Texas Health and Human Services Commission

Program Descriptions

Appendix A

Medicaid

Aged and Disabled Risk Groups

Program Description:

This program includes the hospital, physician, and other medical services provided to eligible aged, disabled, blind and Medicare-related recipients. Services are provided either: 1) through a Fee-For-Service (FFS) fiscal agent arrangement with Affiliated Computer Services (ACS) or 2) through a managed care health delivery system consisting of two health care delivery models – a FFS enhanced Primary Care Case Management (PCCM) or an at-risk, capitated health plan – HMO. Under Title XIX, Medicaid medical services are legally mandated entitlement services.

Eligibility:

Aged & Medicare Related:

- Individuals over age 65 and any individual with Medicare coverage

Disabled & Blind:

- Individuals who are blind or disabled, the majority of which receive Supplemental Security Income (SSI).

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$505.4	$570.5	$686.9	$702.3	$699.7	$772.6
Federal Funds	806.1	901.5	947.0	1,058.1	1,159.0	1,192.3
Other Funds	.6	.4	0	0	0	0
Total All Funds	**$1,312.1**	**$1,472.4**	**$1,633.9**	**$1,760.4**	**$1,858.7**	**$1,964.9**

Aged and Disabled Risk Groups (continued)

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Aged Mo Avg. Cost	$81.75	$87.65	$81.59	$105.07	$128.02	$142.57
Aged Mo Recip Months	307,825	309,596	312,066	316,143	321,629	325,167
Disabled/Blind Mo Avg. Cost	$458.26	$506.53	$539.08	$573.33	$549.66	$523.94
Disabled/Blind Mo Avg. Recip Month	181,812	185,615	194,641	208,957	220,962	232,010

Date of Last Audit: State Auditor's Office November 2003

04-011/An Audit Report on The Health and Human Services Commission's Monitoring of Managed Care Contracts

Findings:

The HHSC has not ensured the timely collection of experience rebates and has reduced the amount of these rebates without proper verification and monitoring. The HHSC has not obtained audits of Medicaid or CHIP MCOs. The HHSC has not effectively managed and integrated Medicaid and CHIP staff since the transfer of Medicaid programs to the Commission.

Status:

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TANF Adults and Children Risk Groups

Program Description:

This program includes the hospital, physician, and other medical services provided to eligible TANF-related adults and children. Services are provided either: 1) through a Fee-For-Service (FFS) fiscal agent arrangement with Affiliated Computer Services (ACS) or 2) through a managed care health delivery system consisting of two health care delivery models – a FFS enhanced Primary Care Case Management (PCCM) or an at-risk, capitated health plan – HMO. Per terms of the contract with ACS, ACS receives a premium based on the number of eligible clients per month and who are served via FFS. ACS is also paid fixed and variable fees based on the number of claims Under Title XIX, Medicaid medical services for these recipients are legally mandated entitlement services.

Eligibility:

TANF (formerly AFDC) Adults:

- Individuals age 21 and over that are eligible for the TANF program. This group may include some women who are pregnant.

TANF (formerly AFDC) Children:

- Individuals under age 21 that are eligible for the TANF program. This group may include some women who are pregnant and children less than one year of age.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$211.6	$231.4	$285.1	$271.9	$252.9	$258.5
Federal Funds	336.0	356.0	428.1	433.0	420.2	398.3
Other Funds	1.0	.8	0	0	0	0
Total All Funds	**$548.6**	**$588.2**	**$713.2**	**$704.9**	**$673.1**	**$656.8**

TANF Adults and Children Risk Groups (continued)

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
TANF Children Mo Avg. Cost	$77.84	$84.27	$96.40	$101.60	$99.65	$98.25
TANF Children Mo Avg. Recip Months	341,031	343,772	361,834	374,821	353,004	354,162
TANF Adults Mo Avg. Cost	$167.12	$180.35	$202.18	$204.50	$209.03	$206.88
TANF Adults Mo Avg. Recip Months	106,724	106,227	113,448	116,710	93,464	96,770

Date of Last Audit: State Auditor's Office November 2003

04-011/An Audit Report on The Health and Human Services Commission's Monitoring of Managed Care Contracts

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Pregnant Women Risk Group

Program Description:

This program includes the hospital, physician, and other medical services provided to eligible pregnant women. Services are provided either: 1) through a Fee-For-Service (FFS) fiscal agent arrangement with Affiliated Computer Services (ACS) or 2) through a managed care health delivery system consisting of two health care delivery models – a FFS enhanced Primary Care Case Management (PCCM) or an at-risk, capitated health plan – HMO. HMOs are paid capitation rates. Under Title XIX, Medicaid medical services for pregnant women up to 133 percent FPL are legally mandated entitlement services.

Eligibility:

Pregnant Women:

- Pregnant women having family income below 158 percent (age 19 or over) or below 185 percent (under age 19) of the Federal Poverty Limit

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$180.6	$241.4	$241.4	$228.3	$275.2	$295.8
Federal Funds	308.8	378.7	365.9	376.7	459.6	458.2
Other Funds	.1	.1	0	0	0	0
Total All Funds	**$489.5**	**$620.2**	**$607.3**	**$605.0**	**$734.8**	**$754.0**

Pregnant Women Risk Group (continued)

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Pregnant Women Mo. Avg. Cost	$491.15	$507.74	$525.75	$526.79	$546.03	$535.41
Pregnant Women Avg. Recip Month	84,393	89,489	96,132	102,736	110,934	117,812

Date of Last Audit: State Auditor's Office November 2003

04-011/An Audit Report on The Health and Human Services Commission's Monitoring of Managed Care Contracts

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Children and Medically Needy Risk Groups

Program Description:

This program includes the hospital, physician, and other medical services provided to eligible newborn infants, children above TANF income eligibility criteria (federal mandate and expansion children), and medically needy persons. Under Title XIX, Medicaid medical services for all of these recipients are legally mandated entitlement services, except the Medically Needy. Services are provided either: through a Fee-For-Service (FFS) fiscal agent arrangement with Affiliated Computer Services (ACS) or through a managed care health delivery system consisting of two health care delivery models – a FFS enhanced Primary Care Case Management (PCCM) or an at-risk, capitated health plan – HMO.

Eligibility:

Newborn:

- Children under age one born to Medicaid-eligible mothers. The premiums for this risk group are broken into two sub-groups:
  - Regular Newborn: Newborn children less than 4 months of age
  - Extended Newborn: Newborn children 4 through 12 months of age

Expansion Children:

- Children under age 18, ineligible for TANF because of the applied income of their stepparents or grandparents
- Children under age one with family income below 185 percent of Federal Poverty Limit
- Children ages 1-5 with family income below 133 percent of Federal Poverty Limit

Federal Mandate Children:

- Children ages 6-18 with family income below 100 percent of Federal Poverty Limit.

Medically Needy:

- Spend Down: Individuals whose family income is below the Medically Needy Standard limit (about 25 percent of poverty) after qualified medical bills are subtracted from their income.

Children and Medically Needy Risk Groups (continued)

- Non-Spend Down: Children under age 18 in families with income between the TANF level (about 17 percent of poverty) and the Medically Needy Standard limit. This group also includes many adults who are parents or guardians of these children as well as parents or guardians of children in some of the other risk groups.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$533.7	$609.6	$768.5	$937.2	$921.9	$1,041.4
Federal Funds	864.1	945.7	1,147.5	1,446.6	1,598.6	1,663.2
Other Funds	2.4	.6	8,2	15.7	35.7	31.1
Total All Funds	**$1,400.2**	**$1,555.9**	**$1,924.2**	**$2,399.5**	**$2,556.2**	**$2,735.7**

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Newborns Mo. Avg. Cost	$476.16	$453.16	`$474.23	$500.64	$490.13	$490.01
Newborn Avg. Recip Months	109,025	115,073	119,030	125,624	135,707	142,221
Expansion Child Mo. Avg. Cost	$122.74	$133.80	$134.46	$144.16	$129.55	$124.06
Expansion Child Avg. Recip Months	293,417	316,490	408,808	565,532	662,234	738,391
Fed Mand Child Mo. Avg. Cost	$45.17	$47.87	$53.83	$61.20	$61.32	$56.55
Fed Mand Child Recip Months	314,013	342,744	438,218	609,796	726,877	817,737

Children and Medically Needy Risk Groups (concluded)

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Medically Needy Mo. Avg. Cost	$616.73	$709.45	$705.70	$626.43	$424.51	$416.76
Medically Needy Avg. Recip Months	21,152	25,740	33,364	45,657	43,563	52,270

Date of Last Audit: State Auditor's Office November 2003

04-011/An Audit Report on The Health and Human Services Commission's Monitoring of Managed Care Contracts

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Medicare Payments

Program Description:

This program includes the hospital, physician, and other medical services provided to Medicaid-eligible aged and disabled clients who are also eligible for Title XVIII Medicare coverage. Services are provided through the payment of premiums to the Social Security Administration, and through the payment of Medicare coinsurance and deductibles by an independent contractor. Dual eligible Medicare/Medicaid clients utilize Medicare services before utilizing Medicaid services, making this a cost-effective program. Eligibility for the array of Medicare payments depends on income, resource limits, and working enough quarters to qualify for Social Security Payments for Medicare include Part A (hospitalization) and Part B (physician, lab, and outpatient services). The eligibility for Qualified Medicaid Beneficiaries (QMB) requires that a person must be enrolled in Medicare Part A, income cannot exceed 100 percent FPL, and resources cannot exceed twice the resource limit of the Supplemental Security Income (SSI) Program.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$168.6	$180.6	$204.5	$197.1	$226.3	$270.0
Federal Funds	270.4	286.9	292.9	343.2	390.9	421.5
Other Funds	.2	.2	0	0	0	0
Total All Funds	**$439.2**	**$467.7**	**$497.4**	**$540.3**	**$617.2**	**$691.5**

Medicare Payments (continued)

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Avg. SMIB (Part B) Premium Per Month	$45.50	$48.51	$52.69	$57.16	$63.99	$71.09
SMIB (Part B) Recipient Mo. per Mo.	373,829	390,101	399,405	422,949	440,130	457,736
Avg. Part A Premium Per Mo.	$301.53	$298.52	311.01	315.48	$332.57	$352.88
Part A Recipient Mo. per Mo.	44,565	45,465	46,058	46,586	46,846	47,565
Avg. Qualified Medicare Beneficiaries per Mo.	$124.29	$112.80	$130.58	$129.50	$120.45	$123.29
Number of Qualified Medicare Beneficiaries	46,430	48,816	50,938	56,993	62,156	66,921

Texas Health Steps Medical

Program Description:

Federal law mandates the provision of periodic medical screens to Medicaid children under 21 years of age. Case management services are also provided to children over age one with severe or complex health problems. These medical services are outside of the payments related to risk groups.

Eligibility:

Medicaid children under 21 years of age

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$31.3	$31.3	$30.1	$30.6	$36.7	$42.3
Federal Funds	40.6	43.3	45.6	49.2	61.7	65.6
Other Funds	0	0	0	0	0	0
Total All Funds	**$71.9**	**$74.6**	**$75.7**	**$79.8**	**$98.4**	**$107.9**

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Avg. cost per TH Steps	$86.35	$86.89	$111.64	$117.42	$116.62	$118.85
Client receiving medical checkups in FFS	768,937	712,312	820,066	979,013	1,074,442	1,172,048

Texas Health Steps Medical (continued)

Date of Last Audit: State Auditor's Office November 2003

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Texas Health Steps Dental

Program Description:

Federal law mandates the provision of periodic dental services to Medicaid children under 21 years of age. Both dental and orthodontic services are provided. These medical services are outside of the payments related to risk groups.

Eligibility:

Medicaid children under 21 years of age

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$55.6	$58.0	$77.2	$95.3	$116.2	$136.1
Federal Funds	88.3	91.6	116.8	153.0	195.1	211.3
Other Funds	0	0	0	0	0	0
Total All Funds	**$143.9**	**$149.6**	**$194.0**	**$248.3**	**$311.3**	**$347.4**

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Avg. cost per TH Steps dental client	$234.69	$218.74	$246.34	$264.02	$275.10	$281.49
Num. of TH Steps dental clients served	588,722	658,040	786,607	1,017,016	1,137,383	1,242,092

Texas Health Steps Dental (continued)

Date of Last Audit: State Auditor's Office June 1999

99-036/An Audit Report on Health and Human Services Commission Medicaid Dental Services

Findings:

HHSC has established an adequate process for researching and investigating suspected provider fraud related to Medicaid dental services.

Status:

HHSC agreed to take appropriate action to make some minor improvements.

Also See SAO #04-011 in Texas Health Steps Medical

Medical Transportation

Program Description:

Federal law mandates the provision non-ambulance transportation to eligible Medicaid recipients to and from the nearest appropriate Medicaid allowable service. TXDoT has medical transportation contracts with local taxi companies, community action agencies, county Commissioners' Courts, Councils of Government, metropolitan transit authorities and regions, public schools, Area Agencies on Aging, private corporations, individual contractors who are volunteers, and other for profit and non-profit service organizations. HHSC provides the federal funds to TXDoT who provides the state match for the program.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$15.4	$17.5	$17.6	$19.0	$0	$0
Federal Funds	19.1	25.9	26.1	30.3	35.4	40.8
Other Funds	0	0	0	0	21.1	0
Total All Funds	**$34.5**	**$43.4**	**$43.7**	**$49.3**	**$56.5**	**$40.8**

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Avg. cost	$10.46	$12.57	$14.62	$13.74	$14.83	$16.05
Num. of one-way trips	2,841,928	2,725,422	2,990,000	3,480,000	3,830,000	4,210,000

Medical Transportation (continued)

Date of Last Audit: State Auditor's Office: April 2002

02-037/Audit of the Medical Transportation Program at the Department of Health Medical Transportation

Findings:

The Department of Health (TDH) did not adequately manage its Medical Transportation Program contracts which resulted in clients receiving less than the contractually agreed-upon level of service. TDH did not consistently refer questionable contractor activities to appropriate investigative and legal authorities for fraud investigation. If TDH had been successful in negotiating rates and/or service areas with bidders, the State could have reduced its costs by at least $1.7 million in fiscal year 2002. TDH MTP updated and refined the contractor quality assurance and performance monitoring process to establish consistent monitoring and reporting protocols for use by MTP staff. MTP is monitoring providers on a risk basis. In compliance with TDH policies, MTP has forwarded multiple instances of potential contractor, recipient, and staff fraud to the TDH Office of Criminal Investigations (OCI) for evaluation. OCI has the responsibility for evaluating the referrals and, as appropriate, making referrals for further investigation and/or legal action.

Status:

Following completion of the evaluation phase of the responses to pilot FY04 NEMT RFP, TDH contacted contingent awardees in order to negotiate rates, operational areas, and awards to multiple vendors for transportation services so that the best value for the State was obtained.

Family Planning

Program Description:

Medicaid Family Planning services provided to eligible, low-income clients include: health screening; health education; contraception counseling and provision; treatment of minor genitourinary infections; and other health-related counseling and referral. Services are delivered to clients through performance-based contracts by local health departments, medical schools, hospitals, rural health clinics, community health centers, private-nonprofit agencies, regional clinics band by private practitioners enrolled in the Medicaid program. These medical services are outside of the premium arrangement. In addition to Medicaid, there are other Family Planning Services provided by TDH.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$2.9	$2.0	$2.8	$2.2	$2.6	$2.8
Federal Funds	22.4	19.9	24.9	19.7	23.4	25.7
Other Funds	0	0	0	0	0	0
Total All Funds	**$25.3**	**$20.9**	**$27.7**	**$21.9**	**$26.0**	**$28.5**

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Avg. Annual Cost per family Planning client	$145.15	$143.09	$145.62	$126.90	$116.71	$116.69
Number Adults & Adolescents receiving Fam. Planning Svcs	168,030	158,123	176,929	205,538	224,146	245,783

Family Planning (continued)

Date of Last Audit: State Auditor's Office November 2003

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EPSDT – Comprehensive Care Program (CCP)

Program Description:

This program includes the hospital, physician, and other medical services provided to eligible Medicaid children under the age of 21 that are not covered or provided under the State Medicaid Plan. The Omnibus Budget Reconciliation Act of 1989 requires States to provide diagnostic/treatment services for conditions identified through a screen performed by the Early and Periodic Screening, Diagnosis, and Treatment program or other health care encounter. These services must be federally allowable Medicaid services and are services that are beyond the scope and durational limits of services covered under the insured premium arrangement. Some services covered under the legislation include freestanding psychiatric hospitals, freestanding inpatient rehabilitation, durable medical equipment/supplies, extended hospital stays, private duty nursing, and speech, occupational, and physical therapies. Also included are administrative services incurred by the Medicaid contractor for the processing of CCP claims.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$65.1	$78.5	$85.6	$94.6	$123.4	$153.1
Federal Funds	117.4	121.8	127.4	169.5	207.9	238.8
Other Funds	.1	.1	0	0	0	0
Total All Funds	**$182.6**	**$200.4**	**$213.0**	**$264.1**	**$331.3**	**$391.9**

EPSDT – Comprehensive Care Program (CCP) (continued)

Date of Last Audit: State Auditor's Office November 2003

04-011/An Audit Report on The Health and Human Services Commission's Monitoring of Managed Care Contracts

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Cost-Reimbursed Services

Program Description:

Some medical services and payments are not risk group specific.

Federally Qualified Health Centers – Medicaid reimbursement is made for services (e.g., comprehensive primary and preventive services, health education and mental health services) provided by physicians, physician assistants, nurse practitioners, clinical psychologists, clinical social workers, and other Medicaid ambulatory services.

Undocumented Aliens – Federal law mandates Medicaid coverage for aliens residing illegally in the U.S. with an emergency condition and meet all other Medicaid eligibility criteria. Legal alien residents with an emergency condition who met all Medicaid eligibility requirements except citizenship must also be covered.

School Health and Related Services Administration – HHSC reimburses administrative services incurred for processing claims by the Medicaid fiscal agent contractor; and school districts and school cooperatives in the federal share of medically necessary services to Medicaid-eligible children under 21.

Medicaid Substance Abuse Services – Texas Commission on Alcohol and Drug Abuse licensed chemical dependency treatment facilities are eligible to enroll in the Medicaid Program to treat persons under the age of 21 on an outpatient basis

Upper Payment Limit (UPL) – Federal Medicaid regulations allow certain providers to receive additional reimbursements for the difference between what Medicare and Medicaid pays (referred to as the Upper Payment Limit). In FY2002, Texas obtained federal approval to implement a UPL program. The first UPL payments were made in FY2003. Texas pays certain eligible urban and rural hospitals from local funds (intergovernmental transfers) that match federal Medicaid funds..

Graduate Medical Education - Medicaid provides reimbursements to teaching hospitals to cover part of the physician's graduate training. Funding for GME in the 2004-05 biennium is dependent upon receipt of additional unclaimed lottery proceeds in excess of what was estimated by the Comptroller in the *Biennial Revenue Estimate*.

Cost-Reimbursed Services (continued)

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$82.7	$88.7	$137.3	$118.7	$151.1	$199.8
Federal Funds	259.8	151.4	201.4	540.4	374.9	404.0
Other Funds	2.0	6.8	0	174.2	80.3	60.3
Total All Funds	**$344.5**	**$246.9**	**$338.7**	**$833.3**	**$606.3**	**$664.1**

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Avg. alien cost per recipient mo.	$2,466.29	$2,613.83	$2,832.88	$2,960.81	$2,999.00	$3,080.02
Avg. num. of aliens receiving emergency medical services	5,093	6,277	7,778	8,890	9,261	10,650

Date of Last Audit: State Auditor's Office July 2003

03-043/An Audit of National Heritage Insurance Company Accounts Receivable, Claims Counts, and Selected Trust Funds Related to Administering Medicaid Claims for the Health and Human Services Commission

Findings:

The analysis of the fund balances in NHIC's Incurred Claims Liability Reserve Fund and its Risk Stabilization Reserve Fund did not identify any material errors. The review of NHIC's investment and cash management practices related to these two funds did not identify any significant issues.

Status:

No recommendations were made.

State of Texas Access Reform (STAR) - STAR+PLUS

Program Description:

STAR+PLUS is a Medicaid managed care pilot designed to integrate primary, acute, and long-term care services into one consumer-driven managed care system; to ensure that clients receive the appropriate level of care in the least restrictive setting, consistent with their personal health and safety; to improve access to health care and improve the quality of that care. The STAR+PLUS program is aimed at recipients with chronic and complex conditions who need more than doctor, lab, x-ray, and hospital services.

STAR+PLUS is the response to Texas Senate Concurrent Resolution 55, which directed the state to develop and implement an acute and long-term care integrated model in a demonstration pilot program. STAR+PLUS operates under authority of 1915(b) and 1915(c) waivers covering all primary, acute, and long-term care Medicaid services for SSI/MAO clients,

Eligibility:

The STAR+PLUS pilot is for the Aged and Disabled Medicaid population in Harris County.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$97.5	$85.5	$90.7	$95.6	$112.8	$124.8
Federal Funds	155.4	131.6	136.6	153.1	189.2	193.6
Other Funds	0	0	0	0	0	0
Total All Funds	**$252.9**	**$217.1**	**$$227.3**	**$248.7**	**$302.0**	**$318.4**

State of Texas Access Reform (STAR) - STAR+PLUS (cont.)

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Avg. number of Aged and Medicare-eligible Recipients per mo: STAR+PLUS Mgd Care	26,765	26,359	27,510	28,662	29,312	30,186
Avg. number Disabled and Blind Recipients per Mo: STAR+PLUS Mgd Care	21,981	21,112	21,094	21,978	23,224	24,493
Avg. mo cost per aged and Medicare-elig Recip: STAR+PLUS Mgd Care	$234.29	$159.07	$177.67	$199.77	$254.83	$263.71
Avg. Mo. Cost per Disabled and Blind Recip: STAR+PLUS Mgd Care	$671.64	$657.09	$651.42	$661.17	$753.89	$758.33

State of Texas Access Reform (STAR) - STAR+PLUS (cont.)

Date of Last Audit: State Auditor's Office November 2003

04-011/An Audit Report on The Health and Human Services Commission's Monitoring of Managed Care Contracts

Findings:

The HHSC has not ensured the timely collection of experience rebates and has reduced the amount of these rebates without proper verification and monitoring. The HHSC has not obtained audits of Medicaid or CHIP MCOs. The HHSC has not effectively managed and integrated Medicaid and CHIP staff since the transfer of Medicaid programs to the Commission.

Status:

HHSC developed and implemented policies and procedures for experience rebates monitoring and reporting. HHSC has drafted an RFP to procure audit services to examine the financial information of 15 CHIP plans for contracts extending from May 2000 through August 2003 and 18 Medicaid plans for contracts in effect from September 1999 through August 2003 in order to verify the information used to calculate experience rebates. Based on the vendor's final reports, HHSC's Health Plan Operations will require MCO modifications to financial statistical reports (FSR) and will collect any experience rebate amounts owed to state, if applicable. Workgroups were formed and have been meeting to develop Agency-wide contract processes and procedures, including HPO contract amendments, and should be completed by May 2004. The Medicaid/CHIP Transformation Project to redesign and improve all business processes is approximately 2/3 complete. When the redesigned processes are implemented, employees' roles and tasks will change to meet those new processes.

Vendor Drug Program

Program Description:

Drugs are another services excluded from the fiscal agent arrangement. HHSC purchases and provides prescription medications, as prescribed by the treating physician, through contracted pharmacies to indigent Texans who qualify for Medicaid. The provision of prescription drugs to these clients requires HHSC to coordinate with the clients, physicians, pharmacists, drug wholesalers, distributors, manufacturers, the federal government, and other State agencies. This program is currently collecting rebate revenues from drug manufacturers as negotiated by the federal government.

Medicaid eligibility typically determines any limitations on the number of prescriptions received. Federal law mandates that Medicaid-eligible children, pregnant women, and nursing facility residents have no drug limitation. In Texas, Medicaid-eligible adults enrolled in managed care, CLASS and CBA waiver adults, also have unlimited prescriptions.

Generally, non-managed care adults and other community care programs have a limit of three prescriptions per month.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$432.1	$510.2	$618.5	$753.1	$836.2	$1,002.5
Federal Funds	692.6	800.9	933.8	1,172.3	1,400.5	$1,553.6
Other Funds	0	0	0	0	0	0
Total All Funds	**$1,124.7**	**$1,311.1**	**$1,552.3**	**$1,925.4**	**$2,236.7**	**$2,556.1**

Vendor Drug Program (continued)

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Avg. Cost per Medicaid Prescription	$42.79	$47.68	$51.65	$55.77	$60.05	$64.21
Total Medicaid Prescriptions Incurred	26,245,401	27,706,197	29,946,750	34,097,754	36,949,047	39,646,427

Date of Last Audit: State Auditor's Office April 2003

03-029/An Audit Report on The Health and Human Services Commission's Prescription Drug Rebate Program

Findings:

HHSC lacks accurate information on outstanding rebate balances. A variety of issues has led to HHSC's inability to determine with certainty the amount or rebate revenue drug labelers owe to the State. Rebate collection and dispute resolution processes are not efficient and result in delays, backlogs, and rework. HHSC has not established performance metrics or standardized methods for assessing the performance of the Program.

Status:

Enhancements to the Drug Rebate Database have been made to provide the necessary current rebate information and monthly management reports. An RFP for a payment posting project (PPP) contract to update the Drug Rebate Database with information dating back to 1/91 has been developed. HHSC has implemented new policies and procedures for the processing of drug rebates. Performance measures are currently being developed for assessing the performance of the Drug Rebate program.

CHIP

CHIP

Program Description:

The Balanced Budget Act of 1997 created a new children's health insurance program under Title XXI of the Social Security Act. This new title enables States to initiate and expand health insurance coverage for uninsured children. The 76th Legislature enacted S.B. 445 (Health and Safety Code, Chapters 62 and 63) which authorized a non-entitlement health insurance benefit program for uninsured children (0-18) at or below 200 percent FPL, ineligible for Medicaid coverage.

The program began providing health coverage in May 2000. The program is a comprehensive health plan providing inpatient and outpatient medical benefits. The program contracts with 13 managed care health plans. The health plans enroll medical providers and arrange for services for CHIP members.

Eligibility:

CHIP

- Children under age 19 with family income below 200 percent of poverty

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$6.9	$96.7	$166.4	$170.8	$117.5	$106.6
GR-Dedicated	0	0	5.7	0		
Federal Funds	11.4	227.1	451.4	390.9	288.9	242.3
Other Funds	0	0	6.7	.4	.0	10.4
Total All Funds	**$18.3**	**$323.8**	**$630.2**	**$562.1**	**$406.4**	**$359.3**

CHIP (continued)

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Avg. CHIP Program Benefit Cost per Recipient Mo. (W/O Rx)	$94.08	$93.64	$97.63	$89.10	$75.45	$78.16
Avg. CHIP Children Recipient Mo. per Mo.	27,945	246,516	488,332	484,364	381,767	321,458

Date of Last Audit: State Auditor's Office March 2003

03-022/An Audit Report on The Children's Health Insurance Program (CHIP) at the Health and Human Services Commission

Findings:

HHSC had to reduce its CHIP drug rebate revenue estimates due to deficiencies in planning and analysis. HHSC's methodology for removing the drug benefit from CHIP HMO premiums was reasonable, but the anticipated cost savings from managing the drug benefit in-house may not be realized.

Status:

A separate CHIP drug formulary and supplemental rebates will be developed after the Preferred Drug List (PDL) has been fully implemented. This will be included in new CHIP rebate contracts in conjunction with the PDL.

HHSC has developed an RFP to procure services to perform audits of the HMO's expenditures.

Immigrant Health Insurance

Program Description:

Title XXI of the Social Security Act excludes certain categories of children, one of which is children with certain legal immigrant status. The Texas Legislature, 76th Session, enacted S.B. 445 (Health and Safety Code, Chapter 62.105) which authorized a non-entitlement health insurance benefit program for these children. These families have not met residency requirements to qualify for other health programs.

The processes and benefits for legal immigrant children are identical to those for other children in the CHIP program. However, unlike CHIP, the funding source is 100 percent State.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$.1	$5.6	$9.4	$16.4	$14.4	$14.0
Federal Funds	0	0	0	0	0	0
Other Funds	0	0	0	0	0	0
Total All Funds	**$.1**	**$5.6**	**$9.4**	**$16.4**	**$14.4**	**$14.0**

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Avg. legal immigrant children member months	474	5,059	9,373	15,034	16,341	15,055

Immigrant Health Insurance (continued)

Date of Last Audit: State Auditor's Office March 2003

03-022/An Audit Report on The Children's Health Insurance Program (CHIP) at the Health and Human Services Commission

Findings:

HHSC had to reduce its CHIP drug rebate revenue estimates due to deficiencies in planning and analysis. HHSC's methodology for removing the drug benefit from CHIP HMO premiums was reasonable, but the anticipated cost savings from managing the drug benefit in-house may not be realized.

Status:

A separate CHIP drug formulary and supplemental rebates will be developed after the Preferred Drug List (PDL) has been fully implemented. This will be included in new CHIP rebate contracts in conjunction with the PDL.

HHSC has developed an RFP to procure services to perform audits of the HMO's expenditures.

State Employee Children Insurance (SKIP)

Program Description:

Title XXI of the Social Security Act excludes certain categories of children, one of which is children of public employees with access to state-paid insurance coverage.

To assist affected families, the Texas Legislature, 76th Session, enacted S.B. 1351 (Insurance Code, Article 3.50) which required the state retirement insurance program (operated by ERS) to subsidize 80 percent of the employee's children health insurance premiums (State Kids Insurance Program – SKIP) beginning in FY2001. SKIP-Eligible state employees must also meet the same income guidelines for CHIP families, up to 200 percent FPL.

The 77th Legislature increased the SKIP state subsidy. This reduced the out-of-pocket contribution of the state employee to be more equivalent to that of the families enrolled in CHIP. For the 2002-03 biennium, the State subsidized all of the SKIP dependent children coverage except for $15 per month or $15 per year, depending on family income. ERS did not request SKIP funding from HHSC last biennium. The 78th Legislature increased out-of-pocket costs during the 2004-05 biennium for those state employees with family income above 150 percent FPL.

Appropriations* ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$0	$2.7	$0	$0	$6.7	$6.7
Federal Funds	0	0	0	0	0	0
Other Funds	0	0	0	0	0	0
Total All Funds	**$0**	**$2.7**	**$0**	**$0**	**$6.7**	**$6.7**

*Cost paid by ERS or through transfers

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
ERS reports SKIP enrollment	n/a	5,640	7,556	6,837	6,007	6,007

Date of Last Audit: State Auditor's Office March 2003

03-022/An Audit Report on The Children's Health Insurance Program (CHIP) at the Health and Human Services Commission

Findings:

HHSC had to reduce its CHIP drug rebate revenue estimates due to deficiencies in planning and analysis. HHSC's methodology for removing the drug benefit from CHIP HMO premiums was reasonable, but the anticipated cost savings from managing the drug benefit in-house may not be realized.

Status:

A separate CHIP drug formulary and supplemental rebates will be developed after the Preferred Drug List (PDL) has been fully implemented. This will be included in new CHIP rebate contracts in conjunction with the PDL.

HHSC has developed an RFP to procure services to perform audits of the HMO's expenditures.

School Employee Children Insurance

Program Description:

Title XXI of the Social Security Act excludes certain categories of children, on of which is children of public employees with access to state-paid insurance coverage.

With the establishment of a new state insurance program for active school district employees, regional educational service center employees, and certain charter school employees (H.B. 3343, 77th Leg.), children of school employees with access to the state coverage were no longer eligible for federally financed CHIP. Therefore, H.B. 3343 also provided that children of school district employees with access to TRS ActiveCare could enroll or continue to be enrolled in CHIP and be financed with General Revenue Funds. Funding for state-funded CHIP for children of school district employees began in FY2003 at 100 percent.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$0	$0	$0	$7.6	$7.5	$8.3
Federal Funds	0	0	0	0	0	0
Other Funds	0	0	0	0	0	0
Total All Funds	**$0**	**$0**	**$0**	**$7.6**	**$7.5**	**$8.3**

School Employee Children Insurance (continued)

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Avg. school employee children recipient months per mo.	n/a	n/a	n/a	7,570	8,651	8,867

Date of Last Audit: State Auditor's Office March 2003

03-022/An Audit Report on The Children's Health Insurance Program (CHIP) at the Health and Human Services Commission

Findings:

HHSC had to reduce its CHIP drug rebate revenue estimates due to deficiencies in planning and analysis. HHSC's methodology for removing the drug benefit from CHIP HMO premiums was reasonable, but the anticipated cost savings from managing the drug benefit in-house may not be realized.

Status:

A separate CHIP drug formulary and supplemental rebates will be developed after the Preferred Drug List (PDL) has been fully implemented. This will be included in new CHIP rebate contracts in conjunction with the PDL.

HHSC has developed an RFP to procure services to perform audits of the HMO's expenditures.

CHIP Vendor Drug Program

Program Description:

Title XXI of the Social Security Act as revised from the Balanced Budget Act of 1997 created a new children's health insurance program. The Texas Legislature, 76th Session, enacted S.B. 445 (Health and Safety Code, Chapter 62.105) which authorized a non-entitlement health insurance benefit program for these children.

In March of 2002, the CHIP program began directly purchasing client medications through the Medicaid Vendor Drug Program. Previously mediations were purchased through the various managed care providers.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$0	$0	$10.5	$27.5	$26.7	$24.6
Federal Funds	0	0	$26.1	67.0	0	0
Other Funds	0	0	0	0	60.1	54.8
Total All Funds	**$0**	**$0**	**$36.6**	**$94.5**	**$86.8**	**$79.4**

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Average cost per CHIP prescription	n/a	n/a	$37.15	$39.51	$44.59	$49.13
Total number of CHIP prescriptions	n/a	n/a	1,032,935	2,448,670	1,946,252	1,615,816

CHIP Vendor Drug Program (continued)

Date of Last Audit: State Auditor's Office March 2003

03-022/An Audit Report on The Children's Health Insurance Program (CHIP) at the Health and Human Services Commission

Findings:

HHSC had to reduce its CHIP drug rebate revenue estimates due to deficiencies in planning and analysis. HHSC's methodology for removing the drug benefit from CHIP HMO premiums was reasonable, but the anticipated cost savings from managing the drug benefit in-house may not be realized.

Status:

A separate CHIP drug formulary and supplemental rebates will be developed after the Preferred Drug List (PDL) has been fully implemented. This will be included in new CHIP rebate contracts in conjunction with the PDL.

HHSC has developed an RFP to procure services to perform audits of the HMO's expenditures.

Programs Transferring to HHSC

TANF Grants

Program Description:

The Temporary Assistance to Needy Families (TANF) program provides temporary time-limited financial assistance benefits to families with needy children. TANF benefits consist of:

- TANF Basic cash assistance to families with needy children deprived of support because of the absence or disability of one or both parents;
- TANF State Program cash assistance for needy children living with both natural or adoptive parents;
- One-time grants of $1,000 to needy families in lieu of ongoing TANF cash assistance benefits;
- One-time grants of $1,000 to needy grandparents caring for children receiving TANF cash assistance;
- Pass-through child support payments;
- ·Once-a-year subsidies of $30 per child timed to coincide with back to school and the state sales tax holiday;
- Contracted assistance to help potential TANF recipients qualify for SSI benefits; and
- Contracted projects to reduce barriers to employment or dependence on public assistance, such as marriage and family formation or fatherhood initiatives.

Eligibility:

Families receiving TANF cash assistance must consist of children living with parents or relatives and must meet the following eligibility requirements:

- Citizenship and residency;
- Deprivation of parental support or care due to the absence, incapacity, unemployment or underemployment of one or both parents;
- Have income below 17 percent of federal poverty guidelines;
- Have assets valued at $1,000 or less (or $2,000 in a household with an elderly or disabled member);
- Must assign rights to child support and cooperate with paternity determination and locating and obtaining payments from the absent parent;
- Must participate in Choices employment services unless exempt; and
- Must sign and comply with the requirements of the Personal Responsibility Agreement regarding employment, child support, substance abuse, parenting training, children's medical screenings and immunizations, and school attendance.

TANF Grants (continued)

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$125.5	$112.7	$118.9	$117.9	$87.6	$90.3
Federal Funds	133.6	151.8	159.3	171.6	160.2	148.3
Other Funds	1.9	4.0	3.5	3.4	2.8	2.8
Total All Funds	**$261.0**	**$268.5**	**$279.7**	**$292.9**	**$250.6**	**$241.4**

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Num. TANF (Basic) Recipients per month	310,777	322,780	330,416	339,036	279,968	307,228
Num. TANF-UP/SP Recipients per mo.	30,597	27,073	28,333	28,861	23,197	25,338
Avg. Num. TANF one-time payments per mo.	96	147	393	909	1,130	695
Avg. Mo. Grant: TANF (Basic)	$56.29	$55.11	$55.88	$55.61	$59.77	$57.14
Avg. Mo. Grant: TANF=UP/SP	50.42	49.09	49.60	49.22	54.17	58.25

Date of Last Audit: State Auditor's Office April 2003

Report Number 03-434 State of Texas Federal Portion of Statewide Single Audit Report for the Year Ended August 31, 2002

Findings

None

Status

No recommendations

Food Stamp Benefits

Program Description:

The Food Stamp program provides supplement assistance to low income households to purchase a nutritionally adequate diet. Recipients receive a monthly allotment that must be used exclusively for food products.

Eligibility:

- Must reside in Texas and apply in the county of their residence.
- Must be U.S. citizens or legally admitted aliens.
- Recipients age 16 through 59 must register for employment and comply with employment service requirements, unless exempt.
- Unemployed 18 to 50 year olds without dependents are ineligible except for an initial 3 month period in a 36 month period, unless exempt.
- Households in which not every member receives TANF or SSI benefits must not have more than $5,000 of liquid resources and motor vehicles of limited value.
- Households must meet gross and net income limits. Categorically eligible households are those in which all members receive TANF or SSI or met the TANF non-cash services resource criteria.

Value of Benefits* (in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Value of Benefits	$1.199.9	$1,239.5	$1,487.3	$1,817.2	$2,234.8	$2,643.4

*Benefits are disbursed directly by Food and Nutrition Services, United States Department of Agriculture and are not in state appropriations.

Food Stamp Benefits (continued)

Key Performance Measures:

Date of Last Audit: State Auditor's Office April 2003

Report Number 03-434 State of Texas Federal Portion of Statewide Single Audit Report for the Year Ended August 31, 2002

Findings

None

Status

No recommendations

Client Self-Support Eligibility Determination & Issuance Services
(TANF, Food Stamps, Medicaid for Children, Medically Needy, and Pregnant Women)

Program Description:

TANF, Food Stamp, and Medicaid Eligibility and Issuance Services encompasses all aspects of program administration from offering an opportunity for self-sufficiency to interviewing applicants and sending benefits to eligible families. It includes caseworkers who determine and re-determine eligibility, as well as supervisory, performance monitoring, reception/clerical support, and regional and state office administrative staff. It also includes the TANF and Food Stamp policy function, the Lone Star Technology staff administering finger imaging and electronic benefits issuance, and the Texas Integrated Eligibility Redesign System (TIERS) core project staff.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$149.1	$152.9	$172.4	$175.9	$185.5	$159.6
Federal Funds	243.6	283.5	271.5	275.5	286.3	234.4
Other Funds	4.0	13.2	16.4	18.0	23.0	6.0
Total All Funds	**$396.7**	**$413.6**	**$460.3**	**$469.4**	**$494.8**	**$400.0**

Client Self-Support Eligibility Determination) - continued
(TANF, Food Stamps, Medicaid for Children, Medically Needy, and Pregnant Women)

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
AVG Num families determined eligible mo: TANF	23,452	23,385	24,442	24,511	23,722	23,163
Avg. num. households determined eligible mo: Food Stamps	130,644	135,195	143,222	158,803	191,168	197,755
Avg. num. cases Deter. Elig. Mo: Children, PW, Med Needy Program (CPW Medicaid)	90,706	102,132	131,463	162,474	185,688	189,297
Avg. num. Recipients per mo.: Food Stamps	1,372,616	1,394,384	1,582,547	1,884,734	2,092,653	2,169,408
Avg. num. Recip. per Mo: C, PW, MN (CPW Medicaid)	709,254	762,204	940,583	1,247,254	1,513,227	1,496,137

Date of Last Audit: State Auditor's Office July 2000

03-035/ An Audit Report on Medicaid Client Eligibility Data at the Department of Human Services

Findings:

No material problems were identified with the data. Individual discrepancies were limited to less than 1 percent of the data. Testing covered about 37 percent of the databases 1,849,182 client records , The Department effectively uses data matching to identify Medicaid recipients who may receive benefits fraudulently or inappropriately

Status:

N/A

Long-Term Care Financial Eligibility Determination
(TANF, Food Stamps, Medicaid for Children, Medically Needy, and Pregnant Women)

Program Description:

Long-Term Care (LTC) Medicaid Eligibility (ME) staff members determine financial eligibility for the medical assistance only (MAO) programs for the aged, blind, and disabled population. Some clients in this population receive community/institutional care. The MAO institutional programs include nursing facilities (NFs), intermediate care facilities-mental retardation (ICF-MR facilities), and institutions for mental diseases (IMDs). Long-Term Care MAO Community Care programs include primary home care (PHC) for the frail elderly and home/community-based waivers. In addition, LTC ME workers determine financial eligibility for Medicaid acute care programs as well as for Medicare cost-sharing programs - Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualifying Individuals (QI). For Medicaid-funded programs, eligibility decisions be completed within 90 days for persons requiring a disability determination, and within 45 days for persons who are age 65 or for whom disability is already established.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$16.3	$16.7	$18.0	$18.4	$16.9	$16.4
Federal Funds	20.3	20.7	20.9	21.4	20.0	19.4
Other Funds	0.2	0.3	0.2	0.3	0.4	0.3
Total All Funds	**$36.8**	**$37.7**	**$39.1**	**$40.1**	**$37.3**	**$36.1**

Long-Term Care Financial Eligibility - Continued
(TANF, Food Stamps, Medicaid for Children, Medically Needy, and Pregnant Women)

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Avg. case equivalents per LTC Medicaid financial eligibility worker (Medical Assistance Only)	214	228	246	291	297	315

Date of Last Audit: State Auditor's Office July 2000

03-035/ An Audit Report on Medicaid Client Eligibility Data at the Department of Human Services

Findings:

No material problems were identified with the data. Individual discrepancies were limited to less than 1 percent of the data. Testing covered about 37 percent of the databases 1,849,182 client records , The Department effectively uses data matching to identify Medicaid recipients who may receive benefits fraudulently or inappropriately

Status:

N/A

Nutrition Services

Program Description:

Special Nutrition Programs (SNP) administers six child and adult nutrition programs and three food distribution programs. to supplement and improve the nutrition of children and adults whose income is insufficient to purchase adequate and healthful food. Child and adult nutrition programs provide cash reimbursement for meals, meeting U.S. Department of Agriculture standards, served to functionally impaired adults or people age 60 or older in adult day-care centers and children in child-care facilities, registered family homes, private schools, residential child-care institutions and summer recreational programs. The food distribution programs furnish USDA-donated commodities to low-income individuals and families, public and private schools, summer food service programs, and soup kitchens. The nutrition education and training program provides education and training to promote healthy eating habits among Texas children. Funding and commodities are provided by the U.S. Department of Agriculture (USDA), except for the Texas Commodity Assistance Program which has a 50/50 match requirement on administrative costs..

Eligibility:

Recipients must meet categorical or means tested eligibility requirements.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$.8	$.8	$.8	$.9	$.1	$.1
Federal Funds	165.5	175.0	192.7	205.2	209.9	218.8
Other Funds	.4	.1	.1	.1	.0	0
Total All Funds	**$166.7**	**$175.9**	**$193.6**	**$206.2**	**$210.0**	**$218.9**

Nutrition Services (continued)

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Avg. num. children/adults served meals through Child and Adult Care Food Program per day	185,823	188,795	203,861	213,161	224,891	234,296

Date of Last Audit: State Auditor's Office April 2003

Report Number 03-434 State of Texas Federal Portion of Statewide Single Audit Report for the Year Ended August 31, 2002

Findings

None

Status

No recommendations

Refugee Assistance

Program Description:

The Refugee Resettlement Program consists of:

- Cash assistance provided through a public private partnership and medical assistance administered by HHSC;
- Social services contracted with local non-profit organizations consisting of employment services, support services, health-related services, emergency services, transportation and child-care assistance;
- Unaccompanied Refugee Minors services administered by the Department of Family and Protective Services; and
- Refugee Health Screening services administered by the Department of State Health Services.

Eligibility:

Cash and medical assistance services are available to refugees ineligible for TANF and Medicaid who have lived in the United States for 8 months or less. Social services are available for refugees that have lived in the United States for 5 years or less.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$.3	$.3	$.2	$.3	$.3	$.3
Federal Funds	9.8	11.3	13.3	18.5	18.5	18.5
Other Funds	0	0	0	0	0	0
Total All Funds	**$10.1**	**$11.6**	**$13.5**	**$18.8**	**$18.8**	**$18.8**

Refugee Assistance (continued)

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Avg. num. refugees receiving financial and medical assistance per mo.	1,793	1,657	1,117	760	762	2,200

Date of Last Audit: State Auditor's Office April 2003

Report Number 03-434 State of Texas Federal Portion of Statewide Single Audit Report for the Year Ended August 31, 2002

Findings

None

Status

No recommendations

Disaster Assistance

Program Description:

The Individuals and Households Program (IHP) provides a one-time grant of up to $25,000 to individuals or families who are victims of a major disaster declared by the President. The maximum grant amount is adjusted annually based on the Consumer Price Index. FEMA directly administers the Housing Assistance portion of the program with federal funds and Texas administers the Other Needs Assistance portion of the program, providing assistance for personal property losses, vehicle losses, moving and storage expenses, or medical and funeral expenses. The Other Needs Assistance grant expense is funded with 75 percent federal funds and a 25 percent state matching share. The state also receives federal funds for temporary administrative expense.

Eligibility:

Eligible ONA recipients are disaster victims who live in an area where the President has declared a disaster, apply within 60 days, have no insurance or are under-insured, do not qualify for loan assistance from the Small Business Administration, and have serious needs and necessary expenses resulting from the disaster not covered by other relief organizations.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$0	$46.7	$21.6	$11.5	$0	n/a
GR-Dedicated	2.1	.3	0	0	0	n/a
Federal Funds	7.4	142.4	68.2	37.7	.4	n/a
Other Funds	0	0	0	0	0	n/a
Total All Funds	**$9.5**	**$189.4**	**$89.8**	**$49.2**	**$0.4**	**n/a**

Key Performance Measures:

None

Disaster Assistance (continued)

Date of Last Audit: State Auditor's Office April 2003

Report Number 03-434 State of Texas Federal Portion of Statewide Single Audit Report for the Year Ended August 31, 2002

Findings

None

Status

No recommendations

Family Violence

Program Description:

Services to victims of family violence are provided through contracts with family violence programs located throughout Texas. Shelter and support services include emergency 24-hour-a-day shelter, 24-hour hotline, intervention, children's services and therapeutic activities, employment and training services, assistance in obtaining medical care, legal assistance, counseling, transportation, law enforcement liaison and community education, and information and referral.

