool which may be useful in service integration, but may not necessarily result in service integration, and is not necessary for service integration. Co-location potential is limited by the following factors:*

- Co-location only occurs as leases expire so that the costs of unnecessary moves are avoided.*
- Agencies continue to co-locate when they can achieve cost-savings and quality service delivery through co-location. This is determined on a case-by case basis as leases expire. Agencies are instructed not to co-locate if the costs of co-location are significantly higher than remaining in separate locations.*
- As agencies change the way they are doing business, the needs for space and thus the co-location potential will be affected. Agencies may have less flexibility to negotiate for lower-cost and quality space.*

*Given these limitations on co-location, and the need for a detailed examination of each co-location opportunity to assess physical and programmatic needs as well as the real estate market in that locality, HHSC has determined that a statewide feasibility is not the best use of limited state staff and fiscal resources.*

*HHSC does agree that there is potential to achieve further cost-savings through co-location. The potential for cost savings is in sharing space such as break rooms, training rooms, etc., and in sharing other facility equipment and costs. The extent to which space, facility management and equipment is shared varies by co-location site. This is not a service integration issue, but a facility issue, and HHSC recommended in its 1996 co-location report to the Texas legislature that:*

*“GSC should examine the feasibility of establishing rules concerning shared spaced and facility management in co-located space to achieve additional cost saving through co-location.”*

*Section 1-E [Section 5] and HR 7, Section 3.08(a)-(b), “Co-location of Offices. . .” The audit report states: “It was also noted that this physical co-location effort has only been achieved for health and human services central offices and a few selected pilot sites...” We disagree with the auditor’s conclusions. Status is complete with qualifications. Of the 1,271 statewide HHS locations, 649 (51.1%) are co-located as of June, 1997. As of June 1997 51.1% of all HHS enterprise locations involved co-locations. 34.1% of all lease requests in FY95 and 52% of all lease requests in FY96 involved co-location. As of June, 1997, 45.6% of least requests have involved co-location during this fiscal year. A database has been compiled that includes all locations of state health and human services staff, including those in state-leased facilities, as well as those housed with local or private organizations in leased or free space. A summary report was presented to the House Appropriations Committee on October 1, 1996 and quarterly reports have been prepared since that date. In addition to the successful co-location efforts, which further service integration, increases the quality of service delivery, and achieves cost savings, exemplary service centers have been established in communities around the state. These centers are located in Abilene, Big Spring, Brownwood, Dallas, Fort Worth, Houston’s Third Ward, Lubbock, Schleicher County, and Shackelford County.*

*HB 7, Section 3.08(b) - SAO Comments: “Co-location is still in progress; however, as yet no process is in place (or study done) that would assist in determining benefits gained from co-location—i.e., in enhancing the effectiveness and efficiency of HHS service delivery.” We disagree with the audit conclusion. HHSC is accomplishing this mandate. A process is in place to assess the feasibility of co-location on a case-by-case basis. For each new lease or lease renewal request, agency leasing personnel must assess co-location possibilities and record the information on the Co-Location Worksheet which is sent to HHSC and GSC. Both spatial and programmatic needs are examined during this process. HHSC uses the information provided on this form to approve/disapprove the lease request; without HHSC approval, GSC does not proceed with the lease. The exception is that GSC does process emergency leases without HHSC approval. The emergency lease process is determined and governed by GSC. GSC is willing for HHSC to approve emergency leases; however, after consulting with GSC staff, it seems that to review emergency leases is not a good use of HHSC staff time, since these are leases that must be processed quickly due to the circumstances that GSC defines as an emergency. Some emergency leases do involve co-location.*

*HB 1675, Section 9(a) - “As leases on office space expire, [HHSC] shall determine the needs for...” HHSC disagrees with the audit report that “as leases expire the commission lets the HHS agencies determine their own needs, and has delegated to GSC to challenge those needs.” HHSC and HHS agencies*

did much background work in 1992 to determine all the co-location issues, and develop guidelines for co-location, including facility management guidelines. These guidelines were provided to agencies, and are used in the leasing process. Furthermore, agencies must fill out the Co-Location Worksheet and submit it to HHSC for approval of each lease request except emergency leases. The actual physical plant specifics are a concern that is delegated to GSC to ensure compliance with state rules; HHSC is mainly concerned with service delivery and fiscal impact aspects of co-location.

**HB 1675, Section 10(a) - . “...may not lease office space to service the needs of any [HHS] agency unless the [HHSC] has approved the office space for the agency...”** We disagree with the audit conclusion, compliance is complete with qualifications. The report correctly states that HHSC approves all lease requests before GSC processes them, except in the case of emergency leases. GSC determines which leases are emergency leases; HHSC could review these, but there is no justification for disapproval of a lease that is classified as emergency. HHSC would like to clarify the audit statement that “emergency leases...currently represent the majority of the leases being renewed.” The percent of HHS leases which are processed as emergency leases varies month to month and may be as much as 50% in one month. For example, 35.3% of leases processed in November 1996 were emergency leases and 50% of leases processed in December 1996 were emergency leases, but only 20% of those processed in March 1997 were emergency leases.

**Section I-H [Section 8], second bulleted item regarding HB 7, Section 14(a)(8) - “Perform independent special outcome evaluation...”** We agree with audit conclusions, with qualifications. An important service integration principle is that service delivery results in positive outcomes for the individuals who are served. In order to assess the extent to which service integration systems changes result in positive outcomes for individuals, evaluations of service integration initiatives are planned and conducted through independent evaluators including university professors, university evaluation centers, and interagency evaluators. Because many of these initiatives and evaluations are incomplete, most evaluation studies have not yet been completed or published (some are available, for example, the IDBN evaluation). In addition, limited resources are available for evaluation studies; most evaluation resources have been obtained through grant funds.

**HB 7, Section 14 concerning “powers and duties of HHSC Transportation and Planning Office.”**

**and**

**Section I-H [Section 8], fourth bulleted item - “Improve access to health and human services through Transportation and Planning Office” -** We disagree with the audit conclusion. The Commission considers this requirement to have been met at this time. Transportation and Planning Office (TPO) staff met with staff from the Governor’s Office policy council, Senate Health and Human

*Services Committee, the Texas Transportation Commission, the Texas Department of Health and others and concluded that funding was not available from TxDOT, nor was it immediately needed, because no specific mobile clinic projects had been developed or were planned which required funding or other assistance. TPO staff concluded that while mobile clinics and similar initiatives are certainly feasible (and currently in use across the state) there was no unmet need that could be addressed by the TPO, the Commission or its partners at the time. In the statewide action plan which the TPO developed through a public process, work on mobile clinics was not included. No comments, objections or questions concerning mobile clinics were received. TPO continues to be open to opportunities in this area but has focused its staff resources on the statewide action plan approved by decisionmakers and stakeholders.*

***Section 1-H [Section 8], fifth bulleted item - "Provide status reports on delivery of services to appropriate over-sight authorities."***

*We agree with audit conclusions, with qualifications. A service integration plan was submitted to leadership in 1996; other reports which focus on specific aspects of service integration (co-location, integrated eligibility, etc.) have also been presented on an ongoing basis. The referenced rule has been drafted and reviewed by an interagency group. HHSC does acknowledge that the referenced rule has not been published; plans are to publish the rule in the fall of 1997.*

***Section 1-H [Section 8], within sixth bulleted item - "Section 13 of SBI675 (74<sup>th</sup> Legislature): Not later than 9/1/97, the HHSC shall develop, using existing state, local and private resources, an integrated approach to the health and human service delivery system that includes a cost-effective one-stop or service center method of delivery to a client. The Commissioner shall determine the feasibility of using hospitals, schools, MHMR centers, health clinics...and other appropriate locations to achieve this integrated approach...Section expires 9/1/97"*** *We disagree with qualifications. To clarify the status of this aspect of our operation, we submit the following. HHSC has developed and implemented several one-stop models. Local communities have chosen to implement these models, some of which are funded through private funds to HHSC. These include sites such as Casey, Brownwood, Schleicher County, Dallas, Lubbock, Riceland, Austin-Travis County, Big Spring, Transportation Pilots, Permanency Planning Sites, I&R Centers. The sites are in various stages of implementation, and evaluation studies are taking place. A report on the one-stop/service center method of service delivery is being prepared and will be available early in FY 1998.*

***HB 7, Section 1.05(a)(2) - "Designing of local system for improved access to services and the efficient delivery thereof, including co-location of offices, computerized integrated eligibility determination, information and referral, and enhanced local decision making."***

***and***

**HR 7, Section 14(a)(2)- “Facilitate and enforce coordinated planning and delivery of HHS services, including compliance with coordinated strategic plan, co-location of services, integrated intake, coordinated referral, case management.”** We disagree with audit conclusions, with qualifications. The audit report does not fairly recognize the work completed and work in progress. The Commission has built or is building the tools necessary to support such a system statewide. In addition, the Commission, as discussed earlier in this section, and in the local planning and governance section, is working with local communities to implement improved access and a streamlined and efficient service delivery system.

*Design of the local service system must take place at the local level, with the involvement of appropriate state agencies at that level. HHSC has facilitated this process in a number of communities, as well as provided technical assistance and/or other supports. HHSC has also provided leadership in developing the tools to support local service delivery systems such as an automated integrated enrollment, automated information and referral, etc. The development of these tools is in progress. Though not complete, the audit should indicate “yes, with qualifications” rather than “no, with qualifications.”*

*Co-location. See earlier comments on co-location. HHSC does enforce co-location through an established lease approval process in which HHSC must approve all but emergency leases. Information is provided to HHSC by the local and/or state leasing staff on the Co-Location Worksheet. If the information provided is not satisfactory, HHSC returns the worksheet for further information and/or contacts the agency staff or GSC for further clarification. This process is in place for all but emergency leases.*

*Coordinated referral. HHSC has established 120 information and referral centers which serve all counties in Texas. A directory (6<sup>th</sup> edition to be released in early 1998) provides a list of I&R programs in the state. In addition, HHSC has designed and is working on the implementation of an automated information and referral network. The design report will be completed in September, 1997, a funding plan is being completed, and implementation will be within the next two years.*

*The Texas Information and Referral Network builds an integrated infrastructure of service information that creates a “no wrong door” entry for clients to locate services. The automated network will provide the capacity for a client to receive information about services in many locations, such as hospitals, schools, and other locations. This access model will further evolve as these concepts are implemented in combination with the integrated service delivery and enrollment systems in progress.*

**Case management.** *HHSC and HHS agencies conducted a survey of case management statewide. An analysis of the data is in progress, and a draft report is complete. In addition, coordinated case management has been implemented in a number of service integration sites and is being evaluated. These include integrated service delivery sites, permanency planning sites, and children’s financing sites. The CRCG process is also a coordinated case management model. Data collected from*

*these sites will provide information for further development of coordinated case management. Further, given significant changes in case management resources in the last few years, as well as the necessity to integrate case management into a system that compliments integrated enrollment, a managed care environment, and other service integration initiatives, the plan is to address case management statewide when the time is appropriate in relationship to the development of other initiatives. It is anticipated that work on case management will intensify in FY99.*

***HB 2698, Section 1(a) - “In conjunction with....shall develop a plan for access to individualized long-term care services for persons with functional limitations or medical needs and their families...”*** We disagree with the audit conclusion, compliance is complete with qualifications. The long-term care plan written pursuant to subsection (a) was not published in deference to legislation under consideration by the 75<sup>th</sup> Legislature. Its contents will be incorporated in implementation of that legislation. HHSC also developed a budget initiative to address the need to increase community long term care options; the initiative was included in the consolidated budget but was not funded.

***HB 2698, Section 1(d) - “..shall coordinate state services to ensure that the roles...of the agencies...are clarified and that duplication ...is minimized.”*** We disagree with the audit conclusion, compliance is complete with qualifications. In addition to addressing duplication in the long-term care plan, HHSC will also study the feasibility of combining some services such as waiver services as directed by the 75<sup>th</sup> Legislature’s HB 460.

## State Auditor’s Follow-Up Comment

We disagree with the Commission on this issue. While it is true that activity has taken place in this area at the agency (offices/programs) level which could have a potential impact on health and human services service delivery, it is equally true that most of this activity is being conducted in a fragmented fashion with no clear picture on how these service integration initiatives tie back into improving health and human services service delivery statewide.

Our review found no meaningful evidence that statewide planning has been done to assess how the health and human services are being delivered by health and human service agencies. No evidence was found that would weigh in the potential costs-benefits of restructuring the programs and operations of all the agencies involved in this effort. No benchmarks appear to have been established that could tell the state what impact if any these services integration efforts have had (or will have) on service delivery.

## Management's Response, continued

### ***Local Planning and Governance***

***In Recommendations the auditor states- “to improve service delivery at the regional/local level implement a formal planning process that incorporates the priority and service needs of local/regional entities delivering health and human services. This would provide greater assurances that local/regional issues and needs will be addressed as required by law;” [page 5] and in Section 1 - “The basis upon which the plan...The focus is to involve regions, counties and municipalities...The commission has never identified these local governmental entities and/or formally developed these partnerships...priorities.” [page 9]***

***and***

***Section 1-A [Section 1] comments on -“The plan and the budget do not address state-wide needs. . .” We disagree with the audit conclusion. The statewide data collected from local CRCGs as well as data collected from local sites through the Casey, children’s financing, and other service integration initiatives is used to identify gaps in services to children. Other means have been used to collect local and statewide input and data on service needs, including the Long Term Care Task Force. Almost all workgroups have public, private, state, local and consumer representation. Planning in the service integration division relies heavily upon input from these workgroups and task forces, as well as upon data collected. For example, the need to increase community-based options for persons who are elderly or disabled has been identified as a strong need in Texas.***

***As part of the 1996 strategic planning process, to address identified statewide needs, two initiatives were developed based upon service integration principles. One focused on children and the other on increasing community based options. These two initiatives were included in the consolidated budget, but were not funded.***

***HB 869, Section 1(e) - “The commissioner shall identify governmental entities that coordinate delivery...and shall request that these entities (1) identify the [HHS] priorities in the entity’s jurisdiction and the most...; (2)develop a coordinated plan for the delivery of [HHS], including transition services that...; and (3)make the information...available to HHSC.” We disagree with the audit conclusion, with qualifications. There are major resource and enforcement issues to consider when evaluating compliance with Section 1(e). HHSC does receive input through public hearings and survey responses. The multitude of local and regional entities across the huge state of Texas means that most methods for gathering information on local needs would be unwieldy and very costly. The staff and fiscal resources have not been available to begin a process that requires more intense contact with local entities statewide.***

Nevertheless, HHSC has been creative in addressing the need for local input and planning. Beyond the public hearing process and surveys done in conjunction with strategic planning, the service integration division partners with local private and public entities in carrying out most division service integration initiatives including CRCG; transportation; information and referral; children's financing; Casey; permanency planning and children with severe disabilities. The division initiatives are funded primarily by federal and private grant funds from sources such as the Casey Foundation, the Council on Developmental Disabilities, the U.S. Department of Transportation Federal Transit Administration, and the Robert Wood Johnson Foundation. Some funds are also provided by HHS agencies through interagency contracts.

The approach to service integration taken by HHSC focuses on local control of service delivery, with increased use of public/private partnerships. The service delivery design is best developed in conjunction with local needs and resources. Communities and sites working with HHSC on service integration initiatives provide considerable input as well as data to HHSC. Local service delivery initiatives are locally designed and operated, with technical assistance from HHSC.

Considerable funding would have to be appropriated for HHSC to have the resources to carry out this task statewide, not only tracking and analyzing the reports provided by local communities, but enforcing the planning and submission of the materials by local communities. It is also an overlapping function with some other agencies, since many state dollars that are provided to local communities are only provided if the community has such a plan in place.

**HB 869, Section 2(3) - "at the request of a governmental entity...assist...in implementing a coordinated plan..."**

We disagree with the audit conclusion. In those communities who have responded to HHSC's RFPs for various service integration initiatives, the funding (through federal and foundation grants) provides the means to offer such technical assistance. The cost is at least \$5,000 per site. This is a minimum cost per site which included staff salary, travel and expert consultation or materials as necessary. The cost of providing this type of assistance statewide is prohibitive and therefore limited to those initiatives for which HHSC has obtained federal or private funding.

## State Auditor's Follow-Up Comment

The Commission acknowledges that it is currently not meeting legislative requirements as prescribed under House Bill 869 (74th Legislature) - Section 1(e) and Section 2(3); however, states that it is trying to address the issue through other channels—public hearings, surveys, etc. We feel that while these (other) efforts may provide useful information to the Commission on areas of health and human services service delivery that need improvement, they cannot come close to

achieving the kind of impact (or results) sought by the State (as prescribed under House Bill 869) in planning and implementing a coordinated service delivery plan statewide at the local level.

## Management's Response, continued

### ***Budget and Planning Functions***

**Section 1-A** [Section 1], **third bullet** - *We disagree with audit conclusions, with qualifications. The formal review and comment time frame is 1-2 weeks. However, HHSC staff were included in the hearings, planning and budget development meetings for months prior to official submission. Exchange of Information and comments occurred prior to the 1-2 week time frame referred to in the SAO report.*

**In the last paragraph of the same section SAO comments the consolidated budget “appeared to have had very limited utility. . .”**- *This budget process is an evolving process. We will cluster measures or benchmarks in our next coordinated strategic plan, due in 1998. It should be noted that while improvements can be made some macro approaches were evident in the last CB.*

*Through statewide public hearings conducted with HHS agencies and HHSC survey, issues and priorities were identified for inclusion in the coordinated strategic plan and the consolidated budget. The outcome was the development of the two initiatives included in both documents. The initiatives focused on community-based services and children's health. The measures and related dollars referenced found in the Appendix C of the 1998-99 Consolidated Budget are also included in the HHS Budget Recommendations.*

**Section 1-B** [Section 2] **states “Lack of a Comprehensive...State-Wide Needs Assessment...”**

*We agree with the audit conclusions, with qualifications. Clarification is needed regarding the audit interpretation of “formal planning process.” Each strategic plan since HHSC was first established has incorporated public input from multiple levels of government and private sector entities. The input has been obtained through public hearings and survey responses. The multitude of local and regional entities across the huge state of Texas means that most methods for gathering information on local needs would be unwieldy, and very costly. An HHS interagency workgroup met in fiscal year 1993 on the development of a state-wide needs analysis project. The group identified the cost of the 2-year project at \$5.9 million with a shelf-life of 5 years. The staff and fiscal resources have not been available to begin a process that requires more funds per year than HHSC's annual budget. Moreover, the annual work plan (attached), which is submitted per statute to state leadership, has never been criticized for not including such an analysis.*

*HHSC has been creative in addressing the need for local input. Beyond the public hearing process and surveys done in conjunction with strategic planning, the service integration division partners with local private and public entities and consumers in carrying out most division service integration initiatives including CRCG; transportation; information and referral; children's financing; Casey; permanency planning and children with severe disabilities. The division initiatives are funded primarily by federal and private grant funds from sources such as the Casey Foundation, the Council on Developmental Disabilities, the U.S. Department of Transportation Federal Transit Administration, and the Robert Wood Johnson Foundation. Some funds are also provided by HHS agencies through interagency contracts.*

*The approach to service integration taken by HHSC focuses on local control of service delivery, with increased use of public/private partnerships. Each initiative has local components. The networks and local counterparts of the service integration initiatives provide considerable input as well as data to HHSC. The local components are also locally designed and operated, with technical assistance from HHSC. The initiatives are developed in partnership with consumers and service providers at both the state and local levels. Some initiatives are statewide: local CRCG interagency service planning for children with complex needs exist statewide; and local information and referral centers also provide statewide coverage. Further, the CRCG, I&R, and Transportation Office initiatives have statewide networks which provide a constant and dynamic exchange of information and technical assistance between the state and local levels regarding planning and operation of the local service integration initiatives. Further, local communities who are ready and willing to participate in efforts to change the way services are delivered in Texas have the opportunity at various times to apply to HHSC through an RFP process to work with HHSC to implement the various service integration initiatives which focus on transportation coordination, information and referral, permanency planning, and/or children's financing. These local efforts incorporate the service integration concepts of private/public partnerships, leveraging and coordination of existing federal, state and local resources; community design and operation; local governance; and client outcome evaluation.*

*Though tools and technical assistance must be provided by the state to support service integration, the real service integration process is at the client level and must be governed at the local level with funding and oversight provided jointly by the local community and the state. The long-term goal is to merge state/local/federal mandates, funding streams and services into local, county, or in some cases, regional procedures and operations. The process of reaching this goal is service integration and involves addressing multiple issues at multiple levels.*

**Section 1-D [Section 4], SAO comments regarding HHSC responsibilities with respect to transfers of funds - We agree with the audit comments. In April 1996, a reminder of HHSC's review and comment requirement of HHS agency fund**

transfers was sent to the HHS agencies. Included in that reminder was a request delineating the required information for transfer review.

