# INTERIM REPORT
# OF THE
# SENATE FINANCE COMMITTEE

## HEALTH AND HUMAN SERVICES CHARGES

**RECOMMENDATIONS**
**TO THE**
**79TH LEGISLATURE**

**DECEMBER 2004**

# SENATE FINANCE COMMITTEE

78th Legislature

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SENATOR JUDITH ZAFFIRINI, Vice Chair
SENATOR KIP AVERITT
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SENATOR ROYCE WEST
SENATOR JOHN WHITMIRE
SENATOR TOMMY WILLIAMS

December 16, 2004

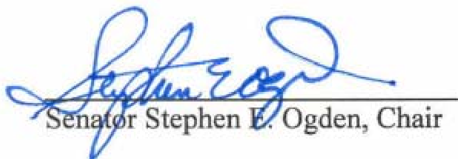
The Honorable David Dewhurst
Lieutenant Governor
State of Texas
Capitol Building, Room 2E.13
Austin, Texas 78701

Dear Governor Dewhurst:

The Senate Finance Committee respectfully submits this report regarding the Committee's Health and Human Services charges to study Major Health-related Caseload and Cost Estimates, Monitor the Implementation of Article II Reorganization, Conduct a Comprehensive Data Review of All Programs in Article II, and Revisit the Rising Health Care Cost Study of the 77th Legislature. We thank you for providing us the opportunity to address these important issues.

The Senate Finance Committee conducted a series of public hearings and received testimony on the aforementioned charges in Austin, Texas on May 24th and 25th, June 7th, and July 19th, 2004. In addition, the Committee created a work group composed of Senator Jane Nelson (chair), Senator Gonzalo Barrientos, Senator Bob Deuell, and Senator Eliot Shapleigh to further study these issues and provide recommendations to the full Committee.

Respectfully submitted,

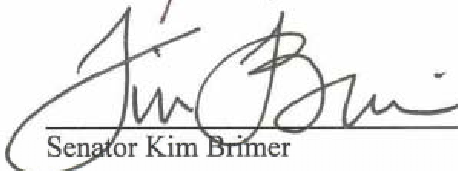


Senator Stephen E. Ogden, Chair

Senator Judith Zaffirini, Vice-Chair

Senator Kip Averitt

Senator Gonzalo Barrientos



Senator Kim Brimer

Senator Bob Deuell

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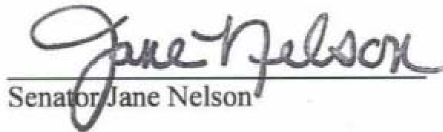
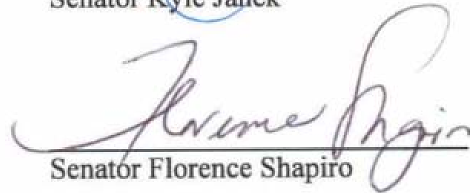
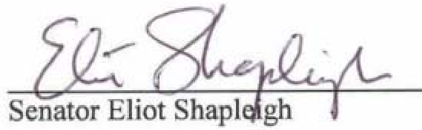
The Honorable David Dewhurst
December 16, 2004
Page 2

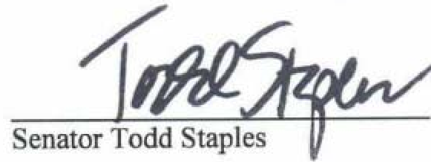
Senator Robert Duncan

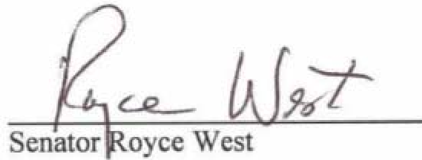
Senator Kyle Janek

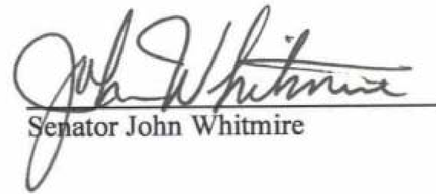

Senator Jane Nelson

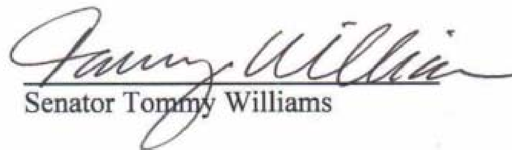

Senator Florence Shapiro


Senator Eliot Shapleigh


Senator Todd Staples


Senator Royce West


Senator John Whitmire


Senator Tommy Williams

# Texas Legislature

December 27, 2004

The Honorable Steve Ogden
Chairman
Senate Finance Committee
Capitol Extension, E1.038

VIA HAND DELIVERY

Dear Chairman Ogden:

Thank you for the opportunity to comment on the Health and Human Services ("HHS") segment of the Senate Finance Committee's Interim Report to the 79th Legislature. Like many other states across the nation, Texas began the 78th Legislative Session facing a severe budget shortfall. Unlike other states, however, we entered this fiscal crisis already near the bottom nationally in health care spending. According to Center for Public Policy Priorities, in 2000, Texas ranked 45th in health care spending per capita and our expectation is that matters have gotten even worse.

In the aftermath of the session, some public officials claimed they had dealt with the budget shortfall in a way that "meets the basic needs of Texans" and had done so without raising taxes. On the contrary, services for many of the most vulnerable Texans have been devastated, major costs have been shifted to local communities, and billions of federal dollars that could have otherwise been drawn down were left unused.

Particularly troubling are the effects of these budget reductions on low-income children. From cuts in Medicaid and CHIP to reduced resources in education, the state budget for 2004-05 shortchanges Texas children and, in doing so, jeopardizes the State's future. Across the state, some people are trying to minimize the extent of CHIP cuts by claiming that more kids than ever are covered by state health insurance. This claim is based on combining CHIP and Children's Medicaid enrollment. It is a misleading statement as CHIP and Children's Medicaid are two distinct programs. As you know, CHIP was designed specifically for children from families with incomes that are too high to qualify for Children's Medicaid. Moreover, Children's Medicaid is a federal entitlement program, and budget cuts passed during the regular session were designed to reduce enrollment growth rather than increase it.

Nevertheless, if you were to look at CHIP and Children's Medicaid enrollment jointly, you would find that combined enrollment in the two programs fell by 19,067 from September 2003 to September 2004. For CHIP alone, recent figures indicate that 171,508 children were cut from the program between September 2003 and December 2004.

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As members of the Senate Finance Committee are aware, a sweeping and ambitious reorganization of our health and human services system is underway. The ongoing consolidation of agencies and streamlining of their business processes has led to the award of multiple private contracts with many more in the works. Given the recent problems in health and human services contracting, we believe current contracts should be carefully monitored and any future decisions about contracting should be subject to legislative scrutiny. The restructuring also includes a new model for eligibility determination and enrollment in social services that proposes to replace the majority of our local eligibility offices with call centers and an Internet application. This model should be fully tested and evaluated prior to its statewide implementation or the award of a contract.

It is imperative that the report provide an impartial look at the impact of cuts made to health and human services as well as an objective evaluation of the status of the reorganization and outsourcing of state jobs and services. We believe that several areas in the of the report lack the information necessary to paint such an objective picture.

Below, please find our comments related to specific recommendations in the report, followed by some general observations and recommended changes.

**Comments on Charge #1**

**Recommendation (b) and (c):** The state should leverage Federally Qualified Health Centers ("FQHCs") as a means to help control health care costs as well as accurately track and serve the Medicaid-eligible population. Efforts to monitor and report on the effectiveness of FQHCs, however, should also include focused coordination with the Office of State-Federal Relations to follow federal financial commitments which have been characterized at times as questionable after the 2006 fiscal cycle.

**Comments on Charge #2**

**Page 26, Paragraph 2:** The Transition Legislative Oversight Committee was indeed created by HB 2292 to have oversight authority over the reorganization of state health and human services agencies. Unfortunately, the committee has played largely a figurehead role thus far in the reorganization and the development of the integrated eligibility initiative. Since its formation, the committee has taken public testimony twice and as a body, has not take any concrete steps to resolve the many concerns and problems raised during the numerous public hearings held by the Health and Human Services Commission ("HHSC") to date (including the 10 public hearings held in conjunction with the implementation of call centers.)

**Page 26, Paragraph 3:** The report indicates that "issues have arisen" regarding the consolidation and the creation of call centers, but does not elaborate upon any of the concerns that have been raised. HHSC has held numerous public hearings on these issues and provided summaries of all the public comment it received. The creation of call centers, in particular, has met with extensive concern and criticism from local governments, the nonprofit and advocacy communities, and various state employee organizations. Accordingly, the report should include a summary of the major concerns and criticisms raised.

**Recommendation (b):** A strong contract is necessary, but not sufficient alone to guarantee the desired outcome. In addition to a strong contracting process, each health and human services agency and the Health and Human Services Commission must have adequate numbers of staff with the requisite skills to monitor and enforce contracts. Prior to signing a contract, the Legislature should explore the impact that the proposed changes (i.e. fewer local offices, new nonprofit role, 211 expansion) will have on clients. This new system should be thoroughly piloted and each component evaluated prior to the award of a large contract or the dismantling of the current network. Any other approach will expose the state (and taxpayers) to increased liability. If the system fails, clients will lose benefits to which they are entitled, lawsuits will be filed as a result, and the State — because it has already dismantled its own infrastructure — could be stuck with a flawed system and contract. In the event a contract is signed, an independent contract monitor should be appointed to evaluate the system as it rolled out, identify potential problems, and recommend solutions.

**Recommendation (c):** This recommendation will only identify decreases in the amount of dollars spent. It will not give us the information we need to answer the critical question, "Are we spending less but getting more in return?" To address this more important question, an in-depth analysis of all changes in FTEs associated with the restructuring should be completed. For example, compare January 2000 FTEs (listing both filled and authorized positions) to September 2003 and September 2004 FTEs. The analysis should also include a breakdown of FTEs by state office, regional office (including the many regional facilities that don't fit the regional office label such as state schools and hospitals), and local level jurisdiction. It appears that regional staff at most health and human services agencies have been reduced by more than half, which will undoubtedly negatively impact service delivery. A regular report on FTE reductions in HHS agencies should be provided to the Transition Legislative Oversight Committee so it can evaluate whether the reduction in force is negatively affecting customer service, service delivery, and administrative performance at each of the various agencies. Lastly, to better understand the value that vendors provide the state, companies who win contracts for outsourced state functions should be required to report quarterly to the Transition Legislative Oversight Committee the number of former state employees that have been hired from any agency which previously provided the same or substantially similar service.