Eligibility:

To be eligible for services, adult clients must be physically, emotionally, or sexually abused by their partner, former partner, or another family member. Information and referral is available for the batterer. Services are available without charge, and there are no income eligibility requirements.

Appropriations ($ in millions)	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
General Revenue	$0	$0	$.0	$.0	$.0	$.0
GR-Dedicated	4.2	4.3	15.3	15.3	17.3	17.3
Federal Funds	13.0	13.2	4.3	4.7	4.8	4.8
Other Funds	0	0	2.0	2.0	0	0
Total All Funds	**$17.2**	**$17.5**	**$21.6**	**$22.0**	**$22.1**	**$22.1**

Key Performance Measures:

Performance Measure	Expended 2000	Expended 2001	Expended 2002	Expended 2003	Projected 2004	Projected 2005
Num. women and children served	67,312	74,347	76,769	78,886	83,349	83,349
DHS avg. cost per person receiving emerg. shelter and/or non-resident svcs.	$251.21	$235.72	$282.10	$279.23	$264.12	$264.12

Family Violence (continued)

Date of Last Audit: State Auditor's Office April 2003

Report Number 03-434 State of Texas Federal Portion of Statewide Single Audit Report for the Year Ended August 31, 2002

Findings

None

Status

No recommendations

References:

HHSC FY 2002 Operating Budget

HHSC FY 2004 Operating Budget

DHS FY 2002 Operating Budget

DHS FY 2004 Operating Budget

DHS LAR FY 2004-05

General Appropriations Act, 78th Legislature, Regular Session

Letter and Attachment from DHS Commissioner to LBB and GOBPP, October 14, 2003

Department of Assistive and Rehabilitative Services
Program Overview

Appendix B

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Independent Living Skills-Blind – Division for Blind Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	1,849,156	1,846,737	1,845,000	2,272,000	2,652,390
FTEs	23.2	22.3	23.5	25	25
Clients Served	4,478	4,523	4,875	5,237	4,890
Cost per Client	413	408	378	434	542

Description of Program ***(what the program does)***	Independent Living Program provides specialized services to eligible individuals whose independence is threatened because of vision loss. The goal is to assist consumers to improve their ability to function independently, which reduces the need for alternate and more expensive care such as nursing homes and in-home care givers. Services are provided primarily by Independent Living Specialists.
Who the Program Serves	Individuals who are blind or visually impaired and want to maintain their independence in their home or community.
Eligibility Requirements	The consumer has a severe visual disability which is a substantial limitation to living independently and the delivery of independent living services will improve the consumer's ability to function, continue functioning, or move toward functioning independently.
Issues	Large and growing population of older blind Texans.
Is there a waiting list; if so, describe how many and how long the wait is.	No

Habilitative Svcs for Blind Children – Division for Blind Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	3,021,666	3,276,822	3,459,000	2,667,000	2,637,629
FTEs	62.6	60.1	60.2	46.0	46.0
Clients Served	7,671	7,294	7,358	3,645	2,946
Cost per Client	394	449	470	732	895

Description of Program ***(what the program does)***	Provides habilitative services to children who are blind or severely visually impaired and their families. Services are delivered primarily by Blind Children Specialists.
Who the Program Serves	Children who are blind or visually impaired.
Eligibility Requirements	The applicant must have a visual impairment (an injury, disease, or other disorder that reduces or may reduce visual functioning OR requires cosmetic treatment, psychological assistance, counseling or other assistance that TCB can provide), be between the ages of birth and 22 (new referrals age 10 and older who are suspected to be PSVI (permanently severely vision impaired) should be referred to Transition), and reside in Texas.
Issues	Children's Program Order of Selection.
Is there a waiting list; if so, describe how many and how long the wait is.	No. However, certain services were eliminated, such as vision screening, restoration services, and respite care. Additionally, eight caseloads were eliminated from this program.

Blindness Education (BEST)– Division for Blind Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	695,299	1,086,414	1,062,000	388,000	388,000
FTEs	.1	1.3	1.1	.5	---
Clients Served	Note 1	Note 1	14,065	8,802	10,238
Cost per Client	N/A	N/A	75	44	38

Note 1: The methodology for reporting these results changed in 2003- prior year results were not comparable

Description of Program ***(what the program does)***	BEST assists uninsured adult Texas residents with the payment for urgently needed eye-medical treatment to prevent blindness. The program assists qualified individuals with diabetic retinopathy, glaucoma, detached retina, or any other eye disease determined to be an urgent medical necessity by the applicant's eye doctor and DBS's State Medical Consultant. Services are provided by eye medical providers who will accept the MAPS fee. BEST also offers non-diagnostic vision screenings to adult Texans and provides public education about risk factors affecting vision loss.
Who the Program Serves	Uninsured adult Texas residents urgently needing eye-medical treatment to prevent blindness or Texans in need of vision screening.
Eligibility Requirements	Referral from physician or optometrist for eye medical treatment, Texas resident, adult (18 +), not insured and have a qualifying eye disease.
Issues	Drop in BEST donations due to DPS changes for license renewals: 4 to 6 years; another option for donations was added to add TDH, and online instead of in-person.
Is there a waiting list; if so, describe how many and how long the wait is.	Yes. This program is based on voluntary donations when Texans renew their drivers' licenses. A waiting list is established when donated funds are exhausted.

Vocational Rehabilitation-Blind – Division for Blind Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	32,361,116	33,102,775	33,243,000	37,504,000	36,293,015
FTEs	426.2	430.0	432.8	450.0	450.0
Clients Served	11,525	11,022	11,055	10,902	10,150
Cost per Client	2,808	3,003	3,007	3,440	3,576

Description of Program ***(what the program does)***	Vocational Rehabilitation Services for the blind or severely visually impaired are designed to assist individuals with visual problems obtain, regain or maintain employment consistent with their abilities, interests and informed consent. Services are delivered primarily by VR counselors and rehabilitation teachers.
Who the Program Serves	Individuals of employment age (generally 18-65) who want to work and are blind or visually impaired. For individuals who are in transition from school to work, they may start receiving services as early as 10 years of age.
Eligibility Requirements	The individual has a visual impairment which constitutes or results in a substantial impediment to employment, the individual can benefit from vocational rehabilitation services in terms of an employment outcome, and the individual requires vocational rehabilitation services to prepare for, secure, retain, or regain employment.
Issues	▪ Reauthorization of the Workforce Investment Act, ▪ Reauthorization of Individuals With Disabilities Education Act (IDEA)
Is there a waiting list; if so, describe how many and how long the wait is.	No

Business Enterprises of Texas – Division for Blind Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	2,059,067	1,719,169	1,800,000	2,177,000	2,186,160
FTEs	17.6	17.6	18.0	18.0	18.0
Clients Served	148	154	160	116	121
Cost per Client	13,912	11,163	11,250	18,767	18,067

Description of Program ***(what the program does)***	Business Enterprises of Texas is the state licensing agency in Texas under the Randolph-Sheppard Act, which together with state law gives priority to blind persons licensed by DBS to operate vending facilities on Federal, State, and other properties. The primary service providers are the Supervising Business Consultants.
Who the Program Serves	Blind adults.
Eligibility Requirements	Must be a U. S. citizen, 18 years of age, and be a consumer on a DBS VR caseload and referred to BET.
Issues	The need for continued expertise of outside counsel and the need for proactive coordination between DARS and TBPC in regards to compliance with the Texas Human Resources Code.
Is there a waiting list; if so, describe how many and how long the wait is.	No

BET Trust Fund – Division for Blind Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	273,632	373,873	507,000	561,000	410,000
FTEs	0	0	0	0	0
Clients Served	0	0	0	0	0
Cost per Client	0	0	0	0	0

Description of Program ***(what the program does)***	The purpose of this strategy is to establish and maintain a retirement and benefit plan for blind or visually impaired vendors as defined in the federal Randolph-Sheppard Act (20 USC, Section 107). This strategy directly relates to the Vocational Rehabilitation and the Business Enterprises of Texas strategies and relates to Statewide Goal 03, reduction of dependence on public assistance through responsibility and self-sufficiency of individuals. This strategy also relates to Benchmark 03-21, percent of people completing vocational rehabilitation services employed.
Who the Program Serves	Individuals licensed to operate vending facilities under Business Enterprises of Texas.
Eligibility Requirements	Must be an individual licensed to operate a vending facility in the Texas BET Program.
Issues	None
Is there a waiting list; if so, describe how many and how long the wait is.	No

Eligibility Awareness – Division for Early Childhood Intervention Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	517,000	520,000	367,000	487,000	407,314
FTEs	6	6	6	6	6
Clients Served	Not reported	Not reported	Not reported	Not reported	Not reported
Cost per Client	na	na	na	na	na

Description of Program ***(what the program does)***	The purpose of this strategy is to provide a statewide public awareness and child find program, required by the Individuals with Disabilities Education Act (IDEA), Part C. The strategy ensures that information is disseminated to primary referral sources and the public so that appropriate and timely referrals are made and interventions are begun early.
Who the Program Serves	The program serves children birth to age three who have disabilities or developmental delays.
Eligibility Requirements	NA
Issues	Several factors, including changes in eligibility and a family cost share requirement, have resulted in a decreased number of referrals.
Is there a waiting list	No

Eligibility Determination – Division for Early Childhood Intervention Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	21,604,000	23,551,000	21,403,000	27,162,000	32,042,996
FTEs	0	0	0	0	0
Clients Served	47,033	53,102	48,286*	38,880	41,602
Cost per Client	459	444	443	699	770

*The method of tabulating client counts changed between the 2 years

Description of Program ***(what the program does)***	The purpose of this strategy is to identify and determine the eligibility of all children under three with developmental disabilities or delays in the state. The strategy ensures that every child referred for ECI services receives a timely and comprehensive evaluation to identify their level of functioning in cognitive, physical, communication, social or emotional, and adaptive development, and the services appropriate to meet those needs.
Who the Program Serves	The program serves children birth to age three who have disabilities or developmental delays.
Eligibility Requirements	Income is not a factor in determining eligibility. ECI determines eligibility for children under age three based on developmental delay, atypical development and medically diagnosed condition. Children who have a medically diagnosed condition that has a high probability for resulting in developmental delay are automatically eligible for ECI services.
Issues	Changes in eligibility were implemented in FY 2004 because of funding limitations
Is there a waiting list	No

Comprehensive Services – Division for Early Childhood Intervention Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	65,609,000	74,682,000	89,355,000	90,020,000	93,566,555
FTEs	12	16	15	15	15
Clients Served	33,649	37,932	42,458	43,304	46,001
Cost per Client	1,950	1,969	2,105	2,079	2,034

Description of Program ***(what the program does)***	Early Childhood Intervention (ECI) is a coordinated system of services available in every Texas County for children, birth to age three, with disabilities or delays. ECI is federally and state funded primarily through the Individuals with Disabilities Education Act. ECI support families through education and family services to help their children reach their potential.
Who the Program Serves	The program serves children birth to age three who have disabilities or developmental delays.
Eligibility Requirements	Income is not a factor in determining eligibility. ECI determines eligibility for children under age three based on developmental delay, atypical development and medically diagnosed condition. Children who have a medically diagnosed condition that has a high probability for resulting in developmental delay are automatically eligible for ECI services.
Issues	Families with eligible children have left the program as a result of cost sharing requirement. Failure to serve eligible children during the critical development stage will result in long-term costs to the state.
Is there a waiting list	No

Quality Services – Division for Early Childhood Intervention Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	974,000	1,090,000	1,086,000	1,537,000	1,490,928
FTEs	15	19	19	19	19
Clients Served	Not reported	Not reported	Not reported	Not reported	Not reported
Cost per Client	na	na	na	na	na

Description of Program ***(what the program does)***	This strategy provides for activities required by IDEA, Part C, including ensuring the availability of qualified personnel to serve all eligible children, involving families and stakeholders in program policy development, collecting and reporting data on services, providing impartial opportunities for resolution of disputes, and guaranteeing that the rights of children and families are protected.
Who the Program Serves	The program serves children birth to age three who have disabilities or developmental delays.
Eligibility Requirements	Income is not a factor in determining eligibility. ECI determines eligibility for children under age three based on developmental delay, atypical development and medically diagnosed condition. Children who have a medically diagnosed condition that has a high probability for resulting in developmental delay are automatically eligible for ECI services.
Issues	None
Is there a waiting list; if so, describe how many and how long the wait is.	No

Respite Care – Division for Early Childhood Intervention Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	615,000	936,000	919,000	400,000	400,000
FTEs	0	0	0	0	0
Clients Served	921	1,850	1,967	1,200	1,200
Cost per Client	668	506	467	333	333

Description of Program ***(what the program does)***	This program ensures that resources are identified and coordinated to provide respite services to help preserve the family unit and prevent costly out-of-home placements. Respite services help to provide emotional support, reduce stress, allow primary caregivers to participate in activities with other family members, and provide emergency care in times of illness.
Who the Program Serves	The program serves children birth to age three who have disabilities or developmental delays.
Eligibility Requirements	Income is not a factor in determining eligibility. ECI determines eligibility for children under age three based on developmental delay, atypical development and medically diagnosed condition. Children who have a medically diagnosed condition that has a high probability for resulting in developmental delay are automatically eligible for ECI services.
Issues	Funding for respite services was reduced by 60 percent from FY 2003 to FY 2004.
Is there a waiting list; if so, describe how many and how long the wait is.	No

Contract Services – Division for Deaf and Hard of Hearing Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	608,937	1,029,090	1,027,000	980,072	980,072
FTEs	3.4	2.7	2.7	2.7	2.7
Clients Served	16,429	18,392	24,235	17,000	16,500
Cost per Client	37	56	42	58	59

Description of Program ***(what the program does)***	Communication Access services for individuals who are deaf or hard of hearing. The focus is on providing necessary life services, such as interpreter services, and ensuring services are accessible for other agencies, programs and organizations. This includes items such as interpreting services, senior citizens services, regional specialist services and hard of hearing services.
Who the Program Serves	For individuals who are deaf or hard of hearing.
Eligibility Requirements	Any individual who is deaf or hard of hearing is eligible for DHHS services. There is a requirement of 60 years of age to receive senior citizens services.
Issues	Hard of hearing services remain under funded and there is a shortage of qualified service providers.
Is there a waiting list; if so, describe how many and how long the wait is.	No

Training and Education – Division for Deaf and Hard of Hearing Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	245,360	358,123	406,000	393,000	511,500
FTEs	0	1.8	1.8	1.8	1.8
Clients Served	1,165	1,242	1,808	1,710	1,590
Cost per Client	211	288	225	230	322

Description of Program ***(what the program does)***	Division sponsored consumer and interpreter training opportunities. DHHS also provides communication access services for six IAC's in this program area.
Who the Program Serves	Individuals who are deaf or hard of hearing, parents of children with hearing loss, businesses, and services providers who may serve individuals who are deaf or hard of hearing including government agencies, non-profit and for profit entities, and other agencies and employers interpreters, hearing aid dispensers, audiologists.
Eligibility Requirements	None
Issues	Funding comes from administrative fees collected on Interagency contracts mainly for interpreter services. The amount of fees collected varies depending on the need of the contracted agencies. It is difficult to determine the funding level available for services within a given fiscal year.
Is there a waiting list; if so, describe how many and how long the wait is.	No

Telephone Assistance – Division for Deaf and Hard of Hearing Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	315,490	412,822	435,000	632,000	657,000
FTEs	5.2	7.6	7.6	7.5	7.5
Clients Served	2,445	12,082	12,259	13,000	13,000
Cost per Client	129	34	35	49	51

Description of Program ***(what the program does)***	The STAP is a financial assistance program which provides vouchers to qualifying individuals for the purchase of specialized telecommunication equipment or services. These vouchers are issued to Texas residents having a disability that interferes with their ability to use the telephone. The devices purchased using these vouchers enable qualifying applicants to access the telephone network.
Who the Program Serves	Individuals with disabilities.
Eligibility Requirements	Texas Resident, individual with a disability that impairs the individual's ability to effectively access the telephone network.
Issues	The program is funded by the Universal Service Fund as a reimbursement program. A rider was established allowing TCDHH to utilize General Revenue funds for cash flow under this program. If this authority is eliminated, DHHS does not have the cash available to provide services under this program.
Is there a waiting list; if so, describe how many and how long the wait is.	Yes. Two months

Interpreter Certifications– Division for Deaf and Hard of Hearing Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	199,412	248,462	219,000	214,837	214,838
FTEs	2.0	2.0	2.0	2.0	2.0
Clients Served	1,378	1,615	1,686	1,739	1,715
Cost per Client	145	154	130	124	125

Description of Program ***(what the program does)***	Tests and certifies sign language and oral interpreters.
Who the Program Serves	Individuals wishing to become tested and certified.
Eligibility Requirements	Must be 18 years of age and possess a high school diploma or GED General knowledge of sign language.
Issues	Interpreters who participate in this program often cannot afford increased fees for testing to become certified. Increasing fees to make the program self-sufficient would preclude many interpreters from becoming certified or maintaining their certification. This would result in untested and non-certified individuals providing services for which there is no assurance that they are qualified. The fees that are collected from interpreter certification applicants are legislatively capped at $130,000. Funds collected above this amount must be returned to the applicant and the Division cannot evaluate and certify these candidates.
Is there a waiting list; if so, describe how many and how long the wait is.	No

Vocational Rehabilitation-General – Division for Rehabilitation Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	168,561,000	168,231,000	168,803,000	169,610,775	169,689,020
FTEs	1291.7	1285.5	1305.0	1354.5	1354.5
Clients Served	120,224	125,474	127,071	126,195	126,195
Cost per Client	1,402	1,341	1,328	1,344	1,345

Description of Program ***(what the program does)***	The vocational rehabilitation (VR) program, a state-federal partnership, assists eligible individuals with disabilities overcome impediments to employment and enables them to prepare for, find and keep jobs. Together, a consumer and qualified vocational rehabilitation counselor determine an employment goal that the consumer wants and can achieve. Employment related services, which may be provided, arranged or purchased, are individualized and guided by informed choice and may include counseling, training, medical treatment, assistive devices, job placement assistance, or other services.
Who the Program Serves	Consumers who have physical or mental disabilities.
Eligibility Requirements	A person is eligible if a qualified vocational rehabilitation counselor determines that the person has a disability that results in substantial problems in finding or keeping employment, Vocational Rehabilitation services from the Division for Rehabilitation Services are required by that person to prepare for, get or keep a job and the person is able to get or keep a job after receiving services.
Issues	▪ Reauthorization of the Workforce Investment Act, Individuals With Disabilities Education Act ▪ A recent federal audit found systemic issues relating to the rehabilitation rate, accuracy of eligibility determination, and adequacy of case file documentation. It is expected that some DARS performance measures will be affected as management addresses these issues in their efforts to enter or maintain employment.
Is there a waiting list	No

Independent Living Services-General – Division for Rehabilitation Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	3,245,000	3,069,000	3,166,000	2,595,000	2,569,459
FTEs	18.9	19.6	19.9	0	0
Clients Served	2,397	2,641	2,728	2,237	2,237
Cost per Client	1,354	1,162	1,161	1,160	1,149

Description of Program ***(what the program does)***	The (ILS) program provides services to eligible individuals with significant disabilities, helping them improve their ability to function independently in the family and the community.
Who the Program Serves	Consumers who have physical or mental disabilities.
Eligibility Requirements	A person must be certified by a qualified rehabilitation counselor to have a significant disability that results in a substantial impediment to their ability to function independently in the family and/or in the community, and there must be a reasonable expectation that ILS assistance will result in the ability to function more independently.
Issues	There is increased emphasis to support individuals in the ILS Program to successfully transition from nursing homes and other institutions into community-based living arrangements. This is expected to increase the number of individuals seeking services from the ILS Program.
Is there a waiting list	Yes. In the ILS program, the average wait for funding for purchased services is 28.49 months.

Independent Living Centers – Division for Rehabilitation Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	1,440,000	1,439,000	1,439,000	1,439,000	1,439,000
FTEs	0	0	0	0	0
Clients Served	5,300	5,405	6,791	6,791	6,791
Cost per Client	272	266	212	212	212

Description of Program ***(what the program does)***	As described in the Rehabilitation Act of 1973 as amended: The term "center for independent living" means a consumer-controlled, community-based, cross-disability, nonresidential private nonprofit agency that is designed and operated within a local community by individuals with disabilities and provides an array of independent living services.
Who the Program Serves	Any individual with a significant disability, defined as an individual with a severe physical, mental, cognitive, or sensory impairment whose ability to function independently in the family or community or whose ability to obtain, maintain, or advance in employment is substantially limited and for whom the delivery of IL services will improve the ability to function, continue functioning, or move toward functioning independently in the family or community or to continue in employment.
Eligibility Requirements	The CIL determines the applicant's eligibility and that the applicant has met the basic requirement of having a significant disability.
Issues	Funding expansion of the network of CILs in order to provide services across the State of Texas, Base funding for a CIL is considered to be $250,000. Most CILs in the state receive less than that from RSA funding. The draft State Plan for Independent Living currently calls for inclusion of increases for CILs in LAR requests submitted by the DSU in each State budget cycle. CILs will likely advocate with the legislature for additional state funding during the next session.
Is there a waiting list	No

Comprehensive Rehab Services – Division for Rehabilitation Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	10,028,000	10,123,000	9,564,000	10,184,000	10,067,355
FTEs	0	0	0	0	0
Clients Served	444	471	470	380	363
Cost per Client	22,586	21,493	20,349	26,800	27,734

Description of Program ***(what the program does)***	Comprehensive Rehabilitation Services helps persons with traumatic spinal cord and traumatic brain injuries receive intensive therapies to increase independence.
Who the Program Serves	Consumers with traumatic brain injury (TBI) and traumatic spinal cord injury (SCI)
Eligibility Requirements	The consumer must have a traumatic brain injury and/or spinal cord injury that result in a substantial impediment to functioning independently. There must also be a reasonable expectation that the consumer's ability to function within the family and/or community will improve with the provision of services. The applicant must also be at least 16 years old when services are completed; a US citizen or immigrant alien of the United States and a resident of Texas for at least six months or have a family member living in Texas for at least six months who is or will become the applicant's primary caregiver; sufficiently medically stable to participate actively in a program of services; and be willing to participate in treatment.
Issues	The key program issue is a waiting period for purchased services that is too long to provide consumers with maximum benefit. Consumers are waiting an average of 11 months for funding for medical rehabilitation. Medical rehabilitation, if provided in a timely manner, prevents long term complications that result in higher costs for long term medical care.
Is there a waiting list	Yes. In the CRS program the average wait for funding for purchased services is 11 months.

Disability Determination Services – Division for Rehabilitation Services	FY2001 Actuals	FY2002 Actuals	FY2003 Actuals	FY2004 Projected	FY2005 Budget
Expenditures	67,217,000	78,148,000	79,744,000	82,314,000	84,872,885
FTEs	792.1	830.5	856.7	900.0	900.0
Clients Served	239,008	256,780	272,808	270,235	270,235
Cost per Client	281	304	292	305	314

Description of Program ***(what the program does)***	The Social Security Act (Titles II and XVI) establishes disability programs which pay cash benefits and provide Medicare or Medicaid coverage for eligible persons determined to meet the definition of disability as contained in the Act. As stated in the Act, the disability determination is made by a state agency in accordance with pertinent provisions of law. These state agencies are 100% federally financed. In Texas that state agency is DARS DDS.
Who the Program Serves	Residents of Texas.
Eligibility Requirements	Eligibility is determined by SSA and is based on paying Social Security taxes (for SSDI) and having low income/resources (for SSI).
Issues	Obtaining sufficient federal funds in a timely manner to maintain service delivery and being able to keep up with increasing numbers of claims due to population growth and aging "baby boomers."
Is there a waiting list; if so, describe how many and how long the wait is.	No. However, newly receipted, non-critical cases from SSA are placed in "staged pending" before being assigned. Initial cases are currently taking 8 calendar days to be assigned.

Department of Aging and Disability Services Program Overview

Appendix C

Intake, Access, & Eligibility

Intake, Access & Eligibility — Strategy 1-1-1

Program Description

Included here are service activities delivered by the local mental retardation authorities that are important to determining eligibility and assisting the consumer in accessing appropriate services and supports. Access and assistance services are also provided by area agencies on aging (AAAs) (directly and through contractor and vendor agreements) to help older persons, their family members and/or other caregivers receive the information and assistance they need in obtaining community services. Service coordination is assistance in accessing medical, social, and educational services; access and assistance services include information, referral and assistance, benefits counseling/legal assistance, legal awareness and care coordination. The Ombudsman Program is charged under federal and state laws to protect the health, safety, welfare, and rights of residents in long-term care facilities and to identify, investigate, and resolve complaints by or on the behalf of these residents.

Program Benefits

MR Assessment and Service Coordination activities serve as the access point for publicly funded mental retardation services. The MR Assessment activity is required to establish clinical eligibility for services funded with general revenue, or Medicaid waiver and ICF/MR Programs. There is no cap on the level of service a client may receive from AAAs. As services are based upon need, program benefits will vary by client. For the Ombudsman Program, complaints and problems are addressed at the lowest level at nursing facilities before they become major issues.

Eligibility Requirements

Adults and children who are in need of mental retardation services are eligible for the Eligibility Determination service in MR Assessment. The assessment is designed to determine if the individual has a diagnosis of mental retardation. The diagnosis of mental retardation is, according to THSC §591.003, significantly sub average general intellectual functioning that is present prior to age 18. Deficits in adaptive behavior or daily living skills must also be present. Eligibility for

Service Coordination requires the person to be a member of the mental retardation priority population and have multiple needs for services. In accordance with the Older Americans Act, any individual age 60 and older is eligible to receive services provided by the AAAs. Additionally, family members and/or other caregivers may receive information and services on behalf of the older individual for whom they are providing care.

Intake, Access, & Eligibility

Intake, Access & Eligibility — Strategy 1-1-1

Client Profile

Persons receiving MR services are adults or children with mental retardation or autism who are typically living in their family's home. The typical client receiving services provided by AAAs is an individual who is 60 years of age or older. Section 307 (42 U.S.C. 3027) of the Older Americans Act requires an emphasis be placed on serving individuals who reside in rural areas; older individuals with greatest economic & social need, low-income minority individuals. The typical client of the Ombudsman Program is a nursing home resident or assisted living facility, age 82 and female. Approximately 65% of Ombudsman clients are Medicaid recipients.

Waiting List

- As of the February 29, 2004 waiting list report there are 229 persons seeking general revenue only services who are waiting more than 30 days for MR Assessment and Service Coordination.

Policy Changes and Impacts on Caseloads

- AAAs provide short-term services, often to individuals who are awaiting eligibility determination or who may be on an interest list for long-term care services. Any reduction in services at the state level will cause an increase in the number of individuals who are trying to access services through an AAA.
- Reduction in the Department of Aging and Disability Services (DADS) Long-Term Care Regulatory budget and/or program operations will have a corresponding impact on the Ombudsman Program by increasing demand for advocacy services.

Future Needs to be Addressed

None

Issues with Federal Funds

None

Intake, Access, & Eligibility

LTC Functional Eligibility — Strategy 1-1-2

Program Description
For some Community Care programs (Medicaid, non-Medicaid & other), LTC case managers develop individualized service plans (ISP) based on client needs/preferences, authorize community care vendors to deliver services and monitor the delivery of those services.

Eligibility Requirements
For certain LTC services both Medicaid and non-Medicaid, such as Community Based Alternatives (CBA), Medically Dependent Children Program (MDCP) and the Consolidated Waiver Program, clients must meet the institutional level of care (LOC) for medical necessity (LOC for nursing facility care or Intermediate Care Facilities – Mental Retardation, dependent upon the service). The clients also must have an ongoing need for certain types and levels of care that cannot be delivered adequately by family or friends.

Client Profile
See specific services/programs

Waiting List
See specific services/programs

Policy Changes and Impacts on Caseloads
See specific services/programs

Future Needs to be Addressed
See specific services/programs

Issues with Federal Funds
See specific services/programs

Intake, Access & Eligibility

LTC Functional Eligibility

Strategy 1-1-2

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	62.3	63.8	66.1	67.9	67.1	69.1
FTEs	1805.7	1795.4	1764.3	1703.1	1486.6	1438.0

Method of Finance (MOF)

(major funding sources)

State	27.6	28.3	30.5	31.2	31.9	28
Other	0.3	0.3	0.2	0.4	0.4	0
Federal	34.4	35.2	35.4	36.3	34.8	41.1
Total Funds	62.3	63.8	66.1	67.9	67.1	69.1

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Average number of persons eligible per month:Community Care	120,208	128,489	138,816	154,666	156,328	167,288
Average number of persons eligible per month:Community Care	120,208	128,489	138,816	154,666	156,328	167,288

Community Care-Entitlement

Primary Home Care (PHC) Strategy 1-2-1

Program Description

Primary Home Care (PHC) is a non-technical, non-medical attendant care service for eligible Medicaid clients of all ages whose chronic health problems impair their daily living.

Eligibility Requirements

Age: No limit-both adults and children may apply for PHC; **Income:** less than $584 /month for an individual; **Resources:** $2,000 or less for an individual, $3,000 or less for a couple; **Functional Assessment Score:** 24 + Functional limitation with at least one personal care task based on medical condition; Physician orders / prior approval by Regional Nurse

Unmet Need: For home management and personal care task(s).

Client Profile

Currently women make up 73% of the people receiving PHC services. People under the age of 21 make up 3.3% of the people receiving PHC services, 34.2% are over age 21 and under age 64, 23.9% are over age 64 and under age 74 and 38.6% are 75 or older. The typical client is a woman over the age of 70 who lives in her own home either alone or with an elderly spouse. She has multiple chronic health problems, which severely impair her daily living activities. She needs daily assistance to remain in her home. She uses 67 hours of attendant care each month to help with seven daily living tasks, five of which are personal-care tasks such as bathing, dressing, toileting, and meal preparation. She receives one other community care service in addition to attendant care to support independent living in the community. She has a monthly income of $584 or less, and less than $2,000 in available assets.

Waiting List No

Policy Changes and Impacts on Caseloads

Opening and closing CBA Waiver enrollment impacts PHC trends

Future Needs to be Addressed None

Issues with Federal Funds None

Community Care - Entitlement

Primary Home Care (PHC)

Strategy 1-2-1

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	241.2	266.8	315.3	374.8	415.0	471.0
FTEs	0	0	0	0	0	0

Method of Finance (MOF)

(major funding sources)

State	93.2	105.2	125.6	144.1	154.9	184.3
Other	0.0	0.0	0.0	0.0	0.0	0
Federal	148	161.6	189.7	230.7	260.1	286.7
Total Funds	241.2	266.8	315.3	374.8	415.0	471.0

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Number of clients per month	40,512	42,883	46,823	51,796	56,871	63,326
Average monthly cost per client	$496.11	$518.55	$561.23	$ 602.98	$ 608.05	$ 619.76

Community Care-Entitlement

Community Attendant Services (CAS) Strategy 1-2-2

(previously Frail Elderly)

Program Description

Primary Home Care/Community Attendant Services: Section §1929 of the Social Security Act allows persons of all ages in Texas who meet the Medical Assistance Only (MAO) financial criteria for nursing home care to be financially eligible for Primary Home Care Services.

Eligibility Requirements

For most community care services, clients must need help to perform routine activities such as bathing, dressing, preparing meals, eating, or toileting, and must meet financial criteria similar to those for nursing home care. For Medicaid-funded services, clients also must have a medical need for services.

Client Profile

Currently women make up 69% of the people receiving CAS services. People under the age of 21 make up 0.1% of the people receiving CAS services, 21.6% are over age 21 and under age 64, 26.6% are over age 64 and under age 74 and 51.7% are 75 or older. The typical CAS client is a woman over the age of 75 who lives in her own home either alone or with an elderly spouse. She has multiple chronic health problems, which severely impair her daily living activities. She needs daily assistance to remain in her home. She uses 66 hours of attendant care each month to help with seven daily living tasks, five of which are personal-care tasks such as bathing, dressing, toileting, and meal preparation. She receives one other community care service in addition to attendant care to support independent living in the community. She has a monthly income between $584 and $1,692 and less than $2,000 in available assets.

Waiting List No

Policy Changes and Impacts on Caseloads

Opening and closing CBA Waiver enrollment impacts PHC trends

Future Needs to be Addressed

None

Issues with Federal Funds None

Community Care - Entitlement

Community Attendant Services

Strategy 1-2-2

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	142.5	162.7	194.9	244.4	284.3	324.6
FTEs	0	0	0	0	0	0

Method of Finance (MOF)

(major funding sources)

State	55.1	64.2	77.6	94.0	106.1	127.0
Other	0	0	0	-	-	0
Federal	87.4	98.6	117.3	150.4	178.2	197.6
Total Funds	142.5	162.7	194.9	244.4	284.3	324.6

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Number of clients per month	24,312	26,651	29,911	34,848	40,126	44,887
Average monthly cost per client	$488.36	$508.84	$543.04	$ 584.44	$ 590.37	$ 602.75

Community Care-Entitlement

Day Activity and Health Services (DAHS) Strategy 1-2-3

Program Description

DAHS facilities provide daytime services Monday through Friday to clients residing in the community in order to provide an alternative to placement in nursing homes or other institutions. Services are designed to address the physical, mental, medical, and social needs of clients.

Eligibility Requirements

Age: For Title XIX – no age limit, For Title XX - 18 years of age or older; **Income:** For Title XIX – must be a Medicaid recipient, For Title XX - $1,692 / month for an individual, $3,384 / month for a couple; **Resources:** $5,000 or less for an individual if not SSI eligible, $6,000 or less for a couple if not SSI eligible. A functional disability related to medical diagnosis. Medical diagnosis and physician's orders requiring care or supervision by a licensed nurse. Prior approval granted by a Regional Nurse. The need for assistance with one or more personal care tasks.

Client Profile

Currently women make up 62.8% of the people receiving DAHS services. People under the age of 21 make up 0.4% of the people receiving DAHS services, 38.3% are over age 21 and under age 64, 25.5% are over age 64 and under age 74 and 35.8% are 75 or older.

Waiting List

No

Policy Changes and Impacts on Caseloads

None

Future Needs to be Addressed

None

Issues with Federal Funds

None

Community Care - Entitlement

Day Activity and Health Services (DAHS)

Strategy 1-2-3

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	62.4	71.8	79.3	88.2	94.3	96.1
FTEs	0	0	0	0	0	0

Method of Finance (MOF)

(major funding sources)

State	24.1	28.3	31.6	33.9	32.7	33.5
Other	0	0	0	-	2.5	4.1
Federal	38.3	43.5	47.7	54.3	59.1	58.5
Total Funds	62.4	71.8	79.3	88.2	94.3	96.1

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Number of clients per month	12,610	14,008	14,955	15,969	17,013	17,119
Average monthly cost per client	$412.99	$427.26	$441.93	$ 460.57	$ 461.74	$ 467.96

Community Care - Entitlement

	FY 2000	FY 2001	FY 2002	Estimated FY 2003	Projected FY 2004	Projected FY 2005
Primary Home Care						
Avg clients per month	40512	42883	46823	51796	56871	63326
Avg units/client/month	58.98	60.5	63.11	65.69	66.98	68.27
Avg cost/unit (hour)	$8.378	$8.537	$8.884	$9.170	$9.069	$9.069
Average monthly cost per client	$ 496.11	$ 518.55	$ 561.23	$ 602.98	$ 608.05	$ 619.76
Annual Expenditures	$241,181,375	$266,846,048	$315,341,616	$374,783,224	$414,963,690	$470,962,887
Community Attendant Services (Frail Elderly)						
Avg clients per month	24312	26651	29911	34848	40126	44887
Avg units/client/month	57.81	58.98	60.54	63.25	64.61	65.96
Avg cost/unit (hour)	$8.414	$8.593	$8.961	$9.231	$9.129	$9.129
Average monthly cost per client	$ 488.36	$ 508.84	$ 543.04	$ 584.44	$ 590.37	$ 602.75
Annual Expenditures	$142,475,806	$162,733,906	$194,914,950	$244,400,710	$284,267,312	$324,665,190
Day Activity and Health Services:Title XIX						
Avg clients per month	12610	14008	14955	15969	17013	17119
Avg units/client/month	32.57	32.67	33.22	33.68	34.14	34.6
Avg cost/unit (half-day)	$12.680	$13.078	$13.303	$13.675	$13.525	$13.525
Average monthly cost per client	$ 412.99	$ 427.26	$ 441.93	$ 460.57	$ 461.74	$ 467.97
Annual Expenditures	$62,493,284	$71,820,404	$79,307,979	$88,258,874	$94,267,577	$96,135,181
Strategy total						
Avg clients per month	**77434**	**83542**	**91689**	**102613**	**114010**	**125332**
Average monthly cost per client	**$480.14**	**$500.15**	**$535.84**	**$574.52**	**$579.99**	**$592.93**
Annual Expenditures	**$446,150,465**	**$501,400,358**	**$589,564,545**	**$707,442,808**	**$793,498,579**	**$891,763,258**
State Share	**$172,392,540**	**$197,702,161**	**$234,823,558**	**$271,941,015**	**$296,213,020**	**$348,946,963**
Federal	**$273,757,925**	**$303,698,197**	**$354,740,987**	**$435,501,793**	**$497,285,559**	**$542,816,295**

Community Care-Waivers

Community Based Alternatives (CBA) Strategy 1-3-1

Program Description

Community-Based Alternatives (CBA) Program provides an array of home and community-based services to aged and disabled adults as cost-effective alternatives to nursing facility care. Services include personal assistance, adaptive aids, medical supplies, adult foster care, assisted living/residential care, nursing, rehabilitative therapies, respite care, home-delivered meals, emergency response, consumer directed services, and minor home modifications.

Eligibility Requirements

Age: 21 or older; **Income / Resources:** Be Medicaid eligible in the community under SSI; or Medical Assistance Only (MAO) protected status; or Meet the income and resource requirements for Medicaid benefits in nursing facilities (Effective January 1, 2004, $1,692/month with resources of $2,000 for an individual. Spousal impoverishment provisions apply). **Individual Plan of Care:** The applicant's cannot exceed the nursing facility payment rate. **Informed Choice:** Choose waiver services instead of nursing facility care based on an informed choice. **Medical Necessity:** Meet the medical necessity determination for nursing facility care. **Risk Assessment:** Be determined at risk for nursing facility placement using the Resident Assessment Instrument for Home Care (RAI-HC).

Client Profile

Currently women make up 70.4% of the people receiving CBA services. People under the age of 64 make up 31.4% of the people receiving CBA services, 68.6% are over age 65. Of the clients receiving CBA services, 9.3% live in Adult Foster Care, 31.9% live alone, 52% live with family members, 6.8% live in other settings.

Waiting List

63,232 as of 2/28/04 (Interest List). 63,625 Projected FY 04; 75,000 Projected FY 05

Policy Changes and Impacts on Caseloads

Because of limited funding, enrollment suspended since 9/1/03

Future Needs to be Addressed

State funds needed to serve more clients

Issues with Federal Funds None

Community Care - Waivers

Community Based Alternatives (CBA)

Strategy 1-3-1

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	303.1	355.7	398.4	458.1	427.6	399.5
FTEs	0	0	0	0	0	0

Method of Finance (MOF)

(major funding sources)

State	117.3	140.3	158.9	176.3	121.9	155.8
Other	0	0	0	-	1.1	0.7
Federal	185.8	215.4	239.5	281.8	304.6	243
Total Funds	303.1	355.7	398.4	458.1	427.6	399.5

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Number of clients per month	23,658	26,329	27,804	30,278	27,664	26,100
Average monthly cost per client	$1,061.72	$1,123.62	$1,188.71	$ 1,256.85	$ 1,284.19	$ 1,271.35
Average number of Interest List clients per month	17905	29458	39,222	50,931	63,625	75,000

Community Care-Waivers

Home and Community Based Services (HCS) Strategy 1-3-2

Program Description

Includes purchased services that enable eligible persons with mental retardation to remain in their community and enable persons in a state school to move to a community setting. Services currently include in-home and residential assistance, habilitation, case management, respite care, dental treatment, adaptive aids, minor home modifications, supported employment, and professional services such as social work, OT/PT, audiology speech/language pathology, dietitian, psychology and licensed nursing services.

Program Benefits

The HCS program provides services to people living in their own or family's home, a foster home, or in a group home. The service plan for the person is individualized based on their identified needs and may include services delivered outside the home. The consumer is able to select the provider of his/her choice and may move through the state and continue to receive services.

Eligibility Requirements

A person must be a SSI (Social Supplemental Income) recipient or meet the income and resource requirements Medicaid coverage in an ICF/MR, be eligible for an ICF/MR Level of Care 1 or meet the requirements for inappropriate nursing facility placement as defined in OBRA 1987, have an Individual Plan of Care for waiver services which does not exceed the dollar limit for services, have made a choice of the waiver program over the ICF-MR Program, and not be enrolled in another 1915(c) waiver program.

Community Care-Waivers

Home and Community Based Services (HCS) Strategy 1-3-2

Client Profile

Most HCS consumers have other disabilities in addition to mental retardation. Many of the individuals are non-ambulatory, have seizure disorders, behavior problems, mental illness, visual or hearing impairments, or a combination of the above. Currently 30.8% of the HCS consumers receive foster care, 30.6% receive services in their own/family home, and 38.5% receive services in a group home. People under the age of 18 make up 8% of the people receiving services in HCS, 88.6% are over age 18 and under age 65, and 3.4% are 65 or older.

Waiting List

As of February 29, 2004 there are 24,502 individuals on the HCS waiting list.

Policy Changes and Impacts on Caseloads

None

Future Needs to be Addressed

Waiting list for HCS continues to grow.

Issues with Federal Funds

None

Community Care - Waivers

Home & Community Based Services (HCS)

Strategy 1-3-2

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	226.4	233.7	211.9	294.5	315.8	344.7
FTEs						

Method of Finance (MOF)

(major funding sources)

State	87.9	92.2	85.5	113.0	118.0	130.0
Other	0	0	0	-	-	3.0
Federal	138.5	141.5	126.4	181.5	197.8	211.7
Total Funds	226.4	233.7	211.9	294.5	315.8	344.7

* Does not include Program Administration

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Average monthly number of consumers receiving Medicaid Waiver services	5,219	5,618	6,380	7,280	8,222	8,835
Average monthly cost per consumer receiving Medicaid Waiver programs per year	3,678	3,474	3,364	3,286	3,200	3,204
Percent of available HCS placements filled				100%	100%	

Community Care-Waivers

Community Living Assistance & Support Services (CLASS)

Strategy 1-3-3

Program Description

Community Living Assistance and Support Services (CLASS) provides home and community-based services to people with related conditions as a cost-effective alternative to ICF-MR/RC institutional placement. Related conditions are disabilities, other than mental retardation, that originated before age 22 and affect the ability to function in daily life.

Eligibility Requirements

Age: No limit (but age of onset of disability must be prior to age 22). Income / Resources: The applicant must be Medicaid eligible in the community under: SSI; Medical Assistance Only (MAO) protected status; or meet the income and resource requirements for Medicaid benefits in nursing facilities. (Effective January 1, 2004; 1,692/month with resources of $2,000 for an individual. Spousal impoverishment provisions apply.) A disabled child who would be eligible for Medicaid if institutionalized and if parental income is not deemed to the child.
Additional Criteria: Have Individual Service Plan (ISP) for waiver services approved by DHS that does not exceed 125% of the cost of ICF-MR/RC institutional care. Meet the institutional Level-of-Care (LOC) criteria for Intermediate Care Facilities for people with Related Conditions (ICF-MR/RC) LOC VIIII. Must have a demonstrated need for habilitation services and case management. Reside in a geographic catchment area.

Client Profile

Currently men make up 56.3% of the people receiving CLASS services. People under the age of 21 make up 52.1% of the people receiving CLASS services, 47.3% are over age 21 and under age 64, 4% are over age 65. The CLASS program serves individuals of all ages which are disabled prior to the age of 22. The disability may be due to a variety of conditions such as cerebral palsy, muscular dystrophy, spina bifda, autism, epilepsy, head injuries, etc.

Waiting List

11,243 as of 2/29/04. 11,381 Projected FY 04 average. 13,063 Projected FY 05 average.

Policy Changes and Impacts on Caseloads None

Future Needs to be Addressed None

Issues with Federal Funds None

Community Care - Waivers

Community Living Assistance & Support Services (CLASS) — Strategy 1-3-3

Budget

	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	33.5	40.6	45.7	56.8	60.2	60.6
FTEs	0	0	0	0	0	0

Method of Finance (MOF)

(major funding sources)

State	12.9	16.0	18.2	21.8	22.5	23.7
Other	0	0	0	-	-	0
Federal	20.6	24.6	27.5	35.0	37.7	36.9
Total Funds	33.5	40.6	45.7	56.8	60.2	60.6

Key Budget Drivers

	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Number of clients per month	1,148	1,410	1,448	1701	1812	1,817
Average monthly cost per client	$ 2,432.70	$ 2,400.49	$ 2,628.17	$ 2,782.28	$ 2,769.62	$ 2,783.47
Average number of Interest List clients per month	5,014	6,177	7,413	8,833	11,381	13,863

Community Care-Waivers

Deaf-Blind Multiple Disabilities (DBMD) Strategy 1-3-4

Program Description

Deaf-blind/Multiple Disabilities (DBMD) Program helps meet the specific needs of people who are deaf, blind, and have multiple disabilities by providing an opportunity to increase independence and communication.

Eligibility Requirements

Age: 18 or older; Income / Resources: The applicant must be Medicaid eligible in the community under: ■ SSI; or ■Medical Assistance Only (MAO) protected status; or ■Meet the income and resource requirements for Medicaid benefits in nursing facilities. (Effective January 1, 2004; $1,692/month with resources of $2,000 for an individual. Spousal impoverishment provisions apply.) Deaf-Blindness: Have Deaf-Blindness with a third disability resulting in a demonstrated need for daily habilitation services; and Individual Plan of Care: The applicant's individual plan of care cannot exceed 115% of the cost of ICF-MR/RC institutional care. Informed Choice: Choose waiver services instead of institutional care based on an informed choice. Level-of-Care: Meet the institutional LOC criteria for ICF-MR/RC LOC VIII.

Client Profile

Currently men make up 64.7% of the people receiving DBMD services. People between the ages of 18 and 20 make up 10.9% of the people receiving DBMD services, 81.0% are over age 21 and under age 44, 8.0% are over age 45.

Waiting List

15 as of 2/29/04. 15 Projected FY 04 and FY 05.

