TEXAS SENATE
COMMITTEE ON HEALTH AND HUMAN SERVICES

INTERIM REPORT
TO THE
85TH LEGISLATURE

November 2016

THE SENATE OF TEXAS
COMMITTEE ON HEALTH AND HUMAN SERVICES

SAM HOUSTON BLDG.
ROOM 420
P.O. BOX 12068
AUSTIN, TEXAS 78711
(512) 463-0360
FAX: (512) 463-9889

E-MAIL:
Charles.schwertner@senate.texas.gov

November 7, 2016

The Honorable Dan Patrick
Lieutenant Governor of Texas
P.O. Box 12068
Austin, Texas 78711

Dear Governor Patrick:

The Senate Committee on Health and Human Services submits this report in response to the interim charges you assigned to the Committee.

We appreciate your leadership and foresight in directing this Committee to identify solutions to some of our state's biggest health and human services challenges, including addressing child safety and capacity issues in our Child Protective Services system, strengthening oversight and improving quality in long-term care settings, building on the state's investment in our behavioral health system, and protecting the sanctity of human life. It is our sincere hope that that the recommendations offered in this report will serve to improve health care and human services in our state.

Respectfully submitted,

Senator Charles Schwertner
Chair

Senator Lois Kolkhorst
Vice-Chair

Senator Donna Campbell

Senator Craig Estes

Senator Charles Perry

Senator Jose Rodriguez

Senator Van Taylor

Senator Carlos Uresti

Senator Judith Zaffirini

Please direct questions or comments to:

Senator Charles Schwertner, Chair
Senate Committee on Health and Human Services
P.O. Box 12068
Austin, Texas 78711
(512) 463-0360

Jordan Dixon	Committee Director
Jonathan Connors	Deputy Committee Director
Drew Graham	Policy Analyst
Alyssa Jones	Policy Analyst

Copies of this report were distributed in compliance with the State Depository Law and are available for public use through the Texas State Publications Depository Program at the Texas State Library and other state depository libraries.

TABLE OF CONTENTS

Interim Charge 1A- Fetal Tissue

***Interim Charge Language**: Examine and make recommendations on the use of fetal tissue provided for research purposes and how related laws governing abortion procedures are interpreted and enforced.*

Hearing Information

Lieutenant Governor Dan Patrick issued a directive on July 15, 2015 for the Senate Committee on Health and Human Services to recommend any necessary changes to law that protect the sanctity of human life and the dignity of human remains.[1]

The Committee on Health and Human Services held a hearing on July 29, 2015 to consider recommendations to strengthen regulations on abortion providers, including further restrictions on the sale of human fetal tissue by these entities. Invited testimony was provided by the Attorney General, the Health and Human Services Commission (HHSC), the Department of State Health Services (DSHS), and several pro-life advocacy groups. Planned Parenthood was invited to testify, but declined to do so.[2]

Introduction

A series of undercover videos released during the summer of 2015 allegedly revealed employees of Planned Parenthood discussing potentially unlawful actions including the sale of human fetal tissue.[3] Since the release of these videos, several judicial bodies have launched investigations, with a range of results, and some of these investigations are ongoing.[4] The investigation of criminal wrongdoing is beyond the scope of responsibilities and expertise of this committee, which is to recommend policy changes. Therefore, this report will focus on recommendations to strengthen regulation and enforcement surrounding the donation of human fetal tissue in Texas. The Legislature should clarify and expand on current statutory prohibitions on the sale and receipt of human fetal tissue, prohibit human fetal tissue donations from elective abortions, and delineate the types of entities that can provide and receive human fetal tissue donations.

Regulatory and Enforcement Entity

During the Senate Committee hearing, it became apparent that while DSHS regulates abortion facilities, no agency is currently responsible for overseeing the practice of human fetal tissue donation. The sale or purchase of human fetal tissue is currently classified as a Class A Misdemeanor in the Texas Penal Code, but no entity is identified in statute as responsible for enforcement of this law. Statute should be changed to clarify that DSHS has the authority to enforce the prohibition on the sale of human fetal tissue and other regulations related to fetal tissue.[5]

Current Statute Regarding Fetal Tissue

Sale and Purchase of Human Fetal Tissue

Federal law makes it "unlawful for any person to knowingly acquire, receive, or otherwise transfer any human fetal tissue for valuable consideration *if the transfer affects interstate commerce*."[6] This prohibition, by itself, is inadequate due to the requirement that the sale affect interstate commerce in order to be unlawful. Additionally, the federal statute does not provide

the state with clear legal authority to enforce its provisions. Another shortcoming of existing federal statute is that it allows for exceptions to the allowable exchange of "valuable consideration", including payments for the transportation, implantation, processing, preservation, quality control, or storage of human fetal tissue.[7] State statute also prohibits the intentional buying, selling or transferring of human fetal tissue, but allows for similar exceptions to "valuable consideration" as are found in federal law, such as fees and expense reimbursement. Although such reimbursements may be acceptable for fully developed organ donations, the committee objects to the commodification of human fetal remains and has concerns that allowances for any fees or reimbursable expenses provides opportunity for the effective sale of human fetal tissue. State statute should be clarified by explicitly banning the sale, receipt, or transfer of human fetal tissue, with no exceptions to "valuable consideration".

Under current statute, the purchase or sale of human fetal tissue is a Class A Misdemeanor.[8] Violators face fines not to exceed $4,000 and/or confinement in jail for a term not to exceed one year.[9] The purchase or sale of human fetal tissue should be reclassified as a state jail felony. If convicted, violators would face prison sentences ranging from 180 days to two years and/or a fine not to exceed $10,000.[10]

Incentivizing Gestation or Abortion to Obtain Fetal Tissue

Federal statute also makes it unlawful to "solicit or knowingly acquire, receive, or accept a donation of human fetal tissue knowing that a human pregnancy was deliberately initiated to provide such tissue" or "knowingly acquire, receive, or accept tissue or cells obtained from a human embryo or fetus that was gestated in the uterus of a nonhuman animal."[11] Again, enforcement of this provision is limited to persons or entities "involved or engaged in interstate commerce" and does not provide clear authority to the state to enforce its provisions. The federal ban on the solicitation or acceptance of tissue from fetuses gestated for research purposes should be incorporated into Texas law and DSHS should be given clear statutory authority to enforce the ban.

Additionally, statute should expressly prohibit offering women monetary or other incentives to consent to the donation of human fetal tissue or to have an abortion for the purpose of donating human fetal tissue. Statute should also prohibit knowingly or intentionally soliciting or accepting tissue from a fetus gestated solely for research purposes.

Limitations on Fetal Tissue Donation

The Committee recognizes the value of research conducted using donated human fetal tissue to treat and cure life-threatening and debilitating diseases, but contends that this research should be limited to tissue acquired from non-elective abortions. Despite the medical breakthroughs that could theoretically occur through the use of human fetal tissue, the ends of advancing medical research do not justify the means of elective abortions that terminate innocent human life. Furthermore, donations should only be permitted from hospitals, birthing centers, and Ambulatory Surgical Centers (ASCs) that perform 50 or fewer abortions per year.

Federal law dictates that all research supported by the U.S. government, directly or indirectly, utilize a rigorous Institutional Review Board (IRB) process.[12,13] IRBs perform critical oversight functions such as approving and reviewing proposed research methods. The Committee

recommends confining the receipt of donated, human fetal tissue to accredited universities that utilize an IRB process.

Informed Consent

No standard form currently exists for consenting to the donation of fetal tissue. DSHS should develop a standardized consent form for authorized donating entities to use in order to obtain formal written informed consent from women wishing to donate their babies' fetal remains to a research institution. This form should be inspected by DSHS as part of both routine and complaint-driven inspections of donating facilities.

Reporting Requirements

To ensure that policymakers and the public have access to reliable data regarding fetal tissue donation, the authorized entities should report on an annual basis each instance of fetal tissue donated, including the type of donation and the research institution to which it was ultimately delivered. This information should be available in aggregate form to the public.

Conclusion

All human life is precious. The videos released earlier this year, regardless of the methods by which they were originally obtained, displayed a disturbing disregard for the sanctity of life and were an affront to moral decency. The sale or purchase of fetal organs and tissues, or the exchange of any monetary or in kind valuable consideration, is simply counter to Texas' commitment to preserve and protect innocent human life. While the committee acknowledges the potential benefits of medical research conducted using human fetal tissue, the practice of abortion cannot be justified by endorsing the use of the tissue of aborted babies for such research.

Recommendations

1. **Identify DSHS as the entity responsible for enforcing the prohibition on the sale of human fetal tissue.**

2. **Criminalize the receipt of any payment made in exchange for human fetal tissue.**

3. **Incorporate the federal prohibition against solicitation or acceptance of tissue from fetuses gestated for research purposes into Texas law.**

4. **Increase criminal penalties for buying or selling human fetal tissue.**
5. **Make it unlawful to offer or provide a woman with incentives to undergo an abortion procedure or donate fetal tissue.**

6. **Prohibit the donation of human fetal tissue acquired as a result of elective abortions.**

7. **Limit the receipt and use of donated human fetal tissue to accredited universities that utilize an Institutional Review Board (IRB) process.**

8. **Require DSHS to develop a standardized consent form to be used by hospitals, birthing centers and Ambulatory Surgical Centers who donate human fetal tissue.**

9. **Create an annual reporting requirement for hospitals, birthing centers and Ambulatory Surgical Centers that donate fetal tissue.**

10. **Require records maintenance of instances of fetal tissue donation for a period of seven years or for five years after a minor reaches majority.**

---

[1] Lt. Governor Dan Patrick, *Letter to Senate Health and Human Services Chairman Schwertner*, July 15, 2015.
[2] http://www.legis.state.tx.us/tlodocs/84R/witlistmtg/pdf/C6102015072909001.PDF
[3] Videos can be accessed at: http://www.centerformedicalprogress.org/cmp/investigative-footage/
[4]Stemple, Jonathan, *Anti-abortion Group Sued Over Video Release*, Reuters, July 31, 2015. Rosenthal, Brian, *Planned Parenthood Cleared, but 2 Indicted Over Video*, Houston Chronicle, February 2, 2016; CBS/AP, *Charges Dismissed Against Duo Who Made Anti-Planned Parenthood Videos*, July 26,2016.
[5] Texas Penal Code, Chapter 48.02.
[6] 42 U.S.C. § 289g-2(a) (2012).
[7] 42 U.S.C. § 289g-2(e)(3).
[8] *Supra* note 4.
[9] Texas Penal Code, Chapter 12.21.
[10] Texas Penal Code, Chapter 12.35.
[11] 42 U.S.C. § 289g-2(c).
[12] 45 C.F.R. 46.

Interim Charge 1B- Wrongful Birth

Interim Charge Language: *Examine the cause of action known as "wrongful birth." The study should examine (1) its history in Texas, (2) its effect on the practice of medicine, and (3) its effect on children with disabilities and their families. Examine related measures proposed or passed in other states.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on Interim Charge 1B, related to wrongful birth causes of action, on February 18, 2016. Invited testimony was provided by the Texas Medical Board and the Texas Alliance for Life.[1]

Introduction

Parents have a right to know prior to giving birth, if possible, whether their child will be born with an abnormality that could cause a disability. This knowledge will help them plan and prepare to care for the special needs of their child. However, the cause of action known as wrongful birth does not respect the sanctity and value of the lives of children born with disabilities, and unnecessarily punishes physicians whose patients, through no fault of the physician, give birth to a child with disabilities. If a physician fails to provide the standard of care in this area, they can and should be reported to the Texas Medical Board.

Background

It is important to fully understand the definition of wrongful birth and delineate it from two similar causes of action, wrongful life and wrongful pregnancy.

- **Wrongful birth-** Cause of action in which the defendant's (doctor's) actions or omissions prevented the woman from making an informed choice about whether to terminate a pregnancy that resulted in the birth of a child with a congenital impairment or disability. The "injury" the parents suffer is having given birth to a disabled child rather than aborting their child. Parents seek to collect the costs of raising their child for his or her entire life.
- **Wrongful life-** Cause of action brought by an impaired child alleging that because his or her mother was deprived of the informed choice to terminate the pregnancy, the child was forced to live a life of such pain and suffering that non-existence would have been preferable. Texas does NOT recognize this cause of action and only four states currently do: California, New Jersey, Louisiana, and Washington.
- **Wrongful pregnancy-** Cause of action brought by a woman who alleges that the defendant's (doctor's) negligence caused her to have an unwanted or unplanned pregnancy. Forty-two states allow this cause of action, including Texas.[2]

This report focuses exclusively on the wrongful birth cause of action.

History of Wrongful Birth Cause of Action

The first court decision to address wrongful birth occurred in 1967 in the New Jersey Supreme Court case *Gleitman v. Cosgrove*.[3] In this case, the mother contracted rubella in the early stages of pregnancy and was assured by her physician that there would be no effects on her unborn child. The parents sued when their child was born with substantial deficits in sight, hearing, and speech and a very low IQ. The court ruled in favor of the defendant.

The first case nationally to recognize and uphold the wrongful birth cause of action was the 1975 Texas Supreme Court case *Jacobs v. Theimer*. This case also involved rubella, but in this case the physician failed to diagnose the mother with rubella and her daughter was subsequently born with significant birth defects. The court allowed recovery of expenses reasonably necessary for the care and treatment of their child's physical impairments.[4]

Previous attempts have been made by the Texas Legislature to eliminate the wrongful birth cause of action, including House Bill 1367 and House Bill 3008 filed during the 84th Legislative session. Both bills failed to achieve final passage.[5,6]

Impact on the Practice of Medicine

The wrongful birth cause of action makes medical professionals liable for a disability they did nothing to cause and may encourage medical professionals to over-cautiously seek out all potential disabilities and promote abortion in order to avoid liability.

In the absence of the wrongful birth cause of action, a parent whose physician negligently failed to diagnose or detect a potential birth defect could still file a claim against the physician through the Texas Medical Board (TMB), although they would not be entitled to monetary damages. In the past decade, the TMB has received five complaints in this area, three of which have been dismissed, one which resulted in a disciplinary action, and one which is currently under investigation. Witnesses at the hearing indicated that there are law firms that specialize in wrongful birth lawsuits and suspect that many cases settle out of court, rather than going through a TMB complaint process.

Impact on Children with Disabilities and their Families

In addition to the potential impact on physicians and the interference the cause of action may present in their relationships with patients, the cause of action sends a message to individuals with disabilities that the families of children with disabilities would have been better off had that child been aborted. The cause of action contemplates that a child born with disabilities constitutes an "injury" to a family and that the family should be compensated for having to care for that child.

Actions In Other States

Twenty-eight states currently allow the wrongful birth cause of action, including Texas. The cause of action has been eliminated from statute in nine other states including Arizona, Idaho, Indiana, Michigan, Minnesota, Missouri, Pennsylvania, South Dakota, and Utah. The elimination of the wrongful birth cause of action has been challenged in Minnesota, Pennsylvania and Utah. In all three cases the courts have upheld the laws eliminating the cause of action.[7,8,9]

Conclusion

The wrongful birth cause of action is overly punitive on physicians and sends the message to children with disabilities and their families that the life of a disabled child is an injury for which one must be compensated. A patients whose physician negligently fail to inform them of known birth defects or disabilities has recourse through the Texas Medical Board's complaint process.

Recommendations

1.) Eliminate the cause of action known as "wrongful birth" from statute.

2.) Direct the Texas Medical Board to continuously track the number and disposition of complaints related to a physician's failure to inform a family of a potential disability in utero or their failure to perform standard testing to detect abnormalities.

---

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List*, February 18, 2016: http://www.legis.state.tx.us/tlodocs/84R/witlistmtg/pdf/C6102016021809001.PDF

[2] Hensel, Wendy, *The Disabling Impact of Wrongful Birth and Wrongful Life Actions*, Harvard Civil Rights-Civil Liberties Law Review, Vol. 40, 2005.

[3] http://law.justia.com/cases/new-jersey/supreme-court/1967/49-n-j-22-0.html

[4] http://law.justia.com/cases/texas/supreme-court/1975/b-4583-0.html

[5] House Bill 1367, 84th Regular Session, (Pena) 2015.

[6] House Bill 3008, 84th Regular Session, (Simmons) 2015.

[7] http://law.justia.com/cases/minnesota/supreme-court/1986/c2-85-2013-2.html

[8] http://law.justia.com/cases/pennsylvania/superior-court/1993/424-pa-super-549-2.html

[9] http://caselaw.findlaw.com/ut-supreme-court/1276849.html

Interim Charge 2A- Recurrence of Abuse and Neglect

Interim Charge Language: *Examine the current process that Child Protective Services uses to track recurrence of child abuse and neglect, and make recommendations to improve data tracking and the use of that data to assist in preventing recurrence. The study should examine the differences in recurrence among families who received services, families who received no services and had their cases closed, and families who had their children removed from the home.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on April 20, 2016 to discuss Interim Charge 2A. Invited testimony was provided by individuals representing the Department of Family and Protective Services (DFPS), Cook Children's Medical Center, The Association for the Protection of Children and Children's Advocacy Centers of Texas.[1]

Introduction

It is a tragedy when any child is a victim of abuse or neglect, but the tragedy is compounded when a child endures subsequent harm after Child Protective Services (CPS) intervention. Unfortunately, this is the case for 17.7% of abused and/or neglected children who have a subsequent allegation of abuse or neglect confirmed within five years of the first reported incident.[2]

Child abuse and neglect fatalities in Texas increased from 151 in Fiscal Year 2014 to 171 in Fiscal Year 2015.[3, 4] Historically, about half of all child abuse and neglect fatalities occur in families with prior CPS involvement. These cases, and this interim charge, offer a chance to examine where the state is missing potentially life-saving opportunities to intervene and provide services to prevent recurrence of abuse and neglect.

Background

Currently, DFPS tracks data on recurrence of abuse and neglect by monitoring certain children for 12 months after interaction with CPS. Specifically, children with the following characteristics are tracked:

- Children reported to have been abused or neglected but who did not receive services (regardless of the disposition of the case) and then had a subsequent confirmed allegation or a case opened for services within the next 12 months;
- Children with a Family Based Safety Services (FBSS) case closed without a removal who then had a subsequent confirmed allegation or a case opened for services within the next 12 months; and
- Children who return home from DFPS conservatorship and then have a subsequent confirmed allegation or a case opened for services within the next 12 months.[5]

Beginning in December 2016, DFPS will begin tracking:

- "child sexual aggression" for children under the conservatorship of DFPS; and
- investigations in which "child sexual aggression" occurred in both conservatorship and child care licensing.

In 2015, 99.9% of children remained safe in substitute care and 97.4% of child victims did not have a subsequent confirmed allegation within 6 months of the prior allegation.[6] However, 2015 data also showed that:

- 12% of children who returned home after being removed due to abuse or neglect had a subsequent confirmed allegation or case opened for services within 12 months;
- 8% of children with a FBSS stage closed had a subsequent confirmed allegation or case opened for services within 12 months; and
- 8% of alleged victims with no ongoing services had a subsequent confirmed allegation or case opened for services within 12 months.[7]

Current Methods to Predict Risk and Prevent Recurrence

Preventing recurrence of abuse and neglect requires CPS staff to predict risk and offer interventions to the families of children at higher risk of harm. There are several tools currently used by statewide intake workers and caseworkers to assess risk which informs their decisions on each case.

Accessing Prior CPS History: Statewide Intake utilizes information on prior CPS history stored in the IMPACT system for the alleged perpetrator, alleged victim, or anyone else involved in the family. This information, along with the facts of the case as determined upon intake, informs which priority designation is assigned to a case. These priorities are:

- *Priority 1 (P1) - C*hild appears to face an immediate risk of abuse or neglect that could result in death or serious harm. Investigations of these reports must start within 24 hours of receiving the call report.
- *Priority 2 (P2)* - All reports of abuse or neglect that are not assigned as Priority 1. These investigations must start within 72 hours of receiving the report.
- *Priority None (PN)* - Some reports do not meet the legal definition of abuse or neglect and are not assigned a priority or investigated. This includes situations that do not appear to involve a reasonable likelihood that a child will be abused or neglected in the foreseeable future such as: allegations that are too vague or general to determine if a child has been or is likely to be abused or neglected; reports with too little information to locate the child or the child's family or household; or situations that are already under investigation.[8]

The priority assigned to the case determines where the case is routed. Statewide intake does not have access to criminal background information outside of the IMPACT system on alleged perpetrators or information on CPS history in other states.[9]

CPS Investigators and Alternative Response workers also use prior CPS history to inform case decisions and to determine risk. Although caseworkers have access to all information in IMPACT, some of this information is periodically purged based on the current DFPS case record retention policy. The ability of caseworkers to gain an accurate picture of a child's history is limited by two factors:

- Limitations of the IMPACT system: IMPACT information on CPS history is difficult to read and decipher. IMPACT modernization will allow for improvements in the way caseworkers search for CPS case histories, but scheduled improvements to IMPACT have been delayed.[10]

- Records retention: CPS retains intake reports and case files for different periods depending on the disposition and outcome of the case. Some records are retained for as little as 6 months while others are retained for as long as 20 years. The agency should review their current records retention schedule to determine if some case files or intake reports should be retained and made available to intake workers and caseworkers for longer periods of time in order to give them a more complete history of the child and family that is the subject of a new investigation. Some examples of different retention periods are shown below[11]:

Calls to Statewide Intake (SWI) that do not rise to the level of a program intake, or calls in which reporters are seeking a referral to another agency	6 months after intake call
Investigation (INV) Ruled out, low or moderate risk, no service authorization, or closed Administratively	18 months after case closed
INV closed/other. Includes Reason to Believe (RTB) and Unable to Determine (UTD)	5 years after case closed or until the youngest principal in the case turns 18; whichever period is longer.
INV closed/other. Disposition of RTB for sustained perpetrator	20 years after case closed

Assessing Risk During Open Cases: Caseworkers are using new actuarial tools, as well as case reads by Child Safety Specialists to assess the risk of child maltreatment during an open case and for the foreseeable future.

- Structured Decision Making (SDM): Once assigned to a case, investigators must use a Structured Decision Making (SDM) 24-hour Safety Assessment to determine safety at the beginning of a case. Caseworkers also use an SDM Risk Assessment to determine the level of risk for recidivism in the next 12-18 months and to help CPS workers determine if a family needs ongoing services. The Risk Assessment utilizes twenty risk indicators including the age of the youngest child in the home, the primary caregiver's abuse/neglect history as a child, and any special needs of the child. Use of the risk assessment has resulted in more cases being opened for services.

  The SDM Family Strengths and Needs Assessment (FSNA) assists caseworkers in assessing the strengths and needs of families in FBSS and conservatorship cases that underlie safety issues in the home. In conservatorship cases, it is used in conjunction with the Child and Adolescent Needs and Strengths (CANS) assessment, which rolled out on September 1, 2016.[12] Providers conducting the CANS are able to utilize family history from the FSNA to create a more complete picture of the child's strengths and needs.

  Development of the remaining elements of SDM, including reassessments of risk level after receiving services and prior to reunification, will be developed for FBSS and Conservatorship stages of services, and will begin in 2017.[13, 14]

- Case Reads: CPS uses staff specialized in identifying safety issues, called Child Safety Specialist (CSS), to further examine high risk cases in Investigations. CSSs are legislatively mandated positions designed to focus on investigation issues and assist regional staff in assessing and addressing risk and safety for children.[15] There is at least one CSS in each region.

  Investigations: CSSs review certain high risk investigations prior to case closure. When a victim under the age of four is identified at intake, IMPACT automatically checks all adults and children involved in the case to determine if any of them have been involved in three or more investigations within the past 12 months. If so, the case is reviewed by a CSS. If a case involving a child under the age of four is being closed without further services (unless it was ruled out), IMPACT flags the case and requires a CSS to perform a case read prior to closure.[16]

  FBSS: Beginning in July 2015, CPS began requiring a specialized FBSS Quality Assurance (QA) team of CSSs to review FBSS cases identified as very high risk of severe recidivism during the open FBSS stage. Severe recidivism refers to a subsequent confirmed allegation of physical or sexual abuse, a case that ended in a fatality, or a case that resulted in the removal of the child from the home.[17] Examples of risk factors that would qualify a case as very high risk include families with very young children, families in which a child was born addicted or exposed to drugs or alcohol, or families with a prior history of abuse. Case reviews occurs within 31-45 days of the case being opened. This review process is used to identify any unaddressed immediate safety concerns, inform the FBSS caseworkers about those concerns, and recommend appropriate follow-up actions needed to protect the child. Items reviewed by the FBSS QA team relate specifically to tasks necessary to ensure safety, such as guaranteeing that background checks were run on all adults involved with the case and that all children in the family are being seen by the caseworker. An estimated 3,600 FBSS cases will be reviewed by the FBSS QA team annually, and information from these case reads will be periodically aggregated and analyzed to inform any needed training, policy or practice changes.[18] The use of the FBSS QA team in the FBSS stage of service has been effective. For example, in a sample of Region 8 cases reviewed by a State Office FBSS program specialist, severe recidivism was 34% lower in cases reviewed by the program specialist versus those in a control group.[19]

Strategies to Improve Risk Assessment and Reduce Recurrence

In order to improve the assessment of risk of child endangerment and reduce recurrence of child abuse and neglect, the agency should focus on enhanced use of experts to assist in initial screening and case disposition at intake, increased use of Prevention and Early Intervention for families with prior CPS history, and improving the quality of FBSS services to families and children.

Focus on Initial Screening and Disposition of Cases:

The agency is currently utilizing information analysts at the Department of Public Safety (DPS) to gather information that is difficult to obtain or unavailable to caseworkers, and to thoroughly

examine the background of household members to provide up-to-date criminal history information, including running intensive background checks and soliciting crime data from other states. The agency has also begun to reevaluate the use of Special Investigators, former law enforcement officers who accompany caseworkers to high risk initial investigation visits to assist the caseworker in determining risk and detecting the presence of criminal activity. The agency has requested additional resources for the Fiscal Years 2018-2019 biennium to increase the number of informational analysts and Special Investigators.[20] The agency also submitted a plan to the Senate Finance Committee requesting funding to hire an additional 100 Special Investigators during FY 2017 to address critical needs in regions of the state experiencing difficulty seeing children in a timely manner as required by law.[21] In response, the Senate Finance Workgroup on Child Protection was appointed by Chair Nelson and recently recommended the approval of 50 additional Special Investigators and 50 additional Investigative caseworkers to address these critical needs.[22] The agency must ensure that law enforcement and forensic resources deployed into the field are positioned to support and compliment the work of caseworkers, and do not create an adversarial atmosphere in caseworker interactions with families.

Multi-disciplinary Team Enhancement Program (MEP):

Children's Advocacy Centers (CACs) are a crucial partner in the investigation and treatment of child abuse. They conduct joint investigations into child abuse with CPS and law enforcement, which helps avoid re-traumatization of child victims by duplicative interviews and exams, and is nationally recognized as a best practice. CACs also conduct forensic interviews of victims, provide medical treatment such as sexual and physical assault examinations, work with families as advocates to connect them to necessary services and supports, and provide mental health services to parents and child victims. In recent years, CACs across the state became concerned that not all cases fitting within the agreed-upon protocols for a CAC joint investigation were actually being referred to CACs by SWI. The Multi-disciplinary Team Enhancement Program (MEP) was initiated as a pilot program in Tyler in August 2014 in order to encourage greater coordination with law enforcement agencies and increase the number of SWI reports of abuse correctly routed to CACs. Under the program, CACs receive, review, and make referrals based on Statewide Intake Reports (SWI). CACs receive SWI reports simultaneously with their respective law enforcement partner agencies and are then able to flag cases that may require forensic interviews or a criminal investigation for both law enforcement and CPS partners.[23]

The 84th Legislature provided $6.7 million for the biennium for CACs to expand the pilot. Currently, 793 law enforcement agencies (51.3% of all agencies) and 58 of 69 CACs are participating in MEP. In Fiscal Year 2017, additional CACs will participate. CACs reviewed over 67,000 SWI notifications in the first half of FY16. During the 2nd quarter of FY16, participating CACs experienced a 14% increase in forensic interviews, 23% increase in family advocacy services delivered, 14% increase in mental health services delivered, and 3% increase in medical services delivered over the previous year. In contrast, CACs not participating in MEP experienced a 3% decrease in forensic interviews, 10% increase in mental health services, no change in family advocacy services, and a 28% decrease in medical services (primarily sexual assault examinations).[24] The Legislature should continue to support the statewide expansion of the MEP program and to continually examine outcomes of the program to ensure best practices are shared among multi-disciplinary teams across the state.

Targeting Prevention and Early Intervention (PEI) Resources for Families with Past CPS History:

In the 84th Legislative Session, the Legislature appropriated an additional $37 million over the previous biennium for PEI programs, an increase of 30%.[25] The goal of PEI services is to preserve and cultivate safe, healthy families and to prevent abuse and neglect from occurring in the first place. However, some PEI programs are also available to families with prior abuse and neglect history. Currently, only 1.6% of the total PEI budget ($1.5 million for the biennium) is targeted specifically for families with prior CPS History.[26] Three PEI programs target families with prior CPS history:

Helping through Intervention and Prevention (HIP): HIP provides extensive family assessments and home visiting that includes parent education and basic needs support. The program, which started in late FY 2014, targets a very specific group of families and currently only serves an average of five families each month. Eligible families include those who:

- have had their parental rights terminated due to child abuse and neglect within the past two years and currently have a newborn child;
- have had a child die with the cause identified as child abuse or neglect within the past two years and currently have a newborn child; or
- are current foster youth who are pregnant or who have given birth in the last twelve months.[27]

100% of the 58 families served in Fiscal Year 2015 have remained safe to date, meaning there have been no further confirmations of abuse or neglect or cases with an Unable to Determine disposition. This outcome measure will be tracked for three years after HIP program completion.[28]

Community-Based Family Services (CBFS): CBFS provides home visitation, case management, parent education and additional services proven to increase the likelihood of a safe and stable home environment. This program serves almost 500 families per year. This program serves families investigated by CPS who were designated low risk cases, or who did not have confirmed allegations of abuse or neglect.[29] In 2015, 98.5% of children served have remained safe to date. This outcome measure will be tracked for three years after CBFS program completion.[30]

Project HOPES: Project Healthy Outcomes through Prevention and Early Support (HOPES) utilizes community-based organizations to provide home visiting and other evidence-based prevention programs. The program targets families with children between 0-5 years of age in high-risk counties, a priority population since 80% of child maltreatment fatalities occur among 0-3 year olds. HOPES locations were selected based on specific risk factors including child abuse and neglect related fatalities, child poverty, substance abuse convictions and treatment facility admissions, domestic violence convictions, and teen pregnancy rates. In addition, the University of Texas is currently conducting a three-year evaluation of HOPES, assessing multiple outcomes centered on parents' improvement in parenting constructs, increased protective factors, and not having substantiated child abuse.

Although the first round of HOPES was limited to primary prevention (families with no open or prior substantiated CPS history), the second round of awards allows providers to serve families regardless of CPS history. Some counties have indicated that they intend to allow families with CPS history to participate but will cap the number or percent of families with CPS history whom they serve. Safe Care is a program used as a HOPES model in Cameron, Webb, and Taylor counties. It is an evidence-based program that is proven to reduce recurrence by providing 18 to 22 weeks of training to parents, that includes 60- to 90-minute weekly or biweekly home visits, and other services chosen by the contractor. PEI is working with the Taylor County contractor to pilot the program and will serve families with and without CPS history. [31]

A comprehensive report from the PEI Division is due to the Legislature on December 1, 2016, detailing the effectiveness of all prevention programs, including those listed above. In addition to child safety measures, additional outcomes such as referral to juvenile courts during or after services, and improvements in protective factors among parents will be examined in this report. The Division should continue to explore opportunities for ongoing, in depth evaluation of prevention programs and the use of data to better target existing prevention resources, as outlined in their PEI Five Year Strategic Plan. [32] Additionally, the Legislature should determine if it is cost-effective to allocate more PEI resources to families with prior CPS history, including the expansion of the HIP program as requested in the agency's Fiscal Year 2018-19 Legislative Appropriations Request. [33]

Improving the Quality of FBSS Purchased Client Services:

Family Based Safety Services (FBSS) are offered after completion of an investigation or during an Alternative Response case in homes where children were determined unsafe, but the safety threats do not meet the threshold for removal. Services are provided in an effort to keep children safe and reduce the need to remove children from the home.

In FY 2015, both children in families who received FBSS services and those who did not receive services had an 8% rate of recurrence of abuse and neglect. Families receiving services should have a lower recurrence rate if FBSS services are truly delivering positive outcomes for families. [34] At the request of DFPS, The Stephen Group (TSG) performed a comprehensive assessment of FBSS Purchased Client Services. TSG examined whether the right services were purchased, whether the services met the family's needs, what outcomes were delivered with services, and the barriers families encountered in fully utilizing available services.

In addition to a shortage of many provider types such as substance abuse treatment and trauma informed therapy, TSG found a lack of accountability for family outcomes by service providers. There is currently no assessment to evaluate whether providers are effectively preventing removals, motivating parents to change their behaviors, or reducing recidivism. In their report, TSG recommended the development of a pilot to test a single-broker model for FBSS services. The model entails a single managing entity per region that is responsible for recruiting service providers, negotiating rates, and managing FBSS cases. The broker would be held accountable for meeting outcomes as outlined in a contract with DFPS. Currently, the agency uses significant resources to recruit new service providers and to facilitate and follow up on services. This pilot would shift those responsibilities, as well as contract management for the delivery of FBSS services and case management, to the single broker. [35]

DFPS is currently working with TSG and stakeholders to launch this pilot in the El Paso region. To determine the effectiveness of the single broker model in addressing the issues surrounding FBSS purchased client services, the agency should carefully monitor changes in provider recruitment, retention rates, and client outcomes including the recurrence of abuse and neglect.[36]

Conclusion

A core function of state government, and a core responsibility of society at large, is to protect the children of our state. DFPS and the Legislature must focus on prevention of child abuse and neglect, and should utilize data to target resources to areas of the state and families most at risk for abuse and neglect. During investigations, DFPS must ensure statewide intake screeners and investigators are given the appropriate tools to assess risk and properly classify the case, and if a family is provided services, DFPS must ensure that the services offered to the family are delivering quality outcomes and ensuring the ongoing safety of the child.