**HB 7, Section 14(a)(10), “Develop a formula for distribution of funds that consider need factors. . . within the regions of the state”** - We agree with the audit conclusion. Development of a formula for distribution of funds that considers all of the appropriate need factors is both time consuming and complex.

In order to estimate the cost of this task, we spoke with central budget staff at the Department of Human Services (DHS) since they have an agency process for distribution of funds. DHS began their process in the mid 1970s and make refinements to it each year. The DHS process distributes funding on a regional basis for certain agency program and administrative dollars (nursing home payments do not go through this process since they are centrally administered) based on multiple need factors, such as:

*economic factors unique to certain regions, demographic factors, metropolitan vs. rural, current vs. projected caseloads, etc.*

Agency staff from regional budget offices, program budget offices, the central budget office, regional administrative offices, and the state office regional operations office participate in this Equity of Service (ESS) process. Although involvement is not constant, the process is ongoing.

DHS central budget estimates that 50 to 60 staff are involved in the process of an average of one to two weeks per year each. Thus, an estimated cost to maintain the existing process for DHS is the equivalent of two FTEs; at an annual cost, including automation support, of approximately \$100,000.

It would be extremely difficult, if not impossible for HHSC to create a process for all HHS agencies that performs a similar function since unique skills, institutional knowledge, program knowledge, and regional perspectives are brought into the DHS process, which continues to be refined each year. HHSC could become a part of the existing process, but the question of how much value that would lend to the process could certainly be raised.

**HB 1675, Section 13A, “Agencies Operating Budgets”** - We agree with the audit conclusion. It is the individual responsibility of each agency to report fund transfers to HHSC. HB 1863 directs the Commission to review and comment on the transfer of funds between strategies before update, but does not authorize the agency to deny or prevent such transfers from occurring. HB 1863 is also silent in the event of non-compliance. HHSC continues to advocate for agency compliance by notifying state agencies of this provision. In fiscal year 1996 (April 1), a memo was distributed to all HHS agencies to remind them of the notification requirement. The memo specified the information requirements and established a response time from the Commission as one week. The Fiscal Policy division within the Commission continued to restate these requirements in monthly

meetings of HHS Chief Financial Officers. Indirectly, a mechanism does exist to alert the Commission of the transfer of funds between HHS agency strategies. HHS agencies are required to submit a quarterly expenditure report that reports estimated expenditures for each agency by strategy. These transfers would be noted by the Budget Analysts within the Commission who are specifically assigned to follow the activities of each HHS agency.

**HB 7, Section 10(a), “Coordinated Strategic Plan. . .”** - We agree with the audit report conclusion. The 1997-2002 Coordinated Strategic Plan was submitted in June, 1996. The 1999-2004 Coordinated Strategic Plan is scheduled to be submitted in December, 1997. This earlier date is to allow the HHS agencies, who are working with HHSC on the Coordinated Plan, to utilize it in the individual agency plan.

**HB 7, Section 10(b), “Goals of the Coordinated Strategic Plan. . .”** We disagree with the audit conclusions. We question whether it was the intent of the legislature to “prescribe” the strategic planning goals for either HHSC or all HHS agencies in HB 7 OR, to “describe” desired direction to HHSC through goal statements in HB 7. Please note, LBB Strategic Planning Instructions define “Goals” as “**the general ends toward which agencies direct their efforts. A goal addresses issues by stating policy intention.**” Furthermore, HB 7 states “the commission’s goals are...” which implies that the goals would belong in the HHSC agency-specific strategic plan, not the Coordinated Strategic Plan which has separate mandates by Government Code 531.022, as revised.(1996) It seems unlikely that these goals could become a part of the agency plan structure with performance measures unless LBB approves a total strategic plan structure re-write. This leads us to believe the intent was much more specific to HHSC. This issue was addressed in a letter to Senator Zaffarini at the time of the last SAO report. (letter text available) Nevertheless, many CPS goals do mirror HB 7,

CSP goal I = HB 7 goal 4  
CSP goal II = HB 7 goal 6 (part of 2)  
CSP goal II = HB 7 goal 3 (part of 2)  
CSP goal III = HB 7 goal 5  
CSP goal V = HB 7 goal 2  
CSP goal VI = HB 7 goal 7

**HB 7, Section 14(a)(6), “Uniform regional boundaries”** - We disagree with the audit conclusions. In 1992, HHSC and the Comptroller’s office worked in conjunction with all HHS agencies and others to define uniform regional boundaries. After a number of discussions, the eleven HHS regions were defined, and each HHS agency agreed to use them. HHSC makes available, via its FTP site and several other routes, electronic data files to enable the agencies to roll up their county data into the uniform regional boundaries. Occasionally, HHSC will find an agency using other boundaries. For example, during the review and comment stage for last year’s agency strategic plans, HHSC staff found that TCB was using a different set of definitions

for regional boundaries. TCB staff was informed of the agreement made by TCB to utilize the 11 uniform HHS regions, and a copy of the appropriate statute was forwarded to the agency. We are aware that some agencies still use a different set of boundaries for internal purposes, but they also conform to the HHS uniform regional boundaries for reporting purposes.

**HB 7, Section 14 (a) (7) “Carry out statewide HHS needs surveys and forecasting”** - We disagree with the audit conclusion, the status is complete with qualifications. HHS agencies perform some program needs assessment and HHSC performs some needs assessment. We anticipate continuing to provide baseline demographic data within the limits of legislative appropriations and 1998-99 biennium FTE limitations.

**HB 1510, Section 27(e)-(f), “Plan for Long-term Care For Persons with Mental Retardation”** - We disagree with the audit conclusions. The facts are that the Long-term Care (LTC) Plan for people with Mental Retardation and Related Conditions, submitted in the HHSC’s Consolidated Budget, specifies the capacity (reflecting the maximum number of beds) that the state will provide.

The HHSC did in fact use the LTC Plan in its recommendations. All of the HHSC’s recommendations came in at or below the original LTC Plan levels. The operating agencies will later revise their targets based upon actual legislative appropriations.

Since MHMR is the operating agency for the ICF-MR program, they are the agency best suited to determine the necessary adjustments to the LTC Plan, which are then passed on to HHSC for final approval.

**HB 1675, Section 13D(a), “The [HHSC] shall coordinate and approve caseload estimates”** - We agree with the audit conclusion that HHSC has met requirements. The 1<sup>st</sup> quarter 97 report went out in Feb, 97, while the 2<sup>nd</sup> quarter report went out in May. The 3<sup>rd</sup> quarter 97 report is currently being finalized, and it is expected to go out late July or early August.

**HB 1675, Section 13D(b), “To implement this section, [HHSC] shall (1) Adopt uniform guidelines to be used and (2) assemble caseload estimates ”** - We agree with the audit conclusion. HHSC guidelines have been issued, and are being used by HHS agencies. The Quarterly Caseload Forecasting Report has been published quarterly since the 1<sup>st</sup> quarter of 1996.

**HB 1675, Section 4(d), “HHSC shall explain caseload estimates using monthly averages. . . and Section 4(e) . . . shall attach a copy . . . to the consolidated budget. . . .”** - We agree with the audit comments. These criteria are all considered in our reports. The HHSC statistician insures these requirements are met prior to approval and inclusion of the data in our report.

A current QCFR was included with the copy of the Consolidated Budget sent to Leadership and each House and Senate member of the 75<sup>th</sup> Legislature.

**HB 1510, Sec. 8, “Consolidated Budget”** - We agree with the audit findings with qualifications. The preparation of a consolidated budget was completed as of the 1/97 audit. Contrary to the auditor’s comment, it should be noted that the 1996 Consolidated Budget recommendation included two initiatives addressing unmet need for community-based services and children’s health from a macro perspective. HHS agencies then identified specific programs that qualified for these initiatives. While not all of statewide needs in health and human services were included in the consolidated budget as identified in the coordinated strategic planning process, these two initiatives were supported by all the HHS agencies.

**HB 7, Section 14(a)(7), SAO comments regarding HHSC demographer** - We agree with the audit conclusion. The position has not been filled in keeping with higher priorities. See attached HHSC Workplan.

**HB 869, Sec.1(e)(2), SAO comments regarding Strategic Plan Development** - We agree with the audit conclusion. As indicated in SAO comments, the Commission has not been appropriated the funds nor FTE’s necessary to execute this. To effectively carry out perceived legislative intent of Subsection (e) would require staff and travel resources not currently available to the commission. An estimated 4 - 6 additional full-time planners with travel budgets sufficient to meet with local governmental entities would be required in order to meet the expectations of the statute.

## State Auditor’s Follow-Up Comment

We maintain our position that the current health and human services consolidated strategic plan and budget, as it is currently being developed, is of little use to the state’s decision makers for allocating the state’s limited health and human services resources with a statewide focus.

## Management’s Response, continued

### ***Integrated Eligibility***

**HB 7, Section 1.05(a)(2), “Design of local system for improved access to services...”**  
We disagree with the audit conclusion, compliance is complete, with qualifications. TESS was jointly developed by TDHS and TDH at the request of HHSC. TESS is currently implemented in the DHS offices and some TDH sites.

HB2777 amended section 9.12 of House Bill 1863. HB2777 directs HHSC to develop and implement a plan for the integration of services and functions related to eligibility determination and streamlined service delivery by state health and human services agencies, the Texas Workforce Commission, and other agencies. The automated system to support integrated eligibility will include the functionality of TESS.

*The comments on TIES are clearly not valid since the passage of HB 2777. Even under HB 1863, the comment about system testing lasting 3 years is wrong. It is possible that TIES would have been fully implemented within 3 years.*

***HB 7, Section 3.05(1), Integrated Eligibility Screening*** - *We disagree with the audit conclusion, compliance is complete with qualifications. TIES was restructured with the last session, but is still aimed at integrated eligibility determination and DHS, TDH and TWC are specifically directed to work with us. HHSC is carrying out the current wishes of the Legislature.*

***HB 1675, Section 11 (a), “The HHSC shall expand its existing IEP to include Harris County Hospital District and UTMB-G”*** - *We disagree with the audit conclusion. Compliance is complete with qualifications. Discussions are continuing with HCHD and UTMB-G in an effort to resolve confidentiality barriers that are not a function of non-negotiable federal rules. Also being discussed are possible modifications to bridge the period leading up to integrated eligibility system implementation.*

***HB 1675, Section 12 - requires action on IED, SDS etc.*** - *We disagree with the auditor’s conclusion. Compliance is complete with qualifications. Compliance with this whole section was being addressed by the TIES project. The SAO comments that TIES was in the procurement phase is incorrect. At the time of the SAO report, the federal agencies (DHHS and USDA, not DOA and DHS) had not committed their financial participation (federal match). The federal commitment has been secured. However, HB 2777 has changed the approach to the project. HHSC is currently working with our federal partners to work out the details.*

## State Auditor’s Follow-Up Comment

While House Bill 2777 (75th Legislature) has added a new focus to this issue, we maintain our position that up till the passage of House Bill 2777, none of the various earlier legislative requirements for enhancing service delivery through integrated automation had been fully implemented. And, due to the lack of any in-depth cost/benefit study, the benefit gained from earlier initiatives is, at best, questionable.

## Management’s Response, continued

### ***Rules, Policies and Procedures***

***SB 1675, Section 8(a)-(c), “. . . rules have not been adopted yet. . . hence (a), (b) and (c) of this Subsection not being done.”*** *We disagree with the audit conclusion. This finding is inaccurate in two respects. First, it incorrectly assumes that rulemaking is necessary to implement these provisions. Second, it ignores the many successful efforts made by the Commission to streamline delivery*

of services, eliminate the duplication of administrative functions, and reduce operating budgets of the Commission and its operating agencies.

**Section 1-A** [Section 1] *continues* - “...powers...to settle interagency disputes...as an example to illustrate the type of issues that would benefit from a more direct role of the Commission in resolving disputes among entities...the Commission has been unable to implement Sub-section 11 of SB1675 (74<sup>th</sup> Legislature) due to disagreements among the parties involved.” We disagree with the audit conclusion. The conclusion is an erroneous finding for two reasons. First, it incorrectly assumes the Commission’s current authority to resolve interagency disputes may be invoked here. To the contrary, the Commission interprets the authority conferred by Government Code Section 521, to apply only to disputes between HHS agencies, not between HHS agencies and non-HHS entities. Second, the finding falsely concludes that the obstacles to implementation are “disputes.” Rather, the limitations to complete implementation of the pilot are non-negotiable federal confidentiality restrictions, unresolved issues of cost related to implementation, and the efficacy of proceeding with the pilot in light of the TIES project. The only state agency involved in the expansion of the eligibility program is the Texas Department of Human Services (DHS). The issues in this case are not “disputes” between agencies, but clear federal limitations on providers of Medicaid services (UTMB, HCHD) having unlimited access to enrollment information granted to the single authorized state agency (DHS).

**Section 1-F** [Section 6] **and HB 1675, Section 12, Information Resources Management** - We disagree with the audit conclusions. The HHS agencies, under the leadership of HHSC, have adopted a standard Information Systems Architecture. All HHS agencies have agreed to migrate towards and adhere to these architectural standards. All systems development and technology decisions are made in the context of the Architecture Report.

This architecture facilitates standard enterprise applications to support integrated and shared functionality; normalized enterprise data stores with single, logical implementation; flexible technology solutions to support migration to client server technology; and specific standards governing application development, data and technology. The standard architecture streamlines and simplifies the delivery of client services while reducing the costs caused by incompatible systems.

The Administrative Service Workgroup includes representatives of all HHS agencies who report regularly on the various initiatives to streamline and simplify the delivery of services while reducing or eliminating duplication of administrative services. Reports on this effort have been presented, through the Administrative Service Workgroup and the HHS Steering Committee to the Governor, Lieutenant Governor, as well as appropriate committees of the Senate and House.

While it is true that these efforts have been accomplished without the adoption of formal rules, the SAO’s report fails to acknowledge the successful efforts and accomplishments of the HHS enterprise.

**Segment 2 and Appendix 4** [Appendix 3], “**Expenditures have not been adequately monitored and controlled**”- We disagree with the audit conclusion.

At the time of the SAO’s review, the Director of Finance shared with the auditing staff the policies and procedures internal to the finance division. A copy of these policies and procedures were also provided to the audit team. In addition, the following formal policies were part of the Commission’s Administrative Policies Handbook at the time of the audit:

Policy 6.0 (May 31, 1996): Contracts and Grants Management

Policy 17.0 (August 21, 1996): Procurement Procedures

Policy 16.0 (October 11, 1996): Property Management

Policy 14.0 (November 4, 1996): Risk Management

Policy 13.0 (January 8, 1997): Travel Regulations

SAO staff were provided copies of the old policies and the new policies, together with the Commission’s schedule to develop and/or update all administrative policies no later than August 31, 1997.

**HB 7, Section 15 (a)-(c), “Review of Agency Rule Making”** - We disagree with the audit conclusion. HHSC has completed compliance with qualifications. Prior to July, 1994, the Commission reviewed HHS agency proposed rules on a sporadic basis. The Commission required amendment of only two proposed rules prior to July, 1994. In July, 1994, staff was hired in the Planning and Evaluation Division. This staff was assigned, among other duties, ongoing review of all non-Medicaid HHS proposed new rules, amendments and repeals. A number of automation and procedural efficiencies were introduced into the process. In addition to reviewing rules, summaries of all HHS rules were given to executive staff for review, and an ongoing index of HHS rules was maintained. (This was prior to updated TAC information being made available over the Internet by the Secretary of State). From July 94 - May 95, a little over 250 rules were reviewed, and catalogued along with a little over 125 Medicaid related rules. Of the 250 rules reviewed, only six required intervention by HHSC staff. Of those six, five were very minor changes (such as definitions or conflicting TAC citations) and one resulted in discussions which resulted in the rule being postponed while waiting for the Legislature to clarify its position on criminal background checks.

In the HHSC Workplan submitted September 1, 1995 (Attached), this function was given a low priority. Other duties with higher priorities took precedence. The Commission continue to review all Medicaid rules and an occasional non-Medicaid rule. HHSC resources are not sufficient to review and summarize all HHS rules.

**HB 1675, Section 8(a)** - “Each...agency shall report quarterly to the governing body of that agency...submit a copy of the report to the [HHSC]....”

and

**HB 1675, Section 8(b) - “[HHSC] shall prepare and deliver a semiannual report...”**

**and**

**HB 1675, Section 8(c) - “...shall adopt rules relating to reports...”** We disagree with the audit conclusion. A service integration plan was submitted to leadership in 1996; reports focused on specific aspects of service integration have also been submitted on an ongoing basis. The referenced rule has been drafted and reviewed by an interagency group. HHSC does acknowledge that the referenced rule has not been published; plans are to publish the rule in the fall of 1997.

**Appendix 4 [Appendix 3], “The Commission has not formalized procedures for serving as fiscal agent for \$55 million in federal funds”-** We absolutely disagree with the audit conclusion. The comments section states: “although no policies & procedures are in place for the commission’s oversight of Empowerment Zones/Enterprise Communities (EZ/EC), the existing memos of agreement (MOA) are an acceptable alternative.”

At the time of the review, HHSC Administrative Policy 6.0, Contracts and Grants Management, was in effect and followed by the contract management staff. This very detailed policy covers the oversight of all grants and contracts, including the EZ/EC grant. The MOA supplements our standard policy. Copies of the policy and MOA, as well as the operating procedures for the contract manager were all shared with SAO audit staff.

The auditor also comments that “no policies and procedures are in place for contract management regarding HHS agencies.” This finding presumes the Commission is under a duty and is equipped with requisite authority to promulgate such policies. Both assumptions are incorrect. The Commission is authorized to promulgate contract management policies only with respect to its own contracts. Its oversight authority does not supersede HHS agencies’ statutory authority to promulgate internal contract management policies and procedures.

**Appendix 4 [Appendix 3], “There is limited oversight regarding the agreement for the Texas Department of Human Services to act as the operating agency for federal Medicaid funds”-** We disagree with audit conclusion. HHSC operates through an interagency agreement with DHS in keeping with our contract policies.

