

# **Administrator's Statement**

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**529 Health and Human Services Commission**

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HEALTH & HUMAN SERVICES COMMISSION

“The mission of health and human service agencies in Texas is to develop and administer an accessible, effective, and efficient health and human services delivery system that is beneficial and responsive to the people of Texas.”

The Health and Human Services Commission (HHSC) was created in 1992 to coordinate & improve the delivery of health and human services across Texas. In 2003, the 78th Legislature, Regular Session charged HHSC with overseeing the transformation of the delivery of health and human services. State leaders envision a coordinated system of health and human services that is rationally organized, effectively managed, centered on client needs, & accountable for results.

In addition to overseeing the health and human services system in Texas, HHSC is responsible for program administration of Medicaid, CHIP, Disaster Assistance, Temporary Assistance for Needy Families, SNAP food benefits, Family Violence & Refugee programs. Thus, HHSC has responsibilities as a leadership, operational, & oversight agency. The agency is accountable to Texans for ensuring that the consolidated Health and Human Services (HHS) agencies provide quality services as efficiently & effectively as possible. The agency executive commissioner is appointed by the Governor and assisted by a nine-member advisory council.

FY 2012-13 PROGRESS & ACCOMPLISHMENTS

During the first fiscal year of the 2012-13 biennium, HHSC has achieved significant successes in Medicaid and Eligibility operations. These milestones are examples of our continued effort to improve the efficiency, effectiveness, & accountability of programs and the service delivery system.

Social Services & Information Technology

Texas Integrated Eligibility Redesign System (TIERS) Rollout & Decommissioning of System of Application, Verification, Eligibility, Referral & Reporting (SAVERR)

- Work that began in 2009 came to fruition this biennium as HHSC successfully converted all remaining SAVERR cases into TIERS by December 31, 2011. After allowing for a six-month period of phase down, HHSC officially de-commissioned SAVERR on May 31, 2012, after 33 years of operation.
- To address timeliness issues, staffing shortages and problems operating under two eligibility systems, HHSC (with legislative & executive concurrence) implemented a number of policy changes, including staffing increases, accelerating full conversion and training to TIERS and addressing the concerns of front-line workers. By creating one automation system for eligibility, TIERS will help increase efficiency and allow for better monitoring of performance.
- In 2011, Texas was nationally recognized as the top state for best payment accuracy and most improved payment accuracy.
- As of July 2012 performance and timeliness continue to be above national averages.

Health Services

Cost Containment Initiatives

HHS agencies were charged with identifying & implementing an unprecedented \$2.2 billion GR & \$5.0 billion AF of savings in Medicaid and CHIP for the 2012-13 biennium. Some of the cost containment initiatives were later adjusted to ensure continuity of care. HHSC now estimates that the achieved savings total almost \$1.9 billion GR & \$4.5 billion All Funds, or 86 percent of the cost containment target.

- Rider 61 reduced HHSC's appropriation by \$450 million offset by 30 cost containment initiatives that focused on improving quality of care and health outcomes. HHSC estimates that it will achieve 80% of the cost containment target or \$360.1 million GR.
- Section 16, Article II Special Provisions, directed a series of rate reductions ranging from 1% to 10.5%. HHSC estimates that it will achieve 85%, or \$486.6 million of the rate reduction target of \$571.3 million.

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- Section 17, Article II Special Provisions, included 14 additional cost containment initiatives affecting DADS, DSHS, & HHSC, including Medicare equalization. HHSC estimates that it will achieve 82%, or \$577.5 million GR of the \$705.0 million GR cost containment target.
- The expansion of Medicaid Managed Care will achieve almost all of the anticipated GR savings of \$385.7 million in Rider 51.
- HHSC Rider 80 & DADS Rider 48) and other initiatives, are also projected to save more than \$80 million GR, or 94 percent of the GR target.

**Federal Flexibility**

Additionally Rider 59 directed HHSC to pursue flexibility in Medicaid by gaining an improved federal match rate with the assumption of a GR of savings of \$700 million offset by a gain of \$700 million federal funds. While HHSC was not successful in increasing the federal match, or federal medical assistance percentage (FMAP) for Texas, HHSC was successful in implementing provisions in Senate Bill 7, 82nd Legislature, First Called Session, 2011 and submitted and received authority to implement a new Medicaid demonstration waiver under Section of 1115 of the Social Security Act.