Policy Changes and Impacts on Caseloads None

Future Needs to be Addressed None

Issues with Federal Funds None

Community Care - Waivers

Deaf-Blind Multiple Disabilities (DBMD)

Strategy 1-3-4

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	3.9	4.1	4.8	5.7	6.1	6.1
FTEs	0	0	0	0	0	0

Method of Finance (MOF)

(major funding sources)

State	1.5	1.6	1.9	2.2	2.3	2.4
Other	0	0	0	-	-	
Federal	2.4	2.5	2.9	3.5	3.8	3.7
Total Funds	3.9	4.1	4.8	5.7	6.1	6.1

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Number of clients per month	98	102	112	130	143	143
Average monthly cost per client	$ 3,311.07	$ 3,408.88	$ 3,514.78	$ 3,542.97	$ 3,480.36	$ 3,480.36
Average number of Interest List clients per month	NA	50	37	3	15	15

Community Care-Waivers

Medically Dependent Children Program (MDCP) Strategy 1-3-5

Program Description

Medically Dependent Children Program (MDCP) provides a variety of services such as respite, adjunct supports, adaptive aids and minor home modifications, to support families caring for children who are medically dependent and to encourage de-institutionalization of children in nursing homes.

Eligibility Requirements

Age: Under 21, **Residence:** Live in Texas , **Income / Resources:** Be Medicaid eligible in the community: SSI (TP 13), or Meet the SSI disability criteria as well as financial criteria based on the child's I&R (TP 14). **Medical Necessity:** Meet the medical necessity determination for nursing facility care.

Client Profile

Currently males make up 55.2% of the people receiving MDCP services. People between the ages of 0 and 9 make up 34.6% of the people receiving MDCP services, 54.9% are between the ages of 10 and 17 and 10.5% are between the ages of 18 and 20.

Waiting List

6,720 as of 2/29/04. 6,840 Projected FY 04. 8,800 Projected FY 05.

Policy Changes and Impacts on Caseloads

Added permancey planning activities and new rules will require extensive policy revisions

Future Needs to be Addressed

Funding for permancey planning

\Issues with Federal Funds None

Waivers
hildren Program (MDCP) Strategy 1-3-5

FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
14.7	16.5	15.5	16.6	16.4	16.4
0	0	0	0	0	0
5.7	6.5	6.2	6.4	6.1	6.4
0	0	0	-	-	0
9	10	9.3	10.2	10.3	10
14.7	16.5	15.5	16.6	16.4	16.4

FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
868	975	923	976	979	983
$ 1,411.19	$ 1,417.39	$ 1,401.44	$ 1,412.14	$ 1,396.61	$ 1,396.61
NA	2,151	3,103	4,505	6,840	8,800

Community Care-Waivers

Consolidated Waiver Program Strategy 1-3-6

Program Description

Consolidated Waiver Program (CWP) is a program operating in Bexar County that provides home and community-based services to adults and children who qualify for care in a nursing facility or intermediate care facility for persons with mental retardation or related conditions. Implementation began in December of 2001. The program tests the feasibility of providing a single array of services to multiple populations, sharing common providers, with consistent rates. Serves 192 clients.

Eligibility Requirements

Age: No limit; **Income / Resources:** The applicant must be Medicaid eligible in the community under: SSI; or Medical Assistance Only (MAO) protected status; or Meet the income and resource requirements for Medicaid benefits in nursing facilities; (Effective January 1, 2003; $1,692/month with resources of $2,000 for an individual. Spousal impoverishment provisions apply.) or As a disabled child who would be eligible for Medicaid if institutionalized and if parental income is not deemed to the child. **Individual Service Plan:** Must be developed through a person-directed planning process in conjunction with the individual and other persons. **Informed Choice:** Choose waiver services instead of nursing facility care based on an informed choice. **Interest List:** Currently on an interest list in Bexar County for CBA, CLASS, DB-MD, or MDCP. **Level-of-Care:** Must meet the institutional LOC criteria for ICF-MR/RC LOC I or LOC VIII. The Individual Services Plan cannot exceed 125% of the average aggregate cost of ICF-MR/RC institutional care. **Medical Necessity:** Must meet the institutional LOC for medical necessity determination for nursing facility services. The Individual Service Plan cannot exceed 150% of the nursing facility payment rate. **Residency:** Reside in Bexar County.

Client Profile

Currently males make up 50.5% of the people receiving services. People under the age of 21 make up 46.2% of the people receiving services, 29.9% are between the ages of 21 and 44 and 23.9% are over 45.

Waiting List No

Policy Changes and Impacts on Caseloads

With expansion of STAR Plus, will Consolidated Waiver still include CBA?

Future Needs to be Addressed

Determine if Consolidated Waiver will expand to other counties

Issues with Federal Funds None

Community Care - Waivers

Consolidated Waiver Program

Strategy 1-3-6

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars * (in millions)	0.0	0.0	1.6	3.9	4.7	4.7
FTEs	0	0	0	0	0	0

Method of Finance (MOF) *

(major funding sources)

State	0	0	1	1.8	2.4	2.4
Other	0	0	0	-	-	0
Federal	0	0	0.6	2.1	2.3	2.3
Total Funds	0.0	0.0	1.6	3.9	4.7	4.7

* Does not include Program Administration

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Number of clients per month			57	175	192	192
Average monthly cost per client			$ 1,535.47	$ 1,638.20	$ 1,620.18	$ 1,620.18

Community Care-Waivers

Texas Home Living Waiver (TxHmL) Strategy 1-3-7

Program Description

The Texas Home Living Waiver (TxHmL) is a Medicaid waiver that will provide community based services and supports to eligible individuals who live in their own homes or their family homes. The service components are divided into two service categories, the Community Living Service category and the Technical and Professional Supports Services Category. Each service category has an annual cost limit.

The TxHmL waiver program was developed in response to Executive Order RP13 issued by Governor Rick Perry in 2002. HHSC was directed to work with TDMHMR to develop a new "selected essential services waiver" using existing general revenue funds that will serve individuals with mental retardation who are registered on the department's waiting list for Medicaid waiver program services. The waiver was approved by Centers for Medicare and Medicaid Services (CMS) in February, 2004.

Program Benefits

The combined cost of the two service categories must not exceed $10,000 per person per year. The Community Support category includes: community support, day habilitation, employment assistance, supported employment; and respite. This category has a limit of $8,000 per person/per year. The Professional and Technical Supports category includes: nursing, behavioral support, adaptive aids, minor home modifications, specialized therapies and dental treatment. This category has a limit of $2,000 per person/per year.

Eligibility Requirements

The person must live in their own or family home, be Medicaid eligible at the time of application for the waiver, meet the criteria for an ICF/MR Level Of Care 1, and not require constant supervision to manage dangerous behavior.

Community Care-Waivers

Texas Home Living Waiver (TxHmL) Strategy 1-3-7

Client Profile

Enrollments in the TxHmL waiver program have not yet begun. A request has been submitted to leadership offices seeking authorization to begin implementation pursuant to Rider 53 in TDMHMR's bill pattern in H.B 1.

Waiting List

There is not a TxHmL waiting list. Upon authorization to implement, persons on the HCS waiting list will be offered enrollment in the TxHmL waiver.

Policy Changes and Impacts on Caseloads

None

Future Needs to be Addressed

None

Issues with Federal Funds

There are approximately 1,300 persons now receiving general revenue services that are eligible to have their services refinanced into this waiver thereby drawing new federal funds.

Community Care - Waivers

Texas Home Living Waiver (TxHmL)

Strategy 1-3-7

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	0.0	0.0	0.0	0.0	0.0	27.4
FTEs	0	0	0	0	0	0

Method of Finance (MOF)

(major funding sources)

State	0	0	0	0	0	10.7
Other	0	0	0	0	0	0
Federal	0	0	0	0	0	16.7
Total Funds	0.0	0.0	0.0	0.0	0.0	27.4

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Average monthly number of consumers receiving Medicaid Waiver services					263	2,121
Average monthly cost per consumer receiving Medicaid Waiver programs per year					1,077	1,077
Percent of available HCS placements filled						

Community Care - Waivers

	FY 2000	FY 2001	FY 2002	Estimated FY 2003	Projected FY 2004	Projected FY 2005
Regular CBA						
Average Clients per month	23658	26329	27804	30278	27664	26100
Average monthly cost per client	$ 1,061.72	$ 1,123.62	$ 1,188.71	$ 1,256.85	$ 1,284.19	$ 1,271.35
Annual Expenditures	$301,418,061	$355,005,492	$396,610,714	$456,658,852	$426,302,281	$398,186,820
CLASS						
Average Clients per month	1148	1410	1448	1701	1812	1817
Average monthly cost per client	$ 2,432.70	$ 2,400.49	$ 2,628.17	$ 2,782.28	$ 2,769.62	$ 2,783.47
Annual Expenditures	$33,512,875	$40,616,291	$45,667,082	$56,791,899	$60,222,617	$60,690,780
MDCP						
Average Clients per month	868	975	923	976	979	983
Average monthly cost per client	$ 1,411.19	$ 1,417.39	$ 1,401.44	$ 1,412.14	$ 1,396.61	$ 1,396.61
Annual Expenditures	$14,698,955	$16,583,463	$15,522,349	$16,538,984	$16,407,374	$16,474,412
Deaf-blind Waiver						
Average Clients per month	98	102	112	130	143	143
Average monthly cost per client	$ 3,311.07	$ 3,408.88	$ 3,514.78	$ 3,542.97	$ 3,480.36	$ 3,480.36
Annual Expenditures	$3,946,385	$4,172,469	$4,813,621	$5,611,033	$6,056,298	$6,056,298
Consolidated Waiver						
Average Clients per month			57	175	192	192
Average monthly cost per client			$ 1,535.47	$ 1,638.20	$ 1,620.18	$ 1,620.18
Annual Expenditures			$1,050,261	$3,440,220	$3,732,895	$3,732,895
Assessments/month	1032	422	1162	737	702	727
Cost/assessment	$ 134.55	$ 133.56	$ 127.52	$ 156.50	$ 154.78	$ 154.78
Annual Expenditures	$1,666,295	$676,363	$1,778,155	$1,384,122	$1,303,867	$1,350,301
HCS						
Average Clients per month	5,219	5,618	6,380	7,280	8,222	8,835
Average monthly cost per client	3,678	3,474	3,364	3,286	3,200	3,204
Annual Expenditures	226,385,658	233,641,880	211,896,222	294,589,000	315,757,793	348,020,401
Average Clients per month	**30,991**	**34,434**	**36,724**	**40,540**	**39,012**	**29235**
Average monthly cost per client	**$ 1,563.97**	**$ 1,574.74**	**$ 1,537.00**	**$ 1,716.44**	**$ 1,772.52**	**$ 2,378.75**
Annual Expenditures (services)	**$581,628,229**	**$650,695,958**	**$677,338,404**	**$835,014,110**	**$829,783,125**	**$834,511,907**
Assessments	**$1,666,295**	**$676,363**	**$1,778,155**	**$1,384,122**	**$1,303,867**	**$1,350,301**
Total Expenditures	**$583,294,524**	**$651,372,321**	**$679,116,559**	**$836,398,232**	**$831,086,992**	**$835,862,208**

Community Care-State

Non-Medicaid Services XX Strategy 1-4-1

Program Description

Community Care services are designed to meet the needs of aged or disabled Texans who seek to avoid premature nursing home placement. Services are provided in the most cost-effective manner through a combination of statewide activities and regional contracts

Program Benefits

Services include:

- Family Care (FC) services which are provided to aged and disabled adults who are functionally limited in performing daily living activities.
- Special Services to Persons with Disabilities (SSPD) contracts with public or private agencies to provide services to help persons with disabilities achieve habilitative or rehabilitative goals that encourage maximum independence.
- Emergency Response Systems (ERS) provide a 24-hour electronic medical emergency call system for functionally impaired elderly or disabled adults who live alone or are physically isolated from the community.
- Adult Foster Care (AFC) is provided in enrolled homes and provides 24-hour living arrangements and includes meal preparation, housekeeping, help with personal care, etc.
- Residential Care (RC) provides services to eligible adults who require access to services on a 24-hour basis, but who do not need daily nursing intervention.
- Consumer Managed Personal Assistant Services (CMPAS) targets adults with disabilities who are mentally and emotionally capable of self-directing their attendant care.
- Home Delivered Meals (HDM) provides hot, nutritious meals served in a client's home by community-based provider agencies

Eligibility Requirements

For most community care services, clients must need help to perform routine activities such as bathing, dressing, preparing meals, eating, or toileting, and must meet financial criteria similar to those for nursing home care. Consumer Managed Personal Assistant Services clients also have a co-payment.

Waiting List (Interest List as of 3/31/04)

Family Care – 3154	RC – 2,013
SSPD – 28	CMPAS – 502
ERS – 12,324	HDM – 9,450
AFC – 212	

Policy Changes and Impacts on Caseloads

None

Future Needs to be Addressed

Growing interest lists due to a freeze in funding

Issues with Federal Funds

None

Community Care - State

Non-Medicaid Services - XX

Strategy 1-4-1

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	62.1	68.0	74.3	73.2	73.5	74.0
FTEs	0	0	0	0	0	0

Method of Finance (MOF) (major funding sources)						
State	0	0	4.8	4.1	0	0.7
Other	1.4	0.3	1.7	1.3	0	1.3
Federal	60.7	67.7	67.8	67.8	73.5	72
Total Funds	62.1	68.0	74.3	73.2	73.5	74.0

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Number of non-Medicaid Community Care clients per month (TitleXX)	13,740	14,892	14,377	13,321	12,727	12,727
Average monthly cost per non-Medicaid Community Care client (TitleXX)	$ 376.77	$ 380.23	$ 430.44	$ 457.97	$ 474.09	$ 474.09
Average number (nonduplicated) of non-Medicaid Community Care Interest List clients per month (Title XX)	2,650	4,011	6,112	6,465	8,643	9,800

Community Care - State

Non-Medicaid Services - GR

Strategy 1-4-2

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars * (in millions)	8.7	7.9	7.8	7.6	0.3	0.2
FTEs	0	0	0	0	0	0

Method of Finance (MOF) *

(major funding sources)

State	8.7	7.9	7.8	7.6	0.3	0.2
Other	0	0	0	0	0	0
Federal	0	0	0	0	0	0
Total Funds	8.7	7.9	7.8	7.6	0.3	0.2

* Includes Program Administration

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Number of non-Medicaid Community Care clients per month (GR)	1,379	1,258	1,236	1,153	-	-
Average monthly cost per non-Medicaid Community Care client (GR)	$ 527.64	$ 521.43	$ 522.63	$ 551.42	$ -	$0
Average number of non-Medicaid Community Care Interest List clients per month (GR)	633	1,207	1,504	1,814	-	-

Community Care-State

MR Community Care Services Strategy 1-4-3

Program Description

This program includes all services provided for persons with mental retardation who reside in the community other than services provided through the Medicaid waiver programs. These services include Independent Living Supports, which are services provided to assist an individual to participate in age-appropriate community activities and services. Employment Services are support services to assist individuals in securing community employment and maintaining that employment. Day Training Services are provided away from an individual's home to help the individual develop and refine skills necessary to live and work in the community. Therapies are support services provided by licensed or certified professionals, including psychology, nursing, social work, occupational therapy, speech therapy, physical therapy, dietary services and behavioral health services. Respite Services can be provided either in or out of the consumer's home to temporarily relieve the individual's family members or other primary care providers of their responsibilities for providing care to the individual.

Program Benefits

MR Community Services provide the support to individuals with mental retardation and their families necessary to allow the individual to live as independently as possible in the community and avoid more restrictive, more expensive institutional care. The services and supports are focused on training and support that promote integration of the person with a disability to live and work in their home community.

Eligibility Requirements

Persons receiving MR Community Programs have a diagnosis of Mental Retardation, Autism or a Pervasive Developmental Disorder and are residents of Texas. Persons receiving these services are charged a sliding scale fee based on their ability to pay.

Community Care-State

MR Community Care Services Strategy 1-4-3

Client Profile

Individuals receiving Mental Retardation Community Services typically are adults or children who are living in their family home. Adults who live with their families receive training and supports to help them work and live in their communities as independently as possible. Children may be involved in school district services and their families may receive respite services, behavioral support services or other therapies that allow the child to remain in the family home.

Waiting List

As of the February 29, 2004 waiting list report, 617 people who have requested only general revenue services have been waiting more than 30 days. An additional number of people that appear on the HCS waiting list are waiting for HCS and general revenue funded MR Community services.

Policy Changes and Impacts on Caseloads

The Provider of Last Resort requirements in HB 2292 may have an impact on who will provide these services by September 1, 2006.

Local authorities, according to the legislation "…may serve as a provider of services only if the authority demonstrates that:

1. the authority has made every reasonable attempt to solicit the development of an available and appropriate provider base that is sufficient to meet the needs of consumers…and
2. there is not a willing provider of the relevant services in the authorities service area or in the county where the provision of services is needed."

Pursuant to Rider 13 in TDMHMR's bill pattern in H.B. 1 the agency is continuing to refinance consumers who receive general revenue services in the MR Community Centers to the Home and Community Based Waiver. This trend will continue to affect this program by moving dollars and consumers to the waiver when appropriate.

Future Needs to be Addressed

The appropriation for MR Community Services was reduced in the last session by $23.5 million each year of the biennium reducing the capacity of community centers to provide these types of services.

Issues with Federal Funds None

Community Care - State

MR Community Services

Strategy 1-4-3

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	146.7	152.8	148.7	138.1	104.1	84.6
FTEs	408	30				

Method of Finance (MOF)

(major funding sources)

State	135	151.6	147.5	136.9	102.9	83.4
Other	6.2	0	0	-	-	0
Federal	5.5	1.2	1.2	1.2	1.2	1.2
Total Funds	146.7	152.8	148.7	138.1	104.1	84.6

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Average monthly number of consumers with MR receiving community services	8,585	8,634	13,863	13,333	10,444	11,306

Community Care - State

MR Community Services Residential

Strategy 1-4-4

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	14.3	9.9	10.2	9.7	4.4	3.9
FTEs	0	0	0	0	0	0

Method of Finance (MOF)

(major funding sources)

State	14.3	9.9	10.2	9.7	4.4	3.9
Other	0	0	0	-	-	0
Federal	0	0	0	-	-	0
Total Funds	14.3	9.9	10.2	9.7	4.4	3.9

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Average monthly number of consumers with MR receiving community services	237	161	122	129	114	95
Average monthly cost per consumer with MR receiving Community Services	5,424	5,508	3,017	3,094	3,105	3,431

Program Description
An initiative that helps individuals transition from an institution into the community

Eligibility Requirements
Resident of an institution

Client Profile
Resident of an institution

Waiting List
No

Policy Changes and Impacts on Caseloads
None

Future Needs to be Addressed
Draw down of federal funds for Promoting Independence activities

Issues with Federal Funds
None

Community Care - State

Promoting Independence

Strategy 1-4-5

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	0.0	0.0	0.2	1.1	0.1	1.3
FTEs	0	0	0	0	0	0

Method of Finance (MOF)

(major funding sources)

State	0	0	0.2	1.1	0.1	1.3
Other	0	0	0	-	-	0
Federal	0	0	0	-	-	0
Total Funds	0.0	0.0	0.2	1.1	0.1	1.3

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)

Program Description

The Texas State Unit on Aging through AAAs supports a statewide, locally based system of nutrition services designed to promote good health and to prevent illness. Nutrition programs target older persons who are malnourished or at risk from poor nutrition because they are unable to shop for, or prepare meals due to physical or mental impairment, and/or limited income. Proper nutrition is essential in helping older individuals remain physically and mentally healthy, allowing them to be independent and live in the community for as long as possible. Proper nutrition maintains quality of life and decreases the cost of health care. Congregate Meal services provide older Texans with meals, nutrition education, nutrition counseling, and socialization in a group setting at nutrition sites or multi-service senior centers. Home Delivered Meals and nutrition education are provided to older Texans who are homebound by illness or other functional limitations/impairments, or who are otherwise isolated. Nutrition services are provided on a short-term basis.

Eligibility Requirements

In accordance with the Older Americans Act, any individual age 60 and older is eligible to receive services. Age is the sole eligibility criteria under the Older Americans Act and no formal verification of age is required. For nutrition services, AAAs and service providers screen nutrition service participants to determine need and ensure service provision requirements are met. In order to receive a home delivered meal, an assessment is completed by AAA staff, service providers or accepted from qualified sources, and is used to determine need.

Client Profile

The typical client is an individual who is 60 years of age or older, their family member or caregiver. However, Section 307 (42 U.S.C. 3027) of the Older Americans Act requires an emphasis be placed on serving individuals who reside in rural areas; older individuals with greatest economic need (with particular attention to low-income minority individuals; older individuals with greatest social need (physical and mental disabilities, language barriers, cultural, social or geographical isolation).

Waiting List

The Department does not maintain a waiting list.

Policy Changes and Impacts on Caseloads

AAAs provide short-term services, often to individuals who are awaiting eligibility determination or who may be on an interest list for long-term care services. Any reduction in services at the state level will cause an increase in the number of individuals who are trying to access services through an AAA.

Future Needs to be Addressed None Issues with Federal Funds None

Community Care - State

Nutrition Services

Strategy 1-4-6

Budget

	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	0.0	0.0	0.0	35.3	35.4	35.4
FTEs	0	0	0	0	0	0

Method of Finance (MOF)

(major funding sources)

State				1.5	1.4	1.4
Other				-	-	0.0
Federal				33.8	34.0	34.0
Total Funds	0.0	0.0	0.0	35.3	35.4	35.4

Key Budget Drivers

	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Number of Congregate Meals Served	3,773,177	4,091,050	4,427,076	4,149,151	4,261,038	
Number of Home Delivered Meals Served	3,657,816	3,950,582	4,383,195	4,353,530	4,168,605	
TDoA Cost per Congregate Meal	4.30	3.07	3.82	3.85	3.75	
TDoA Cost per Home Delivered Meal	3.61	3.27	3.82	3.95	3.98	

Community Care-State

Services to Assist Independent Living Strategy 1-4-7

Program Description

The OAA provides funding for a wide range of community-based social and supportive services. These services support a comprehensive, coordinated community-based system that results in a continuum of services for older individuals. It is the intent of the OAA that allocated funds be used as a catalyst in bringing together public/private and formal/informal resources in the community to assure the provision of a full-range of efficient, well coordinated and accessible services for older individuals. In-home and Other Support services include the following: Homemaker, Personal Assistance, Chore Maintenance, Adult Day Care, Residential Repair, Respite, Health Maintenance, Health Screening/Monitoring, Emergency Response, Instruction and Training, Transportation, Hospice and Senior Center Operations.

Eligibility Requirements

In accordance with the Older Americans Act, any individual age 60 and older is eligible to receive services. Age is the sole eligibility criteria under the Older Americans Act and no formal verification of age is required. Where applicable, AAAs and service providers screen service participants to determine need and ensure service provision requirements are met under the Older Americans Act.

Client Profile

The typical client is an individual who is 60 years of age or older, their family member or caregiver. However, Section 307 (42 U.S.C. 3027) of the Older Americans Act requires an emphasis be placed on serving individuals who reside in rural areas; older individuals with greatest economic need (with particular attention to low-income minority individuals; older individuals with greatest social need (physical and mental disabilities, language barriers, cultural, social or geographical isolation).

Waiting List No

Policy Changes and Impacts on Caseloads

AAAs provide short-term services, often to individuals who are awaiting eligibility determination or who may be on an interest list for long-term care services. Any reduction in services at the state level will cause an increase in the number of individuals who are trying to access services through an AAA.

Future Needs to be Addressed None

Issues with Federal Funds None

Community Care - State

Services to Assist Independent Living

Strategy 1-4-7

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	12.0	12.3	20.4	21.6	20.4	20.4
FTEs	0	0	0	0	0	0

Method of Finance (MOF)

(major funding sources)

State				3.4	3.2	3.2
Other				0.0	0.0	0.0
Federal				18.2	17.2	17.2
Total Funds	12.0	12.3	20.4	21.6	20.4	20.4

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
	4,703	3,642	3,708	3,681	4,791	
Number of Persons Receiving Homemaker Services						
	289	387	429	488	401	
Statewide Average Cost per Person Receiving Homemaker Services						
	1,165,060	1,169,012	1,072,641	1,068,345	1,242,207	
Number of One-way Trips						
	3.58	4.00	4.80	4.76	4.29	
Statewide Average Cost per One-way Trip						

Community Care-State

In-Home and Family Support (IHFS) Strategy 1-4-8

Program Description

This program provides persons with physical disabilities (without diagnosis of a mental disability) with a means to purchase the support they need to remain in the community. Direct grant benefits are provided to eligible individuals to purchase special equipment, medical supplies, adaptive aids, and also to modify the home or an automobile so that they are accessible and usable by the disabled individual. Grants may be provided to persons who are elderly or have disabilities to support their living independently in the community and prevent institutionalization.

Program Benefits

Up to $1,200 per year cash subsidy for the purchase of ongoing services, and/or for the purchase of equipment or architecture modifications. $3,600 lifetime limit for purchases of equipment or modifications costing over $250.

Eligibility Requirements

Eligibility is based on the individual's functional and financial need for services. People with income at or below 100 percent of the state's median income (SMI) level are eligible without co-payment. Applicants with incomes at or above 105 percent of the SMI must contribute to the cost of the services they receive based on a sliding scale. When income exceeds 150 percent of the SMI, the co-pay is 100 percent.

Client Profile

The typical IHFS client: Lives in the community in his/her own home or with family or friends, is 4 years of age or older, has a physical disability that causes a substantial limitation in one or more major life areas (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and/or economic self-sufficiency), and has the need for lifelong or extended care, treatment, or support services.

Waiting List

19,772 on the interest list as of 2/29/04. 19,790 Projected FY 04. 21,503 Projected FY 05.

Policy Changes and Impacts on Caseloads None

Future Needs to be Addressed None

Issues with Federal Funds None

Community Care - State
In-Home and Family Support (IHFS)

Strategy 1-4-8

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	6.5	6.5	8.2	8.7	3.7	4.0
FTEs	0	0	0	0	0	0

Method of Finance (MOF)
(major funding sources)

State	6.5	6.5	8.2	8.7	3.7	4.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
Federal	0.0	0.0	0.0	0.0	0.0	0.0
Total Funds	6.5	6.5	8.2	8.7	3.7	4.0

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Average number of clients per month receiving (non-MR) In Home and Family Support services	3,109	2,905	3,834	3,782	4,221	4,221
Average monthly cost per client receiving (non-MR) In Home and Family Support services	143.51	$ 149.84	$ 150.00	$ 163.43	$ 78.97	$ 78.97
Average number on interest list per quarter:(non-MR) In Home and Family Support services	4,593	7,384	9,435	16,163	19,790	21,503

Program Description

This program funds the mental retardation portion of the In-Home and Family Support (IHFS) program. IHFS is a grant program that provides financial assistance to adults or children with a mental disability or to their families for the purpose of purchasing items that are above and beyond the scope of usual needs, that are necessitated by the person's mental disability and that directly support that person to live in his/her natural home, rather than living in a more restrictive setting at a higher cost. There is a limit of $2,500 per year, with the amount granted depending on the individual's needs, income and the application of a sliding fee scale. This is a resource of last resort meaning that all other available resources must be accessed before these funds are used. These funds are used to purchase services such as respite care, specialized therapies, counseling, adaptive equipment, home modifications, training and non-traditional supports, such as in-home parent training. One-time grants, not to exceed $2,500 each for architectural modifications or specialized equipment are also available. Authority for this strategy is found in Chapter 535 of the Health and Safety Code.

Program Benefits

The program provides the flexibility necessary for families to make efficient use of the funds available to successfully live in the community.

Eligibility Requirements

To be eligible for Mental Retardation IHFS, the individual must have a diagnosis of Mental Retardation, a Pervasive Developmental Disorder or be under the age of 3 and have a developmental delay.

Client Profile

The consumers are adults or children who are living in their own or their family home in the community. The most frequent use of funds is for respite services.

Waiting List

As of February 29, 2004 waiting list report, 1,223 person are waiting for MR In Home and Family Support.

Policy Changes and Impacts on Caseloads

There was a reduction in the IHFS allocation in the last legislative session from $12.7 million for each year of the biennium to $5 million for each year of the biennium. In relation to this reduction, TDMHMR reduced the maximum annual grant amount from $3,600 to $2,500 per year. In addition, local authorities were prohibited from using IHFS dollars to cover any administrative costs.

Future Needs to be Addressed

There is a growing waiting list of persons in need of IHFS funds. Without these supports there is a risk that these individuals will require more intensive services and or institutional placement.

Issues with Federal Funds

None

Community Care - State

MR In-Home Services

Strategy 1-4-9

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	12.7	12.3	12.7	12.6	5.0	5.0
FTEs	0	0	0	0	0	0

Method of Finance (MOF)

(major funding sources)

State	12.7	12.3	12.7	12.6	5.0	5.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
Federal	0.0	0.0	0.0	0.0	0.0	0.0
Total Funds	12.7	12.3	12.7	12.6	5.0	5.0

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Budgeted)
Average monthly number of consumers with MR receiving community services	5,601	5,695	4,345	3,782	1,669	2,273

Community Care - State
Direct Program Administration

Strategy 1-4-10

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	2.0	2.3	2.0	2.0	8.3	8.2
FTEs	48.0	48.0	43.0	43.7	40.5	40.0

Method of Finance (MOF)
(major funding sources)

State	0.9	1.0	1.1	1.1	6.1	6.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
Federal	1.1	1.3	0.9	0.9	2.2	2.2
Total Funds	2.0	2.3	2.0	2.0	8.3	8.2

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)

N/A

Program of All Inclusive Care for the Elderly (PACE) Strategy 1-5-1

Program Description

STAR+Plus (FY 00 – FY 04; FY 05 at HHSC)- The Star+Plus program is a Medicaid Managed Care pilot that integrates acute and long-term care service delivery for the Aged and Disabled Medicaid population in Harris County. The program creates incentives for clients and HMOs to voluntarily integrate both programs into one continuum of care.

PACE (FY 00 – FY 05)- The Star+Plus program is a Medicaid Managed Care pilot that integrates acute and long-term care service delivery for the Aged and Disabled Medicaid population in Harris County. The program creates incentives for clients and HMOs to voluntarily integrate both programs into one continuum of care.

Eligibility Requirements

Age: Over age 55; Choose PACE services; and Qualify for a nursing facility LOC. Live in the PACE catchment area.

Client Profile

80-year old female living at home, living in El Paso or Amarillo.

Waiting List No

Policy Changes and Impacts on Caseloads None

Future Needs to be Addressed None

Issues with Federal Funds None

PACE

Program of All-inclusive Care for the Elderly

Strategy 1-5-1

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 **(Projected)
Dollars (in millions)	9.4	13.4	16.3	17.9	20.1	24.6
FTEs	0	0	0	0	0	0

Method of Finance (MOF)

(major funding sources)

State	3.6	5.3	6.5	6.9	7.5	9.6
Other	0.0	0.0	0.0	0.0	0.0	0.0
Federal	5.8	8.1	9.8	11.0	12.6	15
Total Funds	9.4	13.4	16.3	17.9	20.1	24.6

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Budgeted)
Average number of recipients per month: Program for All Inclusive Care for the Elderly (PACE)	346	470	568	625	707	877
Average monthly cost per recipient: Program for All Inclusive Care for the Elderly (PACE)	$2,259.60	$2,383.83	$2,385.72	$ 2,385.72	$ 2,374.01	$ 2,334.05

Nursing Facility & Hospice Payments

Nursing Facility & Hospice Payments Strategy 1-6-1

Program Description

Nursing Facility Care Program provides institutional nursing care to Medicaid recipients whose medical condition requires the skills of a licensed nurse on a regular basis. The nursing facility must provide for the total medical, nursing, and psychosocial needs of each client, including room and board, social services, over-the-counter drugs (prescription drugs are covered through the Medicaid Vendor Drug program), medical supplies and equipment, and personal needs items. Medicare skilled nursing facility co-insurance payments are also paid for persons who are eligible for both Medicare and Medicaid. Hospice provides palliative care consisting of medical, social, and support services to persons who are diagnosed as terminally ill with a prognosis of six months or less to live.

Eligibility Requirements

To be eligible for Medicaid coverage in a nursing facility, an applicant must reside in a Medicaid-certified nursing facility, demonstrate financial eligibility, and meet appropriate medical necessity requirements. An individual (of any age) must meet the following criteria:

- Financial eligibility – income no greater than $1,692 per month and countable assets no greater than $2,000
- Medical necessity – certified by a physician as having a medical condition that requires daily skilled nursing care. The need for custodial care only does not constitute medical necessity.

Client Profile

The typical nursing facility resident in Texas is a widow over age 80. She will live in the nursing facility for about two years before her death and will be hospitalized at least once during this period. She sold her home or gave up her lease when she entered the nursing facility. She suffers from cardio-vascular disease and diabetes and has some level of cognitive impairment. She takes six prescription drugs daily. If she has any family members, they will visit her infrequently.

Waiting List No

Policy Changes and Impacts on Caseloads None

Future Needs to be Addressed None

Issues with Federal Funds None

Nursing Facility & Hospice Payments

Nursing Facility & Hospice Payments — Strategy 1-6-1

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	1576.5	1678.2	1884.7	1917.8	1931.9	2483.4
FTEs	58.0	78.0	83.1	83.6	78.4	74.0

Method of Finance (MOF) (major funding sources)						
State	607.2	659.8	746.9	730.3	723.0	699.8
Other	0.6	0.6	3.2	4.0	0.0	1.3
Federal	968.7	1017.8	1134.6	1,183.5	1,208.9	1782.3
Total Funds	1576.5	1678.2	1884.7	1917.8	1931.9	2483.4

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Average number of persons receiving Medicaid-funded Nursing Facility Services per month	61,607	61,678	60,291	60,036	59,632	59,321
Average Rider 28 clients served per month					1,186	2,545
Net Nursing Facility cost per Medicaid resident per month	$1,981.44	$2,079.41	$ 2,372.71	$ 2,374.45	$ 2,319.88	$ 2,310.36
Average monthly cost per Rider 28 client served					$ 1,284.19	$ 1,284.19
Average number of clients receiving co-paid Medicaid/Medicare Nursing Facility Services per month	3,026	3,319	3,925	4,621	5,296	5,666
Net payment per client for co-paid Medicaid/Medicare Nursing Facility Services per month	$1,353.00	$1,357.93	$ 1,394.71	$ 1,460.16	$ 1,506.44	$ 1,572.16
Average number of clients receiving Hospice Services per month	2,068	2,636	3,056	3,563	4,075	4,400
Average net payment per client per month for Hospice	$1,788.52	$1,869.57	$ 2,095.69	$ 2,137.29	$ 2,112.42	$ 2,132.39

Nursing Facility & Hospice Payments

	FY 2000	FY 2001	FY 2002	Estimated FY 2003	Projected FY 2004
Nursing Facility					
Average Clients per month	**61,607**	**61,678**	**60,291**	**60,036**	**59,632**
Average daily rate	$ 81.35	$ 85.48	$ 95.46	$ 96.17	$ 95.00
Average applied income per patient day	$ 16.38	$ 17.12	$ 17.45	$ 18.10	$ 18.93
Net cost per patient day	$ 64.97	$ 68.36	$ 78.01	$ 78.07	$ 76.07
Average monthly cost per client	**$1,981.44**	**$2,079.41**	**$2,372.71**	**$2,374.45**	**$2,319.88**
Annual Expenditures	$1,464,848,006	$1,539,045,058	$1,716,635,146	$1,710,633,089	$1,660,069,789
Rider 28 CBA					
Average Clients per month					1186
Average monthly cost per client					$ 1,284.19
Annual Expenditures					$18,274,024
Medicare Skilled					
Average Clients per month	**3,026**	**3,319**	**3,925**	**4,621**	**5,296**
Average days per month per client	16.54	16.45	16.51	16.77	16.63
Average coinsurance per day	$ 96.69	$ 98.39	$ 100.75	$ 103.94	$ 108.07
Average applied income per patient day	$ 14.87	$ 15.83	$ 16.26	$ 16.87	$ 17.50
Net cost per patient day	$ 81.82	$ 82.56	$ 84.49	$ 87.07	$ 90.57
Average monthly cost per client	**$1,353.00**	**$1,357.93**	**$1,394.71**	**$1,460.16**	**$1,506.44**
Annual Expenditures	$49,130,045	$54,083,609	$65,690,796	$80,969,039	$95,737,533
Hospice					
Average Clients per month	**2,068**	**2,636**	**3,056**	**3,563**	**4,075**
Average units per month per client	23.83	24.38	25.02	25.37	25.51
Average cost per unit	$75.06	$76.70	$83.76	$84.26	$82.80
Average monthly cost per client	**$1,788.52**	**$1,869.57**	**$2,095.69**	**$2,137.29**	**$2,112.42**
Annual Expenditures	$44,383,899	$59,138,268	$76,853,032	$91,382,043	$103,297,233
Other Services					
Annual Expenditures	$5,111,693	$9,730,880	$12,959,761	$12,943,014	$6,347,923
Strategy total (excluding Admin)					
Annual Expenditures	**$1,563,473,643**	**$1,661,997,815**	**$1,872,138,735**	**$1,895,927,185**	**$1,883,726,502**
State Share	**$605,726,141**	**$656,915,605**	**$804,607,402**	**$675,527,868**	**$752,845,405**

Intermediate Care Facilities -Mental Retardation

Strategy 1-7-1

Program Description

Includes direct services for privately owned, public owned, and state owned Intermediate Care Facilities for Mental Retardation (ICFs/MR). These are residential facilities of five or more beds. Covered Services include room and board, habilitation services, nursing services, prescription medications, skills training, and adjunctive therapies.

Program Benefits

The program provides comprehensive 24-hour/7 day a week service.

Eligibility Requirements

To be eligible the person must have income within 300% of Supplemental Security Income (SSI), resources of no more than 2 thousand dollars, and have a determination of mental retardation or a related condition and an ABL (Adaptive Behavioral Level) score greater than zero.

Intermediate Care Facilities -Mental Retardation

Strategy 1-7-1

Client Profile

This program serves people with mental retardation and related conditions. Most have other disabilities as well as mental retardation. Many of the individuals are non-ambulatory, have seizure disorders, behavior problems, mental illness, visual or hearing impairments, or a combination of the above. As of 4-15-04, 3% of the residents of community based (non-State School) ICF/MR residents are under the age of 18, 91% are between the ages of 18 and 64, and 6% are age 65 and older.

Waiting List

As of February 29, 2004, there are 438 persons on the ICF/MR waiting list.

Policy Changes and Impacts on Caseloads

The department has a request pending in leadership offices to use available funds to address Promoting Independence Plan commitments by providing 396 waiver placements for persons currently residing in large community Intermediate Care Facilities for the Mentally Retarded.

Future Needs to be Addressed

Large ICF/MR facilities are faced with aging physical plants and declining occupancy rates.

Issues with Federal Funds

None

Intermediate Care Facilities - Mental Retardation

ICF-MR

Strategy 1-7-1

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	355.0	352.8	381.3	385.9	378.2	379.2
FTEs	184.6	29.2	29.2	25.1	25.0	27.6

Method of Finance (MOF) (major funding sources)						
State	137.8	139.8	152.3	149.9	140.1	141.1
Other	0	0	0	-	3.9	3.9
Federal	217.2	213	229	236.0	234.2	234.2
Total Funds	355.0	352.8	381.3	385.9	378.2	379.2

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Budgeted)
Average monthly number of persons in ICF-MR Medicaid beds, Total	7,713	7,691	7,396	7,468	7,282	7,299
Average monthly cost per ICF-MR Medicaid eligible Consumer, Total	3,836	3,920	4,261	4,275	4,328	4,377

MR State Schools Services

MR State Schools Services Strategy 1-8-1

Program Description

Provides direct services and supports to persons with mental retardation admitted to the eleven state school campuses and two state centers for residential services. State MR Facilities are intended to provide residential services for individuals with severe or profound mental retardation and those individuals with mental retardation who are medically fragile or who have challenging behavioral needs. Other services provided by State MR Facilities include time-limited services for persons who reside in the community but require temporary admission to address intensive behavioral or medical needs or for respite care.

Program Benefits

Services provided in State MR Facilities provide specialized treatment and habilitation for persons requiring those services to function most independently. Services are structured specifically to meet the individual needs, preferences and desires of the consumer and to prepare that individual to move to a lesser-restrictive environment when his/her skills/abilities allow.

Eligibility Requirements

Persons eligible for admission to a State MR Facility must:

- Because of diagnosed mental retardation, represent a substantial risk of physical impairment or injury to self or others; or is unable to provide for and is not providing for their most basic personal physical needs;
- Be unable to be appropriately habilitated in an available, less-restrictive setting; and,
- The State MR Facility provides habilitation services, care, training and treatment appropriate to meet the individual's needs.

Client Profile

State MR Facilities provide a full array of residential, treatment and training services (from respite to long-term residential services) for persons with mental retardation. As noted above, the priority service population includes those individuals with severe or profound mental retardation and those with mental retardation who are medically fragile or who have challenging behavioral needs.

Waiting List

As of March 31, 2004, 11 persons with a complete admissions packet are waiting for admission to a State MR Facility.

Policy Changes and Impacts on Caseloads

The demand for providing residential services for persons with mental retardation who are alleged offenders continues to increase in the State MR Facilities. Because of the unique needs of these consumers, more specialized and segregated programs may be necessary in the future and the overall numbers of persons served in the State MR Facilities may not decrease at the rate experienced in the past several years.

Future Needs to be Addressed

Two (2) specific population groups are growing in the State MR Facilities. These include:

- Persons with challenging behavioral needs and those individuals with mental retardation who are alleged offenders;
- Individuals who are aging and experiencing increasingly complex health care challenges with the aging process – includes persons currently in residence at the State MR Facilities and those who have previously received services in a less-restrictive environment, due to increasing health care needs, can no longer adequately function in that environment.

As demand for provision of increasingly specialized services in the State MR Facilities grows, the facilities must recruit and retain highly specialized and qualified staff members to develop, provide and evaluate delivery of these services. Salary demands for staff with specialized skills and training in working with persons with mental retardation who have complex health care needs and/or behavioral challenges will continue to increase. Further specialization of programs within specific facilities and in certain locations throughout the state may be necessary to most effectively meet the increasing acuity and complexity of needs of persons receiving services in the State MR Facilities.

Infrastructure needs continue to be a major issue in the State MR Facilities. Maintaining safe and secure residential and training facilities, providing functional and appropriate equipment for direct and support services and costs associated with providing for safe and functional transportation needs of consumers are all major financial demands on facility operations.

Issues with Federal Funds None

MR State Schools Services

MR State Schools Services - Residential Care — Strategy 1-8-1

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	307.5	327.8	353.1	401.3	386.3	379.1
FTEs	11,508	11,442	11,470	11,616	11,375	11,341

Method of Finance (MOF) (major funding sources)						
State	72.4	94.0	121.7	145.1		155.9
Other	19.8	21.0	22.7	19.5		4.3
Federal	215.3	212.8	208.7	236.7		218.9
Total Funds	307.5	327.8	353.1	401.3	386.3	379.1

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
1) Average number of days MR campus residents wait for community placement	714	609	161	124	180	180
2) Average monthly number of MR campus residents	5,433	5,345	5,133	5,006	4,963	4,963
3) Average monthly number of consumers with MR waiting for admission to any state school campus	-	-	9	15	25	25
4) Average monthly number of consumers with MR waiting for admission to a specific state school	-	-	8	3	5	5
5) Average monthly cost per MR campus resident	4,915	5,058	5,305	6,448	6,525	6,326
6) Average number of days consumers with MR wait for admission to any state school campus	-	-	30	23	45	45
7) Average number of days consumers with MR wait for admission to a specific state school campus	-	-	46	22	60	60

Long Term Care Regulation

Long Term Care Regulation Strategy 2-1-1

Program Description

According to the Health and Safety Code, Chapters 142**,** 242, 247 and 252, and the Human Resources Code, Chapter 103, all long-term care providers must be licensed and maintain compliance with all licensure rules in order to operate in the State of Texas. Long-term care providers include nursing facilities, assisted living facilities, adult day care facilities, privately owned intermediate care facilities for the mentally retarded/related conditions (ICF-MR/RC) and home and community support services agencies (HCSSA), which include hospice agencies. Licensed providers wishing to participate in Medicare and/or Medicaid programs must be certified and maintain compliance with certification regulations according to Titles XVIII and/or XIX of the Social Security Act. State-owned ICF-MR/RC facilities and skilled hospital units are also required to be certified in order to participate in Medicare and/or Medicaid.

Survey teams conduct standard licensure and/or certification surveys routinely to determine the provider's compliance with all applicable state and federal regulations. In addition to conducting standard surveys, survey teams also investigate complaints and incidents reported to the department. Follow-up visits are made whenever deficiencies/violations are cited and/or when additional monitoring is warranted. This program is responsible for obtaining information on the owner/operator and controlling persons for all licensed providers to allow for denial of a license based on the applicant's provider history. Other responsibilities include pursuing enforcement actions against providers cited for non-compliance with regulations, managing Medicaid contracts, and providing information and releasing records to the public.

The types of long-term care providers regulated and the type of regulation are as follows: Nursing Facility Licensure and Certification, Intermediate Care for the Mentally Retarded/Related Conditions Facility Licensure and Certification, Assisted Living Facility Licensure, Adult Day/Health Care Facility Licensure and Home and Community Support Service Agencies (includes HCSSAs or home health agencies and hospice agencies) Licensure and Certification.

Waiting List

No

Policy Changes and Impacts on Caseloads

SB 1084 provides for department to notify police with any abuse/neglect allegations, whether in Regions or State Office, function will impact time/manpower.

Future Needs to be Addressed

Additional funding needed for equipment lease/purchase to upgrade computers to handle new Federal survey reporting requirements. Federal funds not provided; states expected to provide compatible automation equipment.

Issues with Federal Funds

Assisted Living licensure has seen a tremendous growth; funded from pure state funds which leaves fewer state funds to draw down a federal match for other programs. Federal requirement to monitor children psychiatric facilities. If department receives, will be a workload issue but may or may be funded from federal funds.