Recommendations

1. **DFPS should track and utilize additional information including:**
   - Past criminal history of the perpetrator and CPS history in other states.
   - Recurrence of abuse or neglect tied to the same perpetrator, even if the victim is a different child.
   - Cases in which another child living in the same home is subsequently victimized.

2. **DFPS should continue to pursue efforts to utilize the expertise of forensic investigators and analysts to more accurately assess risk and determine case disposition and the level of services that a family may need.**

3. **CPS should continue working with CACs to ensure the MEP rollout continues statewide.** This program has delivered positive preliminary outcomes and has increased communication between law enforcement, CPS, and CAC staff.

4. **DFPS and the Legislature should carefully monitor the launch of an FBSS single broker model of delivering and managing FBSS purchased client services.** DFPS should serve a quality assurance role in the pilot and should discern if services offered to families in FBSS are delivering quality outcomes.

5. **PEI should utilize predictive analytics to locate areas at high risk of abuse and neglect to target prevention efforts and prioritize service delivery.**
   - PEI should continue exploring and expanding the use of data to target specific risk factors in a community such as violent crime, domestic violence, human trafficking, involvement with the juvenile justice system, low school attendance and readiness, etc. that are correlated with child abuse and neglect.
   - Using predictive analytics, PEI programs should concentrate on the highest risk areas for abuse and neglect according to the data, including targeting services at the community or neighborhood level rather than county or zip code level, concentrating on the highest risk areas for abuse and neglect according to the data. This data should

be used to pinpoint areas to target services and prevention efforts, not specific individuals or families.

- PEI should strengthen and grow its partnerships with academic institutions capable of aggregating and analyzing data in these areas to target prevention programs. These institutions should measure outcomes and identify what steps were taken to ensure appropriate services were implemented in high-risk areas.

6. **The Legislature should consider the efficacy of targeting more prevention resources to families with prior CPS case history.** Only three prevention programs target families with prior CPS involvement, and funding for these programs only accounts for 1.6% of the entire PEI budget, about $1.5 million per biennium.

7. **PEI should explore additional outcome measures to determine the effectiveness of targeted prevention programs at improving child welfare and well-being, not just ensuring child safety.** DFPS should collaborate with community partners as well as higher education systems to continue evaluating the effectiveness of these programs.

8. **DFPS should review its record retention policy and determine if it is adequate to ensure children's safety with their biological families.**

---

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* April 20, 2016: *http://www.legis.state.tx.us/Committees/MeetingsByCmte.aspx?Leg=84&Chamber=S&CmteCode=C610*
[2] Department of Family and Protective Services, DFPS 2015 Data book, found at https://www.dfps.state.tx.us/About_DFPS/Annual_Reports_and_Data_Books/2015/pdf/Databook2015.pdf.
[3] *Supra* Note 1
[4]Department of Family and Protective Services, DFPS 2014 Data book, found at https://www.dfps.state.tx.us/About_DFPS/Annual_Reports_and_Data_Books/2014/pdf/Databook14All.pdf.
[5] Department of Family and Protective Services, *Testimony before the Senate Committee of Health and Human Services,* April 20, 2016.
[6] *Supra* note 1
[7] *Supra* note 5.
[8] Information provided by the Department of Family and Protective Services via Email, January 27, 2016.
[9] *Supra* Note 6
[10] The Stephen Group, DFPS CPS Operational Review Phase 1: Assessment/Findings, April 28, 2014.
[11] Department of Family and Protective Services, Records Retention Schedule, found at https://www.dfps.state.tx.us/application/rmg/default.aspx.
[12] *Supra* note 8
[13] *Supra* note 9
[14] Information provided by the Department of Family and Protective Services via Email, September 6, 2016.
[15] Information provided by the Department of Family and Protective Services via in-person meeting, January 28, 2016.
[16] *Supra* Note 9
[17] Information provided by the Department of Family and Protective Services via Email, July 29, 2016.
[18] *Supra* Note 9
[19] Information provided by the Department of Family and Protective Services via Email, July 19, 2016.
[20] Department of Family and Protective Services, *Legislation Appropriations Request, Fiscal Years 2018-2019.*
[21] Department of Family and Protective Services, *Testimony before the Senate Finance Committee*, October 26, 2016.
[22] Senate Finance Committee Workgroup on Child Protection, *Letter to Chair Nelson*, November 7, 2016.
[23] Children's Advocacy Centers of Texas, *Testimony before the Senate Committee of Health and Human Services*, April 20, 2016.
[24] Information provided by Child Advocacy Centers of Texas via email on

[25] Texas General Appropriations Act, State Fiscal Years 2016-2017.
[26] Information provided by the Department of Family and Protective Services via Email, April 15, 2016.
[27] *Supra* note 5.
[28] Information provided by the Department of Family and Protective Services via email on xx.
[29] *Supra* note 5.
[30] *Supra* note 26.
[31] TexProtects, *Testimony before the Senate Committee of Health and Human Services*, April 20, 2016.
[32] Department of Family and Protective Services, *Prevention and Early Intervention Five Year Strategic Plan.*
[33] *Supra* note 20.
[34] *Supra* note 8
[35] The Stephen Group, *Family-Based Safety Services Assessment*, November 2015.
[36] Department of Family and Protective Services, *Testimony before the Senate Committee of Health and Human Services*, September 13, 2016, page 21.

Interim Charge 2B- High Acuity Foster Kids

Interim Charge Language: *Study the increase in higher acuity children with trauma and mental illness in the state foster care system, and recommend ways to ensure children have timely access to appropriate treatment and placement options.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on April 20, 2016 to discuss Interim Charge 2B. Eight individuals provided invited testimony, representing the Department of Family and Protective Services (DFPS), the Health and Human Services Commission (HHSC), Superior Health Plan, The Stephen Group, Texas Alliance of Child and Family Services, ACH Child and Family Services, The Rees-Jones Center for Foster Care Excellence at Children's Medical Center, the Travis County Collaborative for Children, and The Children's Shelter.[1]

Introduction

Recently, the case mix of foster children in Texas has changed as the agency has been successful in placing lower needs children in kinship placements and a greater percentage of children remaining in foster care have acute mental health and medical needs. This change in case mix has contributed to a capacity crisis in the foster care system, requiring extremely costly stop gap measures that may add to the trauma these children have already experienced.[2] Children with high medical and mental health needs must have timely access to appropriate services and supports, including intensive case management, in order to ensure that they heal, thrive, and are able to achieve permanency with a loving family.

Defining High Needs Children

The first step in supporting "high needs foster children" is to identify an agreed-upon definition of this term. Limiting the definition to only those children who are at higher levels of care, or those in more restrictive placement settings is not an acceptable definition because it excludes children with high needs who are *at risk* of entering higher levels of care or more restrictive settings. A report by The Stephen Group issued in 2015 provides a good starting point for developing an accurate definition. This report identifies children as high needs if they meet emotional, medical, or special needs indicators. Examples of each indicator include:

- Emotional indicator: mental illness, emotional disturbance, or exhibiting conduct such as gang activity or sexually aggressive behaviors;
- Medical indicator: visually impaired, medically fragile, traumatic brain injury (TBI), failure to thrive; developmental delays due to failure to thrive, HIV, diabetes, substance abuse;
- Special needs indicator: Intellectual or Developmental Disability (IDD), physical disability, mobility impaired.

Based on this definition, approximately 5,900 out of the more than 30,000 children in conservatorship of the state, or about 20%, are high needs children. Of these 5,900 children:

- 4,345 have an emotional indicator;
- 1,255 have a medical indicator; and

- 4,518 have a special needs indicator. [3]

*Note that there is significant overlap between emotional and special needs indicators.

Ideally, high needs foster children will be identified as early as possible upon entering care so that appropriate services and supports, including intensive wraparound services, can be provided in a therapeutic foster home setting in order to avoid more restrictive placements such as Residential Treatment Centers (RTCs).

Characteristics of High Needs Children

Although high needs foster children are more likely to be assessed at higher levels of care than other foster children, half of the children identified as high needs in the Stephen Group report are assessed as needing only basic or moderate levels of care. However, these children are likely to experience a crisis if not provided adequate supports and services in a timely manner. High needs foster children, particularly those with special needs or emotional indicators, stay in foster care longer, have a higher number of placements, and are four times more likely to reside in RTCs than other foster children.[4]

The average years in care for foster children is 1.93 years. However, this time increases for children who are classified by the Stephen Group report as having high needs. Average time in care for those with:

- Emotional Indicators is 3.91 years;
- Medical Indicators is 3.98 years; and
- Special Needs Indicators is 3.72 years.

In addition, 990 out of 28,301 children in care in August 2015 had 10 or more placements. Of the 990:

- 71.8% could be classified as having an emotional indicator;
- 60.1% could be classified as having a special needs indicator; and
- 11.4% could be classified as having a medical needs indicator.[5]

Foster Care Capacity

The increase in the percentage of high needs foster children is contributing to a capacity crisis and a subsequent budget shortfall in foster care, which currently stands at $45.2 million for the FY '16-'17 biennium. Contributing to this crisis are provider placement suspensions and closures, capacity differences by region, and a decline in the use of Parental Child Safety Placements. Capacity issues have led to DFPS relying increasingly on service level waivers and child specific contracts, and at times has resulted in children sleeping in CPS offices or hotels.

Placement Suspensions and Closures

Over the past several years, due to concerns about safety and quality of care, DFPS has placed a significant number of providers such as Child Placing Agencies (CPAs) and Residential Treatment Centers (RTCs) on placement suspension, resulting in a temporary loss of capacity. In Fiscal Year 2014, DFPS enacted placement suspensions on 10 providers, resulting in the temporary loss of 2,119 beds. In FY 2015, DFPS enacted placement suspensions on 17 providers, 11 of which were RTCs, resulting in the temporary loss of 692 beds. Additionally, 4 RTCs permanently closed in FY 2015, resulting in a loss of 62 beds.[6,7] In FY 2016, a total of

226 beds were lost as a result of termination or closure, and 197 beds were offline temporarily due to suspension.[8] Furthermore, a District Court Judge in the case of *M.D. v Abbott*, commonly referred to as the Children's Rights lawsuit, ordered Texas to stop placing children who are in the Permanent Managing Conservatorship (PMC) of the state in foster group homes that lack 24-hour awake-night supervision. This has impacted the agency's ability to place children in 580 foster group homes, placing a tremendous strain on capacity.[9,10]

Capacity Differs by Region

Capacity availability at various service levels differs by region, so many children are sent to other regions or even other states in order to be placed in an appropriate level of care. For example, RTCs are primarily located in urban areas, which forces children with needs requiring an RTC placement who live in rural areas to leave their home region, their school, and their support system. An increase in therapeutic foster homes in the community, in which highly trained parents help provide intensive wrap-around services, would not only allow for a child to stay close to home, but would allow children with high needs to be placed with loving and supportive families rather than in an institutional setting.

Understanding Regional Differences in Capacity

In light of the current capacity crisis in foster care, DFPS has completed a preliminary occupancy analysis which compares the number of children needing placement in a specific region to the number of children placed in the region, at each service level over time. The analysis utilizes data from Fiscal Years 2014 and 2015, and Fiscal Year 2016 through April, excluding Region 3b where Foster Care Redesign is in place. The analysis showed the following:

- Regions 3a (Dallas), 8b (counties surrounding San Antonio), and 9 (Midland) have the highest rates of children placed outside of their catchment area, while Region 11b (Rio Grande Valley), Region 1 (Lubbock), and Region 10 (El Paso), have the fewest children being placed outside of their catchment areas; and
- Region 6 (Houston) has the highest number of child specific contracts, while Region 10 (El Paso) has utilized very few child-specific contracts.

The analysis showed that a general capacity-building effort is needed to increase bed volume overall, including more basic and moderate beds to accommodate young children new to care and ensure children are not sleeping in CPS offices or hotels. In addition, concerted efforts are needed to expand specialized, professional levels of foster care placements to serve older youth, larger sibling groups, and children with high needs. The agency has completed a more in depth analysis for each catchment area of the state and has organized community stakeholder meetings to review the data and begin discussions on addressing gaps in capacity. These meetings have included regional CPS leadership and providers, including Child Placing Agencies, STAR Health, and Local Mental Health Authorities.[11,12] The agency will develop a capacity needs assessment that will be released in December 2016 to determine capacity-building priorities for the state.

It should be noted that some CPS Regional Directors have been proactive in facilitating these types of local discussions with providers regarding placement disruptions and ongoing capacity issues. To grow and strengthen this effort, the agency should require each local catchment area to develop a local capacity-building plan, led by the Regional Director in collaboration with local

providers, faith based entities and other stakeholders, to be updated annually. Locally-driven efforts to meet both local and statewide goals for capacity building will encourage a strategic approach, rather than a crisis response approach, to build and sustain capacity that will help keep children closer to home and in the least restrictive placements possible.

Foster Care Redesign in Region 3b

Children in conservatorship of the state in Region 3b are served by the Foster Care Redesign model, which requires a Single Source Continuum Contractor (SSCC) to report outcomes related to capacity and child safety, including ensuring that more children stay in their home region, are stable in their placements, and that sibling groups are kept together. In Region 3b during FY 15, 32 children have moved from an RTC to a therapeutic foster home, and 83% of children were placed within 50 miles of their home, compared to the DFPS benchmark of 71%. Workers in Region 3b spend more time with children, DFPS staff overtime has decreased, and caseworkers return supervisor calls in a more timely manner.[13] These results are promising, and DFPS should expand Foster Care Redesign in a thoughtful manner that tailors the plan for each catchment area to the needs and strengths of the community and the foster children in the surrounding region. Prior to expansion, an intensive readiness review should be completed, and future SSCCs should be required to be non-profit entities with connections to the community in question. Due to the structure of Foster Care Redesign, in which responsibilities are phased into the contract over three phases, the SSCC is unable to control services for families and reunification efforts, which impact issues that drive costs such as lengths of stay and placement decisions. In recognition of this, HHSC and DFPS must review the rate setting methodology used to develop SSCC's blended rate and ensure that risk is transferred to the SSCC in a manner consistent with the transfer of these responsibilities. Additionally, as a recent review by The Stephen Group and DFPS found, there is significant overlap in the duties and responsibilities of conservatorship caseworkers and the SSCC in Region 3b. This leads to confusion, duplication, and unnecessary work for caseworkers.[14] Case management functions should be fully transferred to the 3b SSCC during phase two, and DFPS should maintain a strong oversight and quality assurance role over the SSCC.

Decline in Use of Parental Child Safety Placements (PCSPs)

A Parental Child Safety Placement (PCSP) is a voluntary, short-term, out-of-home placement a parent can make when Child Protective Services (CPS) determines that the child is not safe remaining in his or her own home, and the parent places the child with a family member or other responsible caregiver rather than CPS seeking court-ordered removal of the child.

Due to legitimate concerns with the safety of PCSPs after a spike in child fatalities in these placements, the agency halted PCSPs in December 2015 for caregivers with any criminal history and families with any prior allegations of abuse or neglect that had any disposition other than being ruled out. From December 2015 until the moratorium was lifted in February 2016, PCSPs declined by 37% and removals increased by 28%. In addition, PCSPs declined by 20% from March 2015 to March 2016.[15,16] In February 2016 after the moratorium was lifted, new criteria was put into place that bans PCSPs for families with any CPS history other than cases that have been ruled out and bans any adults with a felony conviction in the past 5 years from being caregivers in a PCSP. During FY 2016, there were 25,231 total children in PSCPs.

Increased Reliance on Child-Specific contracts

A child specific contract is arranged when a child in foster care is unable to be placed under any established level of care. A contract is arranged with a provider at a rate higher than the intense level of care in order to induce the provider to provide housing and supervision for the child. The majority of child specific contracts are with medical or psychiatric hospitals, but some are with Home and Community Based Services(HCS) homes, group homes, in-state RTCs or CPAs, or out-of-state RTCs or CPAs. Per its contract, Superior, the single health plan in charge of the STAR Health program, provides 15 placement days beyond medical necessity for children in psychiatric hospitals, but does not provide placement days beyond medical necessity for children in acute care medical hospitals.

The number of children requiring child-specific contracts has drastically increased in recent years. The total unduplicated number of children requiring child-specific contracts grew from 83 in FY 2014 to 348 in the first nine months of FY 2016. The actual number of child-specific contracts has also skyrocketed from 59 in FY 2013 to 651 in FY 2016.[17] These child-specific contracts are costly and may be traumatic for children and disruptive to long-term placement stability, with an average length of child specific contracts in FY 2016 of 102 days.[18] As previously mentioned, the majority of child specific contracts have been entered into with medical and psychiatric hospitals. The number of children who stayed in psychiatric hospitals past medical necessity tripled from Feb. 2015-Feb. 2016, and in 2015, medical hospitals saw a 65% increase in children remaining past placement days, while psychiatric hospitals saw a 45% increase over the previous year.[19]

Increased use of child-specific contracts have increased costs to the state. Costs associated with child-specific contracts arise in two ways:

- DFPS: The agency enters into the child specific contracts with a residential or inpatient provider to cover room, board and supervision. In Fiscal Year 2015, DFPS spent $6.5 million on child specific contracts. As of June 2016, DFPS had spent $10.5 million on child specific contracts this year.[20]
- STAR Health: STAR Health continues to pay for acute and behavioral health services for children in child-specific contracts, and for those placed in psychiatric hospitals, pays the first 15 days of placement beyond medical necessity. Children who have a child specific contract had average per member per month (pm/pm) costs of $3,456 in FY 2014 versus the average pm/pm cost for all foster children of $986. STAR Health costs for child specific contracts in FY 2014 were $2.6 million, increasing to $3.5 million in FY 2015.[21,22]

Currently, the DFPS Placement Division is in the process of reviewing and renegotiating all child-specific contracts that are currently in place to obtain more favorable rates and move children to more appropriate placements if possible.

In addition, DFPS is developing a Texas Treatment Foster Care Pilot to divert children from psychiatric placements. The goal of Treatment Foster Care is to divert children 10 years old or younger with high needs from entering RTCs, psychiatric hospitals, and other institutional settings. Through this pilot, children will receive intensive, time-limited therapeutic services in a foster family home setting from highly skilled foster parents who will be responsible for

stabilizing the child and preparing them for a less restrictive placement. The contractor in the pilot will be paid a rate similar to those provided for placement days in RTCs. The Request for Proposals (RFP) is currently in development, and the agency anticipates executing a contract in Fiscal Year 2017.[23]

Increased Use of Service Level Waivers

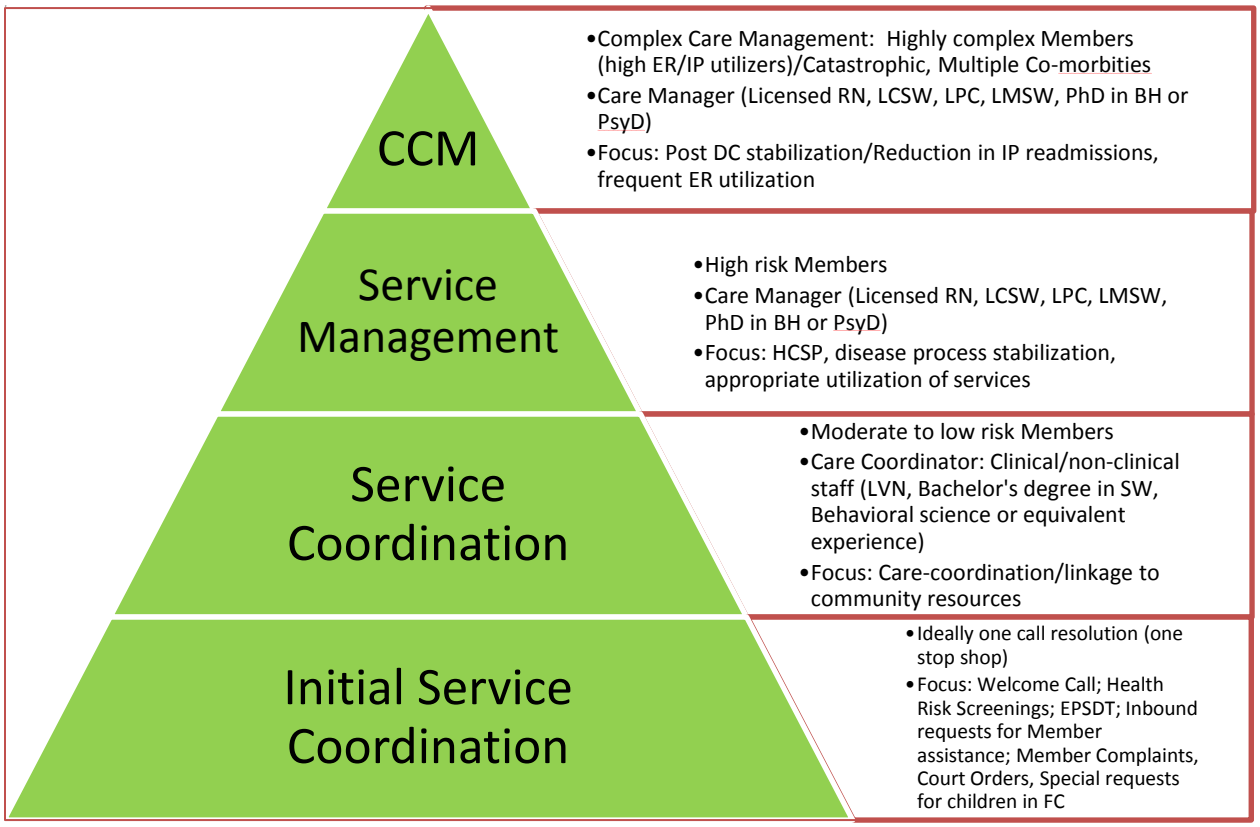
CPS may authorize a higher level of payment than the level at which a child is assessed if there is no capacity at lower levels of care. This results in children being served at a higher, more restrictive level of care than needed, which costs the state additional money and contributes to placement instability.

In 2013, there were 648 waivers granted; by 2015 that number increased to 1,086.[24] As of June 2016, DFPS had granted 867 waivers. As a result of this trend, the agency's Placement Division reviewed the waiver process and put procedures in place to review individual waivers, in an effort to provide stability and permanency for each child with a service level waiver, assist the child in completing the school year without disruptions, prepare for adulthood, complete a treatment program addressing all treatment needs, prevent the child from being without a placement, and/or provide additional therapy and treatment.[25]

STAR Health Services and Supports

Texas was the first state to establish a Medicaid Managed Care Program specifically for children in foster care. The managed care program, known as STAR Health, is delivered through a single health plan, Superior, through a contract with the HHSC. STAR Health was designed to better coordinate and improve access to health care for children in DFPS conservatorship, extended foster care, young adults ages 18 to 20 who were previously in conservatorship and have returned to foster care through voluntary foster care agreements, and young adults ages 21 to 26 eligible for Medicaid for Former Foster Care Children (FFCC).[26]

STAR Health provides service coordination, clinical service management, and complex case management services for their clients that need a higher level of case management. The level of case management a child receives depends on an assessment of the child, which is performed upon entry into the foster care system and again upon each placement change. This assessment occurs as part of the initial service coordination, which is provided to all STAR Health clients. The following shows the various levels of services coordination and case management in STAR Health.[27]



As the level of service coordination and the child's needs increase, the case manager to child ratio decreases and the number of weekly or monthly contacts with a case manager increases. In July 2016, out of 31,165 STAR Health members, 6,672, or 21%, were receiving complex care management, service management or service coordination services. This includes 149 children (0.46%) receiving complex case management, 2,155 (6.7%) receiving service management, and 4,368 (13.7%) receiving service coordination.[28]

A child's health information is maintained in the "Health Passport," an Electronic Health Record populated with information related to health visits, lab work, prescriptions, immunizations, and two years of Medicaid/CHIP claims. The Passport is intended to allow foster parents, caseworkers, and residential and healthcare providers to find needed information about a child's healthcare.[29]

Services

STAR Health provides physical, behavioral, pharmacy, dental, vision, personal care services, help-lines including a 24 hour medical advice line, physical, occupational, speech, and other health-related therapies, and prescribed medication to foster children. In addition, all children in STAR Health receive the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, commonly referred to as Texas Health Steps, which provides comprehensive and preventive health care screening and services for children under age 21.[30] STAR Health's contract with the state requires that all children in the conservatorship of the state receive their initial EPSDT visit within 30 days of entering care.[31] Although 100% of STAR Health clients have their EPSDT *scheduled* within 30 days, only 48% of foster children actually *received* their EPSDT screenings within the first 30 days of being in care in July 2016.[32] This is extremely

problematic for the many children entering the system with severe trauma who need to be assessed and receive appropriate services as soon as possible after entering care. Superior, CPAs, and caseworkers have a shared responsibility to ensure timely comprehensive health screenings for foster children. In order to improve EPSDT screening completion and in recognition of the partnership that must exist between STAR Health and CPAs to achieve compliance with the 30 day requirement, Superior has entered into an agreement with a CPA in the Houston area to pilot a program in which an enhanced payment will be provided to the CPA if a certain percentage of children under their care receive their EPSDT screening within 30 days.[33]

Additionally, HHSC and DFPS recently developed a joint plan to increase compliance with the requirement that children receive their EPSDT screening within 30 days of entering care. The plan calls for a combination of increased monitoring and oversight of CPAs, enhanced training of caseworkers and kinship development workers including the development of a training series on the continuum of care available to foster children through STAR Health, better communication with kinship caregivers and legal stakeholders, and a monitoring plan to ensure that 90% of foster children are receiving their EPSDT screening by the end of FY 2017.

There are currently no financial penalties assessed on Superior or CPAs for failure to meet the 30 day requirement, although the requirement has been added to the performance-based contracting demonstration for CPAs and other providers.[34] Both Superior and CPAs should be held accountable for meeting the benchmark set forth in the joint plan. Specifically, there should be financial sanctions imposed on the health plan and CPAs who fail to meet the benchmark by a certain date.

Behavioral Health Services

STAR Health must provide behavioral health services, including psychosocial rehabilitation services and mental health targeted case management as part of the service array. Only Medicaid credentialed providers, as determined by the Department of State Health Services (DSHS) may provide targeted case management and rehabilitation services, which are effective community-based behavioral health services that can avoid more restrictive and costly services and placements.[35] From October 2015 through April 2016, 1,378 unique STAR Health clients received targeted case management and psychosocial rehabilitation services, an average of 940 children served per month. Although there are more than 31,000 foster children served in STAR Health, Superior estimates that based on the number of children with behavioral health diagnosis who also have functional impairment, between 1,300 and 2,600 children enrolled in STAR Health would be eligible for these services.[36] Superior has attempted to educate all contracted providers about the process for becoming a targeted case management and psychosocial rehabilitation provider, but only a handful of CPAs are currently credentialed through DSHS to provide these services.[37] However, in the last 12 months, two centers have been added as providers of these services, with three more currently in process, to an existing pool of 58 providers statewide. HHSC and DSHS should work collaboratively to ensure training and support is available to all interested providers who have the capacity to become credentialed and contracted to deliver targeted case management and mental health rehabilitative services.

Other behavioral health services available through STAR Health include skills training and development, day programs for acute needs, crisis intervention, medication training and support, and valued-added foster care services for supporting placements. Other services are available on a case-by-case basis depending on medical necessity and cost-effectiveness. These include trauma-informed peer support for caregivers and equine therapy for youth who have frequent psychiatric admissions and have experienced trauma.[38]

Other STAR Health services and supports include:

- YES Waiver: Through the Youth Empowerment Services (YES) waiver, which was made available for foster children on September 1, 2016, eligible kids in STAR Health will receive intensive outpatient services that are currently used to prevent relinquishment of children age 3-18 with a Serious Emotional Disturbance. As of October 24, 2016, 14 foster care youth have received waiver services. DFPS is continuing to communicate with caseworkers and providers about this newly rolled out waiver.[39,40]
- Inpatient Care: STAR Health covers up to 15 additional days in psychiatric hospitals beyond medical necessity to account for placement issues. They continue to cover behavioral health and medical services beyond that time, but child-specific contracts are used by DFPS to cover room and board costs, as previously discussed.[41]
- Turning Point Program: In the Turning Point Pilot program, Superior partners with a CPA to provide crisis intervention, acute stabilization, and family preservation programs to prevent hospitalizations and placement disruptions. The pilot includes Mobile Crisis Teams, use of a psychiatrist to oversee clinical work, and respite services. The original pilot in Fort Worth showed very strong outcomes, with behavioral health readmissions for the pilot group reduced to 12.5%, versus 38% in the comparison group. This program was expanded to San Antonio on March 1, 2016, Houston on April 1, 2016, and Abilene on July 1, 2016.[42]
- Foster Care Centers of Excellence (FCCOEs): These medical homes will specialize in meeting the needs of children and young adults in foster care. The FCCOEs will follow practice guidelines to provide developmental and mental healthcare, and will serve as consultants for less experienced providers in the region. Superior is currently conducting assessments of potential clinics in Houston, San Antonio, Austin, El Paso, Midland, Lubbock, Amarillo and College Station. The goal is that these clinics will develop transformation plans based on these assessments and will be certified FCCOEs by August 31, 2017. Superior's long term goal is to have one FCCOE in every metropolitan area of the state in order to facilitate an initial comprehensive assessment of every child within 72 hours of entering foster care. Most of the planned FCCOE are Network Adequacy Improvement Plans (NAIP) projects for FY 2017, and have received NAIP funding to support transformation.[43]

Overall, Superior has successfully met the often complex healthcare needs of Texas' foster children, with the following outcomes since the implementation of the STAR Health program:

- Reduced physical health readmissions from 9.4% to 7.4%;
- Reduced behavioral health readmissions by 64% for children in complex case management;
- 100% of Children assigned to PCP within first 30 days;

- 100% of Children scheduled (not necessarily seen) for initial EPSDT visit within first 30 days; and
- Creation of Trauma Informed Specialty Provider Network which has 697 in-network Behavioral Health clinicians trained on Trauma Focused-Cognitive Behavioral Therapy.[44]

Despite these accomplishments, additional work is necessary to ensure appropriate behavioral health assessments and services are provided to foster care children as soon as possible to avoid more restrictive and costly services and placements. Although STAR Health is providing a wide array of services and supports, these services are not always known to caseworkers, foster care parents, or CPAs, and are underutilized. One reason for underutilization is the lack of a single entity responsible for coordinating and communicating a specific, individualized care plan for each child.[45]

Need for Coordinated Case Management Services and Updated CPA contracts

Currently, CPAs, caseworkers, STAR Health, and medical providers are all part of managing a child's care plan and each is responsible for a different element of case management. DFPS maintains all decision-making responsibility around permanency, although no single entity bears ultimate responsibility for ensuring case management of all aspects of the child's placement, treatment, and plan for permanency. This patchwork system has resulted in duplicative work, poor communication, and foster parents of children with high needs who are left confused about what services are available and how to access them. Currently:

- CPAs ensure placement and provide services and supports in a foster home, group home, RTC, etc.
- Medical providers conduct child well checks, provide services, provide therapy, etc. that are authorized and reimbursed through STAR Health.
- STAR Health provides service coordination and management, maintains a network of healthcare providers, and certifies the credentialing of targeted case management/psychosocial rehabilitation providers.
- Caseworkers find appropriate placements, provide general service coordination, and ensure requirements of the court are met.
- LMHAs and some CPAs provide psychosocial rehab and targeted case management authorized and reimbursed through STAR Health.[46]

Although each of the above parties are in charge of an aspect of case management, there is no single entity ultimately accountable to ensure all case management functions are performed and that all parties are working collaboratively in the best interest of the child.

In addition to highlighting the need for a single entity responsible for coordinating case management and plans of care for higher needs children, the Stephen Group's High Needs Report found the state's contracts with CPAs need to be strengthened to ensure they are incentivized to deliver positive outcomes for children. Other reforms to CPA contracts, practice, and policy are necessary to properly incentivize these entities to ensure appropriate services supports are delivered, safe and stable placements are provided, and capacity is developed. Ultimately, providers should be held accountable for delivering outcomes such as shorter times to permanency, less frequent placement disruptions, and ensuring children are given appropriate

and beneficial services specific to their needs in a timely manner.[47]

Potential areas in need of reform include:

- No eject/no reject of youth
  Currently, CPAs are not held accountable through their contracts for measurable outcomes surrounding child well-being, permanency, etc. CPAs are able to eject a child from the program at any time, or refuse to take a child. If a child is admitted to a psychiatric or medical hospital, the CPA is not required to take the child back into care during or after their stay in that facility. The current Performance Based contract demonstration has been a positive collaboration between DFPS and providers, including many CPAs, and provides a foundation to move toward a pay-for-performance model.
- Access to Targeted Case Management and Psychosocial Rehabilitation
  Prior to the passage of SB 58 in the 83rd Legislative session, only LMHAs were able to provide targeted case management and psychosocial rehabilitation services. CPAs now have the ability to apply to provide targeted case management and psychosocial rehabilitation. As stated previously, HHSC and DSHS should work collaboratively to ensure training and support is available to all interested providers who have the capacity to become credentialed and contracted to deliver targeted case management and mental health rehabilitative services.[48]
- Step-down Transition Plan
  Currently, there is a lack of transition planning when children leave a psychiatric facility, which results in poor communication with providers and foster parents about the necessary services and supports a child needs to ensure a successful and stable placement.
- Acquiring Placements
  Placements are often secured at the last minute which limits the time providers and caseworkers have to prepare a family and the child for a new placement. This results in the family not being ready and trained to receive the child, and in many cases the family has not even visited the child in the hospital. This lack of preparation can set the stage for a placement disruption and further trauma for the child.
- Single Child Plan of Service
  Currently, there is no single plan of service for each child in foster care. CPS has a plan of service for a child that is separate from the provider's plan of service. This is duplicative and may lead to gaps in care for the child. The Department is currently working to establish a single service plan.[49]
- Incentivizing Higher Level of Care
  Finally, the current pay structure for CPAs encourages these entities to keep a child at a higher level of care to receive additional funding. Children are currently assessed at one of four levels of care, and CPAs and/or RTCs receive additional funding for treatment and services at higher levels of care. However, when a child is appropriately treated through services and supports, the provider is penalized by positively affecting a child's well-being and lowering their level of care. The payment structure and overall level of care structure must be re-evaluated to ensure providers are incentivized to treat a child effectively and place them in an appropriate, least restrictive placement.[50]

Many of these areas for reform are addressed through the foster care redesign model. The committee recognizes the difficulty of incorporating all of these elements into CPA contracts in

the legacy system, but believes it is important to prepare legacy areas for foster care redesign by ensuring a foundation of accountability and pay for performance.