**Appendix 4 [Appendix 3], “Policies and Procedures have not been adopted for all key functional areas”-** We disagree with the audit conclusion. At the time of the SAO’s visit to HHSC, 39% of the administrative policies had been updated. SAO audit staff received copies of the updated policies. It was explained to SAO audit staff, and documentation provided, that the process would be complete by the end of fiscal year 1997. It was also explained to the SAO audit staff, and documentation provided, that while a complete revision and update of the

*administrative policies was in progress, the original policies published in our HHSC Policies and Procedures Manual would continue to be in effect.*

*The SAO also mistakenly reports: “it was noted that the commission’s (sic) has not provided adequate oversight/guidance to staff responsible for this effort. For example, the commission’s policy on how to write effective policies & procedures is not being communicated to policy writers.”*

*The Commission’s policy on writing and adopting effective policies & procedures, Policy 3.0, was routed for review and comment to all divisions within the commission for comment. Appropriate stakeholder comments were incorporated into the final policy, which was distributed to all department heads and administrative staff March 29, 1996. All new, or revised policies, are distributed to department heads with a cover memorandum that summarizes the policy and provides instructions to the stakeholders. These memoranda, including the March 29, 1996, memorandum on Policy 3.0, were shared with SAO audit staff at the time of the review.*

*Further, a reading of Policy 3.0 will disclose that, under section 3.22, Administrative Services (AS) staff are to provide technical assistance to agency staff in the development of policies, procedures, and manuals. Also, section 3.4 of the Policy, includes a detailed checklist of items to be considered, as well as steps to follow in submitting any requested revisions to AS for word processing, editing, and publishing. Policy 3.0 has been subsequently revised and was adopted by HHSC June 25, 1997.*

**Appendix 4 [Appendix 3], “Commission’s automation system has internal control weaknesses”-** *We disagree with the audit conclusion. The offsite backup storage procedures for the Commission’s automation system are completed. All backup tapes are currently stored at a secure facility managed by the Texas Rehabilitation Commission. Backup tapes are made daily and are taken to the TRC facility by TRC automation staff, in accordance with the agreement between the two agencies.*

**Appendix 4 [Appendix 3], “The human resources department does not consistently monitor the entire recruitment and selection process”-** *We disagree with the audit conclusion. The Commission has final policies on recruitment, selection, and hiring. In addition to the policies contained in the human resource services manual, selecting supervisors receive guidelines, suggestions, and other helpful information from human resource services staff, including suggested interview questions.*

*At the time the SAO audit staff visited the Commission, we explained that the agency was under going a major revision of its human resource services policies, primarily to achieve the goals of the HHS enterprise HR Council for uniform policies, procedures, and forms among the HHS agencies. Both the current and draft policies were shared with SAO audit staff, to demonstrate current and future*

*commitment to a fully-documented selection process. This appears to have been taken as an indication that policies being used were of a “draft” nature, which is not correct.*

***Appendix 4*** [Appendix 3], ***“Documentation of employee performance is inconsistent, and the appraisal system is not being monitored for rating accuracy and consistency”***- *We disagree with the audit conclusion. In an effort to continuously improve its management of human resources, Commission staff have recommended to executive management a more participatory performance system, which will include employee self-appraisal, as well as more fully involve the employee in the career development process. Those policies were in draft form at the time the SAO audit staff visited the Commission. Since then, the draft policies have undergone review and revision and a second draft is ready for review of executive management.*

*Like the previous issue, these were policies for the future, rather than current policies. Current policies are in effect and part of the human resource services handbook, which is alluded to in the SAO comment “the agency follows adequate employee appraisal policies and procedures.”*

## State Auditor’s Follow-Up Comment

Regarding responses to Commission policies and procedures, we maintain our stated position. At the time of the review, the Commission staff shared draft versions of the policies and procedures in question. And, we were told by Commission staff that the policies and procedures in question will be formally in effect by the end of fiscal year 1997. The fact that these policies and procedures had not been finalized supports our position that these issues were not completely resolved.

## Management’s Response, concluded

### ***HHSC Work Plan, September, 1996***

#### ***HHSC High Priorities***

- *Prepare quarterly caseload forecasting reports - Sept. 96 thru Aug. 97; monitor, coordinate and approve hhs agencies' caseload forecasts SB 1675.*
- *Prepare consolidated budget (10/15/96) SB 1675.*
- *Submit quarterly report on projected expenditures vs. budget for hhs agencies SB 1675.*
- *Develop and implement plan for integrated eligibility determination SB 1675*

- *Work with Council on Comp. Govt. to competitively bid or contract eligibility determ. SB1675*
- *Analyze and recommend action on confidentiality project*
- *Develop and implement IDBN*
- *Assist in development of workforce eligibility determination automated system. HB 1863, Sec. 11.27*
- *Uniform Accounting Reports of providers who have contracts with the state.*
- *Establish criteria for identifying cases of possible fraud or abuse; establish the methods for referring suspected fraud cases for investigation.*
- *Cooperate with the Medicaid Fraud Control Unit, Office of the AG, by furnishing information and data, and serving as witnesses when requested.*
- *Recoup all overpayments and take other administrative sanctions and actions.*
- *Investigate cases of possible abuse*
- *Data Management*
- *Develop and approve Medicaid policies, rules, and program directions-plan and direct the scope, content and priorities of the Medicaid program MHMR 7, TRC 2.*
- *Oversee, monitor, and evaluate agencies' operations of the Medicaid program SCR 56.*
- *Direct and oversee statewide Managed Care pilots; SB 10.*
- *Prepare, submit, and implement 1115 waiver for statewide managed care with a state-local partnership SB 10, SCR 55.*
- *Apply for waiver for integrated managed long-term-care pilot SCR 55.*
- *Apply for waiver for integrated managed care pilots for mental health and substance abuse 11/1/96-preliminary plan; 11/1/98-plan for statewide expansion SCR 55.*
- *Design and conduct program evaluations.*
- *Oversee and manage EZ/EC project.*
- *Develop long-term care access plan; minimize duplication (HB 2698). Require each agency to provide clients info on alternative community placements HB 1698, TDOA 7.*
- *Develop HHSC Work Plan by 9/30/96 SB 1675.*
- *Receive and resolve complaints.*
- *Review and recommend changes to contract management by hhs agencies.*
- *Review and report Medicaid and Interagency transfers HHSC 10 and 11.*
- *Direct, manage and provide support to the Medical Care Advisory Committee.*
- *Single point of contact with the Health Care Financing Administration (HCFA) and function as the sign-off and approval of all communications with HCFA.*
- *Administer and supervise Medicaid State Plan.*
- *Quarterly Medicaid billing.*

- *Research, analyze, and develop position papers, plans and recommendations for major initiatives and changes (Block grants).*
- *Mediate interagency disputes SB 1675.*
- *Compile quarterly performance measures and produce quarterly reports.*
- *Oversee and monitor the Medicaid federal funds management function performed by TDHS staff.*

#### **SUPPORT FUNCTIONS**

- *Manage Human Resources and payroll (with Budget, including employee incentive program)*
- *Coordinate in-house training*
- *Prepare Fiscal Notes (Nov-May 97).*
- *Revenue billings and collections (other than Medicaid or earned federal funds).*
- *Prepare/monitor internal budgets.*
- *Encumber agency's planned expenditures.*
- *Monitor grants and contracts IX 83, 93.*
- *Track, coordinate and counsel on litigation IX 91.*
- *Cost allocation billing.*
- *Monitor funds availability and cash balance for agency (cash flow management).*
- *Risk management.*
- *Manage legislative, consumer, press and provider relations, including leadership briefings.*
- *Opinions:*
  - *Agency authority*
  - *State business practices*
  - *Administrative procedures*
  - *Open records, open meetings*
  - *Rules and policies SB 1675 sec.7, SB 601, HB 997 (TDH), HB 1698, SB 169, SB 1296*
- *Manage and produce agency reports.*
- *Develop and maintain cost allocation methodology.*
- *Review and process comptroller documents including purchase vouchers, interagency transaction vouchers, travel vouchers, journal vouchers, budget revisions, deposits, expenditure transfer vouchers, multi-payee vouchers, payroll vouchers, warrant cancellations.*
- *Quarterly ABEST-USAS reconciliation IX 77.*
- *Monitor fixed assets.*
- *Prepare financial reports (internal, state, federal) - various due dates HB 1399, HB 2449, IX 76, IX 77, IX 79, IX 84, IX 111.*
- *Manage internal and external accounting systems (maintenance & reconciliation between MIP & USAS).*
- *Track and review state legislation.*
- *Conduct internal audits IX 85.*

### **HHSC Medium Priorities**

- Review and comment on operating budgets SB1675.
- Implement refinancing strategies for children's MH.
- Approve automation plans ( review amendments as needed) SB 1675.
- Develop neighborhood system of care & other reforms (Casey).
- Analyze case management for consolidation; report due (Sen HHS).
- Work with agency planners to coordinate individual agency strategic plans.
- Coordinate local collaboration on early childhood with Dept. of Commerce IX-150.
- Structure HCS waiver services for ICF-MR Level 1 SCR 58.
- Produce and evaluate demographic estimates.
- Review and comment on fund transfers (intra-agency) HB 1863/SB 1675, HHSC 6.
- Support HHSC statewide telecommunication network.
- Develop and assist local CRCGs.
- Restructure support services for hhs agencies II 14.
- Review and approve hhs agency rules regarding abuse/neglect HB 1111.
- Develop and implement routine methods for consumer input including public hearings SB 1675.
- Design and implement coordinated transportation services - report 9/1/96 HB 1863, HB 2891, HB 1020.
- Coordinate DHS child-care, TEA pre-K with Headstart efforts and report to Legislature by 12/1/96 HB 869 & HHSC 9.
- Develop and implement special initiatives and projects to maximize federal Medicaid funds (Administrative Claiming Project, Third Party Resources Project, LBB Federal Funds Analysis Recommendations, etc.) HB 997, TDH 25, MHMR 24a,b,d,e.
- Develop an MR consumer-focused pilot SCR 55.
- Monitor and analyze federal Congressional activities, HCFA activities, and activities of other states; function as liaison with Office of State-Federal Relations regarding Medicaid issues.
- Medicaid fraud prevention HB 2523.
- Develop system to integrate Medicaid database for fraud detection - HB 1863 - Section 8.03- May institute fraud detection through data matching; report by 12/1/96. Examine cost-effective ways to address fraud and error rates in assistance programs SB 1675/HB1863, SB 602, HB 1863, HB 2523.
- Pilot MSAs; 1/1/97 implement or report why not; 1/15/99 report on effectiveness SB 604, SCR 60.
- May review agency federal funding plans SB 1675.
- Federal funds reporting prior to session IX 93.
- Serve on EBT taskforce HB 1863.
- Facilitate improvements in services for children with severe disabilities; annual report to Sen HHS (1/97 per HHSC).
- Support Texas Tots project.

- *Adopt supported work vision statement HB 1863.*
- *Develop process to assign other agency staff to HHSC projects SB 1675.*
- *Develop network of statewide I & R Centers.*
- *Convene Headstart workgroup for training early childhood workers - Workgroup; 12/1/97 - report HB 1863.*
- *Develop and implement plan for integrated service delivery system: SB 1675*
  - *Develop plan to consolidate other admin. and service delivery functions by 10/1/96; report to leg by 1/1/97 SB 1675/HB 1863*
  - *May request agencies to integrate/streamline; recommend specific actions SB 1675/HB 1863*
  - *Develop tools and processes to support streamlined service delivery model (SSDM)*
  - *Coordinate local service delivery & assist as requested HB 869*
  - *Facilitate implementation of SSDM in pilot sites*
  - *Develop integrated one-stop shopping using state, local, private resources by 9/1/97 SB 1675*
- *Approve hhs office space needs for service center approach; and report on co-location by 12/1/96 SB 1675/HB 1863, II 16.*
- *Coordinate and monitor the federal, state, and internal audits performed on the Medicaid program in any of the operating agencies.*
- *Maintain and monitor interagency agreements with operating agencies to operate the Medicaid program.*
- *Establish toll-free hot line SB 601.*
- *Pilot Telephone health care program with report by 2/1/97 SB 10.*

#### **SUPPORT FUNCTIONS**

- *Coordinate public info.*
- *Develop contracts.*
- *Purchasing requisition.*
- *Cash Reconciliation-monthly (Gov. Code 403.036).*
- *Develop & maintain Policy & Procedures Manual.*
- *Update biennial operating plan to DIR as needed (Gov. Code 2054.100).*
- *Standardize project management.*
- *Records Management.*

#### **HHSC Low Priorities**

- *Evaluate regulation of services.*
- *Approve automation standards to allow filing information directly SB 1675-Sec 11.*
- *Review and comment on funding formulae SB 1675.*
- *Develop cost accounting system for hhs agencies.*
- *Expand pilots to HCHD, UTMB Galveston SB 1675/HB 1863.*
- *Develop automation standards that allow local hhs agencies to share data (with DIR) HB 869.*
- *Coordinate residential care rate caps II 17, HB 7-- 72d.*

- *Report on streamlined service delivery semi-annually (rules for agency reporting to their boards) SB 1675.*
- *Study Provider reporting requirements imposed by hhs agencies; make recs by 9/1/96 HHSC 8.*
- *Coordinate interagency legal matters.*
- *Review and require amendment or withdrawal of proposed rules.*
- *Coordinate with Workforce Agency.*
- *Conduct targeted rules analysis.*
- *Study establishing a health purchasing alliance to buy insurance coverage for children; 10/1/96 report SB 793.*
- *Participate on various committees/workgroups HB 2569, PRS 12.*
- *Convene planning group of DHS, TEA, & TRC to improve workload coordination re: AFDC clients, and report to Legislature on progress by 1/15/97 HB 1863.*
- *Review interstate contract on adoption and medical assistance SB 169.*
- *Evaluate and determine deadlines for using DHS' NF reimb. sys. for other Medicaid components; DHS implement by 1/1/97 HB 867.*
- *Update Reference Guide.*
- *Commissioner ex-officio non-voting member of Tx. Health Care Information Council, Council recs by 12/1/96 HB 1048.*
- *Study feasibility of using Medicaid funds for Texas Health Ins. Risk Pool SCR 60.*

#### *SUPPORT FUNCTIONS*

- *Develop and submit Automation Strategic Plan to DIR.*
- *Produce HHSC newsletter.*
- *Provide internal hardware and software support.*
- *Facilities Management.*
- *Prepare speeches.*
- *Mail services.*
- *Buy and maintain law library.*
- *Prepare 1099's.*
- *Transfer funds for workers comp claims (Rider 75) and unemployment claims (Rider 74).*

## Objectives, Scope, and Methodology

### Objectives

- **Review of House Bill 7 Implementation**

- Follow up prior State Auditor's Office work on the implementation status of House Bill 7.
- Inventory the status of health and human services House Bill 7 amending legislation as it relates to the Commission.

- **Follow-Up Review of Prior Management Control Issues**

Follow up significant issues identified in *A Review of Management Controls at the Health and Human Services Commission* (SAO Report No. 96-031, December 1995).

These follow-up reviews were being conducted as a result of the State Auditor's transmittal letter, which stated that a follow-up would be conducted within a specific time frame (less than one year).

- **Performance Measures Certification**

Certify selected fiscal year 1996 performance measures.

### Scope

- **Review of House Bill 7 Implementation**

The scope of this project was limited to collecting sufficient and competent evidence to ascertain to what extent the Commission had formally implemented requirements prescribed by its enabling legislation (House Bill 7), subsequent House Bill 7 amending legislation, and applicable General Appropriation Act riders. Wherever possible, the Commission's effectiveness was also determined by:

- Assessing to what degree the Commission had complied with legislative requirements in planning for and implementing its responsibilities
- Examining and analyzing information provided by processes or systems specifically created by the Commission to measure the impact or effectiveness of its actions

Legislative requirements that did not specifically amend (change, delete, or add) the Commission's responsibilities as stated in Article 4413 (502) under House Bill 7 were not a focus of this review.

- **Follow-Up Review of Prior Management Control Issues**

The scope of this project was limited to collecting sufficient and competent evidence to determine implementation status of issues and recommendations raised in *A Review of Management Controls at the Health and Human Services Commission* (SAO Report No. 96-031, December 1995).

- **Performance Measures Certification**

The scope of this project was limited to certification of fiscal year 1996 performance measures selected by the Legislative Budget Board.

## Methodology

The methodology used on these three projects consisted of collecting information, performing audit tests and procedures for the purpose of analyzing audit information, and evaluating the results against preestablished criteria.

Information collected to accomplish our audit objectives included the following:

- Interviews with management and/or staff of the Commission, other health and human services agencies, the General Services Commission, and applicable Legislative committee members
- Review and analysis of documentary evidence such as:
  - Applicable agency legislation (House Bills 7, 1510, 869, 2698, and 2891 and Senate Bills 10, 509, and 1675)
  - Agency policies and procedures
  - Agency and health and human services strategic plans and budgets
  - Legislative Appropriation Requests
  - Agency financial records/reports
  - Other agency documents/reports
  - Federal documents/reports (applicable)
  - State Auditor's Office reports (applicable)

Criteria used:

- Best business practices related to management of public entities
- Article 4413 (502), House Bill 7 (72nd Legislature), and subsequent amending legislation

- Texas Government Code and Texas Administrative Code
- Standard audit criteria
- Commission's rules, regulations, policies, and procedures

The audit was conducted in accordance with applicable professional standards, including:

- Program Evaluation Standards
- Generally Accepted Government Auditing Standards

There were no significant instances of noncompliance with these standards.

The audit work was performed by the following members of the State Auditor's staff:

- K. A. 'Ash' Hamid, MBA (Project Manager)
- Gary L. Leach, CQA
- Dale A. Kincaid, CIA
- Tom E. Valentine (Audit Manager)
- Deborah L. Kerr, Ph.D. (Audit Director)

We would like to express our appreciation to the management and staff of the Commission, as well as the management and staff of other entities, who assisted us during this review.

Appendix 2:

## Implementation of Legislative Requirements

Appendix 2.1:

### House Bill 7

Implementation of House Bill 7, 72nd Legislature Effective September 1, 1991				
Citation	Complete <sup>1</sup>		Comment Source	Comment
	8/94	1/97		
<b>§8 Personnel Matters</b>	Yes	N/A	HHSC	<i>Note: A more complete discussion of HHSC management comments can be found in the text of the report section entitled "Management Response."</i>
<b>§9 Merit System</b>	Yes	N/A		
<b>§10 Coordinated Strategic Plan for Health and Human Services</b>				
§10 (a) The commissioner shall develop a coordinated, six-year strategic plan for the health and human services in the state and shall update the plan biennially . . . .	Yes, w/ Q	N/A	SAO 8/94  HHSC	Plan was not submitted on time.  <i>Agree, the 1995-2000 plan was late, However, the 1997-2002 plan was submitted in June, 1996. The 1999-2004 will be completed December, 1997 to allow HHS agencies more time to use it in developing their individual plans.</i>
§10 (b) The plan must include the following goals . . . .	No	No, w/ Q	SAO 8/94  SAO 1/97  HHSC	House Bill 7 goals not addressed; instead, goals from Texas Tomorrow used.  Specific goals of House Bill 7 still have not been addressed. However, under the current cluster plan structure, (depending on how one interprets the language used) some of these goals do appear to be addressed in varying degrees.  <i>Disagree, the status is complete with qualifications. The CSP goals are developed by all HHS agencies and reflect their collective objectives. It is not an HHSC document per se, therefore strict adherence to HB7 would be inappropriate. However, many goals do mirror HB7 i.e., HB 7 goal 2 = CSP Goal V; HB 7 goal 3 = CSP Goal II; HB 7 Goal 4 = CSP Goal I; HB7 Goal 5 = CSP Goal III; HB7 goal 6 = CSP Goal II; HB 7 goal 7 = CSP Goal VI.</i>

Yes:	Requirement fully implemented with no exceptions
Yes, w/ Q:	Requirement implemented with minor exception as noted
No, w/ Q:	Requirement implemented with major exception, or not implemented due to extenuating circumstances noted
No:	Requirement not implemented
Partially:	Not all components of requirement fully implemented yet
N/A:	Not applicable for current testing

Implementation of House Bill 7, 72nd Legislature Effective September 1, 1991				
Citation	Complete <sup>1</sup>		Comment Source	Comment
	8/94	1/97		
§10 (c) In developing a strategic health and human services plan and plan updates under this section, the commissioner shall consider . . . .	Yes	N/A		
§10 (d) All health and human services agencies shall submit strategic plans and biennial updates to the commission . . . .	Yes, w/ Q	N/A	SAO 8/94	The Commission receives the health and human services (HHS) agency plans at the same time as the Legislative Budget Board (LBB) and Governor's Office—too late to recommend changes. The Commission proposed a rule in the July 26, 1994, <i>Texas Register</i> . The published rule will now require that agencies provide plans to the Commission before they are due to the LBB and Governor's Office.
<b>§11 Public Hearings on Health and Human Services</b>  §11 (a) and (b) The commission biennially shall conduct a series of public hearings . . . to give citizens of the state an opportunity to comment on health and human services issues. . . . The commission shall, to the greatest extent possible, encourage participation in the hearings process by diverse groups of citizens in the state. . . .	Yes	Yes	HHSC	<i>Agree.</i>

<sup>1</sup> "Complete" denotes status of requirements tested by the State Auditor's Office in August 1994 House Bill 7 Implementation review, and status as of current January 1997 review.

- Our current review for House Bill 7 tested requirements that were stated as "No" in the August 1994 review and on a sample basis, a few requirements that were stated as "Yes."
- Requirements marked as "N/A" in January 1997 column indicate August 1994 "Yes" status requirements not tested by us in January 1997.