**Recommendation (d):** In addition, HHSC and the Transition Legislative Oversight Committee should monitor caseload changes, the change in the number and rate of denials and the change in the number of complaints. This will help identify potential breaches in customer service or service delivery.

**Recommendations (e) and (f):** Finger imaging and any "Smart Card" or "Universal Benefits Card" (UBC) must be successfully piloted in a small test area – and all major bugs resolved – before any statewide implementation. The current finger imaging pilot has not tested most of the major functional issues related to the finger imaging system and cards.

Localized pilot phases should be mandated before any system is implemented statewide. Additional finger imaging and "Smart Card" pilot phases should include: (1) a pilot including children (unless they are to be exempted from card use), and (2) a pilot phase in which use of the card is mandatory and failure to match fingers results in denial of care. Mandate an independent

evaluation of these pilots before statewide implementation and require legislative oversight and monitoring of any contracts awarded for statewide implementation.

**Recommendation (g) and comments above on Page 26, Paragraph 2:** In order to strengthen the powers and authority of the Transition Legislative Oversight Committee to better oversee the ongoing reorganization of HHS agencies, the committee should be given the authority to review contracts before they are awarded by HHSC as well as the ability to request an independent review of a contract by a third party before an award is made. Additionally, the Legislature should require the committee to hold regular public hearings and accept written and oral testimony at each hearing.

**Comments on Charge #3**

**Recommendations (a) and (b):** While the proposed listing of programs and their waiting lists may be useful, the value of the comparative cost data suggested in Recommendation (b) will depend heavily on whether such a listing adequately details the complexity of the clients served as well as the different mix of services provided under each program. For example, it is well known that community care per capita costs for persons with mental retardation are much higher than for elders at risk of nursing home placement. An over-simplification of that data may result in a comparison of populations and programs that are dissimilar, which will be of limited use.

**Comments on Charge #4**

**Recommendation (c):** There is no harm in promoting long-term care insurance, however, most comprehensive research on the topic suggests that only relatively affluent Americans can afford this coverage. Therefore, this kind of insurance is unlikely to help the majority of elderly Texans who will continue to rely on government sponsored programs such as Medicaid.

**Recommendations (g) – (l):** These are all good recommendations that unfortunately will not be effective without a significant amount of new funding appropriated for caseworkers and other Child Protective Services programs.

**Suggested Corrections to the Report**

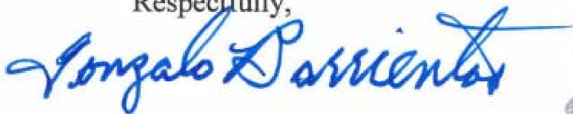
More than once (see paragraph one, p. 3 and paragraph one, p. 13), the report makes it appear as if health and human services spending is growing much more rapidly than other parts of the state budget. Historical data from the annual *Fiscal Size-Up* reports produced by the Legislative Budget Board indicate that spending under Article II over the last decade has grown about as fast as education spending or state spending as a whole. Over the same period, economic development spending has increased at a slightly higher rate than any of these. (Note: The average biennial growth rates from 1994-95 to 2004-05 are: HHS, 10.6%; education, 9.8%; state spending overall, 9.5%; business and economic development: 11.7%).

Bottom of page 18-19: The report estimates that $1 billion in health care is provided to undocumented immigrants and cites a Department of State Health Services county-level report on hospitals' reported uncompensated health care. It is unclear, however, whether the $1 billion estimate referenced in the report represents the total for border counties and if so, whether or not that figure assumes only undocumented people are being served in those counties. Overall, the methodology for extrapolating the $1 billion should be supported with further explanation.

Page 32: For the Teachers Retirement System, the chart does not mention one of the largest health care cuts (the reduction of the $1,000 "pass through" for local school district employees) made in the 2004-05 budget. Paragraph one on the following page of the report refers generally to the reduction in benefits, but does not attribute them specifically to school district employees and/or public school teachers.

Thank you once again for the opportunity to provide our thoughts and recommendations on the Health and Human Services segment of the Interim Report to the 79th Legislature. We respectfully request that you include this letter as an addendum to the report adopted in committee on December 16, 2004.

Respectfully,



Senator Gonzalo Barrientos　　Senator Eliot Shapleigh　　Senator Judith Zaffirini

GB/rd
ES/eh/av

# The Senate of the State of Texas

COMMITTEES:
Finance
Veterans Affairs & Military Installations
Subcommittee on Base Realignment and Closure - Chair
International Relations and Trade - Vice Chair
Infrastructure Development and Security

**Senator Eliot Shapleigh**
District 29

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December 27, 2004

The Honorable Steve Ogden
Chairman
Senate Finance Committee
Capitol Extension, E1.038

VIA HAND DELIVERY

Dear Chairman Ogden:

As the Texas Legislature starts the 79th Session, we believe that the Senate Finance Committee owes the people of Texas an objective view of current conditions in our great state. Texas is blessed with a young, talented, hardworking, and growing population. But unless we as leaders of this great state make the necessary and critical investment in the education, health and safety of our people, we will leave a legacy of the first generation in Texas history to be less prosperous than the one before. We believe that this interim report fails to deliver an accurate assessment of what is happening to our Texas.

As former Governor Bush once said, 'let us deal with issues now and not pass them on to another generation.' Leadership means that we must act now to preserve the life, liberty and pursuit of happiness of all whom we serve. When former Department of Family and Protective Services Director Thomas Chapmond admits to us that he failed to tell the truth about the needs of Texas children in protective services because he feared for his job, we must never again fail to ask the questions to get to that truth. Moreover, we must never fail in our responsibility to future Texans to deal honestly and courageously with the challenges that the truth presents. We ask that you include the sober reality that we present with this letter and include these comments in the Senate Finance Committee Interim Report to the 79th Legislature.

Like many other states across the nation, Texas began the 78th Legislative Session facing a severe budget shortfall. Unlike other states, however, we entered this fiscal crisis already near the bottom nationally in spending. In 2003, Texas ranked 49th in state spending per capita, with average state government spending nationwide 46 percent higher than in Texas. Texas' record is reflected in the following chart, *Texas on the Brink*, which shows Texas facts, and ranking among the 50 states. In life, in business, in government, you get what you pay for.

**Texas on the Brink**
(1st = Highest, 50th = Lowest)

| | |
|---|---|
| Total General Expenditures | 49th |
| *Per Capita Spending in:* | |
| Public Education - State Aid Per Pupil | 39th |
| Public Health | 45th |
| Mental Health | 46th |
| Public Welfare | 47th |
| Parks and Recreation | 48th |
| Environmental Protection | 46th |
| *Education Facts* | |
| High School Completion Rate | 50th |
| Public Education - Average Teacher Salary | 32nd |
| State Government Spending in Higher Education | 34th |

While California has six public universities ranked in the top 50 nationwide,
Texas has only one, the University of Texas at Austin , ranked at number 47.

| | |
|---|---|
| *Health Facts* | |
| Percentage of Uninsured Low-income Children | 1st |
| Percentage of Population Without Health Insurance | 1st |
| Number of People covered by Employer-based Health Insurance | 45th |
| Prevalence of Infectious Diseases | 43rd |

*Public Welfare Facts*
More than 500 children have died of child abuse and neglect over the past 2 1/2 years in Texas.
Child Protective Service (CPS) workers in Texas have 68 cases per caseworker; the national average is 18.
Adult Protective Service Workers in Texas have 72 cases per caseworker; the recommended average is 25.
The Texas Department of Protective and Regulatory Services estimated that in 2002, 297 children were placed into CPS custody as a last resort for mental health services.

| *Environmental Facts* | *National Ranking* |
|---|---|
| Per Capita Spending on Water Quality | 49th |
| Amount of Toxic and Cancerous Manufacturing Emissions | 1st |
| Number of Clean Water Permit Violations | 1st |

In the aftermath of the session, some public officials claimed that they had dealt with the budget shortfall in a way that "meets the basic needs of Texans," and had done so without raising taxes. In reality, public education has been under-funded for years, services for many of the most vulnerable Texans have been devastated, and research cuts to Texas universities and health science centers threaten to make them noncompetitive. Major costs have been shifted to local communities and taxpayers, middle class students are now paying $263 million in new tuition, and billions of federal dollars that would otherwise come to our state stayed in Washington D.C.

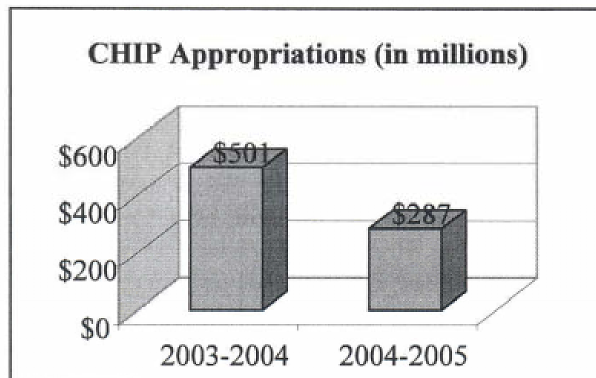
Particularly troubling are the effects of these budget reductions on middle and low-income individuals, especially children. Funding for state supported public and higher education, key health programs, child and adult protective services, nursing home and hospice

care, community care, university teaching hospitals, state and local district employee insurance coverage, and adult and youth inmates, has been cut by:

- reducing income guidelines and eliminating participation;
- making it more difficult for people to become eligible (or remain eligible) for services;
- eliminating benefits that were previously available; and
- reducing payments to health care providers who are serving those who are eligible.

From cuts in Medicaid and CHIP to reduced resources for education, the state budget for 2004-05 shortchanges our children and, in doing so, jeopardizes the state's future. Across the state, some people are trying to distort CHIP cuts by claiming that more kids than ever are covered by state health insurance. This claim is based on combining CHIP and children's Medicaid enrollment. It is a misleading statement as CHIP and children's Medicaid are two distinct programs. As you know, CHIP was designed specifically for children from families with incomes that are too high to qualify for Children's Medicaid. Moreover, Children's Medicaid is a federal entitlement program and budget cuts passed during the regular session were designed not to increase its enrollment growth, but to reduce it.

The chart *CHIP Appropriations* shows that CHIP was appropriated $287 million for the 2004-2005 biennium, representing a 43 percent reduction from what the program spent during the previous year ($501 million). The program also now carries stricter eligibility policies and offers fewer benefits. Furthermore, CHIP has higher co-pays and premiums, and makes beneficiaries wait 90 days before the policy takes effect.