Conclusion

The Texas foster care system is facing a capacity crisis, caused by a decline in the availability of appropriate placements, and increasing medical and behavioral health needs of children in care. In order to avoid placement crises and further trauma to high needs children, DFPS and its partners must ensure that these children are provided appropriate services and supports in a timely manner. To do so, DFPS must immediately identify these children and provide individualized services upon entering conservatorship. Case management for high needs foster children is convoluted, with multiple parties providing different pieces of case management but no single accountable entity. This has resulted in duplicative work, poor communication, and confusion for families. The state should identify a lead case manager for children with high needs and incentivize them by holding them accountable through performance-based outcomes. Additionally, all entities involved in the life of a foster child must be held accountable for delivering positive outcomes surrounding the health, safety, permanency, and well-being of the child. Finally, the state must address the capacity crisis in our foster care system by adequately incentivizing growth in therapeutic placements, and developing and sustaining locally-driven capacity planning at the regional level that involves local faith-based entities, providers, and current and potential foster families.

Recommendations

1. **Develop a clear, uniform definition of children with "High Needs"**
    - Develop a definition that captures not only children currently in crisis, but also those at an elevated risk of experiencing a future crisis without appropriate and timely services.
    - Create a system to identify high needs children as soon as they enter the system to enhance care planning and preventative services and supports.

2. **Expand Services for Children and Families**
    - Encourage more collaboration between CPS and LMHAs to increase utilization of available services such as Targeted Case Management and Psychosocial Rehabilitation.
    - HHSC and DSHS should work collaboratively to ensure training and support is available to all interested providers who have the capacity to become credentialed and contracted to deliver targeted case management and mental health rehabilitative services.
    - Continue expansion of Superior's Turning Point Program statewide, beginning with areas of the state with the greatest number of high needs foster children.
    - DFPS and Superior should continue expansion of Foster Care Centers of Excellence statewide and facilitate relationships regionally with providers.
    - Ensure all foster and adoptive parents, caseworkers, and providers receive evidence-based trauma informed training, especially if they will be caring for a child with high needs.

- Ensure all foster care children receive their EPSDT screening within 30 days of entering care, and impose financial sanctions on Superior and CPAs who fail to meet the 90% benchmark by the end of FY 2018.
- Direct DFPS and HHSC to develop a triage assessment to occur within 3-5 days of entering care to identify high needs children and expedite services and supports for those children.

3. Develop Statewide Capacity

- DFPS should require every catchment area to create and implement a local plan to develop, monitor and maintain capacity based on DFPS' Occupancy Analysis. The local plan should be developed by regional leadership in collaboration with local providers, faith-based entities and other stakeholders and should be updated annually.
- The agency should consider the use of technology to monitor changes in capacity and placement needs on a real-time basis.
- Focus capacity efforts for high needs children on the development of treatment foster homes, wrap-around services, and in-home supports to provide a continuum of services. Consider enhanced funding for these types of placements, including paying CPAs an enhanced rate for the development of capacity in therapeutic foster homes comparable to the rates paid to RTCs. DFPS is pursuing a pilot to test this model. The Legislature should carefully monitor the results of this pilot and consider expanding if it is successful.
- Better utilize the faith-based community to recruit foster homes and therapeutic foster homes for high needs children. More of the agency's efforts will be discussed in the Strengthening Adoptions section of this report, but DFPS should continue to better understand the need for foster and adoptive families by region, and partner with faith-based entities to recruit needed levels of foster and adoptive families in those areas. The state should also ensure that faith-based entities' First Amendment rights are upheld and any barriers to partnering with these entities are removed as the agency works to build and grow these collaborations.

4. Build an integrated and accountable case management system

- Implement the Stephen Group Pilot which will establish a lead agency in a single region to implement integrated case management services for children in foster care who represent the population of children with the most acute medical and behavioral health needs. The lead agency should coordinate the activities of all entities responsible for a child's medical, placement, and behavioral health case management and ensure all components are utilized effectively without duplication to achieve quality outcomes. This lead entity should receive a separate rate for placement and be held accountable through their contract to:
    - assume greater service coordination and risk for children they agree to serve;
    - accept increased placement responsibility by implementing a no eject, no reject policy;
    - be responsible for ensuring the provision of all the services a child needs, including intensive wrap-around services; and

- be responsible for ensuring children move from RTCs and psychiatric hospitals to lower level placements.

The entity should be paid in part based on outcomes, including:
  - Improvements in safety, placement stability and permanency;
  - Decreases in RTC placements and length of stay; and
  - Decreases in inpatient psychiatric placement and length of stay.

- Continue rollout of the Single Child Plan of Service initiative sought to change the practice of separate case planning and bring all parties together to develop one plan for the child. Ensure providers are involved in developing a Single Child Plan of Service.

5. Hold CPAs Accountable and Pay them for Performance

- Expand the performance-based demonstration to apply to all contracted providers across the state.
- Develop additional outcomes related to child health and behavioral health.
- Tie payments to outcomes, including penalties for poor performance and incentives for high performers, beginning in FY 2018.
- Reform the current level of care system in order to incentivize more appropriate treatment and placement decisions.
- Consider increasing rates to adequately cover the costs of caring for high needs children.

6. Expand foster care redesign

- Foster care redesign is working in Region 3b and should be expanded. Expansion to Region 2 is currently underway. CPS should consider strengths, weaknesses, and lessons learned from past and current foster care redesign contracts when developing new contracts with a Single Source Continuum Contractor.
- New SSCCs should be required to be non-profit entities.
- An extensive readiness review should be conducted prior to expanding to a new region, and prior to moving into a new phase of a contract.
- DFPS and HHSC should work to develop rates that accurately reflect the cost of care and the transfer of risk to the SSCC over the three phases of implementation.
- SSCCs should be allowed to transition to phases two and three more quickly if they pass a comprehensive readiness review.
- Conservatorship case management should be fully transferred from DFPS to the SSCC in Phase 2, but CPS should maintain contract oversight and quality assurance roles.

7. Strengthen collaboration and communication between providers, CPS, families, and children

- Continue building networks between CPS well-being specialists and caseworkers to ensure caseworkers are educated about the services and supports available for high needs children, and ensure caregiver knowledge of services and trauma-informed care.

- Improve the Health Passport to make it more accessible and less time-consuming. DFPS and Superior should consult with medical and behavioral health providers, CPAs, families, CASA, etc. to gather feedback and recommendations on how to improve this tool.

---

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* April 20, 2016: *http://www.legis.state.tx.us/Committees/MeetingsByCmte.aspx?Leg=84&Chamber=S&CmteCode=C610.*
[2] Department of Family and Protective Services, *Information Regarding Increasing Foster Care Costs and Lack of Capacity*, November 20, 2015.
[3] The Stephen Group, *Meeting the Needs of High Needs Children in the Texas Child Welfare System*, November 2015.
[4] *Id*
[5] *Supra* note 3
[6] *Supra* note 2
[7] Information provided by DFPS via email on September 26, 2016
[8] Information provided by DFPS via email on September 12, 2016.
[9] *Id.*
[10] M.D.; bnf Stukenburg, et al., v Abbott, United States District Court Southern District of Texas Corpus Christie Division, Civil Action No. 2:11-CV-84, Entered December 17, 2015.
[11] Department of Family and Protective Services, Occupancy Analysis, provided on August 15, 2016.
[12] Information provided by DFPS via phone call on September 27, 2016.
[13] ACH Child and Family Services, *Testimony before the Senate Committee on Health and Human Services*, April 20, 2016, page 8-10.
[14] The Stephen Group, *Analysis of Duplication in the Foster Care Redesign Model*, October 2016.
[15] Supra note 8
[16] email
[17] *Supra* note 8
[18] *Supra* note 7
[19] *Supra*, note 2.
[20] *Supra* note 8
[21] Information provided by HHSC via phone call on April 6, 2016.
[22] Information provided by HHSC via email on October 27, 2016.
[23] Department of Family and Protective Services, *RFI: Texas Treatment Foster Family*, May 31, 2016.
[24] *Supra* note 2
[25] *Supra* note 8
[26] Department of Family and Protective Services, STAR Health - A Guide to Medial Services at CPS. https://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-star.asp
[27] Superior HealthPlan, *Testimony before the Senate Committee on Health and Human Services*, April 20, 2016.
[28] Information provided by Superior Health Plan via email, September 9, 2016.
[29] *Supra* note 25
[30] *Id*
[31] Health and Human Services Commission, STAR Health Contract Terms, found at: https://hhs.texas.gov/sites/hhs/files//documents/laws-regulations/handbooks/STAR-health-contract.pdf
[32] Information provided by Superior Health Plan at a meeting on September 6, 2016.
[33] Information provided by HHSC via phone call September 12, 2016.
[34] *Supra* note 27
[35] Information provided by HHSC via email, October 12, 2016.
[36] Information provided by Superior via email, October 26, 2016.
[37] *Id*
[38] Superior HealthPlan, STAR Health (Foster Care), http://www.superiorhealthplan.com/for-members/programs/star-health/
[39] Information provided by the Department of Family and Protective Services via Email, August 18, 2016 and October 24, 2016.

[40] *Supra* note 7
[41] *Supra* note 2
[42] *Supra* note 26
[43] *Supra* note 31
[44] *Supra* note 26
[45] *Supra* note 3
[46] *Id*
[47] *Id*
[48] Senate Bill 58, 83rd Regular Session (Nelson/Zerwas), 2013.
[49] Information provided by the Department of Family and Protective Services via in-person meeting, April 22, 2016.
[50] *Supra* note 3

Interim Charge 2C- Adoption Disruption

Interim Charge Language: *Examine the frequency, causes, and effects of disrupted foster care adoptions and make recommendations to improve the long-term success of adoptive placements. Study and make recommendations on ways to ensure a smooth transition for foster care children who are exiting the system.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on April 20, 2016 to discuss Interim Charge 2C. Eight individuals provided invited testimony, representing the Department of Family and Protective Services (DFPS), Cook Children's Medical Center, DePelchin Children's Center, and TAPESTRY Adoption and Foster Care Ministry.[1]

Background

Texas currently leads the nation in adoptions by focusing efforts on adoptions of older youth, sibling groups, and children with special needs. In 2014, Texas was nationally recognized for leading the nation in the rate of increase in adoptions of older youth. There has been a 78.8% increase in adoptions in Texas since 2005. In addition, Texas is the only state that has received the Adoption Incentive Award from the U.S. Department of Health and Human Services, Administration on Children and Families every year since the award was established in 1998 for successful adoption work. Over $79 million has been awarded to Texas, which is the highest total amount received by any state.[2]

Overall, Texas is a leader in ensuring positive, permanent adoptions. However, enhancements are needed to improve recruitment efforts, ensure appropriate matches and adequate preparation of adoptive families, and support adoptive families and children throughout the adoption process and throughout the child's life with the family. The agency should fully utilize partnerships with the faith based community to further all of these goals, and should explore ways to expand the involvement of faith-based partners in the furtherance of statewide permanency goals.

Definitions

Adoption Disruption - Occurs when a child is placed in an adoptive home, but the placement disrupts before the adoption is legally finalized and the child is still under the conservatorship of the state. Texas' average disruption rate is 2-3.5%, compared to 10-25% nationally.

Adoption Dissolution - Occurs when an adoption fails *after* it is legally consummated and the child is no longer under the Department's conservatorship. When adoption dissolutions occur, DFPS must take custody of the child and return them to substitute care. Adoption dissolutions often occur as the child ages and their past trauma resurfaces and manifests as emotional disturbance or mental illness. Texas' average dissolution rate is 2-3%, compared to 1-5% nationally.[3]

Children who are most likely to experience disruption or dissolution of an adoption include:

- Children with significant behavioral needs. The adopted family returns the child to DFPS care to receive mental health services or because community services and funding for post-adoption services have been exhausted. In other situations, the family can no longer

care for the child based on the child's behavioral needs and does not want to work with the agency or utilize other community resources;
- Children experiencing abuse and/or neglect by the adoptive family; and
- Children whose adoptive family is unable to care for the child long-term due to family circumstance such as financial hardships, health situations, death, etc.[4]

Adoption dissolutions and disruptions can be prevented by improving recruitment and matching to appropriate families, ensuring families are fully informed and properly trained prior to placement, and providing quality post-adoption services. Sufficient training for adoption caseworkers on how to facilitate effective recruitment and matching for children and families is also necessary to minimize adoption disruptions and/or dissolutions.

Recruitment of adoptive families

CPS adoption units are independently operated by each region, and regional unit and management structure varies across the state. In most regions, children are transferred into an adoption unit from a conservatorship (CVS) unit when parental rights are terminated. A child may already be in their intended permanent placement with the foster parent or relative who intends to adopt the child. If the child is not in their intended permanent placement, the agency will initiate recruitment efforts. The type and frequency of recruitment efforts vary by region and are dependent on the child's specific circumstances.[5] Some of the strategies used to recruit adoptive families include:

- *Operation Placing Us in Safe Homes (Operation PUSH)*: Annual initiative started in 2005 that brings stakeholders and CPS together to increase efficiency and remove barriers such as incomplete home studies and legal issues for children in DFPS conservatorship who are near adoption.[6]
- *The Why Not Me Campaign:* Created using a federal grant that was awarded to Texas in 2005 for increasing adoptions more than any other state. Includes English and Spanish language TV and radio spots and distribution of brochures, fact sheets, bookmarks, and other materials designed to help recruit adoptive parents.[7]
- *Texas Heart Galleries:* Founded by the New Mexico Children, Youth and Families Department in 2001 to use portrait galleries across the state to profile foster children in protective custody who are waiting for adoptive families.[8]
- *Faith Based Initiatives:* Faith-based partnerships at DFPS allow congregations to assist foster children by providing support services for foster families including respite care and transportation, planning events for special occasions in a foster youth's life, and participating in the CARE Portal which is an online portal providing communication between congregations, caseworkers, and foster families to provide supplies and donations.[9] DFPS recently established a goal of acquiring 90 new faith-based partners for the CARE portal in 90 days- they exceeded this goal by acquiring 125 new CARE portal partners within 40 days. DFPS also partners with churches to recruit and license foster and adoptive families from congregations across the state. As of August 2016 there were approximately 562 faith-based partnerships with DFPS. Faith-based entities can and should be an integral partner in efforts to recruit foster and adoptive parents as well as to provide support through supplies, donations, and services like respite care and babysitting for foster children and families. Successful strategies used to build faith community interest and participation in recruitment of foster families should be expanded to harness

the passion and strengths of these communities and expand capacity in the foster care system, connecting more children with safe, loving homes.[10]

- *Texas Adoption Resource Exchange (TARE)*: TARE is a website that helps match children awaiting adoption with adoptive parents. The website includes photos and profile information on children available for adoption and allows families to provide information about their adoption preferences and interests in adopting a child.[11]
    - A recent internal audit of DFPS' adoption practices related to recruitment, matching and selection found that DFPS is not consistently complying with agency policies for timely registrations, updates, and maintenance of children's profiles on TARE, and that opportunities exist to improve the timeliness, completeness, and accuracy of data in TARE to better recruit and match families.
    - The audit found that 98% of children surveyed as part of the audit were not registered on TARE by the 60th day after termination of parental rights as required by CPS policy. Also, in 2015, only 22% of prospective adoptive families who reached out regarding a TARE profile received a response from the agency.[12]
    - DFPS is currently implementing recommendations from the Adoption Internal Audit. State Office and field staff worked in collaboration to complete a massive update of pictures and profiles on TARE, targeting 598 children with 305 of those children's profiles either updated or removed because permanency has been achieved or the permanency goal is no longer adoption.
    - DFPS revised the TARE data warehouse report to accurately reflect the population of children needing TARE profiles in an effort to help field staff better manage recruitment efforts of children who need to be registered on TARE. DFPS also created a resource manual for field staff to help guide them in their efforts to register children on TARE as well as a family resource guide to help families accurately create their family profiles on the TARE website.

Training for Caseworkers

There is currently no specific training manual or curriculum for adoption workers at DFPS. They are conservatorship workers who have chosen to specialize in adoption, and training is conducted by their supervisors and may involve attendance at state or national conferences on adoptions. The agency developed the Adoptions Best Practice Guide in March 2013 to help workers achieve positive, timely permanency for children. The guide includes effective strategies to recruit adoptive placements, prepare a child and a family for adoption, screen adoptive placements, and develop a transition plan. However, only two of the state's 11 regions utilize the Best Practices Guide as part of their standard adoption worker training.[13]

Additionally, 26% of adoption caseworkers and 20% of adoption supervisors surveyed as part of the recent internal audit of DFPS adoptions processes did not feel that the specific adoption training provided to them allows them to effectively perform their jobs. The audit also found that five regions of the state have not provided any formalized agency-developed training for adoption workers in the past two years.[14] DFPS has reviewed the adoption training offered through the DFPS Center for Learning and Organizational Excellence (CLOE) and is making recommendations to enhance training to ensure field staff are better trained and prepared for their role as an adoption preparation worker. As part of the Individualized Training Plan for

Adoptions, field staff who transfer into the adoption program or are newly hired into the adoption program are now required to review the Adoption Best Practice Guide.

DFPS is currently in its 3rd year of the National Quality Improvement Center for the Adoption/Guardianship Support and Preservation (QIC-AG) Project. The QIC-AG is a national 5-year research project, funded by the Children's Bureau, to promote permanency and improve adoption and guardianship preservation and support. The QIC-AG selected eight sites that will implement evidence-based interventions, which if proven effective can be replicated or adapted in other child welfare jurisdictions. Effective interventions are expected to achieve long-term, stable permanence in adoptive and guardianship homes for waiting children as well as children and families after adoption or guardianship has been finalized. DFPS has selected Region 7 for the QIC-AG project. Adoption Clinical Training (ACT) is being implemented with DFPS staff in five counties in Region 7 that serve roughly half the children in the target population. ACT is an adoption and permanency training curriculum for child welfare and mental health professionals developed by the Kinship Center in 2005 and revised in 2009. CASAs serving these five counties will be invited to participate in ACT with DFPS staff. If outcomes of this project are positive, recommendations will be made to DFPS leadership to implement this training to DFPS staff statewide.

Training for Adoptive Families

DFPS requires foster and adoptive parents to attend a pre-service training program that includes Parent Resources for Information, Development, and Education (PRIDE) training, which is a national curriculum developed by the Child Welfare League of America and used by DFPS for adoptions that go through their CPAs. Many CPAs use other training models that are more intensive than PRIDE. DFPS created and completed a workgroup, which has made recommendations to update the PRIDE curriculum.[16] These recommendations, which include additional training related to trauma informed care, have been reviewed and are being considered by DFPS leadership. A new version of PRIDE is currently in development to be more trauma-informed.

Additionally, the 84th Legislature passed House Bill 781, which increased the required training hours for foster and adoptive families, other than kinship families, from 8 to 35 hours.[15] However, the majority of CPAs were already meeting this higher standard. Currently, there is no requirement for advanced or supplemental training for families adopting children with higher levels of need, disabilities or mental illness. There is also no requirement that adoptive families have trauma-informed training. Finally, based on comments received during public testimony at the Senate Committee hearing, adoptive families don't always have a full and complete understanding of the child, and are therefore not always prepared to deal with the special needs that child may have due to the trauma they have endured.[16] Training and preparation for adoptive families should prepare them for the individual, specialized needs of a child to prevent disruptions and dissolutions from occurring, and provide needed services and supports to ensure stability for the child and family.

Post Adoption Services

Post adoption services are provided by contractors throughout the state and are available for adopted children until they turn 18. Available services include information and referral; casework services and service planning; parent groups; parenting programs; counseling services; respite care; residential placement services in critical need situations; and crisis intervention.[17]

In limited circumstances, DFPS provides out-of-home placement for the adoptive child when the child's therapeutic or behavioral needs cannot be met in a family setting, or the child's behaviors are too dangerous to others in the home for the child to remain in the home. To access these services, the adoptive family must have exhausted all community resources, their insurance benefits, and available post-adoptive services.[18] All post adoption families have access to the YES Waiver program through DSHS, whose intensive in-home services can help prevent adoption disruptions and dissolutions.

Many adoptive parents either do not have knowledge of the availability of post adoption services or incorrectly assume CPS will be overly-involved in their lives if they utilize services. To help promote outreach to adoptive families and ensure families are aware of these services, DFPS added a consent statement to the DFPS Adoptive Placement Agreement in order for DFPS to be able to provide families' contact information to the post-adoption contractors to allow for better outreach to these families.[19]

Funding for post adoption services has remained relatively stable over the past several fiscal years, while the number of adoptions has steadily increased. Below is the breakdown of expenditures on post adoption services in Fiscal Year 2015.

FISCAL YEAR 2015	
Post Adoption Services	**Expenditures**
Post Adoption Casework Services	$1,999,880.86
Post Adoption Parent Training	$273,038.69
Post Adoption Residential Services	$759,504.64
Post Adoption Respite Care	$568,974.43
Post Adoption Services Day Treatment	$24,600.00
Post Adoption Therapeutic Counseling	$148,721.50
Therapeutic Camping	$50,370.34
Grand Total	**$3,825,090.46**[20]

There is a lack of information about the quality or effectiveness of services offered by post adoption vendors and a lack of incentives for providers to offer high quality preventative services that will avoid more costly residential care. DFPS should reform performance outcomes in post

adoption provider contracts to ensure quality preventative and out-of-home services are provided to adopted children, to support families, and to prevent future disruptions and dissolutions.

Conclusion

Texas is recognized as a national leader in adoptions of older youth, children with special needs, and sibling groups. Additionally, the state's adoption disruption and dissolution rates are below the national average. However, improvements can still be made. The agency should grow and strengthen its relationships with faith-based entities to bolster recruitment of foster and adoptive families, ensure appropriate, quality services and supports are provided to adoptive children and their families, and provide adoptive families with necessary training and accurate information to ensure they are ready and able to provide a fitting, loving home for a child.

Recommendations

1. **Increase collaboration with faith-based organizations and congregations to recruit, train, and support foster families.**
   - Starting in July 2016, DFPS began working to strengthen its partnerships with faith-based entities and better track its partnerships with them. This work should continue, and the state should explore ways to further develop faith-based partnerships to recruit foster and adoptive families.
   - As of July 2016, DFPS is collecting and tracking data on how many faith-based partnerships involve foster/adoptive recruitment, how many partner with the CARE portal, and how many provide services such as respite. The Committee supports this effort and encourages the agency to continue to better understand, by catchment area and region, where partnerships are needed and how they can be reinforced and better utilized.
   - The Committee supports the Lieutenant Governor's Adoption Summit on November 2, 2016, as an opportunity to foster additional collaboration and communication between faith-based entities, the agency, stakeholders, and the Legislature on how to better recruit foster/adoptive parents and ensure foster children find permanency in safe, loving homes.

2. **DFPS should ensure adoptive families are given a full and complete history of the child.** DFPS should review the information that is redacted from children's records and ensure that the child's history is portrayed accurately to a potential adoptive family. DFPS should ensure potential parents are given these records in a timely manner.

3. **DFPS should focus on ensuring families and caseworkers receive appropriate training.**
   - All adoptive families should receive trauma-informed training.
   - The agency should ensure statewide availability of adoption-specific training for caseworkers and supervisors and should utilize the Best Practices Guidelines created in 2013 as a starting point for this training. Training should include recruitment efforts and matching and selection processes for adoption workers and training for families.
   - The agency should also establish minimum requirements for adoption worker performance.

4. **DFPS should review its adoption process to ensure children are placed in suitable, supportive homes in a timely manner.**
   - DFPS should ensure children are involved in the pre-placement process and are ready for adoption.
   - DFPS should ensure that while its focus is on permanency, it is certain that the child is ready for adoption and understands that they will be adopted.
   - DFPS should identify children most likely to experience an adoption dissolution or disruption and provide individualized services.
   - Triggers should be created to alert caseworkers, agencies, and post adoption service providers of children and adoptive families who are more likely to experience problems.

5. **Post adoption service contracts and performance measures should be evaluated and measured using quality metrics and outcomes.**
   - Targeted funding for in-home, wrap-around services and supports should be considered for children with a higher disruption risk.
   - DFPS should review and reform its performance measures for post adoption contracts to ensure the contracts and outcomes incentivize providers to offer high quality, preventative services, and make data regarding the quality of services available to CPAs, caseworkers, and adoptive families.

6. **DFPS should implement recommendations from the internal adoption audit related to recruitment. Specifically:**
   - Ensure recruitment occurs while simultaneously preparing the child for adoption.
   - Develop and monitor regional outcomes for targeted recruitment efforts.
   - Update TARE by ensuring children's profiles are posted and photos are updated in a timely manner, and require information and inquiries to be reviewed promptly to ensure outdated information is excluded from the website.
   - Ensure inquiries outside of TARE are tracked and performance metrics are established to ensure responsiveness to potential adoptive families.
   - Develop minimum documentation requirements for a child's recruitment activities and matching and selection decisions.

---

[1] Senate Committee on Health and Human Services, Interim Hearing Witness List, April 20, 2016: http://www.legis.state.tx.us/tlodocs/84R/witlistmtg/pdf/C6102016042009001.PDF
[2] Information provided by the Department of Family and Protective Services via email, January 27, 2016.
[3] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services,* April 20, 2016.
[4] Child Welfare Information Gateway, *Adoption Disruption and Dissolution,* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. 2012.
[5] Department of Family and Protective Services, *Child Protective Services Permanency Strategic Plan*, November 2015.
[6] *Supra* Note 5
[7] Department of Family and Protective Services - Why Not You… Why not Me?. http://www.dfps.state.tx.us/Adoption_and_Foster_Care/Why_Not_Me/

[8] Department of Family and Protective Services - Texas Heart Galleries. https://www.dfps.state.tx.us/adoption_and_foster_care/Texas_Heart_Galleries/default.asp
[9] Department of Family and Protective Services- Lt. Governor Requests Help from the Faith Community. http://www.dfps.state.tx.us/adoption_and_foster_care/child/default.asp
[10] Information provided by the Department of Family and Protective Services via email, September 27, 2016.
[11] Department of Family and Protective Services- Welcome to the TARE Website!. https://www.dfps.state.tx.us/application/tare/home.aspx/default
[12] Department of Family and Protective Services, *Audit of Adoption Processes - Recruitment, Matching, and Selection*, August 2016.
[13] *Supra* Note 13
[14] *Supra* Note 13
[15] House Bill 781, 84th Regular Session (Burkett/Zaffirni), 2015.
[16] *Supra* note 1.
[17] Department of Family and Protective Services - DFPS Adoption Support Programs. https://www.dfps.state.tx.us/Adoption_and_Foster_Care/About_Adoption/adoption_support.asp
[18] Department of Family and Protective Services, Child Protective Services Handbook, November 2011.
[19] *Supra* Note 2
[20] Information provided by the Department of Family and Protective Services via email, April 20, 2015.

Interim Charge 3A- Healthy Aging

Interim Charge Language: *Study and make recommendations on innovative methods and best practices to promote healthy aging for the state's population and reduce chronic medical and behavioral health conditions. Identify opportunities for improved collaboration to promote healthy aging in the health and human services system at the state, regional and local levels.*

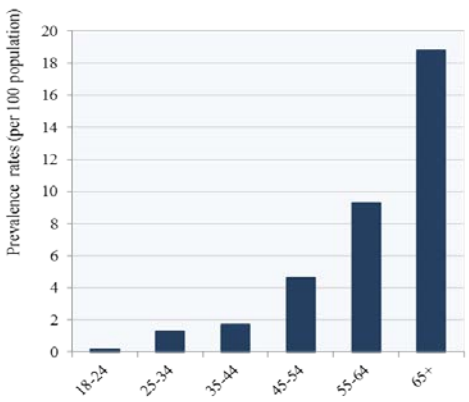
Hearing Information

The Senate Committee on Health and Human Services held a hearing on February 18, 2016, to discuss Interim Charge 3. Individuals representing the Department of State Health Services (DSHS), the Department of Aging and Disability Services (DADS), the Tarrant Aging and Disability Resource Center (ADRC) and Central Texas Area Agency on Aging (AAA) provided invited testimony.[1]

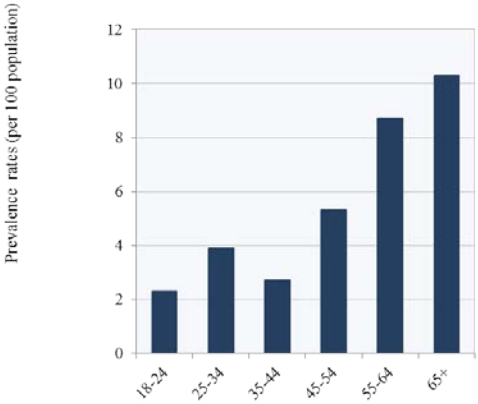
Background

Texas' aging population is growing. In 2010, 10% of Texans were over the age of 65. It is estimated that by 2050, over 17% of Texans will be over the age of 65, an increase of almost 7 million individuals. Texans have higher rates of chronic diseases and associated mortalities and morbidities than national averages, and chronic disease incidence is highest among older Texans.[2] According to a 2013 statewide survey, over 50% of Texans age 60 or older have at least one chronic condition.[3] Advances in medical interventions, public health, and understanding of chronic diseases has increased the average U.S. life expectancy from 66.6 years for males and 73.1 years for females in 1960, to 76.4 years for males and 81.2 years for females in 2014.[4] The graphs below compare prevalence rates of certain chronic conditions among adult Texans.[5]

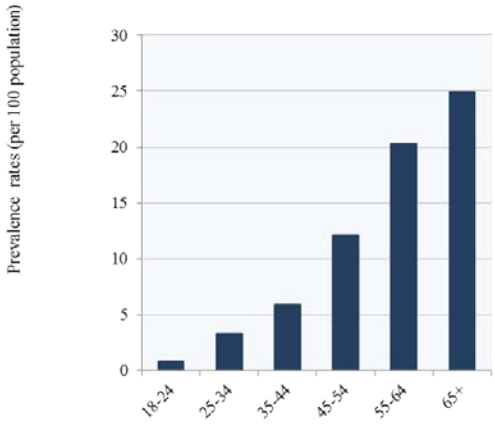
Heart Disease



COPD



Diabetes



The trend of older Texans living longer with a higher prevalence of chronic disease is costly, both in terms of diminished quality of life and increased healthcare costs. As of August 2014, there are 373,835 individuals who are dually eligible for both Medicaid and Medicare in Texas. Of these, 329,866 (over 88%) have been diagnosed with at least one chronic disease.[6] The chart below shows Medicare acute care expenditures associated with caring for these individuals in state fiscal year 2014.[7] Although acute care costs for dual eligibles accrue to the Medicare program, expenditures related to long term services and supports of dual eligibles are paid for by Medicaid. It is likely that serious chronic diseases that lead to complex acute care needs also manifest themselves in the form of increased reliance on long term care services, such as nursing facilities and home health services.

Disease Type	*Number of Adult Dual Eligibles Diagnosed*	*Medicare Amount Paid**
Cardiovascular Disease	271,116	$267,563,351.65
Diabetes	156,203	$178,733,123.26
Hypertension	207,549	$160,878,482.31
Asthma	12,443	$7,688,829.38
Obstructive Pulmonary Disease	58,747	$18,534,870.58

*Some payments may be duplicative as there are enrollees with multiple chronic disease diagnoses.

Evidence-based prevention and disease management programs, along with caregiver supports, are essential to containing costs associated with chronic diseases in the aging population. State agencies that operate these types of programs should collaborate with Texas' institutions of higher education, many of which are engaging in cutting edge research and clinical work to improve the lives of aging Texans.

Prevention

Chronic disease prevention is the most cost effective approach to avoiding high costs associated with treating chronic diseases in the aging population. Ultimately, the success of chronic disease prevention efforts depend on the level of personal responsibility individuals take for their own health.