Implementation of House Bill 7, 72nd Legislature Effective September 1, 1991				
Citation	Complete <sup>1</sup>		Comment Source	Comment
	8/94	1/97		
<p><b>§12 Public Interest Information and Complaints</b></p> <p>§12 (a) The commission shall develop and implement policies that provide the public with a reasonable opportunity to appear before the commission and to speak on any issue under the jurisdiction of the commission.</p>	No, w/ Q	Yes	HHSC	<i>Agree.</i>
<p>§12 (b) The commission shall prepare information of public interest describing the functions of the commission and the commission's procedures by which complaints are filed and with and resolved by the commission. . . .</p>	No	Yes	SAO 1/97  HHSC	Published in <i>Texas Register</i> .  <i>Agree.</i>
<p>§12 (c) The commissioner by rule shall establish methods . . . for the purpose of directing complaints to the commission. . . .</p>	No	Yes	SAO 1/97  HHSC	The methods have been published in the <i>Texas Register</i> . Also, general HHS agency information issued in September 9, 1996, Commission brochure.  <i>Agree.</i>
<p>§12 (d) The commission shall keep an information file about each complaint filed with the commission. . . .</p>	Yes	N/A		

Yes:	Requirement fully implemented with no exceptions
Yes, w/ Q:	Requirement implemented with minor exception as noted
No, w/ Q:	Requirement implemented with major exception, or not implemented due to extenuating circumstances noted
No:	Requirement not implemented
Partially:	Not all components of requirement fully implemented yet
N/A:	Not applicable for current testing

Implementation of House Bill 7, 72nd Legislature Effective September 1, 1991				
Citation	Complete <sup>1</sup>		Comment Source	Comment
	8/94	1/97		
§12 (e) If a written complaint is filed with the commission . . . the commission, at least quarterly . . . shall notify the parties to the complaint of the status of the complaint . . . .	Yes	Yes	SAO 1/97	No complaints have been open longer than one quarter.
<b>§13 Consolidated Health and Human Services Budget</b>				
§13 (a) The commission shall prepare and submit to the Legislative Budget Board and the governor . . . a consolidated health and human services budget recommendation.	Yes	N/A	HHSC	<i>Agree.</i>
§13 (b) The commission shall base the consolidated budget recommendation prepared under this article on priorities set in the commission's coordinated strategic plan for health and human services.	Yes	N/A	SAO 8/94	In 1992, both the consolidated budget analysis and the consolidated strategic plan were derived from the agencies' legislative appropriations requests (LARs).
§13 (c) All health and human services agencies shall submit to the commission a biennial agency legislative appropriations request . . . .	Yes, w/ Q	N/A	SAO 8/94	The Commission receives the HHS agency LARs at the same time the Legislative Budget Board and Governor's Office do—too late to recommend changes. The Commission proposed a rule in the July 26, 1994 <i>Texas Register</i> . The rule, as published, will now require that agencies provide LARs to the Commission before they are due to the Legislative Budget Board and Governor's Office.

<sup>1</sup> "Complete" denotes status of requirements tested by the State Auditor's Office in August 1994 House Bill 7 Implementation review, and status as of current January 1997 review.

- Our current review for House Bill 7 tested requirements that were stated as "No" in the August 1994 review and on a sample basis, a few requirements that were stated as "Yes."
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Implementation of House Bill 7, 72nd Legislature Effective September 1, 1991				
Citation	Complete <sup>1</sup>		Comment Source	Comment
	8/94	1/97		
<p><b>§14</b> <b>General Powers and Duties</b></p> <p>§14 (a) (1) Arbitrate and render decisions on interagency disputes</p>	No	No	<p>SAO 8/94</p> <p>SAO 1/97</p> <p>HHSC</p>	<p>No formal system is in place for dispute resolution. There is a stated preference for resolving problems before arbitration is necessary.</p> <p>The Commission still feels that it is much easier to effect change through informal channels instead of formally forcing its will on sister agencies.</p> <p><i>Disagree, status is complete. The Legislature did not prescribe nor mandate a "formal" process for dispute resolution. The Commission effectively resolves interagency disputes through consensus, negotiation and open communication at monthly CEO meetings. This approach has proven highly successful in the few instances which required Commission intervention.</i></p>
<p>§14 (a) (2) Facilitate and enforce coordinated planning and delivery of health and human services, including compliance with coordinated strategic plan, co-location of services, integrated intake, coordinated referral, case management</p>	Partially	Partially	<p>SAO 8/94</p> <p>SAO 1/97</p> <p>HHSC</p>	<p>The Commission has facilitated these activities but has not enforced them.</p> <p>See comment above. Work is still in progress on most of these issues.</p> <p><i>Disagree. Accomplishment of some of these issues is, by nature, an ongoing process. Enforcement is limited by statute. See report section entitled Management Response for more complete discussion.</i></p>
<p>§14 (a) (3) Request budget execution for the transfer of funds from one agency to another</p>	N/A	N/A	<p>SAO 8/94</p> <p>HHSC</p>	<p>The Commission has not requested execution of budget transfers.</p> <p><i>HHSC influences use of funds within agencies without transfers.</i></p>

Yes:	Requirement fully implemented with no exceptions
Yes, w/ Q:	Requirement implemented with minor exception as noted
No, w/ Q:	Requirement implemented with major exception, or not implemented due to extenuating circumstances noted
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Citation	Complete <sup>1</sup>		Comment Source	Comment
	8/94	1/97		
§14 (a) (4) Establish a federal health and human services fund management system and maximize the availability of those funds	Yes	Yes, w/ Q	SAO 1/97	<p><u>Medicaid Funds:</u> The Commission has contracted with the Department of Human Services (DHS) for the federal funds management aspect (ensuring that all federal funds due to the State for costs incurred are received, and ensuring compliance with federal requirements for programs funded through Medicaid dollars) of this requirement. Review of the Medicaid operating agency contract between DHS and the Commission (and other applicable DHS and Commission documents), and discussion with DHS and Commission staff indicates this to be the case. However, there is no apparent formal effort in place at the Commission or at DHS for federal funds maximization (per legislation).</p> <p><u>Non-Medicaid Funds:</u> The Commission currently has no formal role in managing and/or maximizing non-Medicaid dollars. According to Commission staff, the Commission relies on sister HHS agencies to address this issue primarily. The issue is addressed indirectly at the Commission through issues brought forth in other HHS duties.</p> <p>HHSC <i>Agree. HHSC has not been appropriated funds to implement this requirement and has contracted this function.</i></p> <p><i>It should be noted that in creating the HHSC and providing for the reorganization of HHS agencies, the drafters of HB 7 clearly anticipated and encouraged shared support functions. As an example of compliance with this concept, HHSC management made the decision to utilize DHS experience in federal funds management.</i></p> <p><i>Furthermore, with respect to federal funds overall, assuming these responsibilities would duplicate the federal funds management system established at the LBB.</i></p>
§14 (a) (5) Develop with the Department of Information Resources automation standards for computer systems to enable HHS agencies to share pertinent data	Yes	N/A		

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Implementation of House Bill 7, 72nd Legislature Effective September 1, 1991				
Citation	Complete <sup>1</sup>		Comment Source	Comment
	8/94	1/97		
§14 (a) (6) Establish and enforce uniform regional boundaries (URBs) for all health and human services agencies	Partially	Partially	SAO 8/94 and 1/97  HHSC	The Commission has established URBs, but has not enforced or used them.  <i>Disagree, status is complete. HHSC has corrected TCB for failing to use URBs; they have since complied. While some agencies may use alternative boundaries for internal purposes, all agencies report on a URB basis.</i>
§14 (a) (7) Carry out statewide health and human services needs surveys and forecasting	No	No, w/ Q	SAO 1/97  HHSC	Baseline demographic data has been made available; however, no formal comprehensive needs assessment has been done yet. In addition, effective this fiscal year, the Commission will not be providing baseline demographic data to HHS agencies.  <i>Disagree, status is complete with reservations. HHS agencies perform some program needs assessment and some forecasting is done by HHSC.</i>
§14 (a) (8) Perform independent special outcome evaluations of health and human services programs and activities	Yes	No, w/ Q	SAO 1/97  HHSC	No special outcome evaluation appears to have been done since the last review. Some examples of projects or reviews provided by the Commission as examples for meeting this requirement are not HHS program or activities outcome evaluations; but initiatives taken by the Commission (or those requested of the Commission) to address HHS agency/program needs. However, the Commission has commented that without some clarification of what the Legislature means by "independent special outcome evaluations" it has been and will be hard to address this particular requirement.  <i>Disagree, status is complete with reservations. HHSC's status has not changed since the 8/94 audit. HHSC does need clarification on the legislative intent in order to implement this section.</i>
§14 (a) (9) Adopt rules necessary to carry out the commission's duties under this Act	Yes, w/ Q	Yes	HHSC	<i>Agree.</i>

Yes:	Requirement fully implemented with no exceptions
Yes, w/ Q:	Requirement implemented with minor exception as noted
No, w/ Q:	Requirement implemented with major exception, or not implemented due to extenuating circumstances noted
No:	Requirement not implemented
Partially:	Not all components of requirement fully implemented yet
N/A:	Not applicable for current testing

Implementation of House Bill 7, 72nd Legislature Effective September 1, 1991				
Citation	Complete <sup>1</sup>		Comment Source	Comment
	8/94	1/97		
§14 (a) (10) Develop a formula for distribution of funds that considers such need factors as . . . within the regions of the state	No	No	SAO 1/97  HHSC	The Commission feels that it has limited authority and resources (expertise) to address this issue. However, the Commission feels that this issue is to some extent addressed indirectly through the consolidated strategic planning and budgeting process.  <i>Agree. HHSC has not been appropriated funds needed to implement this section. Implementation would be extremely costly. None of our annual work plans have ever been criticized for not including this.</i>
§14 (b) The commission shall file annually . . . a complete and detailed written report accounting for all funds received and disbursed by the commission . . .	Yes	N/A		
§14 (c) The commissioner shall establish a management information system and a cost accounting system for all health and human services which is compatible with . . . the uniform statewide accounting project.	No	No, w/ Q	SAO 1/97  HHSC	According to the Commission, it currently is in the discussion/planning stage for this requirement.  <i>Agree. HHSC has not been appropriated funds to implement this requirement.</i>

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Implementation of House Bill 7, 72nd Legislature Effective September 1, 1991				
Citation	Complete <sup>1</sup>		Comment Source	Comment
	8/94	1/97		
<p><b>§15</b> <b>Review of Agency Rule Making</b></p> <p>§15 (a) The commission shall review all proposed rules of health and human services agencies...</p>	Yes	No, w/ Q	SAO 1/97  HHSC	The Commission has commented that not all non-Medicaid rules are reviewed, only the sensitive or critical ones. However, all Medicaid rules are reviewed and approved by the Commission.  <i>Disagree, status is complete with qualifications. This subsection is labor intensive. The HHSC appropriations and FTE limits do not provide adequate resources for this level of review.</i>
<p>§15 (b) The commission shall review agency rules for compliance with the coordinated strategic plan, existing statutory authority, rules of other health and human services agencies, and budgetary implications.</p>	Yes	No, w/ Q	SAO 1/97  HHSC	See comment for 15 (a). Those rules that are reviewed by the Commission do appear to meet this requirement.  <i>Disagree, status is complete with qualifications. See response to §15(a).</i>
<p>§15 (c) The commission shall also review and comment on agency rules and notice and public hearing procedures relating to payment rates for providers.</p>	Yes	No, w/ Q	SAO 1/97  HHSC	See comment for 15 (a). Also see comment at the end of the table in Appendix 2.2 for Rider 17 of the General Appropriations Act, "Rates for Residential Placement."  <i>Disagree, status is complete with qualifications. Rules are reviewed and commented on as needed. From July 94-May 95 over 250 rules were reviewed, only 6 required HHSC intervention with minor changes.</i>
<p><b>§16</b> <b>Administration of Medicaid Program</b></p> <p>On approval by the federal government, the commission is the state agency designated to administer federal medical assistance funds.</p>	Yes	N/A		

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Implementation of House Bill 7, 72nd Legislature Effective September 1, 1991				
Citation	Complete <sup>1</sup>		Comment Source	Comment
	8/94	1/97		
<p><b>§17</b> <b>Reference Guide;</b> <b>Dictionary</b></p> <p>The commission shall publish a biennial reference guide describing available health and human services in the state . . . . The reference guide shall include a dictionary of uniform terms and services.</p>	Yes	N/A		
<p><b>§1.05</b> <b>Transition Duties of the Commission</b></p> <p>§1.05 (a) (1) Establishing a federal funds management system for all HHS services to maximize local, state, and federal resources.</p>	Yes	Yes, w/ Q	SAO  HHSC	See comment at §14(a)(4).  <i>Agree. HHSC has not been appropriated funds to fully implement this provision.</i>
<p>§1.05 (a) (2) Designing of local system for improved access to services and the efficient delivery thereof, including co-location of offices, computerized integrated eligibility determination, information and referral, and enhanced local decision making</p>	No	No, w/ Q	SAO 1/97  HHSC	Work is in progress. TESS is in the process of being implemented, and TIES is in the planning stage (being bid out currently). Estimated testing of TIES system will be completed in 3 years, then full implementation will start.  <i>Disagree, status is complete with qualifications. TESS was jointly developed by TDHS and TDH at the request of HHSC. TESS is currently implemented in the DHS offices and at some TDH sites. Passage of HB 2777 invalidates the auditor's comments. The comment about system testing lasting 3 years is wrong. For further comment see report section entitled Management Response.</i>
<p>§1.05 (a) (3) Holding public hearings and establishing uniform regional boundaries for all health and human services agencies by September 1, 1992 . . .</p>	Yes	N/A		

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Implementation of House Bill 7, 72nd Legislature Effective September 1, 1991				
Citation	Complete <sup>1</sup>		Comment Source	Comment
	8/94	1/97		
§1.05 (a) (4) Reviewing programs with similar functions for consolidation . . . and submitting to the 73rd Legislature any statutory revisions necessary	Yes	N/A		
§1.05 (a) (5) Reviewing and recommending to the 73rd legislature any necessary changes in the . . . .	Yes	N/A		
§1.05 (b) The . . . commission shall submit . . . its recommendations and implementation plan for permanent governing structures of health and human services agencies . . . .	Yes	N/A		
§1.05 (c) (d) (e) . . . the commission shall oversee and assist in the transfer of functions among agencies as provided by this article . . . . the commission shall assist the agencies in transferring functions, programs, activities, records, equipment, property, funds, obligations, and employees . . . .	Yes, w/ Q	N/A		

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Implementation of House Bill 7, 72nd Legislature Effective September 1, 1991				
Citation	Complete <sup>1</sup>		Comment Source	Comment
	8/94	1/97		
<b>Additional Items in House Bill 7</b>  <b>§1.13</b> All duties and responsibilities of the Governor's council on Health and Human Services shall be transferred to the . . . commission . . . .	Yes	N/A		
<b>§1.16</b> Not later than September 1, 1995, the commissioner of health and human services shall complete the reorganization of the delivery system . . . .	N/A	No, w/ Q	SAO 1/97  HHSC	Work is in progress. There is still much to do.  <i>Disagree, HHSC has completed all its statutory reorganization requirements outlined in House Bill 7. We are not clear what SAO means by "still much to do."</i>
<b>§3.03 Integrated Data Base Network</b>  §3.03 (a) . . . the administrative head of each health and human services agency shall designate a representative to the interagency work group to develop an integrated data base network. . . . The interagency work group must . . .	Yes	N/A		
§3.03 (b) The interagency work group shall complete all duties . . . and report to the governor and commission before June 1, 1992.	Yes	N/A		

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Implementation of House Bill 7, 72nd Legislature Effective September 1, 1991				
Citation	Complete <sup>1</sup>		Comment Source	Comment
	8/94	1/97		
<p>§3.03 (c) The interagency work group shall assess the adequacy of existing statutory authority relating to the exchange of client information among state agencies . . . . If the work group finds that the state statutory authority does not allow health and human services agencies to share client data . . . the group shall present to the 73rd Legislature a report containing the statutory adjustments necessary to allow those agencies to share . . . .</p>	No	No, w/ Q	SAO 8/94 and 1/97	<p>No such recommendations were submitted to the 73rd Legislature. However, according to the Commission, the issue appears to have been resolved by having the clients sign release or waiver forms that allow sharing of applicable data among health and human services agencies.</p> <p>The Commission initiated a formal review of this issue effective May 3, 1995. The Commission solicited information on this issue from sister health and human services agencies. A letter was submitted to Senate HHS committee on August 4, 1995, by the Commission regarding changes that need to be made in applicable legislation to address the issue of client information exchanges.</p>
			HHSC	<i>Disagree, item is complete. The report to the 73rd Legislature was submitted and is available upon request.</i>
<p><b>§3.05 Expanding Client Eligibility Determination Process</b></p> <p>Based on a cost-benefit analysis:</p> <p>§3.05 (1) The Texas Department of Human Services and the Texas Department of Health shall expand the use of integrated eligibility screening instruments to additional appropriate locations by August 31, 1992.</p>	No	No, w/ Q	SAO 8/94  SAO 1/97	<p>Pilots with Client Access Project Software did not begin until September 1992. TESS was developed in 1994. The Texas Department of Health and the Department of Human Services implemented TESS in May 1994.</p> <p>TESS is in the process of being implemented; TIES is in the planning stage (being bid out currently). Estimated testing of TIES system will be completed in 3 years, then full implementation will start.</p>

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Implementation of House Bill 7, 72nd Legislature Effective September 1, 1991				
Citation	Complete <sup>1</sup>		Comment Source	Comment
	8/94	1/97		
			HHSC	<i>Agree, status is complete with qualifications. TIES was restructured with the last legislative session. Its objective is still integrated eligibility determination. The comment about the 3 year timeline is wrong. See above response and report section entitled Management Response for more details.</i>
§3.05 (2) The Texas Department of Human Services shall, where feasible, relocate an employee with the ability to certify eligibility . . . .	Yes	N/A		
§3.05(3) The commission shall coordinate any further expansion and use of integrated eligibility screening instruments . . . .	Yes	N/A		
<b>§3.06 Client Access Pilot Programs</b>  §3.06 (a) (b) (c) Not later than March 1, 1992, the commission shall . . . select at least one metropolitan, rural, and medium population county to demonstrate the operation of a client access package. . . . the package shall include a countywide client database and registry system . . . . The commission shall report . . . by January 31, 1993, the status of the client access package . . . .	Yes	N/A		

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Implementation of House Bill 7, 72nd Legislature Effective September 1, 1991				
Citation	Complete <sup>1</sup>		Comment Source	Comment
	8/94	1/97		
<p><b>§3.08</b> <b>Co-location of Offices and Facilities</b></p> <p>§3.08(a) The administrative heads of the health and human services agencies shall review the agencies' current office and facility arrangements and study the feasibility of co-locating . . . .</p>	Yes, w/ Q	N/A	SAO 8/94	The Commission Co-Location Report, published in August 1992 by the Co-Location work group, did not really study the feasibility of co-location. Instead, it defined co-location, recommended the creation of regional co-location groups, and provided the HHS agencies an opportunity to state their preferences. There has never been a comprehensive study of feasibility and planned savings from co-location.
			HHSC	<i>Disagree, status is complete. Each co-location situation is studied as part of the lease process to determine whether benefits of co-location exists. Both spatial and programmatic needs are considered in this process. GSC does not proceed with a lease without HHSC approval.</i>
<p>§3.08(b) On receiving approval from the Commission, the administrative heads of two or more health and human services agencies . . . shall co-locate . . . if the results of the study . . . show that client access would be enhanced, the cost of co-location is not greater than the combined operating costs would . . . and that co-location will improve the efficiency of the delivery of services.</p>	No	No, w/ Q	SAO 8/94	No feasibility studies have been done.
			SAO 1/97	Co-location is still in progress; however, as of yet there is no process in place (or study done) that would assist in determining benefits gained from co-location (such as enhancing the effectiveness and efficiency of HHS service delivery).
			HHSC	<i>Disagree, status is complete. See response above.</i>

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## House Bill 7 Amending Legislation and Applicable General Appropriations Act Riders

Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
House Bill 1510, 73rd Legislature Effective Date: September 3, 1993			
<b>§7 Coordinated Strategic Plan</b> Section 10(a), Article 4413 (502)...amended... as follows:  (a) . . . The commissioner shall submit <del>the initial plan</del> each subsequent biennial update of the plan to the governor, lieutenant governor, and speaker of the house of representatives no later than October 1 <del>15</del> of each even-numbered year . . . .	Yes	SAO   HHSC	Submission by October 1 is now part of standard operations.  <i>Agree.</i>

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Underscored text represents new wording in the amended legislation.