Long Term Care Regulation

LTC Facility Regulation — Strategy 2-1-1

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	34.4	39.0	37.8	36.4	39.0	41.0
FTEs	630	607	628	645	635	653

Method of Finance (MOF) (major funding sources)						
State	9.2	11.1	10.1	9.8	10.5	11.4
Other	0	0	0.0	0.0	0.0	0.0
Federal	25.2	27.9	27.7	26.6	28.5	29.6
Total Funds	34.4	39.0	37.8	36.4	39.0	41.0

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Number of Inspections Completed per Year	4,944	5,205	5,050	4,232	4,855	4,127
Number of Complaint & Incident Investigations Completed	16,932	19,642	14,075	15,355	16,566	16,566
Total Dollar Amount Collected from Fines	$ 2,597,329	$ 3,071,056	$ 4,605,423	$ 3,867,358	$ 3,409,124	$ 3,409,124
Number of Home and Community Support Services Agency Licenses Issued	2,801.00	2,223.00	2,468.00	2,817.00	2,398.00	2,398.00
Number Home & Community Support Services Agency Inspections Conducted	1,746.00	1,378.00	1,585.00	1,592.00	1,547.00	1,547.00
Number of Complaint Investigations Conducted: HCSSA	613.00	635.00	848.00	1,053.00	1,100.00	1,100.00

Program Description

Under the authority of federal and state law, the Credentialing Department's four programs license, certify and permit the following individuals for the purpose of employability in facilities and agencies regulated by the department:

- 2,100 licensed nursing facility administrators;
- 108,000 certified nurse aides; and
- 8,000 permitted medication aides.

Nursing Facility Administrator (NFA) Licensing and Investigations Program – Responsibilities include licensing and continuing education activities; investigating complaints or referrals, coordinating sanction recommendations and other licensure activities with the Governor-appointed Nursing Facility Administrators Advisory Committee (NFAAC); imposing and monitoring sanctions; providing due process considerations; and developing educational, training and testing curricula.

Nurse Aide Registry (NAR) and Nurse Aide Training and Competency Evaluation Program (NATCEP) – Responsibilities include nurse aide certification and sanction activities; approving or renewing Nurse Aide Training and Competency Evaluation Programs (NATCEPs); withdrawing NATCEP approval, and providing due process considerations and a determination of nurse aide employability in nursing facilities regulated by the department via the Nurse Aide Registry.

Employee Misconduct Registry (EMR) – Responsibilities include providing due process considerations and a determination of unlicensed staff employability in facilities and agencies regulated by the department via the Employee Misconduct Registry.

Medication Aide Program – Responsibilities include medication aide permitting and continuing education activities, issuance and renewal; imposing and monitoring of sanctions; providing due process considerations; approving and monitoring of medication aide training programs in educational institutions; developing educational, training, and testing curricula, and coordinating and administering examinations.

Waiting List

No

Policy Changes and Impacts on Caseloads

Medication Aide Program rules need revision.

Future Needs to be Addressed

None

Issues with Federal Funds

None

Long Term Care Regulation

LTC Credentialing

Strategy 2-1-2

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	0.8	0.7	0.8	0.8	0.8	0.8
FTEs	19.0	18.0	23.0	24.0	18.8	20.0
Method of Finance (MOF) (major funding sources)						
State	0.4	0.4	0.5	0.4	0.5	0.4
Other	0.1	0.1	0.1	0.1	0.0	0.1
Federal	0.3	0.2	0.3	0.3	0.3	0.2
Total Funds	0.8	0.7	0.8	0.8	0.8	0.8

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Percent of complaints & referrals resulting in disciplinary Action: NFAs	N/A	N/A	N/A		85%	100%
Number of Licenses Issued/Renewed: NFAs	1,224	936	1,207	886	1,200	1,200

Program Description

SB 1839 from the 77th Texas Legislature created a technical assistance program for providers of long term care. The program consists of three components that provide a non-regulatory framework for fostering improvements in the quality of resident services. These components are Quality Monitoring, Joint Training and Liaison functions.

Quality Monitoring

This program's nurses, pharmacists and dietitians provide problem-oriented technical assistance to long term care facility staff in all Texas nursing facilities. Most facilities receive about three visits per year. Quality monitoring focuses on specific clinical problems that represent statewide opportunities for improvement in the quality of resident care. While all facilities are monitored, visit priorities are determined by an Early Warning System that directs monitors to the facilities most likely to need assistance. The development of evidence-based best practices involves systematic review of the clinical literature and the use of clinical expert panels comprised of clinical educators, practicing clinicians and state clinical staff. The program disseminates these practices through the visit process itself, through its provider knowledge resource web site (http://mqa.dhs.state.tx.us/QMWeb), through collaborative joint training opportunities and through in-service education. Long-term care providers can also request technical assistance in the form of an invited Rapid Response Team visit.

Joint Training

The purpose of joint training is to provide additional opportunities for providers and regulators of long term care services to participate in an educational process that addresses both clinical knowledge and knowledge of regulations. The process fosters a common and shared understanding of what is clinically appropriate as well as what is required or mandated by law.

LTC Facility/Surveyor Liaison
This component acts as liaison between facility staff and survey team members. It works to address regulatory questions and improve nursing performance in long-term care facilities in Texas while furthering communications with all parties; maintains excellent medical/nursing knowledge regarding state and federal facility surveys; and performs advanced technical and professional clinical/nursing reviews of certification surveys, licensure inspections, and investigations conducted in long-term care facilities to determine compliance with state/federal requirements and protocols, to ensure clients receive optimal care.

Waiting List
No

Policy Changes and Impacts on Caseloads
None

Future Needs to be Addressed
- Announced visits
- Invited quality Monitoring visits (not only RRT visits)
- Outreach to key non-facility staff (Medical Directors, attending physicians, consultant pharmacists, consulting dietitians

Issues with Federal Funds
Extending this strategy to Assisted Living Facilities would create significant funding issues once these facilities are licensed-only. The state would have to fund 100% of that effort.

Long Term Care Regulation

LTC Quality Outreach

Strategy 2-1-3

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	0.0	0.0	0.0	4.5	9.2	5.1
FTEs	0	0	44.4	71.4	69.0	70.0

Method of Finance (MOF) (major funding sources)						
State	0	0	0	-	0.8	0.3
Other	0	0	0	1.6	3.8	1.6
Federal	0	0	0	2.9	4.6	3.2
Total Funds	0.0	0.0	0.0	4.5	9.2	5.1

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)
Number of Quality Monitoring Visits performed per quarter	N/A	N/A	143	794	966	966

Long Term Care Regulation

Direct Program Administration — Strategy 2-1-4

Budget	FY 2000 (Expended)	FY 2001 (Expended)	FY 2002 (Expended)	FY 2003 (Expended)	FY 2004 (Projected)	FY 2005 (Projected)
Dollars (in millions)	12.7	16.2	11.3	11.8	9.2	10.0
FTEs	210	234	208	190	200	182

Method of Finance (MOF) (major funding sources)						
State	3.9	5.6	3.2	4.1	2.8	3.1
Other	0.1	0.0	0.0	0.1	0.0	0.0
Federal	8.8	10.7	8.1	7.7	6.4	6.9
Total Funds	12.7	16.2	11.3	11.8	9.2	10.0

Key Budget Drivers	FY 2000 (Actual)	FY 2001 (Actual)	FY 2002 (Actual)	FY 2003 (Actual)	FY 2004 (Projected)	FY 2005 (Budgeted)

Albert Hawkins, Executive Commissioner

Presentation to the Senate Finance Committee

Department of Family and Protective Services

May 10, 2004

Appendix D

Albert Hawkins, Executive Commissioner

Overview of DFPS

The mission of the Department of Family and Protective Services is to protect the unprotected.

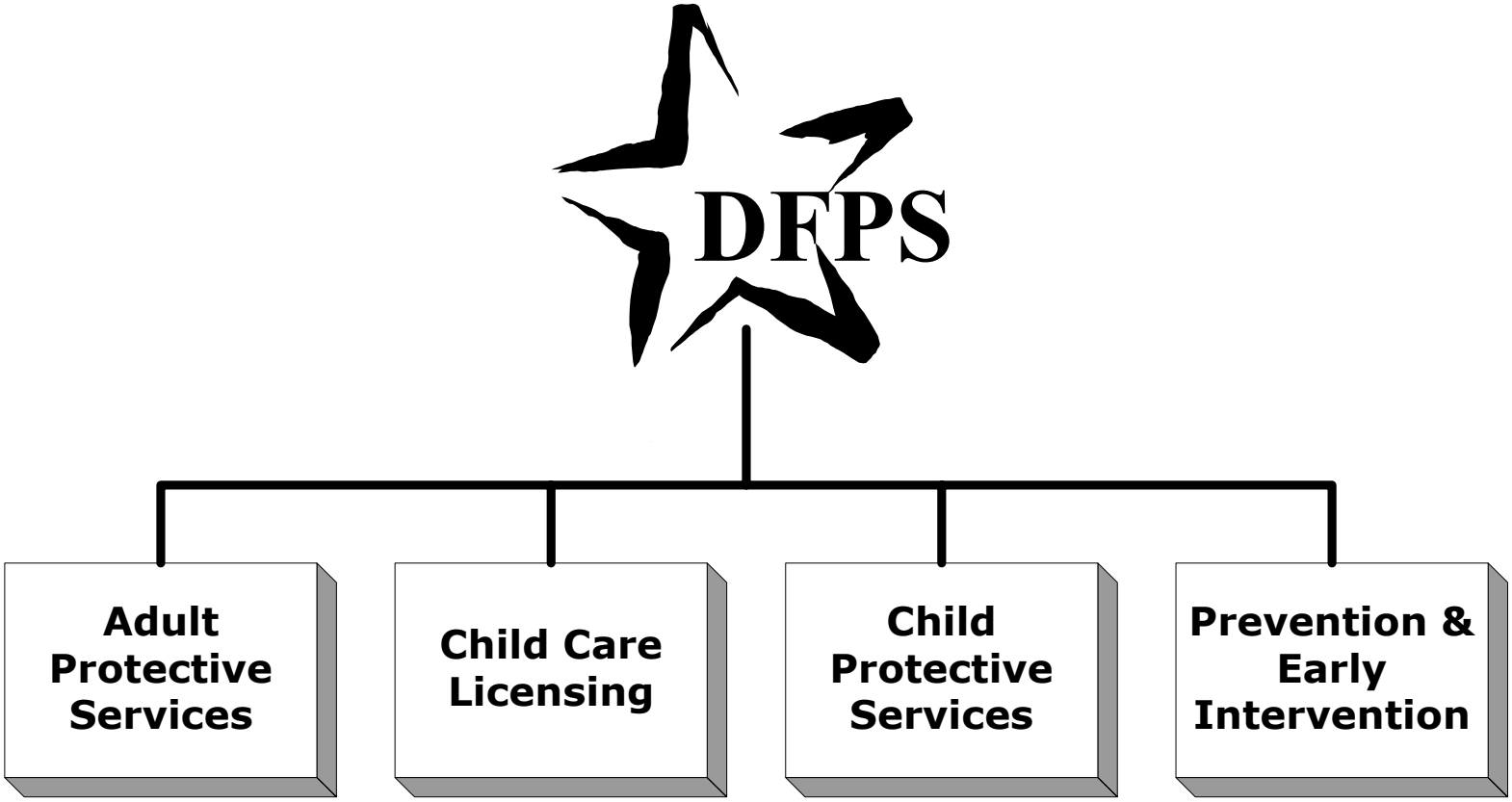
Overview of DFPS

PRS became the Department of Family and Protective Services (DFPS) on February 1, 2004.

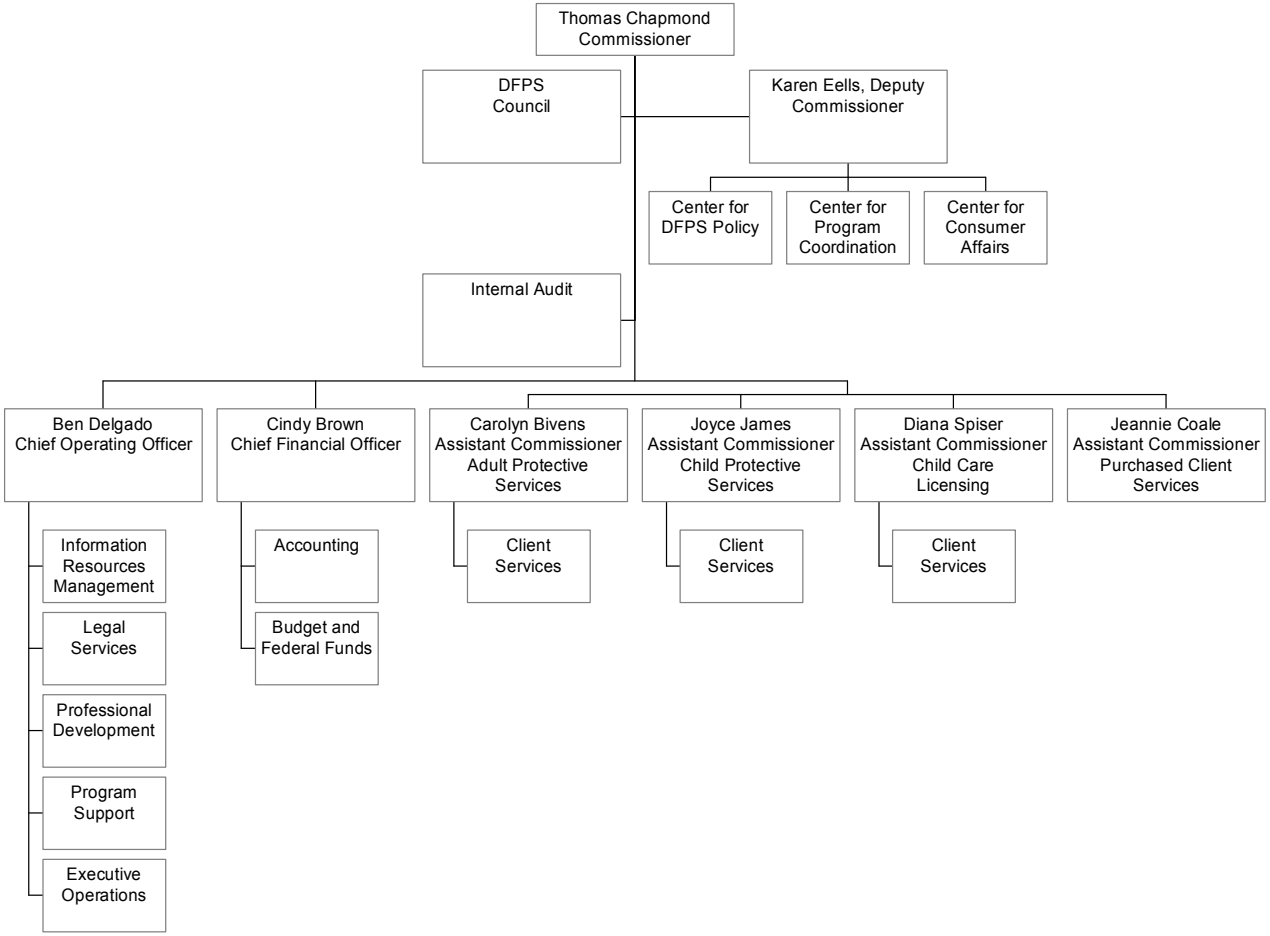
DFPS maintains the programs of PRS

No additional programs transferred to DFPS

Overview of DFPS

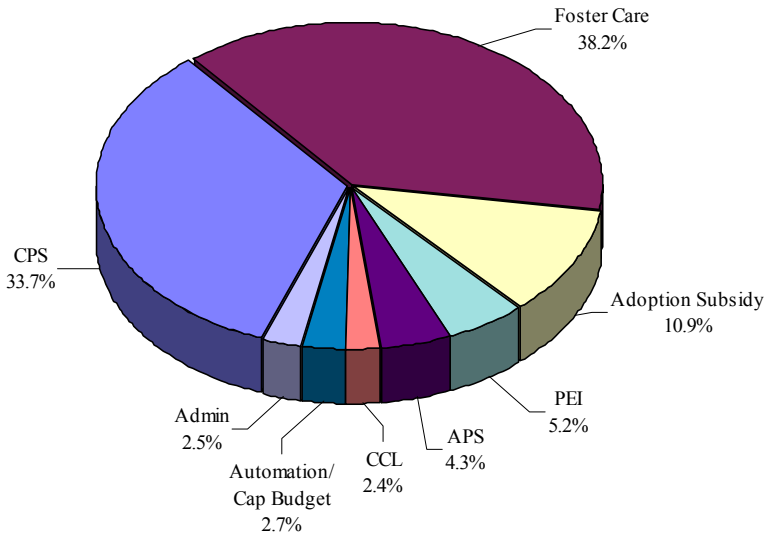


Overview of DFPS



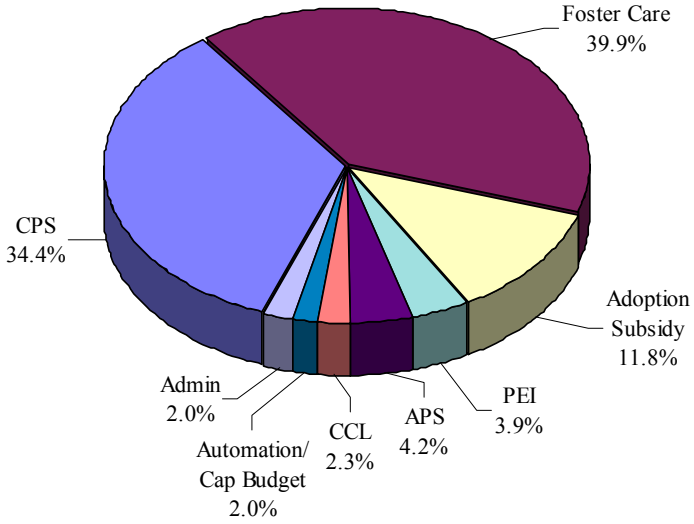
Overview of DFPS

FY 2003 - Expended



Child Protective Services	$283.9
Foster Care Payments	321.7
Adoption Subsidy Payments	92.1
Prevention & Early Intervention	43.9
Adult Protective Services	36.0
Child Care Licensing	20.6
Automation/Capital Budget	22.7
Indirect Administration	20.8
FY 2003 TOTAL	**$841.7**

FY 2004 - Estimated Expenses



Child Protective Services	$290.1
Foster Care Payments	336.7
Adoption Subsidy Payments	99.7
Prevention & Early Intervention	32.5
Adult Protective Services	35.5
Child Care Licensing	19.3
Automation/Capital Budget	12.2
Indirect Administration	17.2
FY 2004 TOTAL	**$843.2**

Child Protective Services (CPS)

- Investigates reports of abuse and neglect of children.
- Provides services to children and families in their own homes.
- Contracts with local agencies to provide services.
- Provides foster care and adoption services.
- Contracts for foster care and adoption services.
- Provides independent living services to children aging out of foster care.

CPS Budget

	FY 2003 Expended	FY 2004 Estimated Expenses
Budget Category		
Salaries	$ 175.5	$ 183.0
Travel	13.1	13.3
Overhead	42.1	40.6
Client Services	467.0	489.6
Foster Care	*321.7*	*336.7*
Adoption Subsidy	*92.1*	*99.7*
Other CPS Purchased Services	*53.2*	*53.2*
Capital Budget	2.3	0.1
Total Budget	**$ 700.0**	**$ 726.6**
Method of Finance		
General Revenue	$ 229.0	$ 240.9
TANF	189.7	189.0
Other Federal	277.0	293.0
Other Funds	4.3	3.7
Total Method of Finance	**$ 700.0**	**$ 726.6**
Number of FTEs	***5,140.3***	***5,294.2***

CPS Trends

- **CPS Investigations**
  - The number of CPS completed investigations has been steadily increasing and this trend is projected to continue.
    - 138,092 projected for FY 2004
    - 131,130 actual for FY 2003
- **CPS Caseload per Worker**
  - The CPS workload equivalency continues to increase as reports of abuse and neglect and subsequent investigations increase more than staffing levels.
    - 28.8 projected for FY 2004
    - 26.7 actual for FY 2003

CPS Trends

- **Foster Care Payments**
  - Foster care caseloads have been increasing steadily, and current forecasts predict continued growth.
    - 15,919 projected for FY 2004
    - 15,008 actual for FY 2003
  - Initiatives to reduce the number of children in care.
    - Faith-based recruitment
    - Kinship Care
  - Initiatives to move foster children into home-based care.
    - Specialized rate
    - Intense rate

CPS Trends

- **Adoption Subsidy**
  - There has been an upward trend in the average monthly number of children provided adoption subsidy payments. Adoption subsidy provides a monthly subsidy and funding for non-recurring adoption expenses for eligible children.
    - 16,779 projected for FY 2004
    - 15,223 actual for FY 2003
  - The adoption subsidy represents an average savings over the cost of foster care for an individual child.

CPS Trends

- **Targeted Case Management (TCM)**
  - Since 1994 when the Medicaid State Plan amendment and the cost allocation plan were approved, DFPS has claimed Medicaid for TCM services.
  - On 2/13/04, the federal Center for Medicaid and Medicare Services (CMS) issued a disallowance of $45.2 million of TCM claims based on a focused financial review.
  - The disallowance was based on CMS' determination that DFPS' case management services were child welfare activities and should be claimed against Title IV-E and Title IV-B.
  - The State has sent a notice to the U. S. Department of Health and Human Services Departmental Appeals Board requesting reconsideration of the disallowance.
  - A settlement agreement is likely that will result in no fiscal impact through FY 2005; however, DFPS will be expected to change its claiming methodology which will result in a much smaller TCM program, requiring more general revenue beginning with FY 2006.

Adult Protective Services (APS)

- Investigates reports of abuse, neglect, and exploitation of elderly people and people with disabilities living at home or who are receiving MHMR services.
- Provides or arranges for protective services to alleviate or prevent further maltreatment.
  - May include referral to other programs, respite care, guardianship, emergency assistance with food, shelter, and medical care, transportation, counseling, or other remedies.

APS Budget

	FY 2003 Expended	FY 2004 Estimated Expenses
Budget Category		
Salaries	$ 26.2	$ 25.5
Travel	1.7	1.7
Overhead	4.7	4.6
Client Services	3.4	3.7
Capital Budget	0.1	-
Total Budget	**$ 36.1**	**$ 35.5**
Method of Finance		
General Revenue	$ 13.5	$ 8.7
TANF	-	-
Other Federal	22.6	26.8
Other Funds	-	-
Total Method of Finance	**$ 36.1**	**$ 35.5**
Number of FTEs	***733.4***	***703.1***

APS Trends

- **APS and MHMR Investigations**
  - The number of completed APS investigations is projected to decrease slightly in FY 2004.
    - 60,959 projected for FY 2004
    - 61,342 actual for FY 2003
  - Due to a 25% appropriation reduction for the FY 2004-2005 biennium, several changes to policy were implemented to reduce workload. Subsequently, the number of completed MHMR investigations is projected to decrease.
    - 7,816 projected for FY 2004
    - 9,805 actual for FY 2003

APS Trends

- **APS Guardianship**
  - Number of clients receiving guardianship services is projected to increase.
    - 728 projected for FY 2004
    - 706 actual for FY 2003
- **APS Caseload per Worker**
  - Average APS in-home caseload per worker is projected to decrease slightly.
    - 39.8 projected for FY 2004
    - 41.5 actual for FY 2003

Child Care Licensing (CCL)

- Develops and enforces minimum standards for child-care facilities and child-placing agencies.
- Investigates complaints and serious incidents occurring at day care and residential-care facilities.
- Licenses day care centers, day care homes, child-placing agencies, and residential child-care facilities.

CCL Budget

	FY 2003 Expended	FY 2004 Estimated Expenses
Budget Category		
Salaries	$ 15.8	$ 14.9
Travel	1.0	1.0
Overhead	3.8	3.4
Capital Budget	3.4	-
Total Budget	**$ 24.0**	**$ 19.3**
Method of Finance		
General Revenue	$ 1.2	$ 1.0
TANF (Converted to CCDF)	0.5	-
Other Federal	22.3	18.3
Other Funds	-	-
Total Method of Finance	**$ 24.0**	**$ 19.3**
Number of FTEs	***452.2***	***415.1***

CCL Trends

- **CCL Inspections**
  - The number of inspections is projected to decrease.
    - 38,536 projected for FY 2004
    - 43,244 actual for FY 2003

- **Background Checks**
  - The number of background checks is projected to increase.
    - 302,400 projected for FY 2004
    - 269,156 actual for FY 2003

Albert Hawkins, Executive Commissioner

Prevention and Early Intervention (PEI)

- Competitively procures contracts designed to strengthen families and communities by preventing child maltreatment and juvenile delinquency.
- Funds services to children in at-risk situations and for the families of those children.
- Assists communities in identifying prevention and early intervention needs and providing community awareness.

PEI Budget

	FY 2003 Expended	FY 2004 Estimated Expenses
Budget Category		
Salaries	$ 2.7	$ 1.3
Travel	0.1	0.1
Overhead	1.6	0.9
Client Services	39.5	30.2
Total Budget	**$ 43.9**	**$ 32.5**
Method of Finance		
General Revenue	$ 17.2	$ 13.8
TANF	6.2	-
Other Federal	20.5	18.7
Other Funds	-	-
Total Method of Finance	**$ 43.9**	**$ 32.5**
Number of FTEs	***68.9***	***31.7***

PEI Trends

- The FY 2004-05 appropriation for prevention and early intervention eliminated 7 of the 14 programs and reduced the budgets of 6 programs. Overall, it is estimated that 1,768 families and 14,371 individuals will no longer be served each year of the biennium.
- **Services to At-Risk Youth (STAR)**
  - The average monthly number of STAR youth served is projected to decrease due to a budget reduction. The statewide presence of STAR in all 254 counties has been continued.
    - 5,367 projected for FY 2004
    - 6,119 actual for FY 2003
- **Community Youth Development (CYD)**
  - The average monthly number of CYD youth served is projected to decrease due to a budget reduction.
    - 6,431 projected for FY 2004
    - 7,620 actual for FY 2003

Albert Hawkins, Executive Commissioner

Other Agency Issues

- **CPS Caseworker Turnover**
  - Turnover among CPS caseworkers has been declining:
    - –In FY 2001, turnover was 27.9%
    - –In FY 2002, turnover was 25.3%
    - –In FY 2003, turnover was 23.5%
    - –FY 2004 year-to-date, turnover is 22.9%

Albert Hawkins, Executive Commissioner

DFPS Program Detail

Children's Protective Services	**Page 25**
Foster Care Payments	**Page 33**
Adoption Subsidies	**Page 38**
Adult Protective Services	**Page 44**
MHMR Investigations	**Page 53**
Child Care Licensing	**Page 59**
Prevention and Early Intervention	**Page 64**
Status Report of Audits	**Page 71**

Albert Hawkins, Executive Commissioner

Children's Protective Services

Program Description:

The purpose of Child Protective Services (CPS) is to protect children from abuse and neglect and to act in the children's best interest. Statewide intake staff operate a toll-free, statewide telephone reporting system, as well as an internet reporting system, to accept in reports of abuse and neglect. Additionally, there is a secure internet reporting site for professionals such as teachers and medical personnel. All reports that meet the statutory definition of abuse or neglect of children are assigned a priority based on the level of risk and severity of harm to the child and routed to the local CPS office for investigation.

CPS caseworkers conduct an investigation of the abuse/neglect allegations by interviewing the child and parents, other witnesses or professionals and by visiting the home, if appropriate. If the child is able to safely remain in the home, a decision is made to close the case, refer the family to services in the community, or provide family services. Family based safety services are provided by CPS staff or contract providers.

Children's Protective Services

Program Description continued:

If the child cannot live safely at home, CPS may petition the court to remove the child from their home and place them in substitute care. When a child is removed from their home they are either placed with relatives, foster family homes, or residential facilities. A service plan is developed with the family to resolve the problem that contributed to the abuse or neglect of the child and the removal. The court decides when to return the child home, name a relative or other person as the managing conservator, appoint the department as the managing conservator or terminating the parent-child relationship in order to place the child in an adoptive home.

If the court does terminate the parent-child relationship, an adoptive home is sought for the child. Adoption services are provided by CPS staff, as well as contracted providers. Post-adoption contracted services are available to adoptive families after the adoption is legally finalized.

Who the program serves:

CPS serves children who are alleged to have been abused or neglected or who have been or are at risk of being abused or neglected, based on the legal definitions of abuse/neglect in the Texas Family Code §261.001. Additionally, CPS serves the parents of these children.

Children's Protective Services

Eligibility Criteria:

The Texas Family Code defines agency authority to investigate allegations of abuse and neglect by parent, caretaker, or person responsible. There are no additional eligibility criteria for investigations. Generally to receive contracted services, children or families must have an open CPS case. In order to receive foster day care services, the child must be under age 6 and placed in a foster home with parents who work full-time.

Appropriations:

	FY 2000 Expended	FY 2001 Expended	FY 2002 Expended	FY 2003 Expended	FY 2004 Projected	FY 2005 Budgeted
General Revenue	59,557,987	63,005,198	66,726,367	63,826,725	65,168,911	66,999,701
Federal Funds	189,095,119	190,291,405	208,489,835	218,363,171	221,711,247	227,866,151
Other Funds	3,360,209	4,106,219	4,729,133	4,039,543	3,297,204	3,297,204
Total All Funds	252,013,315	257,402,822	279,945,335	286,229,439	290,177,362	298,163,056

Children's Protective Services

FTEs:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Projected	FY 2005 Budgeted
	4,972.0	4,977.8	5,086.5	5,138.3	5,292.2	5,470.2

Performance Measures:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Projected	FY 2005 Budgeted
Number of CPS Reports of Child Abuse/Neglect	139,898	142,910	157,544	162,044	195,856	204,127
Number of Completed CPS Investigations	121,732	111,970	125,258	131,130	138,092	143,923
Average Monthly Cost per Open CPS Investigation	$137.83	$169.99	$137.36	$132.29	$123.02	$122.55
Number of Children in State Conservatorship Who Are Adopted	2,063	2,221	2,248	2,444	2,479	2,569

Children's Protective Services

Performance Measures continued:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Projected	FY 2005 Budgeted
CPS Workload Equivalency Measure (WEM)	NA	25.0	25.9	26.7	28.8	28.8
Average Caseload Per Intensified Family Preservation/ Reunification Worker	NA	14.2	13.1	13.7	15.2	16.0
Average Number of Clients Receiving CPS Purchased Services	N/A	N/A	10,432	11,348	9,865	9,865
Average Cost per Client Receiving CPS Purchased Services	N/A	N/A	$259.68	$245.89	$273.07	$273.27

Children's Protective Services

Issues:

As the population served by CPS continues to grow, increased resources are needed to meet the needs of our clients. This includes dollars for purchased services, as well as for additional staff.

If there is a waiting list, how many clients are there?

There is no waiting list for CPS direct delivery services. Local waiting lists may exist for specific services such as parenting classes, psychological evaluations and day care. There is no centralized tracking of these local waiting lists.

Policy Changes and Impact on Caseload:

In December 2003, CPS policy was changed to modify permanency goals to reflect the focus on finding permanent families for all children in care. These policy changes enhance staff efforts to ensure children aging out of care have contacts with adults who can support them after their transition from foster care.

Children's Protective Services

Policy Changes and Impact on Caseload continued:

Policy changes impacting investigations are currently underway. In April 2004, policy changes were implemented requiring specific steps needed prior to case closure when a family refuses to participate with CPS. Policy, rule and automation changes to the disposition codes used in these circumstances will be implemented September 2004. These changes provide clear direction to staff when working with uncooperative families and families that move or cannot be located. The disposition change will provide the ability to clearly identify such, in order to facilitate timely responses if there is a subsequent referral.

These policy changes impact safety, well-being and permanence of clients rather than the size of the CPS caseload .

Future Needs that Should Be Addressed:

To meet the permanency needs of the increasing number of children waiting for adoption, an increase in the availability of funding for contracted adoption services is needed. Additionally, as more and more children are adopted there is an increased need for funding for post-adoption services as well.

Children's Protective Services

Future Needs that Should Be Addressed continued:

CPS needs resources to maintain manageable caseloads and to develop and retain staff. Currently, CPS investigation staff receives an average of 57.9 investigations per month, per worker. At the same time, workers must provide and arrange for services in ongoing cases to alleviate maltreatment. When caseloads get too large, the volume of work presents a barrier to thorough investigations, assessments and quality casework.

CPS faces a significant challenge in hiring and maintaining a skilled workforce. The availability of workers with specialized social work skills trained to work with abused and neglected children and their families is not keeping pace with the growth in the general population.

DFPS has claimed Medicaid for Targeted Case Management (TCM) services since 1994 when the federal cost allocation plan was approved. The feds have issued a disallowance of $45.2 million based on a determination that DFPS' case management services were child welfare activities. The State has sent a notice requesting reconsideration. A settlement agreement is likely whereby the state can continue to claim TCM through the end of FY 2005, but would be expected to change its claiming methodology beginning in FY 2006. DFPS' appropriations request for FY 2006-2007 will likely reflect a need for additional general revenue due to a much smaller TCM program in the future.

Foster Care Payments

Program Description:

The goal of foster care is to protect children while working with their biological family to alleviate the risk of abuse and neglect. If the family cannot solve the problems that will allow the child to live at home safely, CPS may recommend to the court that the parent-child relationship be terminated and the child placed with other permanent families or caregivers.

Who the program serves:

Children who have experienced abuse, neglect, or a high risk of abuse/neglect that results in the need to remove children from their homes to protect them.

Eligibility Criteria:

There is no additional eligibility criteria.

Foster Care Payments

Appropriations:

	FY 2000 Expended	FY 2001 Expended	FY 2002 Expended	FY 2003 Expended	FY 2004 Projected	FY 2005 Budgeted
General Revenue	97,896,189	94,219,163	97,673,599	100,125,274	89,900,529	97,892,816
GR-D Crime Victims Compensation Fund			14,241,354	14,241,354	31,041,354	31,041,354
Federal Funds	132,712,418	151,874,217	186,376,039	207,055,616	215,334,512	229,668,664
Other Funds	259,420	198,162	280,683	279,522	422,428	430,541
Total All Funds	230,868,027	246,291,542	298,571,675	321,701,766	336,698,823	359,033,375

FTEs:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Projected	FY 2005 Budgeted
	1.6	2.0	2.0	2.0	2.0	2.0

Foster Care Payments

Performance Measures:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Projected	FY 2005 Budgeted
Average Number of Children (FTE) Served in Paid Foster Care per Month	12,033	12,763	14,072	15,008	15,919	16,982
Average Monthly Payment per Child (FTE) in Paid Foster Care	$1,563.47	$1,576.49	$1,757.12	$1,765.93	$1,740.77	$1,741.27

Issues:

As the population of children who need protection through foster care services grows, DFPS will continue to need additional resources to maintain program integrity.

If there is a waiting list, how many clients are there?

There is no waiting list for CPS foster care services.

Foster Care Payments

Policy Changes and Impact on Caseload:

As directed by HB 1, Rider 21, passed during the 78th Legislative Session, the six levels of care were consolidated to four service levels. The service levels focus on permanency and the services needed by children instead of the behaviors exhibited by children. Consolidation of service levels was not intended to impact caseloads, nor did it impact the caseload of individual workers.

CPS strengthened efforts in policy and practice to place children in families instead of in nursing homes, institutions for the mentally retarded, and residential facilities. There was no impact on caseloads. However, the positive impact on individual children has been tremendous because of the change from an institutional setting to a family setting.

A family group conferencing program is being developed statewide in an effort to reduce the number of children coming into foster care, and to return home more quickly children currently in foster care.

Foster Care Payments

Future Needs that Should Be Addressed:

The number of children in foster care has continued to increase. To meet the needs of these children, a faith-based recruitment initiative, established by HB 1, Rider 24, is expected to increase the availability of foster parents.

A kinship care pilot has been initiated to locate, stabilize and support relative placements as an alternative to foster care. If the pilot proves successful in reducing foster care expenditures, expansion of the pilot statewide could be considered.

Albert Hawkins, Executive Commissioner

Adoption Subsidies

Program Description:

Adoption subsidies are intended to reduce barriers to adoption of children with special needs. Adoption subsidies consist of reimbursement of certain non-recurring adoption expenses (legal fees and costs of home studies when incurred) and monthly financial assistance when needed and Medicaid coverage.

Who the program serves:

Eligible children in foster care who are free for adoption.

Eligibility Criteria:

To qualify for adoption subsidy the child must be special needs at the time of adoptive placement. The states are required to define "special needs" and Texas definitions are defined in the Texas Administrative Code.

Adoption Subsidies

Eligibility Criteria continued:

To be classified as having special needs, the child must:

•Be six years of age or older;

•Be two years of age or older and a member of a minority group that traditionally is a barrier to adoption;

•Be a member of a sibling group being placed together or joining a sibling; or

•Have a diagnosed handicapping condition.

In addition to the above requirement, the child must meet certain categorical requirements such as qualifying for the AFDC or SSI programs.

Adoption Subsidies

Appropriations:

	FY 2000 Expended	FY 2001 Expended	FY 2002 Expended	FY 2003 Expended	FY 2004 Projected	FY 2005 Budgeted
General Revenue	31,791,623	38,441,133	45,490,100	50,910,015	54,807,209	56,997,423
Federal Funds	28,197,352	33,119,189	37,745,894	41,148,671	44,867,549	47,709,418
Total All Funds	59,988,975	71,560,322	83,235,994	92,058,686	99,674,758	104,706,841

FTEs:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Projected	FY 2005 Budgeted
	0.0	0.0	0.0	0.0	0.0	0.0

Adoption Subsidies

Performance Measures:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Projected	FY 2005 Budgeted
Average Number of Children Provided Adoption Subsidy per Month	10,758	12,224	13,738	15,223	16,779	18,392
Average Monthly Payment per Adoption Subsidy	$450.07	$473.04	$491.52	$491.47	$482.17	$474.25

Issues:

Children whose service needs are greater than basic are less likely to achieve permanency through adoption.

If there is a waiting list, how many clients are there?

There is no waiting list for adoption subsidies.

Adoption Subsidies

Policy Changes and Impact on Caseload:

In September 2003, a tiered payment schedule was established for the adoption subsidy, as directed by HB 1, Rider 26, 78th Legislative Session. A two-tiered payment rate ceiling was implemented which allows the department to provide additional assistance to children whose service needs are moderate or higher at the time of adoptive placement.

The current two-tiered payment ceilings do not adequately support placement of children with moderate to specialized needs. DFPS is proposing to increase the payment ceiling for children with moderate needs from $545 per month to $700 per month and add a third tier for children with specialized needs at $900 per month. Payment ceilings that are more consistent with the child's needs are expected to facilitate the adoption of more children with higher need levels. Placement of these children will reduce foster care costs as well as achieve permanency for these children.

Adoption Subsidies

Future Needs that Should Be Addressed:

Under current rules, adoption assistance is provided until the child reaches age 18. Some children have disabilities that prevent them from becoming self-sufficient at age 18 or they are still in high school and remain dependent on their adoptive parents. The Texas Family Code was amended during the 77th Legislative Session to allow the department to continue adoption assistance in these two circumstances.

Implementation of this initiative and the movement from a two-tiered to a three-tiered payment ceiling is expected to increase adoption of children with special needs. As these adoptions increase, the cost of adoption subsidies increase, and additional funding will be needed to address this growth. However, since the average cost of an adoption subsidy is less than the average cost of foster care, there is an economic benefit to the State when adoptions of children with special needs increase.

Because of this relationship between foster care and adoption subsidies, having additional flexibility to move funds between the two strategies could potentially be cost effective.

Albert Hawkins, Executive Commissioner

Adult Protective Services

Program Description:

Two program areas serve APS clients: in-home investigations/services and guardianship services.

In-home staff investigate allegations of abuse, neglect, and exploitation. If mistreatment is confirmed, staff may arrange for services to their clients through other state and community agencies and access contracted short-term purchased services including emergency shelter, food and medication, heavy cleaning, minor home repairs, restoration of utilities, and mental health assessments. Clients who have the cognitive ability to consent have the right to refuse services. When clients lack capacity and are at risk, APS may pursue legal action to provide involuntary services.

Guardianship staff may be appointed by a court to serve as guardian for incapacitated elders or persons with disabilities who are victims of abuse, neglect, or exploitation and incapacitated children who have severe disabilities when they are aging out of Child Protective Services' care. APS guardianship may be provided directly or through contracts with local entities.

Adult Protective Services

Program Description continued:

APS serves as guardian of the last resort when no family member, interested party, or other community alternative is available. Guardianship services may include managing a ward's estate, living arrangements, medical treatment, funeral arrangement,s and disposal of property.

Who the program serves:

Alleged victims of abuse, neglect and exploitation who are elderly persons or adults with disabilities who reside in their own homes, room-and-board homes not subject to licensure, or adult foster care homes with three or fewer residents.

Eligibility Criteria:

1. 65 years of age or older, or
2. Have a mental, physical, or developmental disability that substantially impairs the person's ability to provide adequately for the person's care or protection and be:
    (a) 18 years of age or older, or
    (b) under 18 years of age legally emancipated

Adult Protective Services

Appropriations:

	FY 2000 Expended	FY 2001 Expended	FY 2002 Expended	FY 2003 Expended	FY 2004 Projected	FY 2005 Budgeted
General Revenue	2,607,761	1,595,401	8,151,361	9,887,045	6,316,329	6,316,329
GR-D Crime Victims Compensation Fund			1,741,355	1,741,354	1,741,355	1,741,355
Federal Funds	25,081,808	26,152,802	20,376,897	18,559,939	22,536,211	22,536,211
Other Funds	83,222	44,140	35,852	30,000	30,000	30,000
Total All Funds	27,772,791	27,792,343	30,305,465	30,258,338	30,623,895	30,623,895

FTEs:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Projected	FY 2005 Budgeted
	585.2	581.8	594.8	598.8	601.3	601.3

Adult Protective Services

Performance Measures:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Projected	FY 2005 Budgeted
Number of APS Reports of Adult Abuse/Neglect/ Exploitation	55,197	58,639	60,785	63,557	63,160	64,848
Number of Completed APS Investigations	51,479	56,170	56,906	61,342	60,959	62,588
Average Monthly Cost per APS Investigation	$152.82	$135.01	$135.29	$124.66	$103.05	$99.81
Number of APS Clients Receiving Guardianship Services	605	624	671	706	728	753
Average APS Caseload Per Worker	31.7	40.2	37.2	41.5	39.8	40.9

Adult Protective Services

Issues:

APS faces a significant challenge in hiring and maintaining a skilled workforce. The availability of workers with specialized geriatric and social work training is not keeping pace with the ever-increasing number of older Americans. APS efforts to build a skilled pool of staff include offering internal and external training, an annual conference, and certification of workers and supervisors. However, the great demand for geriatric social workers often results in highly trained APS workers leaving their jobs for positions with higher pay. Attracting and keeping skilled APS workers is further compounded by the decrease in benefits and increasing caseloads.

Attention has been recently focused on the appropriateness of APS intervention in situations involving persons whose living conditions pose health and safety hazards. The Governor has directed HHSC to undertake a comprehensive review of the APS program. APS will need to be responsive to the direction of HHSC in adjusting policy, training, and organizational structure based upon the outcome of this review. Changes to state statute may also be recommended.

Adult Protective Services

Issues continued:

DFPS's statutory mandate and funding is limited in scope to guardianship of incapacitated adult victims of abuse, neglect and/or exploitation and children aging out of CPS conservatorship. However, courts and other entities are increasingly seeking to appoint DFPS in cases outside its statutory mandate when no other alternatives exist, guardianship will not resolve the problem, or the person is not at risk. This could result in victims of abuse, neglect and/or exploitation being denied adequate services because DFPS staff are overwhelmed with other types of appointments. DFPS has attempted to limit the scope of its guardianship program by educating courts as to its statutory mandate, developing policy, collaborating with the Guardianship Advisory Board, and appealing appointments in some cases.

If there is a waiting list, how many clients are there?

APS does not have a waiting list. Investigations are assigned a priority that determines how quickly APS staff will make an initial face-to-face visit with the client.

Adult Protective Services

Policy Changes and Impact on Caseload:

In August 2003, APS implemented a policy requiring caseworkers to document validated allegations that an elderly person or an adult with a disability is a victim of family violence. The policy requires caseworkers to provide victims with written information about community resources and develop a family violence safety plan to promote the safety of the victim. This policy improves the level of service provided to clients, but it also increases the length of time a case is open for investigation.

In March 2004, APS amended a policy concerning the use of cameras during investigations. The new policy requires photographs in all cases of alleged abuse or neglect resulting in injuries, and suggests that photographs be taken in other situations to document physical condition, incident scene, and living environment. While it is preferable for photographs to be taken on every home visit, the limited availability of cameras does not permit this.

In April 2004, APS implemented more stringent prior approval policies for the use of purchased services. This was done to more closely monitor the limited funds available to assist clients on a short-term basis.

Adult Protective Services

Future Needs that Should Be Addressed:

As the population of elder adults continues to grow, increased resources are needed to meet the needs of our clients. This includes dollars for emergency services as well as additional staff.

APS recommends funding for the extension of foster care payments for medically fragile youth who are aging out of CPS' care and entering APS guardianship. There is a gap in services for this age group because foster care eligibility ends when a youth in CPS custody reaches 20 years of age. Most community residential programs do not serve persons under the age of 21, so there are limited programs to meet the needs of these medically fragile young adults from 20-21 years of age. An extension of service will allow a youth to remain in foster care placements until they can qualify for Community Based Alternatives (CBA) or another community-based settings for adults.

Reports of abuse, neglect, or exploitation of undocumented immigrants are increasing. These individuals are eligible for APS investigation and short-term emergency services. However, as non-citizens, they do not qualify for Medicaid benefits. Due to their age and disability, they are not likely candidates for deportation to their country of origin. APS has no resources to address their financial, medical, and placement needs in this country.

Adult Protective Services

Future Needs that Should Be Addressed continued:

In response to Governor Rick Perry's executive order on April 14, 2004, the Health and Human Services Commission (HHSC) began conducting a detailed review of the APS program, with a focus on training procedures, minimum qualifications for caseworkers and supervisors, and the effective application of all state statutes and policy requirements to protect the safety and well being of older adults and persons with disabilities. HHSC will also ensure the appropriate placement of state resources and program supervisors for proper and sufficient regional oversight and communication in the APS program.

HHSC will develop and submit an implementation plan to the Governor within 90 days to outline the specific actions taken to implement this order. A final report will be submitted no later than November 1, 2004, to review all actions taken and recommended statutory changes developed in compliance with the order.

MHMR Investigations

Program Description:

DFPS' MHMR Investigators investigate allegations of abuse, neglect, and exploitation of adults and children receiving services in MHMR facilities and related programs. APS conducts an investigation when the alleged perpetrator is an employee, agent, or contractor in one of these programs. MHMR investigators provide investigation reports to MHMR for action as appropriate.

Who the program serves:

Alleged victims of abuse, neglect, and exploitation who are clients in Texas Department of Mental Health and Mental Retardation (MHMR) facilities and related programs, including state schools, state hospitals, state centers, community MHMR centers, and home and community-based waiver program.

MHMR Investigations

Eligibility Criteria:

An adult with a disability or a child receiving services in a MHMR facility, community center, or home and community-based waiver program.