While several state agencies attempt to prevent chronic diseases among their employees through the operation of employee wellness initiatives, DSHS is tasked with promoting the health and wellness of all Texans. The agency operates a number of programs focused on promoting healthy lifestyle choices and preventing chronic diseases. Examples of these programs include:

- Potentially Preventable Hospitalizations: A locally driven, evidence-based program that supports community engagement on health, healthcare provider training, and education for patients at risk of chronic disease. The project focuses on high-cost conditions in Texas such as congestive heart failure, COPD, and diabetes. In state fiscal years 2012-2013, DSHS estimated $98 million savings in avoided hospital charges as a result of this program.[8,9]
- The Diabetes Prevention and Control Program: Provides education to health care providers and individuals at risk for diabetes. This program is administered collaboratively by local partners like the El Paso Diabetes Association and the Houston Department of Health and Human Services.[10]
- The Tobacco Prevention and Control Program: Focuses on smoking prevention and cessation efforts and the promotion of the Texas Quitline at the local and state level utilizing collaborations with state agencies and community organizations. These programs contributed to a 3.6% reduction in adult smoking in Texas between 2004 and 2010, which translates to $2.1 billion in cost avoidance of healthcare expenditures and $1.7 billion in cost avoidance for reduced productivity.[11,12]

Disease Control and Management in the Aging Population

Since over half of Texans aged 60 or over have at least one chronic disease, management of these conditions is a crucial component of containing the associated costs and ensuring quality of life for individuals living with these diseases. Many entities are engaged in helping individuals manage their chronic diseases, including university health science centers and health insurance plans.

In the Medicaid program, managed care organizations are required to conduct Performance Improvement Projects (PIPs) designed to achieve significant and sustainable improvements in both clinical and non-clinical care areas through ongoing measurements and interventions. The state's external quality review organization (EQRO) recommends topics for PIPs based on health plan performance, member surveys, and encounter data. The Health and Human Services Commission selects two of these goals, which become health plan projects that target specific areas for improvement. HHSC requires each health plan to conduct two PIPs per program. One PIP must be a collaborative with another Medicaid/CHIP managed care organization, dental maintenance organization, or Delivery System Reform Incentive Payment project. Currently,

two of the active PIPs in the Medicaid managed care program focus on reducing negative outcomes for individuals with COPD or diabetes by better managing these conditions.[13]

Federal law requires each state to designate a State Unit on Aging (SUA) to administer, manage, design and advocate for benefits, programs and services for the elderly and their families. Until September 1, 2016, the Department of Aging and Disability Services (DADS) acted as Texas' SUA. As of September 1, these duties have been transferred to the Health and Human Services Commission (HHSC) as part of the consolidation of the health and human services system.[14] In this capacity, HHSC oversees three chronic disease management programs for aging Texans: Chronic Disease Self-Management, Diabetes Self-Management, and Care Transitions Interventions, which attempts to ensure safe transitions across health care settings from a hospital to their home or another health care facility.[15] The goal of the program is to reduce 30-day hospital readmissions.

These three programs are offered by Area Agencies on Aging (AAAs) and Aging Disability Resource Centers (ADRCs). AAAs and ADRCs serve as "front doors" to help simplify the process of finding long-term services and supports. The state's 28 AAAs and 22 ADRCs are overseen by HHSC and operated locally by nonprofits or governmental entities, such as a Council of Governments (COGs). AAAs are federally required under Section 305 of the Older Americans Act (OAA). Approximately 85% of AAA programs are federally funded but require a state General Revenue match.[16] AAAs determine the needs of older persons in their planning and service area. Services include care coordination, legal assistance, prevention programs, and more. ADRCs improve access to supports by assisting individuals in navigating multiple health related systems such as long term care services, mental health services, and Medicaid eligibility services. Additionally, 17 ADRCs provide veteran-specific services such as job training, assistance for caregivers, and help with homelessness. Three ADRCs operate Veteran-Directed Home and Community Based Services (VD-HCBS) programs which allow veterans who would likely require nursing home placement to receive services in their homes or in their communities.[17]

The OAA and HHSC require AAAs and ADRCs to report program data, primarily focused on expenditures. For example, AAAs submit a cost of service information to HHSC and ADRCs report on LBB performance measures, including the number of individuals served by their programs. HHSC should require these entities to report additional data on the outcomes of their disease management programs to assist the agency in determining the effectiveness of these endeavors.

This Committee's Interim Report to the 82nd Legislature contains more detailed information on AAAs and ADRCs and can be found on the Committee's website.

State Plans

In addition to administering prevention and disease management programs, HHSC (formerly DADS) and DSHS are required to create a number of statewide health plans related to aging Texans.

HHSC must develop two major plans related to healthy aging:

- Aging Texas Well Plan: Executive Order 42 issued in 2005 by former Governor Rick Perry created the Aging Texas Well Advisory Committee for the purpose of advising DADS in the creation of a working plan to "identify and discuss aging policy issues, [and] guide state government readiness and promote increased community preparedness for an aging Texas." The plan is updated biannually to include a review of state aging policy and state readiness to care for the aging population.[18]
- State Plan on Aging: The federal government requires HHSC, as the SUA, to submit the State Plan on Aging (OAA Sec. 307) biannually, with any annual revisions as necessary in order to be eligible for program grants. The Plan must include AAA plans specific to their region of the state, an evaluation by HHSC of the need for support services, and an assessment of care preparedness, among other requirements.[19]

While the plans above focus on slightly different aspects of healthy aging, they share common themes and goals, and HHSC, as the newly designated SUA, should attempt to combine these reports into a single effort to develop a statewide strategic plan for improving the health of aging Texans. The agency should use the federally-required State Plan on Aging as a starting point.

The Legislature also created the Legislative Committee on Aging with the passage of HB 610 in the 81st regular session. The Committee is required to study issues related to aging, including an analysis of the availability of, and the unmet needs for, state and local services to care for the aging population. The Committee must make any applicable recommendations to the Legislature by November 15th of each even numbered year.[20]

Community Outreach and Readiness

HHSC and DSHS operate several initiatives to raise awareness of the programs offered by the state to prevent and manage chronic diseases among the aging population, as well as to ensure that communities are prepared to deal with the state's growing aging population.

- Age Well Live Well (AWLW): This campaign encourages people and communities to take the necessary actions to ensure healthy outcomes in the future by focusing on awareness of aging-related issues and resources offered through AWLW partners, HHSC, and the federally sponsored aging network. Currently, there are six AWLW community collaboratives with two more soon to be in operation.[21]
- Aging Texas Well: This program provides communities with resources and expertise to help them assess their infrastructure and readiness for the aging population. It includes an advisory committee that provides recommendations to HHSC and the aging network.[22]

As part of an effort to create a statewide strategic plan on healthy aging, HHSC should consolidate these efforts into one comprehensive outreach and readiness effort.

- Healthy Texas Communities: This program, operated by DSHS, provides technical assistance to communities wanting to improve their environments to include healthy living options. HHSC and DSHS have initiated collaborative efforts between AWLW

and Healthy Texas Communities for the purpose of increasing access and sharing of limited resources. The agencies should pursue more collaborative opportunities between these two campaigns.

Caregiver Supports

As with all areas of healthcare, there is a workforce shortage among professionals who specialize in the treatment and care of aging Texans. The responsibility for caring for these individuals often falls to family members who take on the role of caregiver.

Approximately $35 billion in service fees are forgone by 3.4 million unpaid caregivers in Texas each year.[23] The stress of caregiving can be overwhelming and ultimately takes a toll on the caregiver's health and relationships. It is important that caregivers have the necessary supports to care for their family members in order to preserve their own health and to avoid more costly and restrictive settings for their loved ones.

To provide relief to caregivers, HHSC operates the Texas Lifespan Respite Care Program (TLRCP). TLRCP was created by the Legislature in 2009 to increase the availability of respite services for family members who care for a person of any age with any chronic health condition or disability.[24] TLRCP offers short-term respite care services for caregivers to provide a brief period of relief or rest. Services are targeted toward the need of each caregiver and can be in the form of in-home or out-of-home respite care. Currently, TLRCP funding is allocated to four ADRCs representing Harris County, the Coastal Bend, East Texas and Central Texas.[25] The program is offered to individuals caring for those who do not receive Medicaid assistance in long term care settings, which can delay expensive Medicaid coverage.

Research

Texas has some of the best research institutions in the country, many of which are at the forefront of research on prevention and management of chronic diseases in older Texans. State agencies responsible for promoting and operating programs to prevent and manage chronic diseases among aging Texans have not fully utilized the resources and expertise within the state's academic system. More collaboration and coordination between these institutions is also needed. Some examples of the work occurring at Texas' institutions of higher education include:

- Texas A&M Healthy South Texas Program, Program on Healthy Aging: Provides education and services that focus on the highest impact diseases in 27 counties spanning South Texas. In an effort to understand the fiscal impact of preventive health and disease management, the 84th Legislature appropriated $10 million to the Texas A&M System to operate the program.[26]

- Texas A&M Center for Translational Research in Aging and Longevity: Engaged in ongoing translational research on nutrition, exercise, and metabolism in relation to aging and the most common diseases among the aging population including cancer, heart failure, chronic obstructive pulmonary disease (COPD), obstructive sleep apnea (OSA), mild cognitive impairment/dementia, and autism spectrum disorder.[27]

- UT System Brain Health Initiative: UT launched a multi-campus initiative focused on brain health, including conditions such as Alzheimer's, stroke, and the lasting effects of concussions.[28]

- University of Texas Health Science Center
    - UTHealth Consortium on Aging: The Consortium brings together individuals from each of the six schools of health who are engaged in aging-related education, research, clinical care, and community outreach.
    - UTHealth Pavilion for Healthy Aging and Geriatric Hospital Model: The Pavilion for Healthy Aging expands the successes of the Consortium on Aging by turning research into practice. The Pavilion, an aging specific delivery model, will be available to all UT schools. UTHealth has designed the Geriatric Hospital model, a comprehensive geriatric healthcare delivery model to provide age-specific hospital care. They are currently working to obtain additional partnerships to make the hospital a reality.[29]

- University of Texas at Dallas
    - Center for Vital Longevity: Focuses on advanced brain-imaging technology to understand, maintain and improve vitality of the aging mind and develops interventions to slow age-related cognitive decline.
    - Center for Brain Health: Develops practices to translate promising research to clinical applications related to brain health in the aging population.[30]

- University of Texas Rio Grande Valley (UTRGC): UTRGC operates a research program focused on Alzheimer's Disease and clinical research and development of a Memory Disorders Clinic.[31]

- University of Texas Southwestern Medical Center: The Center for Alzheimer's and Neurogenerative Disease focuses on identifying therapies to cure or halt the progression of dementia and related disorders. It also develops research on progressive protein aggregation in human disease to be able to improve detection of neurodegeneration before symptoms arise and cause a disability. The Geriatric Psychiatry division provides multidisciplinary inpatient and outpatient care, including working with patients with dementia at Parkland, the Veterans Administration Hospital and the University Hospital.[32]

- University of Texas Medical Branch (UTMB) Galveston: The Sealy Center on Aging focuses on improving the health and well-being of the elderly through interdisciplinary research, education, and community service by integrating the resources and activities relevant to aging at UTMB. The Center implements research findings in hospitals and clinics to improve the health of Texan seniors.[33]

- Baylor College of Medicine Huffington Center on Aging: This Center is recognized as one of the leading academic centers in the field of aging and geriatrics. The Center is

devoted to a multifaceted approach to improving the lives of aging individuals, and maintains excellence through:

- Pursuing leading research in the basic understanding of aging and novel therapeutic and treatment options;
- Educating future leaders in gerontology, geriatrics, and the biology of aging;
- Enhancing the quality of life of older people by providing inpatient and outpatient care in collaboration with the Geriatrics section in the Department of Medicine; and
- Providing resources to the general public to improve their knowledge of aging and healthcare, and providing consumers advice for healthy aging.[34]

- Texas Tech University Health Science Center Garrison Institute on Aging (GIA): This initiative helps seniors successfully approach and extend the years of quality life. The GIA addresses health issues of the aging population by investigating the causes of neurodegenerative disease and preparing health care professionals for the growing demands of geriatric care. The GIA is a collaborative initiative of the Health Sciences Center schools: Health Professions, Medicine, Nursing, and Pharmacy.[35]

Conclusion

Texas' aging population is growing and will continue to grow. The state can and should be prepared to handle the needs of the elderly population. This will require increased collaboration between HHSC, DSHS, and our institutions of higher education to establish and encourage the use of the most effective and cost efficient prevention, disease management, and caregiver support programs.

Recommendations

1. **HHSC should better utilize universities to study the effectiveness of existing state programs focused on preventing and controlling chronic diseases.**

2. **Establish a collaborative leadership council to bring together universities with research programs focused on healthy aging in order to increase collaboration and share best practices.**
    - This Council would bring together state leaders in aging research and clinical care to better understand the determinants of healthy aging in older adult populations, expand interventions that promote healthy aging, and translate the state's investment in healthy aging research into sustainable community-based programs and interventions.

3. **Require the Executive Commissioner to appoint a Statewide Aging Coordinator to coordinate efforts on healthy aging and to lead the development of a comprehensive strategic state plan.**
    - Require state agencies that receive funding for aging-related research, clinical care and community programs to report expenditures to the Aging Coordinator in order to identify areas where more collaboration could improve program effectiveness, and areas where the state may be duplicating efforts. The

Coordinator should spearhead efforts to eliminate duplicative programs, committees, reports, and campaigns.

- The Coordinator would facilitate the creation of a comprehensive state wide Strategic Plan on Healthy Aging, beginning with the federally-required State Plan on Aging, and adding additional elements as appropriate.
- The Coordinator would also be required to promote collaboration within the enterprise, across all state agencies, and between state and local entities.

4. **Expand veteran specific supports to the state's aging veteran population through ADRCs.**
    - HHSC should assist in the expansion of veteran-specific services from 17 ADRCs to all 22 ADRCs.[36] The agency should consider requiring a collaborative link between ADRCs that do not provide these services with those that do in order to maximize the efficient use of existing resources.
    - HHSC should assist in the expansion of Veteran-Directed Home and Community Based Services (VD-HCBS) programs by examining what areas of the state would benefit most from the program. Since these programs are federally funded, the agency should assist ADRCs in pursuing grant opportunities.

5. **Remove the Legislative Committee on Aging from statute.**
    - Given the multitude of plans, advisory bodies, and programs focused on healthy aging, and the work of standing committees in the House and Senate on this issue, a separate Legislative Committee is no longer necessary.

6. **Require the revamped Strategic State Plan on Aging to contain outcome data for disease prevention and management programs.**
    - HHSC should use this data to compare programs and examine ways to support the most successful programs.
    - As mentioned above, HHSC should also utilize the expertise of university aging experts to analyze the effectiveness of current programs.

7. **Support respite services for caregivers.**
    - The Legislature should consider expanding the Texas Lifespan Respite Care Program to additional areas of the state.
    - HHSC should also engage with our federal partners to expand the availability of respite benefits for caregivers of Medicare-eligible individuals who do not qualify for hospice but have a serious chronic serious health condition and requires assistance for at least two activities of daily living.

---

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List*, February 18, 2016: *http://www.legis.state.tx.us/Committees/MeetingsByCmte.aspx?Leg=84&Chamber=S&CmteCode=C610.*
[2] Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, February 18, 2016.
[3] Department of Aging and Disability Services, *2013 Aging Texas Well Indicators Survey*, April 2, 2014.
[4] Centers for Disease Control and Prevention.
[5] *Supra* note 2.
[6] Information provided by Health and Human Services Commission via email on July 20, 2016.

[7] *Supra* note 6.
[8] *Supra* note 2.
[9] Information provided by Department of State Health Services via email on March 3, 2016.
[10] *Supra* note 2.
[11] *Supra* note 2.
[12] *Supra* note 7.
[13] Information provided by Health and Human Services Commission via email on June 23, 2016.
[14] Senate Bill 200 (Nelson/Price), 84th Regular Legislative Session, 2015.
[15] Department of Aging and Disability Services, *Testimony before the Senate Committee on Health and Human Services*, February 18, 2016.
[16] Information provided by the Department of Aging and Disability Services via email on April 4, 2016.
[17] Information provided by Department of Aging and Disability Services via email on July 26, 2016.
[18] Governor Perry Executive Order 42, 2005.
[19] Section 307 of the Older Americans Act.
[20] Chapter 161, Subchapter G, Human Resources Code.
[21] *Supra* Note 13.
[22] *Supra* note 13.
[23] AARP Public Policy Institute, *Valuing the Invaluable: 2015 Update*, July 2015.
[24] House Bill 802 (Davis/Zaffirini), 81st Regular Legislative Session, 2009.
[25] Information provided by the Department of Aging and Disability Services, *Overview of FY 2016-2017 Exceptional Item Request*, February 23, 2015.
[26] Information provided by Texas A&M Agrilife Extension, *http://healthytexas.tamu.edu/about-us/*, 2016.
[27] Information provided by Texas A&M Center for Translation Research in Aging and Longevity, *http://ctral.org/*, 2015.
[28] Data collected and compiled by The University of Texas System, April 2016.
[29] *Supra* Note 28.
[30] *Supra* Note 28.
[31] *Supra* Note 28.
[32] *Supra* Note 28.
[33] *Supra* Note 28.
[34] Information provided by Baylor College of Medicine, *https://www.bcm.edu/centers/huffington-center-on-aging/about-us*, 2016.
[35] Information provided by Texas Tech University, *https://www.ttuhsc.edu/centers/aging/history.aspx*, 2016.
[36] *Supra* note 12.

Interim Charge 3B- Long Term Care Quality and Oversight

Interim Charge Language: *Examine and recommend ways to improve quality and oversight in longterm care settings, including nursing homes and ICF/HCS programs. Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services during the 84th Regular Session related to the revocation of nursing home licenses for repeated serious violations.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on February 18, 2016 to discuss Interim Charge 3B. Individuals representing the Health and Human Services Commission (HHSC), the Department of Aging and Disability Services (DADS), the Texas Association of Health Plans (TAHP), Leading Age Texas, AARP, Texas Health Care Association (THCA), Texas Assisted Living Association (TALA), Private Providers Association of Texas (PPAT), the Texas Council of Community Centers, Texas Association for Home Care and Hospice (TAHCH), Providers Alliance for Community Services of Texas (PACSTX), and the ARC of Texas provided invited testimony.[1]

Background

The state has a responsibility to ensure the health and safety of vulnerable Texans, including those who are elderly or disabled and receive long term services and supports (LTSS). At the same time, Texas should foster a regulatory environment for long term care providers that is consistent, fair, ensures quality care, and encourages innovation in the delivery of care. Many individuals receiving LTSS in Texas reside in or are served by one of the following entities:

- Nursing Facilities: Nursing facilities are licensed by DADS to provide organized and structured nursing care and services. Certification by the federal Centers for Medicare and Medicaid Services (CMS) is required to receive payment under the Medicaid or Medicare programs, and DADS also conducts certification surveys for nursing facilities.[2]

- Assisted Living Facilities (ALFs): ALFs are licensed by DADS to provide food and shelter to four or more people who are unrelated to the owner/proprietor of the establishment. ALFs provide personal care services and administration of medication by a person licensed or otherwise authorized to administer the medication. ALFs may also provide skilled nursing services limited to:
    - coordination of resident care with outside home health or hospice providers and other health care professionals;
    - resident assessments to determine the level of care required; and
    - delivery of temporary skilled nursing treatment for a minor illness, injury, or emergency.[3]

- Intermediate Care Facilities for Individuals with Intellectual Disability or Related Condition (ICFs/IID): These facilities are licensed by DADS and/or certified by CMS to provide food, shelter, and treatment or services to four or more persons with an intellectual or developmental disability (IDD) or a related condition who are unrelated to the owner or proprietor of the establishment.[4] The primary purpose of an ICF/IID is to

provide for diagnosis, treatment, or rehabilitation in a protected setting with continuous evaluation, planning, 24-hour supervision, coordination and integration of healthcare or rehabilitative services to help each resident function at their greatest ability.[5] There are small, medium and large ICFs/IIDs in Texas. State supported living centers (SSLCs) are classified as large ICFs/IID and are operated by DADS. Thirteen SSLCs around the state provide services to more than 3,000 individuals and are certified by CMS, but are not licensed by the state. The majority of individuals in Texas ICFs/IID receive services in small facilities with up to eight beds located in neighborhood homes.[6] ICF/IID slots are an entitlement, so there is no wait list to receive services. As of June 30, 2016, there is a 12.9% vacancy rate in ICF/IIDs, excluding SSLCs.[7]

- Home and Community-based Services (HCS): HCS is a Medicaid-funded waiver program that serves as a community-based alternative to ICFs/IID, including SSLCs. Once an individual enters the HCS waiver program, they have the option to receive services in their own home/family home, in a host home/companion care setting, or in a residential home that supports three or four individuals.[8] The waiver provides person-centered services including but not limited to: day habilitation, employment services, therapies, minor home modifications and adaptive aids, transportation, nursing and dental services.[9] HCS program providers are certified annually by DADS but do not have a state license.[10] An interest list for HCS is maintained by local intellectual and developmental disability authorities (LIDDAs). Individuals leaving an SSLC through the HCS waiver program do not have to wait on the interest list, nor do individuals with IDD diverted from a nursing facility or state hospital facility under the requirements of Preadmission Review and Resident Screening (PASRR) regulations. Once an individual is assigned to an HCS provider, the provider must continue to serve the client.

- Home and Community Support Service Agencies (HCSSAs): HCSSAs are licensed by DADS to provide home health services, hospice services, and personal assistance and habilitation services. All HCSSAs are required to be licensed by DADS, and 56% have Medicare certification from CMS.[11] HCSSAs may also choose to become a Medicaid enrolled provider, regardless of whether they have Medicare certification. There are three types of HCSSAs:

    - *Licensed home health agencies:* These entities may be Medicare certified if they wish to bill Medicare for home health services, or may only be licensed by DADS to serve private pay, insurance or other non-Medicare populations. As of July 2016, there are a total 2,608 Medicare-certified parent home health agencies and 1,075 licensed-only parent home health agencies. There is a statewide moratorium on new Medicare certifications for home health agencies as of July 29, 2016, due to concerns about Medicare fraud.[12]

    - *Personal Assistance Services Agencies*: These entities are licensed by DADS to provide ongoing routine care and non-medical services that are necessary to enable an individual to engage in activities of daily living or to perform functions that allow them to remain independent. As of July 2016, there were 4,090 agencies that provide Personal Assistance Services, and 98 of those also provide

hospice care.[13]

- *Hospice agencies*: Hospice agencies may be Medicare certified or licensed by DADS only, but licensure requirements must be as stringent as Medicare certification requirements. 78% of hospice agencies are Medicare certified. Services include palliative care for terminally ill clients and support services for clients and their families. Services must be available 24 hours a day, seven days a week, including during death and bereavement, and must be provided by a medically directed interdisciplinary team. Services may be provided in the home, a nursing facility, a residential unit or an inpatient unit.[14]

- Day Habilitation Centers: These entities provide services to assist individuals with IDD in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the community. This can include prevocational and educational services. Day habilitation centers contract with community-based IDD providers and ICFs/IID. Day habilitation centers are not licensed by any federal, state, or local government entity. Instead, DADS relies on the program providers that place their clients into such care to ensure that these centers provide safe and adequate services. The program's subcontracted providers are responsible for all services and the overall safety of the individuals they serve.[15]

- Day Activity and Health Services (DAHS) Facilities: These facilities are licensed by DADS to provide daytime activities for up to 10 hours per day on weekdays to individuals residing in the community to provide an alternative to nursing facilities and other institutional placements. Services are designed to address the physical, mental, medical, and social needs of individuals through the provision of rehabilitative/restorative nursing and social services and include noon meal and snacks, nursing and personal care, physical rehabilitation, social, educational, and recreational activities, and transportation.[16] A DAHS license issued by DADS is valid for two years. DADS conducts an initial survey of a DAHS facility and a survey every two years for license renewal, as well as complaint investigations.[17]

Regulation/Enforcement Tools

The state must balance the need to sufficiently protect clients through regulation and oversight with the need to ensure that those regulations are not overly burdensome in a manner that diminishes providers' ability to focus on improving quality of care and outcomes. The majority of the providers discussed in this report are heavily regulated, in many cases by both state and federal regulatory authorities, at a level sufficient to ensure the health and safety of residents and clients. For some providers, changes in agency policies and procedures are delivered in an uncoordinated, confusing, and ad-hoc manner without sufficient opportunity for stakeholder questions or input. In order to ease administrative burdens on providers and DADS, licenses for all long term care providers should be issued for a three year period. Survey frequency would remain unchanged, but the lengthening of the licensure period would lessen paperwork and other administrative requirements on providers.

Although current regulations appear to be sufficient for the majority of LTSS providers, DADS is limited in how they can enforce these regulations. A combination of low penalty caps, extensive right to correct provisions, and the lack of progressive sanctions hinder DADS' ability to utilize administrative penalties as a deterrent for failure to comply with minimum standards. DADS should be empowered to fully utilize enforcement tools to hold providers accountable and to discourage violations. Specifically, the Legislature should address the following issues, all of which were raised by the Sunset Advisory Commission report on DADS in 2014 and many of which were included in Senate Bill 204 during the 84th Legislature, which failed to pass.[18]

- **Progressive Sanctions:** When a facility has repeated serious violations for the same offense, sanctions should increase with each violation. In their 2014 review of DADS, Sunset found that DADS fails to adequately track violations and the scope and severity of those violations. This makes it impossible to design and enforce meaningful progressive sanctions. Currently, only nursing facilities have a scope and severity scale, which is based on federal law, to allow surveyors to accurately track and distinguish between violations. Only ICFs/IID currently have a penalty matrix that ties increased penalty amounts to second and third offenses.[19, 20]

  Sunset issued a management recommendation directing the agency to improve tracking of violations of all providers, with a specific focus on ALFs and DAHS. In response, DADS has modified their tracking systems to ensure that immediate jeopardy/immediate threat is an available selection for ALFs and DAHS and has trained staff on these changes.[21] However, additional work is needed to develop and utilize progressive sanctions on long term care providers.

- **Penalty Caps:** Low caps on the total penalty permitted per violation or per inspection has the potential to make administrative penalties for violations simply a cost of doing business for some providers. There are different penalty caps for each provider type, but only nursing facilities currently have adequate penalty caps to discourage future violations.

  - **ICFs/IID:** Penalty caps for a single violation range from $1,000 for facilities with fewer than 60 beds, to $5,000 per violation per day for facilities with 60 or more beds. However, per inspection caps restrict DADS' ability to effectively deter bad actors. The per-violation administrative penalty cap is $5,000 for small ICFs/IID, and $25,000 for large ICFs/IID. For example, if a small facility has a serious violation that continued for 12 days, instead of a $12,000 penalty, the facility would only be subjected to a $5,000 penalty.[22]
  - **ALFs:** Administrative penalties are capped at $1,000, and there is no authority to apply a per day penalty.[23]
  - **HCSSAs:** The highest administrative penalty caps are $1,000 per violation, per day, even for a violation resulting in serious harm or death of a patient.[24]
  - **DAHS:** Administrative penalties are capped at $500 per violation, per day.[25]
  - **HCS:** Currently, DADS has limited enforcement authority to discipline HCS providers. The agency is only able to place a vendor hold (temporary suspension of payment), or terminate the contract. However, when rules implementing

Senate Bill 1385 which was passed by the 84th Legislature go into effect, DADS will be permitted to assess administrative penalties of $100-$5,000 per violation, per day starting in 2017. Senate Bill 1385 will also allow progressive sanctions for repeated violations.[26] Rules are currently in development.

- **Right to Correct:**
  In general, all licensed providers are granted 45 to 60 days to correct violations without being assessed an administrative penalty unless the violation:
    - results in serious harm or death to a client;
    - constitutes an actual serious threat to the health and safety of a client;
    - substantially limits the entity's ability to provide care; or
    - involves one of the following:
        - provider making a false claim to DADS in their application for licensure or renewal;
        - refusal of the provider to allow a DADS representative to inspect a facility or records;
        - provider willfully interfering with the work of a DADS representative;
        - failure to notify DADS of change of ownership in a timely manner; or
        - failure to pay an assessed penalty within 30 days.[27]

The right to correct deficiencies is a useful tool to ensure that providers are not disproportionally punished for small errors, administrative oversights and violations that pose no actual threat to patient health and safety. However, right to correct should be limited to these low-level violations, and should not be permitted for incidents that cause actual harm to a client. Current right to correct rules provisions limit the number of administrative penalties assessed on providers.

In Fiscal Year 2015, administrative penalties were assessed on just 0.9% of all reported ICF/IID violations, 0.7% of all reported ALF violations, and 1.2% of reported DAHS violations. In nursing facilities, the state only assessed penalties on 0.3% of violations in Fiscal Year 2015, and federal regulators only assessed penalties on 2.6% of federal violations. The state assessed administrative penalties on a much higher percentage of HCSSA violations, 38%, collecting $1.4 million in penalties in Fiscal Year 2015. Combined, federal and state monetary penalties on nursing facilities in Fiscal Year 2015 totaled $3.9 million. Total assessment amounts were much smaller for other provider types, with a total penalty amount of less than $155,000 for all 12,651 violations cited collectively in ALFs, DAHS, and ICFs/IID.[28] In many cases, these penalties are insufficient to adequately sanction facilities for violations or to incentivize facilities to change practices and improve quality of care.

In July 2016, CMS issued a revision to the State Operations Manual for nursing facilities requiring that civil monetary penalties be imposed, without the opportunity to correct the violation, for any violation involving immediate jeopardy. This includes violations in which a resident of a nursing facility suffers significant harm. The revisions also

reiterated that state survey agencies have no statutory or regulatory obligation to provide noncompliant facilities an opportunity to correct their deficiencies prior to immediately imposing federal enforcement remedies.[29] This provides assurance that nursing facilities will be held accountable for the most serious violations at the federal level.

Day Habilitation Centers

Day habilitation centers are unique among long term care providers in Texas and merit a separate discussion because there are currently no state or federal licensure or certification requirements in place for these centers. As Sunset's 2014 review of DADS pointed out, there is currently no system of measuring or tracking quality in day habilitation facilities.[30] This is concerning since many ICFs/IID and HCS clients spend multiple hours each week in these facilities.

State expenditures on day habilitation services have increased significantly over the past several years, increasing by 28% from Fiscal Year 2011 to Fiscal Year 2015.[31] As more individuals with IDD are served by these entities, the state must ensure that services provided deliver quality outcomes for clients and that individuals are safe in the care of these centers.

DADS staff only visit day habilitation centers in order to monitor an individual client's care as part of an annual inspection of a program provider. If DADS staff observe that a day habilitation facility is not properly serving a client or failing to provide services that meet the client's service plan, DADS holds the program provider accountable. However, DADS has no direct regulatory authority over day habilitation centers and cannot take any action against the day habilitation provider itself.

Sunset's 2014 review of DADS included a management action requiring the agency to develop, in rule, minimum standard requirements for all community-based IDD program providers to include in their contracts with day habilitation centers. Specifically, the rules must require providers to include in contracts with day habilitation providers requirements to conduct background checks on employees and volunteers, have an emergency response plan, conduct fire drills, post abuse hotline information, and follow an individual's service plan. In response to this management action, DADS has adopted rules requiring community-based IDD providers to establish written agreements with day habilitation centers with whom they subcontract to require the following:

- A fire drill to be conducted at least every 90 days;
- An emergency preparedness response plan to be developed;
- Prominently posting a notice of how to report an allegation of abuse, neglect or exploitation to the Department of Family and Protective Services (DFPS);
- Searching the Nurses Aide Registry and the Employee Misconduct Registry before hiring and at least once per year to confirm that unlicensed employees, independent contractors, and volunteers are not listed in either registry as unemployable;
- Conducting criminal history checks and verifying that unlicensed applicants, independent contractors, and volunteers do not have a criminal history that bars employment; and
- Providing active treatment to individual clients in accordance with the client's Individual Program Plan (IPP), and to keep a copy of the IPP in the day habilitation center.

These requirements will provide some safeguards for individuals receiving care at day habilitation centers. However, the Legislature should consider enacting additional provisions adopted by the Sunset Advisory Commission in 2014 that were included in Senate Bill 204 during the 84th Legislative Session, but the bill failed to achieve final passage. These provisions include:

- Creation of an advisory committee to address the development of a licensure or certification program for day habilitation facilities, with recommendations to the 86th Legislature;
- Requiring DFPS to track data on abuse, neglect, and exploitation in day habilitation facilities and report the findings on at least an annual basis; and
- Requiring DADS to compile basic information and data on day habilitation facilities providing services to persons in these programs, including data on violations and deficiencies found during inspections.[32]

When determining whether to adopt these statutory changes, the Legislature, with input from providers and DADS, should carefully consider the impacts of CMS' final Home and Community-Based Services (HCBS) Settings rule, which requires day habilitation programs to meet qualifications related to more intensive integration into the community. This rule will have far-reaching impacts on the day habilitation model as it is allowed to exist in Medicaid LTSS waivers.[33]

Alzheimer's Certification and Memory Care

Another specialized topic that merits discussion in this report is the use of the term "memory care certification" among nursing facilities and ALFs. The creation of an Alzheimer's certification process for nursing facilities was established in 1989, and was expanded to ALFs in 1998.[34] This certification allows a facility to advertise to consumers that they are a certified Alzheimer's care facility. Certified facilities must meet additional staff training and educational requirements, offer specialized care and activities to residents with Alzheimer's, and meet specific requirements to ensure facilities and premises are locked and secure.[35] As of February 2016, 45 of the state's 1,225 nursing facilities were certified to provide Alzheimer's care and 469 of the state's 1,827 ALFs were certified to provide Alzheimer's care.[36]

In contrast to Alzheimer's certification, the term "memory care certified" is not a category recognized by the state, and there are no known national or industry standards associated with the term "memory care certified". There is no mechanism in place for DADS to track the number of facilities that market themselves as memory care certified, but anecdotally, there has been a proliferation of the use of this term in recent years.[37] The use of terms like "memory care facility" in advertising and marketing to consumers could lead individuals seeking services to believe a facility has been certified by the state to provide specialized care when it has not- and when, in fact, no such certification exists.