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Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
House Bill 1510, 73rd Legislature Effective Date: September 3, 1993 (continued)			
<p><b>§14</b> Section 2, Article 4413 (701) . . . is amended to read as follows: Sec. 2. Powers and Duties.</p> <p>(a) The Health and Human Services Transportation and Planning Office shall . . .</p> <p><u>(10) review the feasibility of taking medical care to those in need, including the use of mobile clinics, and review the possibility of using federal funds for those transportation needs.</u></p>	No, w/ Q	SAO  HHSC	<p>See comments at House Bill 2891- Subsection 15 (a) (10).</p> <p><i>Disagree, status is complete. HHSC's TPO staff met with staff from the Governor's Office policy council, Senate Health and human services Committee, the Texas Transportation Commission TDH and others and concluded that funding was not available from TXDOT nor needed at this point because there are no mobile clinics at present. TPO is open to opportunities in this area but has focused its staff resources on the statewide action plan approved by decisionmakers and stakeholders.</i></p>
<p><b>§26</b> Section 222.042, Health and Safety Code, is amended to read as follows:</p> <p>Licensing of ICF-MR Beds and Facilities. The department may not <u>license or</u> approve as meeting licensing standards new ICF-MR beds or the expansion of an existing ICF-MR facility unless: <del>(1)</del> the new beds or the expansion was included in the plan approved by the <u>Health and Human Services Commission in accordance with Section 533.062 interagency . . . Statutes</u>.</p>	Yes	SAO  HHSC	<p>Plans come out every biennium and are approved by the Commission. The latest version of the plan is attached as Appendix C to the fiscal years 1997 and 1998 Health and human services consolidated budget request.</p> <p><i>Agree.</i></p>

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Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
House Bill 1510, 73rd Legislature Effective Date: September 3, 1993 (continued)			
<p>§27 Section 533.062, Health and Safety Code, is amended to read as follows:</p> <p>Sec. 533.062. PLAN ON <u>LONG-TERM CARE FOR PERSONS WITH MENTAL RETARDATION ICF-MR FACILITIES</u></p> <p>(c) . . . Not later than July 1 of each <u>even-numbered</u> year, the department shall submit the plan [proposal on long-term care for persons with mental retardation] to the <u>Health and Human Services Commission Interagency Council on ICF-MR Facilities</u> for approval.</p>	No, w/ Q	SAO  HHSC	<p>The plan was actually received by the Commission for approval in September.</p> <p><i>Disagree, status is complete w/ Q. The plan submitted was delayed in order to incorporate advocate input and negotiations. The plan was late due to LBO's misunderstanding of why numbers were changed to be consistent with our LAR.</i></p>
<p>(d) . . . <u>In determining the appropriate number of ICF-MR facilities . . . the department and the Health and Human Services Commission shall consult with the Texas Department of Human Services</u> <del>the board by rule shall adopt the plan . . . Facilities.</del></p>	Yes		<p>According to the Commission, the plan was developed in consultation with the Department of Mental Health and Mental Retardation (MHMR), the Department of Human Services (DHS), and the Texas Rehabilitation Commission (TRC). In addition, public hearings were also held to receive input from affected parties.</p> <p><i>Agree.</i></p>

Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
House Bill 1510, 73rd Legislature Effective Date: September 3, 1993 (continued)			
(e) <u>The Health and Human Services Commission shall submit the proposed plan as part of the consolidated health and human services budget recommendation required under Section 13, Article 4413(502), Revised Statutes</u> <del>The department may submit proposed amendments to a plan in operation that the department considers necessary.</del>	Partial	SAO	The Commission does submit the proposed plan as part (Appendix C) of the Health and human services consolidated budget request. However, it appears that the Commission does not use the plan's ICF-MR facilities data in making its Health and human services budget recommendations. The Commission hopes to capture that data indirectly through the budget/strategies of MHMR, TRC, and DHS.
		HHSC	<i>Disagree, status is complete with qualifications. HHSC did in fact use the LTC Plan in its recommendations. All of the Commission's recommendations came in at or below the original LTC Plan levels. HHS agencies revised their targets based on actual legislative appropriations.</i>
(f) <u>After legislative action on the appropriation for long-term care services for persons with mental retardation, the Health and Human Services Commission shall adjust the plan to ensure that the number of ICF-MR beds licensed or approved as meeting license requirements and the capacity of the HCS waver program are within appropriated funding amounts.</u>	Yes, w/ Q	SAO	After the legislative action has taken place, the plan again goes through its review cycle—MHMR, TRC, DHS, and then to the Commission for final approval. House Bill 1510 states that the Commission shall adjust the plan to ensure that the number of ICF-MR beds licensed are within appropriated funding amounts. Actually, MHMR does it.
		HHSC	<i>Agree. Since MHMR is the operating agency for the ICF-MR program, they are the agency best suited to determine the necessary adjustments to the LTC Plan, which are then passed on to HHSC for final approval. The data is also used in the consolidated budget.</i>
(g) <u>After any necessary adjustments, the Health and Human Services Commission shall approve the final biennial plan . . .</u>	Yes	SAO	It is reviewed by the Commission to ensure the adjustments take into consideration the level of care provided by the facility, all 11 regions are served, and the oldest registered facilities in the program are covered first.
		HHSC	<i>Agree.</i>

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Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
<u>.and the Health and Human Services Commission shall publish the plan in the <i>Texas Register</i>.</u>	Yes, w/ Q	SAO  HHSC	The entire plan is not published; however, the plan summary is published.  <i>Agree that only a summary of the plan was published by MHMR. However, the Texas Register Plan clearly tells the public where to get a copy of the entire plan.</i>

Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
House Bill 1510, 73rd Legislature Effective Date: September 3, 1993 (concluded)			
<p><b>§41</b> Sections 34.22 (b) and (c), Family Code, are amended to read as follows:</p> <p>(c) The Health and Human Services Commission <del>Office of Youth Care Investigations</del> shall review and approve such rules to ensure that all agencies implement appropriate standards for the conduct of investigations and that uniformity exists among agencies in the investigation and resolution of reports.</p>	Yes, w/ Q	SAO  HHSC	Although the Commission does appear to track all rules proposed, not all (non-Medicaid) rules are reviewed and approved by the Commission. Only the ones that are determined to be sensitive or critical by the Commission are reviewed.  <i>Agree.</i>
Senate Bill 10, 74th Legislature Effective Date: September 1, 1995			
<p><b>SB10</b> <u>"Purpose</u> As enrolled, SB10 requires the commission to develop a health care delivery system in an effort to restructure the delivery of Medicaid health care services. Sets forth regulation for the creation of intergovernmental initiatives to administer the system in a geographical area." <i>Source: Senate Research Center's Analysis of Bills, 74(R).</i></p>	Partially	SAO  HHSC	According to the Commission, the Medicaid Plan is close to approval by the federal oversight agency; however, it has not been implemented yet.  Senate Bill 10 required the Commission to file for 1115 waiver to the Medicaid program. The waiver submitted by the Commission has not yet been approved by the federal oversight agency. The Commission has made requested changes to the original waiver as requested by the federal oversight agency and resubmitted waiver.  <i>Agree. The commission developed the required waiver and submitted it to the federal government in August, 1995. The commission then modified the plan to address federal concerns and resubmitted it November, 1996. As recently as June 5, 1997 HHSC engaged in a conference call with the federal government staff to address additional federal concerns.</i>

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Citation	Complete 1/97	Comment Source	Comments
Senate Bill 509, 74th Legislature Effective Date: September 1, 1995 (concluded)			
<p>§4 Clarifying Amendment. Subsection (c), Section 32.029, Human Resources Code is amended to read as follows:</p> <p>(c) If [HHSC or agency operating part of medical assistance program, as applicable] elects to make direct vendor payments, the payments shall be made by vouchers and warrants drawn by the comptroller on the proper account of the <del>[DHS] fund</del>. [HHSC or agency operating part of medical assistance program, as applicable] shall furnish the comptroller with a list of those vendors entitled to payments and the amounts to which each is entitled. When the warrants are drawn, they must be delivered to the <u>[HHSC or agency operating part of medical assistance p.m., as applicable]</u>, <del>which commissioner,</del> <u>who</u> shall supervise the delivery to vendors.</p>	N/A	SAO	The Commission does not make direct vendor payments because it does not have contracts for medical services. All contracts relating to medical services are between the vendors and the operating agencies. Health and human services agencies make the payments.

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Implementation of Amending Legislation and General Appropriations Act Riders				
Citation	Complete 1/97	Comment Source	Comments	
House Bill 869, 74th Legislature Effective Date: August 28, 1995				
<p>§1 Section 10, Article 4413 (502) is amended to read as follows:</p> <p><b>Re: Strategic Plan Development</b> (c) In developing a strategic plan and plan updates under this section, the commissioner shall consider: (2) <u>the health and human services priorities and plans submitted to the commissioner by governmental entities under Subsection (e) of this section</u></p> <p><u>(e) The commissioner shall identify governmental entities that coordinate the delivery of health and human services in different regions, counties, and municipalities in the state, and shall request that each of these entities</u></p> <p><u>(1) identify the health and human services priorities in the entity's jurisdiction and the most effective ways to deliver and coordinate services in that jurisdiction;</u></p> <p><u>(2) develop a coordinated plan for the delivery of health and human services, including transition services that prepare special education students for adulthood, in the entity's jurisdiction; and</u></p> <p><u>(3) make the information described by Subdivisions (1) and (2) of this section available to the Commission.</u></p>	No	SAO	See comment for Subsection 1 (e) below.	
			HHSC	Agree.
	No	SAO	The Commission currently has no plans for meeting this requirement. The Commission feels it lacks resources and needs more direction from the Legislature regarding expectations for this issue.	
			HHSC	<i>Disagree, status is complete with qualifications. HHSC has input through public hearings and survey responses. HHSC has been creative in addressing the need for local input and planning by partnering with local private and public entities in carrying out most division service integration initiatives including CRCG; transportation; information and referral; children's financing; Casey; permanency planning and children with disabilities.</i>
	No	SAO	See comment above for §1 - amended Section 10(e), Article 4413 (502).	
		HHSC	<i>Disagree, status is complete with qualification. See response to Sec. 1(e) above.</i>	
No	SAO	See comment above for §1 - amended Section 10(e), Article 4413 (502).		
		HHSC	<i>Disagree, status is complete with qualifications. In those communities who have responded to HHSC's RFPs for various service integration initiatives funded via federal and foundation grants provides the means to offer such technical assistance. The cost of providing this type of assistance state-wide is prohibitive. HHSC initiatives are limited to those with federal or private funding.</i>	
No	SAO	See comment above for §1 - amended Section 10(e), Article 4413 (502).		
		HHSC	<i>Disagree, completed with qualifications. See response to Sec. 1(e)(2) above.</i>	

Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
House Bill 869, 74th Legislature Effective Date: August 28, 1995 (continued)			
§2 Section 14 (a), Article 4413 (502) is amended to read as follows:  (a) The commissioner shall:  (1) arbitrate and render <del>the</del> a final decision on interagency disputes;  <hr/> (3) <u>at the request of a governmental entity identified under Section 10 (e) of this article, assist the governmental entity in implementing a coordinated plan, which may include co-location of services, integrated intake, and coordinated referral and case management, tailored to the needs and priorities of that entity;</u>	No, w/ Q	SAO	The Commission currently has an informal (mediation) system for resolving interagency disputes. The Commission feels that the current system has served it well to date; however, the Commission concedes that there may be a need for a more formal system in the future (due to increased likelihood of disputes arising from the upcoming TIES and those as a result of Medicaid Fraud).
		HHSC	<i>Disagree, completed with qualifications. The Legislature did not prescribe a formal process. Currently, the Commission resolves interagency disputes through consensus negotiations and monthly CEO meetings. This approach has proven effective since our reorganization in 1995.</i>
	No	SAO	See comment above for §1 - amended Section 10(e), Article 4413 (502).
		HHSC	<i>Disagree, status is complete with qualifications. HHSC enforces co-location via its lease approval process. HHSC has established state-wide information and referral centers, publishes a service directory for coordination of referrals. A state-wide case management survey has been completed by HHSC and HHS agencies. Several HHSC projects such as CRCG, permanency planning and children's integrated funds sites are evaluating coordinated case management.</i>

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Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
House Bill 869, 74th Legislature Effective Date: August 28, 1995 (concluded)			
<u>(6) (5)</u> develop with the Department of Information Resources automation standards for computer systems to enable health and human services agencies, <u>including agencies operating on a local level</u> , to share pertinent data;	Yes	SAO  HHSC	This is being implemented via two methods: (1) The Commission has created an Information Architect position. This person coordinates with Health and human services agencies and the Department of Information Resources. (2) The Commission has created a Technical Architecture Workgroup which includes members from all 12 Health and human services agencies.  <i>Agree.</i>
House Bill 2698, 74th Legislature Effective Date: August 28, 1995			
§1 Section 1. Art 4413 (502) ... amended by adding... Section 10 A is amended as follows:  <u>Sec. 10A: Long-Term Care Vision.</u>  <u>(a) In conjunction with the appropriate state agencies, the commissioner shall develop a plan for access to individualized long-term care services for persons with functional limitations or medical needs and their families that assist them in achieving and maintaining the greatest possible independence, autonomy, and quality of life.</u> [(b) and (c) provide details of what the principles and goals of the two plans must include]	Partially	SAO  HHSC	The Commission is in the process of completing a plan in conjunction with appropriate agencies. The rough draft is expected in December 1996, the final draft in January 1997, and the release is expected in February or March 1997.  <i>Disagree, status is complete with qualifications. The plan written pursuant to subsection (a) was not published in deference to legislation under consideration by the 75th Legislature. Its contents will be incorporated in implementation of that legislation.</i>
<u>(d) The Commission shall coordinate state services to ensure that the roles and responsibilities of the agencies providing long-term care are clarified and that duplication of services and resources is minimized.</u>	No, w/ Q	SAO  HHSC	This is in progress. See comment above for §1 amended §1 by adding section 10 (A) (a), of Article 4413 (502). However, according to the Commission, Section (d) is covered in the plan being developed.  <i>Disagree, status is completed with qualifications.</i>

Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
House Bill 2891, 74th Legislature Effective Date: September 1, 1995			
<p>§15 Section 131.002, Human Resources Code is amended to conform to Section 14, Chapter 747, Acts of the 73rd Legislature, Regular Session, 1993 and is amended to read as follows:</p> <p>Sec. 131.002. Powers and Duties. <u>(a)</u> The office Health and Human Services Transportation and Planning Office shall:</p> <p><u>(10) review the feasibility of taking medical care to those in need, including the use of mobile clinics, and</u></p>	No, w/ Q	SAO	The Commission held meetings with the Texas Department of Transportation (TxDOT) regarding this requirement; however, no formal plan of action was developed to address this issue. The Commission was not sure (and still is not sure) what action was/is required.
		HHSC	<i>Disagree, status is completed with qualifications. See response to HB 1510 Section 14 (a)(10), page 18 [page 78].</i>
<p><u>review the possibility of using federal highway funds for those transportation needs.</u></p>	Yes, w/ Q	SAO	According to Commission staff, TxDOT informed the Commission that no funds were available for this issue. No further formal investigation was done by the Commission to determine any other federal funding sources; however, an informal search for other potential federal funds was conducted but none were found.
		HHSC	<i>Agree.</i>

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Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
House Bill 2891, 74th Legislature Effective Date: September 1, 1995 (concluded)			
<p><u>(b) The Health and Human Services Transportation and Planning Office (now part of the Commission) shall . . .</u></p> <p><u>. . . coordinate with the Commission and health and human services agencies in implementing the goals listed in Section 10 (b), Article 4413 (502), Revised Statutes. . . .</u></p>	Yes	SAO	This requirement is modified by Senate Bill 1675, in that the Transportation and Planning Office is now part of the Commission. Currently, the Commission has an Agency Transportation Coordinating Council (members designated by each Health and human services agency) which meets monthly to coordinate Health and human services efforts.
		HHSC	<i>Agree.</i>
<p><u>. . . shall report its findings and proposals to the governor, LBB, the secretary of state, and the commissioner of [HHSC] not later than September 1 of each even-numbered year.</u></p> <p>[See comment above for §1 - amended Section 10(e), Article 4413 (502).]</p>	Yes	SAO	The findings and proposals are reported in the biennial report.
		HHSC	<i>Agree.</i>

Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
Senate Bill 1675, 74th Legislature Effective Date: September 1, 1995			
§1 Section 10, Article 4413 (502) . . . is amended to read as follows:  (d) All health and human services agencies shall submit strategic plans and biennial updates to the Commission on a date to be determined by commission rule. <u>The Commission shall review and comment on the strategic plans and biennial updates.</u>	Yes, w/ Q	SAO	Requirement is being met. However, according to Commission staff, the Commission does not feel that it has adequate time to review and comment on Health and human services agencies' strategic plans and LARs (the Commission has about a two-week turn-around time). And, more importantly, the Commission feels it lacks sufficient authority (under the current process) to make changes to Health and human services agencies' board- approved plans and LARs.
		HHSC	<i>Agree.</i>
<u>(e) Not later than January 1 of each even-numbered year, the Commission shall begin formal discussions with each health and human services agency regarding that agency's strategic plan or biennial update.</u>	Yes	SAO	Requirement is being met.
		HHSC	<i>Agree.</i>

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Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
Senate Bill 1675, 74th Legislature Effective Date: September 1, 1995 (continued)			
§2 Section 12, Article 4413 (502) is amended to read as follows:  Sec. 12. PUBLIC <del>INPUT</del> INTEREST INFORMATION AND COMPLAINTS.  <u>(b) The Commission shall develop and implement routine and ongoing mechanisms, in accessible formats:</u>  <u>(1) to receive consumer input:</u>	Yes	SAO	Requirement is being met.
		HHSC	<i>Agree.</i>
	<u>(2) to involve consumers in planning, delivery, and evaluation of programs and services under the jurisdiction of the commission; and</u>	Yes	SAO
HHSC			<i>Agree.</i>
<u>(3) to communicate to the public on the input received and actions taken in response.</u>	Yes	SAO	Requirement is being met.
HHSC		<i>Agree.</i>	



Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
Senate Bill 1675, 74th Legislature Effective Date: September 1, 1995 (continued)			
<p>§4 Article 4413 (503) is amended to read as follows:</p> <p><u>Sec. 13A. Health and Human Services Agencies Operating Budgets.</u></p> <p><u>(a) In addition to the provisions of the General Appropriations Act, the Commission shall review and comment on:</u></p> <p><u>(1) the annual operating budget of each health and human services agency; and</u></p>	Yes, w/ Q	SAO	Requirement is being met. However, the Commission stated that without approval authority it can do little through review and comment to effect change.
		HHSC	<i>Agree. The enrolled version of HB7 gave HHSC significant oversight responsibility. As the legislation evolved, however, much of the authority to do so was lost limiting the Commission's authority to review and comment.</i>
<p><u>(2) the transfer of funds between budget strategies made by each health and human services agency prior to the transfer of the funds.</u></p>	No, w/ Q	SAO	Requirement is only being met for those agencies that self-report this information to the Commission. The Commission does not mandate Health and human services agencies to report all transfers made. In addition, there do not appear to be any checks in place to alert the Commission of this action if not reported by a sister Health and human services agency.
		HHSC	<i>Disagree, status is completed with qualifications. HB 1863 directs the Commission to review and comment on the transfer of funds between strategies, but does not authorize the agency to deny or prevent such transfers. HHSC periodically reminds HHS agencies of the requirement to notify it about transfers.</i>
<p><u>(b) The Commission shall issue a report, on a quarterly basis, regarding the projected expenditures by budget strategy of each health and human services agency compared to each agency's operating budget.</u></p>	Yes	SAO	Requirement is being met. However, according to Commission staff, without approval authority the Commission would just do away with this requirement. The current process of review and comment carries insufficient authority to mandate changes or action.
		HHSC	<i>Agree.</i>

Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
Senate Bill 1675, 74th Legislature Effective Date: September 1, 1995 (continued)			
<u>Sec 13C. AUTOMATED SYSTEMS. A health and human services agency may not submit its plans to the Department of Information Resources under Subchapter E, Chapter 2054, Government Code, until those plans are approved by the Commission.</u>	Yes		Requirement is being met.  <i>Agree.</i>
<u>Sec. 13D. COORDINATION AND APPROVAL OF CASELOAD ESTIMATES.</u>  <u>(a) The Commission shall coordinate and approve caseload estimates made for programs administered by health and human services agencies.</u>	Yes		Requirement is being met. The Commission expects a fiscal year 1997 first quarter report to go out some time in February 1997. (The report was delayed because the employee responsible for this requirement left the Commission in September 1996. The position was recently filled in January 1997.)  <i>Agree.</i>
<u>(1) adopt uniform guidelines to be used by health and human services agencies in estimating their caseloads, with allowance given for those agencies for which exceptions from the guidelines may be necessary;</u>	Yes	SAO  HHSC	Guidelines have been issued.  <i>Guidelines have been issued and are being complied with by HHS agencies.</i>