Appropriations:

	FY 2000 Expended	FY 2001 Expended	FY 2002 Expended	FY 2003 Expended	FY 2004 Projected	FY 2005 Budgeted
General Revenue	451,822	286,102	1,137,072	1,878,798	679,613	679,613
Federal Funds	4,383,695	4,455,094	4,329,050	4,018,135	4,179,002	4,179,002
Total All Funds	4,835,517	4,741,196	5,466,122	5,896,933	4,858,615	4,858,615

FTEs:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Projected	FY 2005 Budgeted
	121.4	119.9	127.2	134.6	101.8	101.8

MHMR Investigations

Performance Measures:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Projected	FY 2005 Budgeted
Number of MHMR Reports of Abuse/ Neglect/Exploitation	8,372	8,319	9,627	10,154	8,094	8,466
Number of Completed MHMR Investigations	6,493	5,615	9,194	9,805	7,816	8,175
Average Monthly Cost per MHMR Investigation	$441.02	$491.78	$432.20	$443.63	$418.63	$400.33
Average MHMR Caseload Per Worker	8.1	7.7	8.6	9.2	9.4	9.8

MHMR Investigations

Issues:

As a result of the reorganization of the health and human services agencies, MHMR programs for which APS has investigative responsibility will be divided between two state agencies. State mental health services will be transferred to the Department of State Health Services (DSHS), while state mental retardation services will be transferred to the Department of Aging and Disability Services (DADS). At a minimum, these changes will require revisions to existing rules, handbooks, and operating procedures. APS will need to closely monitor the process in order to respond to any additional implications for its investigations.

The Texas Home Living waiver program became effective in April, 2004. The initial phase of this new program will refinance services clients are already receiving through community MHMR centers and is not expected to increase the MHMR investigations client base. However, the second phase of the program is expected to increase the client base, but currently there are no projections available on the magnitude of the increase or the impact on MHMR investigations workload.

MHMR Investigations

If there is a waiting list, how many clients are there?

APS does not have a waiting list. Investigations are assigned a priority that determines how quickly APS staff will make an initial face-to-face visit with the client.

Policy Changes and Impact on Caseload:

In January 2004, the Texas Administrative Code (TAC), Chapter 711 was amended in an effort to reduce the workloads of APS staff handling the MHMR investigations. These changes were implemented following the legislatively mandated 25% staff reduction. One change in the TAC involved amending the definition of emotional/verbal abuse so that allegations must involve "observable distress or harm." APS also implemented changes to the priority system for investigations. Previously, priorities were assigned based on the length of time since the alleged incident. The new priority system takes into consideration the seriousness of the allegation and the likelihood that evidence will be lost without a quick initiation.

MHMR Investigations

Future Needs that Should Be Addressed:

As a result of staff reductions, APS is closely monitoring caseloads to ensure that the rule and policy changes implemented earlier this year provide the necessary relief to maintain the quality of MHMR investigations. DSHS and DADS management staff are dependent upon these investigations to take appropriate personnel action against perpetrators of abuse, neglect, and exploitation in the mental health and mental retardation programs they operate.

Albert Hawkins, Executive Commissioner

Child Care Licensing

Program Description:

The purpose of the Child Care Licensing program is to protect the health, safety, and well-being of children, ages birth through 17 years of age, who attend or reside in regulated child-care facilities and homes. Chapter 42 of the Human Resources Code gives DFPS the authority to establish statewide rules and minimum standards used in regulating both day care and residential child-care operations, which include but are not limited to day care centers, foster homes, and residential treatment centers.

The Child Care Licensing Program also provides technical assistance and training to child-care operators to assist and encourage the improvement of child-care programs; and, provides information to parents and consumers to educate and assist them in making informed decisions about child-care services.

Child Care Licensing

Who the program serves:

Child Care Licensing regulates privately owned child-care operations who may determine which client population they want to serve, such as day care services for infants or after school care for school age children, 24 hour care for medically fragile children, or therapeutic foster care. DFPS determines whether each child-care operation complies with minimum standards that address the needs of the population the operation chooses to serve.

Eligibility Criteria:

There is no additional eligibility criteria.

Appropriations:

	FY 2000 Expended	FY 2001 Expended	FY 2002 Expended	FY 2003 Expended	FY 2004 Projected	FY 2005 Budgeted
General Revenue	2,094,363	3,213,003	1,854,833	1,237,156	1,058,134	1,058,134
Federal Funds	16,635,744	21,426,735	21,009,069	22,752,228	18,268,086	18,268,086
Total All Funds	18,730,107	24,639,738	22,863,902	23,989,384	19,326,220	19,326,220

Child Care Licensing

FTEs:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Projected	FY 2005 Budgeted
	423.2	423.4	436.3	452.2	415.1	415.1

Performance Measures:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Projected	FY 2005 Budgeted
Number of Inspections	40,396	39,850	42,471	43,244	38,536	38,536
Average Cost per Inspection	$205.48	$206.87	$222.05	$225.98	$229.93	$228.34
Number of Licenses, Certifications, Registrations and Listings	35,199	33,105	33,756	34,022	33,366	33,366
Number of New Licenses, Cert., Registrations and Listings Issued	4,275	4,366	4,897	4,862	4,407	4,407
Average Cost per Issuance	$806.53	$778.57	$769.38	$847.41	$696.01	$691.18

Child Care Licensing

Issues:

Child Care Licensing has the authority to inspect child-care operations more often than currently required by policy; however, limited agency resources prohibit this. Broadening the law or interpretations of the law always impacts the division's ability to inspect, enforce and investigate in a timely and thorough manner. For example, a recent change in the law broadened the definition of what constitutes abuse/neglect in child-care operations. This change resulted in broadening the scope and priority of abuse/neglect investigations, without additional resources to support this.

If there is a waiting list, how many clients are there?

There is not a waiting list.

Policy Changes and Impact on Caseload:

Minimum standards rules for Residential Child Care Licensing (RCCL) are currently undergoing revision. Once new rules have been adopted, implementation procedures will begin. This includes a review and update of all existing licensing and CPS policies and procedures to ensure they do not conflict with these new regulations, preparation of training materials, training RCCL and CPS staff and permit holders, and addressing consistency of enforcement issues as they arise.

Child Care Licensing

Future Needs that Should Be Addressed:

A mobile automation solution for Licensing would address the current delay of approximately 10 – 15 days before a provider receives in writing the finding of the inspection. The provider has 15 days from the date of receipt of the notification to request an administrative review. If a review is requested, there is a time period allowed for the review to take place. All of this results in the public not being timely informed of the compliance history through the Child Care Licensing website.

Child Care Licensing conducts a minimum number of background checks to protect children in care; however, additional resources would allow follow-up of matches to be expedited and additional checks to be conducted.

Albert Hawkins, Executive Commissioner

Prevention and Early Intervention

Program Description:

The Prevention and Early Intervention (PEI) Division was created to consolidate prevention and early intervention programs within the jurisdiction of a single state agency. Consolidation of these programs is intended to eliminate fragmentation and duplication of services for at-risk children, youth, and families. PEI programs are designed to prevent child abuse and neglect, truancy, running away, and delinquency by providing services that reduce risk factors for families and children and increase protective factors within communities. Competitively procured contractors deliver PEI program services.

Who the program serves:

Community Based Child Abuse Prevention (CBCAP) Grant. The CBCAP program increases community awareness of existing prevention services, strengthens community and parental involvement in child abuse prevention efforts, and encourages families to engage in services that are already available. Projects supported by CBCAP are located in Bexar, Dallas, Denton, El Paso, Galveston, Jefferson, Harris, Midland, Potter, Randall, Tarrant, Taylor, Tom Green, Travis, and Webb counties.

Prevention and Early Intervention

Who the program serves continued:

Dan Kubiak Buffalo Soldiers Heritage Program. The Buffalo Soldiers program operates in three counties: Bexar, Tarrant, and Dallas. Service components include mentoring, tutoring, Buffalo Soldier history classes, character development, self-esteem building, life skills training, field trips to state parks, encampments, and community service activities.

Services To At-Risk Youth (STAR) Program. STAR services are provided to youth under the age of 18 who are runaways, truants, and/or living in family conflict, youth who are age 9 and younger who have allegedly been involved in or committed delinquent offenses, and 10 to 16 year olds who have allegedly committed misdemeanor or state jail felony offenses but have not been adjudicated delinquent by a court. Services must include family crisis intervention counseling, short-term emergency residential care, individual and family counseling. In addition, STAR providers dedicate at least 10% of their contract funds to providing child abuse prevention services within their service areas, including elements such as media campaigns, parenting classes, and other awareness activities. STAR services are available all 254 Texas counties.

Prevention and Early Intervention

Who the program serves continued:

Tertiary and Secondary Child Abuse Prevention. This program provides community-based, volunteer-driven services for prevention, intervention and aftercare services for the families of children who have been abused or neglected, or who are at risk of child maltreatment. Communities supported by these services are located in Andrews, Brazos, Ector, Midland, Ward, and Winkler counties.

Texas Runaway and Youth Hotlines. Hotline staff and volunteers provide statewide 24-hour crisis intervention and telephone counseling; information and referrals to callers in need of food, shelter, or transportation to their homes; conference calls to parents and shelters; a confidential message relay service between runaways and parents.

Texas Families: Together and Safe (TFTS) Program. TFTS provides family support services designed to alleviate stress, promote parental competencies, and increase the ability of families to successfully nurture their children. Services are provided through community-based agencies. The program is available in Bexar, Brazos, Brown, Burleson, Cameron, Coleman, Coke, Comanche, Crosby, Eastland, El Paso, Grimes, Harris, Hidalgo, Irion, Lamb, Leon, Lubbock, Madison, Maverick, McCulloch, Mills, Robertson, San Saba, Starr, Sterling, Tarrant, Tom Green, Travis, Val Verde, Webb, Willacy, and Washington.

Prevention and Early Intervention

Who the program serves continued:

Community Youth Development (CYD) Program. CYD provides community-based delinquency prevention services in 15 areas of the state known to have high incidence of juvenile crime. The program is ZIP code based and is currently available in Amarillo (79107), Austin (78744), Brownsville (78520), Corpus Christi (78415), Dallas (75216, 75217), El Paso (79924), Fort Worth (76106), Galveston (77550), Houston (77081), McAllen (78501), San Antonio (78207), Waco (76707), Lubbock (79415), and Pasadena (77506). Youth leadership development, community service programs, life skills development, character education, conflict resolution, recreation, sports and fitness, enrichment, education, employment, mentoring, and family support are examples of approaches used by communities to support positive youth development and prevent juvenile crime.

Eligibility Criteria:

See above.

Prevention and Early Intervention

Appropriations:

	FY 2000 Expended	FY 2001 Expended	FY 2002 Expended	FY 2003 Expended	FY 2004 Projected	FY 2005 Budgeted
General Revenue	21,723,573	23,560,516	18,303,397	15,764,977	10,540,399	10,540,399
GR-D Child Abuse/ Neglect Prevention Operating Account	1,744,884	1,589,013	1,562,023	1,403,853	3,297,500	3,297,500
Federal Funds	18,203,595	19,754,298	25,009,296	26,725,819	18,684,822	18,684,822
Other Funds	201,780	228,249	17,111	26,163		
Total All Funds	41,873,832	45,132,076	44,891,827	43,920,812	32,522,721	32,522,721

FTEs:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Projected	FY 2005 Budgeted
	62.4	72.1	70.5	68.9	31.7	31.7

Prevention and Early Intervention

Performance Measures:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Projected	FY 2005 Budgeted
Average Number of STAR Youth Served per Month	5,145	6,129	6,367	6,119	5,367	5,367
Average Monthly DFPS Cost Per STAR Youth Served	$307.90	$265.25	$261.66	$272.81	$288.52	$288.52
Average Number of CYD Youth Served Per Month	4,420	5,443	6,300	7,620	6,431	6,431
Average Monthly DFPS Cost Per CYD Youth Served	$91.99	$82.26	$89.38	$76.24	$91.56	$91.56

Issues:

The FY 2004-05 appropriation for prevention and early intervention eliminated 7 of the 14 programs and reduced the budgets of 6 programs. Overall, it is estimated that 1,768 families and 14,371 individuals will no longer be served each year of the biennium.

Prevention and Early Intervention

If there is a waiting list, how many clients are there?

There is not a waiting list for any PEI program.

Policy Changes and Impact on Caseload:

No policy changes are planned that will impact caseload.

Future Needs that Should Be Addressed:

It is recommended that funding be restored for the existing programs and for the eliminated programs.

Albert Hawkins, Executive Commissioner

Status Report of Audits

•KPMG Federal Portion of SAO Statewide Single Audit for Fiscal Year Ending 8/31/03

Purpose of Audit:

To obtain reasonable assurance about whether the Schedule of Expenditures of Federal Awards of the State of Texas for the year ended August 31, 2003 is free of material misstatement. To determine compliance with requirements applicable to major federal programs and on internal control over compliance in accordance with OMB Circular A-133.

Status of Major Findings:

Finding – The agency does not have the appropriate information technology controls in place to ensure the cash management (i.e., pre-issuance) funding from the Federal programs will be paid out within three days after the receipt of Federal Funds.

Status – DPFS was unable to use the Grant Draw Down Supplemental Report developed by the Statewide ISAS Team, and did not attempt to modify this report in FY 2003 due to implementing the Health and Human Service Administrative System. DFPS has now created a version of the HHSAS Grant Draw Down Supplemental Report to resolve the issue, and this report was placed in production on March 12, 2004.

Status Report of Audits

Status of Major Findings continued:

Finding – DFPS could not provide documentation in 3 of 40 adoption assistance cases reviewed that safety considerations with respect to the caretaker(s) have been addressed. Status – The agency is in the process of modifying forms to require that the criminal history check be a required attachment to Form 2251A, Documentation of Eligibility. The earliest revision date will be May or June 2004.
Finding – From a sample of 30 children for whom Foster Care, Title IV-E payments were made during FY 2003, the following types of non-compliance were noted with foster care providers: criminal background checks overdue, requests for background checks not submitted within 2 days of employment, required 24-month follow-up background checks overdue, background checks were missing on employees of foster care providers and employees of foster care providers had misspelled names on their background checks. Status – All identified deficient criminal background checks have been corrected and the required documentation has been submitted. All Residential Licensing Representatives and Supervisors were re-trained on law/policy and procedures for ensuring that background checks are monitored at each inspection for all newly hired staff and every 24 months for current staff. This training was conducted on March 30, 2004. Quality assurance provided through case reading, case review, standardized forms, management reports and supervisory monitoring are fully implemented.

Status Report of Audits

•SAO Audit #03-046 "A Review of New Foster Care and Adoption Subsidy Rates Proposed by the Department of Protective and Regulatory Services"

Purpose of Audit:

To review the proposed 2004-2005 biennium foster care and adoption subsidy rates for the purposes of determining whether: 1) The rates were calculated in compliance with Texas Administrative Code, 2) The cost projections made by the Department upon implementation of the rates are reasonable, 3) The cost projections are within appropriated funds.

Status of Major Findings:

The overall conclusion of the audit was that the agency calculated rates in compliance with Texas Administrative Code, and that the cost projections were reasonable and were within appropriated funds. SAO also concluded that the agency complied with Rider 18 of the 2004-2005 General Appropriations Act specifying rate analysis and reporting requirements prior to increasing foster care rates or adoption subsidy rates. There were no formal findings in the Report.

Status Report of Audits

•SAO Audit "Financial Review of Family and Protective Services"

Purpose of Audit:

To determine whether DFPS provides key oversight entities and department management with accurate and consistent financial information. To determine whether the Department is using state appropriations in accordance with applicable state laws and regulations. To determine if the resources used have been in alignment with stated outcomes. To determine if the budget process adequately reflects DFPS service levels and needs.

Status of Major Findings:

This audit is currently in process, with expected completion in July 2004.

Status Report of Audits

•Comptroller's Post Payment Audit for FY 2003

Purpose of Audit:

The Comptroller performs an annual risk assessment and enters into a written contract with selected state agencies authorizing the Comptroller to audit the agency's expenditures on a post-payment basis.

Status of Major Findings:

This audit is currently in process.

Department of State Health Services Program Overview

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Department of State Health Services

Immunizations

Program Description:
The Immunization program is responsible for purchasing and accounting of all vaccines that are distributed to local health departments, regional offices, Texas Vaccines for Children (TVFC) Program providers, and Children's Health Insurance Program (CHIP) providers; distributing vaccines and immune globulins during disease outbreaks; conducting surveillance for vaccine preventable diseases and assisting with disease control measures; estimating vaccination levels for all Texans; preventing transmission of hepatitis B virus; monitoring school and child-care facility compliance with state laws regarding immunization requirements; operating and maintaining the statewide childhood immunization registry (ImmTrac); designing, developing, and distributing immunization education and promotional materials for parents, providers, and the general public; providing public and professional education on vaccines, vaccine-preventable diseases, vaccine safety and vaccine administration; and operating a toll free consumer information line.

Who the program serves:
The Immunization program provides childhood vaccines and related services to low-income children in Texas accessing health care in public health clinics, other public providers, and in private health care facilities. The program serves all adult Texans by encouraging age-appropriate immunization and by assuring a vaccine-preventable disease free Texas.

The exact number of children served is unknown. A single child served may receive one or many doses of vaccine in any given year. The program retains records of the number of doses of vaccine that are administered, 6,779,302 doses were administered in FY2003.

The cost per child served or dose administered is also not available. Vaccine prices vary widely, frequent vaccine shortages occur and the venues and associated costs for delivering vaccine are highly variable. These and other factors make a cost per dose calculation extremely misleading and would not be a useful management tool.

Eligibility Criteria:
Children are eligible to receive vaccine through TVFC if they are eligible for Medicaid or CHIP, are uninsured or are underinsured. No child is denied vaccine because of an inability to pay, and no financial eligibility is required.

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue	$23,934	$27,424	$25,596	$25,941	$26,275	$26,015
General Revenue, Ded.	$7	$18	$0	$0	$0	$0
Federal Funds	$8,594	$8,924	$10,454	$15,398	$12,766	$12,482

Immunizations

Other Funds	$1,802	$2,134	$2,442	$3,151	$2,970	$2,681
Total All Funds	$34,337	$38,500	$38,492	$44,490	$42,011	$41,179

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
252.8	262.6	270.5	284.1	291.7	291.7

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Number of doses administered	5,678,470	6,199,220	6,266,134	6,779,302	7,285,520	7,285,520
Number of vaccine doses purchased with state funds	1,510,309	1,129,188	1,376,165	1,130,652	1,686,564	1,686,564
Average cost per dose of vaccines purchased with state funds	$9.43	$13.67	$10.19	$10.21	$15.06	$15.06
Vaccination Coverage among children aged 19 to 35 months	74.7%	69.5%	75.0%	71.3%	75.0%	75.0%

Are there issues with federal funds?
No

If there is a waiting list, how many clients are there?
There is no waiting list for services. However, because of funding availability, not all recommended childhood vaccines are available at all TVFC sites. For example, Prevnar is only available to underinsured children in FQHCs and RHCs. Prevnar is a new vaccine that protects young children from infection with Streptococcus pneumonia bacteria, an organism that is the most common cause of middle ear infection and a

common cause of pneumonia in children.

Policy changes and impact on caseload?
The 78th legislature passed several bills addressing immunization issues, including SB 40, SB 43, SB 486, HB 1920, HB 1921 and HB 2292. The department is actively reviewing and implementing these legislative mandates that address provider awareness, statewide public education efforts, the immunization registry and the Texas Vaccines for Children Program (TVFC) with a goal to improve immunization rates in Texas.

Future needs that should be addressed.
Underinsured children do not have access to Prevnar unless they present for services at a Federally Qualified Health Center (FQHC) or a Rural Health Center (RHC), and then only if they meet the criteria for the FQHC or RHC to obtain services. This leaves a large number of children with no access to this vaccine and the result is an increase in disease incidence, putting children at risk. Additional funds are required to make all vaccines available to all underinsured children in all TVFC sites in Texas. Additional funding would simplify the TVFC for all providers enrolled by eliminating a two-tiered eligibility system: one for Prevnar, and one for all other vaccines provided by the TVFC.

Program Audit Information:
Date of last audit and findings/resolutions:
State Auditor, Statewide Single Audit, February 2004. No findings.

Department of State Health Services

HIV

Program Description:
The HIV/STD programs provide life-sustaining or curative medications to treat HIV and sexually transmitted diseases (STD), medical and social services, provide counseling and testing services; ensure access to HIV/STD comprehensive preventive services statewide; collect, analyze, interpret and disseminate data on HIV and other STDs in Texas and evaluate HIV/STD prevention and services programs.

Comprehensive preventive services are delivered through contracts with community-based organizations, local health departments and others. HIV/STD medications are delivered through a network of 280 participating pharmacies and through regional and local health departments. Epidemiology and surveillance activities and services are delivered through contracts with local health departments and by central office and regional staff.

Who the program serves:
The HIV/STD program serves all Texans. The HIV Medication program serves low-income, uninsured or underinsured HIV-positive Texans. Ninety-five percent of the clients are over the age of 19.

Eligibility Criteria for HIV Medication Program:
1. Proof of Texas residency
2. Proof of being HIV- positive
3. Uninsured or underinsured for prescription medications (HIV Medication Program)
4. An adjusted gross family income of 200% or less of the current Federal Poverty level (FPL)

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue	$25,576	$28,739	$27,766	$29,727	$46,517	$37,905
Federal Funds	$64,280	$75,069	$98,174	$97,489	$93,067	$91,333
Other Funds	$365	$385	$795	$317	$0	$1,251
Total All Funds	$90,221	$104,193	$126,735	$127,533	$139,584	$130,489

HIV

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
218.3	222.7	229.2	229.8	242.4	242.4

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Number of Persons Served by the HIV Medications Program	10,041	11,076	12,243	12,317	14,189	14,189
Number of Persons Provided Social and Medical Services After Diagnosis	19,978	21,142	21,093	24,896	22,665	22,665
Cost Per HIV Prevention Counseling	$34.00	$42.00	$33.09	$36.07	$42.00	$42.00

Are there issues with federal funds?
For the last several years, federal funding for the National AIDS Drug Assistance Program (ADAP) has not kept pace with program growth. For example, in FY 04, it was estimated that, nationally, the ADAP's would need an additional $185 Million to keep up with the increased costs of medications and the increased demand for services by HIV-positive persons living in the United States. However, Federal appropriations increased for ADAP by $35 Million. Fifteen (15) State-ADAP programs have closed their doors and developed waiting lists and many others have implemented other types of restrictions. The Texas ADAP already limits the maximum number of antiretrovirals a client can obtain at one time to four and may be required to implement additional cost containment strategies in FY05.

If there is a waiting list, how many clients are there?
Currently there is no waiting list; however, this is one of the possible cost containment measures that have recently been authorized in Board of Health rules.

Policy changes and impact on caseload?
In August 2003, the Board of Health adopted rules authorizing the implementation of cost containment measures should trends in actuarial projections

indicate the need. If necessary, an initial measure would be to implement medical criteria for new enrollment into the program. These criteria would target enrollment and treatment to those with more advanced HIV disease, as opposed simply to being infected with HIV. Estimated savings from implementation of the medical criteria would be approximately $2.8 million.

Future needs that should be addressed.
Effective, new drug treatments continue to become available for clients. Newer, more effective, and user-friendly versions of older medications are also becoming more common. Both classes of these drugs continue to be very expensive.

The federal government has several incentive programs for early HIV testing and also for getting clients into care/service earlier, which includes HIV Medication Programs/ADAPs. However, federal funding of state HIV Medication programs/ADAPs is inadequate to support the increase in caseloads resulting from these programs.

In 2006, the Medicare prescription drug benefit will become available. The impact this program will have on the Texas HIV Medication Program/ADAP is still not clear. The program is following this issue closely.

Program Audit Information:
Date of last audit and findings/resolutions:
State Auditor, Statewide Single Audit, February 2004. An audit of the
HIV Medication Program by the State Auditors Office found the program in compliance with best practices.

Department of State Health Services

Cancer Registry

Program Description:
The Texas Cancer Registry (TCR) is a state program mandated under Chapter 82, Health and Safety Code administered by the Cancer Registry Division (CRD) of the Texas Department of Health. The program's broad responsibility is to collect, analyze and disseminate information on the occurrence of cancer in Texas. Specific program activities include maintaining a population-based statewide cancer registry whose data can be used for identifying Texans at increased risk of cancer; monitoring changes in cancer over time; investigating public concerns of excess cancer; and, providing cancer data to evaluate and understand causes of cancer, needs for services and cancer control interventions.

Who the program serves:
The Cancer Registry serves the general public; the medical community; academic researchers; the legislature; and environmental experts.

Eligibility Criteria:
Not applicable

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue	$830	$1,040	$942	$1,041	$1,150	$1,150
Federal Funds	$1,035	$847	$1,413	$1,238	$2,291	$2,291
Total All Funds	$1,865	$1,887	$2,355	$2,279	$3,441	$3,441

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
40.0	41.0	43.8	51.4	47.6	47.6

Cancer Registry

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Number of Cancer Reports handled by Registry	N/A	N/A	N/A	196,738	185,000	185,000

Are there issues with federal funds?
Approximately two-thirds of the Cancer Registry's budget is grant funding from the federal Centers for Disease Control and Prevention (CDC) through its National Program of Cancer Registries (NPCR). A State match of 33.33% (in-kind from non-DSHS sources) is required, as well as a Maintenance of Effort of $1,104,347 in General Revenue funds. The Cancer Registry currently is not able to meet all CDC-NPCR required registry operations activities.

If there is a waiting list, how many clients are there?
For all diagnosis year data, there is currently a backlog of 23,740 cancer cases to be processed.

Policy changes and impact on caseload?
For 2004 diagnosis year cancer data, the Cancer Registry has been required to collect six (6) additional data items and implement a new, additional set of edits and criteria in order to comply with CDC, Surveillance, Epidemiology, and End Results (SEER), and North American Association of Central Cancer Registries (NAACCR) requirements. We must now utilize and maintain two (2) sets of criteria and edits: one for 2004 diagnosis year and another for diagnosis years prior to 2004.

Future needs that should be addressed.
The Texas Cancer Registry is a passive surveillance system that is mandated to receive reports of cancer from health care facilities, clinical laboratories and health care practitioners. Currently, health care facilities are the primary reporting entities, with minimal to no reports being received from independent (non-hospital) clinical laboratories and physicians. In addition, the completeness, timeliness and quality of data received from health care facilities vary greatly. Efforts are underway to fully implement the Texas Cancer Incidence Reporting Act by expanding reporting to include independent pathology laboratories and physician offices. Specific emphasis will be placed on unreported cancer cases that are solely diagnosed or treated in a physician or other non-hospital setting. This current underreporting affects the TCR's case completeness, a NAACCR certification standard that remains unmet. This additional case collection is expected to increase the number of cancer reports requiring processing and follow-back and no new resources have been identified to meet this need.

One other primary goal of TCR is improving certain aspects of registry operations to achieve "Gold Standard" certification from the NAACCR. This level of certification is necessary for recognition as a nationally certified cancer registry. "Gold Standard" certification has significant

implications for acceptance and publication of data produced by TCR as well as funding of cancer research in Texas. Improvements aimed at obtaining NAACCR certification will also help assure TCR meets CDC/NPCR requirements for data completeness, timeliness and quality, which could impact future funding for TCR operations.

Program Audit Information:
Date of last audit and findings/resolutions:
North American Association of Central Cancer Registries (NAACCR) Data Quality Audit of 1996 Cancer Cases- June 1999

Finding: A completeness rate of 81.8% compared with the NAACCR standard of 95%.
Finding: A data quality error rate of 6.6%, statistically above the NAACCR median for race, primary cancer site, subsite of primary site, grade and sequence number.

Resolution: Efforts to improve TCR data quality and completeness include expanding reporting to include independent pathology laboratories and physician offices, increase record processing capabilities, preliminary discussions for partnering with academic centers for implementation of a pilot border regional registry in McAllen, funding circuit rider abstractors to improve and increase data collection, acquisition of some funding and staff for death clearance activities, approval of federal funds for cancer reporter training, and addition of reabstracting (data quality auditing) as part of the annual casefinding contract activities. These foregoing efforts are underway through current savings from grant funds or cooperative funding.

Cancer data diagnosed in 2001 were submitted for evaluation to the CDC/NPCR in January 2004. TCR data met all evaluation criteria, including an 89.9% completeness, which was rounded to 90%, the minimum acceptable level for CDC “high quality data”. Although significant improvements in data quality and completeness have been made, TCR data still do not meet NAACCR certification standards.

Department of State Health Services

Kidney Health Care

Program Description:
The Kidney Health Care Program (KHC) was established in 1973 to use State funds and resources for the care and treatment of persons suffering from end-stage renal disease (ESRD). The following services are provided to eligible recipients:

- Medical Benefit – KHC provides limited payment to participating providers for dialysis and access surgery services provided to KHC recipients.
- Transportation Benefit – This program benefit reimburses patients for allowable travel for ESRD related treatment. Travel benefits are limited to an established reimbursement rate, mileage on record, and a monthly maximum. As a result of HB2292, on 9/1/03, all TDH transportation services were transferred to the Texas Department of Transportation. Currently, KHC is continuing to administer this benefit under an HHSC Interagency Agreement with TxDOT.
- Drug Benefit – KHC provides payment of up to 4 prescriptions per month for recipients. Payments are made directly to participating pharmacies and claims are processed through the HHSC Medicaid Vendor Drug Electronic Claims Management (ECM) system.

The KHC also awards grants under the Anatomical Gift Educational Program to provided innovative organ donor educational programs to the general public, schools, universities, community/worksite and civic groups and targeted minority populations.

Who the program serves:
KHC serves all age groups, however, the majority of the patients are 45 through 74 years of age. A high percentage of program applicants are Hispanic. The growth of patients within the KHC Hispanic population continues to be more dramatic than that among patients of any other race or ethnicity. Between FY93 and FY03, the number of Hispanic applicants almost doubled.

Eligibility Criteria:
To be eligible for KHC benefits the following criteria must be met:

1. Have a diagnosis of end-stage renal disease (ESRD)
2. Meet the Medicare criteria for ESRD
3. Be receiving a regular course of chronic renal dialysis treatments or have received a kidney transplant
4. Be a resident of Texas
5. Submit application through a participating facility
6. Have an adjusted gross income of less than $60,000.

Department of State Health Services

Kidney Health Care

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	*2004 Budgeted	*2005 Appropriated
General Revenue	$ 21,223	$ 20,500	$ 22,540	$ 26,385	$ 15,731	$ 20,220
Other Funds	$ 0	$ 79	$ 0	$ 171	$ 6,706	$ 4,394
Total All Funds	$ 21,223	$ 20,579	$22,540	$ 26,556	$ 22,437	$ 24,614

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
37.5	37.4	39.1	42.1	42.2	42.2

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Number of Kidney Health Clients Provided Services	19,440	21,189	21,123	22,280	25,666	28,232
Average cost per Chronic Disease Service – Kidney Health Care	$1,012.00	$908.00	$958.00	$886.50	$834.00	$821.00

* 2004 General Revenue was reduced pursuant to Article II, Special Provisions, Contingency Reduction for Transportation Services (HB 2292). Funding for transportation services is provided through a HHSC interagency contract with TXDOT (included in Other Funds). In addition, General Revenue amounts above assume appropriations will be carried forward from 2004 to 2005.

Are there issues with federal funds?
Kidney Health Care does not receive federal funds.

If there is a waiting list, how many clients are there?
Currently, KHC does not have a waiting list.

Policy changes and impact on caseload
In order to remain within the available funding for FY 2004, program benefits were modified. KHC discontinued drug coverage for Medicaid recipients, estimated to affect 6,030 Medicaid recipients; implemented a $6.00 drug co-pay, impacting an estimated 11,700 clients; and discontinued coverage of Renagel (phosphate binder) after December 31, 2003, a change which will impact about 3,600 clients. The cost continuation measures are anticipated to continue for FY 2005.

Future needs that should be addressed.

1. *New Medicare Prescription Drug Benefit Part D for Medicare Beneficiaries Impact on KHC Drug Benefit*—In January of 2006, Medicare will provide outpatient drug coverage to Medicare aged and disabled beneficiaries who are eligible for Part A and Part B. In FY 2003, KHC provided drug benefits to 16,858 clients and, of these clients, 8,767 (52%) were Medicare beneficiaries. The new Medicare Prescription Drug Program under Part D will shift the cost of drug coverage for KHC clients who are Medicare beneficiaries from the State GR funds to Federal funds.

2. *Coverage of Medicare Beneficiaries under Part B who are Transplant Recipients*— Medicare beneficiaries who are transplant recipients receive their immunosuppressive drugs under Medicare Part B which will continue in 2006. In 2004 and 2005, the Medicare Discount Card Program will provide some relief. These clients are responsible for a 20% co-insurance that can be as high as hundreds of dollars per month for these expensive medications. KHC is exploring providing coverage of the co-insurance with some of the potential savings from the Medicare Part D Prescription Drug Benefit Program.

3. *Reimbursement Rates for Dialysis Services*—KHC reimbursement rate for dialysis services is a flat rate of $70.20 per dialysis treatment, which is more than 60% less than the Medicare reimbursement. KHC clients who do not have other coverage, such as Medicare or Medicaid, are becoming almost impossible to place in outpatient facilities because of KHC low reimbursement rate. This leaves a burden on local hospitals, especially the city/county hospitals and hospital districts; however, non-profit and some for profit hospitals are also affected.

4. *Medicare Prescription Drug Benefit Part D Impact on Vendor Drug Rebate*—In FY 2003, KHC collected over $4 million in drug rebates from drug manufacturers based on $18.3 million in drug expenditures. In 2006, the Medicare Prescription Drug Benefit will reduce the overall drug expenditure for KHC clients which, in turn, will lower the drug rebate collected.

Kidney Health Care

Program Audit Information:
Date of last audit and findings/resolutions:
Texas Department of Health Internal Audit, August 31, 2002.

Finding: Service provider agreements (for payments to physicians and hospitals) could be strengthened.
Resolution: The Program has developed and implemented written agreements with hospitals and physicians.

Finding: The Program lacks an adequate system for monitoring delivery of services.
Resolution: The Program has developed and implemented a yearly audit plan. Recoupment procedures were finalized and implemented.

Children With Special Health Care Needs (CSHCN)

Program Description:
Children with Special Health Care Needs (CSHCN) is a safety net program providing comprehensive health care benefits to eligible clients. The benefit package includes medical, dental, and case management services. Case management assists families in accessing available health care resources and services. CSHCN has served children with special needs since 1933.

Who the program serves:
CSHCN provides comprehensive health care benefits to children with special health care needs who meet program eligibility criteria.

Eligibility Criteria:
1. Under the age of 21 with a chronic physical or developmental condition
2. Person of any age with cystic fibrosis
3. Bonafide resident of Texas
4. Family income up to 200% of Federal Poverty Income Level (some spend-down provisions allowable)

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue	$25,504	$25,598	$24,757	$19,075	$24,052	$23,825
General Revenue, Ded.	$175	$200	$2	$107	$107	$107
Federal Funds	$12,042	$13,369	$7,575	$8,165	$12,257	$12,529
Other Funds	$111	$942	$229	$200	$577	$200
Total All Funds	$37,832	$40,109	$32,563	$27,547	$36,993	$36,660

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
187.6	189.3	186.3	165.0	144.6	144.6

Children With Special Health Care Needs (CSHCN)

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Number of CSHCN (CDIC) clients receiving case management	48,827	46,386	63,183	45,217	31,372	31,372
Number of CSHCN clients receiving medical services	n/a	3,829	3,359	1,925	2,663	2,663
Number of CSHCN clients receiving Family Support Services	n/a	137	5	5	5	5
Number of CSHCN clients receiving enabling services	n/a	980	1,057	927	900	900
Average cost per CSHCN client	$5,434.34	$5,480.43	-	-	-	-
Average cost per CSHCN client receiving case management	n/a	n/a	$92.54	$87.67	$105.51	$105.51
Average cost per CSHCN client receiving medical services	n/a	n/a	$6,632.95	$6,400.00	$7,327.14	$7,327.14
Average cost per CSHCN client receiving Family Support Services	n/a	n/a	$1,200.00	$1,236.36	$1,274.32	$1,274.32

Children With Special Health Care Needs (CSHCN)

Average cost per CSHCN client receiving enabling services	n/a	n/a	$791.46	$815.60	$840.48	$840.48
Number of clients removed from waiting list and provided services	n/a	n/a	-	150	250	250

Are there issues with federal funds?
CSHCN program is supported through a combination of federal (Title V Block Grant) and state (General Revenue) funds. At least 30% of the Title V Block Grant funds must be spent on CSHCN. In addition, Title V program must make state funded expenditures equal to a designated maintenance of effort level ($40.2 million/annual).

If there is a waiting list, how many clients are there?
A waiting list for health care benefits was initiated October 5, 2001. Before being placed on the CSHCN waiting list, clients are determined eligible for the program. As of March 31, 2004, there are 1,060 clients on the waiting list. 347 clients have been removed from the waiting list in 2004.

Policy changes and impact on caseload?
Effective September 1, 2003, provider reimbursement rates were reduced to mirror reductions in provider reimbursement rates for Medicaid. Reduction in client benefit dollars spent on clients receiving benefits has provided some dollars, within the existing budget, to allow for removal of a limited number of clients from the waiting list.
Effective September 1, 2003, six (6) months of continuous program eligibility limitation was implemented. Previously, the eligibility period was one (1) year. The change is being phased in over the first six (6) months of implementation based on the client's eligibility renewal date. There is a potential that the attrition rate for clients receiving benefits may increase due to the shortened eligibility period; however, adequate time to evaluate such has not transpired.

Future needs that should be addressed.
Continued work to maximize available funding in an effort to serve current and future eligible clients on the CSHCN waiting list.

Program Audit Information:
Date of last audit and findings/resolutions:
This program has not been audited. HHSC Program Review, December 2001.

Children With Special Health Care Needs (CSHCN)

HHSC, at the request of Texas Department of Health, conducted a review of CSHCN in December of 2001. The review team proposed 18 recommendations to address improvement in program financial management. Recommendations included the following categories: administrative functions, contracts and grants, medical services, financial management and issues for further study. The departments' response to recommendations has resulted in improved financial management and the ability to operate within the budget.

Department of State Health Services

Family Planning

Program Description:
The Family Planning program administers/facilitates statewide delivery of preventive, comprehensive health care services to low-income women, men and adolescents. Voluntary and confidential services are provided without regard to age, sex, race, color, parenthood, disability, national origin, religion, contraceptive preference, or marital status. Preventive services include medical exams, laboratory tests, counseling, and education that reduce unintended pregnancies, improve health status, assist individuals in managing their fertility, and positively affect future pregnancy outcomes.

Initiatives in the Family Planning program include the Family Violence Prevention project, which is funded by the Centers for Disease Control and Prevention and is a collaborative effort to develop a strategic plan to prevent violence against women in Texas. Other innovative initiatives are the Male Involvement research and demonstration projects, HIV and Family Planning Integration Projects, and Hard-to Reach projects for the underserved such as homeless, substance abusers, and individuals recently released from incarceration.

Who the program serves:
The program provides statewide family planning services to eligible, low-income women, men and adolescents. Services are provided by public and private non-profit agencies with funds awarded through a competitive procurement process. It is estimated that there were approximately 1,819,900 low-income women in Texas (Women-In Need for Family Planning Services) in FY 2001 (based on the most recent census data and federal poverty income levels). Approximately, 90 % of the eligible clients are at or below 100 % of the federal poverty level (FPL.)

Services are provided by a wide variety of contract agencies across the state. Large university health systems may provide services to over 1,000 clients every month; whereas, a smaller county health department may provide services to approximately 250 clients per month. All contract agencies are required to provide family planning services regardless of the individual's ability to pay and must offer services at times that enable clients to access services, i.e. evening and Saturday clinic hours.

Eligibility Criteria:
Eligibility for services is assessed at the clinic level. Eligibility is determined according to the following funding sources:

Title X – self-declared family income at or below 250% FPL (set by federal law). There is no cost for services for clients at or below 100% of FPL.
Title XIX – Medicaid eligibility is at or below 17% of FPL (set by State in Medicaid state plan.
Title XX – self-declared family income at or below 150% FPL (set by DSHS policy)

Department of State Health Services

Family Planning

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue					$218	$199
Federal Funds	$37,844	$38,432	$42,350	$46,961	$43,476	$43,482
Total All Funds	$37,844	$38,432	$42,350	$46,961	$43,694	$43,681

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
23.5	29.1	33.8	32.9	34.1	34.1

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Number of adults and adolescents receiving family planning services	384,622	360,955	200,447	220,749	266,157	444,260
Average Annual cost per Family Planning Client	$171.02	$204.86	$145.82	$131.83	$108.09	$192.60

*Appropriations for Family Planning Medicaid Services were transferred to HHSC in 2004/2005 and therefore have been excluded from amounts above for all years.

Are there issues with federal funds?
None

If there is a waiting list, how many clients are there?
Clinics do not maintain a waiting list, as they are contractually required to provide services when requested.

Policy changes and impact on caseload?
No program policy changes that will impact caseloads.

The implementation of legislation related to Family Planning is ongoing:

Rider 8—*Prohibition on Abortion*—this rider prohibits TDH, and subsequently DSHS, from using D.1.2 family planning funds (Titles X, XX, and XIX) to contract with any individual or agency that performs or contracts with anyone who performs elective abortion procedures. Six plaintiffs sued the State of Texas and, as a result, TDH was enjoined in August of 2003 from applying certain provisions in Rider 8. TDH has not implemented Rider 8 during the FY2004 contract period.

Rider 10—*Parental Consent*—this rider requires TDH to obtain parental consent for the medical, dental, or psychological treatment of a minor in accordance with the Health and Safety Code. Confidential family planning services are a requirement under Title X and Title XIX, and TDH family planning contractors are prohibited from obtaining parental consent for family planning services for a minor who is eligible under Title X or XIX. Contractors that provide family planning services under the Title V and Title XX programs must obtain parental consent prior to providing services to a minor.

Rider 11—*Reporting of Child Abuse*—TDH is prohibited from contracting with any agency that does not show a good faith effort to comply with all child abuse reporting requirements as established in Chapter 261 of the Family Code. DSHS has implemented a policy for programs, such as Family Planning, that serve minors. The Quality Assurance & Monitoring Division routinely monitors all contractors for compliance with this rider.

Future needs that should be addressed.
Current funding enables 1 out of every 4 women-in-need to receive subsidized family planning services (based on the Women-In-Need FY 2001 data and program eligibility guidelines.) The program continues to assess the need for services to ensure statewide availability so that services can be accessed by those most in need.

Program Audit Information:
Date of last audit and findings/resolutions:
State Auditor, Statewide Single Audit, February 2004. Title X audit for 2003 – 2004, no report findings issued.

Community Health Services – Federally Qualified Health Center (FQHC) Incubator Program

Program Description:
The FQHC Incubator Program, authorized by the 78th Legislature in SB 610, allows TDH to make grants to establish new or expand existing facilities that can qualify as federally qualified health centers, including planning grants, development grants, capital improvement grants, and transitional operating support grants.

The goal is to assist 17 organizations in Texas to receive new or additional, federal funding as a FQHC or federally certified as an FQHC Look-Alike (FQHC-LA).

Who the program serves:
The FQHC Incubator Program staff serves current FQHCs or FQHC-LAs, and communities with an interest in seeking FQHC designation or FQHC-LA certification.

- In December 2003, 4 New Access Point applications were submitted to HRSA
- Several Communities are in the process of applying for FQHC Look Alike certification
- In May 2004, 11 communities have indicated that they will be submitting applications to HRSA for full FQHC funding
- There are 7 current FQHCs receiving Incubator funds, with 2 FQHCs applying for New Access Point funds and 5 applying for Expanded Medical Capacity funds (based on awards for both grant cycles)
- Incubator grant service areas include 60 counties

Eligibility Criteria:
Organizations must fall into one of three organizational categories to be eligible for grants:

1. a currently-designated FQHC or FQHC-LA;
2. an I.R.S-designated non-profit 501(c)(3) organization, including but not limited to, hospitals and community organizations; or,
3. a public entity such as county, city, or local public health departments; hospital or health districts.

All organizations must provide or propose to provide primary health care in Medical Underserved Areas or to Medically Underserved Populations (MUA/MUP).

Organizations must make the commitment to support the sustainable development or expansion of FQHCs) and FQHC-LAs. Organizations cannot propose to replace local or state funds with FQHC Incubator Program grants funds.

There are additional criteria that each of the above organizational types must meet depending on the component (planning, development, transitional operating support and/or capital improvements) for which the grant is awarded. These criteria range from having a completed feasibility study to determine community need for an FQHC or FQHC-LA, providing primary health care, development of a business plan, and so

Community Health Services – Federally Qualified Health Center (FQHC) Incubator Program

forth that meet all of Bureau of Primary Health Care (BPHC) FQHC requirements.

All organizations must first become compliant with the governance expectations outline in the BPHC Policy Information Notice 98-23.

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue	$0	$0	$0	$0	$5,000	$5,000
General Revenue, Ded.	$0	$0	$0	$0	$0	$0
Total All Funds	$0	$0	$0	$0	$5,000	$5,000

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
0.0	0.0	0.0	0.0	0.0	0.0

Key Performance Measures

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Not applicable					

Are there issues with federal funds?
In FY 2000**,** President Bush implemented a five-year plan to support new FQHCs or expand existing FQHCs. A key component of the President's Initiative is to double the number of people served by community health centers by making awards to 1200 applicants over a five-year period through New Access Points, Service Expansions, and Expanded Medical Capacity grants. October 2004 will mark the beginning of the fourth year of the President's Initiative.

The Health Resources and Services Administration (HRSA) has projected a much smaller number of grant awards for FY 2004 than originally

anticipated. For the December 2003 federal grant application cycle, 187 eligible applications were received and HRSA projects that it will make only 13 new access point awards. In addition to the new access point grant reductions, HRSA reduced awards for expanded medical capacity from 94 to 63 (a reduction from $47 million to $8.5 million). HRSA had originally projected making between 120 and 140 service expansion awards, but has reduced that number to 78 awards (a reduction from $14 million to $8.5 million). These reductions make the federal awards even more competitive, and it is likely that HRSA will continue to favor existing FQHCs who are applying for expanded medical capacity and service expansion funding. In Texas, the greatest interest in FQHC development is from organizations that are not currently an FQHC.

If there is a waiting list, how many clients are there?
Not applicable.

Policy changes and impact on caseload?
Not applicable.

Future needs that should be addressed.
The final year for the FQHC expansion, under the President's initiative, is October 2005 through September 2006.

Program Audit Information:
Date of last audit and findings/resolutions:
The FQHC program has not been audited since it was implemented. The Office of Internal Audit at TDH conducted an audit of the Primary Health Care program during FY02. The program was cited for not having adequate controls in place to monitor funds used for supplemental services. The monthly reporting form was modified to address this finding and was approved by the Office of Internal Audit.