Quality of Care

Long term care facilities and providers are heavily regulated in Texas by both the state and federal government, not simply to ensure the health and safety of residents, but to ensure that

quality care is provided and that positive health outcomes for patients and residents are encouraged and incentivized. In many areas, Texas' long term care facilities excel. For example, the 2014 State LTSS Scorecard ranked Texas 10th in LTSS access and affordability, 11th in supports for family caregivers, and 16th in choice of providers and settings. However, quality of care is an area many of the state's long term care providers and regulators of these entities continue to struggle with, as evidenced by Texas' rank as 49th in quality of care and quality of life.[38] As discussed below, different quality measures and quality incentive programs exist for different provider types.

Nursing Facilities:
Overall, the quality of Texas nursing facilities is poor. Among the five states with the most senior citizens, Texas had the highest number of low-rated nursing facilities in a May 2015 report, and over 50% of the state's nursing facilities received one or two stars out of a five star federal rating system.[39] This system bases ratings on state health inspection measures captured through annual CMS recertification surveys, nurse staffing ratios, and quality measures based on the Long-Term Care Minimum Data Set (MDS). MDS is a standardized assessment tool of health status used for all residents in Medicare and/or Medicaid-certified long-term care facilities. The MDS assessment, which is conducted on each resident upon admission and each quarter, contains 11 outcome measures that measure physical, psychological and psychosocial functioning.[40] Since the carve in of nursing facilities into managed care in March 2015, HHSC has implemented programs aimed at improving quality in nursing facilities.

The 82nd Legislature passed Senate Bill 7 in 2011, requiring HHSC to create a Pay for Quality program. Under this program, HHSC would base a portion of Medicaid Managed Care Organizations (MCOs) capitated payments on their performance on outcome measures, including the reduction of Potentially Preventable Events (PPEs) such as preventable admissions (PPAs), preventable complications (PPCs), preventable readmissions (PPRs), and preventable ER Visits (PPVs).[41] The following session, the 83rd Legislature passed Senate Bill 7, directing HHSC to include outcome measures related to LTSS in the Pay for Quality program.[42] Although outcome measures have been developed, the program does not currently include LTSS measures as required by law.[43] Until recently, HHSC was planning to implement the Pay for Quality program by placing 4% of MCO's capitated payments at-risk for recoupment for failure to achieve quality outcomes. However, the agency recently decided to hold MCOs harmless for calendar years 2014, 2015 and 2016 and not to recoup or award any capitation at-risk for those years. Additionally, the agency has decided that there will not be a Pay for Quality program in 2017, and have stated that the agency will "use this time to develop and formalize a new program".[44]

A budget rider included in the appropriation act passed by the 84th Legislature required HHSC to report to the Legislature by December 1, 2016 on the effectiveness of the pay for quality (P4Q) program, including:

- How providers and MCOs use the measures to improve health care delivery;
- Whether these initiatives result in a higher quality of care and improved health outcomes; and
- Efforts to make the P4Q program more effective.[45]

In their Legislative Appropriations Request for FY 2018-19, the agency has requested that this rider be deleted with the following justification:

"HHSC will not have a Pay for Quality (P4Q) program in 2017 and is holding the MCOs harmless for 2014, 2015 and 2016. A new program will be developed in 2018. Meaningful results from this program would not be available until 2021 at the earliest. HHSC recommends deletion of this rider or delay of the required report until December 1, 2021."[46]

While the Committee understands that implementation of at-risk capitation based on quality is a complex undertaking, quality metrics are already developed and the agency should place at least a portion of MCO's capitated payments at risk based on those measures while the agency and stakeholders work though any issues that exist with how to tie payments to those measures. Additionally, the revised program should be implemented by the close of 2018 and outcomes should be available in 2019, rather than 2021, a full decade after the legislature issued a clear directive to tie capitated payments to outcomes.

HHSC has implemented the Dual Demonstration Project which tests a capitated model to integrate care and align financing for beneficiaries eligible for both Medicare and Medicaid. The project utilizes two strategies to align payments with the delivery of quality care:

- *Dual Demonstration Quality Withhold:* Under the Demonstration, both CMS and HHSC withhold a percentage of their respective components of the capitation payment. The withheld amounts are repaid to the STAR+PLUS Medicare-Medicaid Plans' (MMPs) subject to their performance on several quality measures, including one measure related to nursing facility transitions and hospital readmissions.
- *Dual Demonstration Shared Savings***:** HHSC developed a quality incentive program that will require the MMPs to pass through quality incentive payments from HHSC to nursing facilities. A set percentage of the savings HHSC accrues through the Demonstration is shared with nursing facilities based on specific performance metrics related to preventable hospital admissions and readmissions, and medication management.[47]

To some extent, Managed Care Organizations (MCOs) are unable to truly hold nursing facility providers accountable for delivering quality care because state statute requires MCOs to accept any willing provider and prevents them from using their own credentialing standards, limiting their ability to build networks of the highest quality providers. These restrictions should be permitted to expire as scheduled in 2018.[48]

As MCOs are given more tools to hold nursing facilities accountable for quality outcomes, and HHSC moves forward with initiatives to more closely link payments to performance, the state should closely monitor the aggregate impacts on quality of care in nursing facilities. Additionally, as multiple quality initiatives are implemented, the state must ensure that all nursing facilities are striving to reach the same set of outcome measures and that there is a common understanding of what "quality outcomes" mean in the context of skilled nursing care. The committee recommends that outcomes be focused primarily on reducing PPEs, as these

measures are consistent with the P4Q program and are an accurate indicator of how effectively facilities avoid negative outcomes that occur prior to PPEs such as mismanagement of medications and pressure sores.

Antipsychotic Medication in Nursing Facilities: In addition to extremely high nurse staffing ratios and staff turnover, a major contributor to low nursing facility quality rankings has been the large number of nursing facility residents who are receiving antipsychotic medication. This has surfaced as a major issue in nursing facilities across the country, not just in Texas. In 2011, testimony by the U.S. Department of Health and Human Services Inspector General found that nearly a quarter (22 %) of antipsychotic medications prescribed in nursing homes failed to meet CMS standards for avoiding unnecessary drugs. Additionally, the Inspector General found that 83% of Medicare claims for antipsychotic drugs in nursing homes were prescribed "off label".[49]

Through the concerted efforts of DADS, HHSC, and nursing facility providers and advocates, Texas has reduced the use of antipsychotic medication among long-stay nursing facility residents by over 33% since the fourth quarter of Fiscal Year 2011. As of the first quarter of Fiscal Year 2016, ranks 43rd among states in this regard.[50] Additionally, Texas' 33.5% decline exceeded the CMS goal of reducing the use of antipsychotics in nursing facilities by 30% between Fiscal Year 2011 and Fiscal Year 2015.[51] Despite these accomplishments, the use of antipsychotics in Texas nursing homes still hovered near 19% as of May 2016.[52] DADS, HHSC, Medicaid MCOs, and the nursing facility industry should continue to prioritize the reduction of antipsychotic medication use among nursing facility residents as a quality improvement goal.

Assisted Living Facilities:
The majority of ALF residents are private pay--therefore, the state has limited leverage over quality and performance in these facilities. However, as the state regulatory body responsible for ensuring oversight of ALFs, DADS has a duty to ensure quality of care is provided to residents of these facilities. There are currently no standard quality measures in place specifically for ALFs. However, the national Assisted Living Federation, known as Argentum, is in the process of developing standards that member facilities would be expected to adopt. One of these standards relates to quality improvement and contemplates providers collecting data relating to quality indicators and assessing their performance based on those indicators. The state, as the regulator of these facilities, should have access to this data.

HCS and ICFs/IID:
Nationally, there is not yet a standard set of accepted quality measures for LTSS for the IDD population. Outcomes are difficult to measure because the care provided won't improve a person's underlying condition. However, measures that capture a person's quality of life and satisfaction with the services they receive should continue to be developed. Providers in the HCS program and in other waiver programs are still paid on a fee-for-service basis. As the long term vision of SB 7 (83R) materializes and the Legislature continues to consider carving more LTSS program for individuals with intellectual and developmental disabilities into managed care, HHSC should continue to work with MCOs, providers, and consumers to develop outcome measures that focus on PPEs and quality of life. Ultimately, all Medicaid LTSS providers should be paid based on quality outcomes.

HCSSAs:
The majority of HCSSA services for the IDD population are LTSS, which are still paid for on a fee-for-services basis, making it difficult to collect quality measures. Quality outcomes for *acute* care services provided by HCSSAs are tracked by MCOs. HCSSA services for children with disabilities are provided through STAR Kids as of November 1, 2016. Although the STAR Kids contracts with MCOs do not currently include value based payments (VBPs), the long term vision is to incorporate VBPs into these contracts in order to pay MCOs, and ultimately providers, based on quality. One possibility that the agency should begin exploring is tying regulatory performance to VBPs. For example, in addition to quality outcome measures such as preventable ER admissions for home health clients, a contract provision may reduce the level of payment by a certain percentage if the HCSSA is cited for a specified number of serious regulatory violations. This approach, connecting regulatory compliance to quality, should be explored in more depth as the division that regulates long term care facilities moves into the same agency as the Medicaid and CHIP Division in 2017.

Survey Issues

One consistent complaint among providers regarding long term care regulations is the level of variation in how surveys are conducted, when violations are found, and what enforcement actions are taken. There will always be some level of discretion and subjectivity in surveys, but the agency should strive to minimize those inconsistencies as much as possible.

In recognition of survey consistency issues, the 84th Legislature passed SB 914, creating a Long-term Care Facility Survey and Informal Dispute Resolution (IDR) Council to study the survey and IDR processes at nursing facilities, ALFs and ICFs/IID and make recommendations on improving processes. The council will submit a report to the Legislature by January 1, 2017.[53]

In addition to participating in the SB 914 council, DADS has undertaken efforts to improve survey consistency based on Sunset management actions. Specifically, the agency has:

- Streamlined the complaint intake process;
- Conducted a gap analysis of surveyor orientation and training materials;
- Developed a new investigator training and certification process that has been completed by regulatory investigations staff;
- Implemented customer service training for regulatory staff that interact with providers and other stakeholders;
- Increased internal communication by implementing regular calls and/or meetings with DADS regional directors, managers and staff;
- Increased external communication and partnerships with stakeholders through routine meetings and presentations to provider associations and other stakeholder groups;
- Implemented recurring all-staff conferences to provide opportunities for training, information sharing and best practice identification across regions;
- Launched an online form for providers to submit examples of inconsistencies in the survey process so management can take appropriate action;
- Initiated a review of the compliance and enforcement processes, as initial data indicates this is where inconsistencies are most likely to occur; and

- Continues to review data identifying differences between regions, such as IDR results, the number of citations issued by survey teams and the number of immediate jeopardy situations.[54]

Additionally, DADS is statutorily required to conduct joint training to surveyors and long term care providers annually, including specific training on the top ten most frequently cited deficiencies.[55]

Staffing Issues

Texas has severe workforce shortages in many areas of the state. These workforce issues are especially pronounced in the long term care industry. A 2014 report released by AARP ranked Texas 50th in nursing home staff turnover, with a nursing facility staff turnover rate of 72% -- nearly double the national average. Although estimates of the turnover rate for direct care workers in community based long term care settings varies, it ranges between 50 and 65%.[56]

Any future increases in funding for nursing facilities or waiver providers should be targeted to improve staff turnover, wages, and staff to client ratios. One possibility is to fully fund, or increase funding for, the Nursing Facility Direct Care Staff Enhancement and the Community-based Provider Wage Enhancement Program:

- *Nursing Facility Direct Care Staff Enhancement:* Nursing facilities opting to participate in the enhancement program agree to maintain a certain staffing level in return for increased direct care staff revenues. Currently, 982 out of 1,139 (86.2%) Medicaid nursing facilities participate in the enhancement program. Enhancement payments total approximately $77 million all funds per annum.[57]
- *Community-based Provider Wage Enhancement Program:* This program provides rate enhancements to HCS, ICF, and Texas Home Living Waiver providers' base rates, 90% of which must be expended directly on attendant compensation. Since 2010, rate reductions have reduced the amount of funds available for this program by 3% for ICF providers and 1% for HCS providers. An additional $1.2 million All Funds would be required to fund all requested amounts for the program.[58]

If the Legislature decides to fully fund these programs, payments to providers should be based on their ability to achieve quality outcomes for residents and clients.

Conclusion

The state has a duty to ensure that our most vulnerable citizens, including the elderly and individuals with disabilities, are treated in a manner that protects their health and safety and preserves their quality of life. The following recommendations focus on enhancing the regulatory tools of state agencies, reducing administrative burdens on providers, addressing survey inconsistencies, and addressing staffing issues in long term care settings.

Recommendations

Enhancing Regulatory Tools:

1. **Where appropriate, increase administrative penalty caps. Specifically:**
    - Remove per inspection caps on ICFs/IID penalties;
    - Increase ALF penalty caps to $5,000 for the most serious violations;
    - Increase the penalty cap for HCSAAs to $5,000 for the most serious violations. The highest level violations should be delineated to ensure only those violations that result in actual harm or serious jeopardy are subject to the higher penalty cap.

2. **Remove right to correct for violations that cause actual harm to clients.**

3. **Direct DADS, through rule, to create a matrix of progressive sanctions based on scope and severity of violations for each provider type.**

4. **Increase transparency for dementia related care by requiring all nursing facilities to inform residents and potential residents whether or not they have Alzheimer's certification.**

Reducing Administrative Burden on Providers:

5. **Require that, unless they are issued in response to an emergency situation or at the request of the federal government or providers, informational letters, policy changes, and policy clarifications must be issued to providers in a monthly or quarterly packet in a streamlined and coordinated fashion. All such documents should clearly explain the objective, how to implement the changes, and what existing policy, if any, is being altered.**

6. **Consider allowing a three year licensure period for all long term care providers, while maintaining current survey schedules.**

Survey Consistency:

7. **Consider requiring surveys that result in administrative penalties to be signed off on by individuals with expertise in the area in which the violation occurred.**

Staffing

8. **Encourage partnerships between nursing facility and long term care providers, and medical and nursing schools to increase interest in entering the field of caring for geriatric patients and individuals with intellectual or developmental disabilities.**

9. **The Legislature should consider increasing funding for the nurse staff enhancement and the community-based provider wage enhancement program. If funding is appropriated for this purpose, payments to providers should be based on the achievement of performance measures tied to quality.**

10. **Continue efforts to leverage expertise at SSLCs to support clients in the community.** DADS plans to implement a pilot in the fall of 2016 to provide dental services to HCS

clients at the Austin and Richmond SSLCs. The benefits of this pilot should be monitored to determine additional ways to leverage appropriations that are allocated to SSLCs to ensure the most efficient use of resources as the SSLC census continues to decline.

[1] http://www.legis.state.tx.us/tlodocs/84R/witlistmtg/pdf/C6102016021809001.PDF
[2] TAC Title 40, Ch 19
[3] HSC Ch. 147
[4] Health and Safety Code, Chapter 252.002.
[5] TAC Title 40, Ch. 90
[6] Department of Aging and Disability Services and Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services*, February 18, 2016, page 5.
[7] Provided by Department of Aging and Disability Services via email, January 28, 2016.
[8] *Supra* note 6
[9] TAC Title 40, Chapter 9.154
[10] *Supra* note 6
[11] Document provided by Department of Aging and Disability Services on July 7, 2016
[12] U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, *Press Release: CMS extends, expands fraud-fighting enrollment moratoria efforts in six states, July 29, 2016. Available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-07-29-2.html*
[13] Provided by Department of Aging and Disability Services via email, July 22, 2016.
[14] *Supra* note 12.
[15] Sunset Advisory Commission, *Department of Aging and Disability Services Staff Report with Final Decisions*, Chapter 4, July 2015.
[16] Statute; TAC Title 40, Chapter 98.2
[17] Information provided by DADS via email, August 31, 2016.
[18] *Supra* note 16 and Senate Bill 204, 84th Regular Session (Hinojosa/Raymond), 2015.
[19] *Supra* note 16
[20] 40 TAC 90.236(f)
[21] DADS follow up to hearing
[22] 40 TAC 90.236(l) and (m)
[23] 40 TAC 92.551(a)
[24] 40 TAC 97.602(h)(2)
[25] 40 TAC 98.105(d)
[26] Senate Bill 1385, 84th Regular Session (Schwertner, Price), 2015.
[27] 40 TAC 90.240; 40TAC 90.105€; 40TAC 19.2114; 40TAC 97.602©; 40 TAC 92.551(g).
[28] Information provided by DADS via email, August 26, 2016.
[29] U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Survey & Certification Group, *Mandatory Immediate Imposition of Federal Remedies and Assessment Factors Used to Determine the Seriousness of Deficiencies for Nursing Facilities*, S&C: 16-31-NH, July 29, 2016.
[30] *Supra* note 16.
[31] Information provided by DADS via email, April 6, 2016.
[32] Senate Bill 204, 84th Regular Session (Hinojosa/Raymond), 2015.
[33] Centers for Medicare and Medicaid Services, Fact Sheet: Summary of Key Provisions of the Home and Community-Based Services (HCBS) Settings Final Rule (CMS 2249-F/2296-F), January 10, 2014.
[34] Senate Bill 1134, 70th Regular Session (Brooks/Evans), 1987; House Bill 2510, 75th Regular Session (Hilderbran/Zaffirini), 1997.
[35] 40 TAC 19.2208; 40TAC 92.53.

[36] Department of Aging and Disability Services, *Memo to Chairman Schwertner providing follow up information in response to questions raised at the Senate Committee on Health and Human Services hearing on February 18, 2016 to discuss Interim Charge #3B*, March 7, 2016.
[37] *Id.*
[38] Susan C. Reinhard, Enid Kassner, Ari Houser, Kathleen Ujvari, Robert Mollica, and Leslie Hendrickson, *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*, AARP, The Commonwealth Fund, and The Scan Foundation, 2014.
[39]The Henry J. Kaiser Family Foundation, "*Issue Brief: Reading the Stars: Nursing Home Quality Star Ratings, Nationally and by State*", May 15, 2015.
[40] *Id.*
[41] Senate Bill 7, 82nd Legislature (Nelson/Kolkhorst), 2011.
[42] Senate Bill 7, 83rd Regular Session (Nelson/Raymond), 2013.
[43] Information provided by HHSC via email, October 16, 2016.
[44] https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement/pay-quality-p4q-program
[45] Rider 67, Health and Human Services, Article II of the General Appropriations Act passed by the 84th Legislature
[46] Health and Human Services Commission, *Legislative Appropriations Request*, Fiscal Years 2018-19.
[47] *Supra*, note 42.
[48] House Bill 3523, 84th Regular Session (Raymond/Perry), 2015.
[49] *Supra*, note 38.
[50] National Partnership to Improve Dementia Care in Nursing Homes, *Antipsychotic Medication Use Date Report*, July 2016.
[51] *Id.*
[52] *Id.*
[53] Senate Bill 914, 84th Regular Session (Kolkhorst/Schubert), 2015.
[54] Information provided by DADS in response to questions raised at the Senate Committee on Health and Human Services hearing on February 18, 2016 to discuss Interim Charge #3B, March 21, 2016.
[55] Information provided by DADS via email, August 29, 2016.
[56] Supra note 39.
[57] Information provided by HHSC via email, December 3, 2015.
[58] Document provided by Health and Human Services Commission via email, April 11, 2016.

Interim Charge 4: Medicaid Reform and the 1115 Transformation Waiver

Interim Charge Language: *Study the impact of the Section 1115 Texas Healthcare Transformation and Quality Improvement Program Waiver on improving health outcomes, reducing costs, and providing access to health care for the uninsured, and monitor the renewal process of the waiver. Explore other mechanisms and make recommendations to control costs and increase quality and efficiency in the Medicaid program, including the pursuit of a block grant or a Section 1332 Medicaid State Innovation Waiver for the existing Medicaid program.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on September 13, 2016 to discuss Interim Charge 4. Individuals representing the Health and Human Services Commission (HHSC), Regional Health Partnership 1 in east Texas, the Texas Hospital Association, the Texas Organization of Rural and Community Hospitals, the Texas Public Policy Foundation, and the Texas Council of Community Centers provided invited testimony.[1]

Introduction

As the committee stated in its report to the 84th Legislature, the cost of the Medicaid program continues to grow at an unsustainable rate, from $57.2 billion for the Fiscal Years (FYs) 2014-15 biennium, to an appropriated $61.2 billion for the FY 2016-17 biennium, an increase of 7%.[2] Adding the $1.5 billion of supplemental need for FY 2017 brings that increase to 9.7% over the previous biennium.[3] For the FY 2018-19 biennium, HHSC has requested $69.3 billion for the Medicaid program, which if fully funded would represent an increase of more than 13% over the current biennium.[4] Medicaid continues to account for a higher percentage of the state's budget, crowding out other important budget priorities such as child protective services, education, transportation, public safety, and water. The program accounts for nearly 80% of the state's total health and human services budget, and nearly 30% of the total state budget for all items.[5]

The 1115 Medicaid Transformation Waiver has allowed Texas to sustain its safety net and provide increased access to care for thousands of uninsured Texans. The state received a 15 month extension of the waiver at current funding levels, which expires in December 2017. A longer-term renewal of the waiver is crucial to sustain the state's safety net.

Containing costs in the Medicaid program is an absolute necessity if the program is to continue to be a viable safety net for the vulnerable Texans who rely on it for medical care, including individuals with disabilities, the elderly, and low-income children and pregnant women. The Legislature and HHSC should ensure that the waiver, and the Medicaid program overall, are focused on containing costs to the state, increasing quality of care, and improving health outcomes.

Background

At the direction of the Legislature, HHSC sought approval from the federal Centers for Medicare and Medicaid Services (CMS) to preserve the Upper Payment Limit (UPL) program, which was no longer allowed in states pursuing managed care expansions.[6] In December 2011, Texas received federal approval of a five year, $29 billion 1115 Medicaid Transformation Waiver that preserved UPL funding under a different methodology, but allowed the state to continue to

expand managed care in the Medicaid program.[7] The major components of the waiver are expansion of managed care in the Medicaid program and funding pools for providers.

Managed Care Expansion

The 1115 waiver allows statewide expansion of Medicaid managed care services. After the roll out of STAR Kids in November, 92% of all Texas Medicaid services are now provided through managed care.[8] The state has chosen to pursue expansion of Medicaid managed care aggressively since 2011 as a cost containment measure, to increase cost certainty for the state, and to ensure clients' care is managed in a more comprehensive way than is possible in a fee-for-service system. Although the managed care system is not without its flaws, namely administrative burdens for providers, the state has saved $7.1 billion All Funds since FY 2010 through the expansion of managed care.[9] Some of this cost savings has come through the reduction of Potentially Preventable Events (PPEs). For example, in the STAR+PLUS program, Potentially Preventable Admissions (PPAs) were reduced by 10% and associated costs were reduced by 18% from 2012 through 2015.[10] Potentially Preventable Complications (PPC) in the STAR+PLUS program were reduced by 19% and associated costs were reduced by 40% from 2012 to 2015.[11] In addition to generating cost savings, reductions in PPEs are an indicator of the improved quality of care and care coordination that is possible under a managed care system.

Funding Pools

Historical UPL and new funds are earned by hospitals and other providers through two pools:

Uncompensated Care (UC) Pool:

The UC pool replaces UPL and is intended to help cover the difference between Medicaid rates paid to providers and their actual cost of care (the Medicaid shortfall), as well as the cost of providing care to low-income uninsured individuals. The UC pool for the original five year waiver period totaled $17.58 billion, and hospitals and other providers received $17.4 billion of the available pool in Demonstration Years (DYs) 1 through 5. An additional $3.875 billion in UC funds are available for DY 6 and partial DY 7, the 15 month extension period.[12] UC payments are cost-based, and in order to receive payments, providers must submit an annual application on costs and payments for the two years prior to the DY in question. HHSC collects actual cost and payment data and reconciles it with the original application, recouping all overpayments. To mitigate any possible recoupments, HHSC withholds 5% of the UC pool annually.[13]

A portion of UC funding is set aside for "Rider 38 hospitals", rural hospitals located in counties with populations below 60,000, critical access hospitals, and sole community hospitals. The set aside is equal to the total of all Hospital Specific Limits (HSL- the total cost of inpatient and outpatient hospital care for Medicaid and uninsured patients) across all of the Rider 38 hospitals. Funding is distributed proportionately among all Rider 38 hospitals.[14] According to testimony provided by the Texas Organization of Rural and Community Hospitals (TORCH), rural hospitals earned $754.8 million from the UC pool in the first four years of the waiver.[15]

The remaining available UC funds are then separated into seven pools:

- *State-owned hospital pool:* The sum of HSLs related to physician and/or mid-level professional direct patient care costs and pharmacy costs only.
- *Large public hospital pool:* The sum of HSLs with an adjustment for the cost related to the Intergovernmental Transfers (IGTs) provided to fund Disproportionate Share Hospital (DSH) payments.
- *Small public hospital pool:* The sum of HSLs with an adjustment for the cost related to the IGTs provided to fund DSH payments, excluding the HSLs for Rider 38 hospitals.
- *Private hospital pool:* The sum of HSLs excluding the HSLs for Rider 38 hospitals.
- *Physician group practice pool*: The sum of UC costs as reported on the UC physician application for physicians and mid-level professionals.
- *Governmental ambulance pool:* The sum of total allowable UC costs.
- *Publically-owned dental pool:* The sum of total allowable UC costs (based on a cost-to-billed-charges ratio).

In FY 2015, 59.4% of available UC funds were paid to private hospitals, 33.7% were paid to public hospitals, 1.1% to state owned hospitals, and 5.7% to non-hospital providers.[16]

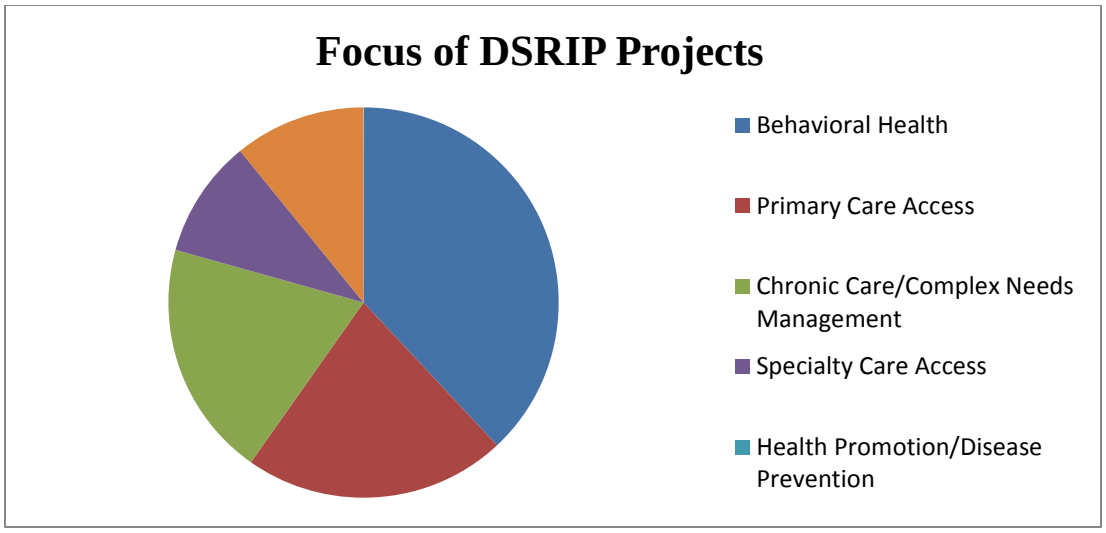
Almost all Texas hospitals have some level of uncompensated care. Texas continues to have a high rate of uninsured citizens, with 19.1% of Texans currently uninsured, and the state's population is growing at twice the national population growth rate.[17] Additionally, illegal immigrants account for more than 6% of the state's population, nearly twice the national average.[18] These factors continue to place a significant strain on the state's safety net and underline the ongoing need for Uncompensated Care funding.

Delivery System Reform Incentive Payments (DSRIP) Pool:
The DSRIP pool provides incentive payments to hospitals and other providers to transform service delivery practices in order to improve quality, health status, patient experience, coordination, and cost-effectiveness. DSRIP projects must target Medicaid recipients and low-income individuals.

1115 Waiver funding in DY 1 was heavily weighted to the UC Pool (88%), and gradually evened out until DY 5 when the UC and DSRIP pools were each able to earn 50% of the total waiver funds. During DY 6 and DY 7, the waiver extension period, DSRIP and UC pools will each be able to earn 50% of the total waiver funds. $11.4 billion was authorized for the initial 5 year waiver period for the DSRIP funding pool, and as of July 2016, over $7.9 billion has been earned and allocated to providers. An additional $2.9 billion could be paid out by July 2018 if all outcome metrics are met and the full available pool is earned. $3.87 billion is available for DY 6 and partial DY 7.[19]

There are 1,451 active DSRIP projects across 297 providers.[20] Projects fall into one of four approved categories: (1) Infrastructure development; (2) Program Innovation, including pilots, tests, and replicating innovative care models; (3) Quality improvements based on improvements in outcomes of Category 1 and 2 projects; and (4) Population-focused improvements. Under this category, all hospitals are required to report on the same standard

measures, and are paid for reporting data.[21] The focus of DSRIP projects varies, but the majority focus on behavioral health and access to primary care. Of the 297 providers participating in DSRIP projects, 219 are hospitals (91 public, 128 private), 39 are Community Mental Health Centers, 21 are local health departments, and 18 are physician groups.[22]



Impacts of the 1115 Waiver

This interim charge directs the committee to explore the tangible impacts of the waiver in terms of increased access, improved health outcomes, and reduced costs.

- *Increased Access to Care:* The waiver has certainly *maintained* access to care by ensuring that hospitals are able to continue to serve Medicaid and uninsured patients. This is particularly true for rural hospitals. According to the Texas Organization of Rural and Community Hospitals (TORCH), many rural hospitals report that between 25 and 33% of their income now comes from waiver funding. Fifteen rural Texas hospitals have closed since the beginning of 2013, but the closure rate among rural hospitals has slowed, with only two closures in 2015. This slowdown in closures is partially attributable to the increase in Medicaid outpatient payments to rural hospitals authorized by the 84th Legislature and the inflow of dollars from the 1115 waiver. According to TORCH, the waiver has helped many rural hospitals keep their doors open, maintaining access to care for millions of rural Texans.[23] Beyond simply maintaining access to care, DSRIP projects have collectively served over 5.2 million additional individuals through almost 6.5 million additional encounters compared to the service levels they provided prior to implementing the DSRIP projects.[24]

- *Improved Health Outcomes*
  As of April 2016, 1,451 active DSRIP projects have 2,112 quality outcome measures with most projects reporting at least one year of performance. Providers have received payments for 81% of outcomes for improvement over their prior year of reporting. For DY 3, HHSC reports that DSRIP program participants experienced a 17% improvement in HbA1C levels for diabetics, a 16% reduction in Emergency Department visits related

to diabetes, a 24% increase in cancer screenings, and a 10% decline in hospital readmissions, among other outcomes.[25]

- *Reduced Costs:* The waiver has allowed the state to leverage funding, including previously unmatched funds flowing to Local Mental Health Authorities (LMHAs), in order to draw down increased federal funding. This has allowed the state to avoid utilizing General Revenue to provide the state match to draw down supplemental payments for hospitals and other providers. However, measuring actual cost *savings* resulting from the waiver is difficult due in part to the sheer number of outcome measures tied to DSRIP projects.

  Calculating cost savings is more straightforward for projects that measure Potentially Preventable Events (PPEs) such as Emergency Room visits and hospital readmissions. Fifty-six DSRIP projects are reporting on hospital readmissions. 75% of outcomes reporting performance in DY4 received incentive payments for improving over their baseline, with a median reduction in readmissions of 10%. 88% percent reported improvement in their second year of performance, with a median reduction in readmissions of 15%.[26] Behavioral health DSRIP projects, even those not primarily focused on reducing PPEs, can have a profound impact on cost savings. A major portion of hospital UC is attributable to Potentially Preventable Admissions (PPAs) and Potentially Preventable Readmissions (PPRs). A 2013 DSHS analysis of 1.2 million PPAs to Texas hospitals found that 32% of the individuals readmitted had a co-occurring mental health or substance abuse disorder. Additionally an HHSC analysis of FY 2012 data found that bipolar disorders, schizophrenia, and major depression were the top three diagnoses of individuals with PPRs.[27]

  While other outcome measures, such as improvements in blood sugar levels or increased screenings for cancer and other diseases, may be useful to gauge the impact of DSRIP projects on health outcomes, if a project is having a positive impact in those areas, there will ultimately be a down stream impact on PPEs. The committee fully supports a long-term renewal of the waiver, and HHSC's proposed renewal application which calls for extending the DSRIP program in its current form. However, if during negotiations on renewal of the waiver with CMS there is an opportunity to revise the structure of the DSRIP pool, the committee recommends streamlining the thousands of outcome measures to a much more succinct list and tying outcome measures to cost savings, with an increased focus on reducing PPEs.

Waiver Renewal

In May 2016, CMS approved a 15 month extension of the waiver at current funding levels through December 2017. In the renewal letter, CMS stipulated certain guidelines that must be met for approval of the waiver at the end of the extension period:

- UC funding should not be used to fund costs associated with uninsured individuals that would otherwise be insured under Medicaid expansion; and

- If new 1115 funding levels are not agreed upon, DSRIP funding will decrease by 25% in 2018 with a 25% decrease in funding for each subsequent year, zeroing out in the fifth year.[28]

Uncompensated Care Study

As part of the 15 month extension, CMS altered the Special Terms and Conditions (STCs) of the waiver to included a requirement for HHSC to submit an independent study related to the to how the DSRIP and UC Pools interact with the state Medicaid shortfall and total uncompensated care, and the potential impact on hospitals if the state decided to expand Medicaid under the Affordable Care Act (ACA). The study was completed in August 2016 by Health Management Associates (HMA) and sent to CMS on September 1, 2016. Some key findings are as follows:

- *Large uncompensated care costs:* Texas' uncompensated care costs, even after factoring in supplemental payments, are large, and will continue to grow. For FY 15, the Medicaid shortfall is estimated to be $3.5 billion, and costs of treating uninsured are expected to total $5.2 billion- a total of $8.7 billion in uncompensated care. This falls to $4 billion after supplemental payments are deducted. In FY 2017, total UC costs are expected to increase to $9.6 billion.[29] This is in part due to a large illegal immigrant population (almost twice the national average), a much higher population growth rate than the rest of the country, and the highest uninsured rate in the country, which is being exacerbated by the abysmal failure of the ACA exchanges and the unaffordability of employer-sponsored coverage.