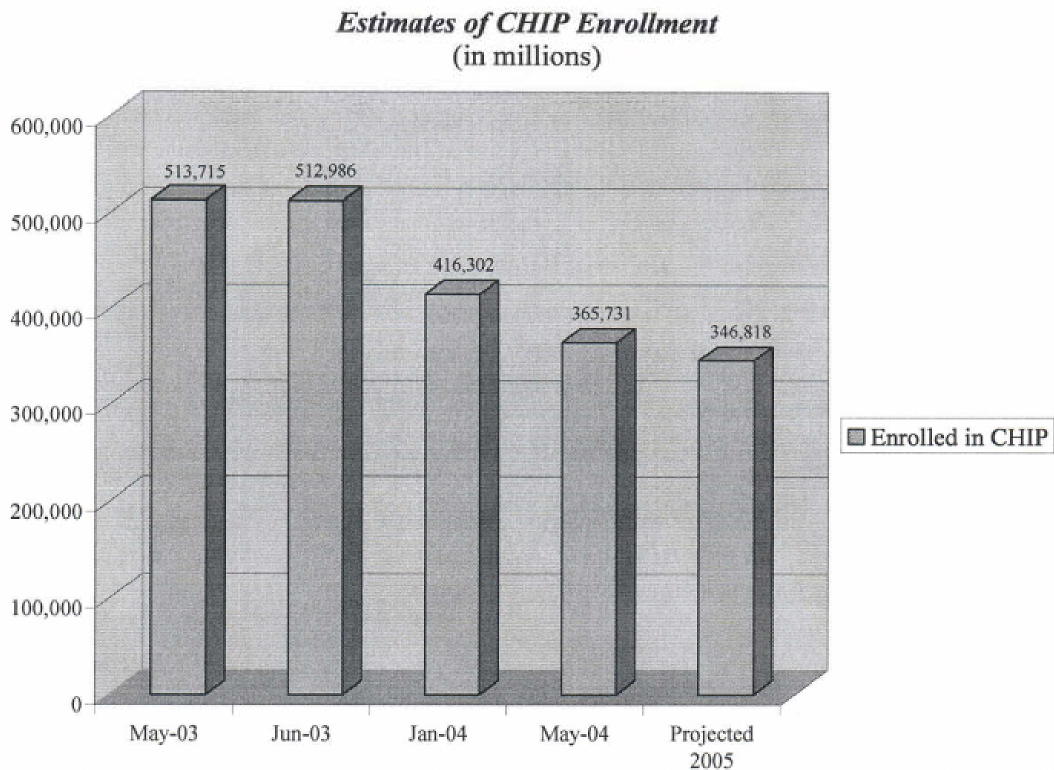



These burdensome eligibility requirements are projected to decrease the number of children enrolled in the program by 30 percent by the year 2005. The 30 percent reduction translates to more than 169,000 Texas children being dropped from the program. To illustrate how dramatic a reduction this is, consider that Texas had 507,259 children enrolled in the CHIP program as of September 1, 2003. A month later, when the new eligibility standards took effect, the number of children enrolled had already dipped to 488,690. These inhumane cuts were made despite Texas already ranking 50th in the percentage of children who have health insurance.

Nevertheless, even if you were to look at CHIP and Children's Medicaid together, you would find that combined enrollment in the two programs fell by 19,067 from September 2003 to September 2004. For CHIP alone, the latest figures indicate that 171,508 children have been cut from the program as of December 2004.

The chart *Estimates of CHIP Enrollment* illustrates the dramatic difference the new eligibility requirements have had and will continue to have on the number of Texas children enrolled in CHIP. The projections were made using estimates from the Health and Human Services Commission (HHSC).

***Estimates of CHIP Enrollment***
(in millions)




Source: Health and Human Services Commission

Medicaid also took a severe hit during the 78th Legislative Session. Funding for the 2004-2005 biennium rose a meager 3.8 percent, and new eligibility standards and enrollment procedures will have far-reaching ramifications that will leave many citizens out in the proverbial cold, with no benefits. For 2003, approximately 2.5 million Texans, including 1.6 million children, received Medicaid acute care services on a monthly basis. By 2005, this number is expected to shrink by 4,000. If these cuts had not been made, 350,000 additional Texas children and adults would have been covered by Medicaid. Although some health care programs did received more funding in 2004-2005 than in 2002-2003, this increase did not keep

up with rapidly increasing health care costs, which are rising at a rate of more than 10 percent annually.

In the area of mental health, there is a great strain on families and communities due to the inability of the public mental health care system to serve those at risk. The economic downturn, unemployment, and threats to homeland security have only exacerbated the gap between need and availability of mental health services.. Texas' harsh treatment of its most vulnerable citizens deserves immediate attention. In testimony to the Senate Health and Human Services Committee in February 2002, the Commissioner of the former Department of Mental Health and Mental Retardation testified that of the 658,000 Texas children that are in need of mental health services, only 39,000 were actually receiving services. When they cannot get their children the care they so desperately need, mothers and fathers are increasingly terminating their parental rights so that their children may enter the juvenile justice system and receive mental health services there.

As we all know, lack of adequate coverage for mental health treatment leads to desperate choices. Without proper intervention, children's mental health issues often lead to far worse problems later, including involvement in the juvenile justice system. An estimated 50 percent of youth in the Texas Youth Commission (TYC) have a psychiatric disorder. Webb and Val Verde County have higher rates of TYC commitment than the state as a whole. In fact, their commitment rates exceed all Texas counties but Lubbock. In 2002, the Department of Protective and Regulatory Services reports that parents had to relinquish the custody of 244 children because they were unable to access mental health care.

Other health and human services programs also were reduced through stricter eligibility requirements. Temporary Assistance for Needy Families (TANF) provides cash assistance on a monthly basis for poor Texas families with children under the age of 18. A family of three (mother and two children) may qualify for TANF assistance if their gross income is below $784 a month and their assets are valued at less than $1,000. Three-quarters of the people who have lost their benefits because of these new policies are children. On September 1, 2003, more than 71,000 people, including 51,903 children (74%), lost their benefits because of the new full-family sanction policy, and 17,659 of these adults also lost their Medicaid benefits. From fiscal 2003 to fiscal 2004, TANF caseloads dropped by 25 percent, with 94,000 fewer individuals receiving TANF in 2004 than in 2003.

The cuts also wiped out coverage for such basic necessities as eyeglasses and hearing aids for adults on Medicaid. It also eliminated coverage for elderly, disabled and adult TANF recipients seeking help in such high-demand areas as social work, marriage and family therapy, podiatric and chiropractic care, psychological counseling, and licensed professional counselors. Further, the state chose not to maximize its federal matching dollars requested by the Health and Human Services Commission, leaving approximately $1.6 billion in federal Medicaid and CHIP funds "on the table" that could have gone toward providing health care to Texans.

In the areas of adult and child protective services the cuts enacted during the last legislative session had devastating consequences as well. In April 2004, the Health and Human

Services Commission (HHSC) issued a report on Adult Protective Services that included the following findings:

- In 2003, there were 44,694 confirmed cases of abuse/neglect. The report released by HHSC stated that 35 percent of APS investigations were insufficient.
- No steps were taken to address a client's mental illness in 44 percent of the cases involving mental illness.
- 30 percent of the cases resulted in an incomplete service plan, and severe cases often didn't lead to increased contacts with clients.
- HHSC's deputy commissioner Gregg Phillips was quoted in May of 2004 as saying □No piece of Adult Protective Services appears to be working properly.□

The root cause of these problems is inadequate state funding for APS. On July 26, 2004, the Austin American-Statesmen reported that:

- The average caseload in Texas is 48, although the national recommendation is 12 to 18 cases.
- Texas spends only $7.04 on adult protection for every elderly or disabled resident.
- The turnover rate for caseworkers is 16.5 percent.

Funding is so inadequate it could be argued that the agency is prevented from providing basic services required under federal and state law.

In CPS, the results of the budget cuts were equally disastrous. More than 500 children have died of child abuse and neglect over the past 18 months. At least 137 of those cases were investigated by CPS, which is failing to take appropriate action 66.6 percent of the time, according to the Inspector General.

During Senate Finance committee hearings in the last legislative session, and again during this interim, we had a serious discussion about the extraordinary worker turnover in child protective services (CPS) and adult protective services (APS), the high caseloads and inadequate funding. Despite these discussions and the fatal impact a poorly funded system has had on our most vulnerable citizens; state agencies were asked by the leadership to submit a budget with a five percent reduction.

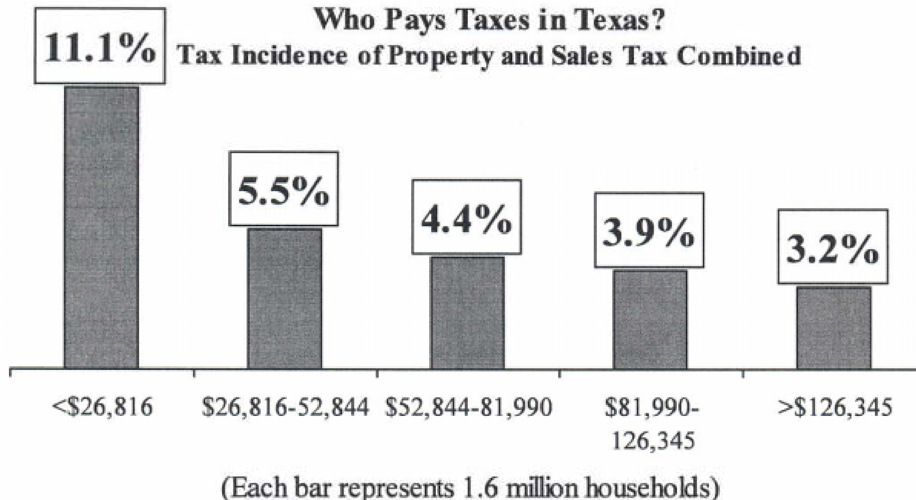
In sum, the budget cuts and reductions will cost the state and local jurisdictions millions of dollars in unnecessary emergency care that could have been prevented. Balancing the budget on the backs of kids and people who need them the most contradicts government's mission.

Medicaid and CHIP are social insurance programs designed to protect our most vulnerable citizens. By cutting these services, we are forcing more and more Texans to fend for themselves and exposing them to a greater risk of chronic or debilitating illness, or even premature death. Further, costs shifted to the local level are only passed on to taxpayers through increased local taxes. This is neither a recipe for a healthy populace or a vibrant economy.