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Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
Senate Bill 1675, 74th Legislature Effective Date: September 1, 1995 (continued)			
<u>(2) assemble a single set of economic and demographic data and provide that data to each health and human services agency to be used in estimating its caseloads; and</u>	Yes, w/ Q	SAO  HHSC	Requirement was being met in the past; however, it is currently not being done by the Commission. The position (demographer) has been vacant since October 1997. The Commissioner has not decided whether the position will be filled in the near future. The last report issued by the Commission was for the fourth quarter of 1996.  <i>Agree.</i>
<u>(3) seek advice from health and human services agencies, Legislative Budget Board, the governor's budget office, the comptroller, and other relevant agencies as needed to coordinate the caseload estimating process.</u>	Yes, w/ Q	SAO  HHSC	This has not been done since the departure of the person responsible in September 1996. The Commission recently hired a person to fill the vacated position, and hopes to resume this responsibility.  <i>Agree.</i>
<u>(c) The Commission shall assemble caseload estimates made by health and human services agencies into a coherent, uniform report, and</u>	Yes	SAO  HHSC	Report is issued quarterly by the Commission.  <i>Agree.</i>
<u>shall update the report quarterly, with assistance from those agencies.</u>	Yes	SAO  HHSC	See above comment.  <i>Agree.</i>
<u>The Commission shall publish the report and make it readily available to state and local agencies and interested private organizations.</u>	Yes	SAO  HHSC	Requirement is being met.  <i>Agree.</i>
<u>(d) In the report prepared under Subsection (c) of this section, the Commission shall explain the caseload estimates using monthly averages, annual unduplicated recipients, annual service usage, and other commonly used measures.</u>	Yes	SAO  HHSC	Requirement is being met.  <i>Agree.</i>

Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
Senate Bill 1675, 74th Legislature Effective Date: September 1, 1995 (continued)			
<u>(e) The Commission shall attach a copy of the report prepared under Subsection (c) of this section to the consolidated health and human services budget recommendation submitted to the Legislative Budget Board under Section 13 of this article, and</u>	Yes	SAO  HHSC	Requirement is being met.  <i>Agree.</i>
<u>shall also submit the report to the legislature when it convenes in regular session.</u>	Yes	SAO HHSC	Requirement is being met. <i>Agree.</i>
§5 Section 14, Article 4413 (502) is amended to read as follows:  (a) The commissioner shall:  (1) arbitrate and render <del>the a</del> final decision on interagency disputes	No w/ Q	SAO HHSC	See comment at House Bill 869 Subsection 2 (a) (1).  <i>Disagree, the status is complete. Decisive action has been taken when necessary. See Comment on Sec. 14(a)(1) HB7.</i>
(10) <u>review and comment on health and human services agency formulas develop a formula for the distribution of funds to ensure that the formulas, to the extent permitted by federal law, consider</u> <del>considers</del> such need factors as client base, population, and economic and geographic factors within the regions of the state.	No, w/ Q	SAO  HHSC	According to Commission staff, the Commission does not have the resources or the expertise to meet this requirement. However, the Commission does appear to (on occasion) indirectly address this requirement during the course of addressing its other Health and human services responsibilities.  <i>Agree. HHSC has not been appropriated funds to implement this requirement.</i>

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Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
Senate Bill 1675, 74th Legislature Effective Date: September 1, 1995 (continued)			
<u>(d) Not later than the end of the first month of each fiscal year, the commissioner shall submit to the governor, the lieutenant governor, the speaker of the house of representatives, the comptroller, and the Legislative Budget Board a work plan outlining the activities of the Commission for that fiscal year. The work plan must establish priorities for the Commission's activities based on available resources.</u>	Yes	SAO  HHSC	Submitted.  Agree.
§8 Article 4413 (502) is amended to read as follows: <u>Sec. 24. REPORTS ON DELIVERY OF SERVICES.</u>  <u>(a) Each executive head of a health and human services agency shall report quarterly to the governing body of that agency on that agency's efforts to streamline and simplify the delivery of services. The agency shall submit a copy of the report to the Commission.</u>	No	SAO  HHSC	See comment for requirement 8 (c) below.  <i>Disagree, complete with qualifications. Health and human services agencies inform their boards of all significant activities. Agencies also report all significant activities involving service integration efforts to HHSC.</i>
<u>(b) The Commission shall prepare and deliver a semiannual report to the governor, the lieutenant governor, the speaker of the house of representatives, the comptroller, the Legislative Budget Board, and appropriate legislative committees on the efforts of the health and human services agencies to streamline the delivery of services provided by those agencies.</u>	No	SAO  HHSC	See comment for requirement 8 (c) below.  <i>Agree, with qualifications. A service integration plan was submitted in 1996. Reports regarding specific aspects of service integration have been submitted on a regular basis ever since.</i>
<u>(c) The commissioner shall adopt rules relating to reports required by Subsection (a) of this section, including rules specifying when and in what manner an agency must report and what information must be included in the report. Each agency shall follow the rules adopted by the commissioner under this section.</u>	No	SAO  HHSC	Rules have not been adopted yet by the Commission, hence (a) , (b), and (c) of this Subsection are not being done. The Commission staff members anticipate rules will be proposed in the <i>Texas Register</i> sometime mid-year. The rules are currently being drafted by agency council.  Agree.

Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
Senate Bill 1675, 74th Legislature Effective Date: September 1, 1995 (continued)			
<p><b>§9</b> Section 3.08, Chapter 15, Acts of the 72nd Legislature, 1st Called Session, 1991 (Article 4413 (505) . . .) is amended to read as follows:</p> <p><del>Sec. 3.08. LOCATION OF OFFICES AND FACILITIES.</del></p> <p>(a) <u>As leases on office space expire, the commission shall determine the needs for space and the location of health and human services agency offices to enable the Commission to achieve a cost-effective one-stop or service center method of health and human services delivery.</u> <del>The . . . 1992.</del></p>	Partially	SAO  HHSC	<p>Currently, as leases expire the Commission lets the Health and human services agencies determine their own needs, and has delegated to the General Services Commission (GSC) to challenge those needs.</p> <p><i>Disagree. Status is complete. HHSC approves all leases, with the exception of emergency leases, based upon physical and programmatic information.</i></p>
<p><b>§10</b> Subsection (a), Section 6.031, State Purchasing and General Services Act . . . is amended to read as follows:</p> <p>(a) <u>Notwithstanding any other provision of this article, the commission may not lease office space to service the needs of any a single health and human services agency unless the Health and Human Services Commission has approved the office space for the agency</u> <del>agency can provide . . .</del></p>	Partially	SAO  HHSC	<p>All leases (except emergency leases) are approved by the Commission before GSC processes them. According to Commission policy, emergency leases (which currently represent the majority of the leases being renewed), are submitted directly to the GSC by the Health and human services agency, and are not reviewed and/or approved by the Commission.</p> <p><i>Disagree. See response to Sec. 9 above.</i></p>

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Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
Senate Bill 1675, 74th Legislature Effective Date: September 1, 1995 (continued)			
§11 (a) The Health and Human Services Commission shall expand its existing integrated eligibility pilot programs to include Harris County Hospital District and The University of Texas Medical Branch at Galveston.	No, w/ Q	SAO	According to Commission staff, this requirement is still pending. There are two areas of contention that have delayed implementation:  (1) The Harris County Hospital District (HCHD) and The University of Texas Medical Branch at Galveston (UTMB-G) want complete access to the Department of Human Services' (DHS) SAVER system; however, DHS does not feel it can do that under current federal rules regarding confidentiality of client information  (2) HCHD and UTMB-G want the ability to download client data from DHS. DHS is not willing to incur the cost (a somewhat significant amount) to modify an old system to do this given that TIES is just around the corner.  The Commission staff members feel that this issue will remain open and probably will be addressed when TIES goes on-line.
		HHSC	<i>Disagree, status is completed with qualifications. Discussions are continuing with HCHD and UTMB-G in an effort to resolve confidentiality barriers that are not a function of non-negotiable federal rules. Also being discussed are possible fixes to bridge the period leading up to integrated eligibility system implementation. For more detail see the report section entitled Management Response.</i>
(b) A contract with [HCHD] or [UTMB-G] shall: ...(requirement specifies certain contractual provisions)	No	SAO	See comment for Sub-section 11(a) above.
		HHSC	<i>Disagree, status is complete with qualifications. See comment at 11(a).</i>
(c) Subject to approval by the Health and Human Services Commission, the Texas Department of Human Services shall establish standards for other automated systems to allow other entities to file information directly.	No	SAO	See comment for Sub-section 11(a) above.
		HHSC	<i>Disagree, status is complete with qualifications. See comment at 11(a).</i>

Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
Senate Bill 1675, 74th Legislature Effective Date: September 1, 1995 (continued)			
(d) The Health and Human Services Commission shall study the feasibility of enabling contractors or agencies other than the Texas Department of Human Services to provide or assist in the provisions of client eligibility studies, determinations, and certifications. In determining feasibility, the Commission shall consider . . . (requirements specifies factors)	No	SAO  HHSC	See comment for Sub-section 11(a) above.  <i>Disagree, status is complete with qualifications. See comment at 11(a).</i>
(e) If more than one agency is directed to perform any study under this section, the agencies involved shall sign a memorandum of understanding to prevent duplication of efforts and cost to the state.	No	SAO  HHSC	See comment for Sub-section 11(a) above.  <i>Disagree, status is complete with qualifications. See comment at 11(a).</i>
<b>§12</b> (a) Not later than September 1, 1996, the Commission, subject to the availability of funds to the commission and the health and human services agencies, shall have completed the development and substantial implementation of a plan for an integrated eligibility determination and service delivery system (IED and SDS) at the local and regional levels. The plan shall specify the dates by which all elements of the plan must be implemented.	No	SAO  HHSC	The Commission currently is in the development stage of the IED/SDS plan. Plans have recently been submitted to the oversight federal agencies (DOA and DHS) and are awaiting approval (plus dollar commitment). Approval is anticipated for mid-February, then the Commission will initiate procurement phase.  <i>Disagree. The plans referred to have been in Washington D.C. for approximately one year. Without federal funding it would be fiscally irresponsible to proceed.</i>

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Partially:	Not all components of requirement fully implemented yet
N/A:	Not applicable for current testing

Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
Senate Bill 1675, 74th Legislature Effective Date: September 1, 1995 (continued)			
(b) The IED and SDS . . . shall be developed and implemented to achieve at least a one percent savings in the cost of providing administrative and other services.	No, w/ Q	SAO  HHSC	See comment for Sub-section 12 (a) above.  Commission staff stated that the cost savings aspects have been addressed in the plan prepared/presented. Require in proposals that entities specify the percentage of savings to the State.  <i>Disagree, status is completed with qualifications. See comment for 12(a) above.</i>
The commission shall use the resulting savings to further develop the integrated system and to provide other health and human services.	N/A	SAO	See comment for Sub-section 12 (a) above.
(c) The commission shall examine cost-effective methods to address: (1) fraud in the assistance programs; and (2) the error rate in eligibility determination.	No	SAO  HHSC	See comment for Sub-section 12 (a) above.  <i>Agree. HHSC has not been appropriated funds to implement this requirement.</i>
(d) In consultation and coordination with the State Council on Competitive Government, the commission shall make and implement recommendations on services or functions of the IED and SDS that could be provided more effectively through the use of competitive bidding or by contracting with local governments and other appropriate entities.	No	SAO  HHSC	See comment for Sub-section 12 (a) above.  According to Commission staff, the Commission has coordinated extensively with the State Council on Competitive Government and the Governor's Office in the development of the plan and the Request for Offer (RFO) submitted to the federal oversight agencies.  <i>Disagree, status is completed with qualifications. See comment for 12(a) above.</i>
If the commission determines that private contracting may be effective, the commission may automate the determination of client eligibility by contracting with a private firm to conduct application processing.	No	SAO	See comment for Sub-section 12 (a) above.

Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
<b>Senate Bill 1675, 74th Legislature</b> Effective Date: September 1, 1995 (concluded)			
(e) Not later than Oct. 1, 1996, the commission shall develop a plan to consolidate administrative and service delivery functions in addition to the IED and SDS in order to minimize duplication.	No, w/ Q	SAO  HHSC	In progress. See comments above regarding "Service Integration" and "IED/SDS" requirements.  <i>Agree.</i>
The commission shall prepare a report of the plan for submission to the governor. . .	Yes	SAO  HHSC	A report was submitted to the Lieutenant Governor on October 22, 1996 by the Commission. The report discusses the plan for Integrated Service Delivery and Integrated Enrollment System.  <i>Agree.</i>
<b>§13</b> (a) Not later than September 1, 1997, the Health and Human Services Commission shall develop, using existing state, local, and private resources, an integrated approach to the Health and human services delivery system that includes a cost-effective one-stop or service center method of delivery to a client. The commission shall determine the feasibility of using hospitals, schools, mental health and mental retardation centers, health clinics . . . and other appropriate locations to achieve this integrated approach.	N/A	SAO	See comment in the body of the report regarding this requirement (Section 8, last bullet).
(c) This section expires September 1, 1997.	N/A		

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Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
<b>Special Provisions Relating to Health and Human Services Agencies (General Appropriations Act, 74th Legislature, Regular Session)</b>			
<b>Rider 16 Health and Human Service Agencies Progress Towards Co-location.</b>  . . . The Health and Human Services Commission shall report on the progress of co-location to the Governor, Lieutenant Governor, Speaker of the House and Members of the 75th Legislature not later than December 1, 1996.	Yes	HHSC	<i>Agree.</i>
<b>Rider 17 Rates for Residential Placement.</b>  None of the funds appropriated to the various state agencies for residential placement of clients shall be expended by the agencies unless the rates paid for residential placements do not exceed the maximum amount for each level of care recommended by the Health and Human Services Commission.	Partially	SAO  HHSC	The Commission feels it does not have appropriate expertise to meet this requirement. The Commission has delegated responsibility to each Health and human services agencies' commissioner to solicit the Commission's help in this matter (on an as-needed basis). Changes in published rate ceilings do require the approval of the Commission.  <i>Disagree. The commission does not set rates and therefore does not have the relevant expertise. As HB 2913, 75th Texas Legislature, is implemented, however, this requirement will be revisited in conjunction with the transfer to the Commission of Medicaid rate-setting authority.</i>
State agencies contracting directly with the private residential care providers shall use a standard application form and shall require each contractor to submit cost reports according to procedures specified by the Commission. . . .		SAO	See comment above.

Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
<b>Health and Human Services Commission Riders General Appropriations Act, 74th Legislature, Regular Session</b>			
<b>Rider 8 Uniform Reporting Standards.</b>  The Health and Human Services Commission shall complete a study of the various reporting requirements and data elements maintained by health and human services agencies under its jurisdiction. Based on the findings, the commission shall make recommendations regarding the standardization of data collection and reporting for health and human services agencies to the Legislative Budget Board and Governor's Office of Budget and Planning by September 1, 1996.	Yes	HHSC	<i>Agree.</i>

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Implementation of Amending Legislation and General Appropriations Act Riders			
Citation	Complete 1/97	Comment Source	Comments
<b>Health and Human Services Commission Riders General Appropriations Act, 74th Legislature, Regular Session (concluded)</b>			
<b>Rider Program Coordination.</b> <b>9</b>  (a) The Commissioner of Health and Human Services, in collaboration with the state agencies listed in this section and the Regional Administration for Children and families Head Start Bureau, the Texas Head Start Association, and the Texas Association Of Community Action Agencies shall coordinate the programs, services, eligibility requirements, funding, enrollment periods, fees, and administrative functions of the following programs by no later than December 1, 1996: (1) the child care programs of the Texas Department of Human Services; and  (2) the prekindergarten programs of the Central Education Agency.	Yes	HHSC	<i>Agree.</i>
(b) The Commissioner of Health and Human Services shall report the results of the initiative prescribed by this provision to the Legislature on or before December 1, 1996.	Yes	HHSC	<i>Agree.</i>

## Status of Prior Management Control Audit Issues

Issue	Status	State Auditor's Comments	Commission Responses
<b>Fiscal Activities (Controls)</b>			
The Commission does not adequately forecast and track revenues.	Resolved	The Commission has taken adequate steps to address this issue.	<i>Agree.</i>
The Commission's cost allocation plan is not structured to maximize federal funding.	Resolved	The Commission has taken steps—improving timeliness of billing and performing follow-ups with agencies that have delinquent payments—which should (if implemented correctly) assist the Commission in enhancing recovery of indirect costs from other HHS agencies.	<i>Agree.</i>
Expenditures have not been adequately monitored and controlled.	Not resolved, with qualifications	The Commission has improved controls over positions and activities relating to financial or accounting activities. However, the Commission has yet to establish policies and procedures over all accounting functions.	<i>Disagree. Copies of policies and procedures in effect at the time of the audit were proved to the SAO.</i>
Controls are weak over fixed assets.	Resolved	The Commission has established and implemented controls over the recording and safeguarding of fixed assets.	<i>Agree.</i>
<b>Grants And Contracts (Fiscal Monitoring)</b>			
The Commission has not formalized procedures for serving as fiscal agent for \$55 million in federal funds.	Not resolved, with qualifications	Although no policies and procedures are in place for the Commission's oversight of Empowerment Zones/Enterprise Communities, the existing memos of agreement (MOA) are an acceptable alternative.  No policies and procedures are in place for contract management regarding HHS agencies.	<i>Disagree. At the time of the audit, HHSC policy 6.0, Contracts and Grants Management was in effect and followed by contract management staff for <u>all</u> contracts and grants, including EZ/EC. The MOA supplements the policy. HHSC neither has the duty nor the authority to promulgate policies and procedure for contract management by other HHS agencies.</i>

Issue	Status	State Auditor's Comments	Commission Responses
The Commission is not in compliance with contract requirements for certain grant funds.	Not resolved, with qualifications	The Commission has made great strides in complying with its contract management monitoring requirements. However, the Commission has yet to develop and implement contract management policies and procedures for HHS agencies.	<i>Disagree. The commission is authorized to promulgate contract management policies for HHSC contracts only. This comment is outside the scope of the prior management control audit.</i>
There is limited oversight regarding the agreement for the Texas Department of Human Services to act as the operating agency for federal Medicaid funds.	Not resolved, with qualifications	The Commission does appear to monitor the federal (Medicaid) funds management responsibilities of DHS. However, no policies and procedures are in place for the contracting system used by HHS agencies.	<i>Disagree. This comment is also outside the scope of the original audit. Again, the commission is not authorized to promulgate policies and procedures for contract management by other HHS agencies.</i>
<b>Multi-Agency Information System Projects (Oversight and Control)</b>			
The integrated database network (IDBN) pilot project is not fully implemented.	Resolved	The IDBN pilot project is fully operational.	<i>Agree.</i>
Plans are not developed for a post-implementation review of the integrated data base network pilot.	Not resolved, with qualifications	A post-implementation review was initiated. However, it was not completed. It still requires a cost/benefit analysis and results of a user survey.	<i>Disagree. This has been published.</i>
The Commission has not had a formal system to gather feedback and clearly communicate results on multi-agency (information system) projects.	Resolved, with qualifications	<p>The Commission has:</p> <ul style="list-style-type: none"> <li>- Increased information resource management (IRM) personnel allocation for coordinating and managing multi-agency IR initiatives</li> <li>- Focused responsibilities of its IR Associate Commissioner position to full-time statewide planning and coordination</li> <li>- Prepared and disseminated periodic status reports regarding HHS IRM efforts.</li> </ul> <p>However, implementation results appear weak according to House Bill 7 status review.</p>	<i>Agree.</i>

Issue	Status	State Auditor's Comments	Commission Responses
<b>Operational Activities (Controls)</b>			
Policies and procedures have not been adopted for all key functional areas.	Not resolved, with qualifications	Only a small portion of the planned policies and procedures have been implemented. The Commission does not have a policies and procedures implementation schedule. In addition, it was noted that the Commission has not provided adequate oversight/guidance to staff responsible for this effort. For example, the Commission's policy on how to write effective policies and procedures is not being communicated to policy writers.	<i>Disagree. At the time of the audit, 39% of all policies had been updated. Original policies continue to be in effect. All policies will be updated by 8/31/97. Policy 3.0, which has been in effect since 3/29/96 and was distributed to all divisions, provides the needed oversight. All draft policies are routed for comment with final policies distributed to all divisions.</i>
Commission's automation system has internal control weaknesses.	Resolved, with qualifications	Appropriate measures have been taken to affect internal control over automation including password usage, assignment of Novell "supervisor-level" accounts, LAN account and password removal for terminated employees, and reviews of LAN utility reports. However, the logistics of the off-site backup storage procedures have yet to be completed, noting that the system already has a documented plan, backup drives and tapes, and a storage facility.	<i>Disagree. Backup storage procedures are complete. Backup tapes are made daily and are taken to a secure facility by Texas Rehabilitation Commission (TRC) staff, in accordance with the agreement between the two agencies.</i>
The Commission is not in compliance with historically underutilized business (HUB) guidelines.	Resolved	The Commission has taken corrective action to become in compliance with HUB guidelines.	<i>Agree.</i>
<b>Performance Measures Information (Management)</b>			
The Commission's performance measure definitions are not effectively documented.	Resolved	The Commission has taken corrective action to define, document, and monitor performance measures information.	<i>Agree.</i>
Performance measures have not been utilized by the Commission.	Resolved	The Commission appears to have taken adequate steps to monitor and use this information. In addition, this information is disseminated quarterly to applicable (internal and external) personnel.	<i>Agree.</i>

Issue	Status	State Auditor's Comments	Commission Responses
<b>Human Resources (Management)</b>			
The human resources department does not consistently monitor the entire recruitment and selection process.	Resolved, with qualifications	The Commission has (at present) generally resolved concerns raised for this issue. However, it was noted that the recruitment and selection procedures are currently in draft form, and have yet to be formally adopted by Commission's management.	<i>Disagree. The commission has final policies on recruitment, selection, and hiring. HHSC is undergoing a major revision of HR policies to achieve the goals of the HHS enterprise for uniform policies, procedures, and forms.</i>
Documentation of employee performance is inconsistent, and the appraisal system is not being monitored for rating accuracy and consistency.	Resolved, with qualifications	The Commission follows adequate employee appraisal policies and procedures. However, these policies and procedures are in draft form and have not been formally accepted by Commission's management.	<i>Disagree. Performance appraisal policies are in effect and part of the HR handbook. Commission staff have recommended to executive management a more participatory system which is under second review.</i>

## Background Information

### Health and Human Services Enterprise Profile

#### *Agencies Included*

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

The Legislature had also originally placed the Texas Youth Commission under the Health and Human Services Commission, but removed it in 1993.