**Texas Healthcare Transformation & Quality Improvement Program Waiver**

Historically the majority of payments under the Upper Payment Limit (UPL) program have been outside of the state appropriations process, primarily funded with intergovernmental transfers (IGT) from public hospitals for supplemental payments for hospital & physician services. These payments to hospitals would have been negatively affected by the expansion of Medicaid managed care. HHSC sought a federal waiver to preserve the federal funding available through UPL, while expanding managed care. In July 2011 HHSC submitted a proposal for a five-year waiver from the Centers for Medicare and Medicaid Services (CMS). On December 12, 2011, CMS approved Texas' request for a waiver allowing the state to expand Medicaid managed care while preserving hospital funding, to provide incentive payments for health care improvements and to direct more funding to hospitals that serve large numbers of uninsured patients. It is estimated that the waiver could provide up to \$29 billion in federal funding over a five-year period.

Replacing the UPL payment methodology are two funding pools – the Uncompensated Care (UC) & Delivery System Reform Incentive Payment (DSRIP) pools. Uncompensated Care Pool Payments are designed to help offset the costs of uncompensated care provided by the hospital or other providers. DSRIP Pool Payments are incentive payments to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served.

The addition of the UC & DSRIP payments also has presented new opportunities to revisit Texas' other hospital supplement payment program, the Disproportionate Share (DSH) Program. The DSH program expenditures historically also have been outside of the appropriations process.

**Statewide Managed Care Expansion**

In the LAR last biennium, HHSC proposed several initiatives to expand Medicaid managed care in an effort to improve health outcomes and generate savings. S.B. 7, 82nd Legislature, First Called Session, 2011, directed the HHSC to expand Medicaid managed care statewide.

- On September 1, 2011, the STAR & STAR+Plus managed care programs were extended to 28 counties adjacent to urban areas already covered by managed care.
- On March 1, 2012 HHSC expanded Medicaid managed care statewide for STAR with rollouts in the South Texas Service Area and rural areas of state, covering 3 million people in capitated managed care. Certain services that were previously fee-for-service only, such as hospital inpatient care, vendor drug services, and dental services are now delivered through managed care.

**System Support Services**

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HHS Office Consolidation

In an effort to implement administrative reductions, HHSC in April 2012 announced the closure of 56 HHS offices statewide and the reassignment of 256 employees to nearby offices. The closures which occurred in both urban & rural areas are expected to save more than \$2 million All Funds a year in lease payments and related costs once the consolidations are complete.

HR Payroll Upgrade

Since FY 2010, HHS agencies have been working with the Comptroller of Public Accounts (CPA) and the HHS Human Resources (HR) contractor to develop and upgrade the HR module to be used by the CPA as the statewide basis of CAPPs (Centralized Accounting & Payroll/Personnel System), the official name of the statewide Enterprise Resource Planning system. In October 2012, HHS agencies will begin using the upgraded HR module and hand it off to CPA staff for any changes needed for statewide purposes.

The comptroller will continue to host the HHS agencies for 2 years when the support of the HR systems for the HHS agencies will move to the Data Center.

Federal Legislation & Policies

Affordable Care Act

In March 2010, the Patient Protection and Affordable Care Act & the Health Care and Education Reconciliation Act of 2010 were signed into law. These two acts together are known as the Affordable Care Act (ACA), or federal health care reform legislation. On June 28, 2012, the U.S. Supreme Court determined that the Medicaid expansion was optional for states.

HHSC's LAR does not include a funding request to expand the Medicaid program. However, there is funding requested in both the base and as exceptional items to support other ACA provisions. The ACA initiatives at HHSC are found on Schedule 6.J in Volume 2.

Women's Health Initiative

In March 2012, the federal government denied Texas's request to continue the Medicaid Women's Health Waiver, and HHSC responded to State's leadership directive to maintain women's health services to over 100,000 low-income women without federal funding. The LAR assumes continued state funding for providing women's health services.

BUDGET REQUEST FOR THE 2014-15 BIENNIUM

FY 2012-13 Expenditures

The 2012-13 estimated base expenditures total \$45.4 billion in All Funds & \$18.2 billion in state funding. The 2012-13 biennial budget assumes a state-funded supplemental appropriation of \$3.6 billion for Medicaid & \$83.7 million for CHIP. The biennial shortfall is due primarily to the lack of funding for five months of cost & utilization growth and caseloads slightly higher than appropriated levels. The 2012-13 expenditures include anticipated savings associated with the cost containment initiatives.