In the end, you get what you pay for. As long as Texas is dead last in the amount of state revenue raised and services offered, we will also be dead last in results. In the area of public education, as in any almost every other single area, unless we adequately fund the system, Texas will continue to rank in the bottom half of the nation on key performance measures: 32nd in teachers' salaries, 41st in state aid per pupil, 48th in average SAT scores, and 50th, or dead last in high school graduates. Not only does this place our state on the margins of the new knowledge-based economy, but companies will not locate in a state where students do not graduate from high school or perform well on the SAT. If we don't improve current education outcomes in Texas, the state demographer predicts that Texas household incomes will decline $5,000 by the year 2030. Is that the legacy that we want to leave for our children?

Texas' "low-tax, low-service ideology" denies opportunity, lowers standards for quality education, and denies access to health care for millions of low and middle-income Texans, especially Hispanics, who will compromise the majority of the Texas population by 2025.

The state's rankings are the expected outcome of an inadequate, outdated and regressive tax system. Currently, Texas ranks 49th in the nation on tax revenue raised. Texas achieves this dubious ranking by taxing those least able to pay the most. With CHIP cuts, Medicaid reimbursement cuts, teacher health cuts, new tolls on existing highways, traffic fines and tuition hikes, last session marked a huge shift to even more excessive and remarkably regressive local fees, fines and tax hikes. The chart *Who Pays Taxes in Texas?* illustrates who really pays taxes in Texas when local and state tax revenues are combined.




Source: Comptroller of Public Accounts, *Tax Exemptions & Tax Incidence*, Jan. 2003. (http://window.state.tx.us/taxinfo/incidence03/), calculations by Center for Public Policy Priorities.

Today, our state is at a crossroads. Many believe that last session marked the passage from compassionate conservatism to just plain old mean spirit. We as leaders in our great state must demand and establish a government that invests in her people and her future. We must

establish a public school system that truly educates our children, pays good teachers and funds great schools. We must restore CHIP and Medicaid services to 160,000 Texas children and needy adults, who now go without health care and end up in emergency rooms across this great state. Last session, Texas leaders cut $322 million in inheritance taxes to millionaires and made up the difference with $263 million in tuition hikes to students. If our great state is to succeed, we must make responsible choices and put 500,000 more Texas students into higher education, and not saddle them with more debt.

Now is the time for our government and leaders who care for our young, our sick, our elderly and our poor to act. Texas cannot prosper under an ideology where tax cuts are more important than Texans. Unless our state and her leaders make a commitment to invest in our future, we will reap the consequences of an uneducated state, whose people are treated to third world services, and leave a legacy of the first generation in our great state's history that is less prosperous than the last.

Mr. Chair, we stand ready with you to invest in our future.

Very truly yours,

Eliot Shapleigh　　　　Gonzalo Barrientos

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# Report on the Health

# and

# Human Services Charges

# TABLE OF CONTENTS

Executive Summary………………………………………………………………… 2

Summary of Recommendations for the 79th Legislature…………………………...... 4

Procedural Background…………………………………………….………………..7

Background……………………………………………………….……….…...…..9

Charge 1 - Major Health-Related Caseload and Cost Estimates……………….……. 13

Charge 2 - Monitor Implementation of Article II Reorganization…………………... 17

Charge 3 - Conduct Comprehensive Data Review of All Programs in Article II…… 23

Charge 4 - Revisit Rising Health Care Cost Study of the 77th Legislature…………. 24

Appendices ……..………………………………………………………………. 33

A. HHSC - Program Descriptions………………………………..… 33
B. DARS - Program Overview…………………………………..… 91
C. DADS - Program Overview…………………………………… 113
D. DFPS - Presentation to the Senate Finance Committee……….. 183
E. DSHS - Program Overview…………………………………..… 258
F. Updated Prescription Drug Data…………………………..…… 318

## EXECUTIVE SUMMARY

Health and human service expenditures are a large and rapidly-growing aspect of the Texas state budget. According to the Legislative Budget Board (LBB), All Funds appropriated to agencies of health and human services (HHS) in Fiscal Year 2004 - 05 biennium total just over $39.76 billion, or approximately 33.6 percent of all state appropriations. In discretionary General Revenue, $15.57 billion was appropriated to HHS agencies in the current biennium.[1] Recent information reported by the Health and Human Services Commission (HHSC) show projected expenditures for FY 04-05 to reach $15.92 billion in General Revenue and $43.6 billion in All Funds.[2] This is a 9.7 percent increase in total All Funds expenditures above appropriated amounts. In comparison, the All Fund totals for HHS agencies in FY 1994 - 95 totaled approximately $23.45 billion; however this still represents approximately 33 percent of the state's total budget of $70.79 billion All Funds even at that time.[3] Health care and its associated expenses are among the largest drivers in our biennial state budget.

Additionally, health and human service agencies are undergoing perhaps the largest transformation in our state's history. House Bill 2292, 78th Legislature, Regular Session, 2003, consolidated twelve existing HHS agencies into four departments overseen by the Health and Human Services Commission. Consolidation of all agencies is largely complete and is designed to streamline and integrate service delivery while eliminating duplicative administrative costs. As the key goal of HB 2292 is to improve client services

[1] Legislative Budget Board, Fiscal Size-Up, Texas State Services (2004-05), at pp. 4-5.
[2] *Texas Health and Human Services Commission First Submitted Consolidated Budget Fiscal Years 2006-2007, at p. 19.*
[3] FY 1994 - 95 General Appropriations Act, 73rd Legislature, Regular Session, at p. II-95. Article II, in FY 1994 - 95, also included approximately $200 million for the Texas Youth Commission.

in a more efficient environment, the Commission's success in achieving this will have to be carefully monitored as implementation continues.

Health care costs do not only affect funding for HHS agencies. The Teacher Retirement System (TRS), the Employees Retirement System (ERS), the University of Texas and Texas A&M Systems, and the Texas Department of Criminal Justice have all experienced large increases in the utilization and price of health care in recent years. Since 1998, the state's share of the Uniform Group Insurance Program, administered by ERS for state employees, has grown by almost $420 million, or about 60 percent.[4]

The Senate Finance Committee was given four specific charges related to health and human services and health care cost related issues on which to examine and report. They include:

- Charge #1: Major Health-Related Caseload and Cost Estimates
- Charge #2: Monitor Implementation of Article II Reorganization
- Charge #3: Conduct Comprehensive Data Review of All Programs in Article II
- Charge #4: Revisit Rising Health Care Cost Study of the 77th Legislature

This report addresses each of the above-referenced charges and includes recommendations where improvements can be made. Additionally, appendices are attached to provide further data when necessary.

[4] Senate Finance Subcommittee on Rising Medical Costs, Interim Report, January, 2003, at p. 31.

## Summary of Recommendations for the 79th Legislature

**Charge #1:** Major Health-Related Caseload and Cost Estimates

a. Continue to refine caseload and cost estimates within HHS agencies through the coordination of resources between the various HHS departments and the expertise and staff of HHSC.

b. Continue to implement and expand the use of Federally Qualified Health Centers as a method of controlling health care costs, Medicaid expenditures, and identifying clients eligible for Medicaid services so that more accurate caseload estimates may be used for appropriation purposes.

c. Require HHSC to track and report on the effectiveness of FQHCs in serving currently unmet health care needs and Medicaid clients, including how much is expended on Medicaid clients and the number of clients served.

**Charge #2:** Monitor Implementation of Article II Reorganization

a. If the 2-1-1 Information & Referral system is to serve as the gateway to health and human service programs, consider enhancing the state and local partnership to expand the 2-1-1 infrastructure.

b. In the event the state decides to outsource certain functions to private companies, contract negotiations should clearly set forth the private company's responsibilities, penalties for non-compliance, mechanisms for identifying failures to fulfill obligations, remedies that compel compliance, and remedies available for clients and the state.

c. Continue to monitor reductions in expenditures and generated savings with HHS administrative restructuring, including reductions in FTEs. This estimate should be separate from those savings achieved through benefit changes.

d. Provide performance measures aimed at maximizing efficiencies in delivering client services. These could vary by agency, but could focus on time to first benefit, satisfaction with outcome, etc. One example might be the percentage of clients in a given program who receive follow-up or first contact from a trained caseworker within a given time.

e. The Legislature should consider authorization and appropriate approval mechanisms for HHSC to expand the use of front-end fraud reduction methods statewide only if indicated as successful by the results of an assessment of the Medicaid Integrity Pilot. This might prevent much of the work that must be done on the back-end to detect fraud after it has already occurred.

f. Provide authorization for HHSC to assess the feasibility and cost-effectiveness of using a Universal Services Card or another method of consolidating recipient identification

and benefits issuance to replace multiple forms and cards used by various HHS programs. Such a change could make the HHS system more convenient for clients and prevent the need to produce multiple, often complex, forms.

g. Strengthen the powers and authority of the Transition Legislative Oversight Committee to oversee the ongoing reorganization of HHS agencies.

**Charge #3:** Comprehensive Data Review of All Programs in Article II

a. Require the HHSC to provide and update on an annual basis, a uniform and complete listing of HHS programs that includes which agencies offer which programs, contact information, historical expenditures, total program budget, average cost per client, description of average client, numbers served and waiting/interest list size. Such a list should be made available by electronic means to reduce costs. Hard copies could be produced upon request for members of the Legislature or for a small fee to the public to cover printing/copy costs.

b. Require the HHSC to work with each department and interested parties to develop a basic guideline for cost per client based on acuity, available providers, geographic area, etc. in those programs providing long-term services to individuals. These guidelines would not be used to determine actual appropriations, but rather to identify programs with similar clients that are unduly costly or inefficient.