Department of State Health Services

Community Health Services – Primary Health Care

Program Description:
The Primary Health Care (PHC) program provides a range of preventive and primary health care services to the medically uninsured, underinsured and indigent populations. Primary health care services, including medical and social history; physical examination; client education and counseling for needs identified during the visit; health risk assessment; client education for identified health risks; and screening and lab test as clinically indicated.

PHC enables communities to identify, design and implement the comprehensive primary care services that are most appropriate to reduce the morbidity and economic burden of major diseases (diabetes, cardiovascular disease, cancer) through treatment programs.

Who the program serves:
The program provides primary health care services to Texas residents who could otherwise not receive such care. PHC makes awards for the provision of primary health services to local entities (i.e., local health departments, universities, community health centers, and non-profit agencies) through a competitive request for proposal procurement process. A total of 56 contractors currently receive PHC funds and are expected to provide primary care services to an estimated 85,000 eligible clients in 134 counties during FY 2004. Approximately 65% of these counties are designated as rural and the rest are designated as urban.

Eligibility Criteria:
The program serves Texas residents at or below 150% of Federal Poverty Level who are not eligible for other programs that provide the same services.

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue	$15,826	$16,512	$15,515	$15,924	$13,171	$13,355
General Revenue, Ded.	$0	$0	$0	$0	$60	$0
Federal Funds	$324	$221	$245	$215	$523	$303
Other Funds	$28	$84	$19	$18	$0	$0
Total All Funds	$16,178	$16,817	$15,779	$16,157	$13,754	$13,658

Department of State Health Services

Community Health Services – Primary Health Care

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
60.2	58.0	55.8	52.7	28.9	28.9

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Eligible patients provided primary care services	89,443	92,831	76,010	87,380	75,000	75,000
Average cost per primary health care eligible patient	$178.56	$149.68	$185.54	$162.54	$190.00	$190.00
Average Cost per minority health initiative developed	$84,321.00	$84,246.00	$57,324.00	$20,357.11	$66,648.00	$66,648.00

Are there issues with federal funds?
None.

If there is a waiting list, how many clients are there?
Not Applicable.

Policy changes and impact on caseload?
The program's rules are up for review and will be presented to the Board of Health (July 2004 Session). This review will include no major changes to the program as discussed at the 16 key local primary care stakeholders meetings that were held in October 2003.

Future needs that should be addressed.
PHC program must develop a long-range plan, covering at least six years (2006-2011) that includes program priorities and plan of action to address these priorities, as stipulated in Chapter 31. The program is planning to reconvene the 16 member stakeholder workgroup to assist in identifying the program priorities, assessing resources, and developing recommendations to achieve the program's goals and objectives.

Program Audit Information:
Date of last audit and findings/resolution:
The Office of Internal Audit at TDH conducted an audit of the Primary Health Care program during FY02. The program was cited for not having adequate controls in place to monitor funds used for supplemental services. To address this finding, the monthly reporting form was modified and subsequently reviewed by the Office of Internal Audit.

Department of State Health Services

Tobacco

Program Description:
The program provides comprehensive tobacco prevention and control activities at various levels statewide. These activities include tobacco prevention education in schools and communities, cessation activities through education and a statewide telephone counseling service, enforcement of state and local tobacco laws including a statewide tobacco awareness class, public education through use of various mediums, and receiving tobacco ingredient lists and evaluation of program outcomes. Using tobacco settlement funding, the program implements the Texas Tobacco Prevention Initiative pilot project in the East Texas area. To implement these programs, TDH contracts with local health departments, Education Service Centers, law enforcement agencies, a media firm (for the development of tobacco prevention and cessation messages) voluntary health organizations (for telephone cessation) and state institutions of higher education (for evaluation studies). Additionally, nine regional TDH tobacco specialists carry out activities statewide.

In the 2003 calendar year, just over 5000 tobacco prevention activities were implemented reaching approximately 2,800,000 people statewide. Of these totals, over half of the activities were conducted in the East Texas pilot area reaching an approximate total of 1,200,000 youth and 700,000 adults.

After the East Texas pilot project's first year, there was a 36 percent reduction in sixth-through-12th-grade tobacco users in the East Texas area. Approximately 57,700 fewer sixth-through-12th-graders are using tobacco products as a result of the comprehensive program. There has also been an 18.6 percent reduction in adult smoking rates, which translates to some 85,370 fewer adult smokers in the area.

Who the program serves:
The citizens of Texas. Special efforts are targeted to youth aged 9-18, young adults, and diverse/special populations that are targeted by the tobacco industry or have a higher burden of tobacco-related disease. Comprehensive services are provided to persons living in Jefferson, Harris, Fort Bend and Montgomery counties, which has a total populations of approximately 4,156,595.

Eligibility Criteria:
Not applicable

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue	$112	$107	$4,768	$5,077	$123	$123
General Revenue, Ded.	$6,413	$11,026	$7,241	$7,488	$5,994	$5,994
Federal Funds	$417	$717	$726	$697	$864	$864

Department of State Health Services

Tobacco

Other Funds	$444	$359	$367	$394	$399	$399
Total All Funds	$7,386	$12,209	$13,102	$13,655	$7,380	$7,380

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
22.3	24.9	27.1	22.1	28.5	28.5

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Statewide prevalence of tobacco use among middle school youth	23.0%	17.6%	16.6%	16.6%	17.0%	17.0%
Statewide prevalence of tobacco use among high school youth	42.1%	34.6%	33.4%	33.4%	32.0%	32.0%
Average cost per capita for populations served in pilot target areas	$1.09	$1.88	$2.29	$2.71	$3.00	$3.00
Number of people served in pilot targeted area	5,880,000	5,880,000	4,300,849	4,156,575	2,500,000	2,500,000

Tobacco

Are there issues with federal funds?
None

If there is a waiting list, how many clients are there?
Not applicable

Policy changes and impact on caseload?
Not applicable

Future needs that should be addressed.
The Texas Inter-Agency Tobacco Task Force reviewed "best practices" and experiences from other states and identified that it would take at least $3.00 per person in the state (approximately $60 million) to fund a comprehensive statewide tobacco prevention and control program. CDC has estimated that the minimum investment should be at least $5.31 per person ($103,288,000) to implement a comprehensive statewide program in Texas. Efforts in the East Texas pilot have demonstrated that there are known, effective interventions that can reduce tobacco use, and consequently health and financial burden of tobacco use on the state. Additional funding is required to expand the pilot program to a state-wide program.

Program Audit Information:
Date of last audit and findings/resolutions:
Texas Department of Health Internal Audit, March 2003.

Recommendations from the review included: 1) Establish quantifiable contract performance measures for all contracts, 2) Develop a quality assurance monitoring system to include the comparison of measurable contract performance measures with actual contractor performance and 3) Develop written procedures for the calculation, data collection and reporting of non-key ABEST performance measures.

Resolution: The program has implemented all recommendations as of 09/01/03. Contracts now include quantifiable performance measures related to the number and types of activities that contractors must implement in order to fulfill contract requirements. These activities are reported into an on-line reporting system where the program can track progress towards meeting contract requirements. Finally, the program has developed consistent, maintained procedures for reporting progress towards non-key ABEST performance measures.

Department of State Health Services

Substance Abuse

Program Description:
Substance abuse services consist of prevention, intervention and treatment. They range from evidence-based prevention curricula in communities and schools to intervention programs that link clients with appropriate services to treatment services targeting a variety of populations. Collaborations with other state programs include co-occurring psychiatric and substance use disorders services, NorthSTAR (the Dallas-area behavioral health managed care project), and service agreements with the Texas Department of Criminal Justice and the Department of Family and Protective Services.

Services are available through an outsourcing model contracting with about 200 community organizations. Contractors are linked to TCADA through the Behavioral Health Integrated Provider System (BHIPS), an Internet-based computer system designed to meet state and federal data collection and reporting requirements.

Who the program serves:
TCADA serves a variety of populations, depending on the particular service. Universal prevention messages and community coalition efforts are aimed at general populations and communities around the state, while more specific population subgroups and individuals are targeted by other prevention, intervention and treatment efforts. These include school-age youth, persons with HIV/AIDS, pregnant and parenting women, intravenous drug abusers, and those with both psychiatric and substance abuse disorders.

Eligibility Criteria:
Clinical Admission Eligibility: Persons who meet the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (current edition) criteria for Substance Use Disorders.

Financial Assistance Eligibility: A person meeting the clinical criteria of the APA DSM whose income is 200% or less of the federal poverty guidelines (FPG) receive full assistance and others on a sliding scale based on income above 200% of FPG.

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue	20,800	27,300	27,300	$17,800	$17,200	27,200
Federal Funds	140,100	115,000	125,200	$147,000	$151,300	122,300

Substance Abuse

Other Funds	1,800	2,000	1,500	$1,700	$1,500	1,600
Total All Funds	162,700	144,300	154,000	$166,500	$170,000	151,100

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
206.7	184.0	179.0	178.0	170.0	187.8

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Prevention Youth Served	221,712	226,779	227,093	262,385	494,013	419,685
Intervention Adults Served	197,051	178,673	229,907	221,274	163,123	143,767
Treatment Adults Served	32,363	30,366	38,552	43,702	44,168	36,014
Prevention Youth Avg Cost	$91.00	$79.00	$81.00	$79.00	$50.00	$50.00
Intervention Adults Avg. Cost	$88.00	$88.00	$56.00	$67.00	$81.00	$81.00
Treatment Adults Avg. Cost	$1,919	$1,764	$1,497	$1,496	$1,706	$1,706

Are there issues with federal funds?
The Substance Abuse Prevention and Treatment (SAPT) Block Grant requires a maintenance of effort. This is calculated as the average of the prior two years General Revenue expenditures authorized for substance abuse expenditures. HB 7 reduced substance abuse General Revenue by $9.5M and the FY 2004 General Revenue appropriations is $17.2M (a $10M reduction.) The FY 2005 General Revenue was restored to full level of $27.2M. As a result of this reduction, the MOE requirement for the FY 2004 Block Grant was not met. A waiver request was submitted as well as additional information to support material compliance. A preliminary determination has been made that Texas has not materially complied

with the Maintenance of Effort requirement. Upon final determination of non-compliance, the Substance Abuse and Mental Health Services Administration will recommend to the Secretary of Health and Human Services that he provide the State with an opportunity for a hearing. If a determination of non-compliance is made after the hearing, the penalty amount will be paid through a reduction of the current or future year's award. A proposal will be made to carry back $5M General Revenue from FY 2005 to FY 2004 to mitigate the potential MOE penalty impacting FY 2005.

If there is a waiting list, how many clients are there?
The waiting list is a tool for contracted providers and TCADA to manage the priority admission flow into residential detoxification and residential treatment centers. The SAPT Block Grant issued a mandate for the state to establish a waiting list and capacity management program to ensure that persons meeting the block grant definition of priority populations would have preferential admission into SAPT BG funded treatment centers. The priorities are pregnant women, intravenous drug users, women with children; or women with children in the protective custody of the state as a condition of reunification.

Very few individuals are waiting for treatment by the strict SAPT BG definition. Most individuals wait because of geographic preference and not availability.

Approximately 400 persons per day are waiting for admission into a treatment center. The definition of the waiting list has evolved to include all persons waiting for admission into treatment regardless of their SAPT BG preferential status. This presents a different perspective to the available capacity of the TCADA funded system. Though capacity may exist in other areas, the indigent nature of the clients presents transportation problems to other areas, missed work opportunities, and family barriers for the client to seek services outside their immediate area. Also, non-prioritized clients are placed behind the prioritized clients in the admission process.

The waiting list and capacity management is managed through the Behavioral Health Integrated Provided System. It alerts TCADA to priority admissions and allows all contracted providers to view available capacity.

Policy changes and impact on caseload:
A request for proposal for the FY 05 contracts shift priorities to increase capacity for non-residential services, including services such as:

Ambulatory detoxification, providing intensive outpatient counseling and other services during this initial phase of treatment;
Expansion of pregnant and postpartum intervention services in each region; and
Expanded use of outreach, screening, assessment and referral (OSAR) providers to manage access to services for clients, approving admissions and extending lengths of stay as necessary.

These changes are intended to utilize limited treatment resources in the most cost-effective manner possible.

Substance Abuse

In collaboration with research centers at Texas Christian University and the University of Texas at Austin, we are implementing an evidence-based approach to all of our services, intended to improve outcomes and, hopefully, reduce recidivism.

Future needs that should be addressed.
National estimates place the number of offenders to be released next year from jails and prisons at 1 million, 600,000 of whom will have substance abuse problems needing treatment. Similarly, legislative initiatives to mandate treatment in lieu of incarceration for drug offenders, including expansion of drug courts, will reduce the demand on correctional institutions but will increase the demand on treatment services.

Program Audit Information:
Date of last audit and findings/resolutions:
State Auditor, August 2002, Contract Management Audit.

During the SAO's review, the agency was in transition of the capacity management program from a contracted program to one managed by the state through Behavioral Health Integrated Provider System (BHIPS). Recommendations were made to strengthen its goals and procedures for capacity management. The capacity management program provides an automated system to monitor available beds and slots in Agency-funded treatment programs.

A follow-up report indicated the agency has made significant improvement in contract management and commended the agency for creating a culture of accountability. Three findings were issued that recommended strengthening controls for the capacity management process. The department implemented these findings by transitioning capacity management to Behavioral Health Integrated Provider System (BHIPS), clarifying policies and procedures of the program, clearly defining and communicating the purpose and goals of the program, and defining roles and responsibilities of staff who administer the program.

Department of State Health Services

Adult MH Community Services

Program Description:
This program includes community services designed to allow a person with mental illness to attain the most independent lifestyle possible. Research shows that among the critical factors impacting success for people with serious mental illnesses are housing, meaningful work and supports. These program models offer interventions that are tailored to individual needs and choices and to foster independence. They have proven to be cost-effective alternatives to expensive hospitalization. Studies in the provision of psychiatric services over the last several years have identified Best Practice (ACT, Supported Housing, and Supported Employment) services as the most effective means of assisting people in returning to their communities and greatly reducing the need for institutional services.

Dollars for these services are allocated to the local mental health authorities via annual performance contracts. Dual Diagnosis Services are also purchased through an interagency contract with TCADA. Services provided are as follows:

- **Assessment & Case Management** includes service activities at the local level that are important to determining eligibility and managing resources. Functions include outreach, screening and assessment, service coordination, monitoring, and service planning. The services provided are delivered by the local mental health authorities that cover all areas of the state except for the NorthSTAR service area. Assessment activities are focused on identifying the clinically appropriate services that consumers want and need. Case Coordination services provide assistance with arrangement of needed mental health services, and facilitate a consumer's access to other resources and services as needed. Service Coordination activities assist consumers in gaining access to medical, social, educational and other appropriate services available in the community that can help them achieve an improved quality of life.
- **Rehabilitation Services** provide training and support to assist the consumer in managing their symptoms of mental illness and achieving his or her goals in recovery.
- **Assertive Community Treatment (ACT)** is a very proactive, integrated effort to provide comprehensive community-based care to high users of mental hospitals.
- **Supported Housing (SH)** is a set of activities designed to help people with serious mental illnesses choose, get and keep regular integrated housing in their communities.
- **Supported Employment (SE)** provides individual assistance in choosing and gaining employment in integrated work sites in regular community jobs, and long-term supports in keeping employment and/or finding another job if necessary.
- **Counseling and Psychotherapy** is individual or group interaction, focusing on the treatment of mental illness or emotional disturbance.
- **Medication-related Services** include pharmacological management or medication planning, medication monitoring or administering, medication training for the consumer and/or family and provision of new generation medications, as appropriate.
- **Inpatient Services** are hospital services provided in a local general hospital or private psychiatric hospital other than a legislatively authorized Community Hospital.
- **Intensive Crisis Residential** are 24-hour residential services, usually short-term, offered to persons who are demonstrating psychiatric crisis.

Adult MH Community Services

The mix of service array for each local mental health authority varies by local needs and priorities. Additionally, the services listed above are available for the NorthSTAR area and are funded in a separate strategy for NorthSTAR.

Those MH services that are covered by Medicaid are consistent with Medicaid policy. Not all MH services are covered by Medicaid.

Who the program serves:
These services are provided to persons who meet the priority population criteria. In targeting services to the priority populations, the choice of and admission to services is determined jointly by the individual seeking service and clinicians at the local authority. Criteria used to make these determinations are the level of functioning of the individual, the need of the individual and the availability of resources.

Eligibility Criteria:
The priority population for mental health services consists of adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders, which require crisis resolution or ongoing and long-term support and treatment.

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue	$134,926	$132,020	$156,236	$151,852	$144,265	$140,004
Federal Funds	$60,234	$87,767	$72,289	$80,982	$75,593	$69,834
Other Funds	$1,384					
Total All Funds	$196,544	$219,787	$228,525	$232,834	$219,858	$209,838

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
17.4	0.0	0.0	0.0	0.0	0.0

2000 was the last year that MHMR provided community medical services at State Operated Community Service centers. Employees at these service centers were state employees. By 2001, these centers had all transitioned to local control. FTEs to administer this program are included in MHMR strategy for Central Administration.

Department of State Health Services

Adult MH Community Services

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Percent of adults receiving MH community services whose functional level stabilized or improved	86%	86%	87%	87%	87%	80%
Average monthly number of adult MH consumers receiving MH community services	*49,977	*48,778	60,771	52,631	51,461	60,771
Average monthly number of consumers receiving MH supported housing services	2,733	2,731	2,813	2,665	2,606	2,813
Average monthly number of MH consumers receiving assessment and services coordination (regardless of age)	76,340	73,698	35,149	45,382	44,590	35,149
Average monthly cost per adult MH consumer receiving community services	*$339	*$355	$391	$373	$361	$374
Average monthly cost per adult MH consumer receiving Supported Housing	$374	$434	$441	$396	$384	$421

*Due to strategy structure changes in the 78th legislative session, the MH community services measures now include assessment and service coordination, which had been a separate strategy in previous years. These numbers are not comparable with the FY02 forward numbers.

Are there issues with federal funds?
There is an issue with potentially not meeting the state's obligation for the FY04 Mental Health Block Grant maintenance of effort.

If there is a waiting list, how many clients are there?
As the Resiliency & Disease Management initiative is implemented across the state, a consistent waiting list procedure will also be implemented. There is no current statewide consistent application of waiting list procedures. However, the data that is currently available indicates there are 6,193 persons waiting for a mental health community service. This does include persons receiving some service but waiting for additional services.

Policy changes and impact on caseload?
The impact of Resiliency & Disease Management has yet to be experienced as the initiative will not be fully implemented across the state until FY05. However, there are two assumptions that will be applicable. First, there will be an overall increase in cost as persons with severe needs receive the more intensive level of services. Secondly, there will be an overall decrease in the number of persons served as the system refines its service delivery to provide more intensive services to fewer persons.

In the future, a claims management process will be developed to pay for these services in a fee for service environment.

Program Audit Information:
Date of last audit and findings/resolutions:
State Auditor, April 2002.

Recommendation #1: MHMR should establish procedures to monitor the clearance patterns of all programs subject to CMIA Subpart A on a yearly basis. For those programs where the clearance pattern changes, MHMR should notify the State of Texas Comptroller's Office during the CMIA report preparation process.
Resolution: TDMHMR response was "The Comptroller's Office is the Single State Agency responsible for administering CMIA activities in the State of Texas including reporting and coordinating with the Federal Government." MHMR believes it is in full compliance with the agreement the Comptroller's Office has entered into with the Federal government and all other relevant CMIA requirements issued by the Comptroller to State agencies. MHMR is confident it has designed and maintained the necessary control system to identify any risk or irregularities that may affect its ability to meet these requirements.

Recommendation # 2: For both Adult and Children MH Community Services, TDMHMR should develop and implement an independent peer review process for entities that provide treatment services or obtain clarification of this requirement from the Center for Mental Health Services.

This process began in February 2002.

Resolution: MHMR and Substance Abuse and Mental Health Services Administration (SAMHSA) negotiated an agreement that resolved this finding in January 2002. The agreement called for the Texas Mental Health Planning Advisory Committee (MHPAC) to form a subcommittee of three members that will participate with MHMR's Quality Management staff in the required independent peer review process of the Mental health Block grant recipients. This process began in February 2002.

Notwithstanding the aforementioned agreement, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a request for comments notice in the Federal Register (Vol. 67, No. 247/Tuesday, December 24, 2002, Notices, pages. 78496-78504) in which SAMHSA proposed the elimination of the requirement that States independently peer review five (5) percent of facilities under the program each year. MHMR agrees with the SAMHSA proposal to eliminate the independent peer review component. However, MHMR will continue to implement the agreed upon resolution until such time as the requirement is formally eliminated.

Recommendation # 3: MHMR should implement a payroll effort system that requires employees working solely on a single Federal award to certify at least semi-annually that they worked solely on the program. For individuals working on multiple activities, the time sheets should (1) reflect an after-the-fact distribution of actual activity, (2) account for total activity each pay period, (3) be prepared at least monthly, and (4) be signed by the employee. Any substitute systems for allocating salaries should be approved by the U.S. Department of Health and Human Services.
Resolution: The timesheet allocations began in August 2003.

Department of State Health Services

Children MH Community Services

Program Description:
Children's Mental Health Services provides community services to children and adolescents ages 3 through 17. These service activities are designed to support children and their families to achieve the quality of life and community participation acceptable to the child and family. The program emphasizes services for very young children through early identification and intervention services as well as children and adolescents who have intensive service needs, including the juvenile justice population. Also included in this program is the Texas Integrated Funding Initiative (TIFI), which is an inter-agency initiative to serve children and adolescents with serious emotional disturbance who have multiple and complex needs through locally operated systems of care.

Since no single agency can adequately meet all the needs of young children with serious emotional disturbances as well as children and adolescents who have intensive service needs, including the juvenile justice population, interagency coordination and parent involvement in service planning and delivery is critical.

Services in this program include the following:

- **Assessment & Case Management** includes service activities at the local level that are important to determining eligibility and managing resources. Functions include outreach, screening and assessment, service coordination, monitoring, and service planning. The services provided are delivered by the local mental health authorities that cover all areas of the state except for the NorthSTAR service area. Assessment activities are focused on identifying the clinical needs of the child or adolescent and the most appropriate service to support and meet those needs. Case Coordination services provide assistance with arrangement of needed mental health services, and facilitate a consumer's access to other resources and services as needed. Service Coordination activities assist consumers in gaining access to medical, social, educational and other appropriate services available in the community that can help them achieve an improved quality of life.
- **Skills Training** services provide opportunities to the child to acquire and improve the skills needed to function as independently as possible in the community.
- **Family Training** is provided to the family of a child in service for the purpose of broadening the family's knowledge of the effects and treatment of the child's emotional/behavioral disorder.
- **Wraparound Planning** is a collaborative planning process that is intended to assist the child and family in the development of community supports that will allow the child to remain in or return to the preferred living or day care environment.
- **Respite Services** provide temporary, short-term, and periodic relief of the primary caregiver(s) of a child in services.
- **Acute Services** include in-home crisis intervention, crisis stabilization beds, inpatient services, and acute day treatment for children experiencing acute and severe psychiatric symptomatology.
- **Residential Services** such as therapeutic foster care and group care for children and adolescents with serious emotional disturbances who are unable to receive needed services while living with their parents/primary caregivers.
- **Medication Related Services** includes pharmacological management with the child and family, medication training, medication monitoring and

medication administration. These activities include the provision of new generation medications, as appropriate.

- **Counseling and Psychotherapy** are face-to-face problem resolution services provided in a variety of settings to individuals, families and groups.
- **Flexible Community Supports** maintain quality of life and family integration for children and are generally provided as part of wraparound planning. These supports are based on the preferences of the child and family and focus on outcomes they choose. Flexible community supports are non-clinical, unavailable through other TDMHMR funding and not readily available through other social service resources (community and agency). Mentors, tutors, family aides, specialized camps, transportation services and initial independent living supports are examples.

The mix of service array for each local mental health authority varies by local needs and priorities. Children's services for the NorthSTAR area are funded in a separate strategy for NorthSTAR.

Those MH services that are Medicaid services are consistent with Medicaid policy. Not all MH services are Medicaid services.

Who the program serves:
This program serves priority population children and adolescents, ages 3 through 17.

Eligibility Criteria:
The priority population for children's mental health services are those children, ages 3 through 17, with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental disorders and who:

1. Have a serious functional impairment (a Global Assessment of Functioning Scale, GAF, of 50 or less; or
2. Are at risk of disruption of a preferred living or childcare environment due to psychiatric symptoms; or
3. Are enrolled in a school system's special education program because of a serious emotional disturbance.

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue	$43,298	$43,459	$41,031	$38,549	$39,250	$39,547
Federal Funds	$19,069	$22,121	$18,966	$20,085	$20,041	$19,143
Other Funds	$21					

Department of State Health Services

Children MH Community Services

Total All Funds	$62,388	$65,580	$59,997	$58,634	$59,291	$58,690

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
2.5	0.0	0.0	0.0	0.0	0.0

2000 was the last year that MHMR provided community medical services at State Operated Community Service centers. Employees at these service centers were state employees. By 2001, these centers had all transitioned to local control. FTEs to administer the program are included in MHMR strategy for Central Administration.

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Percent of parents who are satisfied with MH services delivered to their children	95%	96%	82%	83%	83%	70%
Average monthly number of children receiving MH community services	13,852	11,678	11,322	11,419	11,294	11,322

Are there issues with federal funds? There is an issue with potentially not meeting the state's obligation for the FY04 Mental Health Block Grant maintenance of effort.

If there is a waiting list, how many clients are there? As the Resiliency & Disease Management initiative is implemented across the state, a consistent waiting list procedure will also be implemented. There is no current statewide consistent application of waiting list procedures. However, the data that is currently available indicates there are 632 children waiting for a mental health community service. This does include children receiving some service but waiting for additional services.

Policy changes and impact on caseload: The impact of Resiliency & Disease Management has yet to be experienced as the initiative will not be fully implemented across the state until FY05. In the future, a claims management process will be developed to pay for these services in a fee for service environment.

Program Audit Information:
Date of last audit and findings/resolutions:
State Auditor, April 2002.

Recommendation #1: MHMR should establish procedures to monitor the clearance patterns of all programs subject to CMIA Subpart A on a yearly basis. For those programs where the clearance pattern changes, MHMR should notify the State of Texas Comptroller's Office during the CMIA report preparation process.
Resolution: TDMHMR response was "The Comptroller's Office is the Single State Agency responsible for administering CMIA activities in the State of Texas including reporting and coordinating with the Federal Government." MHMR believes it is in full compliance with the agreement the Comptroller's Office has entered into with the Federal government and all other relevant CMIA requirements issued by the Comptroller to State agencies. MHMR is confident it has designed and maintained the necessary control system to identify any risk or irregularities that may affect its ability to meet these requirements.

Recommendation # 2: For both Adult and Children MH Community Services, TDMHMR should develop and implement an independent peer review process for entities that provide treatment services or obtain clarification of this requirement from the Center for Mental Health Services. This process began in February 2002.
Resolution: MHMR and Substance Abuse and Mental Health Services Administration (SAMHSA) negotiated an agreement that resolved this finding in January 2002. The agreement called for the Texas Mental Health Planning Advisory Committee (MHPAC) to form a subcommittee of three members that will participate with MHMR's Quality Management staff in the required independent peer review process of the Mental health Block grant recipients. This process began in February 2002.

Notwithstanding the aforementioned agreement, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a request for comments notice in the Federal Register (Vol. 67, No. 247/Tuesday, December 24, 2002, Notices, pages. 78496-78504) in which SAMHSA proposed the elimination of the requirement that States independently peer review five (5) percent of facilities under the program each year. MHMR agrees with the SAMHSA proposal to eliminate the independent peer review component. However, MHMRwill continue to implement the agreed upon resolution until such time as the requirement is formally eliminated.

Recommendation # 3: MHMR should implement a payroll effort system that requires employees working solely on a single Federal award to certify at least semi-annually that they worked solely on the program. For individuals working on multiple activities, the time sheets should (1)

reflect an after-the-fact distribution of actual activity, (2) account for total activity each pay period, (3) be prepared at least monthly, and (4) be signed by the employee. Any substitute systems for allocating salaries should be approved by the U.S. Department of Health and Human Services.

Resolution: The timesheet allocations began in August 2003.

Department of State Health Services

Other Programs (NorthSTAR)

Program Description:
NorthSTAR is an integrated behavioral health initiative that joins the collaborative efforts and blended funding of The Texas Health and Human Services Commission, Texas Department of Mental Health and Mental Retardation and the Texas Commission on Alcohol and Drug Abuse to provide managed behavioral healthcare (mental health, substance abuse and chemical dependency) services

NorthSTAR offers a number of unique features:
- Blended Funding-The complexity of funding restrictions is transparent to the consumer.
- Integrated Services-Mental health and chemical dependency treatment are brought together under the broader category of “behavioral health,” allowing a coordinated approach to treatment in a single system of care.
- Consumer Choice-Individuals can choose from an extensive provider network of over 500 specialty mental health and chemical dependency providers.
- Management of Care-Each individual receives the proper amount of care while cost efficiency is ensured.
- Open Access- Clients in need are served immediately if their condition requires emergency treatment.
- Data-Based Decision Support-NorthSTAR utilizes a modern data warehouse and decision support software to evaluate and manage the system of care.

Who the program serves:
Medicaid eligible and indigent individuals residing in Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall counties including TDMHMR and TCADA priority populations.

TDMHMR defines mental health priority populations as adults with severe and persistent mental illness. Children and adolescents ages 3 through 17 years with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental disorders and who:
- Have a serious functional impairment (GAF of 50 or less currently or in the past year); or
- Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
- Are enrolled in a school system's special education program because of a serious emotional disturbance.

TCADA defines Chemical Dependency and Substance Abuse Priority Populations as:
- Pregnant injecting drug users;
- Pregnant substance abusers;
- Injecting drug users;
- Parents with children in foster care; and
- Veterans with honorable discharges

Other Programs (NorthSTAR)

During SFY 2003 NorthSTAR served 34,847 adults and 8,017 children.

Eligibility Criteria:

- TANF and TANF related category recipients.
- SSI and SSI related category recipients.
- Residency in Dallas, Hunt, Collin Rockwell, Kaufman, Ellis, or Navarro counties.
- Income of less than or equal to 200% of the federal poverty level.
- Must not have third party coverage for the medically necessary behavioral health services the individual is seeking.
- Must meet clinical eligibility requirements.

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue	$34,624	$37,408	$38,149	$48,053	$37,511	$37,684
Federal Funds	$17,349	$22,039	$24,490	$27,961	$27,629	$27,472
Other Funds	$19,340	$22,459	$24,047	$16,359	$25,693	$26,618
Total All Funds	$71,313	$81,906	$88,686	$92,373	$90,833	$91,774

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
0.0	0.0	0.0	0.0	0.0	0.0

FTEs to administer this program are included in MHMR strategy for Central Administration.

Other Programs (NorthSTAR)

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Average monthly number of persons covered by NorthSTAR	1,179,000	1,179,000	1,130,859	1,216,250	1,241,374	1,259,619
Average monthly cost per persor covered by NorthSTAR	$5.20	$5.44	$6.28	$6.23	$6.00	$6.00

Are there issues with federal funds?
Changes in Medicaid Managed Care regulations require the use a new methodology for rate setting. This may result in a decrease in rates under the waiver.

If there is a waiting list, how many clients are there?
All NorthSTAR enrollees receive services without being placed on a waiting list. If specific New Generation Medications are requested in lieu of alternative medications a NorthSTAR client may experience some delay in receiving these specific medications attributable to levels of demand and funding.

Policy changes and impact on caseload
Changes in Medicaid eligibility have impacted the caseloads in both Medicaid recipients and indigent recipients. Clients have moved from the Medicaid category to the indigent category decreasing the funds available to provide treatment to the NorthSTAR population.

Future needs that should be addressed.
Additional resources may be necessary to address growing needs. In the past year, the number of actively served clients has continued to expand.

Program Audit Information:
Date of Last Audit and Results:
State Auditor, April 2002.

Recommendation #1: MHMR should establish procedures to monitor the clearance patterns of all programs subject to CMIA Subpart A on a yearly basis. For those programs where the clearance pattern changes, MHMR should notify the State of Texas Comptroller's Office during the CMIA report preparation process.

Resolution: TDMHMR response was "The Comptroller's Office is the Single State Agency responsible for administering CMIA activities in the State of Texas including reporting and coordinating with the Federal Government." MHMR believes it is in full compliance with the agreement the Comptroller's Office has entered into with the Federal government and all other relevant CMIA requirements issued by the Comptroller to State agencies. MHMR is confident it has designed and maintained the necessary control system to identify any risk or irregularities that may affect its ability to meet these requirements.

Recommendation # 2: For both Adult and Children MH Community Services, TDMHMR should develop and implement an independent peer review process for entities that provide treatment services or obtain clarification of this requirement from the Center for Mental Health Services. This process began in February 2002.
Resolution: MHMR and Substance Abuse and Mental Health Services Administration (SAMHSA) negotiated an agreement that resolved this finding in January 2002. The agreement called for the Texas Mental Health Planning Advisory Committee (MHPAC) to form a subcommittee of three members that will participate with MHMR's Quality Management staff in the required independent peer review process of the Mental health Block grant recipients. This process began in February 2002.

Notwithstanding the aforementioned agreement, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a request for comments notice in the Federal Register (Vol. 67, No. 247/Tuesday, December 24, 2002, Notices, pages. 78496-78504) in which SAMHSA proposed the elimination of the requirement that States independently peer review five (5) percent of facilities under the program each year. MHMR agrees with the SAMHSA proposal to eliminate the independent peer review component. However, MHMR will continue to implement the agreed upon resolution until such time as the requirement is formally eliminated.

Recommendation # 3: MHMR should implement a payroll effort system that requires employees working solely on a single Federal award to certify at least semi-annually that they worked solely on the program. For individuals working on multiple activities, the time sheets should (1) reflect an after-the-fact distribution of actual activity, (2) account for total activity each pay period, (3) be prepared at least monthly, and (4) be signed by the employee. Any substitute systems for allocating salaries should be approved by the U.S. Department of Health and Human Services.
Resolution: The timesheet allocations began in August 2003.

Program Description:
The Mental Health Facilities provide specialized assessment, treatment, and psychiatric services that are needed by the Local Mental Health Authorities to serve their consumers. The service array is planned jointly by the facility and the Local Mental Health Authorities in each facility's service area of the state. Upon admission to Mental Health Facility services, the consumer is assessed and an appropriate individual treatment plan is developed which focuses on the unique needs of each person. A seamless interaction of campus-based and community-based services is promoted through coordination, collaboration, and communication between the two service entities on behalf of the consumer.

The application of a shared set of values, principles, and agreed-upon approaches to assisting persons to resume living in their home communities provides a common understanding for service coordination and delivery between these system components. Specialized and long-term treatment services to support the needs of the consumers and communities are available from the Mental Health Facilities along with traditional intervention when crisis and acute services are indicated. For all services provided, there exists a focus on addressing five areas of common need: access to needed services, skills, friends and family, jobs, and a place to live.

Who the program serves:

Eligibility Criteria:
General Eligibility Criteria:
A person may be admitted to a SMHF only if the person has a mental illness and, as a result of the mental illness, the person:
1) Presents a substantial risk of serious harm to self or others; or
2) Evidences a substantial risk of mental or physical deterioration.

Admission Criteria for Waco Center for Youth
A. A person may be admitted to Waco Center for Youth only if the person:
   1) Is at least 10 but younger than 18 years of age and whose age at admission allows adequate time for treatment programming prior to reaching age 18 years;
   2) Is diagnosed as emotionally or behaviorally disturbed;
   3) Has a history of behavior adjustment problems;
   4) Needs a structured treatment program in a residential facility; and
   5) Meets either of the following criteria:
      (a) the person is in the managing conservatorship of the Texas Department of Protective and Regulatory Services (TDPRS) and has been referred for admission by TDPRS; or
      (b) the person is currently receiving LMHA services or inpatient services at a SMHF and has been referred for admission by:
         (i) the LMHA after endorsement by the local Community Resource Coordinating Group (CRCG); or

State Mental Health Facilities (State Hospitals)

(ii) the SMHF.

B. A person may not be admitted to Waco Center for Youth if the person:
1) Has been found to have engaged in delinquent conduct or conduct indicating a need for supervision under the Texas Family Code, Title 3;
2) Is acutely psychotic, suicidal, homicidal, or seriously violent;
3) Or is determined to have mental retardation.

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue	$198,676	$206,930	$212,135	$233,097	$219,131	$228,070
Federal Funds	$25,407	$26,465	$33,914	$32,310	$28,380	$19,616
Other Funds	$17,852	$18,247	$19,260	$15,661	$18,739	$25,666
Total All Funds	$241,935	$251,642	$265,309	$281,068	$266,250	$273,352

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
7,187.6	7,107.4	7,158.0	7,159.5	7,007.8	7,343.6

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Percent of consumers receiving MH campus services whose functional level stabilized or improved	97%	98%	98%	99%	98%	98%
Average daily census of state mental health facilities	2,356	2,394	2,281	2,265	2,285	2,295

Department of State Health Services

State Mental Health Facilities (State Hospitals)

Average monthly number of state mental health facility consumers receiving new generation medications	1,997	2,542	2,562	2,787	2,787	2,829
Average daily facility cost per occupied state mental health facility bed	$283	$283	$297	$332	$319	$326
Average monthly cost of new generation medications per state mental health facility consumer receiving new generation medications	$295	$272	$312	$301	$305	$303
Number of admissions to state mental health facilities	15,863	16,895	17,680	19,247	19,910	19,910

If there is a waiting list, how many clients are there?
No waiting list except at Waco Center for Youth, which generally has around 40 on this list**.**

Policy changes and impact on caseload
Implementation of the Resiliency and Disease Management model in the community could have an adverse effect on the number of admissions and length of stay in the hospital.

Future needs that should be addressed.

- **Staffing** - The ability to maintain appropriate staffing levels to provide a constitutional level of care to all patients treated in State Mental Health Facilities is critical. Recruiting and retaining psychiatrists, registered nurses, pharmacists and other specialty staff has become more difficult as a result of the ongoing efforts at privatization and closures.
- **Maintain Appropriate/Therapeutic Environment** - Patient satisfaction surveys indicate problems with the therapeutic environment. These environmental issues: noise, lack of privacy, and overcrowding also correspond with increased injuries.
- **Capital Equipment -** Aging infrastructure and vehicles are an increasing problem because very little funding for these purposes has been available in recent years.

Program Audit Information:
Date of last audit and findings/resolutions:
State Auditor, April 2002.

Recommendation #1: MHMR should establish procedures to monitor the clearance patterns of all programs subject to CMIA Subpart A on a yearly basis. For those programs where the clearance pattern changes, MHMR should notify the State of Texas Comptroller's Office during the CMIA report preparation process.
Resolution: TDMHMR response was "The Comptroller's Office is the Single State Agency responsible for administering CMIA activities in the State of Texas including reporting and coordinating with the Federal Government." MHMR believes it is in full compliance with the agreement the Comptroller's Office has entered into with the Federal government and all other relevant CMIA requirements issued by the Comptroller to State agencies. MHMR is confident it has designed and maintained the necessary control system to identify any risk or irregularities that may affect its ability to meet these requirements.

Recommendation # 2: For both Adult and Children MH Community Services, TDMHMR should develop and implement an independent peer review process for entities that provide treatment services or obtain clarification of this requirement from the Center for Mental Health Services. This process began in February 2002.
Resolution: MHMR and Substance Abuse and Mental Health Services Administration (SAMHSA) negotiated an agreement that resolved this finding in January 2002. The agreement called for the Texas Mental Health Planning Advisory Committee (MHPAC) to form a subcommittee of three members that will participate with MHMR's Quality Management staff in the required independent peer review process of the Mental health Block grant recipients. This process began in February 2002.

Notwithstanding the aforementioned agreement, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a request for comments notice in the Federal Register (Vol. 67, No. 247/Tuesday, December 24, 2002, Notices, pages. 78496-78504) in which SAMHSA proposed the elimination of the requirement that States independently peer review five (5) percent of facilities under the program each year. MHMR agrees with the SAMHSA proposal to eliminate the independent peer review component. However, MHMR will continue to implement the agreed upon resolution until such time as the requirement is formally eliminated.

Recommendation # 3: MHMR should implement a payroll effort system that requires employees working solely on a single Federal award to certify at least semi-annually that they worked solely on the program. For individuals working on multiple activities, the time sheets should (1) reflect an after-the-fact distribution of actual activity, (2) account for total activity each pay period, (3) be prepared at least monthly, and (4) be signed by the employee. Any substitute systems for allocating salaries should be approved by the U.S. Department of Health and Human Services.
Resolution: The timesheet allocations began in August 2003.

MH Community Hospitals

Program Description:
This program provides for relatively small psychiatric hospitals located in three communities in the state that provide inpatient and outpatient treatment, crisis assessment, and medical services to persons served in community hospitals.

Community hospitals are generally operated in conjunction with a teaching hospital and major university medical school. The largest is the Harris County Psychiatric Center, a 190-bed inpatient facility operated by the UT Health Science Center at Houston under contract with the MHMR Authority of Harris County. The 30-bed Sunrise Canyon Hospital in Lubbock is operated by the local mental health authority. The Gulf Coast Community Center contracts with the University of Texas Medical Branch for 20 beds in Galveston. Effective September 1, 2002, the El Paso Psychiatric Center, a 52-bed facility began operating as part of a 10-facility network of state mental health facilities.

The service arrays of these hospitals vary from site to site in response to local needs. The services provided include outpatient services as well as inpatient services such as assessment, crisis stabilization, and medication stabilization services. This strategy also funds training of psychiatric residents at the hospitals and a limited amount of research on treatment protocols and methodologies. These hospitals provide an alternative to leaving the community for inpatient treatment at a distant state hospital.

Community hospitals are considered IMDs. Medicaid is charged for children and the elderly with Medicaid coverage, consistent with Medicaid policy.

Who the program serves:
This program serves persons in the priority population.

Eligibility Criteria:
The priority population for adults is defined as adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders that require crisis resolution or ongoing and long-term support and treatment.

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue	$33,422	$32,309	$33,219	$29,251	$20,164	$20,164
Total All Funds	$33,422	$32,309	$33,219	$29,251	$20,164	$20,164

MH Community Hospitals

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
0.0	0.0	0.0	0.0	0.0	0.0

FTEs to administer this program are included in MHMR strategy for Central Administration.

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Average daily number of occupied community hospital beds	230	237	214	187	168	168
Average daily cost per occupied community hospital bed	$282	$265	$259	$297	$329	$330

Are there issues with federal funds?
No.

If there is a waiting list, how many clients are there?
There is no waiting list associated with this service.

Future needs that should be addressed.
As other resources in the community such as private psychiatric hospitals continue to decline, the demand for this service could increase.

Program Audit Information:
Date of last audit and findings/resolutions:
State Auditor, April 2002.

Recommendation #1: It states that MHMR should establish procedures to monitor the clearance patterns of all programs subject to CMIA Subpart A on a yearly basis. For those programs where the clearance pattern changes, MHMR should notify the State of Texas Comptroller's

Office during the CMIA report preparation process.
Resolution: TDMHMR response was "The Comptroller's Office is the Single State Agency responsible for administering CMIA activities in the State of Texas including reporting and coordinating with the Federal Government." MHMR believes it is in full compliance with the agreement the Comptroller's Office has entered into with the Federal government and all other relevant CMIA requirements issued by the Comptroller to State agencies. MHMR is confident it has designed and maintained the necessary control system to identify any risk or irregularities that may affect its ability to meet these requirements.

Recommendation # 2: For both Adult and Children MH Community Services, TDMHMR should develop and implement an independent peer review process for entities that provide treatment services or obtain clarification of this requirement from the Center for Mental Health Services. This process began in February 2002.
Resolution: MHMR and Substance Abuse and Mental Health Services Administration (SAMHSA) negotiated an agreement that resolved this finding in January 2002. The agreement called for the Texas Mental Health Planning Advisory Committee (MHPAC) to form a subcommittee of three members that will participate with MHMR's Quality Management staff in the required independent peer review process of the Mental health Block grant recipients. This process began in February 2002.

Notwithstanding the aforementioned agreement, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a request for comments notice in the Federal Register (Vol. 67, No. 247/Tuesday, December 24, 2002, Notices, pages. 78496-78504) in which SAMHSA proposed the elimination of the requirement that States independently peer review five (5) percent of facilities under the program each year. MHMR agrees with the SAMHSA proposal to eliminate the independent peer review component. However, MHMR will continue to implement the agreed upon resolution until such time as the requirement is formally eliminated.

Recommendation # 3: MHMR should implement a payroll effort system that requires employees working solely on a single Federal award to certify at least semi-annually that they worked solely on the program. For individuals working on multiple activities, the time sheets should (1) reflect an after-the-fact distribution of actual activity, (2) account for total activity each pay period, (3) be prepared at least monthly, and (4) be signed by the employee. Any substitute systems for allocating salaries should be approved by the U.S. Department of Health and Human Services.
Resolution: The timesheet allocations began in August 2003.

Community Mental Health Medications – New Generation

Program Description:
New generation medications, due to their increased efficacy and reduced number of side effects, continue to play a significant role in the treatment of mental illness. New generation medication funding provides more consumers the opportunity to receive the newer, more effective medications for mental illnesses, such as schizophrenia, bipolar disorder and major depression.

Who the program serves:
These medications are provided to persons who meet the priority population criteria set by the agency.

Eligibility Criteria:
The priority population for adults is defined as adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders that require crisis resolution or ongoing and long-term support and treatment.

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue	$33,842	$33,269	$35,580	$37,459	$35,759	$37,459
Total All Funds	$33,842	$33,269	$35,580	$37,459	$35,759	$37,459

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
0.0	0.0	0.0	0.0	0.0	0.0

Community Mental Health Medications – New Generation

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Average monthly number of community consumers receiving New Generation medications	19,190	24,196	13,038	15,898	16,020	16,020
Average monthly cost per MH community consumer receiving New Generation medications	$265	$244	$240	$246	$263	$263

Are there issues with federal funds?
There is an issue with potentially not meeting the state's obligation for the FY04 Mental Health Block Grant maintenance of effort.

If there is a waiting list, how many clients are there?
As the Resiliency & Disease Management initiative is implemented across the state, a consistent waiting list procedure will also be implemented. Currently, there is no consistent statewide application of waiting list procedures.

Policy changes and impact on caseload:
The impact of Resiliency & Disease Management has yet to be experienced as the initiative will not be fully implemented across the state until FY05.

Future needs that should be addressed.
The cost of medications continues to rise even with cost saving techniques in place such as bulk purchasing and the use of drug manufacturer coupons.

Department of State Health Services

Community Mental Health Medications – Other Drug Costs

Program Description:
Persons receiving mental health services are provided with services, including access to medications, necessary to treat their conditions. There are no separate "programs" for medication services and the differentiation for New Generation Medications is as a dedicated funding source. Drugs are prescribed as deemed most effective by the physician to treat each person's condition.