*Environment* - Both the Federal Government and state governments exert a heavy influence on the programs and activities of the HHS enterprise. In addition, changes in the State's demography, economy, and geography also significantly impact the needs for health and human services.

*Financial Aspects* - HHS is the second largest function of Texas state government with appropriations for the 1996-1997 biennium totaling approximately \$26 billion or 33 percent of all state appropriations. The majority of these appropriations are associated with federal entitlement programs under Medicaid and Aid to Families with Dependent Children (AFDC). Additionally, the Medicaid's Disproportionate Share program (\$1.5 billion in fiscal year 1995) and the food stamps disbursements (\$2.3 billion in fiscal year 1995) also impact total HHS enterprise funds.

*Human Resources* - Based on expenditures data, the total number of full-time employees (FTEs) in the HHS enterprise in fiscal year 1995 was approximately 62,100. Targeted reductions established by the Legislature are expected to reduce the number of budgeted FTEs for fiscal year 1996 to approximately 61,400. The HHS enterprise also relies on contractual and volunteer resources in fulfilling its mission.

Source: Commission Strategic Plan 1997-2001

### Agency Profile

The Health and Human Services Commission was created by the Legislature in 1991 as an umbrella organization to integrate the strategic planning and budgeting processes for the State's health and human services agencies. Unlike most other commissions in Texas state government, the Health and Human Services Commission has no governing board, and its commissioner holds final authority over its operations.

The commissioner of the Commission has the authority and responsibility to arbitrate and decide interagency disputes and to enforce state agencies' compliance with the Commission's consolidated strategic plan and consolidated budget. The Commission, among other things, is charged with improving service delivery through:

- Local and regional planning
- Service integration
- Integrated automation
- Coordinated referral and case management
- Maximization/management of all health and human services enterprise funds, including medical assistance funds

The commissioner can review and comment on health and human services agencies' operating budgets and transfers among budget strategies. And, if needed, request the transfer of funds from one agency to another, and utilize other health and human services agency's staff to accomplish its mandate(s).

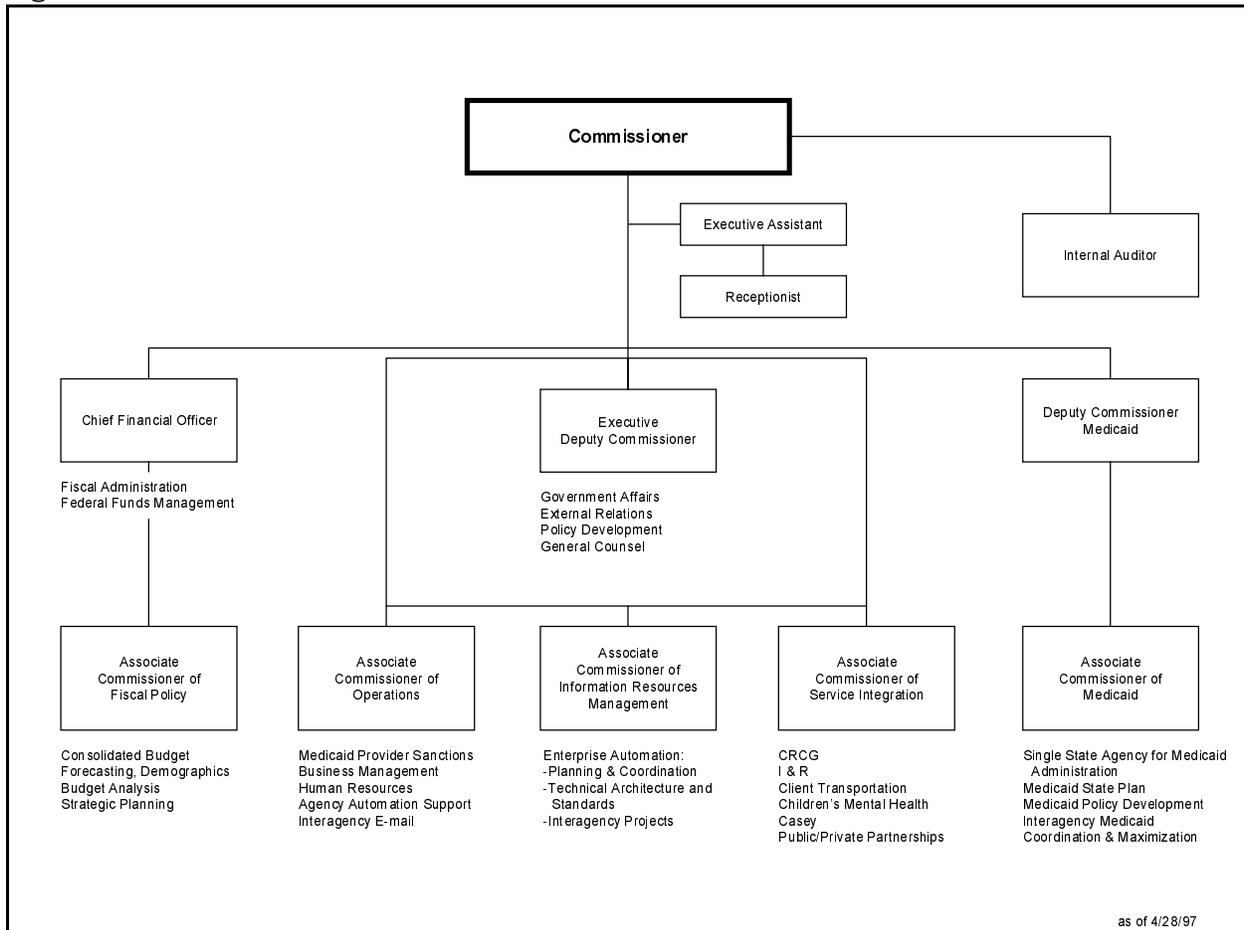
To deal with the many complex and varied challenges it faces, the Commission has been staffed with a well-paid, highly educated, and diverse workforce.

Health and Human Services Commission Human Resources FTE Profile Fiscal Year 1996				
Budgeted	87.6			
Authorized	84			
Filled	85.6 (1.6 Temporary)			
Education	33 with Bachelor's Degrees 20 with Master's Degrees 6 with Ph.D., J.D., or M.D.			
			Annual Salary Range	Average Annual Salary
Exempt Positions	12 (14.3% of Authorized FTEs)		\$60,000 to \$156,000	\$80,000
Senior Classified Positions (Level 19 to Level 21)	32 (38% of Authorized FTEs)		\$37,000 to \$50,000+	\$43,000
			Administrative	Professional
Diversity	8%	African American	0%	10%
	16%	Hispanic	10%	16%
	76%	Female	50%	75%

Source(s): Commission Organizational Chart, State HRIS report December 1996, Commission Strategic Plan 1997-2001