For the 2012-13 biennium, caseloads continue to increase for Medicaid and CHIP.

- Current average Medicaid caseload projections total 3,659,009 recipients in FY 2012 & 3,720,656 recipients in FY 2013.
- Current average CHIP caseload projections total 606,726 recipients in FY 2012 & 629,260 recipients in FY 2013.
- For TANF Cash Assistance, the current average caseload projections total 107,599 recipients in FY 2012 & 99,020 recipients in FY 2013. TANF caseloads have

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resumed decreasing after a brief increase during the 2010-11 biennium.

From January 2013 through December 2014, the federal government will fund with 100 percent federal funding the difference between Medicaid and Medicare reimbursement levels for certain Medicaid primary care providers. Due to the timing of the Supreme Court decision and LAR preparation, the fiscal year 2013 budget does not include the estimated \$247.0 million federal funds associated with this increase in the Medicaid program. However, the fiscal year 2013 budget includes an estimated \$5.0 million GR necessary to restore rates for these Medicaid providers to the reimbursement level in effect in July 2010 in order to receive the increased federal funding.

FY 2012-13 cost estimates for the Office of the Inspector General in Strategy G.1.1 reflect an internal reorganization implemented during the current biennium that redirected certain staff to focus areas on HHS programs with better financial returns from investigative efforts.

**FY 2014-15 Base Request**

The baseline request for FY 2014-15 totals \$48.8 billion, of which \$19.1 billion is general revenue. This request represents an increase of approximately \$0.9 billion in GR, or about 5 percent increase than projected 2012-13 biennial expenditures. The biennial increase is associated with Medicaid and CHIP caseload growth that was considered entitlement for baseline request. However FY 2014-15 Medicaid and CHIP costs were held flat at FY 2013 levels in the base request.

As a part of the FY 2013 cost trend, the 2014-15 base request assumes the two percent rate restoration for the Medicaid primary care providers who are also eligible for the 100 percent federally-funded increase -\$262.0 million federal in FY 2014 & \$92.7 million federal funds for four months in FY 2015. The Medicaid and CHIP projections for FY 2014-15 assume continuation of the other rate reductions and cost containment initiatives implemented during the 2012-13 biennium.

- CHIP caseloads are projected to increase to 641,082 in FY 2014 to 653,191 recipients in FY 2015.
- Medicaid caseloads are projected to increase to 3,947,805 recipients in FY 2014 & to 4,191,665 recipients in FY 2015.

Medicaid caseloads include anticipated growth due to the individual mandate for insurance required under the federal Affordable Care Act. HHSC projects that 131,070 children in FY 2014 & 298,446 in FY 2015 will enroll due to the individual mandate. Because these children would have been eligible for coverage under the existing Medicaid program, the normal federal match rate will apply.

The CHIP match rate is assumed to be 71.86 percent in FFY 2014 & FFY 2015. The Medicaid match rate is assumed to be 59.80 percent in FFY 2014 & FFY 2015.

FY 2014-15 caseloads in the TANF Cash Assistance Program are projected to remain close to FY 13 caseloads, decreasing slightly in FY 2014 to 97,508 monthly recipients and then increasing again in FY 2015 to 98,8457 monthly recipients. The portion of the federal TANF maintenance of effort (MOE) requirement in HHSC's request is met in the base request.

In the Family Violence strategy, \$4.6 million that was expended in FY 2012 from the Crime Victims Compensation Account is continued in the 2014-15 biennium. However there is an additional adjustment in the Family Violence strategy for FY 2014-15 where HHSC has re-purposed general revenue from a one-time project in FY 2012-13 to replace \$2.3 million federal funds that were used to maintain the Family Violence services when HHSC was requested to discontinue further expenditures from Crime Victims Compensation Account appropriations during FY 2012-13 due to changes in the revenue collections for that account.