**Charge #4:** Revisit Rising Health Care Cost Study of the 77th Legislature

a. Continue to explore methods of reducing pharmaceutical costs among state-financed health care programs, possibly through the continued use of bulk purchasing and treatment plans developed in conjunction with provider groups and other interested parties.

b. Provide incentives for exercise classes and other preventive health programs that reduce the risk of obesity and other diseases in persons insured through the state that would possibly require future prescription medication and other medical care.

c. Require the appropriate state agencies to explore methods of increasing the market penetration of long-term care insurance in an effort to encourage prudent planning for long-term care needs, thus decreasing reliance on Medicaid long-term care services now and in the future, and protecting the assets of seniors who would otherwise become indigent long-term care clients.

d. Require each agency administering a state health insurance program to provide to legislative leadership and the appropriate committees at the beginning of each legislative session a comprehensive list of options to reduce health care costs and to provide care in the most cost-effective and efficient manner possible.

e. Continue to implement and expand the use of Federally/Qualified Health Centers as a method of reducing local health care costs and, possibly, Medicaid expenditures. This recommendation and background was outlined under Charge 1d.

f. Reduce financial barriers to the adoption of special needs children by increasing the monthly adoption subsidy ceiling from $545 to $700 for those in the moderate service level and from $545 to $900 for those in the intense service level.

g. In keeping with the new initiative Congregations Helping in Love & Devotion (CHILD), created by the 78th Legislature, continue to recruit foster care families in churches and other faith based organizations to increase the number of qualified foster parents.

h. Establish LBB performance measures for foster family recruitment and retention to motivate CPS and private agencies to make this a priority.

i. Provide financial support for kinship care providers who do not want to and/or cannot become licensed foster homes. Last session, the Legislature appropriated $250,000 for a pilot project in one region of the state to provide a $1,000 one-time payment plus day care, counseling, and other support services to relatives. Expanding the pilot program may enable more kin-placements, resulting in significant cost savings to the state.

j. Restore funding and provide additional funding for early intervention services, including additional risk assessment training for CPS investigators so they can catch abuse before it escalates to the point of necessitating traumatic and costly removal.

k. Increase funding to address waiting lists for family-based services such as counseling and parenting classes.

l. Create an automated system to track openings in foster homes, emergency shelters, and residential treatment centers. Added efficiencies in the system can ultimately lead to better protection of children, as well as cost avoidance for the state.

m. Investigate the need for further law enforcement involvement in child and adult protective cases where a parent, guardian, or care provider chooses not to cooperate with agency personnel. Such involvement may decrease the need for serious and costly care in the future and improve the quality of life for abused children and adults.

n. Continue to develop new accelerated and alternate degree programs to speed up the graduation of nurses and to help attract students from underrepresented groups to the profession.

o. Establish further incentives, such as loan repayment programs and financial aid, for undergraduate and graduate nursing students who are interested in careers in nursing education.

p. Set statewide goals for increasing the number of initial RN licensure graduates and identify funding required to meet those goals, especially for nursing faculty.

q. Extend the expiration date for redirecting the Tobacco Settlement Funds under the Nursing, Allied Health and Other Health-Related Education Grant Program to nursing from August 2007 to August 2011.

r. Employ part-time faculty to help masters-level nurses remain in clinical practice and retain their licenses.

s. Support initiatives that promote supportive workplace environments for nursing personnel, such as offering flexible schedules for beginning nurses and creating mentor roles for experienced nurses.

t. Increase nursing faculty salaries at community and four-year programs to be more competitive with nurse practice salaries.

u. Encourage colleges to allow nursing departments greater flexibility in faculty compensation packages.

v. If proven necessary by other interim studies regarding Graduate Medical Education, provide a portion of health science center formula resources to the education of resident physicians.

w. Encourage experienced physicians to serve as mentors for resident physicians to augment the training received as part of their actual residency.

## PROCEDURAL BACKGROUND

The Senate Finance Committee (the committee) was charged with conducting a thorough and detailed study of the following issues and preparing recommendations to address problems or issues that are identified. The Senate Finance Committee met in accordance with the following Health and Human Services interim charges as follows:

> **Major Health-related Caseload and Cost Estimates.** Study the sources of and means by which state agencies track and report on budget-driving caseload and health care cost increases submitted to the Legislature. Make recommendations for improvement, as needed.

The Committee met pursuant to the aforementioned interim charge in a public hearing in Austin, Texas, on July 19, 2004, to consider invited testimony provided by the Texas Health and Human Services Commission.

> **Monitor Implementation of Article II Reorganization.** Monitor the budget elements of the Health and Human Services Commission reorganization. Coordinate work with the Legislative Oversight Committee and the Senate Committee on Health & Human Services.

The Committee met pursuant to the aforementioned interim charge in a joint public hearing with the Senate Health and Human Services Committee in Austin, Texas, on May 24, 2004, to consider invited testimony provided by the Texas Health and Human Services Commission and the Texas Department of Health.

> **Conduct Comprehensive Data Review of All Programs in Article II.** Develop comprehensive tables of information on programs at each agency that convey historical information about method of finance, appropriations, program description, performance highlights, number of FTEs, and date of last audit in a manner that is conducive to the Legislature's decision-making.

The Committee met pursuant to the aforementioned interim charge in a public hearing in Austin, Texas, on May 25, 2004, to consider invited testimony provided by the Texas Department of Health, the Texas Department of Family and Protective Services, the Texas Department of Mental Health and Mental Retardation, the Texas Department of Assistive and Rehabilitative Services, the Texas Department of Aging and Disability Services, and the Texas Department of State Health Services.

> **Revisit Rising Health Care Cost Study of the 77th Legislature.** Review the cost study and determine which cost elements of the study have not been controlled and make recommendations to the 79th Legislature to address bringing them under control. Examine the budget impact of policy decisions of the 78th Legislature and make recommendations for improvement.

The Committee met pursuant to the aforementioned interim charge in a joint public hearing with the Senate State Affairs Committee in Austin, Texas, on June 7, 2004, to

consider invited testimony provided by the Texas Employees Retirement System, the Texas Teacher Retirement System, Texas Correctional Managed Health Care, the Texas A&M University System, and the University of Texas System

The Committee also met pursuant to the aforementioned interim charge in a public hearing in Austin, Texas, on July 19, 2004, to consider invited testimony provided by the Texas Health and Human Services Commission.

The Committee solicited public testimony on all of the interim charges listed above in a public hearing in Austin, Texas, on July 20, 2004; however, none was provided.

The Committee extends its thanks to those who participated in the hearings, and assisted with or made presentations before the Committee.

## BACKGROUND

Growth in spending for HHS agencies has risen steadily in recent years, despite cutbacks in many areas during the 78th Regular Session. While grants for Temporary Assistance for Needy Families (TANF) peaked in the middle 1990s, largely because of federal and state welfare reform, costs associated with items such as Medicaid, children's protective services, mental health and retardation, and programs for other disabled Texans have, in some cases, grown at double-digit rates.

According to the HHSC, Medicaid caseloads are forecasted to grow over 60 percent from 1,785,693 recipient months in FY 2000 to 2,925,447 in FY 2005.[5] Child risk groups and pregnant women are continuing to make up a higher proportion of the Medicaid population as time progresses. However, the Aged and Medicare related and the Blind and

[5] *Texas Health and Human Services System First Submitted Consolidated Budget, Fiscal years 2006 -2007 at p. 8.* Also, Health and Human Services Commission, Presentation to Senate Finance Committee, July 19, 2004, at p. 6.

Disabled make up just 20 percent of the total Medicaid population, but assume almost 60 percent of total expenditures. Even more enlightening is data related to the state's Medicaid Vendor Drug Program. In FY 2000, 26,245,401 prescriptions were filled at an average cost of $42.79 per prescription. In 2005, those numbers are expected to reach 39,646,427 and $64.21 respectively.[6] This reflects a 50 percent increase in average cost and in the number of prescriptions since FY 2000.

Rising pharmaceutical costs have triggered significant cost increases in almost all areas of HHS and state health insurance services. The above Medicaid statistics point to the role of utilization and not just cost in increased drug expenditures.

As important as prescription drugs are to rising health care costs, other areas, such as in-and out-patient hospital expenses, physician payments, and rising physical medicine expenses, such as chiropractor costs, have also contributed to increasing costs.

Finally, the state has certain obligations to some needy Texans that do not fall under the usual definition of health coverage. For example, reports from the new Department of Family and Protective Services (DFPS) indicate that utilization caseloads for foster care have increased from 12,033 to 16,982 since FY 2000. Appropriations for foster care during that same time have risen from $230.87 million to $359.03 million.[7] This is a 55 percent increase in total funding.

Additionally, despite appropriations that have risen over the past five years for basic Child (CPS) and Adult Protective Services (APS), reports continue regarding

[6] Health and Human Services Commission, Presentation to the Senate Finance Committee, July 19, 2004, at p 9.
[7] Presentation to the Senate Finance Committee, Department of Family and Protective Services, May 24 - 25, 2004, at pp. 34-35.

grievous cases of abuse in both programs.[8] CPS data indicates that more than 500 Texas children have died of abuse and neglect in the past two and one-half years. According to CPS, 78,475 children suffer from abuse and neglect each year. Addressing these issues is likely to be a top priority in both the Senate and House of Representatives during the 79th Legislative Session.

HHSC has released a portion of an extraordinary review of CPS/APS services which will likely serve as a valuable resource effecting change to Texas' current CPS and APS systems Preliminary information from review of these programs indicate significant problems with our current systems including overburdened and insufficiently trained caseworkers. Adult abuse cases, such as those found in El Paso and Tarrant County, and child abuse cases, like the recent death of a young boy in Dallas, are tragedies that must be addressed by the DFPS and the state.

Mental health and mental retardation services are separated under HB 2292, but an examination of costs in those programs also reflect increases in caseloads and cost. State schools, now numbering 11, have experienced increasing acuity over the years because of efforts to move less disabled individuals out of state school settings. New generation medications have prompted significant increases in available mental health therapies, while also increasing pharmaceutical costs.

Consolidation of HHS agencies, because of its unique nature, has been forced to occur in a staged process, taking into account public needs, complexity, and the size and nature of each agency. On December 29, 2003, HHSC announced its commissioner appointments for the four HHS departments.

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[8] Ibid. at pp. 27 and 46.

The first agency consolidation, that of the Department of Family and Protective Services (DFPS), occurred on February 2, 2004. The Department of Assistive and Rehabilitative Services (DARS) was soon to follow, consolidating on March 1, 2004. The Departments of State Health Services (DSHS) and Aging and Disability Services (DADS) consolidated operations on September 1, 2004.[9]

HHS consolidation has brought about a number of issues regarding improved access to services, the role of government versus parents in providing health coverage for their children, and the use of centralized call centers and newer technology for initial application and eligibility determination. The lessons learned through this process should help guide the Legislature in making informed decisions regarding future policies. While the consolidation of HHS agencies is only one charge under this Committee's review, its effects will reach well into every other charge, be it caseload forecasting, available programs, or expected health-related costs.

Although HHSC-related agencies are the largest providers of health services in the state budget, medical cost and caseload factors also have an enormous impact on agencies such as ERS, TRS, the UT and A&M Systems, and correctional managed health care (TDCJ). In almost all of these agencies, double-digit increases are anticipated in basic medical costs and prescription drug expenses. ERS and TRS have testified before numerous legislative committees to the need for additional health-related resources in recent months.

[9] Health and Human Services Website, HHS Transformation, Frequently Asked Questions. Available: http://www.hhsc.state.tx.us/Consolidation/Consl_FAQ.html.