Who the program serves:
Persons who are eligible for services from this agency as members of the priority populations for adult and children's mental health services.

Eligibility Criteria:
The priority population for mental health services consists of adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long term support and treatment, as well as children, ages 3 through 17, with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental disorders and who:

1. Have a serious functional impairment (a Global Assessment of Functioning Scale, GAF, of 50 or less; or
2. Are at risk of disruption of a preferred living or childcare environment due to psychiatric symptoms; or
3. Are enrolled in a school system's special education program because of a serious emotional disturbance.

Appropriations

($ in thousands)	2000 Expended	2001 Expended	2002 Expended	2003 Expended	2004 Budgeted	2005 Appropriated
General Revenue	$19,145	$20,677	$21,717	$21,104	$19,411	$22,451
Federal Funds	$8,594	$9,867	$8,156	$8,352	$8,342	$8,260
Total All Funds	$27,739	$30,544	$29,873	$29,456	$27,753	$30,711

FTEs

2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
0.0	0.0	0.0	0.0	0.0	0.0

Community Mental Health Medications – Other Drug Costs

Key Performance Measures

	2000 Actual	2001 Actual	2002 Actual	2003 Actual	2004 Budgeted	2005 Appropriated
Not applicable						

Are there issues with federal funds?
No

If there is a waiting list, how many clients are there?
As the Resiliency & Disease Management initiative is implemented across the state, a consistent waiting list procedure will also be implemented. Currently, there is no consistent statewide application of waiting list procedures.

Policy changes and impact on caseload:
The impact of Resiliency & Disease Management has yet to be experienced as the initiative will not be fully implemented across the state until FY05.

Future needs that should be addressed.
The cost of medications continues to rise even with cost saving techniques in place such as bulk purchasing and the use of drug manufacturer coupons.

Appendix F

Correctional Managed Care: Top Ten Drugs By Volume

Top Ten Drugs by Volume (FY 2001)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures, drug acquisition only minus rebates: Total Costs	Actual prescriptions filled: #RX	Total costs column divided by #Rx column: $/RX*	Average: Package Size	Actual cost per tab or cap include date completed: 2/6/02: Unit Cost*	OTC	Generic Equivalent	St. Copay %
1	Engerix-B Vaccine	Hepatits B Vaccine	SKB	$3,589,868	231,475	$15.51	VIAL	$21.40	no	none	N/A
2	Triamterene/HCTZ 50/25m	Hypertension	Generic	$57,271	93,704	$0.61	1000/BTL	$0.03	no	yes	N/A
3	Ibuprofen 600mg	Inflamm/pain	Generic	$73,568	93,502	$0.79	500/BTL	$0.05	no	yes	N/A
4	Ranitidine 150mg	GI	Generic	$56,541	77,649	$0.73	500/BTL	$0.03	no	yes	N/A
5	Ibuprofen 800mg	Inflamm/pain	Generic	$82,367	72,451	$1.14	500/BTL	$0.03	no	yes	N/A
6	Aspirin Enteric Coated	Cardiovascular	Generic	$17,665	62,665	$0.28	1000/BTL	$0.01	no	yes	N/A
7	Albuterol Inhaler	Asthma/COPD	Generic	$179,801	61,605	$2.92	INHALER	$3.86	no	yes	N/A
8	Atenolol	Cardiovasvular	Generic	$25,114	58,375	$0.43	1000/BTL	$0.01	no	yes	N/A
9	HCTZ 25mg	Hypertension	Generic	$24,926	56,015	$0.44	1000/BTL	$0.02	no	yes	N/A
10	Antacid 500mg	GI	Generic	$149,054	49,921	$2.99	500/BTL	$0.02	yes	yes	N/A

* TDCJ reclaims unused medication, as a result cloumn G / H will not equal I

Top Ten Drugs by Volume (FY 2003)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures, drug acquisition only minus rebates: Total Costs	Actual prescriptions filled: #RX	Total costs column divided by #Rx column: $/RX*	Average: Package Size	Actual cost per tab or cap FY 2003: Unit Cost*	OTC	Generic Equivalent	St. Copay %
1	Ranitidine 150mg	GI	generic	$ 292,141.78	118,740	$2.46	30	$ 0.053	no	yes	N/A
2	Ibuprofen 600mg	inflamm/pain	generic	$ 49,504.58	105,343	$0.47	30	$ 0.015	no	yes	N/A
3	Aspirin Enteric 325mg	antihypertensive	generic	$ 20,578.34	105,247	$0.20	30	$ 0.006	no	yes	N/A
4	Triamtere/HCTZ 50/25	antihypertensive	generic	$ 87,557.73	88,777	$0.99	9	$ 0.032	no	yes	N/A
5	Hydrochlorothiazide 25mg	antihypertensive	generic	$ 22,230.74	85,200	$0.26	30	$ 0.009	no	yes	N/A
6	Ibuprofen 800mg	inflamm/pain	generic	$ 118,009.18	79,257	$1.49	30	$ 0.043	no	yes	N/A
7	atenolol 50mg	antihypertensive	generic	$ 54,778.99	69,134	$0.79	30	$ 0.020	no	yes	N/A
8	enalapril 20mg	antihypertensive	generic	$ 687,160.67	59,052	$11.64	30	$ 0.269	no	yes	N/A
9	sulfameth/trimeth DS	antiinfective	generic	$ 64,275.30	56,852	$1.13	20	$ 0.049	no	yes	N/A
10	engerix B vaccine 20mcg	vaccine	SKB/Merck	$ 435,276.00	56,809	$7.66	1	$ 21.40	no	yes	N/A

* TDCJ reclaims unused medication, as a result cloumn G / H will not equal I

UTMB-TDCJ patients receive PHS (340B) pricing (approximately 80% of total patient population). UTMB-TT patients receive Novaton (GPO) pricing (remaining 20% of patient population).

Health and Human Services Commission
Vendor Drug Program - Medicaid Expenditures

Top Ten Drugs by Expenditure for (FY 2003)			Actual Expenditures Pre-Rebate	Estimated Expenditures - After Rebates	Actual Prescriptions Filled	Total Costs (After Rebates) column divided by #/Rx Column	Total Quantity for All Rxs	Avg. Qty per Rx	Avg. Cost per Unit After Rebates		
Rank Drug Name	Use	Manufacturer	Total Costs	Total Costs	# Rx	$/RX	Total Quantity	Units per Rx	Unit Cost	OTC	Generic Equivalent
1 ZYPREXA	Atypical Antipsychotic	Eli Lilly & Co.	$ 81,795,387	$ 68,861,698	236,967	$ 290.60	10,785,687.00	45.52	6.38	No	No
2 RISPERDAL****	Atypical Antipsychotic	Janssen	$ 56,212,586	$ 38,474,429	272,635	$ 141.12	15,750,338.75	57.77	2.44	No	No
3 CELEBREX	Anti-inflammatory	Pharmacia	$ 32,055,043	$ 28,883,285	250,467	$ 115.32	13,676,134.00	54.60	2.11	No	No
4 SEROQUEL	Atypical Antipsychotic	Astra Zeneca LP	$ 30,765,046	$ 23,733,825	138,120	$ 171.83	10,938,281.00	79.19	2.17	No	No
5 PREVACID****	Gastric Acid Inhibitor - Anti Ulcer	Tap Pharmaceuticals	$ 30,135,425	$ 15,786,197	252,991	$ 62.40	8,071,753.49	31.91	1.96	No	No
6 LIPITOR	Cholesterol lowering agent	Pfizer (Warner Lambert)	$ 29,010,581	$ 23,566,689	234,174	$ 100.64	11,286,253.00	48.20	2.09	No	No
7 PLAVIX	Platelet Aggregation Inhibitor/Prevention of clotting	Bristol Myers Squibb/Sanofi	$ 23,380,609	$ 16,207,250	165,073	$ 98.18	6,590,132.00	39.92	2.46	No	No
8 ZITHROMAX****	Antibiotic	Pfizer	$ 23,364,923	$ 19,513,305	604,727	$ 32.27	9,458,329.76	15.64	2.06	No	No
9 NEURONTIN****	Anticonvulsant	Pfizer (Warner Lambert)	$ 22,815,778	$ 17,486,890	163,027	$ 107.26	19,233,872.26	117.98	0.91	No	No
10 ZOLOFT****	Antidepressant	Pfizer-Roerig	$ 22,697,575	$ 18,759,794	237,506	$ 78.99	10,280,247.00	43.28	1.82	No	No

Top Ten Drugs by Expenditure for (FY 2001)			Actual Expenditures Pre-Rebate	Estimated Expenditures - After Rebates	Actual Prescriptions Filled	Total Costs (After Rebates) column divided by #/Rx Column	Total Quantity for All Rxs	Avg. Qty per Rx	Avg. Cost per Unit After Rebates		
Rank Drug Name	Use	Manufacturer	Total Costs	Total Costs	# Rx	$/RX	Total Quantity	Units per Rx	Unit Cost	OTC	Generic Equivalent
1 ZYPREXA	Atypical Antipsychotic	Eli Lilly & Co.	$ 52,286,118	$ 44,818,424	169,836	$ 263.89	8,229,759.00	48.46	5.45	No	No
2 RISPERDAL****	Atypical Antipsychotic	Janssen	$ 44,377,739	$ 36,334,533	262,233	$ 138.56	14,511,796.00	55.34	2.50	No	No
3 PRILOSEC	Gastric Acid Inhibitor - Anti Ulcer	Astra Zeneca LP	$ 32,198,694	$ 25,392,598	237,243	$ 107.03	8,534,788.74	35.97	2.98	No	No
4 CELEBREX	Anti-inflammatory	Pharmacia	$ 30,427,616	$ 21,940,793	272,161	$ 80.62	15,277,947.00	56.14	1.44	No	No
5 PREVACID****	Gastric Acid Inhibitor - Anti Ulcer	Tap Pharmaceuticals	$ 23,964,840	$ 16,491,085	206,633	$ 79.81	6,706,336.60	32.46	2.46	No	No
6 CLARITIN****	Antihistamine -Non Sedating	Schering	$ 20,244,795	$ 14,155,338	288,188	$ 49.12	15,736,752.47	54.61	0.90	No	No
7 AUGMENTIN****	Antibiotic	SmithKline Beecham	$ 20,188,144	$ 13,028,035	332,865	$ 39.14	26,236,435.37	78.82	0.50	No	No
8 LIPITOR	Cholesterol lowering agent	Pfizer (Warner Lambert)	$ 18,309,439	$ 15,874,137	164,621	$ 96.43	8,057,243.00	48.94	1.97	No	No
9 DEPAKOTE****	Anticonvulsant	Abbott	$ 16,931,942	$ 13,465,349	143,750	$ 93.67	15,570,046.00	108.31	0.86	No	No
10 ZOLOFT****	Antidepressant	Pfizer-Roerig	$ 16,607,972	$ 14,560,321	190,237	$ 76.54	7,808,972.00	41.05	1.86	No	No

**** Products in this group are combined. Example: Suspension and tablets

Health and Human Services Commission
Vendor Drug Program - Medicaid Expenditures

Top Ten Drugs by Volumn for (FY 2003)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures Pre-Rebate Total Costs	Estimated Expenditures - After Rebates Total Costs	Actual Prescriptions Filled # Rx	Total Costs (After Rebates) column divided by #/Rx Column $/RX	Total Quantity for All Rxs Total Quantity	Avg. Qty per Rx Units per Rx	Avg. Cost per Unit After Rebates Unit Cost	OTC	Generic Equivalent
1	IBUPROFEN****	Anti-Inflammatory/Fever Reduction	Generic	$7,215,534.00	$ 6,976,713	677,428	$9.88	81,490,239.55	120.29	0.086	No	Yes
2	ZITHROMAX****	Antibiotic	Pfizer	$23,364,923.42	$ 19,513,305	604,727	$9.40	9,458,329.76	15.64	2.063	No	No
3	HYDROCODONE W/ACETAMINOPHEN	Analgesic	Generic	$6,084,544.04	$ 5,909,543	586,102	$12.61	30,229,947.40	51.58	0.195	No	Yes
4	ALBUTEROL SULFATE	Bronchodilator/Asthma	Generic	$5,449,233.45	$ 5,274,908	418,880	$8.16	57,870,712.44	138.16	0.091	No	Yes
5	AMOXICILLIN****	Antibiotic	Generic	$3,351,359.07	$ 3,334,275	418,607	$32.35	42,036,552.00	100.42	0.079	No	Yes
6	FUROSEMIDE	Diuretic	Generic	$2,800,779.11	$ 2,748,037	407,947	$6.52	20,063,590.40	49.18	0.137	No	Yes
7	ZYRTEC****	Antihistamine	Pfizer	$19,629,847.53	$ 16,738,953	405,664	$39.14	40,604,547.82	100.09	0.412	No	No
8	TYLENOL****	Analgesic/Fever Reduction	McNeil Pharmaceutical	$3,214,321.86	$ 2,970,393	365,318	$7.20	36,801,441.62	100.74	0.081	Yes	Yes
9	PEDIALYTE	Electrolyte Replacement	Abbott Laboratories	$5,578,121.76	$ 5,164,391	317,402	$49.12	827,461,776.60	2,606.98	0.006	Yes	No
10	AMOXIL****	Antibiotic	SmithKline Beecham	$3,708,525.06	$ 2,648,423	293,828	$80.62	34,774,611.35	118.35	0.076	No	Yes

Top Ten Drugs by Volumn for (FY 2001)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures Pre-Rebate Total Costs	Estimated Expenditures - After Rebates Total Costs	Actual Prescriptions Filled # Rx	Total Costs (After Rebates) column divided by #/Rx Column $/RX	Total Quantity for All Rxs Total Quantity	Avg. Qty per Rx Units per Rx	Avg. Cost per Unit After Rebates Unit Cost	OTC	Generic Equivalent
1	HYDROCODONE W/ACETAMINOPHEN	Analgesic	Generic	$5,584,104	$ 5,290,880	535,715		31,225,555.65	58.29	0.169	No	Yes
2	IBUPROFEN****	Anti-Inflammatory/Fever Reduction	Generic	$5,019,043	$ 4,615,248	490,774	$9.40	61,135,384.92	124.57	0.075	No	Yes
3	ALBUTEROL SULFATE	Bronchodilator/Asthma	Generic	$5,739,167	$ 5,356,828	424,749	$12.61	55,196,547.49	129.95	0.097	No	Yes
4	TYLENOL****	Analgesic/Fever Reduction	McNeil Pharmaceutical	$3,703,767	$ 3,432,819	420,892	$8.16	40,662,741.89	96.61	0.084	Yes	Yes
5	ZITHROMAX****	Antibiotic	Pfizer	$14,568,999	$ 13,009,603	402,204	$32.35	5,971,709.07	14.85	2.179	No	No
6	FUROSEMIDE	Diuretic	Generic	$2,636,401	$ 2,580,960	395,758	$6.52	19,277,521.78	48.71	0.134	No	Yes
7	AUGMENTIN ****	Antibiotic	SmithKline Beecham	$20,188,144	$ 13,028,035	332,885	$39.14	26,236,435.37	78.82	0.497	No	No
8	AMOXICILLIN****	Antibiotic	Generic	$2,247,109	$ 2,187,446	303,876	$7.20	30,362,215.86	99.92	0.072	No	Yes
9	CLARITIN****	Antihistamine	Schering	$20,244,795	$ 14,155,338	288,188	$49.12	15,736,752.47	54.61	0.900	No	No
10	CELEBREX	Anti-Inflammatory	Pharmacia	$30,427,616	$ 21,940,793	272,161	$80.62	15,277,947.00	56.14	1.436	No	No

**** Products in this group are combined. Example: Suspension and tablets

Health and Human Services Commission
Vendor Drug Program - CHIP Expenditures

Top Ten Drugs by Expenditure for (FY 2003)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures Pre-Rebate	Estimated Expenditures - After Rebates	Actual Prescriptions Filled	Total Costs (After Rebates) column divided by #/Rx Column	Total Quantity for All Rxs	Avg. Qty per Rx	Avg. Cost per Unit After Rebates	OTC	Generic Equivalent
				Total Costs	Total Costs	# Rx	$/RX	Total Quantity	Units per Rx	Unit Cost		
1	SINGULAIR	Asthma	Merck & Co., Inc.	$ 4,036,630	$ 4,036,630	54,545	$ 74.01	1,641,751.00	30.10	$ 2.46	No	No
2	ZYRTEC****	Antihistamine	Pfizer	$ 3,446,894	$ 3,446,894	93,263	$ 36.96	9,240,764.99	99.08	$ 0.37	No	No
3	ZITHROMAX****	Antibiotic	Pfizer	$ 3,257,837	$ 3,257,837	109,928	$ 29.64	1,935,264.47	17.60	$ 1.68	No	No
4	CLARITIN****	Antihistamine	Schering	$ 2,861,163	$ 1,999,899	38,109	$ 52.48	2,153,379.35	56.51	$ 0.93	No	No
5	ADVAIR DISKUS	Inhaled corticosteroid (Asthma)	GlazoSmithKline	$ 2,779,040	$ 1,935,306	24,933	$ 77.62	1,506,741.00	60.43	$ 1.28	No	No
6	CONCERTA	Attention Deficit Disorder	Alza Corp.	$ 2,706,084	$ 1,840,404	35,300	$ 52.14	1,147,441.00	32.51	$ 1.60	No	No
7	AMOX TR/POTASSIUM CLAVULANATE****	Antibiotic	Generic	$ 2,644,830	$ 2,644,167	37,494	$ 70.52	2,609,607.65	69.60	$ 1.01	No	Yes
8	ADDERALL XR	Attention Deficit Disorder	Shire US Inc.	$ 2,439,721	$ 2,156,515	33,646	$ 64.09	1,148,030.00	34.12	$ 1.88	No	No
9	CEFZIL	Antibiotic	Bristol-Myers Squibb Co.	$ 2,398,937	$ 2,036,070	37,596	$ 54.16	3,303,813.00	87.88	$ 0.62	No	No
10	PULMICORT	Inhaled corticosteroid (Asthma)	AstraZeneca LP	$ 2,036,130	$ 1,742,286	13,743	$ 126.78	925,053.00	67.31	$ 1.88	No	No

~ The Vendor Drug Program began processing CHIP prescription claims on March 1, 2002

Top Ten Drugs by Expenditure for (FY 2001)*

Rank	Drug Name	Use	Manufacturer	Actual Expenditures Pre-Rebate*	Estimated Expenditures - After Rebates	Actual Prescriptions Filled	Total Costs (Pre Rebates) column divided by #/Rx Column	Total Quantity for All Rxs	Avg. Qty per Rx	Avg. Cost per Unit After Rebates**	OTC	Generic Equivalent
				Total Costs	Total Costs	# Rx	$/RX	Total Quantity	Units per Rx	Unit Cost		
1	CLARITIN****	Antihistamine	Schering	$ 15,374,018	N/A	229,034	$ 67.13	N/A	N/A	N/A	No	No
2	AUGMENTIN	Antibiotic	SmithKline Beecham	$ 6,274,547	N/A	94,457	$ 66.43	N/A	N/A	N/A	No	No
3	CEFZIL	Antibiotic	Bristol-Myers Squibb Co.	$ 5,584,463	N/A	93,505	$ 59.72	N/A	N/A	N/A	No	No
4	ZYRTEC****	Antihistamine	Pfizer	$ 4,514,715	N/A	105,190	$ 42.92	N/A	N/A	N/A	No	No
5	IBUPROFEN	Anti-Inflammatory/Fever Reduction	Generic	$ 3,883,988	N/A	328,639	$ 11.82	N/A	N/A	N/A	No	Yes
6	NASONEX	Allergies	Schering	$ 3,832,928	N/A	71,782	$ 53.40	N/A	N/A	N/A	No	No
7	ZITHROMAX****	Antibiotic	Pfizer	$ 5,279,909	N/A	154,480	$ 34.18	N/A	N/A	N/A	No	No
8	AMOXIL	Antibiotic	SmithKline Beecham	$ 1,107,947	N/A	71,100	$ 15.58	N/A	N/A	N/A	No	Yes
9	TRIMOX	Antibiotic	Apothecon	$ 931,001	N/A	121,099	$ 7.69	N/A	N/A	N/A	No	Yes
10	ALBUTEROL	Bronchodilator/Asthma	Warrick	$ 775,681	N/A	71,278	$ 10.88	N/A	N/A	N/A	No	Yes

* CHIP FY 2001 costs are based on data reported by health plans
** Units per prescription and, therefore, unit costs are not provided to the program by the health plans
*** Co-pays vary by income. Co-Pay as % is not available
**** Products in this group are combined. Example: Suspension and tablets

Health and Human Services Commission
Vendor Drug Program - CHIP Expenditures

Top Ten Drugs by Volumn for (FY 2003)~

Rank	Drug Name	Use	Manufacturer	Actual Expenditures Pre-Rebate	Estimated Expenditures - After Rebates	Actual Prescriptions Filled	Total Costs After Rebates column divided by #/Rx Column	Total Quantity for All Rxs	Avg. Qty per Rx	Avg. Cost per Unit After Rebates			
				Total Costs	Total Costs	# Rx	$/RX	Total Quantity	Units per Rx	Unit Cost	OTC	Generic Equivalent
1	ZITHROMAX****	Antibiotic	Pfizer	$ 3,257,837	$ 3,257,837	109,928	$ 29.64	1,935,264.47	17.60	$ 1.68	No	No
2	ZYRTEC****	Antihistamine	Pfizer	$ 3,446,894	$ 3,446,894	93,263	$ 36.96	9,240,764.99	99.08	$ 0.37	No	No
3	IBUPROFEN	Anti-Inflammatory/Fever Reduction	Generic	$ 897,459	$ 897,455	84,322	$ 10.64	11,174,625.61	132.52	$ 0.08	No	Yes
4	AMOXICILLIN	Antibiotic	Generic	$ 591,199	$ 586,367	79,698	$ 7.36	8,053,512.00	101.05	$ 0.07	No	Yes
5	SINGULAIR	Asthma	Merck & Co., Inc.	$ 4,036,630	$ 4,036,630	54,545	$ 74.01	1,641,751.00	30.10	$ 2.46	No	No
6	ALBUTEROL	Asthma	Generic	$ 528,239	$ 470,986	52,968	$ 8.89	1,144,005.70	21.60	$ 0.41	No	No
7	ALBUTEROL SULFATE	Asthma	Generic	$ 532,360	$ 525,661	50,322	$ 10.45	7,017,498.53	139.45	$ 0.07	No	Yes
8	AMOXIL	Antibiotic	SmithKline Beecham	$ 388,901	$ 132,670	48,429	$ 2.74	6,598,921.00	136.26	$ 0.02	No	Yes
9	CLARITIN****	Antihistamine	Schering	$ 2,861,163	$ 1,999,899	38,109	$ 52.48	2,153,379.35	56.51	$ 0.93	No	Yes
10	CEFZIL	Antibiotic	Bristol-Myers Squibb Co.	$ 2,398,937	$ 2,036,070	37,596	$ 54.16	3,303,813.00	87.88	$ 0.62	No	No

~ The Vendor Drug Program began processing CHIP prescription claims on March 1, 2002

Top Ten Drugs by Volumn for (FY 2001)
*

Rank	Drug Name	Use	Manufacturer	Actual Expenditures Pre-Rebate*	Estimated Expenditures - After Rebates	Actual Prescriptions Filled	Total Costs After Rebates column divided by #/Rx Column	Total Quantity for All Rxs	Avg. Qty per Rx	Avg. Cost per Unit After Rebates**		
				Total Costs	Total Costs	# Rx	$/RX	Total Quantity	Units per Rx	Unit Cost	OTC	Generic Equivalent
1	IBUPROFEN	Anti-Inflammatory/Fever Reduction	Generic	$ 3,883,988	N/A	328,639	$ 11.82	N/A	N/A	N/A	No	Yes
2	CLARITIN****	Antihistamine	Schering	$ 15,374,018	N/A	229,034	$ 67.13	N/A	N/A	N/A	No	No
3	ZITHROMAX****	Antibiotic	Pfizer	$ 5,279,909	N/A	154,480	$ 34.18	N/A	N/A	N/A	No	No
4	TRIMOX	Antibiotic	Apothecon	$ 931,001	N/A	121,099	$ 7.69	N/A	N/A	N/A	No	Yes
5	ZYRTEC****	Antihistamine	Pfizer	$ 4,514,715	N/A	105,190	$ 42.92	N/A	N/A	N/A	No	No
6	AUGMENTIN	Antibiotic	SmithKline Beecham	$ 6,274,547	N/A	94,457	$ 66.43	N/A	N/A	N/A	No	No
7	CEFZIL	Antibiotic	Bristol-Myers Squibb Co.	$ 5,584,463	N/A	93,505	$ 59.72	N/A	N/A	N/A	No	No
8	AMOXICILLIN	Antibiotic	Teva	$ 683,276	N/A	91,247	$ 7.49	N/A	N/A	N/A	No	No
9	NASONEX	Allergies	Schering	$ 3,832,928	N/A	71,782	$ 53.40	N/A	N/A	N/A	No	Yes
10	ALBUTEROL	Bronchodilator/Asthma	Warrick	$ 775,681	N/A	71,278	$ 10.88	N/A	N/A	N/A	No	No

* CHIP FY 2001 costs are based on data reported by health plans
** Units per prescription and, therefore, unit costs are not provided to the program by the health plans
*** Co-pays vary by income. Co-Pay as % is not available
**** Products in this group are combined. Example: Suspension and tablets

Employees Retirement System
HealthSelect Prescription Drug Program Experience
(All Pharmacies)

Rank	Drug Name	Use	Manufacturer	Total Cost	Number of Prescriptions	Avg Cost per Rx	Units per Rx	Avg Cost per Unit	OTC	Generic Equivalent	Plan Share of Total Cost
FY2003 - Top 10 Drugs by Expenditure (Ingredient Cost)											
1	Lipitor	lower cholesterol	Parke-Davis	$ 15,281,479	141,561	$ 107.95	43.900	$ 2.46	no	no	72.2 %
2	Zocor	lower cholesterol	Merck	$ 10,273,471	68,011	$ 151.06	44.283	$ 3.41	no	no	80.1 %
3	Nexium	gastrointestinal	AstraZenaca	$ 8,331,780	54,049	$ 154.15	41.192	$ 3.74	no	no	81.5 %
4	Celebrex	analgesic	Searle	$ 6,788,041	52,080	$ 130.34	57.139	$ 2.28	no	no	78.4 %
5	Prilosec	gastrointestinal	AstraZenaca	$ 5,205,886	28,933	$ 179.93	44.774	$ 4.02	yes	yes	85.9 %
6	Prevacid	gastrointestinal	TAP	$ 4,999,064	30,894	$ 161.81	42.225	$ 3.83	no	no	71.7 %
7	Effexor	antidepressant	Wyeth	$ 4,687,175	36,834	$ 127.25	54.398	$ 2.34	no	no	78.6 %
8	Zoloft	antidepressant	Pfizer	$ 4,516,202	46,531	$ 97.06	44.559	$ 2.18	no	no	71.8 %
9	Allegra	antihistamine	Aventis	$ 4,414,659	56,630	$ 77.96	47.700	$ 1.63	no	no	65.3 %
10	Vioxx	analgesic	Merck	$ 4,411,264	41,690	$ 105.81	42.513	$ 2.49	no	no	73.8 %
FY2001 - Top 10 Drugs by Expenditure (Ingredient Cost)											
1	Prilosec	gastrointestinal	AstraZenaca	$ 12,579,039	82,814	$ 151.90	44.530	$ 3.41	no	no	85.7 %
2	Lipitor	lower cholesterol	Parke-Davis	$ 9,128,847	107,899	$ 84.61	41.408	$ 2.04	no	no	74.4 %
3	Zocor	lower cholesterol	Merck	$ 6,738,582	56,169	$ 119.97	41.231	$ 2.91	no	no	81.7 %
4	Claritin	antihistamine	Schering	$ 5,793,216	82,764	$ 70.00	41.339	$ 1.69	no	no	71.1 %
5	Celebrex	analgesic	Searle	$ 5,494,173	55,741	$ 98.57	53.398	$ 1.85	no	no	78.7 %
6	Vioxx	analgesic	Merck	$ 4,086,149	47,287	$ 86.41	39.941	$ 2.16	no	no	76.0 %
7	Prozac	antidepressant	Dista	$ 3,874,369	33,237	$ 116.57	48.930	$ 2.38	no	yes	81.7 %
8	Prevacid	gastrointestinal	TAP	$ 3,421,765	26,490	$ 129.17	40.228	$ 3.21	no	no	72.3 %
9	Glucophage	diabetes	Bristol-Myers Sq	$ 2,992,339	42,970	$ 69.64	91.934	$ 0.76	no	yes	69.1 %
10	Premarin	hormone	Wyeth-Ayerst	$ 2,884,643	114,252	$ 25.25	40.398	$ 0.62	no	no	20.7 %

Notes:
1. Experience for an individual drug is reported for all strengths combined.
2. Plan Share of Total Cost equals the plan payment divided by the total cost.
3. Prilosec is available OTC at a lower strength and different salt.
4. Manufacturers may have changed due to mergers or acquisitions.
5. Total Cost equals ingrediant cost plus dispensing fee.

Employees Retirement System
HealthSelect Prescription Drug Program Experience
(All Pharmacies)

Rank	Drug Name	Use	Manufacturer	Total Cost	Number of Prescriptions	Avg Cost per Rx	Units per Rx	Avg Cost per Unit	OTC	Generic Equivalent	Plan Share of Total Cost
FY2003 - Top 10 Drugs by Volume (Number of Scripts)											
1	Lipitor	lower cholesterol	Pfizer	$ 15,281,479	141,561	$ 107.95	43.900	$ 2.46	no	no	72.2 %
2	Synthroid	thyroid	Abbott	$ 1,545,468	92,514	$ 16.71	41.789	$ 0.40	no	yes	1.1 %
3	Hydroco/APAP	analgesic	generic	$ 631,909	89,833	$ 7.03	41.846	$ 0.17	no	yes	38.4 %
4	Premarin	hormone	Wyeth-Ayerst	$ 3,300,286	89,362	$ 36.93	43.416	$ 0.85	no	no	29.5 %
5	Zocor	lower cholesterol	Merck	$ 10,273,471	68,011	$ 151.06	44.283	$ 3.41	no	no	80.1 %
6	Zithromax	antibiotic	Pfizer	$ 2,515,764	64,010	$ 39.30	9.005	$ 4.36	no	no	49.2 %
7	Norvasc	hypertension	Pfizer	$ 3,955,514	62,748	$ 63.04	43.699	$ 1.44	no	no	55.5 %
8	Lisinopril	hypertension	generic	$ 1,474,098	62,489	$ 23.59	46.709	$ 0.51	no	yes	61.0 %
9	Atenolol	hypertension	generic	$ 526,376	60,760	$ 8.66	46.057	$ 0.19	no	yes	30.4 %
10	Allegra	antihistamine	Aventis	$ 4,414,659	56,630	$ 77.96	47.700	$ 1.63	no	no	65.3 %
FY2001 - Top 10 Drugs by Volume (Number of Scripts)											
1	Premarin	hormone	Wyeth-Ayerst	$ 2,884,643	114,252	$ 25.25	40.398	$ 0.62	no	no	20.7 %
2	Lipitor	lower cholesterol	Pfizer	$ 9,128,847	107,899	$ 84.61	41.408	$ 2.04	no	no	74.4 %
3	Hydrocodone	analgesic	generic	$ 905,036	91,278	$ 9.92	49.931	$ 0.20	no	yes	61.8 %
4	Prilosec	gastrointestinal	AstraZeneca	$ 12,579,039	82,814	$ 151.90	44.530	$ 3.41	no	no	85.7 %
5	Claritin	antihistamine	Schering	$ 5,793,216	82,764	$ 70.00	41.339	$ 1.69	no	no	71.1 %
6	Zocor	lower cholesterol	Merck	$ 6,738,582	56,169	$ 119.97	41.231	$ 2.91	no	no	81.7 %
7	Celebrex	analgesic	Searle	$ 5,494,173	55,741	$ 98.57	53.398	$ 1.85	no	no	78.7 %
8	Norvasc	hypertension	Pfizer	$ 2,799,223	51,122	$ 54.76	41.545	$ 1.32	no	no	62.2 %
9	Zithromax	antibiotic	Pfizer	$ 1,744,126	51,095	$ 34.13	8.778	$ 3.89	no	no	48.3 %
10	Allega	antihistamine	Aventis	$ 2,784,975	50,763	$ 54.86	50.603	$ 1.08	no	no	64.0 %

Notes:
1. Experience for an individual drug is reported for all strengths combined.
2. Plan Share of Total Cost equals the plan payment divided by the total cost.
3. Prilosec is available OTC at a lower strength and different salt.
4. Manufacturers may have changed due to mergers or acquisitions.
5. Total Cost equals ingrediant cost plus dispensing fee.

Employees Retirement System
HealthSelect Prescription Drug Program Experience
(Retail Pharmacies)

Rank	Drug Name	Use	Manufacturer	Total Cost	Number of Prescriptions	Avg Cost per Rx	Units per Rx	Avg Cost per Unit	OTC	Generic Equivalent	Plan Share of Total Cost
FY2003 - Top 10 Drugs by Expenditure (Ingredient Cost)											
1	Lipitor	lower cholesterol	Pfizer	$ 8,546,895	109,395	$ 78.13	30.497	$ 2.56	no	no	71.1 %
2	Zocor	lower cholesterol	Merck	$ 5,665,023	52,231	$ 108.46	30.781	$ 3.52	no	no	79.0 %
3	Nexium	gastrointestinal	AstraZeneca	$ 5,479,725	45,080	$ 121.56	31.393	$ 3.87	no	no	81.0 %
4	Celebrex	analgesic	Searle	$ 4,231,789	42,454	$ 99.68	42.210	$ 2.36	no	no	77.4 %
5	Prevacid	gastrointestinal	TAP	$ 3,437,539	26,309	$ 130.66	33.115	$ 3.95	no	no	70.7 %
6	Effexor	antidepressant	Wyeth	$ 3,362,601	32,032	$ 104.98	43.674	$ 2.40	no	no	78.1 %
7	Prilosec	gastrointestinal	AstraZeneca	$ 3,289,458	23,583	$ 139.48	33.601	$ 4.15	yes	yes	84.9 %
8	Paxil	antidepressant	GlaxoSmithK	$ 3,170,752	38,625	$ 82.09	33.255	$ 2.47	no	yes	72.3 %
9	Zoloft	antidepressant	Pfizer	$ 3,132,820	39,929	$ 78.46	35.062	$ 2.24	no	no	71.0 %
10	Allegra	antihistamine	Aventis	$ 2,924,784	47,673	$ 61.35	36.607	$ 1.68	no	no	64.2 %
FY2001 - Top 10 Drugs by Expenditure (Ingredient Cost)											
1	Prilosec	gastrointestinal	AstraZeneca	$ 8,384,426	69,596	$ 120.47	34.200	$ 3.52	no	no	84.6 %
2	Lipitor	lower cholesterol	Pfizer	$ 5,834,771	89,294	$ 65.34	31.023	$ 2.11	no	no	72.1 %
3	Claritin	antihistamine	Schering	$ 4,353,662	74,121	$ 58.74	34.897	$ 1.68	no	no	69.0 %
4	Zocor	lower cholesterol	Merck	$ 4,214,967	45,972	$ 91.69	30.458	$ 3.01	no	no	79.9 %
5	Celebrex	analgesic	Searle	$ 3,832,528	48,069	$ 79.73	42.131	$ 1.89	no	no	76.9 %
6	Vioxx	analgesic	Merck	$ 2,926,337	41,232	$ 70.97	31.819	$ 2.23	no	no	74.2 %
7	Prozac	antidepressant	Dista	$ 2,848,259	29,339	$ 97.08	40.013	$ 2.43	no	yes	80.4 %
8	Prevacid	gastrointestinal	TAP	$ 2,632,671	23,796	$ 110.64	33.720	$ 3.28	no	no	70.7 %
9	Zoloft	antidepressant	Pfizer	$ 2,200,897	31,792	$ 69.23	34.869	$ 1.99	no	no	73.6 %
10	Allegra	antihistamine	Aventis	$ 2,161,785	46,067	$ 46.93	42.457	$ 1.11	no	no	61.8 %

Notes:
1. Experience for an individual drug is reported for all strengths combined.
2. Plan Share of Total Cost equals the plan payment divided by the total cost.
3. Prilosec is available OTC at a lower strength and different salt.
4. Manufacturers may have changed due to mergers or acquisitions.
5. Total Cost equals ingrediant cost plus dispensing fee.

Employees Retirement System
HealthSelect Prescription Drug Program Experience
(Retail Pharmacies)

Rank	Drug Name	Use	Manufacturer	Total Cost	Number of Prescriptions	Avg Cost per Rx	Units per Rx	Avg Cost per Unit	OTC	Generic Equivalent	Plan Share of Total Cost
FY2003 - Top 10 Drugs by Volume (Number of Scripts)											
1	Lipitor	lower cholesterol	Pfizer	$ 8,546,895	109,395	$ 78.13	30.497	$ 2.56	no	no	71.1 %
2	Hydroco/APAP	analgesic	generic	$ 586,396	88,293	$ 6.64	39.374	$ 0.17	no	yes	37.4 %
3	Synthroid	thyroid	Abbott	$ 967,448	74,878	$ 12.92	30.683	$ 0.42	no	yes	1.0 %
4	Premarin	hormone	Wyeth-Ayerst	$ 2,054,156	71,774	$ 28.62	32.279	$ 0.89	no	no	29.6 %
5	Zithromax	antibictic	Pfizer	$ 2,495,762	63,930	$ 39.04	8.968	$ 4.35	no	no	48.9 %
6	Zocor	lower cholesterol	Merck	$ 5,665,023	52,231	$ 108.46	30.781	$ 3.52	no	no	79.0 %
7	Norvasc	hypertension	Pfizer	$ 2,514,763	51,572	$ 48.76	32.565	$ 1.50	no	no	54.4 %
8	Allegra	antihistamine	Aventis	$ 2,924,784	47,673	$ 61.35	36.607	$ 1.68	no	no	64.2 %
9	Furosemide	diuretic	generic	$ 118,658	46,272	$ 2.56	41.284	$ 0.06	no	yes	8.6 %
10	Toprol XL	hypertension	AstraZeneca	$ 1,224,010	46,067	$ 26.57	33.001	$ 0.81	no	no	26.9 %
FY2001 - Top 10 Drugs by Volume (Number of Scripts)											
1	Premarin	hormone	Wyeth-Ayerst	$ 1,941,363	95,805	$ 20.26	31.124	$ 0.65	no	no	18.1 %
2	Hydrocodone	analgesic	various	$ 868,311	90,300	$ 9.62	48.321	$ 0.20	no	yes	61.2 %
3	Lipitor	lower cholesterol	Pfizer	$ 5,834,771	89,294	$ 65.34	31.023	$ 2.11	no	no	72.1 %
4	Claritin	antihistamine	Schering	$ 4,353,662	74,121	$ 58.74	34.897	$ 1.68	no	no	69.0 %
5	Prilosec	gastrointestinal	AstraZeneca	$ 8,384,426	69,596	$ 120.47	34.200	$ 3.52	no	no	84.6 %
6	Zithromax	antibictic	Pfizer	$ 1,733,529	51,047	$ 33.96	8.749	$ 3.88	no	no	48.1 %
7	Celebrex	analgesic	Searle	$ 3,832,528	48,069	$ 79.73	42.131	$ 1.89	no	no	76.9 %
8	Allegra	antihistamine	Aventis	$ 2,161,785	46,067	$ 46.93	42.457	$ 1.11	no	no	61.8 %
9	Zocor	lower cholesterol	Merck	$ 4,214,967	45,972	$ 91.69	30.458	$ 3.01	no	yes	79.9 %
10	Norvasc	hypertension	Pfizer	$ 1,967,189	44,067	$ 44.64	32.822	$ 1.36	no	no	59.9 %

Notes:
1. Experience for an individual drug is reported for all strengths combined.
2. Plan Share of Total Cost equals the plan payment divided by the total cost.
3. Prilosec is available OTC at a lower strength and different salt.
4. Manufacturers may have changed due to mergers or acquisitions.
5. Total Cost equals ingrediant cost plus dispensing fee.

Employees Retirement System
HealthSelect Prescription Drug Program Experience
(Mail Order Pharmacies)

Rank	Drug Name	Use	Manufacturer	Total Cost	Number of Prescriptions	Avg Cost per Rx	Units per Rx	Avg Cost per Unit	OTC	Generic Equivalent	Plan Share of Total Cost
FY2003 - Top 10 Drugs by Expenditure (Ingredient Cost)											
1	Lipitor	lower cholesterol	Parke-Davis	$ 6,734,585	32,166	$ 209.37	89.485	$ 2.34	no	no	73.5 %
2	Zocor	lower cholesterol	Merck	$ 4,608,448	15,780	$ 292.04	88.975	$ 3.28	no	no	81.4 %
3	Nexium	gastrointestinal	AstraZeneca	$ 2,852,054	8,969	$ 317.99	90.441	$ 3.52	no	no	82.7 %
4	Celebrex	analgesic	Pharmacia	$ 2,556,251	9,626	$ 265.56	122.984	$ 2.16	no	no	80.1 %
5	Prilosec	gastrointestinal	AstraZeneca	$ 1,916,428	5,350	$ 358.21	94.024	$ 3.81	yes	yes	87.6 %
6	Fosamax	osteoporosis	Merck	$ 1,781,357	11,047	$ 161.25	15.118	$ 10.67	no	no	66.3 %
7	Actos	diabetes	Takeda	$ 1,672,562	4,587	$ 364.63	88.551	$ 4.12	no	no	84.8 %
8	Vioxx	analgesic	Merck	$ 1,572,795	7,133	$ 220.50	94.658	$ 2.33	no	no	76.0 %
9	Prevacid	gastrointestinal	TAP	$ 1,561,525	4,585	$ 340.57	94.498	$ 3.60	no	no	74.1 %
10	Allegra	antihistamine	Aventis	$ 1,489,875	8,957	$ 166.34	106.742	$ 1.56	no	no	67.5 %
FY2001 - Top 10 Drugs by Expenditure (Ingredient Cost)											
1	Prilosec	gastrointestinal	AstraZeneca	$ 4,194,613	13,218	$ 317.34	98.920	$ 3.21	no	no	88.2 %
2	Lipitor	lower cholesterol	Parke-Davis(Pfiz	$ 3,294,075	18,605	$ 177.05	91.248	$ 1.94	no	no	78.7 %
3	Zocor	lower cholesterol	Merck	$ 2,523,616	10,197	$ 247.49	89.797	$ 2.76	no	no	84.8 %
4	Celebrex	analgesic	Searle	$ 1,661,645	7,672	$ 216.59	123.995	$ 1.75	no	no	82.8 %
5	Claritin	antihistamine	Schering	$ 1,439,554	8,643	$ 166.56	96.592	$ 1.72	no	no	77.7 %
6	Vioxx	analgesic	Merck	$ 1,159,812	6,055	$ 191.55	95.250	$ 2.01	no	no	80.6 %
7	Prozac	antidepressant	Dista	$ 1,026,110	3,898	$ 263.24	116.044	$ 2.27	no	yes	85.4 %
8	Premarin	hormone	Wyeth-Ayerst	$ 943,281	18,447	$ 51.13	88.562	$ 0.58	no	no	26.8 %
9	Glucophage	diabetes	Bristol-Myers Sq	$ 923,049	5,883	$ 156.90	214.338	$ 0.73	no	yes	75.2 %
10	Norvasc	hypertension	Pfizer	$ 832,034	7,055	$ 117.94	96.029	$ 1.23	no	no	68.0 %

Notes:
1. Experience for an individual drug is reported for all strengths combined.
2. Plan Share of Total Cost equals the plan payment divided by the total cost.
3. Prilosec is available OTC at a lower strength and different salt.
4. Manufacturers may have changed due to mergers or acquisitions.
5. Total Cost equals ingrediant cost plus dispensing fee.

Employees Retirement System
HealthSelect Prescription Drug Program Experience
(Mail Order Pharmacies)

Rank	Drug Name	Use	Manufacturer	Total Cost	Number of Prescriptions	Avg Cost per Rx	Units per Rx	Avg Cost per Unit	OTC	Generic Equivalent	Plan Share of Total Cost
FY2003 - Top 10 Drugs by Volume (Number of Scripts)											
1	Lipitor	lower cholesterol	Parke-Davis	$ 6,734,585	32,166	$ 209.37	89.485	$ 2.34	no	no	73.5 %
2	Synthroid	thyroid	Abbott	$ 578,020	17,636	$ 32.78	88.944	$ 0.37	no	yes	1.2 %
3	Premarin	hormone	Wyeth-Ayerst	$ 1,246,130	17,588	$ 70.85	88.865	$ 0.80	no	no	29.3 %
4	Zocor	lower cholesterol	Merck	$ 4,608,448	15,780	$ 292.04	88.975	$ 3.28	no	no	81.4 %
5	Lisinopril	hypertension	generic	$ 523,726	11,841	$ 44.23	99.852	$ 0.44	no	yes	55.4 %
6	Norvasc	hypertension	Pfizer	$ 1,440,750	11,176	$ 128.91	95.077	$ 1.36	no	no	57.4 %
7	Fosamax	osteoporosis	Merck	$ 1,781,357	11,047	$ 161.25	15.118	$ 10.67	no	no	66.3 %
8	Atenolol	hypertension	generic	$ 345,428	9,796	$ 35.26	101.825	$ 0.35	no	yes	46.6 %
9	Celebrex	analgesic	Searle	$ 2,556,251	9,626	$ 265.56	122.984	$ 2.16	no	no	80.1 %
10	Toprol XL	hypertension	AstraZeneca	$ 642,983	9,213	$ 69.79	94.923	$ 0.74	no	no	30.1 %
FY2001 - Top 10 Drugs by Volume (Number of Scripts)											
1	Lipitor	lower cholesterol	Pfizer	$ 3,294,075	18,605	$ 177.05	91.248	$ 1.94	no	no	78.7 %
2	Premarin	hormone	Wyeth-Ayerst	$ 943,281	18,447	$ 51.13	88.562	$ 0.58	no	no	26.8 %
3	Prilosec	gastrointestinal	AstraZeneca	$ 4,194,613	13,218	$ 317.34	98.920	$ 3.21	no	no	88.2 %
4	Zocor	lower cholesterol	Merck	$ 2,523,616	10,197	$ 247.49	89.797	$ 2.76	no	no	84.8 %
5	Claritin	antihistamine	Scherinig	$ 1,439,554	8,643	$ 166.56	96.592	$ 1.72	no	no	77.7 %
6	Celebrex	analgesic	Searle	$ 1,661,645	7,672	$ 216.59	123.995	$ 1.75	no	no	82.8 %
7	Prempro	antidepressant	Wyeth-Ayerst	$ 507,034	7,589	$ 66.81	83.229	$ 0.80	no	no	43.7 %
8	Prinivil	hormone	Merck	$ 587,556	7,520	$ 78.13	99.434	$ 0.79	no	no	51.9 %
9	Norvasc	hypertension	Pfizer	$ 832,034	7,055	$ 117.94	96.029	$ 1.23	no	no	68.0 %
10	Vioxx	analgesic	Merck	$ 1,159,812	6,055	$ 191.55	95.250	$ 2.01	no	no	80.6 %

Notes:
1. Experience for an individual drug is reported for all strengths combined.
2. Plan Share of Total Cost equals the plan payment divided by the total cost.
3. Prilosec is available OTC at a lower strength and different salt.
4. Manufacturers may have changed due to mergers or acquisitions.
5. Total Cost equals ingrediant cost plus dispensing fee.