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Also reflected in the FY 2014-15, is the reallocation of funding related to an internal reorganization of HHSC's Information Technology Division for FY 2013. This reorganization actually increases the overall GR by an estimated \$0.8 million and redistributes funding for IT differently throughout administrative strategies. Approximately \$7.1 million GR shifts from two strategies (Strategy 5.1.2, IT Program Support & Strategy 5.1.3 Regional Program Support) to the other administrative strategies when compared to FY 2012-13. Due to the timing of the reorganization and preparation of this budget request, the budget for FY 2013 does not reflect the reallocation of funds resulting from this reorganization.

#### FY 2014-15 Exceptional Item Requests

HHSC is seeking funding for 30 exceptional items totaling \$1.7 billion in GR & \$4.4 billion All Funds. There are ten exceptional item funding requests that maintain some level of current services or operations at HHSC and other HHS agencies. The remaining 20 exceptional items address critical needs or system improvements at HHSC and the other HHS agencies.

#### Maintaining Current Services

Approximately \$1.37 billion GR & \$3.53 billion All Funds are needed to maintain current services in Medicaid, CHIP, Data Center Services, and other agency programs and administration.

#### Medicaid Acute Care & CHIP

The biennial cost to maintain current services in client service programs totals more than \$1.2 billion GR & \$3.2 billion All Funds in Medicaid and CHIP. Exceptional Item funding addresses only cost and utilization since caseload growth is assumed in the base request.

- The overall FY 2014-15 Medicaid cost growth trend over fiscal year 2011 is 9.9 percent (from 2011 to 2015), averaging 2.3 percent per year. In general, acute care medical costs grew at a rate of 1.6 percent a year from FY 2013 to FY 2015 (only these years were used to mitigate the impact of STAR+Plus LTSS costs coming into the budget in FY 2012 & FY 2013). Vendor Drug costs have a 4.5 percent growth trend for each year of the biennium, which is in line with the average growth for the past five years.
- Traditional CHIP recipient month premiums are assumed to grow at 3.9 percent each year in FY 14 & FY 15. Total CHIP vendor drug cost growth over the base LAR request is 3.9 percent in FY 2014 & 8 percent in FY 2015. Total CHIP Perinatal cost growth over the base LAR request is 2.1 percent in FY 2014 & 4.2 percent in FY 2015.

One of the Affordable Care Act provisions would provide \$107.0 million GR & \$266.2 All Funds to maintain the increase to primary care Medicaid providers with state and federal funding for the last eight months of FY 2015 as the 100 percent federal funding increase expires December 31, 2014. There is another exceptional item related to broadening the reimbursement to other primary care providers as well as other programs that base their reimbursements on Medicaid rates at HHSC.

#### Current Operating Levels-HHSC

Four exceptional items that total \$16.1 million GR & \$25.0 million All Funds would maintain FY 2013 operating levels for other HHSC operations.

- Funding to support increased costs in eligibility determination support services resulting from caseload growth totals \$8.5 million GR & \$17.4 million All Funds.
- The funding request for maintaining the Office of Acquired Brain Injury would replace expiring federal funding and expand services, \$0.9 million GR & All Funds.
- The cost to maintain the Children's Litigation is \$5.6 million GR & All Funds.
- The cost to replace 36 vehicles used by HHSC in regional operations is \$1.1 million GR & All Funds.

#### Current Operating Levels-HHS Agencies

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On behalf of the other HHS agencies, there are three funding requests to maintain current operating levels that totals \$25.0 million GR & \$34.4 million All Funds.

- There is a request to maintain funding to support the Department of Information Resource's Data Center (\$20.8 million GR & \$27.9 million All Funds).
- There is also a request totaling \$4.0 million GR & \$6.3 million All Funds to maintain support of the state-supported living centers and state hospitals for frozen food and storage, an inventory system upgrade, replacement of equipment and vehicles for laundry services, and HHSC IT support for upgrading the CARE system at DADS and the CMBS system at DSHS which are exceptional item requests in each of those agencies' requests for FY 2014-15.
- The Texas Office for the Prevention of Developmental Disabilities has requested state funding in lieu of donations to maintain a core staff - \$0.2 million GR & All Funds.

**Critical Services & Improvements**

There are 20 exceptional item funding requests that address critical programs, technology needs, and some program expansions that total \$337.8 million GR & \$836.3 million All Funds. These requests represent programs at HHSC as well as HHS system-wide initiatives.