## CHARGE 1
## MAJOR HEALTH-RELATED CASELOAD AND COST ESTIMATES

### BACKGROUND

Health and human service caseloads and their accompanying cost estimates drive a significant portion of the state budget. Over $39.76 billion in All Funds was appropriated for such agencies during the last regular session.[10] In discretionary General Revenue, the state is expected to spend over $15.92 billion in the current biennium on healthcare-related items.[11] Medicaid, at $11.3 billion in General Revenue and $29.4 billion in All Funds, is the largest program within the HHS agencies.[12] While efforts such as maintaining six-month eligibility were adopted to slow the rate of growth in Medicaid caseloads, monthly Medicaid numbers continue to increase. In FY 2003, monthly caseloads averaged 2,466,119 clients.[13] The comparable number in FY 2005 is expected to be 2,925,447.[14] These numbers reflect monthly average caseload estimates higher than those anticipated in the appropriations bill by 217,506 in FY 2004 and 397,889 in FY 2005.[15] Costs per client are expected to decrease slightly, however, from $194.41 to $179.08 per month. Costs per client are slightly lower than anticipated. A significant portion of the increase in Medicaid caseloads is due to increases in the number of pregnant women served. In all, the Medicaid caseload is expected to grow over 60 percent from FY 2000 to FY 2005.[16]

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[10] Legislative Budget Board, Fiscal Size-Up, Texas State Services (2004-05), at pp. 4-5.
[11] *Texas Health and Human Services System First Submitted Consolidated Budget, Fiscal Years 2006-2007 at p. 19.*
[12] Ibid, at p. 121.
[13] Health and Human Services Commission, Presentation to the Senate Finance Committee, July 19, 2004, at p 6.
[14] *Texas Health and Human Services System First Submitted Consolidated Budget, Fiscal Years 2006 -2007 at p. 8.*
[15] Health and Human Services Commission, Presentation to the Senate Finance Committee, July 19, 2004, at pp. 5-6.
[16] Ibid, at p. 6.

Children's Health Insurance Program (CHIP) caseloads are expected to decline over the biennium due to a number of factors, most prevalent are failure to complete the renewal process (38 percent), status change to enrollment in Medicaid (24 percent), and family found ineligible after renewal application (18 percent).[17] Other changes, such as reduced income deductions and an assets test, were made to eligibility determination for the program but their effects are still to be determined as some items, like the assets test, only recently went into effect. Dental services and eye care were removed from the program during the last legislative session in order to maintain current income eligibility levels at 200% of the federal poverty level. Average monthly caseloads have declined from 506,968 in FY 03[18] to 409,865 in FY 2004, and are expected to decline further to 351,849 in FY 2005. The average monthly caseload and cost per client for the biennium for CHIP are greater than that expected in the appropriations bill.[19]

Taking into account both programs, a monthly average of 2,048,805 children were receiving state-sponsored health insurance in FY 2003.[20] At the end of FY 2005, that number is expected to be 2,452,241. The mix of children per program has changed, but the total number of insured has risen.[21]

Appropriations for HHSC total $19.37 billion over the biennium in All Funds

[17] Health and Human Services Commission. "CHIP Caseload Fact Sheet Spring 2004 Forecast" Available at http://www.hhsc.state.tx.us/chip/reports/042304_CaseloadFactSheet.html.
[18] Health and Human Services Commission. "CHIP Enrollment, Renewal and Disenrollment Rates (November 2004)" Available at http://www.hhsc.state.tx.us/research/CHIP/ChipRenewStatewide.html.
[19] *Texas Health and Human Services System First Submitted Consolidated Budget, Fiscal years 2006 -2007 at p.* 8. Also Health and Human Services Commission, Presentation to the Senate Finance Committee, July 19, 2004, at p. 3.
[20] Amount includes 506,968 CHIP recipients and 1,541,837 Medicaid children. Figures are drawn from CHIP and Medicaid spreadsheets at the HHSC agency website.
[21] *Texas Health and Human Services System First Submitted Consolidated Budget, Fiscal years 2006 -2007 at p.* 8.

out of a total $39.21 billion appropriated in Article II. The bulk of the remaining funds have been allocated to the Department of Human Services (now part of DADS), the Department of Mental Health and Mental Retardation (now split between DSHS and DADS), the Texas Department of Health (now part of DSHS), and the Department of Protective and Regulatory Services (now DFPS). Caseload estimates and costs are budget drivers for all of these agencies. In particular, caseload estimates for entitlement programs. have a substantial budgetary impact.[22]

According to HHSC material, Medicaid forecasts are performed primarily by HHSC and DADS staff through time-series models that make predictions based on trends and seasonality in historical data. Data for Acute Care forecasts is further disaggregated by Risk Groups such as children, medically needy, adult, and aged and disabled. Forecasts are performed every three to four months but are based on assumptions that can change due to policy, economic, or other factors.[23]

Forecasts for CHIP are based on past caseloads and proportional models, but lack the long-term consistent data needed for true time series analysis. They are broken down by Federal Poverty Level and by state and federally-funded groups. Finally, HHSC also forecasts foster care, adoption subsidy, and Early Childhood Intervention caseloads and assumed responsibility for TANF caseload projections as of September 1 of this year.[24]

Texas, because of its unique geographic location, is subject to the benefits and expenses provided by undocumented immigration. Benefits come from productivity in a number of economic sectors. The State does bear, however, significant expenses in health

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[22] Exact appropriations amounts can be found in the Legislative Budget Board, Fiscal Size-Up, Texas State Services (2004-05), at p. 119.
[23] Summary materials provided for workgroup report by HHSC, 8/31/04.
[24] Ibid

care treatment. Many of these costs are hidden at the local level in emergency rooms and other areas.

Given that the children of immigrants born in Texas qualify for Medicaid services under federal guidelines, Texas' position as a border state makes it even more challenging to make precise Medicaid projections. Senate Bill 610, 78th Legislature, Regular Session, 2003, relating to the funding of Federally/Qualified Health Centers (FQHCs), proposed to ease the financial burden on local governments for care, in many cases using federal funding. As these centers become more prominent, they may also become helpful in identifying Medicaid-eligible Texans so that caseload forecasts and necessary appropriations can be more accurate. Additionally, as more children are treated at earlier stages of their need for care, further expenses, possibly through Medicaid, could be avoided for acute or emergency care.

State funding for continuation and expansion of FQHCs, currently at $5 million per year, has been requested in the DSHS Legislative Appropriation Request for FY 2006 - 07 with $150,000 per year in additional funding to be allocated to assisting facilities in receiving FQHC or FQHC look-alike designation. There is some question as to the federal commitment for these facilities after 2006.

## RECOMMENDATIONS

a. Continue to refine caseload and cost estimates within HHS agencies through the coordination of resources between the various HHS departments and the expertise and staff of HHSC.

b. Continue to implement and expand the use of Federally Qualified Health Centers as a method of controlling health care costs and Medicaid expenditures, and in identifying clients eligible for Medicaid services so that more accurate caseload estimates may be used for appropriation purposes.

c. Require HHSC to track and report on the effectiveness of FQHCs in serving currently unmet health care needs and Medicaid clients, including how much is expended on Medicaid clients and the number of clients served .

## CHARGE 2
## MONITOR IMPLEMENTATION OF ARTICLE II REORGANIZATION

### BACKGROUND

When the 78th Legislature met in January of 2003, it faced a large shortfall of available funds. Finding greater efficiencies within the twelve former HHS agencies to enable a larger percentage of dollars to be directed toward service provision, rather than administration, was seen as critical in balancing the budget while maintaining service levels. The largest providers of social services in Texas are the HHS agencies charged with administering critical programs such as Medicaid, CHIP, Food Stamps, and TANF. Together, they employ approximately 50,000 people.[25]

House Bill (HB) 2292 focused on finding necessary cost savings by "consolidating organizational structures and functions, eliminating duplicative administrative systems, and streamlining processes and procedures that guide the delivery of services."[26] Its goals were fourfold: improving client services, reducing administrative costs, strengthening accountability, and spending tax dollars more effectively.[27] The need for structural reform within the health and human service agencies was also apparent, given fragmented oversight by the HHSC.

[25] Health and Human Services Commission, "Overview of 2292: 78th Legislature, Regular Session, 2003. Available: http://www.hhsc.state.tx.us/Consolidation/post78/HB2292_Summary.html.
[26] Ibid.
[27] Health and Human Services Commission, "HHS in Transition, An Overview of the Texas Health and Human Services Reorganization: Requirements and Processes," September 2003. Available: http://www.hhsc.state.tx.us/news/HB_2292/091203_PH_VideoHandouts.html.

Beyond structural reform, HB 2292 sought to contain rising health care costs, an issue addressed in another of the Committee's charges. Between FY 2000 and FY 2003, Medicaid expenditures rose approximately 50 percent, from $10.087 billion in FY 2000 to $15.018 billion in FY 2003.[28] Especially dramatic were increases in the cost of prescription drugs in the Medicaid program, rising 43 percent from FY 2001 to FY 2004.[29] HB 2292 contained a variety of cost containment measures, including implementation of a Preferred Drug List, enhanced fraud prevention measures, integrated eligibility, and managed care expansion.

HB 2292 consolidated the existing twelve health and human service agencies into four departments overseen by the HHSC. An executive commissioner, appointed by the governor for a two-year term and approved by the Senate, oversees the operations of the Commission. Each of the other departments has its own commissioner appointed by the executive commissioner with the approval of the Governor. Agency boards, which once were vested with rule and policy making authority, are replaced by advisory councils, whose membership is determined by the Governor. These councils are responsible for advising agency commissioners on policy making, but ultimate authority in that regard now rests with the executive commissioner, with input from the agency commissioners and councils.