Teacher Retirement System of Texas
FY 2003 Top 10 Drugs (Retail and Mail)
TRS-ActiveCare

By Expenditures

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$4,063,893	42,844	$94.85	37.7	$2.51	No	Single Source	72.1%
2	NEXIUM	ANTI-ULCERANT/GERD	ASTRAZENECA	$2,712,394	19,942	$136.01	35.8	$3.80	No	Single Source	81.4%
3	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$2,457,380	18,020	$136.37	37.7	$3.62	No	Single Source	80.6%
4	ZOLOFT	ANTIDEPRESSANT	PFIZER	$2,018,901	23,544	$85.75	38.3	$2.24	No	Single Source	70.2%
5	ALLEGRA	ALLERIGIC RHINITIS	AVENTIS	$1,916,927	27,801	$68.95	40.8	$1.69	No	Single Source	64.7%
6	PREVACID	ANTI-ULCERANT/GERD	TAP	$1,884,031	13,236	$142.34	36.6	$3.89	No	Single Source	70.3%
7	EFFEXOR XR	ANTIDEPRESSANT	WYETH/AYERST	$1,804,830	17,196	$104.96	41.8	$2.51	No	Single Source	76.5%
8	PREMARIN	HORMONE REPLACEMENT	WYETH/AYERST	$1,642,950	46,520	$35.32	38.0	$0.93	No	Single Source	30.5%
9	ZYRTEC	ALLERIGIC RHINITIS	PFIZER	$1,626,137	29,037	$56.00	57.1	$0.98	No	Single Source	57.2%
10	CELEBREX	ANTI-INFLAMMATORY	PHARMACIA	$1,479,738	12,344	$119.88	51.1	$2.35	No	Single Source	78.6%

By Volume

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	HYDROCODONE/ACETAMINOPHEN	PAIN RELIEF	MALLINCKRODT PHARM	$435,872	47,490	$9.18	41.2	$0.22	No	Generic	47.3%
2	PREMARIN	HORMONE REPLACEMENT	WYETH/AYERST	$1,642,950	46,520	$35.32	38.0	$0.93	No	Single Source	30.5%
3	SYNTHROID	THYROID REPLACEMENT	ABBOTT LABORATORIES	$724,188	45,337	$15.97	34.9	$0.46	No	Single Source	1.2%
4	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$4,063,893	42,844	$94.85	37.7	$2.51	No	Single Source	72.1%
5	ZYRTEC	ALLERIGIC RHINITIS	PFIZER	$1,626,137	29,037	$56.00	57.1	$0.98	No	Single Source	57.2%
6	ZITHROMAX Z-PAK	ANTIBIOTIC	PFIZER	$1,133,044	27,921	$40.58	5.9	$6.83	No	Single Source	43.0%
7	ALLEGRA	ALLERIGIC RHINITIS	AVENTIS	$1,916,927	27,801	$68.95	40.8	$1.69	No	Single Source	64.7%
8	ORTHO TRI-CYCLEN	BIRTH CONTROL	ORTHO-MCNEIL	$929,085	26,664	$34.84	29.6	$1.18	No	Single Source	31.1%
9	ZOLOFT	ANTIDEPRESSANT	PFIZER	$2,018,901	23,544	$85.75	38.3	$2.24	No	Single Source	70.2%
10	LISINOPRIL	CARDIOVASCULAR AGENTS	ZENECA	$447,340	22,137	$20.21	38.3	$0.53	No	Generic	71.0%

* Paid / (Ingredient Cost + Dispensing Fee)

Teacher Retirement System of Texas
FY 2003 Top 10 Drugs (Retail)
TRS-ActiveCare

By Expenditures

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$2,801,107	36,790	$76.14	29.2	$2.60	No	Single Source	69.8%
2	NEXIUM	ANTI-ULCERANT/GERD	ASTRAZENECA	$2,099,149	18,007	$116.57	29.9	$3.90	No	Single Source	80.4%
3	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$1,664,141	15,373	$108.25	28.9	$3.74	No	Single Source	78.7%
4	ZOLOFT	ANTIDEPRESSANT	PFIZER	$1,604,000	21,478	$74.68	32.5	$2.30	No	Single Source	68.6%
5	ALLEGRA	ALLERIGIC RHINITIS	AVENTIS	$1,508,243	25,333	$59.54	34.4	$1.73	No	Single Source	62.5%
6	EFFEXOR XR	ANTIDEPRESSANT	WYETH/AYERST	$1,485,110	15,945	$93.14	36.3	$2.56	No	Single Source	75.3%
7	PREVACID	ANTI-ULCERANT/GERD	TAP	$1,467,066	12,009	$122.16	30.7	$3.98	No	Single Source	68.6%
8	ZYRTEC	ALLERIGIC RHINITIS	PFIZER	$1,305,779	26,766	$48.79	52.0	$0.94	No	Single Source	54.7%
9	PREMARIN	HORMONE REPLACEMENT	WYETH/AYERST	$1,226,903	40,859	$30.03	30.8	$0.98	No	Single Source	27.6%
10	ADVAIR DISKUS	ASTHMA	GLAXOSMITHKLINE	$1,160,439	9,596	$120.93	58.0	$2.08	No	Single Source	80.5%

By Volume

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	HYDROCODONE/ACETAMINOPHEN	PAIN RELIEF	MALLINCKRODT PHARM	$429,821	47,293	$9.09	40.7	$0.22	No	Generic	47.0%
2	SYNTHROID	THYROID REPLACEMENT	ABBOTT LABORATORIES	$587,946	41,316	$14.23	29.5	$0.48	No	Single Source	0.9%
3	PREMARIN	HORMONE REPLACEMENT	WYETH/AYERST	$1,226,903	40,859	$30.03	30.8	$0.98	No	Single Source	27.6%
4	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$2,801,107	36,790	$76.14	29.2	$2.60	No	Single Source	69.8%
5	ZITHROMAX Z-PAK	ANTIBIOTIC	PFIZER	$1,133,010	27,920	$40.58	5.9	$6.83	No	Single Source	43.0%
6	ZYRTEC	ALLERIGIC RHINITIS	PFIZER	$1,305,779	26,766	$48.79	52.0	$0.94	No	Single Source	54.7%
7	ORTHO TRI-CYCLEN	BIRTH CONTROL	ORTHO-MCNEIL	$824,367	25,419	$32.43	27.1	$1.20	No	Single Source	29.5%
8	ALLEGRA	ALLERIGIC RHINITIS	AVENTIS	$1,508,243	25,333	$59.54	34.4	$1.73	No	Single Source	62.5%
9	ZOLOFT	ANTIDEPRESSANT	PFIZER	$1,604,000	21,478	$74.68	32.5	$2.30	No	Single Source	68.6%
10	LISINOPRIL	CARDIOVASCULAR AGENTS	ZENECA	$354,182	19,897	$17.80	31.8	$0.56	No	Generic	70.2%

* Paid / (Ingredient Cost + Dispensing Fee)

Teacher Retirement System of Texas
FY 2003 Top 10 Drugs (Mail)
TRS-ActiveCare

By Expenditures

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$1,262,786	6,054	$208.59	89.4	$2.33	No	Single Source	77.3%
2	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$793,239	2,647	$299.67	88.6	$3.38	No	Single Source	84.6%
3	NEXIUM	ANTI-ULCERANT/GERD	ASTRAZENECA	$613,245	1,935	$316.92	90.5	$3.50	No	Single Source	85.0%
4	CELEBREX	ANTI-INFLAMMATORY	PHARMACIA	$457,532	1,708	$267.88	124.0	$2.16	No	Single Source	82.7%
5	PREVACID	ANTI-ULCERANT/GERD	TAP	$416,964	1,227	$339.82	94.6	$3.59	No	Single Source	76.0%
6	PREMARIN	HORMONE REPLACEMENT	WYETH/AYERST	$416,047	5,661	$73.49	90.1	$0.82	No	Single Source	39.0%
7	ZOLOFT	ANTIDEPRESSANT	PFIZER	$414,902	2,066	$200.82	98.4	$2.04	No	Single Source	76.3%
8	ALLEGRA	ALLERIGIC RHINITIS	AVENTIS	$408,683	2,468	$165.59	106.6	$1.55	No	Single Source	72.4%
9	ACTOS	ANTI-DIABETIC AGENT	TAKEDA CHEMICAL INDUSTRIES	$329,371	890	$370.08	90.0	$4.11	No	Single Source	88.1%
10	ENBREL	ARTHRITIS	IMMUNEX	$323,178	113	$2,859.98	22.3	$128.25	No	Single Source	98.4%

By Volume

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$1,262,786	6,054	$208.59	89.4	$2.33	No	Single Source	77.3%
2	PREMARIN	HORMONE REPLACEMENT	WYETH/AYERST	$416,047	5,661	$73.49	90.1	$0.82	No	Single Source	39.0%
3	SYNTHROID	THYROID REPLACEMENT	ABBOTT LABORATORIES	$136,243	4,021	$33.88	90.3	$0.38	No	Single Source	2.5%
4	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$793,239	2,647	$299.67	88.6	$3.38	No	Single Source	84.6%
5	ALLEGRA	ALLERIGIC RHINITIS	AVENTIS	$408,683	2,468	$165.59	106.6	$1.55	No	Single Source	72.4%
6	ZYRTEC	ALLERIGIC RHINITIS	PFIZER	$320,357	2,271	$141.06	117.6	$1.20	No	Single Source	67.3%
7	LISINOPRIL	CARDIOVASCULAR AGENTS	ZENECA	$93,158	2,240	$41.59	95.3	$0.44	No	Generic	74.1%
8	NORVASC	CALCIUM CHANNEL BLOCKE	PFIZER	$275,521	2,122	$129.84	94.0	$1.38	No	Single Source	65.2%
9	ZOLOFT	ANTIDEPRESSANT	PFIZER	$414,902	2,066	$200.82	98.4	$2.04	No	Single Source	76.3%
10	TOPROL XL	ANGINA	ASTRAZENECA	$143,452	2,005	$71.55	95.1	$0.75	No	Single Source	39.5%

* Paid / (Ingredient Cost + Dispensing Fee)

Teacher Retirement System of Texas
Top 10 Drugs By Expenditures (Retail and Mail)
TRS-Care

FY 2001

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	PRILOSEC	ANTI-ULCERANT/GERD	ASTRAZENECA	$10,757,851	45,162	$238.21	70.1	$3.40	No	Single-Source	93.3%
2	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$10,098,817	53,739	$187.92	67.8	$2.77	No	Single-Source	91.5%
3	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$6,218,525	47,951	$129.68	62.9	$2.06	No	Single-Source	87.7%
4	CELEBREX	ANTI-INFLAMMATORY	PHARMACIA	$5,770,669	38,726	$149.01	81.2	$1.84	No	Single-Source	89.3%
5	VIOXX	ANTI-INFLAMMATORY	MERCK	$3,717,752	28,575	$130.11	61.2	$2.13	No	Single-Source	87.7%
6	NORVASC	CALCIUM CHANNEL BLOCKE	PFIZER	$3,223,346	38,124	$84.55	63.3	$1.34	No	Single-Source	81.1%
7	PREMARIN	HORMONE REPLACEMENT	WYETH/AYERST	$2,899,764	75,359	$38.48	64.7	$0.59	No	Single-Source	58.6%
8	CLARITIN	ANTHISTAMINE	SCHERING	$2,799,396	24,769	$113.02	55.9	$2.02	No	Single-Source	85.8%
9	PREVACID	ANTI-ULCERANT/GERD	TAP	$2,659,117	14,313	$185.78	56.6	$3.28	No	Single-Source	91.4%
10	GLUCOPHAGE	ANTI-DIABETIC AGENT	BRISTOL-MYERS SQUIBB	$2,354,288	21,871	$107.64	139.9	$0.77	No	Single-Source	85.2%

FY 2003

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$15,197,991	74,102	$205.10	62.9	$3.26	No	Single Source	89.0%
2	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$11,395,846	82,473	$138.18	58.0	$2.38	No	Single Source	83.4%
3	NEXIUM	ANTI-ULCERANT/GERD	ASTRAZENECA	$7,787,720	36,526	$213.21	60.3	$3.54	No	Single Source	89.5%
4	CELEBREX	ANTI-INFLAMMATORY	PHARMACIA	$7,194,371	42,055	$171.07	77.9	$2.20	No	Single Source	86.8%
5	FOSAMAX	OSTEOPOROSIS	MERCK	$5,678,710	51,750	$109.73	10.6	$10.31	No	Single Source	78.8%
6	PRILOSEC	ANTI-ULCERANT/GERD	ASTRAZENECA	$5,054,395	19,660	$257.09	67.3	$3.82	Yes	Generic	91.2%
7	PLAVIX	ARTHERSCLEROSIS	BRISTOL-MYERS SQUIBB	$4,910,952	29,240	$167.95	49.7	$3.38	No	Single Source	85.2%
8	NORVASC	CALCIUM CHANNEL BLOCKE	PFIZER	$4,459,920	53,068	$84.04	59.6	$1.41	No	Single Source	74.6%
9	VIOXX	ANTI-INFLAMMATORY	MERCK	$4,192,344	29,532	$141.96	58.9	$2.41	No	Single Source	84.4%
10	PREVACID	ANTI-ULCERANT/GERD	TAP	$3,888,804	20,629	$188.51	49.6	$3.80	No	Single Source	87.5%

* Paid / (Ingredient Cost + Dispensing Fee)

Teacher Retirement System of Texas
Top 10 Drugs By Expenditures (Retail)
TRS-Care

FY 2001

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	PRILOSEC	ANTI-ULCERANT/GERD	ASTRAZENECA	$2,287,164	18,515	$123.53	33.1	$3.74	No	Single-Source	87.1%
2	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$1,878,273	19,714	$95.28	30.5	$3.12	No	Single-Source	83.2%
3	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$1,523,447	22,222	$68.56	30.8	$2.23	No	Single-Source	76.7%
4	CELEBREX	ANTI-INFLAMMATORY	PHARMACIA	$1,521,075	18,969	$80.19	40.5	$1.98	No	Single-Source	80.1%
5	VIOXX	ANTI-INFLAMMATORY	MERCK	$1,090,925	14,781	$73.81	31.8	$2.32	No	Single-Source	78.3%
6	PREVACID	ANTI-ULCERANT/GERD	TAP	$1,035,167	8,985	$115.21	32.8	$3.51	No	Single-Source	86.1%
7	NORVASC	CALCIUM CHANNEL BLOCKE	PFIZER	$938,398	19,560	$47.98	32.6	$1.47	No	Single-Source	66.7%
8	CIPRO	ANTIBIOTIC	BAYER	$871,994	12,943	$67.37	17.2	$3.92	No	Single-Source	76.3%
9	LEVAQUIN	BRONCHITIS/PNEUMONIA	ORTHO-MCNEIL	$845,948	12,341	$68.55	9.2	$7.44	No	Single-Source	76.7%
10	CLARITIN	ANTHISTAMINE	SCHERING	$842,035	13,239	$63.60	28.9	$2.20	No	Single-Source	74.9%

FY 2003

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$3,521,645	32,912	$107.00	29.7	$3.60	No	Single Source	81.6%
2	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$3,346,963	43,337	$77.23	29.7	$2.60	No	Single Source	73.6%
3	NEXIUM	ANTI-ULCERANT/GERD	ASTRAZENECA	$2,292,895	18,807	$121.92	30.7	$3.96	No	Single Source	83.7%
4	CELEBREX	ANTI-INFLAMMATORY	PHARMACIA	$2,062,445	22,103	$93.31	39.3	$2.38	No	Single Source	78.4%
5	PLAVIX	ARTHERSCLEROSIS	BRISTOL-MYERS SQUIBB	$2,021,146	19,078	$105.94	29.2	$3.63	No	Single Source	76.9%
6	PREVACID	ANTI-ULCERANT/GERD	TAP	$1,924,778	14,998	$128.34	31.8	$4.04	No	Single Source	82.2%
7	FOSAMAX	OSTEOPOROSIS	MERCK	$1,666,225	26,915	$61.91	5.7	$10.87	No	Single Source	67.3%
8	LEVAQUIN	BRONCHITIS/PNEUMONIA	ORTHO-MCNEIL	$1,507,163	19,262	$78.25	9.2	$8.51	No	Single Source	76.3%
9	NORVASC	CALCIUM CHANNEL BLOCKE	PFIZER	$1,501,313	30,197	$49.72	31.9	$1.56	No	Single Source	62.2%
10	PROTONIX	ESOPHAGITIS	WYETH/AYERST	$1,376,668	14,379	$95.74	30.3	$3.16	No	Single Source	76.5%

* Paid / (Ingredient Cost + Dispensing Fee)

Teacher Retirement System of Texas
Top 10 Drugs By Expenditures (Mail)
TRS-Care

FY 2001

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	PRILOSEC	ANTI-ULCERANT/GERD	ASTRAZENECA	$8,469,354	26,647	$317.84	95.8	$3.32	No	Single-Source	95.0%
2	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$8,218,797	34,025	$241.55	89.5	$2.70	No	Single-Source	93.4%
3	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$4,693,769	25,729	$182.43	90.6	$2.01	No	Single-Source	91.3%
4	CELEBREX	ANTI-INFLAMMATORY	PHARMACIA	$4,248,594	19,757	$215.04	120.3	$1.79	No	Single-Source	92.6%
5	VIOXX	ANTI-INFLAMMATORY	MERCK	$2,626,117	13,794	$190.38	92.6	$2.06	No	Single-Source	91.6%
6	NORVASC	CALCIUM CHANNEL BLOCKE	PFIZER	$2,284,005	18,564	$123.03	95.6	$1.29	No	Single-Source	87.0%
7	PREMARIN	HORMONE REPLACEMENT	WYETH/AYERST	$2,235,905	44,201	$50.58	88.4	$0.57	No	Single-Source	68.5%
8	CLARITIN	ANTHISTAMINE	SCHERING	$1,956,782	11,530	$169.71	86.9	$1.95	No	Single-Source	90.6%
9	GLUCOPHAGE	ANTI-DIABETIC AGENT	BRISTOL-MYERS SQUIBB	$1,701,318	10,778	$157.88	211.3	$0.75	No	Single-Source	89.9%
10	PREVACID	ANTI-ULCERANT/GERD	TAP	$1,623,681	5,382	$304.74	96.7	$3.15	No	Single-Source	94.8%

FY 2003

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$11,676,346	41,190	$283.48	89.4	$3.17	No	Single Source	91.2%
2	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$8,048,883	39,136	$205.66	89.3	$2.30	No	Single Source	87.4%
3	NEXIUM	ANTI-ULCERANT/GERD	ASTRAZENECA	$5,494,825	17,719	$310.11	91.7	$3.38	No	Single Source	92.0%
4	CELEBREX	ANTI-INFLAMMATORY	PHARMACIA	$5,131,925	19,952	$257.21	120.7	$2.13	No	Single Source	90.2%
5	FOSAMAX	OSTEOPOROSIS	MERCK	$4,012,486	24,835	$161.57	16.0	$10.10	No	Single Source	83.6%
6	PRILOSEC	ANTI-ULCERANT/GERD	ASTRAZENECA	$3,848,616	10,889	$353.44	95.0	$3.72	Yes	Generic	93.0%
7	NORVASC	CALCIUM CHANNEL BLOCKE	PFIZER	$2,958,607	22,871	$129.36	96.2	$1.35	No	Single Source	80.9%
8	PLAVIX	ARTHERSCLEROSIS	BRISTOL-MYERS SQUIBB	$2,889,806	10,162	$284.37	88.2	$3.22	No	Single Source	90.9%
9	VIOXX	ANTI-INFLAMMATORY	MERCK	$2,886,132	13,344	$216.29	93.3	$2.32	No	Single Source	88.4%
10	EVISTA	OSTEOPOROSIS	LILLY	$2,380,756	13,357	$178.24	88.7	$2.01	No	Single Source	85.5%

* Paid / (Ingredient Cost + Dispensing Fee)

Teacher Retirement System of Texas
Top 10 Drugs By Volume (Retail and Mail)
TRS-Care

FY 2001

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	PREMARIN	HORMONE REPLACEMENT	WYETH/AYERST	$2,899,764	75,359	$38.48	64.7	$0.59	No	Single-Source	58.6%
2	SYNTHROID	THYROID REPLACEMENT	ABBOTT LABORATORIES	$1,339,727	64,524	$20.78	62.7	$0.33	No	Single-Source	32.1%
3	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$10,098,817	53,739	$187.92	67.8	$2.77	No	Single-Source	91.5%
4	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$6,218,525	47,951	$129.68	62.9	$2.06	No	Single-Source	87.7%
5	PRILOSEC	ANTI-ULCERANT/GERD	ASTRAZENECA	$10,757,851	45,162	$238.21	70.1	$3.40	No	Single-Source	93.3%
6	CELEBREX	ANTI-INFLAMMATORY	PHARMACIA	$5,770,669	38,726	$149.01	81.2	$1.84	No	Single-Source	89.3%
7	NORVASC	CALCIUM CHANNEL BLOCKE	PFIZER	$3,223,346	38,124	$84.55	63.3	$1.34	No	Single-Source	81.1%
8	FUROSEMIDE	CARDIOVASCULAR AGENTS	ABBOTT LABORATORIES	$232,201	35,958	$6.46	68.3	$0.09	No	Generic	19.9%
9	ACETAMINOPHEN-HYDROCODONE BITARTRATE	ANALGESIC	VARIOUS	$350,159	31,318	$11.18	54.5	$0.20	No	Generic	44.5%
10	ATENOLOL	CARDIOVASCULAR AGENTS	GENEVA PHARMACEUTICS	$611,623	30,765	$19.88	69.3	$0.29	No	Generic	67.6%

FY 2003

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	SYNTHROID	THYROID REPLACEMENT	ABBOTT LABORATORIES	$1,932,827	85,964	$22.48	58.0	$0.39	No	Single Source	19.1%
2	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$11,395,846	82,473	$138.18	58.0	$2.38	No	Single Source	83.4%
3	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$15,197,991	74,102	$205.10	62.9	$3.26	No	Single Source	89.0%
4	PREMARIN	HORMONE REPLACEMENT	WYETH/AYERST	$3,390,368	70,181	$48.31	58.9	$0.82	No	Single Source	57.5%
5	FUROSEMIDE	CARDIOVASCULAR AGENTS	ABBOTT LABORATORIES	$321,327	53,399	$6.02	62.4	$0.10	No	Generic	8.2%
6	NORVASC	CALCIUM CHANNEL BLOCKE	PFIZER	$4,459,920	53,068	$84.04	59.6	$1.41	No	Single Source	74.6%
7	FOSAMAX	OSTEOPOROSIS	MERCK	$5,678,710	51,750	$109.73	10.6	$10.31	No	Single Source	78.8%
8	HYDROCODONE/ACETAMINOPHEN	PAIN RELIEF	MALLINCKRODT PHARM	$627,040	50,350	$12.45	58.0	$0.21	No	Generic	42.6%
9	ATENOLOL	CARDIOVASCULAR AGENTS	GENEVA PHARMACEUTICS	$797,221	43,498	$18.33	63.9	$0.29	No	Generic	54.3%
10	TOPROL XL	ANGINA	ASTRAZENECA	$1,953,050	43,479	$44.92	58.8	$0.76	No	Single Source	55.9%

* Paid / (Ingredient Cost + Dispensing Fee)

Teacher Retirement System of Texas
Top 10 Drugs By Volume (Retail)
TRS-Care

FY 2001

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	PREMARIN	HORMONE REPLACEMENT	WYETH/AYERST	$661,655	31,158	$21.24	31.0	$0.68	No	Single-Source	25.5%
2	SYNTHROID	THYROID REPLACEMENT	ABBOTT LABORATORIES	$367,385	29,455	$12.49	31.0	$0.40	No	Single-Source	4.0%
3	ACETAMINOPHEN-HYI	ANALGESIC	VARIOUS	$264,428	28,821	$9.17	44.1	$0.21	No	Generic	33.6%
4	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$1,523,447	22,222	$68.56	30.8	$2.23	No	Single-Source	76.7%
5	FUROSEMIDE	CARDIOVASCULAR AGENTS	ABBOTT LABORATORIES	$91,101	22,045	$4.13	39.1	$0.11	No	Generic	1.3%
6	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$1,878,273	19,714	$95.28	30.5	$3.12	No	Single-Source	83.2%
7	NORVASC	CALCIUM CHANNEL BLOCKE	PFIZER	$938,398	19,860	$47.98	32.6	$1.47	No	Single-Source	66.7%
8	ACETAMINOPHEN-PROPOXYPHENE NAPSYLATE	ANALGESIC	VARIOUS	$287,612	19,248	$14.94	44.2	$0.34	No	Generic	48.1%
9	CELEBREX	ANTI-INFLAMMATORY	PHARMACIA	$1,521,075	18,969	$80.19	40.5	$1.98	No	Single-Source	80.1%
10	PRILOSEC	ANTI-ULCERANT/GERD	ASTRAZENECA	$2,287,164	18,515	$123.63	33.1	$3.74	No	Single-Source	87.1%

FY 2003

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	HYDROCODONE/ACET	PAIN RELIEF	MALLINCKRODT PHARM	$524,461	47,168	$11.12	48.8	$0.23	No	Generic	38.2%
2	SYNTHROID	THYROID REPLACEMENT	ABBOTT LABORATORIES	$614,396	45,429	$13.52	30.2	$0.45	No	Single Source	2.7%
3	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$3,346,963	43,337	$77.23	29.7	$2.60	No	Single Source	73.6%
4	FUROSEMIDE	CARDIOVASCULAR AGENTS	ABBOTT LABORATORIES	$173,236	37,168	$4.66	39.3	$0.12	No	Generic	1.4%
5	PREMARIN	HORMONE REPLACEMENT	WYETH/AYERST	$1,054,918	35,587	$29.64	31.2	$0.95	No	Single Source	43.7%
6	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$3,521,645	32,912	$107.00	29.7	$3.60	No	Single Source	81.6%
7	NORVASC	CALCIUM CHANNEL BLOCKE	PFIZER	$1,501,313	30,197	$49.72	31.9	$1.56	No	Single Source	62.2%
8	PROPOXYPHENE-N/ACETAMINOP	ANALGESIC	VARIOUS	$278,510	27,544	$10.11	46.2	$0.22	No	Generic	27.8%
9	FOSAMAX	OSTEOPOROSIS	MERCK	$1,666,225	26,915	$61.91	5.7	$10.87	No	Single Source	67.3%
10	TOPROL XL	ANGINA	ASTRAZENECA	$701,482	25,653	$27.35	32.1	$0.85	No	Single Source	39.4%

* Paid / (Ingredient Cost + Dispensing Fee)

Teacher Retirement System of Texas
Top 10 Drugs By Volume (Mail)
TRS-Care

FY 2001

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	PREMARIN	HORMONE REPLACEMENT	WYETH/AYERST	$2,235,905	44,201	$50.58	88.4	$0.57	No	Single-Source	68.5%
2	SYNTHROID	THYROID REPLACEMENT	ABBOTT LABORATORIES	$970,599	35,069	$37.68	89.4	$0.31	No	Single-Source	42.8%
3	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$8,216,797	34,025	$241.55	89.5	$2.70	No	Single-Source	93.4%
4	PRILOSEC	ANTI-ULCERANT/GERD	ASTRAZENECA	$8,469,354	26,647	$317.64	95.8	$3.32	No	Single-Source	95.0%
5	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$4,693,769	25,729	$182.43	90.6	$2.01	No	Single-Source	91.3%
6	CELEBREX	ANTI-INFLAMMATORY	PHARMACIA	$4,248,594	19,757	$215.04	120.3	$1.79	No	Single-Source	92.6%
7	NORVASC	CALCIUM CHANNEL BLOCKE	PFIZER	$2,284,005	18,564	$123.03	95.6	$1.29	No	Single-Source	87.0%
8	PRINIVIL	CARDIOVASCULAR AGENTS	MERCK	$1,386,080	16,629	$83.35	101.5	$0.82	No	Single-Source	80.9%
9	ATENOLOL	CARDIOVASCULAR AGENTS	GENEVA PHARMACEUTICS	$501,127	15,782	$31.75	101.7	$0.31	No	Generic	77.1%
10	PREMPRO	HORMONE REPLACEMENT	WYETH/AYERST	$1,036,480	14,893	$69.60	82.7	$0.84	No	Single-Source	77.1%

FY 2003

Rank	Drug Name	Use	Manufacturer	Ingredient Cost Plus Dispensing Fee	Number of Scripts	Ingredient Cost Plus Dispensing Fee / Number of Scripts	Average Package Size	Unit Cost	OTC	Generic Equivalent	State Copay % *
1	ZOCOR	CHOLESTEROL-LOWERING	MERCK	$11,676,346	41,190	$283.48	89.4	$3.17	No	Single Source	91.2%
2	SYNTHROID	THYROID REPLACEMENT	ABBOTT LABORATORIES	$1,318,431	40,535	$32.53	89.3	$0.36	No	Single Source	26.7%
3	LIPITOR	CHOLESTEROL-LOWERING	PFIZER/WARNER-LAMBERT	$8,048,883	39,136	$205.66	89.3	$2.30	No	Single Source	87.4%
4	PREMARIN	HORMONE REPLACEMENT	WYETH/AYERST	$2,335,450	34,594	$67.51	87.5	$0.77	No	Single Source	63.7%
5	FOSAMAX	OSTEOPOROSIS	MERCK	$4,012,486	24,835	$161.57	16.0	$10.10	No	Single Source	83.6%
6	NORVASC	CALCIUM CHANNEL BLOCKE	PFIZER	$2,958,607	22,871	$129.36	96.2	$1.35	No	Single Source	80.9%
7	CELEBREX	ANTI-INFLAMMATORY	PHARMACIA	$5,131,925	19,952	$257.21	120.7	$2.13	No	Single Source	90.2%
8	LISINOPRIL	CARDIOVASCULAR AGENTS	ZENECA	$813,942	18,531	$43.92	99.8	$0.44	No	Generic	71.8%
9	ATENOLOL	CARDIOVASCULAR AGENTS	GENEVA PHARMACEUTICS	$654,165	18,387	$35.58	103.3	$0.34	No	Generic	65.8%
10	TOPROL XL	ANGINA	ASTRAZENECA	$1,251,569	17,826	$70.21	97.2	$0.72	No	Single Source	65.1%

* Paid / (Ingredient Cost + Dispensing Fee)

University of Texas System (Self-Funded Plan)*

Top 10 Drugs by Expenditure (Ingredient Cost)				Actual Expenditures (Avg. Wholesale Price minus discounts)	Actual prescriptions (Rx) filled	Total Costs divided by #Rx	Average no. of tabs/caps per RX	Actual cost per tab or cap			
Rank	Drug Name	Use	Manufacturer	Ingredient Cost	#RX	$/RX	Units per RX	Unit Cost	OTC	Generic Equivalent	Plan % of Total Cost
(FY2001)											
1	Prilosec	gastrointestinal	AstraZeneca	$ 2,696,802.31	13,292	$ 202.89	60.740	$ 3.34	no	no	84.9%
2	Lipitor	cardiovascular	Parke-Davis	$ 2,013,481.73	17,617	$ 114.29	56.513	$ 2.02	no	no	72.9%
3	Claritin	antihistamine	Schering	$ 1,862,256.82	21,542	$ 86.45	50.852	$ 1.70	no	no	67.8%
4	Zocor	cardiovascular	Merck	$ 1,590,549.07	9,478	$ 167.81	62.668	$ 2.68	no	no	80.4%
5	Prozac	antidepressant	Dista	$ 1,200,850.98	7,771	$ 154.53	63.787	$ 2.42	no	yes	81.1%
6	Celebrex	analgesic (nsaid)	Schering	$ 1,132,221.87	9,156	$ 123.66	69.778	$ 1.77	no	no	76.0%
7	Vioxx	analgesic (nsaid)	Merck	$ 971,406.44	8,919	$ 108.91	50.255	$ 2.17	no	no	73.5%
8	Zoloft	antidepressant	Pfizer	$ 900,671.36	8,541	$ 105.45	54.152	$ 1.95	no	no	73.0%
9	Allegra	antihistamine	Aventis	$ 820,446.70	11,875	$ 69.09	65.325	$ 1.06	no	no	60.1%
10	Glucophage	antidiabetic	Bristol-Myers Sq	$ 712,999.33	7,640	$ 93.32	127.746	$ 0.73	no	no	72.8%
(FY 2003)											
1	Lipitor	cardiovascular	Parke-Davis	$ 2,785,571.58	21,036	$ 132.42	57.39	$ 2.31	no	no	73.2 %
2	Zocor	cardiovascular	Merck	$ 2,434,564.45	12,486	$ 194.98	61.45	$ 3.17	no	no	80.8 %
3	Nexium	gastrointestinal	AstraZeneca	$ 1,655,348.78	8,831	$ 187.45	53.93	$ 3.48	no	no	82.3 %
4	Celebrex	analgesic (nsaid)	Schering	$ 1,238,590.78	8,254	$ 150.06	70.88	$ 2.12	no	no	77.8 %
5	Prilosec	gastrointestinal	AstraZeneca	$ 1,137,046.66	4,617	$ 246.27	65.54	$ 3.76	yes	yes	85.6 %
6	Effexor	antidepressant	Wyeth-Ayerst	$ 1,101,638.24	7,271	$ 151.51	68.18	$ 2.22	no	no	80.4 %
7	Zoloft	antidepressant	Pfizer	$ 1,097,478.02	9,838	$ 111.55	54.18	$ 2.06	no	no	72.6 %
8	Allegra	antihistamine	Aventis	$ 1,002,769.33	11,066	$ 90.62	60.31	$ 1.50	no	no	65.3 %
9	Fosamax	osteoporosis	Merck	$ 957,852.84	8,908	$ 107.53	11.57	$ 9.29	no	no	65.9 %
10	Vioxx	analgesic (nsaid)	Merck	$ 879,792.98	7,101	$ 123.90	52.58	$ 2.36	no	no	73.8 %

*Pharmacy Benefits Manager of the self-funded UT SELECT plan was Medco Health Solutions (formerly Merck-Medco Managed Care).

Notes:

1. FY2003 experience for the self-funded UT SELECT plan only.
2. All data is retail and mail order pharmacies combined.
3. Experience for an individual drug is reported for all strengths combined.
4. "Plan % of Total Cost" equals the plan payment divided by the total cost (equals ingredient cost plus dispensing fee).

University of Texas System (Self-Funded Plan)*

Top Ten Drugs by Volume (Number of Scripts)				Actual Expenditures (Avg. Wholesale Price) minus discounts	Actual prescriptions (Rx) filled	Total Costs divided by #Rx	Average	Actual cost per tab or cap			
Rank	Drug Name	Use	Manufacturer	Ingredient Cost	#RX	$/RX	Package Size	Unit Cost	OTC	Generic Equivalent	Plan % of Total Cost
(FY2001)											
1	Claritin	antihistamine	Schering	$ 1,862,256.82	21,542	$ 86.45	50.85	$ 1.70	no	no	67.8%
2	Premarin	hormone,estrogen	Wyeth-Ayerst	$ 656,216.52	19,818	$ 33.11	55.58	$ 0.60	no	no	16.9%
3	Lipitor	cardiovascular	Parke-Davis	$ 2,013,481.73	17,617	$ 114.29	56.51	$ 2.02	no	no	72.9%
4	Prilosec	gastrointestinal	AstraZeneca	$ 2,696,802.31	13,292	$ 202.89	60.74	$ 3.34	no	no	84.9%
5	Zithromax	antibiotic	Pfizer	$ 460,863.68	12,759	$ 36.12	8.90	$ 4.06	no	no	34.5%
6	Allegra	antihistamine	Aventis	$ 820,446.70	11,875	$ 69.09	65.33	$ 1.06	no	no	60.1%
7	Prempro	hormone,estrogen	Wyeth-Ayerst	$ 458,269.71	10,300	$ 44.49	53.15	$ 0.84	no	no	30.6%
8	Zocor	cardiovascular	Merck	$ 1,590,549.07	9,478	$ 167.81	62.67	$ 2.68	no	no	80.4%
9	Celebrex	analgesic (nsaid)	Schering	$ 1,132,221.87	9,156	$ 123.66	69.78	$ 1.77	no	no	76.0%
10	Vioxx	analgesic (nsaid)	Merck	$ 971,406.44	8,919	$ 108.91	50.26	$ 2.17	no	no	73.5%
(FY2003)											
1	Lipitor	cardiovascular	Parke-Davis	$ 2,785,571.58	21,036	$ 132.42	57.39	$ 2.31	no	no	73.2%
2	Synthroid	thyroid	Abbott	$ 390,742.60	19,924	$ 19.61	52.17	$ 0.38	no	no	0.7%
3	Hydroco/APAP	analgesic	(generic)	$ 108,977.92	15,856	$ 6.87	42.70	$ 0.16	no	yes	17.9%
4	Premarin	hormone, estrogen	Wyeth-Ayerst	$ 587,510.63	13,407	$ 43.82	56.14	$ 0.78	no	no	23.7%
5	Zithromax	antibiotic	Pfizer	$ 528,669.82	12,998	$ 40.67	8.88	$ 4.58	no	no	42.0%
6	Zocor	cardiovascular	Merck	$ 2,434,564.45	12,486	$ 194.98	61.45	$ 3.17	no	no	80.8%
7	Allegra	antihistamine	Aventis	$ 1,002,769.33	11,066	$ 90.62	60.31	$ 1.50	no	no	65.3%
8	Zyrtec	antihistamine	Pfizer	$ 745,634.41	10,304	$ 72.36	64.87	$ 1.12	no	no	58.4%
9	Zoloft	antidepressant	Pfizer	$ 1,097,478.02	9,838	$ 111.55	54.18	$ 2.06	no	no	72.6%
10	Atenolol	hypertension	(generic)	$ 152,338.75	9,702	$ 15.70	57.86	$ 0.27	no	yes	38.9%

*Pharmacy Benefits Manager of the self-funded UT SELECT plan was Medco Health Solutions (formerly Merck-Medco Managed Care).

Notes:

1. FY2003 experience for the self-funded UT SELECT plan only.
2. All data is retail and mail order pharmacies combined.
3. Experience for an individual drug is reported for all strengths combined.
4. "Plan % of Total Cost" equals the plan payment divided by the total cost (equals ingredient cost plus dispensing fee).

The Texas A&M University System
A&M Care Self-Insured Health Plan
Top Ten Drugs Ranked by Total Co

FISCAL YEAR 2001

Top 10 Drugs by Volume

Rank	Drug Name	
1	Lipitor	Carc
2	Celebrex	Anal
3	Prilosec	Gas
4	Norvasc	Carc
5	Claritin	Antil
6	Vioxx	Anal
7	Allegra	Antil
8	Pravachol	Carc
9	Fosamax	End
10	Zoloft	Anti

Top 10 Drugs by Expenditure

Rank	Drug Name	Use	Manufacturer	(Ingredient costs less rebates) Total Cost	Actual l costs prescriptioed by filled ‡Rx #Rx	/Rx	Units Per Rx
1	Lipitor	Cardiovascular	Parke-Davis	900,146	9,7	92.79	45.120
2	Prilosec	Gastrointestinal	AstraZeneca	796,059	5,1	54.10	44.848
3	Celebrex	Analgesic (nsaids)	Pharmacia	551,176	5,2	05.93	56.789
4	Prevacid	Gastrointestinal	TAP	543,035	3,4	58.88	49.432
5	Pravachol	Cardiovascular	Bristol-Myers Squibb	454,503	3,7	21.33	48.805
6	Zocor	Cardiovascular	Merck	385,863	3,0	26.51	42.736
7	Claritin	Antihistamine	Schering	371,304	4,8	76.09	41.269
8	Vioxx	Analgesic (nsaids)	Merck	367,546	4,0	90.53	41.355
9	Prozac	Antidepressant	Eli Lilly	311,847	2,4	27.39	53.825
10	Fosamax	Endocrinological	Merck	309,440	3,6	83.66	29.616

FISCAL YEAR 2003

Top 10 Drugs by Volume

Rank	Drug Name	
1	Lipitor	Carc
2	Synthroid	End
3	Premarin	End
4	Norvasc	Carc
5	Toprol XL	Carc
6	Hydrocodone/	Anal
7	Fosamax	End
8	Zyrtec	Antih
9	Prevacid	Gast
10	Allegra	Antih

Top 10 Drugs by Expenditure

Rank	Drug Name	Use	Manufacturer	(Ingredient costs less rebates) Total Cost	Actual il costs prescriptided by filled ‡Rx #Rx	/Rx	Units Per Rx
1	Lipitor	Cardiovascular	Pfizer	1,450,423	13,1	110.43	47.476
2	Prevacid	Gastrointestinal	TAP	879,926	4,8	181.43	49.000
3	Pravachol	Cardovascular	Bristol-Myers Squibb	678,262	4,6	144.50	48.265
4	Celebrex	Analgesic (nsaids)	Pharmacia	648,214	4,3	148.37	66.918
5	Zocor	Cardiovascular	Merck	610,543	4,1	146.10	43.189
6	Nexium	Gastrointestinal	Astzen	553,853	3,3	165.77	45.974
7	Fosamax	Endocrinological	Merck	475,823	5,2	89.91	8.748
8	Zoloft	Antidepressant	Pfizer	420,053	4,6	90.68	42.914
9	Norvasc	Cardiovascular	Pfizer	376,905	5,9	63.07	46.501
10	Allegra	Antihistamine	Aventis	367,151	4,8	76.22	46.900

Notes:
1. A&M Care plans only (self-insure
2. Includes retail and mail order pha
3. All strengths and forms are inclu
4. Total Costs equals ingredient cos
5. The % Paid by Employer is calcu (ingredient costs plus dispensing
6. Total Costs for FY 2001 were adj as originally reported.

Notes:
1. A&M Care plans only (self-insured PPO).
2. Includes retail and mail order pharmacies.
3. All strengths and forms are included for each drug. i.e. Lipitor includes 10MG, 20MG, 40MG and 80MG
4. Total Costs equals ingredient costs less rebates. Dispensing fees were not included.
5. The % Paid by Employer is calculated by dividing Employer Costs (ingredient costs plus dispensing feebates less employee (ingredient costs plus dispensing fees less rebates).
6. Total Costs for FY 2001 were adjusted to reflect ingredient costs less rebates in order to conform to theeported by other ag as originally reported.

Correctional Managed Care: Top Ten Drugs By Expenditure

Top 10 Drugs by Expenditure (FY 2001)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures, drug acquisition only minus rebates Total Costs	Actual prescriptions filled #RX	Total costs column divided by #Rx column $/RX*	Either average per RX or Estimate based on most common Qty dispensed for the agent Units per RX	Actual cost per tab or cap include date completed: 2/6/02 Unit Cost*	OTC	Generic Equivalent	St. Copay %
1	Nefinavir 250mg	HIV	Agouron	$4,633,336	8,571	$540.58	300	$1.89	no	none	N/A
2	Engerix-B Vaccine	Hepatits B Vaccine	SKB	$3,589,868	231,475	$15.51	1	$21.40	no	none	N/A
3	Lamivudine 150mg	HIV	Glaxowelcome	$3,070,231	14,129	$217.30	60	$3.88	no	none	N/A
4	Stavudine 40mg	HIV	BMS	$2,650,969	11,290	$234.81	60	$4.30	no	none	N/A
5	Efavirenz 200mg	HIV	BMS-DuPont	$1,648,502	5,424	$303.93	90	$3.57	no	none	N/A
6	Zidovudine 300mg	HIV	Glaxowelcome	$1,564,007	6,123	$255.43	60	$4.54	no	none	N/A
7	Sertraline 100mg	Depression	Pfizer	$1,434,002	22,730	$63.09	30	$1.97	no	none	N/A
8	Abacavir 300mg	HIV	Glaxowelcome	$1,199,541	4,069	$294.80	60	$5.22	no	none	N/A
9	Olanzapine 10mg	Psychosis	Lilly	$1,161,627	3,189	$364.26	60	$7.58	no	none	N/A
10	Indinavir	HIV	Merck	$949,556	2,617	$362.84	180	$2.27	no	none	N/A

* TDCJ reclaims unused medication, as a result column G / H will not equal I

Top 10 Drugs by Expenditure (FY 2003)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures, drug acquisition only minus rebates Total Costs	Actual prescriptions filled #RX	Total costs column divided by #Rx column $/RX*	Either average per RX or Estimate based on most common Qty Units per RX	Actual cost per tab or cap FY 2003 Unit Cost*	OTC	Generic Equivalent	St. Copay %
1	Nelfinavir 250mg	HIV	Agouron/Pfizer	$ 2,689,579.20	6,084	$442.07	300	$ 1.52	no	no	N/A
2	Lamivudine 150mg	HIV	GSK	$ 2,595,149.64	15,514	$167.28	60	$ 2.91	no	no	N/A
3	Efavirenz 600mg	HIV	DuPont	$ 1,948,435.20	6,959	$279.99	30	$ 9.60	no	no	N/A
4	Kaletra	HIV	Abbott	$ 1,582,585.20	3,259	$485.60	180	$ 2.52	no	no	N/A
5	Stavudine 40mg	HIV	BMS	$ 1,485,367.38	8,687	$170.99	60	$ 2.94	no	no	N/A
6	Zidovudine 300mg	HIV	GSK	$ 1,343,773.05	6,363	$211.19	60	$ 3.65	no	no	N/A
7	Abacavir 300mg	HIV	GSK	$ 1,334,293.87	5,380	$248.01	60	$ 4.27	no	no	N/A
8	Didanosine 400mg EC	HIV	BMS	$ 1,324,692.19	4,540	$291.78	30	$ 10.03	no	no	N/A
9	Tenofovir 300mg	HIV	Gilead	$ 988,089.20	3,638	$271.60	30	$ 9.38	no	no	N/A
10	Epogen 10,000	Dialysis	Amgen	$ 967,907.16	4,554	$212.54	0	$ 212.54	no	no	N/A

* TDCJ reclaims unused medication, as a result column G / H will not equal I