- *Provider and local financing:* Texas' use of provider and local government funding to finance the non-federal share of Medicaid is well below the national average.[30]

- *Medicaid Expansion:* The impact of expanding Medicaid would be less significant for Texas hospitals than expected, reducing uncompensated care costs by $358 million, or just 3.7% of total uncompensated care costs in FY 2017, While a shift from uninsured to Medicaid would increase hospital revenues and decrease uncompensated care costs, a shift from individual and group health coverage to Medicaid would decrease hospital revenue in most cases.[31] This is a more likely scenario based on the performance of ACA exchanges, with double digit annual increases in premiums and diminished options for consumers as insurers continue to abandon the exchanges.[32] Additionally, an increase in overall hospital care due to increased access under expansion would increase hospital operating costs.[33]

- *Medicaid rate sufficiency:* Like most states, Texas pays hospitals Medicaid base rates well below 100% of costs. Base Medicaid payments as a percentage of cost are 68.8% before supplemental payments, based on FY 2015 data. The report found that, including all current supplemental payments, Texas meets federal statutory requirements for payment adequacy, which requires that the shortfall faced by providers not be so large that it results in insufficient beneficiary access to care. The report also found that compared to other states reviewed in the analysis (Oklahoma, Florida, New York), Texas falls within the normal range of Medicaid reimbursements

rates (69.6% of cost in Texas vs 43.9%, in Oklahoma, 78.7% in Florida, and 79.4% in New York).[1] Further, the study stated that "Texas Medicaid rates as a percentage of cost are closer to the top end of the range for comparable states".[34] These figures are in conflict with the percentage of costs paid by Medicaid that is often cited by hospitals, 58%.[35] It is important to understand that actual Medicaid costs as they are described by hospitals are based on Medicare cost reports. Although these reports are audited, they allow the inclusion of expenses incurred in operating the facility as a whole that are not directly associated with furnishing patient care such as, but not limited to mortgage, rent, plant operations, administrative salaries, utilities, telephone, and computer hardware and software costs.[36]

- *Medicaid rate increases:* The report contemplated the impacts on the burden of uncompensated care if Texas were to fully fund hospital Medicaid rates. This would require a 36% rate increase at a cost of $3.1 billion. The report points out three issues to consider:
    - The majority of Medicaid beneficiaries are in managed care, and federal regulations prohibit the state from directing managed care premiums to providers, so there is no way to ensure increased rates would translate to actual increases for providers.
    - This level of an increase would violate at least one of Texas' four constitutional spending limits, preventing the state from meeting the non-federal match.
    - Assuming part of the cost of rate increases would be paid by reducing UC and DSH payments, large public hospitals that care for a disproportionate share of the uninsured would experience huge losses in revenue that would threaten their survival.[37]

The findings of the independent study makes clear that the state's uncompensated care costs are significant and will continue to grow, further supporting the need for a long term renewal of the 1115 waiver. It also presents a smaller Medicaid shortfall than presented by hospitals.[38] In order to contain costs in the Medicaid program, state leaders including the Chairman and several members of the Committee have repeatedly called on the federal government to grant a block grant to allow the state the flexibility to operate Texas' Medicaid program in a more efficient and effective manner. This interim charge directs the Committee to explore other avenues for flexibility, including pursuit of a Section 1332 waiver.

1332 State Innovation Waiver

Section 1332 waivers, also known as State Innovation Waivers, allow states to utilize innovative approaches and waive certain key elements of the Affordable Care Act (ACA) pertaining to the individual mandate, the employer mandate, benefits, subsidies, exchanges and Qualified Health Plans. For a waiver to be approved, it must follow four guidelines:

1) The waiver must provide coverage to at least as many people as the ACA would provide without the waiver;

[1] 69.9% was from FY 2013, hence the difference from the FY 15 number listed above

2) The waiver must provide coverage that is at least as "comprehensive" as coverage offered through the Exchange. Whether coverage is as comprehensive as Exchange coverage must be certified by the CMS chief actuary based on data from the state and comparable states;
3) The waiver must provide "coverage and cost sharing protections against excessive out-of-pocket" spending that is at least as affordable as Exchange coverage; and
4) The waiver must not increase the federal deficit. The guidelines also give specific consideration to vulnerable populations such as low-income adults, the elderly, and those with pre-existing, chronic conditions.[39]

In December 2015, CMS clarified additional guidelines for states seeking approval including:

- 1332 waivers may not be used to change state Medicaid/CHIP plans;
- When filed in conjunction with an 1115 waiver, each waiver will be considered individually (savings realized using an 1115 waiver cannot be used to offset costs associated with a 1332 waiver);
- To apply for a 1332 waiver, the state must follow a stringent application process such as allowing for public comment periods and passing statute giving authority to implement the waiver prior to waiver approval; and
- The waiver application must contain analyses of costs and benefits, impact on employers, insurers, consumers, and other affected groups, an implementation timeline, and an explanation on how the waiver will expand on the goals of the ACA.[40]

Given the clarifications issued by CMS regarding the 1332 waiver in December 2015 that prohibit 1332 waivers from being used to change the existing Medicaid program, it does not appear that the 1332 waiver is a viable option for the state of Texas.

Conclusion

Texas has a significant uncompensated care burden that will continue to grow. Renewal of the waiver is crucial to maintaining the state's healthcare safety net. If the waiver is not renewed, coupled with a scheduled loss of DSH funding, hospitals will face a funding crisis and significant access to care issues will result. As the committee has stated previously, expansion of Medicaid or any other expansion of coverage using public funds are not viable options for consideration in Texas unless CMS allows for significant increases in the state's flexibility to alter the existing Medicaid program. Additionally, as the UC study conducted by HMA has shown, a Medicaid expansion would just scratch the surface in terms of addressing the state's uncompensated care costs, covering just 3.7% of total hospital UC costs in FY 2017.[41]

Under the best case scenario, Texas would secure a block grant to allow the state to operate its Medicaid program in a way that is right for Medicaid beneficiaries and the taxpayers of Texas. However, this would require an act of Congress. In light of this, Texas lawmakers and agency leadership should focus on renewal of the 1115 waiver with a renegotiation of DSRIP outcome measures to focus on cost savings, and should continue to develop cost containment measures to ensure the long-term viability of the Medicaid program to care for the citizens of Texas who truly cannot care for themselves.

Recommendations

1.) **HHSC should aggressively pursue a longer term renewal of the 1115 Transformation Waiver.**

2.) **HHSC and the Legislature should continue to have a clear focus on bending the cost curve in the Medicaid program.**

3.) **During negotiations, HHSC should pursue a streamlining of DSRIP project outcome measures to ensure that CMS and the state can accurately measure the cumulative impact of DSRIP projects on health outcomes and cost savings.**

---

[1] http://www.legis.state.tx.us/tlodocs/84R/witlistmtg/pdf/C6102016091309001.PDF
[2] Legislative Budget Board, *Fiscal Size-Up FY 2016-17,* May 2016.
[3] Texas Health and Human Services System, *Health and Human Services Consolidated Budget Request 2018-2019 Biennium*, October 2016.
[4] *Id*
[5] *Supra* note 2.
[6] Senate Bill 7, 81st Regular Session, (Nelson/Zerwas), 2011.
[7] Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services,* Sept 13, 2012.
[8] Information provided by HHSC via email, October 26, 2016.
[9] Texas Association of Health Plans, *Testimony before the Senate Committee on Health and Human Services*, Sept 13, 2012.
[10] *Id*; Texas Association of Health Plans, *Testimony before the Senate Committee on Health and Human Services*, February 18, 2016.
[11] *Supra* note 7
[12] *Supra* note 7
[13] Texas Health and Human Services Commission, *Evaluation of Uncompensated Care and Medicaid Payments in Texas Hospitals and the Role of Texas' Uncompensated Care Pool,* As prepared by Health Management Associates, August 26, 2016.
[14] *Id*
[15] Texas Organization for Rural and Community Hospitals, *Testimony before the Senate Committee on Health and Human Services*, Sept 13, 2012.
[16] *Supra* note 13
[17] Texas Hospital Association, *Testimony before the Senate Committee on Health and Human Services*, Sept 13, 2012.
[18] *Supra* note 13
[19] *Supra* note 13
[20] *Supra* note 7
[21] *Supra* note 13
[22] Information provided by HHSC via email, August 30, 2016.
[23] *Supra* note 15
[24] *Supra* note 7, cumulative totals of DY 3, 4 and 5 reporting to date
[25] *Supra* note 7
[26] Information provided by HHSC via email August 30, 2016.
[27] Texas Council of Community Centers, *Role of Community Mental Health Centers in Texas Medicaid 1115 Demonstration Waiver*, March 1, 2016.

[28] *Supra* note 13.
[29] *Supra* note 13
[30] *Supra* note 13
[31] *Supra* note 13
[32] Small, Leslie, *Benchmark ACA Exchange Premiums will Rise by Double Digits in 2017*, Fierce Healthcare, October 24, 2016; Cox, Cynthia, et al, *2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces, Kaiser Family Foundation, October 24, 2016.*
[33] *Supra* note 13
[34] *Supra* note 13
[35] *Supra* note 17
[36] Centers for Medicare and Medicaid Services, *Medicare Provider Reimbursement Manual, Part 2: Provider Cost Reporting Forms and Instructions*, Chapter 43, Form CMS-1984-14, Transmittal 1, August 2014.
[37] *Supra* note 13
[38] *Supra* note 13; *Supra* note17
[39] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html#Fact Sheets
[40] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-12-11.html
[41] *Supra* note 13

Interim Charges 5 and 6- Inpatient Mental Health Reform/Diversion and Forensic Capacity

Interim Charge Language:
-Study and make recommendations on establishing collaborative partnerships between state-owned mental health hospitals and university health science centers to improve inpatient state mental health services, maximize the state mental health workforce, and reduce healthcare costs.
-Study the impact of recent efforts by the legislature to divert individuals with serious mental illness from criminal justices settings and prevent recidivism. Study and make recommendations to address the state's ongoing need for inpatient forensic capacity, including the impact of expanding community inpatient psychiatric beds.

Hearing Information

The Senate Committee on Health and Human Services held a hearing on June 16, 2016 to discuss Interim Charges 5 and 6. Seven individuals provided invited testimony, representing the Department of State Health Services (DSHS), the University of Texas System, the Meadows Mental Health Policy Institute, the Texas Council of Community Centers, the Harris County Psychiatric Center, Texas Correctional Office on Offenders with Medical of Mental Impairments, and the Harris County Jail Diversion Program.[1]

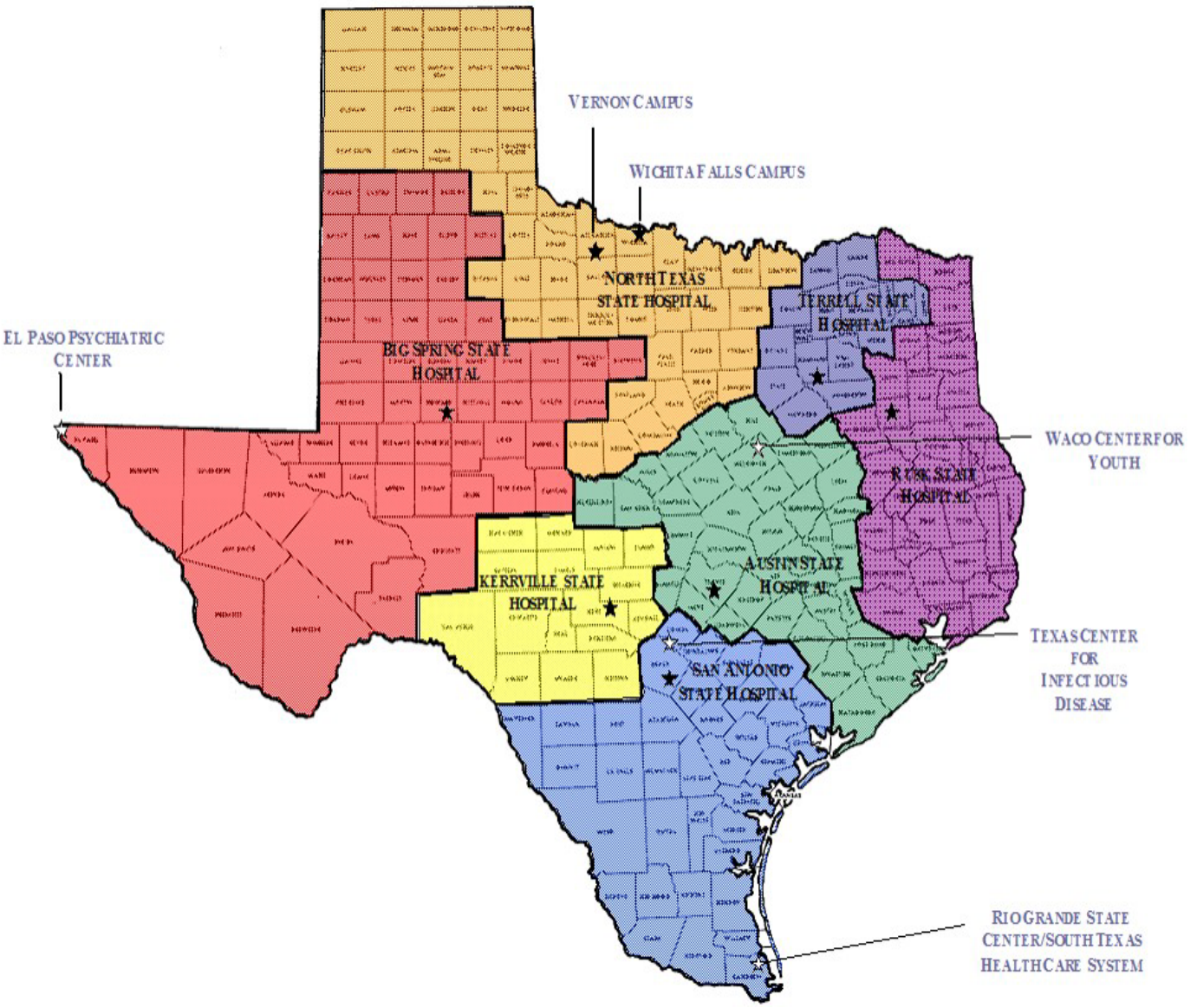
Introduction

The Legislature has made a significant investment in mental health services over the past two legislative sessions, increasing funding by $300 million during the 83rd Legislative session and an additional $244 million during the 84th session.[2] This funding has allowed for increased access to community services, expanded wraparound services, the creation of a robust crisis intervention system, and programs to help divert individuals with mental illness from the criminal justice system. While Texas should be proud of these accomplishments, there are still significant gaps and unmet needs in the state's mental health system.

The inpatient psychiatric system in Texas is facing a crisis, particularly relating to forensic capacity in the state's network of mental health hospitals. In addition to sustaining the significant investments made in recent years, lawmakers should focus on expanding inpatient capacity, growing the mental health workforce, and addressing unmet needs across the continuum of care for "high utilizers", individuals whose ongoing serious behavioral and physical health needs manifest themselves in frequent utilization of the crisis stabilization, inpatient psychiatric, hospital emergency room, and criminal justice systems. The following report combines both mental health related charges assigned to the committee.

Background: Inpatient System

The state hospital system in Texas is made up of nine hospitals and one psychiatric residential treatment facility for youth. The purpose of these hospitals is to stabilize patients in order for them to be treated in a less restrictive setting in the community and to restore competency for those who have entered a state hospital through the criminal justice system.[3] Currently, DSHS oversees the administration of the system. However, this authority will transition to the Health and Human Services Commission (HHSC) on September 1, 2017 as part of enterprise consolidation.[4] Below is a map of the state hospital system and each hospital's service area[5]:



In total, the 10 campuses include 557 buildings with an average age of 55 years spread across more than 2,000 acres. Construction dates range from 1857 to 1996, which has led to a number of infrastructure inadequacies and growing deferred maintenance costs. As of June 6, 2016, the total bed capacity in the system was 2,216 beds, including 918 civil commitment beds and 1,298 forensic commitment beds.[6]

In addition to state operated capacity in the state hospital system, DSHS has purchased 550 beds in the community as of the end of Fiscal Year (FY) 2016 to expand capacity.[7] Both the 83rd and 84th Legislatures appropriated additional funding to expand efforts to contract for capacity in the community. Last session, $50 million in General Revenue was appropriated to contract for 100 additional psychiatric beds in FY 2016 and 150 beds in FY 2017.[8]

Background: Civil and Forensic Commitments

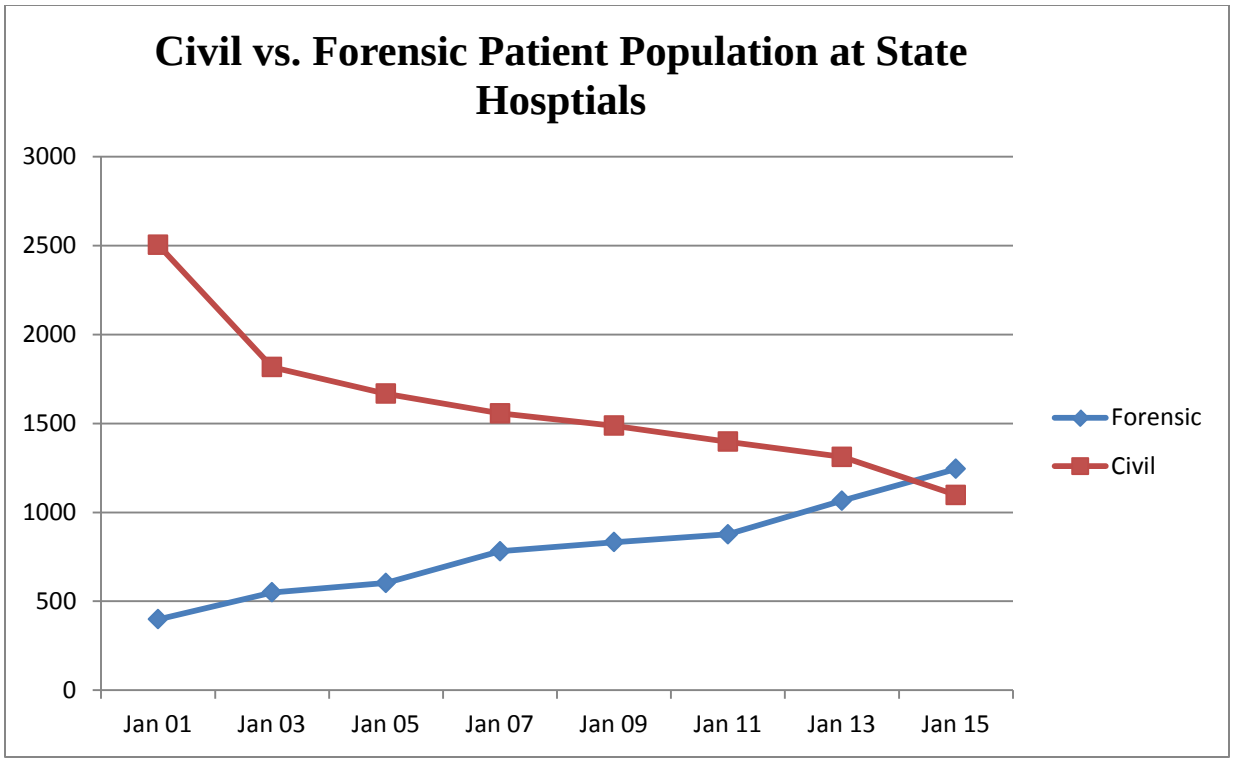
The Texas Code of Criminal Procedure defines ways in which individuals can be committed to the state hospital system. There are two types of commitments:

- *Civil Commitments:* A person with a mental illness who presents a danger to themselves is voluntarily or involuntarily committed.[9] This may involve an Order of Protective Custody or Emergency Detention. Situations also arise in which an individual is committed to a Civil Maximum Security Unit (MSU). These situations usually occur when an individual is already civil committed but needs to be moved to a MSU because they are found to be manifestly dangerous.[10] As of June 6, 2016, there were 26 individuals in civil MSU beds.[11]

- *Forensic Commitments:* A person is accused of a crime but is found incompetent to stand trial or not guilty by reason of insanity.

    - Incompetent to Stand Trial (IST): Chapter 46B of the Code of Criminal Procedure requires an individual found IST to be committed to an inpatient mental health facility (such as a state hospital) or residential care facility (such as a state supported living center), or an outpatient setting for restoration to competency. Whether restoration is inpatient or outpatient is at the discretion of the sentencing judge. Once competency is restored, the individual returns to the criminal justice system for trial.[12]
    - Not Guilty by Reason of Insanity (NGRI): An individual is acquitted of charges and committed to inpatient or residential care until the court determines that they are no longer an imminent risk to themselves or others and can safely be treated in a less restrictive setting.[13]
    - Forensic Commitments requiring Maximum Security: An individual is charged with capital murder or a similar offense, or an offense involving use or display of a deadly weapon.[14] While all nine state hospitals serve forensic and civil patients, only Rusk and Vernon state mental health hospitals have MSUs.[15]

The Joint Committee on Access and Forensic Services released a report in June 2016 which describes the forensic commitment process in more detail.[16] The Committee recommends reviewing pages 7-10 of that report for further background on forensic commitments.



Analysis: Issue Impacting Inpatient Capacity

Texas' inpatient mental health system is facing a capacity crisis, with a forensic waiting list of 342 individuals as of October 7, 2016.[17] Forensic waitlists have resulted in litigation against the state. In 2007, a lawsuit was filed against the state by Disability Rights, Texas on behalf of criminal defendants who had been determined IST and had to wait for what they described as an excessive amount of time between being judicially determined IST and actual admission to a state hospital for competency restoration treatment.[18] There was a claim in the pleadings that a delay in admission to a state hospital of more than three days is a denial of the forensic patient's "due-course-of-law" rights under the Texas Constitution. While the District Court in the case found that having forensic patients on a waiting list for any period of time exceeding 21 days prior to their state hospital admission violates the Texas Constitution, the Third District Appeals Court ultimately ruled that DSHS' existing system of coordination and scheduling of forensic detainees' admissions did not violate the detainees' constitutional rights.[19] The court noted that DSHS's use of a forensic waiting list was rationally related to the state's objective of providing equitable access to limited state psychiatric hospital beds. Although the state prevailed in the lawsuit, DSHS informally adopted the 21 day standard as a benchmark for wait times for forensic beds. Using this 21 day standard, the forensic waitlist was reduced to less than 100 individuals by February 2013, primarily by converting civil beds to forensic and contracting for civil beds. However, the waitlist climbed to more than 400 individuals by February 2016. As of October 21, 2016 the forensic waitlist was as follows[20]:

- MSU: 286 waiting, with 250 waiting longer than 21 days
- Non-MSU: 94 waiting, with six waiting longer than 21 days

A new, similar suit was recently filed in federal court.[21] The plaintiffs argue that "the delays caused by the Department violate the due process rights of these incompetent detainees as guaranteed by the Fourteenth Amendment." While this lawsuit is in the early stages of the legal process, it is in the Legislature's interest to address the issue as a governing body rather than waiting for the court to potentially mandate the manner in which the forensic waitlist must be addressed.

There are a number of complex contributing factors to the forensic capacity issue that can ultimately be explained as a problem of increasing demand for inpatient capacity and reduced supply.

Increased Demand

The demand for forensic beds has continuously increased in the past five years, resulting in a decline in available civil beds for individuals who are severely mentally ill but have not committed a crime. For example, DSHS converted 30 civil beds at San Antonio State Hospital to help address the forensic waitlist, which has caused a backlog of civil commitments in Bexar County. Factors impacting increased demand for inpatient capacity include:

- *Increased Population:* Although the Legislature has invested in increased inpatient capacity in recent years, total inpatient capacity declined from 3,343 beds in 1994 to 2,557 in 2015, while the state's population increased by about 30% from 1990 to 2014.[22] With this population growth comes a proportional increase of individuals with severe mental illness who require inpatient treatment.
- *Judicial Discretion:* Arguably, not all individuals who are currently being treated in an inpatient setting, even those who have been forensically committed, present a danger to themselves or society that should preclude them from being treated in a less restrictive setting, such as an Outpatient Competency Restoration program. However, judges, under pressure from citizens and local leadership, have an incentive to commit individuals who have committed any offense, even low-level misdemeanors, to state hospitals. This ensures that the individual will no longer be an issue for local authorities who may be frequently transporting the individual to county jails, and shifts the cost burden- which can be enormous, particularly for small local governments- to the state.
- *Success of Jail Diversion Programs:* Jail diversion programs divert individuals suffering from mental illness from county jails with the goal of reducing arrests and incarceration while increasing access to appropriate mental health care. The success of these programs has diverted individuals away from the criminal justice system and in many cases has resulted in increased utilization of inpatient psychiatric facilities, including the state hospital system. Some examples of successful jail diversion programs include:

  Harris County Jail Diversion Pilot: This program was created by 83rd Legislature and funded with $5 million in General Revenue and $5 million in local matching funds per biennium. To be eligible for the program, participants must have been booked into Harris County Jail three or more times in the past two years and have a diagnosed serious mental illness. The program is voluntary and excludes certain offenses

such as homicide and sexual offenses. Services are provided by the Harris Center for Mental Health and IDD and include continued engagement, substance abuse intervention, peer support services, medication management, intensive case management, and permanent supportive housing. The results of the program have been promising thus far:

- Participants received an average of eight months of appropriate services;
- 44.1% have had no further bookings into the Harris County Jail; and
- Jail days were reduced by approximately 53 days per person, or a total of 19,744 jail days which has led to a cost avoidance of $2.9 million.[23]

Other Local Initiatives: Local Mental Health Authorities (LMHAs) are responsible for jail diversion planning, and many operate their own jail diversion programs. For example, STARCARE has operated a jail diversion program in Lubbock County since 1999 via a Memorandum of Understanding (MOU) with the Lubbock County Sheriff's Department and additional agreements with the Lubbock County Juvenile Justice Center. Their model, which utilizes the 30 bed Sunrise Canyon Psychiatric Facility to provide intensive inpatient care in lieu of a jail or state hospital, has produced positive results and avoided costs. In FY 2015, the cost of a typical episode of care at Sunrise Canyon was $10,405, compared to $31,620 for a typical episode of care at a state hospital.[24] This model is locally-driven and has allowed for local resources to be leveraged.

Decreased Supply

In the past 20 years, Texas has experienced an overall decline in inpatient psychiatric capacity, from 3,343 in 1994 to 2,557 in 2016. 2,216 of the funded 2,557 beds, or about 87%, were actually in use as of June 6, 2016.[25] There are many factors contributing to the decreased supply of inpatient beds:

- *Inadequate Infrastructure:* Although the state has invested over $100 million of resources in state hospital maintenance since FY 2008, this is a fraction of the needed deferred maintenance cost at these aging campuses. Maintenance issues in the state hospital system have lead to the closure of entire buildings on state hospital campuses. For example, Rusk State Hospital was recently cited by the Centers for Medicare and Medicaid Services (CMS) for issues involving mold.[26] This led to DSHS having to take a number of forensic beds offline and relocate patients to other parts of the campus. This is not an uncommon occurrence at older state hospitals such as Rusk and Austin State Hospital (ASH). Maintenance needs have resulted in a loss of capacity at some hospitals and has contributed to a backlog in county jails of individuals waiting for inpatient beds in the state hospital system. Recognizing this, the Legislature has directed DSHS to begin looking into options to remedy the infrastructure issue.

Specifically, DSHS budget Rider 83 included in the FY 2014-15 biennial budget by the 83rd Legislature required the agency to create a ten year plan to address the needs of the state hospital system. The plan, completed by Cannon Design, identified:

- Five hospitals for replacement: ASH, North Texas - Wichita Falls, Rusk, San Antonio, and Terrell at a total cost of $935.4 million; and[27]
- Five hospitals in need of major renovations: Rio Grande, North Texas - Vernon, Big Springs, Kerrville, and El Paso at a total cost of $174.7 million.[28]

While appropriating the $1.1 billion necessary to replace and repair all of the facilities identified in the ten year plan was not a viable option, the 84th Legislature appropriated $18.3 million to address life and safety maintenance issues at state hospitals. Additionally, the Legislature charged DSHS to focus current replacement efforts on Austin State Hospital[29] and Rusk State Hospital[30] as they are two of the oldest in the system with a number of buildings on their campuses unoccupied due to maintenance issues.

- *Staffing Issues:* The statewide shortage of mental health professionals such as psychiatrists, nurses, social workers, and psychiatric nursing assistants is felt acutely in the state hospital system. According to a recent report on state hospital staffing, the system is experiencing high staff turnover and is suffering from a critical shortage of mental health providers.[31] There are currently a number of forensic beds offline at Vernon State Hospital due to staff shortages. In order to meet staffing needs, DSHS contracts with providers at a much higher cost than the cost of paying a full time state hospital employee. The 84th Legislature appropriated $5.6 million for targeted increases for nursing staff and an across the board increase for psychiatric nurse aides in state hospitals.[32] Additionally, the Legislature continues to fund 15 residency slots through DSHS contracts with Texas medical school departments of psychiatry.[33] Despite these efforts, staff turnover and shortages persist due to difficult working conditions, deteriorating facility conditions, an aging workforce, and highly competitive salaries in similar fields outside of the state hospital system.

- *Improved Access to Outpatient Services:* The Legislature's increasing focus on expanding access to outpatient services, including crisis stabilization, has resulted in a higher acuity population at our state hospitals. Essentially, as local systems have been developed to care for severely mentally ill individuals in the community, the subset of severely mentally ill individuals who find themselves in state hospitals are those who have interacted with the criminal justice system or are so ill that they need intensive inpatient treatment. This has resulted in longer lengths of stay. The average length of stay for MSU increased from 158.1 days in 2012 to 192.9 days in 2015. For those IST (forensic but not MSU), the length of stay has increased from 176 days in 2012 to 217 days during the first two months of 2016. This compares to an average length of stay for civil commitments of about 44 days in Fiscal Year 2016 so far.[34]

Potential Solutions

Solutions to the issues facing the inpatient psychiatric system in Texas should focus on expanding capacity, addressing staffing issues, and building a continuum of care for high utilizers.

Capacity

The Mental Health Advisory Panel, created by House Bill 3793 in the 83rd Legislative Session, was tasked with determining the minimum number of beds needed in the state hospital system to adequately serve forensic and civil patients. The Panel recommended adding 1,500 new state operated and contracted hospital beds to address current capacity needs, and an additional 60 beds annually for population growth.[35] Similarly, the Joint Committee on Access and Forensic Services (JCAFS), created by SB 1507 in the 84th Legislative Session, released a report calling for 1,400 new beds, and an additional 50 beds a year to accommodate population growth.[36] While this Committee agrees that additional forensic capacity needs to be built within the system, the costs and staffing requirements of adding 1000+ beds are prohibitive and unrealistic. Instead, the state should focus limited resources on growing maximum security capacity and developing intensive outpatient capacity in the community.

- *Focus on Maximum Security:* While there is a need for additional non-MSU forensic and civil beds, in the face of limited resources, the state should focus on expanding maximum security beds. The MSU waitlist has quadrupled since 2013 and the majority of those on the waitlist have been waiting for over 21 days for inpatient treatment.[37] The fact that only Rusk and Vernon house MSU patients complicates matters further, as both hospitals are plagued with major infrastructure and staffing issues.

- *Outpatient Competency Restoration (OCR):* Judges have the option to release individuals found incompetent to stand trial on bail and order them to participate in outpatient treatment programs. There are currently 12 OCR programs operated by 12 LMHAs with the capacity to serve 324 individuals.[38] OCR is just as successful as inpatient competency in achieving ongoing competency and costs about half as much. The state should work with local communities to expand OCR to areas where an adequate supply of mental health professionals can be recruited, there is buy-in from local judges and law enforcement officials, and there are sufficient housing options and substance abuse treatment programs.

Addressing Staffing Issues

Adding inpatient capacity is only an effective strategy if there is an adequate professional workforce to actually serve patients. The state should build on existing efforts to expand the mental health workforce by continuing and pursuing the following strategies:

- *University Collaboration:* The state should consider ways to better partner with university health science centers that are already training future mental health providers. Examples of current partnerships include:
  - The University of Texas Health Science Center at Tyler (UT Health Northeast) contracts with the State to operate 30 beds for long term psychiatric patient.[39]

- The University of Texas Health Science Center in Houston operates the Harris County Psychiatric Center (HCPC). In addition to beds contracted via the LMHA, HCPC provides a setting for inpatient competency restoration outside of the state hospital system.[40]

The Legislature should explore expansion of both of these arrangements and foster additional collaborations between state hospitals and university health science centers.

- *Residency Training:* In addition to contracting with universities for inpatient beds, there are also a number of residency agreements between DSHS university health science centers. For example:
  - Texas Tech University Health Science Center provides much of the staffing at the El Paso Psychiatric Center. This contract was recently amended to allow faculty supervision of residents which will enhance the training experience.[41]
  - In July 2017, Rusk and Terrell will benefit from a residency program supported by the UT Health Science Centers at Tyler. The program will have a required one month rotation for first year residents at each hospital as well as 2.5 months of experience for second year residents covering forensic psychiatry, sub-acute treatment-resistant inpatient psychiatry, and geriatric psychiatry.[42]

These residency programs should be supported, and additional opportunities for residency programs in underserved areas of the state should be explored.