In order to eliminate duplicative administrative systems, functions such as information technology, human resources, financial services, and purchasing, are consolidated under HHSC, resulting in an estimated cost savings of $95.6 million in FY 03

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[28] Health and Human Services Commission, Presentation to the House Select Committee on State Health Expenditures, January 29, 2004.
[29] Health and Human Services Commission, Presentation to the House Appropriations Subcommittee on Health and Human Services, April 27, 2004.

and FY 04.[30] Eligibility determination is also consolidated into HHSC with a net savings of $79.2 million (FY 03 and FY 04). Chart 1 shows how agencies are consolidated pursuant to HB 2292.[31]

Chart 1.

| **Prior to HB 2292** | **After H.B. 2292** |
|---|---|
| Health and Human Services Commission | Health and Human Services Commission |
| Department of Human Services (DHS)<br>Department of Mental Health and Mental Retardation (State Schools & Community Services)<br>Department on Aging | Department of Aging and Disability Services |
| Department of Health<br>Commission on Alcohol and Drug Abuse (TCADA)<br>Department of Mental Health and Mental Retardation (State Hospitals & Community Services)<br>Health Care Information Council | Department of State Health Services |
| Department of Protective and Regulatory Services | Department of Family and Protective Services |
| Interagency Council on Early Childhood Intervention<br>Commission for the Blind<br>Commission for the Deaf and Hard of Hearing<br>Rehabilitation Commission | Department of Assistance and Rehabilitative Services |

Immediately after the passage of HB 2292, HHSC began its implementation. The Transition Plan was submitted to the Governor and Legislative Budget Board in November 2003. The Integration Phase, which began after the submission of the Transition Plan, is expected to be completed by August 2005, but significant progress has already been made. On December 29, 2003, HHSC announced its commissioner appointments for the four health and human service departments. In January 2004, planning for the agency councils began. To date, all of the councils have been established and members have been

[30] HHS Major Initiatives, Health and Human Services Commission, May 24, 2004.
[31] Ibid.

appointed by the Governor with the exception of the Department of Assistive and Rehabilitative Services (DARS). It is expected that the council for DARS will be established by early 2005. Also in January 2004, consolidation of many of the administrative functions including human resources, Office of Civil Rights, procurement, and planning and evaluation was completed. Finally, the creation of the Office of Inspector General occurred in January 2004. "The Office of Inspector General assumed all the duties of HHSC's Office of Investigation and Enforcement and also all fraud and abuse functions of other HHS agencies."[32]

The first agency consolidation, that of the Department of Family and Protective Services, occurred on February 2, 2004. The Department of Assistive and Rehabilitative Services was soon to follow, consolidating on March 1, 2004. The Departments of State Health Services and Aging and Disability Services began consolidated operations on September 1, 2004.[33]

The Optimization Phase "will be that phase…where the longer-range vision of HB 2292 and HHSC begins to be realized. Immediately following the integration [phase]…leaders…will be expected to begin rationalizing and streamlining the business processes for which they are responsible."[34] And lastly, the Transformation Phase will "include continued implementation of changes in health and human services department management activities, continuation of risk assessments, and conducting a transformation

[32] Health and Human Services Website, Overview of the Office of Inspector General. Available: http://www.hhsc.state.tx.us/OIE/OIE_info.html.
[33] Health and Human Services Website, HHS Transformation, Frequently Asked Questions. Available: http://www.hhsc.state.tx.us/Consolidation/Consl_FAQ.html.
[34] Health and Human Services Commission, H.B. 2292 Transition Plan, November 3, 2003.

review of the changes to the delivery of health and human services"[35] in an effort to become a continuously improving agency.

In an effort to ensure that Medicaid resources flow to qualified clients, HB 2292 directs the Commission to implement a front-end Medicaid fraud reduction pilot based on biometrics technology in one or more counties of the state. The Medicaid Integrity pilot has been in operation in six counties since March 2004, operated by four vendors who offer different technology approaches to the pilot objective. This pilot also explores the capabilities of technology such as the use of a smart card for an integrated eligibility system. The results of this pilot are due in report to the Legislature no later than February 1, 2005. The report will identify and evaluate the benefits of this program and make recommendations regarding its expansion statewide.

Throughout this entire process, the Transition Legislative Oversight Committee has exercised oversight authority. Created by HB 2292, the committee is tasked with "[facilitating] the transfer of powers, duties, functions, programs, and activities between the state's health and human services agencies and the Health and Human Services Commission…with a minimal negative effect on the delivery of those services in this state."[36] The oversight committee is composed of four legislative members, two from the House and two from the Senate, three public members, and HHSC's executive commissioner. Between September 2003 and June 2004, the committee held five hearings. At each, HHSC's commissioners presented updates on their progress and recent public testimony, and committee members were able to address areas of concern.

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[35] Ibid.
[36] H.B. 2292, Section 1.22, Health and Human Services Transition Legislative Oversight Committee.

While issues have arisen at public hearings regarding the possible negative impact to client services and service delivery with the implementation of certain aspects of the consolidation plan , the overall goal of consolidation is to streamline the delivery system and create cost savings to better serve clients. However, the impact of these changes will likely take several years to quantify.

## RECOMMENDATIONS

a. If the 2-1-1 Information & Referral system is to serve as the gateway to health and human service programs, consideration should be given to enhancing the state and local partnership to expand the 2-1-1 infrastructure.

b. In the event the state decides to outsource certain functions to private companies, contract negotiations should clearly set forth the private company's responsibilities, penalties for non-compliance, mechanisms for identifying failures to fulfill obligations, remedies that compel compliance, and remedies available for clients and the state.

c. Continue to monitor reductions in expenditures and savings with HHS administrative restructuring, including reductions in FTEs. This estimate should be separate from those savings achieved through benefit changes.

d. Provide performance measures aimed at maximizing efficiencies in delivering client services. These could vary by agency, but could focus on time to first benefit, satisfaction with outcome, etc. One example might be the percentage of clients in a given program who receive follow-up or first contact from a trained caseworker within a given time.

e. Provide authorization and appropriate approval mechanisms for HHSC to expand the use of front-end fraud reduction methods statewide if indicated as successful by the results of an assessment of the current pilot. This might prevent much of the work that must be done on the back-end to detect fraud after it has already occurred.

f. Provide authorization for HHSC to assess the feasibility and cost-effectiveness of using a Universal Services Card or another method of consolidating recipient identification and benefits issuance to replace multiple forms and cards used by various HHS programs. Such a change could make the HHS system more convenient for clients and prevent the need to produce multiple, often complex, forms.

g. Strengthen the powers and authority of the Transition Legislative Oversight Committee to oversee the ongoing reorganization of HHS agencies.

# CHARGE 3

## CONDUCT COMPREHENSIVE DATA REVIEW OF ALL PROGRAMS IN ARTICLE II

### BACKGROUND

Under this charge, the Finance Committee was asked to examine all programs offered under Article II (Health and Human Services) of the appropriations bill. In response to the Committee's request, testimony and programmatic information was received from the HHSC and all the major HHS agencies. The State of Texas offers hundreds of specific programs each with its own client base. In some cases, programs serve thousands of individuals at the cost of billions of dollars. In others, only a very small number of clients are served, sometimes at a very minimal cost.

Provided as attachments to this report are presentations by the HHSC, DARS, DADS, DSHS, and DFPS. Appendices A through E are summaries of the many programs offered by each agency.

### RECOMMENDATIONS

a. Require the HHSC to provide and update on an annual basis, a uniform and complete listing of HHSC programs that includes which agencies offer which programs, contact information, historical expenditures, total program budget, average cost per client, description of average client, numbers served and waiting/interest list size. Such a list should be made available by electronic means to reduce costs. Hard copies could be produced upon request for members of the Legislature or for a small fee to the public to cover printing/copy costs.

b. Require the HHSC to work with each department and interested parties to develop a basic guideline for cost per client based on acuity, available providers, geographic area,

etc. in those programs providing long-term services to individuals. These guidelines would not be used to determine actual appropriations but, rather, to identify programs with similar clients that are unduly costly or inefficient.

## CHARGE 4
## REVISIT RISING HEALTH CARE COST STUDY OF THE 77TH LEGISLATURE

### BACKGROUND

The 77th Legislature's Senate Finance Subcommittee on Rising Medical Costs issued its interim report in January of 2003. It included summaries of the major health care programs operated by the state as well as synopses of past cost increases in each program and projections for future appropriation needs. Detailed information on each health care program's financing and most utilized pharmaceuticals and procedures was also included. Finally, agencies provided a list of options that could be taken by the 78th Legislature to reduce expected cost increases.

The 78th Legislature implemented a number of options designed to reduce expected cost increases. Much of these actions were done in the face of a revenue shortfall approaching $9.9 billion. Chart #2 lists some of the cost reduction options adopted by the Legislature and agencies in FY 2004 - 2005.

Chart 2.

| Program/Agency | Cost Control Options |
|---|---|
| Medicaid [37] | 1) Maintained term of children's coverage at 6-months.<br>2) Allowed establishment of cost-sharing according to federal guidelines for some recipients.<br>3) Eliminated coverage of services for some providers, such as marriage and family therapists.<br>4) Placed limits on prescription medications.<br>5) Established rules for purchase of over-the counter medications if more cost-effective.<br>6) Required implementation of preferred drug lists for certain medications (applies to CHIP as well).<br>7) Provided for negotiation of supplemental rebates from drug manufactures supplying HHS programs.<br>8) Required prior authorization for drugs not on the preferred drug list.<br>9) Required delivery of acute care Medicaid in the most cost effective manner possible, including HMOs.<br>10) Strengthened fraud and abuse statutes and powers. |
| CHIP [38] | 1) Implemented 90-day waiting period for new enrollees, with certain exemptions.<br>2) Instituted assets test for clients above the 150 percent of poverty level.<br>3) Reduced benefit levels in certain areas.<br>4) Eliminated certain income deductions for eligibility purposes.<br>5) Allowed greater flexibility in cost-sharing with clients, subject to federal regulations (some initiatives have been delayed at executive direction).<br>6) Placed restrictions on brand-name prescriptions.<br>7) Altered restrictions on making CHIP benefits actuarially equivalent to state HMO benefits. |
| TRS [39] | 1) Instituted new school district-level contributions for TRS-Care.<br>2) Increased certain premiums and co-payments (medical and prescriptions).<br>3) Implemented new 3-tier prescription payment structure. |

[37] Overview of HB 2292, 78th Legislature, Regular Session, 2003, found at http://www.hhsc.state.tx.us/Consolidation/post78/HB2292_Summary.html.
[38] Ibid

| | |
|---|---|
| | 4) Implemented a 90-day waiting period for health insurance for new hires and some retirees.<br>5) Reduced state contribution for part-time employees. |
| ERS [40] | 1) Implemented a 90-day waiting period for health insurance for new hires and some retirees.<br>2) Reduced state contribution for part-time employees.<br>3) Increased co-payment and co-insurance amounts for HealthSelect members (medical and prescriptions).<br>4) Encouraged use of mail-order medications. |
| UT System [41] | 1) Added $50 prescription drug deductible.<br>2) Introduced a pilot disease management program for certain illnesses.<br>3) Implemented a 90-day waiting period for health insurance for new hires and some retirees.<br>4) Reduced contribution for part-time employees (including removal of contribution for graduate student workers). |
| A&M System [42] | 1) Implemented a 90-day waiting period for health insurance for new hires and some retirees.<br>2) Added a $100 per member prescription drug deductible.<br>3) Split office visit co-payments to $25 for primary care and $45 for specialists.<br>4) Discontinued annual eye exams.<br>5) Began charging individuals with no dependents a $33 monthly premium for basic health coverage.<br>6) Reduced contribution for part-time employees (including removal of contribution for graduate student workers). |
| TDCJ Correctional Managed Care [43] | 1) Developed Offender Health Services Plan.<br>2) Reduced hours of coverage at some units.<br>3) Implemented an employee reduction in force (360 positions).<br>4) Reduced freeworld offsite hospital visits. |