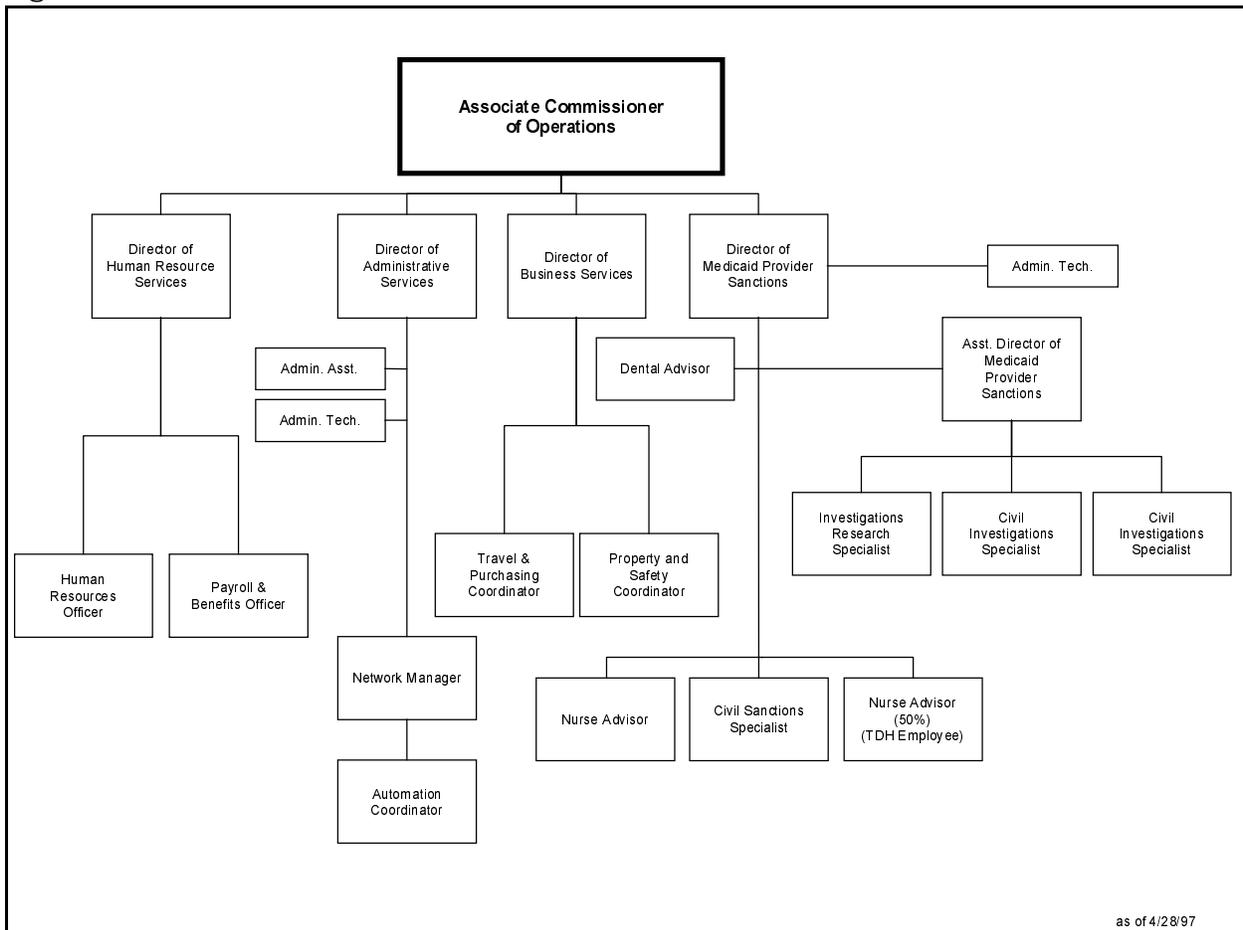
# Organizational Structure

Figure 1



as of 4/28/97

Figure 2



as of 4/28/97

Figure 3

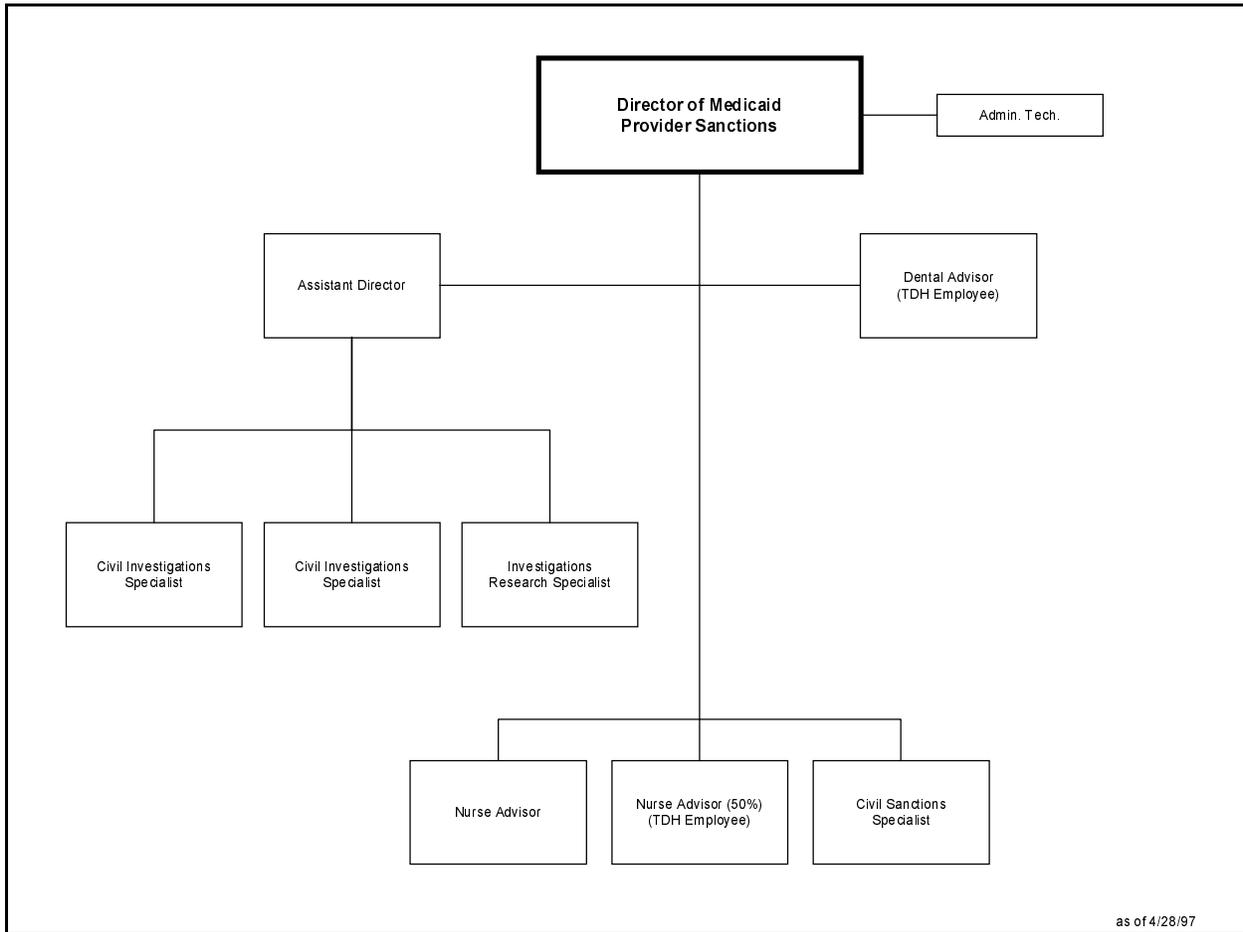


Figure 4

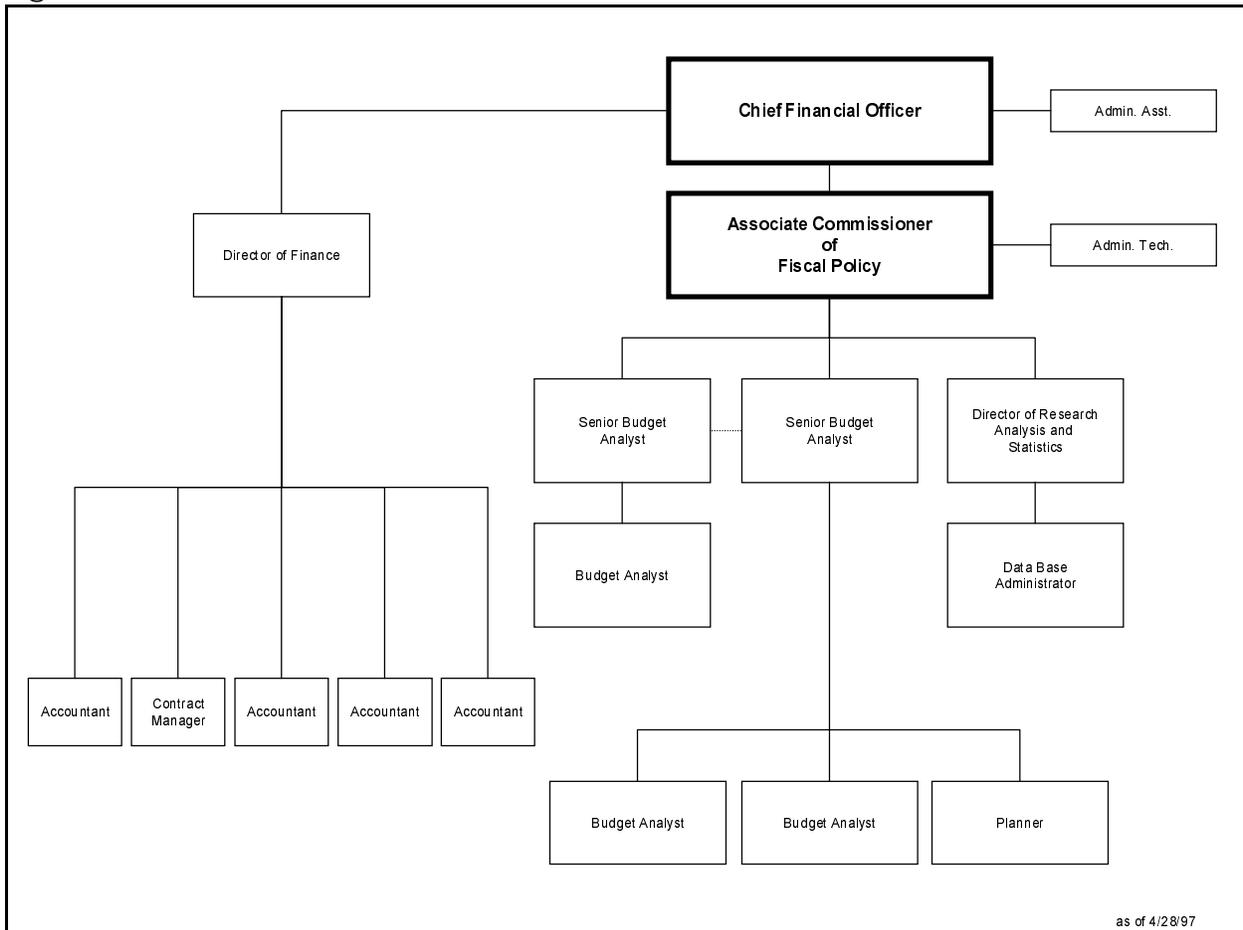


Figure 5

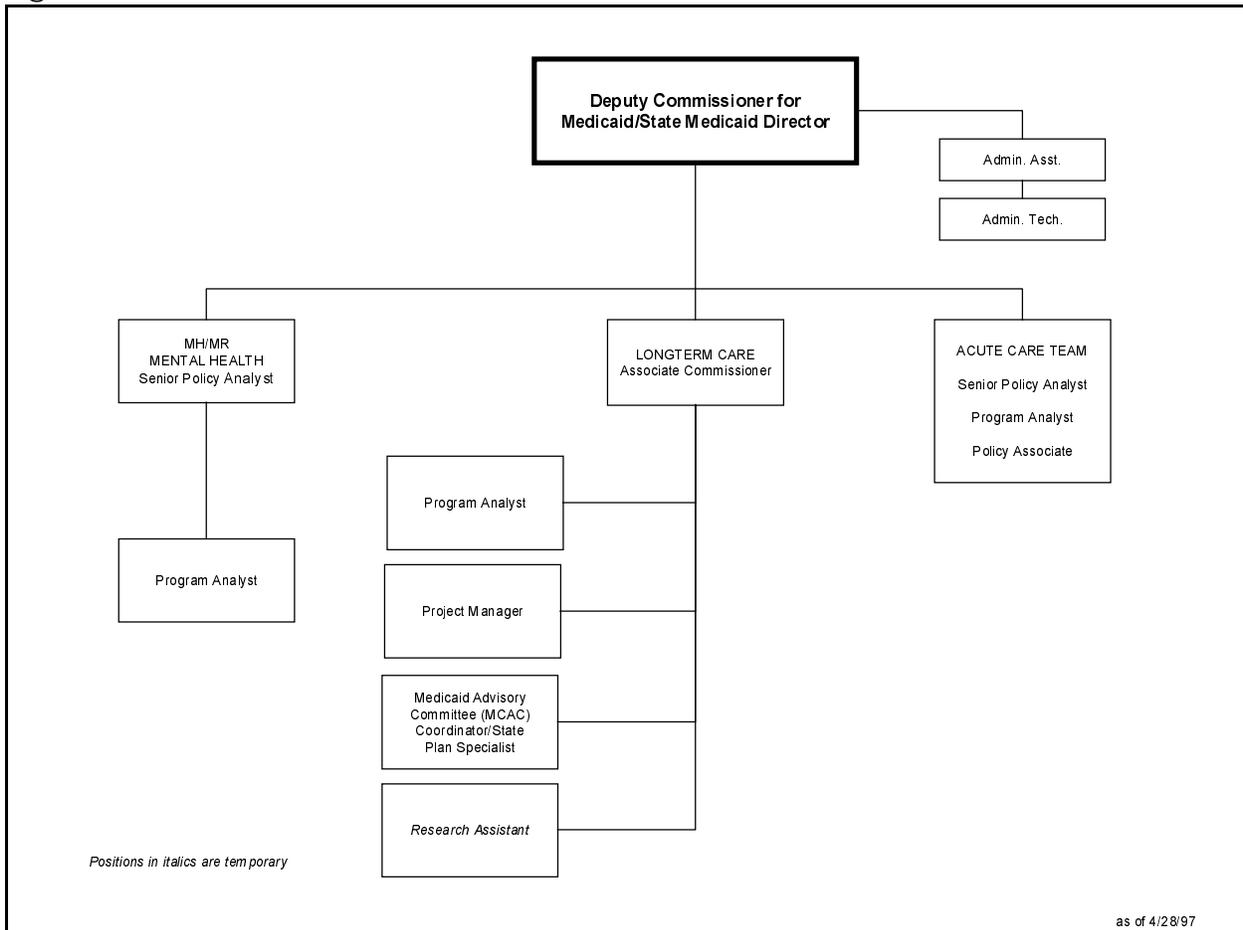


Figure 6

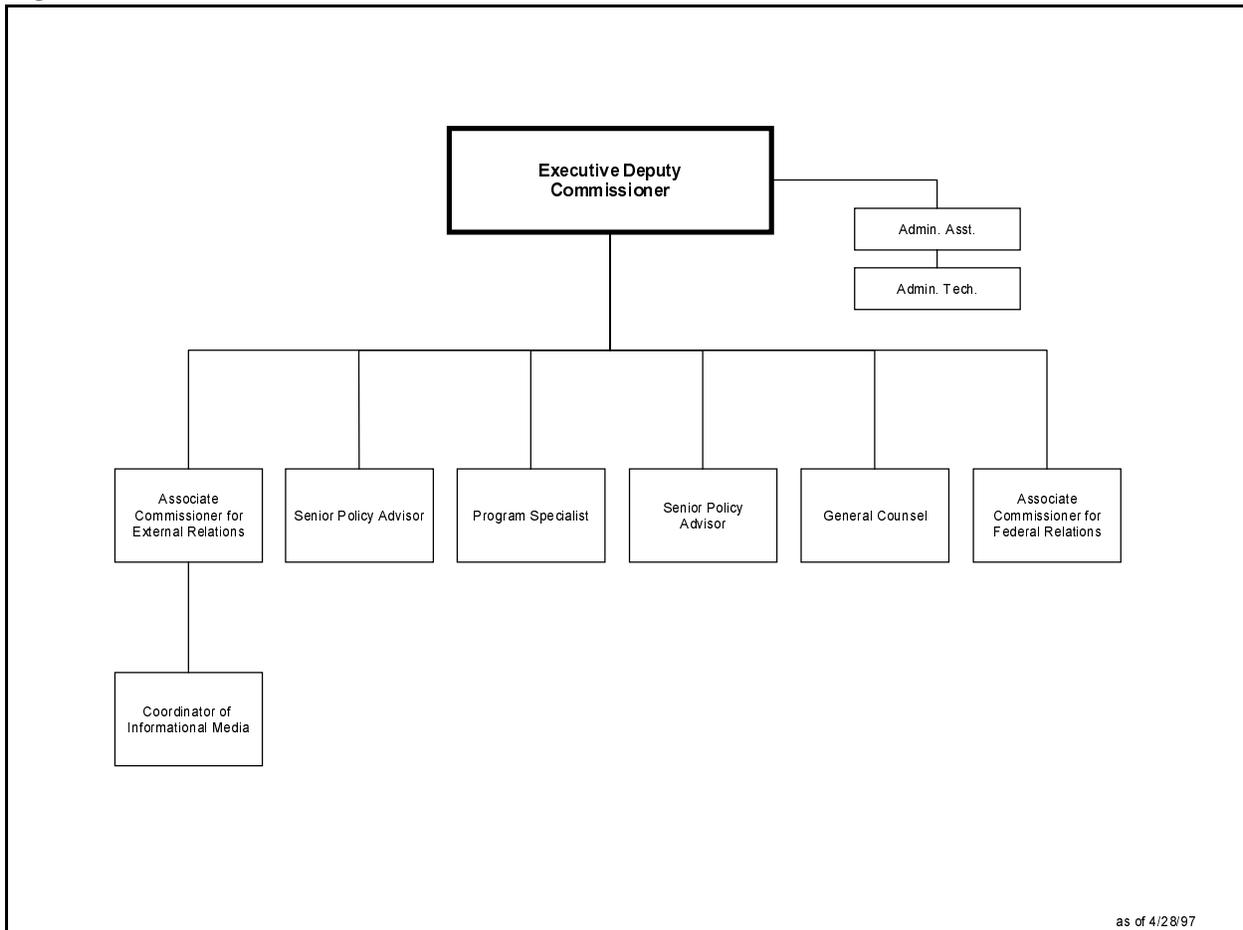


Figure 7

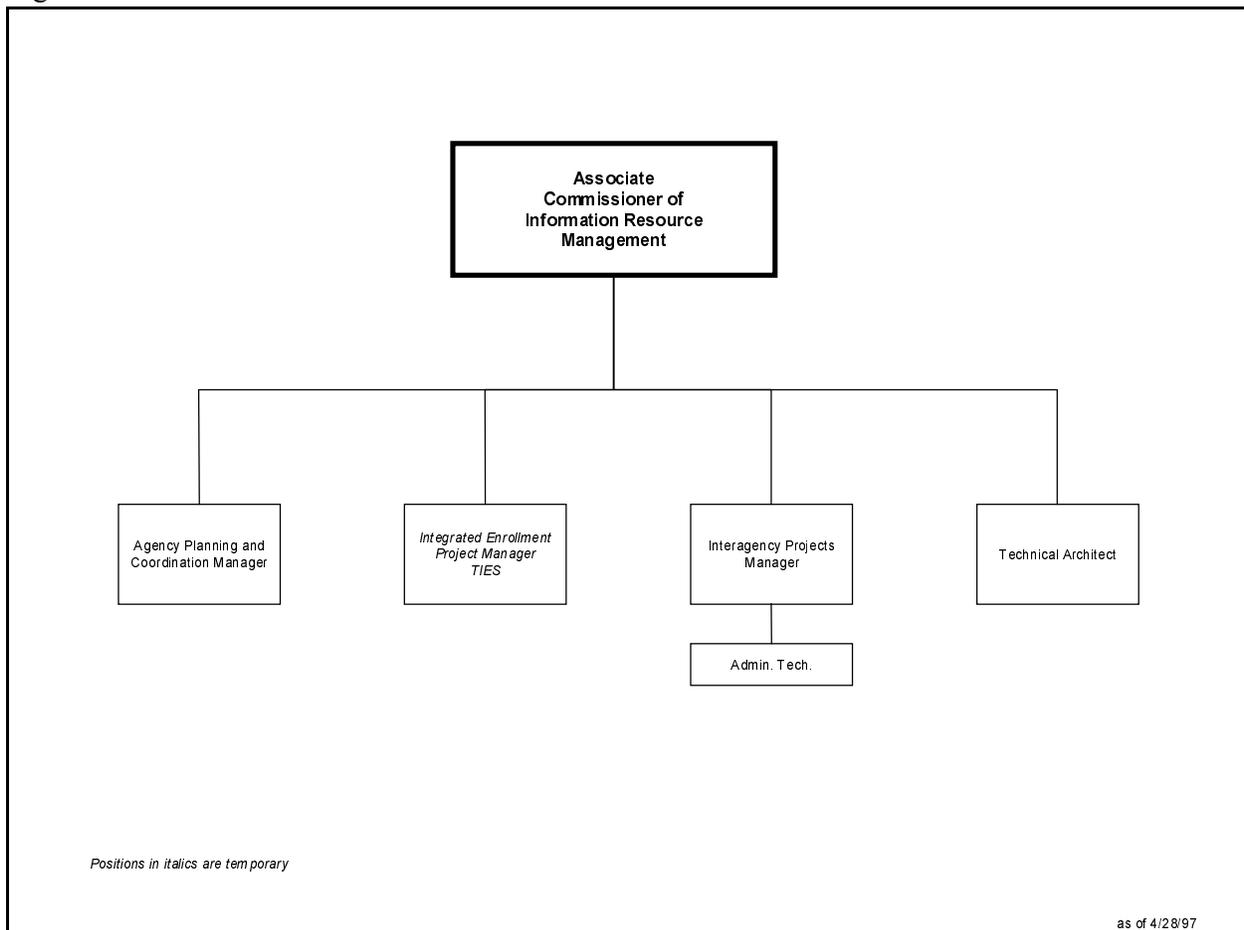
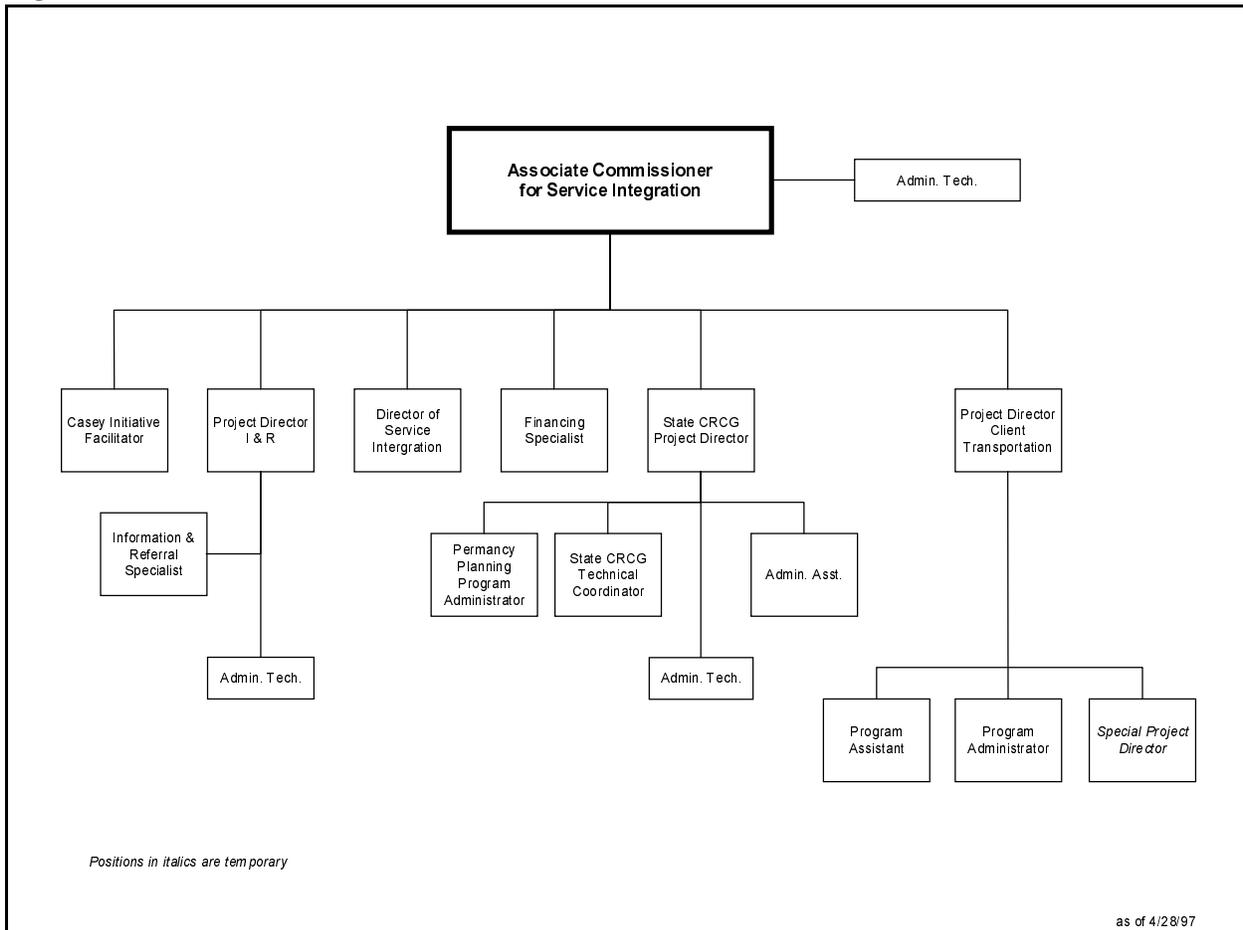


Figure 8



**Financial Information**

<b>Texas Health And Human Services Commission Fiscal Year 1996 Departmental Budgets versus Expenditures <sup>1</sup></b>				
<b>Department or Activity</b>	<b>Primary Account</b>	<b>Amount</b>	<b>Year-To-Date Expenditures (includes Year-to-Date encumbrances)</b>	<b>Year-To-Date Budgets</b>
Commissioner's Office	Salaries	\$204,366	\$242,104	\$257,147
Legislative and Legal Affairs	Salaries	\$415,782	\$492,415	\$381,437
Operations	Salaries	\$753,498	\$929,157	\$1,027,904
Information Resource Management	Salaries	\$231,794	\$325,398	\$338,417
IDBN-Casey II	Professional Fees and Services	\$325,957	\$325,957	\$345,000
Integrated Enrollment	Professional Fees and Services	\$1,056,235	\$1,062,857	\$1,184,984
Fiscal Policy	Salaries	\$424,564	\$520,043	\$580,463
State Medicaid Office	Salaries	\$378,014	\$542,039	\$578,756
Medicaid Sanctions	Salaries	\$146,272	\$190,498	\$275,382
Service Integration	Salaries Professional Fees and Services	\$132,605 \$36,836	\$194,672	\$201,797
Casey Project	Grants	\$447,733	\$491,850	\$737,812
CRCG	Salaries	\$109,534	\$163,750	\$165,000
I&R Grant -Federal Funds	Salaries Professional Fees and Services	\$45,199 \$37,322	\$113,231	\$152,973
Client Transportation	Salaries	\$108,596	\$121,886	\$124,398
Children's Bureau	Salaries	\$46,839	\$54,250	\$71,151
Headstart	Salaries	\$89,517	\$134,448	\$187,481
Central Administration Fd.	Computer Equipment and Software	\$62,362	\$164,301	\$230,795
TOTALS	Salaries	\$3,886,580	\$7,352,342	\$7,214,731
	Professional Fees and Services	\$1,456,350		
	Grants	\$443,733		
	Computer Equipment and Software	\$62,362		

Source: Commission Fiscal Office

<sup>1</sup> Expenditure amounts do not include fiscal year 1996 activity that occurred in fiscal year 1997. Also, accounts that are deemed immaterial (less than \$50,000) or those that relate to federal pass-through funds (account number 00401 Enterprise Zones) have also not been included.

General Appropriations		
Goal/Strategy	Appropriated and Requested Appropriation Amounts	
Agency Programs, Services and Operations	1992 <sup>1</sup> \$2,000,000 1993 <sup>1</sup> \$2,500,000	
<b>A. GOAL: COORDINATE SERVICES</b> The Health and Human Services Commission will facilitate and enforce coordinated delivery of health and human services in a manner that uses an integrated system to determine client eligibility; maximizes the use of federal, state, and local funds; and that emphasizes coordination, flexibility and decision making at the local level.		
<b>A.1.1 DEVELOP HEALTH AND HUMAN SERVICES SYSTEM</b> - Develop integrated service delivery system for health and human services agencies by September 1, 1995.	1994 <sup>1</sup> \$3,897,923 1995 <sup>1</sup> \$3,894,076 1998 <sup>2</sup> \$2,156,632 1999 <sup>2</sup> \$2,156,632	
<b>A.1.1. SERVICE DELIVERY</b> - Direct and evaluate the improvements of the delivery of health and human services.	1996 <sup>1</sup> \$2,048,397 1997 <sup>1</sup> \$2,050,586	
<b>A.1.2. PROGRAM COORDINATION</b> - Improve efficiency and effectiveness of health and human services through program collaboration and maximization of resources.	1996 <sup>1</sup> \$1,544,133 1997 <sup>1</sup> \$1,544,133	
<b>A.1.2. GRANTS MANAGEMENT</b>	1998 <sup>2</sup> \$5,683,328 1999 <sup>2</sup> \$5,683,328	
<b>A.1.3. STATE MEDICAID OFFICE</b> - Set the overall policy direction of the state Medicaid program, manage inter-agency initiatives to maximize federal dollars and improve quality of services by serving as the single state Medical agency.	1996 <sup>1</sup> \$1,050,653 1997 <sup>1</sup> \$1,050,653 1998 <sup>2</sup> \$856,580 1999 <sup>2</sup> \$856,580	
<b>B. GOAL: SALARY INCREASE/INDIRECT ADMINISTRATION</b>		
<b>Section 146, 1993 SALARY INCREASE</b>	1994 <sup>1</sup> \$66,192	
<b>B.1.1. INDIRECT ADMINISTRATION</b>	1996 <sup>1</sup> \$568,941 1997 <sup>1</sup> \$562,232 1998 <sup>2</sup> \$1,182,127 1999 <sup>2</sup> \$1,182,127	

<sup>1</sup> Appropriated per General Appropriations Act, excluding amounts for riders and including administrative costs within strategies.

<sup>2</sup> Requested per Commission LAR submitted to LBB and GBO on 8/16/96