**Critical Services & System Program Improvements**

- There are two requests associated with programs where the reduction of state funding for the 2012-13 biennium resulted in minimal support for those activities. Exceptional items for the Healthy Marriage program (\$1.2 million GR & All Funds) and the Community Resource Coordination Group Program (\$0.3 million GR & \$0.5 million All Funds) would enable HHSC to continue these programs.
- Two requests would expand Family Violence services (\$2.5 million GR & All Funds) and the Center for the Elimination of Disproportionality and Disparities (\$0.5 million GR & \$0.6 million All Funds) at HHSC.
- The Office of Inspector General has a request of \$18.5 million GR & \$37.6 million All Funds to address fraud in HHS programs with 101 FTEs. This is in additional to a request to the request associated with ACA provisions.
- HHSC has requested \$1.2 million GR & \$1.7 million All Funds to install surveillance & access control systems in 69 local offices to strengthen protection of our employees and clients.
- There is an HHS request to expand the array of services in STAR+Plus and certain long-term care waivers at DADS to provide cognitive therapies to over 700 individuals with an acquired brain injury (\$1.9 million GR & \$4.6 million All Funds).
- HHSC has an exceptional item that would provide a 10 percent salary increase totaling \$28.8 million GR & \$47.5 million All Funds to improve the retention and recruitment of certain health professionals delivering client care in the DADS state-supported living centers and the DSHS state hospitals. This request is in addition to as similar request in each of those agencies for salary increases for medical personnel delivering direct care.

**Critical Information Technology Improvements**

In addition to the request for maintaining Data Center services, there are six exceptional funding requests associated with HHS information technology projects totaling \$29.2 million GR & \$75.0 million All Funds.

- The largest request would launch an HHS effort to increase the security of the communications infrastructure statewide to enable HHS agencies to support a mobile workforce (\$14.1 million GR & \$25.4 million All Funds).
- Continuation of the Enterprise Data Warehouse Initiative that began in the 2008-09 biennium with initial planning and development costs is anticipated to cost \$6.6 million GR & \$35.6 million All Funds in FY 2014-15, assuming federal approval is obtained.
- There is a \$4.4 million GR & \$6.0 million All Funds request for hardware, software and services to implement additional information security controls and data protection at all HHS agencies.
- A funding request for \$2.2 million GR & \$4.0 million All Funds would complete an infrastructure upgrade of the Data Center located in the Winters Office Building

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which would include an emergency generator, chillers, and related circuits and switch gear.

- The remediation of the technology platform supporting the financial systems for the all HHS agencies costs \$1.2 million GR & \$1.6 million All Funds.
- The exceptional request to fund an update of systems at HHSC, DADS, DSHS, & DARS to the 10th generation of international diagnosis coding, known as ICD-10 totals \$0.8 million GR & \$2.3 million All Funds.

#### Medicaid Cost Containments

There are two Medicaid cost containment requests.

- The first request would expand STAR+Plus services into rural areas. STAR+Plus was expanded to South Texas and additional urban counties in March 2012 at a cost of \$15.8 million GR & \$39.0 million All Funds. Premium tax collections estimated at \$4.5 million would partially offset the cost in the 2014-15 biennium.

Accounting for the premium tax collections, savings are anticipated in future years.

- There is an additional Medicaid cost containment exceptional item being submitted with no financial estimates. This proposal would carve-in four months of nursing home services into the STAR+Plus capitated rate.

#### Affordable Care Act (ACA)

There are five exceptional items related to provisions under ACA. Four are system improvements or expansions & one maintains current services. At the time of HHSC's LAR submission, there are still several items that require CMS to provide additional information and guidance before calculating complete costs. Two of the items are being submitted as placeholders. Those placeholder items are the Dual Eligibles Integrated Care Project & the Balancing Incentives Payment Program. The other two exceptional items total \$238.8 million GR & \$626.1 million All Funds.

- The Fraud Integrity Initiative \$9.7 million GR & \$38.4 million All Funds, is part of ACA. The request involves Medicaid operations and the Office of the Inspector General. The method of finance for this item is estimated because the revenue collection associated with the provider enrollment fees it is unknown at this time.

The remaining exceptional item request relates to the increased reimbursement for primary care providers and has two components and totals \$229.1 million GR & \$587.6 million All Funds.