The combination of these program changes offset the substantial cost increases projected at the beginning of the legislative session. As medical costs continue to become

[39] TRS presentation to the Joint Meeting of the Senate Finance Committee and the Senate State Affairs Committee, June 7, 2004.
[40] ERS presentation to the Joint Meeting of the Senate Finance Committee and the Senate State Affairs Committee, June 7, 2004.
[41] UT System presentation to the Joint Meeting of the Senate Finance Committee and the Senate State Affairs Committee, June 7, 2004.
[42] The Texas A&M System presentation to the Joint Meeting of the Senate Finance Committee and the Senate State Affairs Committee, June 7, 2004.
[43] TDCJ Correctional Managed Health Care presentation to the Joint Meeting of the Senate Finance Committee and the Senate State Affairs Committee, June 7, 2004..

a larger portion of the state's budget, however, important decisions will have to be made as to the level of benefits offered under each program and who (state, client, member, etc.) pays for those increases. Appendix E updates prescription drug data included in the original 2003 report. While not a policy decision adopted to curb rising health costs, the 78th Legislature did take action, for budgetary reasons, to reduce the $1,000 yearly school employee health stipend to $500 for many employees and eliminate it for some.

Both TRS and ERS have reported expected double-digit increases in health insurance costs in the coming biennium. TRS, for instance, is predicting yearly medical cost increases of 14 percent and prescription drug increases of 20 percent.[44]

Additionally, HHSC reports that recent changes in federal Medicare statutes may have a significant impact on the state budget. Specifically, new Medicare Part D, created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, will offer optional drug coverage to all Medicare eligible clients. A subsidy for low-income individuals is also included. While the act requires Medicare to assume responsibility for outpatient drugs for those eligible for both Medicare and Medicaid (dually eligible clients, many times in nursing homes and state schools), the state will be forced to expend possibly significant funds in the determination of eligibility for the low-income subsidy. In addition, the state will have reduced leverage in negotiating rebates due to reductions in drug expenditures.

Most important, a "phase down" or “clawback” provision in the new federal bill requires states to make payments to the federal government based on what would have been necessary to continue services to dually eligible clients. The federal formula begins with calendar year 2003 expenditures and phases down to 75 percent of that amount by

[44] Presentations by ERS and TRS to the Senate State Affairs Committee, September 22, 2004.

2015, adjusted for inflation. In 2003, Texas did not enjoy the benefits of certain cost containment efforts, such as the Preferred Drug List and supplemental rebates. Given the recent nature of federal regulations relating to this issue, it is difficult to determine an exact fiscal impact to the state.

It is important to note that a recent study released by the Kaiser Family Foundation and the Health Research and Educational Trust found that job-based health premiums for all employers increased an average 11.2 percent in 2004. This marks the fourth straight year of double-digit rate increases. Since 2000, health insurance premiums have increased 59 percent. These increases have prompted examination and adoption of items such as waiting periods for new employees, increased co-payments and co-insurance, and other methods for cost reduction recently explored by the state.[45]

The Committee would like to emphasize the responsibility of each Texas citizen to take personal pride and responsibility for their health and the health of their children. Nothing can do more to lower future medical expenses than a healthy population. Issues such as preventing obesity, especially in children, moderate eating and exercise, and regular physical exams can do much to affect the need for health treatment. Assuming a 1 percent in-state migration, Texas could have over 14 million obese citizens by 2040, approximately 10 million more than we have today.[46]

Another factor likely to contribute extensively to health care expenses in future years is the expected aging of Texas' population. According to Steve Murdoch, Texas State Demographer, the number of citizens 75 years of age or older will to grow by 302 percent between now and 2040. Those under 18 will increase by a lower 83.6 percent.

[45] "Health Costs for Workers Take Leap", Austin American-Statesman, September 10, 2004.
[46] Presentation by Steve Murdoch, State Demographer, The Population of Texas: Historical Patterns and Future Trends Affecting the State of Texas, September 22, 2004.

Citizens over the age of 75 are statistically much more likely to need medical treatment during a given year and need on average more expensive types of care.[47] These trends will have enormous effects on programs like Medicaid, which provide coverage for many Texans in long-term care. The fact that market penetration of long-term care insurance in Texas is very low amplifies those effects.

Child and adult protective services continue to be a significant cost driver in the state budget. Recent data from the new Department of Family and Protective Services (DFPS) indicate that more than 500 Texas children have died of abuse and neglect in the past two and one-half years. Over 78,000 Texas children suffer from abuse and neglect each year. Very publicized adult abuse cases in El Paso and Tarrant Counties point to the fact that children are not the only Texans subject to serious abuse and neglect.

Identifying abuse or neglect cases earlier and placing children and adults, if necessary, in foster care or other settings will ultimately lead to savings in state resources and, more importantly, improve the quality of life of many young and elderly Texans.

Finally, the ability of the state to attract, train, and retain high-quality nurses and physicians has a large impact on the efficiency of health delivery in Texas. Most hospitals and other medical facilities report alarming shortages in the availability of qualified nurses. Nursing schools, both four and two-year, on the other hand, remain frustrated at the number of applicants they must turn away each year as a result of insufficient faculty and other factors. Quality nursing is key to efficient and compassionate health care. Fewer mistakes, greater ability to focus intervention by a physician on the appropriate needs, and

[47] Presentation by Steve Murdoch, State Demographer, Population Change in Texas: Implications for Human and Socioeconomic Resources in the 21st Century, February 23, 2004.

prompt care by qualified individuals are key, especially in the long-term to reducing our burgeoning health expenditures.

Just as the need for quality nursing is high, effective graduate medical education (GME) for resident physicians is also an absolute necessity. While the state is a relatively small player in the funding of GME in Texas, with Medicare being the largest, every effort should be made to attract and keep the best and brightest physicians in-state. Studies have continually shown that physicians are more likely to practice in the area of their residency, despite the location of their initial medical training. More highly-trained physicians mean less unnecessary testing, more effective treatment, and the latest knowledge in medical care. Higher quality treatment will benefit the state by producing healthier patients more quickly, less reliance on expensive, highly-advertised medications, and more effective care in general. While promoting cost savings for the state, the quality of care to Texans would be improved, as well.

## RECOMMENDATIONS

a. Continue to explore methods of reducing pharmaceutical costs among state-financed health care programs, possibly through the continued use of bulk purchasing and treatment plans developed in conjunction with provider groups and other interested parties.

b. Provide incentives for exercise classes and other preventive health programs that reduce the risk of obesity and other diseases in persons insured through the state that would possibly require future prescription medication and other medical care.

c. Require the appropriate state agencies to explore methods of increasing the market penetration of long-term care insurance in an effort to encourage prudent planning for long-term care needs, thus decreasing reliance on Medicaid long-term care services now and in the future, and protecting the assets of seniors who would otherwise become indigent long-term care clients.

d. Require each agency administering a state health insurance program to provide to legislative leadership and the appropriate committees at the beginning of each legislative session a comprehensive list of options to reduce health care costs and to provide care in the most cost-effective and efficient manner possible.

e. Continue to implement and expand the use of Federally Qualified Health Centers as a method of reducing local health care costs and, possibly, Medicaid expenditures. This recommendation and background was outlined under Charge 1d.

f. Reduce financial barriers to the adoption of special needs children by increasing the monthly adoption subsidy ceiling from $545 to $700 for those in the moderate service level and from $545 to $900 for those in the intense service level.

g. In keeping with the new initiative Congregations Helping in Love & Devotion (CHILD), created by the 78th Legislature, continue to recruit foster care families in churches and other faith based organizations to increase the number of qualified foster parents.

h. Establish LBB performance measures for foster family recruitment and retention to motivate CPS and private agencies to make this a priority.

i. Provide financial support for kinship care providers who do not want to and/or cannot become licensed foster homes. Last session, the Legislature appropriated $250,000 for a pilot project in one region of the state to provide a $1,000 one-time payment plus day care, counseling, and other support services to relatives. Expanding the pilot program may enable more kinship placements, resulting in significant cost savings to the state.

j. Restore funding and provide additional funding for early intervention services, including additional risk assessment training for CPS investigators so they can catch abuse before it escalates to the point of necessitating traumatic and costly removal.

k. Increase funding to address waiting lists for family-based services such as counseling and parenting classes.

l. Create an automated system to track openings in foster homes, emergency shelters, and residential treatment centers. Added efficiencies in the system can ultimately lead to better protection of children, as well as cost avoidance for the state.

m. Investigate the need for further law enforcement involvement in child and adult protective cases where a parent, guardian, or care provider chooses not to cooperate with agency personnel. Such involvement may decrease the need for serious and costly care in the future and improve the quality of life for abused children and adults.

n. Continue to develop new accelerated and alternate degree programs to speed up the graduation of nurses and to help attract students from underrepresented groups to the profession.

o. Establish further incentives, such as loan repayment programs and financial aid, for undergraduate and graduate nursing students who are interested in careers in nursing education.

p. Set statewide goals for increasing the number of initial RN licensure graduates and identify funding required to meet those goals, especially for nursing faculty.

q. Extend the expiration date for redirecting the Tobacco Settlement Funds under the Nursing, Allied Health and Other Health-Related Education Grant Program to nursing from August 2007 to August 2011.

r. Employ part-time faculty to help masters-level nurses remain in clinical practice and retain their licenses.

s. Support initiatives that promote supportive workplace environments for nursing personnel, such as offering flexible schedules for beginning nurses and creating mentor roles for experienced nurses.

t. Increase nursing faculty salaries at community and four-year programs to be more competitive with nurse practice salaries.

u. Encourage colleges to allow nursing departments greater flexibility in faculty compensation packages.

v. If proven necessary by other interim studies regarding Graduate Medical Education, provide a portion of health science center formula resources to the education of resident physicians.

w. Encourage experienced physicians to serve as mentors for resident physicians to augment the training received as part of their actual residency.