- *Telehealth:* Advances in telehealth services, such as telepsychiatry, have helped expand access to behavioral health. Examples of programs utilizing telehealth can be found later in this report as part of the discussion on Interim Charge 7. Notably, only four state hospitals utilize telehealth.[43] The effectiveness of telehealth within the state hospitals system should be studied and expanded if the system is experiencing positive outcomes, such as shorter length of stays.

- *Loan Forgiveness:* The 84th Legislature created and funded a Mental Health Professional Loan Repayment Program to incentivize certain mental health care providers to provide care in underserved areas for five years.[44] Out of the 490 that applied, 109 commitments have been made, indicating a large unmet need for this type of program and leaving ample opportunity for expansion of the program.[45]

- *Recruiting Out of State Psychiatrists:* The state's shortage of psychiatrists is severe, even when compared to other mental health professional shortages. According to a recent report on the mental health workforce shortage in Texas, only 1,933 psychiatrists were actively licensed and offering direct patient care in Texas as of September 2013 to serve the four million Texans with moderate to severe mental illness.[46] Texas' five most populous counties (Harris, Dallas, Tarrant, Bexar, and Travis) had roughly 43.4% of the population and 63% of the state's psychiatrists.[47] To remedy this issue, the Legislature should consider ways to recruit out of state psychiatrists.

Addressing the Needs of High Utilizers

According to the Meadows Mental Health Policy Institute, there are 22,000 individuals in poverty who suffer from severe mental illness and cycle through jails, emergency rooms, hospitals, and crisis stabilization units.[48] However, the state only has capacity to serve about 1 in 7 of these individuals. To ensure long-term recovery for these individuals and to relieve a tremendous cost burden on state and local taxpayers, the state should partner with local communities to build a continuum of care for these individuals, including:

Improving Outreach and Engagement: The state funds a number of Assertive Community Treatment (ACT) Teams, which provide outreach to individuals with the most severe and persistent mental illnesses by providing support and wraparound services in the consumer's home and other community settings. While state funded ACT teams are successful in making contact with individuals, non-statutory contract requirements prevent ACT teams from continuing outreach to individuals in the community once initial contact is made. For example, LMHA contracts require an average of 10 hours of active treatment in order to receive funding. This prevents LMHA ACT teams from continued outreach to an individual who has not yet agreed to begin treatment. ACT teams funded by the 1115 Medicaid Transformation Waiver, such as the Housing First ACT team at Austin Travis County Integral Care, are not constrained by contract requirements. With this flexibility, the Housing First ACT team can supply continued and sustained outreach to the high utilizer population, which has resulted in 85% of the individuals served achieving 12 months of housing stability, a 71% reduction in psychiatric inpatient stays, 51% decrease in incarcerations, and 70% decrease in psychiatric crisis services.[49]

Expanding Supported Housing: Housing is a key component of sustained treatment for severely mentally ill individuals and provides the foundation for care and recovery. The Harris County Psychiatric Center (HCPC) has proposed the creation of a community based continuum of care model to serve SMI individuals who lack stable housing and have four or more admissions per year. This model would provide residential treatment and supported housing with the intent to transition the individual to independent living with outpatient case management as needed. The goal is to reduce recidivism and rapid re-admission to acute care hospitals.[50]

Address Substance Abuse and Physical Health Conditions: Nationally, 7.9 million of the 35.6 million American adults with mental illness, or about 22%, also suffer from a Substance Abuse Disorder.[51] Additionally, severely mentally ill individuals often have undetected or untreated chronic diseases. In providing a continuum of care for high utilizers, co-occurring substance abuse and chronic disease issues must be addressed in order to achieve long-term success in treating the underlying mental illness.

Maximize Crisis Intervention Services: Last session, the State appropriated $13.3 million to expand mental health crisis services, including adding extended observation and crisis stabilization units.[52] This is in addition to the hundreds of millions the state has invested in crisis services over the past several biennium. Rider 80 in the Appropriations Act last session requires DSHS to conduct a comprehensive review of state funded crisis and treatment facilities in order to identify best practices and barriers to effective service delivery in the current crisis system. A report, along with recommendations, is due to the Legislature by December 1, 2016. The

Legislature should work to remove these barriers and identify any gaps in crisis capacity across the state.

Conclusion

Texas should be proud of the recent accomplishments made to develop a comprehensive mental health system, but there is still work to be done to address gaps in the system and address the inpatient psychiatric capacity crisis. The Legislature should focus on protecting past investments in the state's mental health system while considering ways to expand capacity, address the perennial issue of workforce shortages, and develop a continuum of care for high utilizers, utilizing local matching funds, to address wait lists, reduce recidivism, and alleviate pressure on the inpatient mental health and criminal justice systems.

Recommendations

1. **Protect the investment the Legislature has made in developing the state's mental health system.** State budget writers will face serious budget constraints in developing the budget for the next biennium, and difficult decisions will have to be made in order to live within the state's means. However, the Committee recommends that the Legislature should prioritize protecting past investments in mental health. If not, Texas will lose capacity in both forensic and community based settings, compounding the issues that are currently facing the state.

Expand Capacity

2. **Address the inpatient forensic wait list by expanding capacity in the current system.**
    - **State Hospitals:**
        - **Fund additional maximum security beds at Rusk and/or Vernon.** This would reduce the MSU waitlist and increase the current MSU capacity in the state.
        - **Begin plans to replace ASH on its current campus, including residency or operational agreements with UT's Dell Medical School.** ASH's situation is unique when compared to other state hospitals because of its location in an urban center less than four miles from a medical school. The state should research opportunities for external funding partners, including philanthropy.

    - **Community Beds:** In addition to growth within the state hospital system, the state should consider options for contracting forensic beds in the community. The benefit is twofold: community beds allow individuals to receive services closer to their home and are often cheaper than state hospital beds. While the committee recognizes the budget constraints facing the state, we recommend prioritizing the following:
        - **Contract for additional forensic capacity with University of Texas Health Science Center Tyler (UT HSC-Tyler).** The State currently contracts with UT HSC-Tyler to operate 30 residential inpatient beds and has the capacity to expand from 30 to 60 civil and/or low risk forensic patients. The capacity is already in place and can be operational as soon as funding is available.

- **Contract for additional forensic capacity with Harris County Psychiatric Center (HCPC).** There is significant outstanding need for inpatient capacity in Harris County. Harris County falls within the catchment area of Rusk, meaning that if an individual is found incompetent to stand trial in Harris County and no beds are available at HCPC or Montgomery County Psychiatric Center, they must be transported to Rusk three hours away. There the individual is restored to competency and transported back to Harris County. Treating individuals closer to home is not only better for long term recovery and continuity of care, it reduced costs and burdens on staff, often law enforcement, who have to transport individuals over long distances.
- **Strongly Consider Options For Contracting with other University Health Science Centers to operate facilities similar to UT HSC-Tyler and UT Health at HCPC.** The University of Texas Southwestern Medical Center (UTSW) provides another unique opportunity for the State to contract with a university health science center for the operation of a psychiatric facility that treats forensic and civil patients. This would allow the state to reduce state hospital capacity by moving civil capacity from Terrell State Hospital to this new facility along with opportunities to care for low risk forensic patients, while at the same time provide training opportunities for psychiatric residents and other mental health care students at UTSW.

3. **Expand successful Outpatient Competency Restoration Programs.** This would allow additional individuals to be served in a more appropriate and less restrictive setting, while taking pressure off the state mental health hospital system.

4. **Consider restricting where an individual charged with a Class B Misdemeanor can be committed for care.** Modify Chapter 46B of the Code of Criminal Procedure to prevent an individual found incompetent to stand trial and charged with a Class B Misdemeanor from being committed to a state hospital. Instead, the individual could be committed to an inpatient facility other than a state hospital or released on bail for outpatient restoration if the individual is not a danger to others.

Building a Continuum of Care for High Utilizers

5. **Remove unnecessary process measures from LMHAs to allow them flexibility to appropriately and effectively serve high utilizers.** Contract requirements with local LMHAs prevent effective outreach to individuals in need of service. Building flexibility in contracts would allow local providers to better serve their population. Funding flexibility should be tied to reduced recidivism rates in the LMHA service area. General Revenue funded ACT teams should have the same flexibility as non-GR funded ACT teams, such as the Housing First ACT team at Austin Travis County Integral Care.

6. **Expand the Harris County Jail Diversion Program to other areas of the state, with a local match requirement and local option to utilize funding to address other capacity issues such as forensic waitlists.** The successes of the Harris County Jail

Diversion Program should be expanded to other areas of the state that could benefit from such a program. However, it may not make sense to expand the exact same program in certain areas of the state, so flexibility needs to be built in to allow local communities to create programs for the purpose of achieving specific outcomes related to recidivism and forensic commitments.

7. **Consider piloting a psychiatric step-down program as proposed by HCPC.** The program should include ongoing case management, supportive housing, and substance abuse treatment and should focus on individuals with multiple psychiatric inpatient stays. The pilot should be required to closely track outcomes such as recidivism rates and cost savings.

8. **Apply recommendations made as a result of Rider 80 related to crisis intervention.** Make any changes necessary to fully develop and maximize capacity in the crisis intervention system.

Addressing Workforce Issues

9. **Address major staffing issues in our state hospitals and local mental health system by partnering with universities.** Continue funding the Psychiatric Residency Stipend Program which provides for residency rotations at a number of LMHAs. Pursue additional residency training programs between state mental health hospitals and university health science centers, such as the contract between the UT Health Science Center at Tyler and Rusk State Hospital. The state should also track the number of residents who decide to remain working in the public mental health system.

10. **Require the Texas Medical Board to create an expedited licensure process for out-of-state psychiatrists.** A psychiatrist applying for expedited licensure in Texas would need to be board certified; possess a full and unrestricted license to practice in another state that has no disciplinary action, suspension, or restrictions; have never been convicted or received adjudication; and not be under active investigation by a licensing agency or law enforcement in any state, federal, or foreign jurisdiction.

11. **Expand the Mental Health Professional Loan Repayment Program.** Continue funding and expand the Mental Health Professional Loan Repayment Program. Examine opportunities for additional funding options, such as federal matching programs.

---

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* June 16, 2016: http://www.legis.state.tx.us/Committees/MeetingsByCmte.aspx?Leg=84&Chamber=S&CmteCode=C610.
[2] Senate Bill 1, 83rd Regular Legislative Session (Williams/Pitts), 2013 and House Bill 1, 84th Regular Legislative Session (Otto/Nelson), 2015.
[3] Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services,* June 16, 2016.
[4] Senate Bill 200, 84th Regular Session (Nelson/Price), 2015.
[5] Map provided by Department of State Health Services via email on September 22, 2016.

[6] *Supra* note 3.
[7] Information provided by Department of State Health Services via email on September 27, 2017.
[8] House Bill 1, 84th Regular Session (Otto/Nelson), 2015.
[9] Texas Code of Criminal Procedure, Chapter 46B, Subchapter E and Subchapter F.
[10] Information provided by Department of State Health Services via email on October 18, 2017.
[11] *Supra* note 3.
[12] Texas Code of Criminal Procedure, Chapter 46B.
[13] Texas Code of Criminal Procedure, Chapter 46C.
[14] *Supra* notes 11 and 12.
[15] *Supra* note 3.
[16] Joint Committee on Access and Forensic Services, *Recommendations for the Creation of Comprehensive Plan for Forensic Services,* June 2016.
[17] Information provided by Department of State Health Services via email on October 7, 2016.
[18] Lakey v. Taylor, No. D-1-GN-07-837, 2012 WL 6840143, at *1(Tex. Dist., Feb. 02, 2012).
[19] Lakey v. Taylor, No. 03-12-00207-CV, (Tex. App. - Austin, May 2, 2014).
[20] Information provided by Department of State Health Services via email on October 21, 2016.
[21] Ward et al v. Hellerstedt, No. 1:16-cv-00917(Texas Western District Court, July 29, 2016).
[22] *Supra* note 3.
[23] Information provided by Harris County Mental Health Jail Diversion Program, *Testimony before the Senate Committee on Health and Human Services,* June 16, 2016.
[24] Information provided by Texas Council of Community Centers, *Testimony before the Senate Committee on Health and Human Services,* June 16, 2016.
[25] *Supra* note 3.
[26] *Supra* note 3.
[27] *Supra* note 3.
[28] *Supra* note 3.
[29] *Supra* note 4.
[30] House Bill 1, 84th Regular Session (Otto/Nelson), Article II, Department of State Health Services, Rider 86b.
[31] Texas Department on State Health Services, *Fiscal Year 2015 Report on State Hospital Staffing by Quarter.*
[32] *Supra* note 3.
[33] Information provided by the Department of State Health Services via email on August 10, 2016.
[34] *Supra* note 3.
[35] Department of State Health Services, *Allocation of Outpatient Mental Health Services and Beds in State Hospitals,* January 2015.
[36] *Supra* note 15.
[37] *Supra* note 3.
[38] Information based on Department of State Health Services website, *Outpatient Competency Restoration Programs: An Overview,* July 17, 2014.
[39] University of Texas System, *Testimony before the Senate Committee on Health and Human Services,* June 16, 2016.
[40] Harris County Psychiatric Center, *Testimony before the Senate Committee on Health and Human Services,* June 16, 2016.
[41] *Supra* note 33.
[42] *Supra* note 33.
[43] Information provided by Department of State Health Services via email on August 15, 2016.
[44] Senate Bill 239, 84th Regular Session (Schwertner/Zerwas), 2015.
[45] Information provided by the Texas Higher Education Coordinating Board via email on October 28, 2016 and November 1, 2016.
[46] Department of State Health Services, *The Mental Health Workforce Shortage in Texas,* September 2014.
[47] *Supra* note 46.
[48] Meadows Mental Health Policy Institute, *Testimony before the Senate Committee on Health and Human Services,* June 16, 2016.
[49] Information provided by Austin Travis County Integral Care via email on October 24, 2016.
[50] Information provided by Harris County Psychiatric Center, *Testimony before the Senate Committee on Health and Human Services,* June 16, 2016.

[51] Substance Abuse and Mental Health Services Administration (SAMHSA), *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health*, September 2015.
[52] House Bill 1, 84th Regular Session (Otto/Nelson), Article II, Department of State Health Services.

Interim Charge 7: TeleHealth

Interim Charge Language: *Study and make recommendations on the appropriate use, scope, and application of tele-monitoring and telemedicine services to improve management and outcomes for adults and children with complex medical needs and for persons confined in correctional facilities. Examine barriers to implementation of these services and any impact on access to health care services in rural areas of the state.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on June 16, 2016 to discuss Interim Charge 7. Individuals representing the Texas Medical Board (TMB), the Health and Human Service Commission (HHSC), Texas Tech University, the University of Texas Medical Branch-Galveston, and Children's Health System of Texas provided invited testimony.[1]

Background

For many years, the Texas Legislature has attempted to address the state's medical workforce shortage through significant investments in graduate medical education, loan forgiveness programs, targeted wage and rate increases for direct care workers, incentives for providers to practice in underserved areas, and a complete overhaul of tort statutes to ease the burden of frivolous lawsuits on physicians. However, due to Texas' size and exceptional growth, access to appropriate medical care continues to be an issue, especially in rural areas.

According to the U.S. Department of Health and Human Services, over half of Texas' 254 counties are designated as full or partial Primary Care Health Professional Shortage Areas (PC-HPSAs), federally designated regions with shortages of primary care providers based on a physician to population ratio of 1:3,500.[2] Shortages of mental health providers are even more severe: as of January 1, 2015, 199 Texas counties were designated as Mental Health Professional Shortage areas (MHPAs), which are defined as a geographic area with a psychiatrist to population ration of 1:30,000.[3] In September of 2014, the Department of State Health Services (DSHS) released a report outlining the mental health workforce shortage in Texas. The report highlighted shortages of mental health professions such as clinical psychologists, clinical social workers, and licensed professional counselors.

Medical teleservices are currently used throughout the state to address access to care issues in primary care, behavioral health, and specialty areas such as trauma care and post-transplant care. This report will outline successful uses of medical teleservices and discuss potential ways to further utilize medical teleservices to address access to care and workforce shortage issues. The committee supports the premise that telemedicine should be utilized to support and strengthen existing doctor-patient relationships, not to supplant them.

Definitions

In the context of this report, "medical teleservices" encompasses three types of services:

- *Telemedicine:* The practice of medical care delivery, initiated by a distant site provider who is physically located at a remote site for the purposes of evaluation, diagnosis, consultation, or treatment which requires the use of advanced

telecommunications technology that allows the distant site provider to see and hear the patient in real time.[4]

- *Telehealth*: A health service, other than telemedicine, delivered by a licensed or certified health professional acting within the scope of their license or certification. The primary difference between telemedicine and telehealth is that only a doctor or delegated Physician's Assistant (PA) or Advanced Practice Nurse (APRN) can provide telemedicine services, while other certified or licensed health professionals may provide telehealth services.[5]
- *Telemonitoring*: Scheduled, remote monitoring of data related to a patient's health, and the transmission and review of that data. This type of service must be ordered by a physician.[6]

Current Allowable Uses of Telemedicine in Texas

Texas Medical Board (TMB) Rule 174 outlines the legal uses of telemedicine in Texas and specifies requirements for adequate patient notification, provider protocols to prevent fraud and abuse, adequate security, and regulations on when, where, and how telemedicine can be administered.[7]

These rules specify two ways in which medical care can be administered through telemedicine:

1. *Established Medical Site*: A patient may receive care via telemedicine if the patient is physically located at an established medical site. Established sites include any location where an individual would seek medical care, such as a hospital or clinic, so long as a patient site presenter is present. TMB rule defines a patient site presenter as an "individual at the patient site location who introduces the patient to the distant site physician for examination and to whom the distant site physician may delegate tasks and activities. A patient site presenter must be licensed to perform health care services…and is delegated only tasks and activities within the scope of individual's licensure." The patient site presenter must use the appropriate medical diagnostic technology to allow the distant site provider to perform an adequate physical examination.[8]

2. *Follow Up Visits*: After an initial diagnosis is made, follow-up care for that diagnosis may be administered through telemedicine from any location for up to a year. New conditions may be treated in this manner for 72 hours, after which an in-person visit is required.[9]

Additional requirements include:

- *Physician-Patient Relationship*: A physician-patient relationship is defined by Texas Medical Board Rule 190.8(1)(L) and is required before telemedicine can be utilized. This relationship can be established either through a face-to-face visit with a physician or via telemedicine if care is administered by a qualified patient site presenter at an established site. Rule 190 also requires the establishment of a physician-patient relationship before a physician can prescribe dangerous drugs or controlled substances.[10]

In 2015, as a result of a lawsuit filed against the Texas Medical Board, a federal judge issued a temporary injunction that allowed physicians to prescribe certain drugs through telemedicine without a physician-patient relationship. The ruling has been appealed to the 5th U.S. Circuit Court of Appeals.[11]

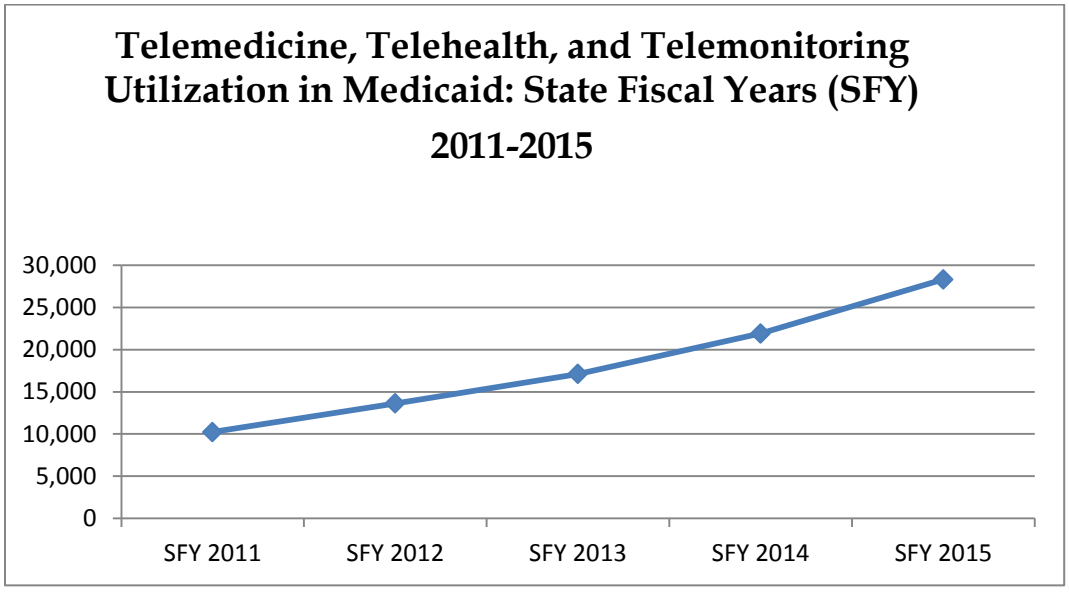
- *Technology and Security Requirements:* Chapter 174, Rule 174.9 requires the use of advanced communication technology and adequate security measures to keep all patient information HIPAA compliant. All telemedicine visits are required to be stored in the patient's medical record by both the distant site provider and the patient site provider.[12]

Texas law provides different requirements for the appropriate use of telehealth:

- Telehealth is any health service provided via teleservice that is provided by any health professional other than a physician.[13] Typically, this term is used to describe the use of advanced telecommunications to facilitate the delivery of mental health services. Mental telehealth services do not require a physician-patient relationship because a physical exam is not a traditional component of mental health services.[14] Telehealth is also not required to be delivered at an established medical site.[15] There are two exceptions to this:
    1. If the standard of care dictates a physical exam, such as a behavioral health emergency;[16] or
    2. Federal Regulation - Ryan Haight Act: If the standard of care requires the prescription of a controlled substance.[17]

Current Uses of Teleservices in the Medicaid program

The state authorized the establishment of a telemedicine Medicaid benefit in the late 1990s and expanded the benefit to include telehealth and telemonitoring in 2011.[18] There has been a steady growth of medical teleservices utilization in Medicaid since that time.



[19]

The 82nd Legislature authorized the creation of a telemonitoring benefit in the Medicaid program.[20] Medicaid clients who are diagnosed with diabetes and/or hypertension and meet additional risk factors such as frequent ER visits or hospitalizations, lack of informal supports, or a frequent history of falls, are eligible for the service.[21] Telemonitoring is provided by a hospital or home health agency and must be monitored 24 hours a day, seven days a week.

Medicaid reimbursement of telemonitoring is available for:

- One time equipment installation costs;
- Review of data transmissions at a daily rate, regardless of the number of data transmissions per day; and
- Providers, for services delivered including patient assessment, diagnosis, consultation or treatment. Providers are reimbursed once every seven days regardless of the number of data transmissions.[22]

The enabling legislation passed in 2011 required the telemonitoring benefit to expire in 2015, but legislation was passed by the 84th Legislature extending the benefit until 2019 to allow more time to collect and analyze data to determine the effectiveness of the benefit.[23] The enabling legislation also required the agency to issue a report by December 31, 2012, including information regarding utilization of the home telemonitonring benefit, the health outcomes of Medicaid recipients who received the benefits, the hospital admission rate of Medicaid recipients who receive home telemonitoring services under the program, the cost of the home telemonitoring services provided under the program, and the estimated cost savings to the state as a result of the program.[24] Although the benefit was not in place and available to clients until October 2013, this report was never issued. As of the publication of this report, the agency is not able to distinguish telemonitoring utilization separately from other teleservices such as telemedicine and telehealth services. The purpose of this reporting requirement, and of calls from legislators since the creation of this benefit to inform them about outcomes of the program, is to determine how effective and beneficial the benefit is, and whether the legislature should authorize additional diagnoses to be treated utilizing telemonitoring. Without this type of data, the Legislature should refrain from expanding the benefit. It is the understanding of this Committee that the report due December 1, 2016, will include a specific analysis of each teleservice separately as well as recommendations on expansion of telemonitoring. Without this information, the Committee cannot make informed decisions on the effectiveness of this service, whether it should be expanded, or even whether it should be continued in its current form.

Medical Teleservices in Managed Care: With 92% of Texas Medicaid services now offered through managed care, the utilization of teleservices in Medicaid depends in part on efforts of Medicaid Managed Care Organizations (MCOs) to support and incentivize the use of these services among their providers and members.[25] Although MCOs are required to process Medicaid provider claims for medical teleservices, it is unclear whether MCOs are allowed or encouraged to utilize teleservices to meet network adequacy standards. In 2014, HHSC surveyed 19 MCOs about the use of teleservices by their members. None of the MCOs surveyed incentivized the use of teleservices, 14 of the 19 MCOs did not track the use of teleservices, and one MCO had zero providers utilizing the technology.[26]

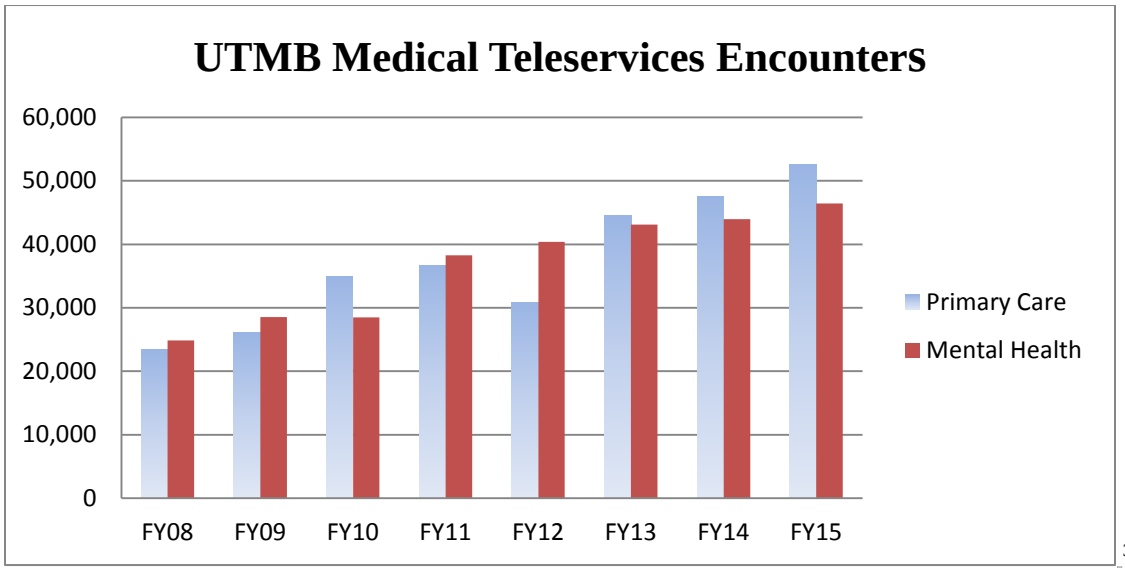
Medical Teleservices DSRIP Projects: There are 80 medical teleservices projects funded through the Delivery System and Reform Incentive Payment Program (DSRIP) under the 1115 transformation waiver.[27] These programs range from delivering specialty care via telemedicine to tele-psychiatry for emergency and nonemergency situations, all with the goal of expanding access to care. A total of 132,006 health encounters can be attributed to these projects.[28]

Examples of Current Teleservices Use in Texas

Correctional Managed Care: Inmates confined in the Texas Department of Criminal Justice (TDCJ) system receive health care services though Correctional Managed Health Care (CMHC). CMHC is a collaboration between TDCJ, Texas Tech University Health Science Center (TTUHSC), and the University of Texas Medical Branch Galveston (UTMB).[29] Medical teleservices allow TTUHSC and UTMB to provide timely access to needed medical care in areas of the state experiencing provider shortages.

TTUHSC contracts with TDCJ to provide health services to inmates in the western half of the state, or approximately 22% of offenders. In the first eight months of state Fiscal Year 2016, TTHSC provided 5,353 telemedicine visits.[30] Telemedicine facilitated timely access to subspecialties such as urology, internal medicine, dermatology, and psychiatry.

UTMB contracts with TDCJ to provide health services to inmates in the eastern half of the state, or approximately 78% of offenders. In state Fiscal Year 2015, UTMB had more than 131,000 medical teleservices encounters.[31] The number of telemedicine and telehealth encounters have nearly doubled for UTMB from 2008 to 2015.



[32]

School-based Telemedicine and Telehealth

Children's Health System of Texas operates a school based telemedicine program which connects medical providers with school nurse offices. The program is active in 97 K-12 schools, accounting for more than 3,300 visits.[33] The program is intended to keep kids in school if they

are suffering from minor, non-contagious conditions, allowing their parents to stay at work. The Committee looks forward to reviewing outcome data of this program.

Texas Tech University's Telemedicine Wellness, Intervention, Triage and Referral Project (TWITR) provides school-based screening, assessment, and referral services to students who are an immediate threat to themselves or others. The services are provided via telehealth, connecting TTUHSC with rural schools in areas that lack mental health providers such as counselors and psychiatrists. TWITR is active in 10 West Texas Independent School Districts (ISDs) and has shown very promising outcomes, including a 17% reduction in truancy, 25% reduction in student discipline referrals, 3.6% increase in student overall GPA, and a reduction in wait time for services from six weeks to three days.[34]

Expanding Access to Care in Rural Texas

TTUHSC operates an HIV telemedicine program that serves 140 HIV-positive uninsured patients over a 19-county region which doesn't have an adequate number of infectious disease physicians. Without this program, uninsured HIV/AIDS patients would go without care or be forced to visit an emergency room to receive specialty care.[35]

Based on House Bill 479 passed by the 84th Legislature, the Next Generation 911 Telemedicine Services pilot project was created to address access to designated trauma facilities and practitioners in rural west Texas. The pilot will connect surgeons at trauma facilities with rural EMS providers responding to emergency situations in order to provide stablization for travel to the nearest appropriate health facility.[36]

The Texas A&M TeleHealth Counseling Clinic (TCC) provides counseling and assessment services via telehealth free of charge to underserved individuals in Brazos, Grimes, Leon, Madison, and Washington counties, all of which are MHPAs. Over 5,200 sessions have been provided by counseling and clinical psychology doctoral students at Texas A&M University.[37]

Potential Uses of Telehealth to Further Expand Access to Care

State Hospital Staffing

The severe shortage of mental health providers at state hospitals has made it difficult to provide appropriate patient care.[38] While telehealth would help alleviate this issue, only four state hospitals have the ability to provide care via telehealth.[39] DSHS should determine the effectiveness of telehealth on the state hospital population (i.e. potential reduction of bed days due to quicker competency restoration) and the cost associated with expanding telehealth capabilities system-wide.

Child Protective Services

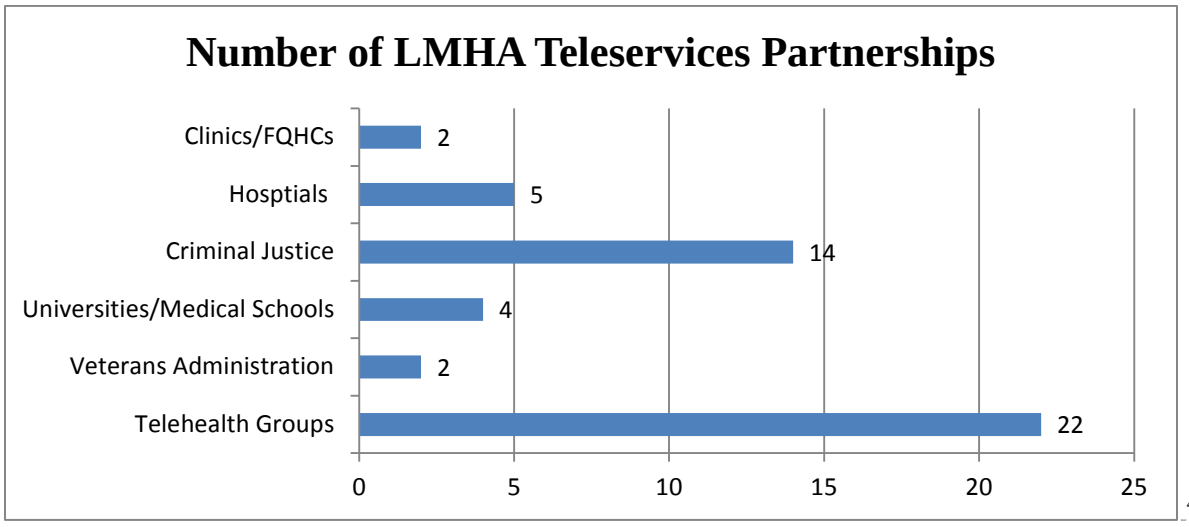
The foster care system is currently experiencing an increase in the intensity of the mental health and medical needs of children entering care, as detailed in an earlier section of this interim report. Many of these children are not receiving timely access to necessary medical services. In July 2016, only 48% of foster children received their Early Periodic Screening and Diagnostic Testing (EPSDT) exam within 30 days, as required in the state's STAR Health contract with Superior Health Plan.[40] Better utilization of telehealth will not, and should not, replace this

extensive screening that must be performed by a primary care provider, but telehealth can be used to allow caseworkers and Child Placing Agencies (CPAs) to triage children upon entrance into conservatorship of the state, allowing providers and STAR Health to more quickly connect them with necessary services. The section of this report on Interim Charge #2B relating to High Acuity Foster Children includes a recommendation for the Department of Family and Protective Services (DFPS) to create a system to triage children within 3-5 days of entering care to ensure children with high levels of need are seen quickly. DFPS should consider ways to utilize telehealth to implement this recommendation.