- The first component would apply the mandated primary care rate increase to those same providers reimbursed by CHIP and DSHS programs for the entire 2014-15 biennium at a cost of \$48.0 million GR & \$126.4 million All Funds because these programs base their reimbursements on the Medicaid rates at HHSC.
- The second component is the cost to broaden the increased reimbursement to other primary care providers not mandated in ACA. Providers in Medicaid, CHIP & DSHS programs would receive these increased funding throughout the 2014-15 biennium at a cost of \$181.1 million GR & \$461.3 million All Funds.

#### THE 10 PERCENT REDUCTION SCHEDULE

HHSC took a different approach to this reduction schedule than in previous biennia. HHSC identified \$15.3 million GR & \$32.33 million All Funds in administrative and programmatic savings in an effort to meet our GR reduction target of \$132.3 million for the 2014-15 biennium. Of the administrative GR reductions, \$0.9 million is associated with crediting the 2014-15 for one-time expenses; \$1.4 million is achieved by applying a 10 percent reduction to programs with GR funding and no matching federal funding (the TANF Two-Parent Program, the Umbilical Cord Blood Bank, the Promoting Independence Program, Computers for Learning, Alternatives to Abortion, and Faith-Based Initiatives); and \$11.4 million is associated with savings & efficiencies in Eligibility Services. The balance of \$1.6 million GR are reductions in other administrative areas for travel, contracted IT services, and other operating expenses. A total of 10 FTEs would be reduced.

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To impose the full target on HHSC's programs and staff would dismantle the foundation & support of the successes achieved this biennium and result in the backlogs, delays, and errors of prior years. Additionally HHSC is involved in several major projects to improve the efficient of state programs, including the Medicaid Transformation Waiver, modernizing eligibility services and strengthening the Office of Inspector General. These initiatives require program staff time and that of support staff as well as adequate technology resources. Therefore the balance of HHSC's target reduction, \$117.0 million GR, would equate to a 1.0 percent rate cut to acute Medicaid and CHIP providers in both years of the 2014-15 biennium. Primary care providers subject to the ACA increases would be excluded from the rate reduction.

#### COST ALLOCATION

The methods of finance submitted in HHSC's LAR are based upon a federally-approved cost allocation plan. However, because the data elements supporting the plan may change monthly, the share of federal and state funding represents HHSC's best estimate for these monthly funding shifts.

#### THE FUTURE OF MEDICAID

The FY 2014-15 funding challenges for Medicaid do not get easier. Texas has made significant gains in improving the effectiveness and efficiency of its Medicaid program within the parameters allowed by the U.S. Centers for Medicare and Medicaid. But federal Medicaid reform is needed.

Medicaid already consumes a quarter of our state budget, and it provides health care for one out of every four children in Texas. The current federal funding formula is inherently flawed and forces states to spend more to get more. Moving Medicaid to a block grant program would allow states to develop effective programs that meet their unique needs.

Reform at the federal level must begin with the formula used to determine how much federal funding each state gets for Medicaid. Texas gets 6.8 percent of federal Medicaid dollars but has 10 percent of the nation's residents living below the poverty line. Converting Medicaid to a federal block grant could provide the state with increased flexibility while at the same time achieving federal goals to ensure access to care. Texas could design a program that promotes preventive care and encourages healthy, responsible behaviors instead of rewarding bad ones, such as inappropriate emergency room use. The state could pay providers based on outcomes and results rather than quantity.

HHSC's Council & staff are ready to be a part of this needed reform, but it will take support and involvement from executive, legislative & Congressional bodies to enact the needed reforms.

Hospital funding has become too dependent on a handful of coalition hospitals. This has created challenges in maintaining the Disproportionate Share Program (DSH) which is funded from intergovernmental transfers from state and local public hospitals and allocated to public and private hospitals throughout the state. The Medicaid Transformation Waiver presents public hospitals with a better return on their investment than the DSH program, and it provides greater accountability for public funds. Legislative guidance is needed to help ensure that all our hospitals have continued access to the federal funding needed to serve our neediest citizens.

#### CONCLUSION

HHSC will be submitting the HHS Consolidated Budget in October 2012 which will provide additional details on provider rates and other HHS system-wide funding

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issues and initiatives. The staff of HHSC looks forward to working with you and your staff during the 83rd Legislative Session.

Respectfully submitted,

Thomas M. Suehs  
Executive Commissioner