Mental Health- Increased Access in Rural Areas

Local Mental Health Authorities (LMHAs): A number of LMHAs have noted provider shortages as a reason for not reaching targets or outcome measures. As a result, nearly all of the LMHAs utilize telehealth to provider mental health care to their patients: 38 of the 39 LMHAs provide psychiatric services via telehealth, and 13 of the 39 provide counseling services via telehealth. LMHAs have a number of partnerships with local entities to increase mental health care in their service areas. This has improved patient and provider satisfaction, and reduced travel times for providers resulting in increased efficiency and productivity.[41] The state should support ongoing LMHA telehealth efforts to ensure adequate and timely access to mental health services.

Expanding Project Texas Tech University's Telemedicine Wellness, Intervention, Triage and Referral Project (TWITR): TWITR is already a successful program in North-West Texas and should be considered for expansion into other rural areas of the state that lack adequate mental health providers. For example, the program could be expanded to rural East Texas and operated by the University of Texas Health Science Center at Tyler with initial assistance from TTUHSC.



[42]

Telehealth Groups: LMHAs contract with telehealth practice groups, such as JSA Helath Telepsychaitry, to provide services.
Criminal Justice: LMHAs partner with entities such as county jails and law enforcement offices for assessment and diversion.
Universities/Hospitals/Clinics: LMHAs provide telehealth services to patients in crisis or in need of integrated mental and physical care.

Conclusion

Telemedicine is alive and well in Texas. Telemedicine increases access to care and increases patient and provider satisfaction. While the state should continue to build on the successes of telemedicine within public and private systems, any expansion of telemedicine should not replace a physical provider-patient visit when determined to be necessary according to the standard of care.

Recommendations

1. **Any further expansion of telemedicine should fall within the standard of care.**

2. **Increase the use of telemedicine and telehealth across state health agencies.**
    - DSHS: Ensure Telehealth capability in all state hospitals. Only four state mental health hospitals currently utilize telehealth services. DSHS should report on the use of telehealth services in the state hospital system and determine if expanding telehealth services system wide would be beneficial, the cost associated with expanding telehealth to additional state hospitals, and the potential impact expanding telehealth services would have on length of stay, cost containment, and capacity.
    - DFPS: Ensure children with high medical and mental health needs are more quickly connected to necessary services and supports by allowing CPS case workers to be authorized patient site presenters. The Texas Medical Board and DFPS should create an education and certification process for CPS case workers to be telepresenters. The process should teach case workers how to perform a triage survey in order to identify children who need higher levels of care and how to properly use telemedicine equipment. This should not take the place of an in-person medical visit, but should be used to better triage children with high levels of need.

3. **Work with Congress and the Drug Enforcement Agency to allow psychiatrists registered with the DEA to prescribe controlled substances via telehealth.** The Ryan Haight Online Pharmacy Consumer Protection Act requires that any prescription of a controlled substance must be obtained by a practitioner who has conducted at least one in-person medical evaluation. There are some exceptions, including an instance in which the patient is located in a facility registered with the DEA and is being treated by a DEA-registered provider.[43] Since an in-person visit is not required for telehealth services, the requirement that the patient be in a DEA registered facility should be removed. However, due to the prevalent issue of prescription drug addiction, the prescribing psychiatrist should be allowed to prescribe all necessary medications to treat a mental illness, excluding opioids and other pain medications with a high risk of dependency.

4. **Expand the University of Texas's Virtual Health Network (UT-VHN) to other health institutions.** In February 2016, the UT Board of Regents approved $10.8 million over four years for the development of a Virtual Health Network, building on current telemedicine services used in the system.[44] This recommendation would allow different university health systems to share resources and expertise across the state. Other

university health systems would then be able to connect to other health care settings in their region, increasing access to all levels of care statewide.

5. **Expand the use of telemedicine to ensure timely access to trauma services.** Allow telemedicine to satisfy certain trauma facility designation requirements for facilities located in rural counties. Additionally, the Legislature should monitor the success of the Next Generation 911 Telemedicine Services Pilot in West Texas to determine the success of the program in connecting more rural Texans to EMS and trauma services, and whether an expansion of the pilot is warranted.

---

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List*, June 16, 2016: http://www.legis.state.tx.us/Committees/MeetingsByCmte.aspx?Leg=84&Chamber=S&CmteCode=C610
[2] United States Department of Health & Human Services, Health Resources & Services Administration (HRSA) Data Warehouse.
[3] Department of State Health Services, *The Mental Health Workforce Shortage in Texas,* September 2014.
[4] Texas Administrative Code, Title 22, Part 9, Chapter 174.
[5] Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services,* June 16, 2016, page 8.
[6] Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services,* June 16, 2016, page 11.
[7] *Supra* note 4.
[8] *Supra* note 4.
[9] *Supra* note 4.
[10] Texas Administrative Code, Title 22, Part 9, Chapter 190.
[11] Teladoc, Inc., et al., V. Texas Medical Board, Et al., Case 1:15-cv-00343- RP, Document 44.
[12] Texas Administrative Code, Title 22, Part 9, Chapter 174, Rule 174.9.
[13] Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter A, Division 33, Rule 354.1430.
[14] Texas Administrative Code, Title 22, Part 9, Chapter 174, Rule 174.6.
[15] *Supra* note 14.
[16] *Supra* note 14.
[17]Ryan Haight Online Pharmacy Consumer Protection Act of 2008, H.R. 6353 (110th).
[18] Texas Health and Human Services Commission, *Telemedicine, Telehealth, and Home Telemonitoring Texas Medicaid Services,* December 1, 2014.
[19]Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services,* June 16, 2016, page 19.
[20] Senate Bill 293, 82nd Regular Session (Watson/Davis), 2011.
[21] Government Code, Chapter 531, Section 531.02164.
[22] Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services,* June 16, 2016, page 14.
[23] House Bill 3519, 84th Regular Session (Guerra/Watson), 2015.
[24] *Supra* note 20.
[25] Information provided by HHSC via email, October 26, 2016.
[26] Information provided by Texas eHealth Alliance via email on July 29, 2016.
[27] Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services,* June 16, 2016, page 17.
[28] Information provided by Texas Health and Human Services Commission via email on September 6, 2016
[29] Texas Department of Criminal Justice, *Correction Managed Health Care Committee.*
[30] Texas Tech University Health Sciences Center, *Testimony before the Senate Committee on Health and Human Services,* June 16, 2016.
[31] University of Texas Medical Branch, *Testimony before the Senate Committee on Health and Human Services,* June 16, 2016.
[32]*Supra* note 30.

[33] Children's Health System of Texas, *Testimony before the Senate Committee on Health and Human Services,* June 16, 2016.
[34] *Supra* note 29.
[35] *Supra* note 29.
[36] *Supra* note 29.
[37] Texas A&M University, *Telehealth Counseling Clinic.*
[38] Texas Department of State Health Services, *Fiscal Year 2015 Report on State Hospital Staffing by Quarter.*
[39] Information provided by Texas Department of State Health Services via email on August 15, 2016.
[40] Information provided by Superior Health Plan at a meeting on September 6, 2016.
[41] Information provided by the Texas Council of Community Centers via email on August 8, 2016.
[42] *Supra* note 39.
[43] *Supra* note 17.
[44] Dvorak, Katie. *University of Texas System set to create statewide telemedicine network*, Fierce Healthcare, February 12, 2016.

Interim Charge 8 - Refugee Resettlement

Interim Charge Language: *Study the impact to the state of the increasing number of refugees relocating to Texas, including the range of health and human services provided. Examine the authority of the state to reduce its burden under the Refugee Resettlement Program and any state-funded services.*

Hearing Information

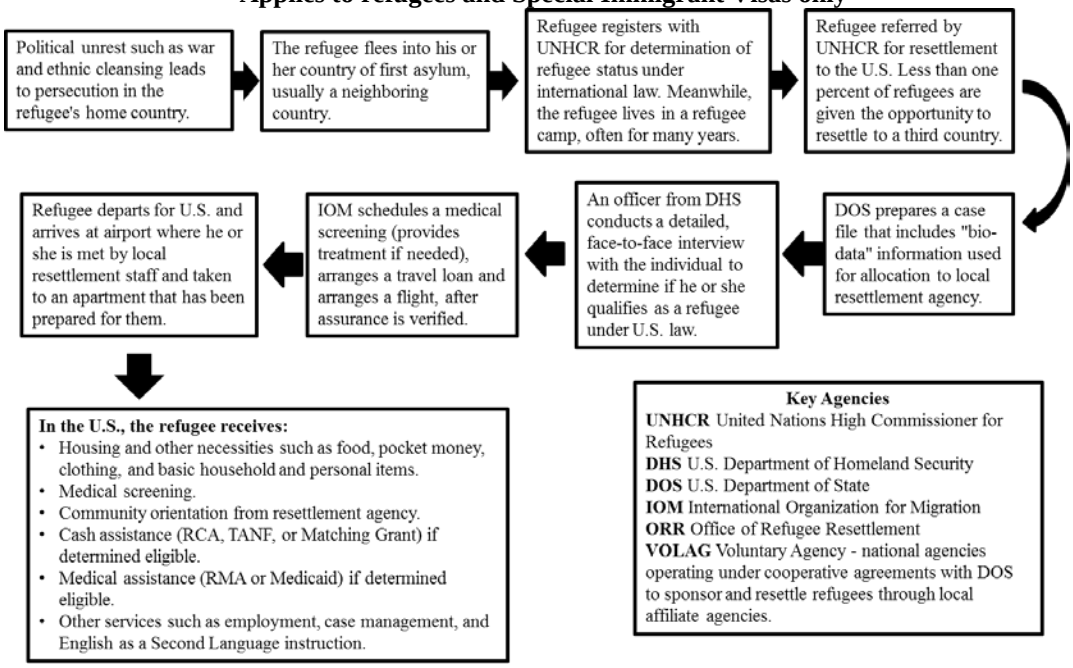
The Senate Committee on Health and Human Services held a hearing on April 21, 2016 to discuss Interim Charge 8. Invited testimony was provided by individuals representing the Health and Human Services Commission (HHSC) Office of Immigration and Refugee Affairs, the Department of Family and Protective Services (DFPS), the Department of State Health Services (DSHS), Refugee Services of Texas, Catholic Charities of Fort Worth, and the City of Amarillo.[1,2]

Introduction

Our values as Texans and Americans demand that we assist those in need who are fleeing from violence and persecution, but our first obligation must be to protect the citizens of Texas. Therefore, the Legislature must have confidence in the stringency of the federal screening process for refugees, 14,761 of whom entered Texas in State Fiscal Year (SFY) 2015.[3] The federal government has historically conducted an arduous, multi-step screening process that can take many years for refugees to enter the United States. This process includes background checks by Homeland Security, the Federal Bureau of Investigation, the State Department, and the National Counterterrorism Center. A chart of this process is found below, *The Resettlement Process through U.S. Department of State*.[4] For some refugees, however, this process has been circumvented and expedited by the Obama administration's recent efforts to create a "surge operation" for Syrian refugees. The surge operation, which aims to process 10,000 refugees in a matter of months, allows Syrian refugees to apply directly to the United States government for screening and resettlement as opposed to going through other organizations such as the United Nations. It also allows for videoconferencing rather than in-person security screening interviews and permits individual family members to be resettled, instead of waiting for the whole family to be approved.[5]

The state does not have a role in the screening of refugees relocating to Texas and does not conduct an additional screening once a refugee has arrived in the state. Although a very small percentage of individuals applying for refugee status reach the United States, it takes just one individual with malicious intentions to inflict harm on the citizens of this country. The expedited process currently in place for Syrian refugees lacks the necessary scrutiny and safeguards to ensure that such an individual is not allowed to enter the United States. Recently, the Department of Homeland Security's Office of Inspector General revealed that 858 immigrants with pending deportation orders were mistakenly granted citizenship. These immigrants were from countries of concern to national security or with high rates of immigration fraud.[6] Such egregious oversights by our federal partners have contributed to concerns about the federal government's ability to adequately vet incoming refugees.

The Resettlement Process through U.S. Department of State
***Applies to refugees and Special Immigrant Visas only**



Background

Before discussing the specifics of Texas' Refugee Resettlement Program, it is important to understand that "refugee" is a broad term that can encompass any of the following groups, although they enter the country in different ways:

- *Refugees* - Individuals officially granted refugee status by U.S. Citizenship and Immigration Services (USCIS) with the Department of Homeland Security because they cannot return home due to fear of persecution based on race, religion, or membership in a particular social/political group
- *Asylees* - Individuals officially granted asylum by USCIS because of persecution or well-founded fear of persecution due to race, religion, nationality, or political opinion (status happens after they have entered the U.S.)
- *Cuban and Haitian Entrants* - Nationals of the these countries who have been granted temporary status by USCIS due to humanitarian reasons or because their entry is in the public interest (this group of people are also referred to as parolees)
- *Victims of Human Trafficking* - Individuals certified by the Federal Office of Refugee Resettlement (ORR) who have been sexually exploited or forced into labor
- *Special Immigrant Visas* - Individuals from Afghanistan and Iraq who have been employed by the U.S. government or armed forces, with their spouses and children
- *Unaccompanied Refugee Minors (URM)* - Children in the categories above, special Immigrant Juveniles who have suffered abuse, and U status recipients who have helped law enforcement. U status recipients are victims of certain crimes who have suffered mental or physical abuse and are helpful to law enforcement or government officials in the investigation or prosecution of criminal activity.[7]

Mechanics of the Refugee Resettlement Program

Resettlement services and social services for refugees are funded by different federal agencies. The State Department Reception and Placement Program allocates funding to national Volunteer Agencies, called VOLAGs, which sponsor and resettle refugees through local affiliate resettlement agencies. Services such as vocational training, cultural orientation, English classes, and case management are also provided through local affiliate resettlement agencies of VOLAGs. Funding for these services flows directly to VOLAGs from the federal Office of Refugee Resettlement (ORR). Cash assistance and medical assistance may be provided by the state or the VOLAGs, depending on the model the state has chosen.[8]

In Texas, the Office of Immigration and Refugee Affairs (OIRA) at HHSC administers some services directly, but the majority are provided through contracts with local resettlement agencies. States may choose from three models to operate their Refugee Program. Texas currently operates under the Public/Private Partnership model with HHSC serving as the state coordinator. Below is a description of the three models under which states may choose to operate their refugee programs:

1.) Public-Private Partnership: The state enters into contracts with local resettlement agencies to administer the Refugee Cash Assistance (RCA) program through a public/private partnership, administers the Refugee Medical Assistance (RMA) program directly, and enters into contracts with local refugee providers to provide social services. Texas currently operates under this model, along with four other states (Minnesota, Oregon, Oklahoma, and Maryland).
2.) State-Operated: The state administers the RCA and the RMA programs directly and enters into contracts with local resettlement agencies to provide other social services. Thirty-two states operate using this model.
3.) Federally-Operated Wilson-Fish: All programs are administered by local resettlement agencies contracting directly with the federal government. Beginning on January 31, 2017, HHSC will no longer be the federally designated state coordinator. The federal government will begin working with a local resettlement agency or other nonprofit provider. Recently, Kansas and New Jersey announced their intent to stop being the federally designated state coordinator and are in the process of transferring to the Wilson-Fish model.[9] These three states are not alone, twelve other states use this model including Alabama, Alaska, Colorado, Idaho, Kentucky, Louisiana, Massachusetts, Nevada, North Dakota, South Dakota, Tennessee, and Vermont.[10]

After ORR refused to agree to Texas' request that the federal government ensure that incoming refugees do not pose a risk to the state, Governor Abbott made the decisions that, effective January 31, 2017, HHSC will no longer be the state designated coordinator and the state will transition to a federally-operated Wilson-Fish model. After January 31, 2017, the federal government will begin working with a local resettlement agency or other nonprofit provider as they transition to the new model.[11] An official letter was sent from Texas' Refugee Coordinator for a transition period to begin October 1, 2016, and federal law requires the state to give the federal government 120 days to transition the program.[12] Wyoming is the only state without a refugee program.[13] This is because the state chose not to operate a program and there are no

local nonprofit organizations operating a refugee resettlement program with which the federal government could directly contract.[14]

Services offered for refugees in Texas

Currently, the state provides multiple services for refugees through the Health and Human Services agencies, in addition to the many services provided by local entities such as school districts, hospital and trauma systems, and community health and social services providers. Beginning on January 31, 2017, the programs listed below, all of which are fully federally funded, will be operated by a local resettlement agency or other nonprofit provider.

Health and Human Service Commission Programs

Refugee Cash Assistance (RCA): This is an entitlement program which refugees can receive for eight months after their arrival if they do not qualify for Temporary Assistance for Needy Families (TANF). HHSC allocates funding to local organizations to administer RCA. All employable adults must participate in employment programs offered through Refugee Social Services (see below).[15]

Refugee Social Services (RSS): These services are offered for up to five years, but the priority is to provide all refugees with at least one year of services. Services include programs such as English language classes, employment training (required for employable adults), driver's education, cultural orientation, and case management services. HHSC contracts with local refugee service providers for these services.[16]

Refugee Medical Assistance (RMA): This is an entitlement administered by HHSC which refugees can receive for eight months after their arrival if they do not qualify for Medicaid/CHIP. Federal law requires states to provide Medicaid/CHIP to eligible refugees. HHSC has interpreted this to mean that refugees must default to the Medicaid/CHIP program upon arrival if they meet eligibility requirements.[17]

Special Discretionary Grants: These can vary, but current discretionary grants include school impact grants to school districts for the effective integration and education of refugee children, and targeted assistance grants.[18]

Department of Family Protective Services Programs

The Unaccompanied Refugee Minor Program (URMP): DFPS contracts with refugee service providers in Fort Worth and Houston to administer this program. It provides the full range of assistance that is available to all foster youth. This program is only for officially assigned refugee children-minors crossing the border are not part of this program. Refugee children up to age 18 are eligible to receive all available services, while some programs like higher education vouchers and extended foster care are available up to age 21.[19]

Department of State Health Services Programs

The Refugee Health Screening Program: This assessment focuses on early identification of health conditions, preventing the spread of communicable diseases, and making appropriate follow-up referrals. Although the National Institutes of Medicine (IOM) initiates the health screening and vaccination process prior to relocation to Texas, follow-up vaccines or visits are

often needed. Screening is available within the first 90 days of relocation and vaccinations are available for up to 1 year after relocation. Over 90 percent of refugees entering Texas participate in this program. DSHS contracts with city and county health departments to administer this program, and it is fully federally funded, excluding follow-up care.[20]

Fiscal Impact of Refugees

While the Refugee Resettlement Programs described in the previous section are fully federally funded, there is a significant additional fiscal burden on state and local governments, including through the Medicaid program and costs to local education and healthcare systems. The full fiscal burden of refugees on the state cannot be calculated because of the unavailability of data on the reliance of refugees on systems such as school districts, emergency response including Emergency Medical Services, fire and law enforcement, and healthcare systems such as the trauma system, uncompensated care at medical hospitals and care provided by local mental health authorities. Federal funds for refugee-related services in Texas totaled $196.2 million in SFY 2015 (this includes the federal share of safety net programs). Additionally, state costs for refugees in entitlement programs alone totaled $57 million in SFY 2015.[21]

Costs of Refugees by Program (SFY 15)

Program	Average Monthly Caseload	Cost to all Funds	Cost to GR
Medicaid	24,830	$ 131,574,236	$ 55,129,605
CHIP	1,499	$ 3,542,997	$ 1,038,807
TANF	175	$ 151,801	$27,256
SNAP	36,033	$ 49,802,871	100% fed funds
TWHP	427	$ 83,686	$ 83,686
Other Program*	118	$ 1,667,484	$ 698,676
Total:	**N/A**	**$186,823,076**	**$56,978,030**

*Other program caseload and costs include refugees identified in the following programs: Emergency Services for Non-Citizens (TP 30), Qualified Medicare Beneficiary (QMB), Specified Low Income Beneficiary (SLMB).

Federal Communication with Local Communities

Local refugee resettlement agencies work with their national partners to decide when and where in Texas refugees will be resettled with little to no input from the state. Federal law requires the federal government to consult regularly (not less often than quarterly) with state and local governments concerning the sponsorship process and the intended distribution of refugees among states and localities before their placement. However, little communication with the state occurs, and it is unclear how much consultation with local government officials is actually occurring. During the Committee hearing on this interim charge, the mayor of Amarillo, a city that has received a disproportionate number of refugees in recent years, said the city has not had any communication with either the federal government or local refugee agencies prior to refugees being resettled in the city.[22]

The 84th Legislature passed SB 1928, requiring HHSC to publish rules to ensure local government and community input regarding federal refugee resettlement in Texas.[23] The new rules, which were effective May 1, 2016, require local resettlement agencies to:

- convene meetings at least quarterly at which local resettlement agencies can consult with local governmental entities and officials and other community stakeholders on proposed refugee placement;
- consider input from meetings with local governmental entities and officials and other community stakeholders when providing information on refugee placements to their national organizations for annual reporting; and
- provide HHSC, local governmental entities and officials, and local community stakeholders with a copy of each proposed annual report.[24]

State Oversight of Local Refugee Agencies

Despite effectively removing the state's role in the Refugee Resettlement Program effective January 31, 2017, the state cannot eliminate the refugee program, nor can it stop the federal government from relocating refugees in Texas.[25] Additionally, the state has little information on how effective local agencies are at administering funding. It is difficult to obtain this information from HHSC under the current system because some refugee programs are funded directly by the federal government and do not flow through HHSC. This makes it difficult for the state to track the success of certain programs. For example, there are two funding streams for job training- one flows through HHSC and the other flows directly to the local resettlement agency. HHSC is able to track job placement rates for the program funded through HHSC, but not for programs funded directly through the local resettlement agencies.[26] The state will have even less information on program effectiveness and will no longer have a contractual relationship with local resettlement agencies when the state transfers to the Wilson-Fish model.

Conclusion

The state must assist those in need who are fleeing from violence and persecution, but our first obligation must be to protect the citizens of Texas and ensure the state makes sound fiscal decisions when using taxpayer dollars. In light of the fact that the state has no input regarding which refugees come to Texas, when they are resettled, or what services are provided, the state should ensure adequate oversight of the agencies that administer this program at the local level. Implementing these recommendations will provide an avenue to reduce the state's fiscal burden and ensure proper oversight is in place to mitigate the risk to Texans associated with this program.

Recommendations

1.) **Require HHSC to consider the creation of a state license for local refugee resettlement agencies.** The state has a vested interest in ensuring the security of Texans and in protecting vulnerable refugees from exploitation once they arrive in our state. The Legislature chooses to regulate certain industries that work with vulnerable populations through licensure, such as Child Placing Agencies that are licensed by DFPS. This allows for oversight and maintenance of minimum standards. Currently, the only oversight the state has over local refugee resettlement agencies is contractual, but that will end once the state is no longer the federally designated state coordinator, effective January 31, 2017. The legislature should consider licensure for local refugee resettlement agencies to ensure adequate security measures are taken prior to relocating refugees to Texas, to ensure refugees are being cared for in accordance with state laws, and to provide the legislature and local entities with more

information on when and where refugees are entering Texas. This would also allow the state to evaluate the success of programs provided to refugees by local agencies.

2.) **Explore options to require refugees to default into Refugee Medical Assistance program instead of Medicaid/CHIP.** Currently, the RMA is the payer of last resort, and refugees default into Medicaid or CHIP, as applicable. This arrangement is unique to the refugee program because Medicaid and CHIP are typically the payer of last resort. This leads to higher costs for the state and reduces the financial burden on the federal government.

3.) **Petition Congress for a higher FMAP from the federal government for refugees enrolled in Medicaid/CHIP.** The federal government currently uses the standard Federal Medicaid Assistance Percentage (FMAP) to determine what percentage of Medicaid costs attributable to refugees are borne by the federal versus the state government.[27] Since the state has no power to determine how many refugees are resettled in our state or what services they are entitled to, there should be an enhanced FMAP for refugees.

4.) **Direct HHSC to work with local communities who are disproportionately impacted by the refugee program to submit an annual fiscal impact report to ORR.** The state has an interest in protecting the financial stability of the state and local communities from unfunded mandates by the federal government. The federal government chooses to send refugees to the state with little to no input from the state and local communities, and fails to recognize the full costs of accommodating those refugees. HHSC should assist local communities with calculating the full costs of refugee resettlement to local governments including local ISDs, healthcare systems, Emergency Medical Services and law enforcement, and reporting those costs annually to ORR to provide a more accurate picture to the federal government of the financial burden placement of refugees will have on local communities.

---

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List*, April 21, 2016: http://www.legis.texas.gov/tlodocs/84R/witlistmtg/pdf/C6102016042109001.PDF.
[2] Senate Committee on Health and Human Services, *Interim Hearing Minutes*, April 21, 2016: http://www.legis.texas.gov/tlodocs/84R/minutes/pdf/C6102016042109001.PDF.
[3] Texas Health and Human Services System, *Presentation to the Senate Committee on Health and Human Services: Overview of the Texas Health and Human Services System's Involvement in Refugee Services*, April 21, 2016: http://www.senate.state.tx.us/75r/senate/commit/c610/h2016/042116-HHSC_DSHS_DFPS.pdf.
[4] *Id*
[5] Reuters, *White House sees surge in Syrian refugee admissions this year*, June 6, 2013: http://www.reuters.com/article/us-mideast-crisis-usa-refugees-idUSKCN0Z22R4.
[6] CBSNEWS, *More than 800 immigrants accidentally granted U.S. citizenship*, September 19, 2016: http://www.cbsnews.com/news/more-than-800-immigrants-accidentally-granted-u-s-citizenship/.
[7] *Supra* note 3
[8] *Supra* note 3
[9] The New York Times, *Texas Threatens to Pull Out of Refugee Resettlement Program*, September 21, 2016: http://www.nytimes.com/2016/09/22/us/texas-threatens-to-pull-out-of-refugee-resettlement-program.html?_r=1.
[10] *Supra* note 3
[11] Office of the Governor Greg Abbott, *Governor Abbott Statement On Texas' Intention To Withdraw From Refugee Resettlement Program*, September 21, 2016: http://gov.texas.gov/news/press-release/22682.

[12] 45 CFR § 400.301; and Texas Health and Human Services Commission, *Letter of the Office of Refugee Resettlement*, September 21, 2016: http://gov.texas.gov/files/press-office/RefugeeResettlementLetter_09212016.pdf.
[13] Office of Refugee Resettlement, *Find Resources and Contacts in Your State*: http://www.acf.hhs.gov/orr/state-programs-annual-overview.
[14] Wyoming Public Media Statewide Network, *Wyoming Debates Refugee Resettlement Program*, September 25, 2015: http://wyomingpublicmedia.org/post/wyoming-debates-refugee-resettlement-program.
[15] *Supra* note 3
[16] *Supra* note 3
[17] *Supra* note 3
[18] *Supra* note 3
[19] *Supra* note 3
[20] *Supra* note 3
[21] *Supra* note 3
[22] Paul Harpole, Mayor of Amarillo, *Testimony before the Senate Committee on Health and human Services*, April 21, 2016: http://tlcsenate.granicus.com/MediaPlayer.php?view_id=40&clip_id=11020.
[23] Senate Bill 1928, 84th Regular Session (Seliger/ Price), 2015.
[24] Texas Administrative Code §§ 375.701 and 376.1001.
[25] 45 CFR § 400.301.
[26] *Supra* note 3; and Texas Health and Human Services System, *Handout to the Senate Committee on Health and Human Services: OIRA Programs*, April 21, 2016: http://www.senate.state.tx.us/75r/senate/commit/c610/h2016/042116-HHSC_Refugee_Program_Charts.pdf.
[27] United States Department of Health and Human Services, *Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures FMAP*, March 1, 2015: https://aspe.hhs.gov/federal-medical-assistance-percentages-or-federal-financial-participation-state-assistance-expenditures.

Interim Charge 9A: DFPS Sunset Implementation

Interim Charge Language: *Monitor the implementation of legislation and riders related to health and human services that were considered by the 84th Legislature, Regular Session and make recommendations for any legislation needed to improve, enhance, and/or complete implementation, including but not limited to the impact of changes made by the Department of Family and Protective Services, Child Protective Services on child safety, workforce retention, prevention, and permanency.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on September 13, 2016 to discuss Interim Charge 9A. Invited testimony was provided by individuals representing the Department of Family and Protective Services (DFPS) and The Stephen Group.[1]

Background

Over the past decade, significant legislation has been passed to reform the Department of Family and Protective Services (DFPS) with varying degrees of success. Additionally, the agency's budget has increased by 35% from the Fiscal Years (FY) 2008-09 biennium to the current biennium.[2] With a growing state population, additional resources are certainly necessary to improve the foster care system, build and retain a stable workforce, and better protect children. However, no amount of statutory changes or increased resources will ultimately yield positive outcomes for children and families without internally-driven culture and management changes. Child Protective Services (CPS) Transformation is a self-improvement process that began in 2014 after extensive top to bottom reviews of the agency's inner working by both The Stephen Group and the Sunset Advisory Commission. Transformation is a long-term, bottom-up effort built on the knowledge and insights of front-line staff and led by both regional and state office staff. Transformation priorities include:

- Ensuring child safety, permanency and well-being;
- Establishing effective organization and operations; and
- Developing a professional and stable workforce.[3]

As DFPS is implementing transformation efforts, consolidation of the Texas Health and Human Services system is occurring simultaneously, with impacts on the structure of DFPS. This includes:

Consolidation of Prevention and Early Intervention (PEI)
Phase 1- The Nurse Family Partnership and Texas Home Visiting programs were transferred to DFPS under the Prevention and Early Intervention division (outside of CPS) on **May 1, 2016**. **Phase 2-** The Pregnant Post-Partum Intervention, Parenting Awareness, and Drug Risk Education programs will be evaluated to be transferred to the same division by **September 1, 2017**.[4]
Consolidation within the Health and Human Services Commission
Phase 1- The following functions/positions were transferred to HHSC as of September 1,

2016: Select DFPS legal staff associated with human resources, open records, and litigation liaisons. As part of this change, the DFPS General Counsel will also report to the HHSC Chief Counsel instead of the DFPS Commissioner. The DFPS Medical Director was transferred to the Medicaid and CHIP Services department.

Phase 2- The following will be transferred to HHSC by September 1, 2017: All regulatory functions, including Child Care Licensing; facility support, business continuity, accessibility coordination, veteran hiring, outreach, and advance travel payments and processing will transfer to the Administrative Services Division at HHSC; The Office of Consumer Affairs will be transferred to the HHSC Office of the Ombudsman; and all remaining legal staff except Regional Legal Services.[5]

Additionally, the HHSC Executive Commissioner will study the need to continue DFPS as a separate agency to operate PEI, CPS and Adult Protective Services (APS), and will report recommendations to the Texas Legislature by September 1, 2018.[6]

CPS Business Plan

In October 2015, CPS published the first annual business plan. As CPS continues to transform, they will seek to be transparent in their goals, objectives, and outcomes by using the business plan as a roadmap for the future and to ensure CPS is accountable for outcomes. The annual business plans for both FY 2016 and 2017 lay out performance goals and metrics for CPS to achieve safety, permanency, and well-being for the children it serves. Below are the actual data for Fiscal Years 2012-2016, and the long-term performance targets established in Fiscal Year 2016 in the FY 2017 CPS Business Plan.

FY 16 CPS Business Plan Performance Targets

PERFORMANCE TARGETS	FY12	FY13	FY14	FY15	FY16	FY 17 Target
Safety						
Recidivism for Alternative Response	-	-	-	-	1.6%	1.4%
Recidivism for Investigations	7.0%	7.1%	7.5%	7.7%	7.5%	7.1%
Recidivism for Family Based Safety Services	7.0%	7.2%	7.8%	7.6%	7.6%	7.2%
Recidivism for Conservatorship	11.0%	11.6%	11.6%	11.5%	11.7%	11.1%
Permanency						
Time to permanency (reunification, permanent placement with relative,	18.5	18.9	18.8	18.4	18.4	17.3

adoption) in months						
Exits to permanency for children in care 2 or more years	28%	31%	32%	33%	34%	37%
Visiting with parents and siblings in foster care *	-	-	-	-	81%	89%
Children in substitute care placed with relatives	39%	40%	41%	42%	43%	47%
Average number of placements for children in foster care	3.4	3.4	3.2	3.2	3.1	2.8
Well-Being**						
Children's educational needs are met	97%	97%	96%	93%	99%	100%
Children's physical health needs are met	93%	89%	91%	87%	91%	100%
Children's mental/behavioral health needs are met	94%	92%	91%	88%	97%	100%
Youth completing Preparation for Adult Living (PAL)	75%	76%	76%	72%	74%	80%
Youth 18 and older living in foster care	602	634	615	667	666	733
Siblings in substitute care placed together	63%	66%	66%	65%	65%	68%
Workforce						
Turnover for CPS overall	26%	26%	25%	26%	26%	25%
Turnover for Investigations***	34%	32%	34%	33%	33%	31%
Turnover for Family Based Safety Services	26%	25%	23%	28%	25%	24%
Turnover for Conservatorship	24%	22%	23%	23%	23%	22%

*Visitation in foster care is a new well-being data measure for Round 3 of the Child and Family Services review that will be collected through case reads.
**Fiscal Year 2015 data for educational, physical and behavioral health needs are based on Child and Family Service Case reviews through Quarter 3. For FY 16, data is through Quarter 2.
*** Turnover for Alternative Response is included in Investigations turnover.

Child Safety

To enhance child safety, DFPS continues to implement various initiatives to support CPS staff in making informed decisions throughout the life of a case. Many of these initiatives were discussed previously in this report including the newly rolled out Structured Decision Making tools, the Family Based Safety Services Broker Pilot, and the Signs of Safety tool for caseworkers. In addition, DFPS is improving child safety through a performance demonstration for Child Placing Agencies (CPAs) and its Continuous Quality Improvement Initiative.[7]

Performance-based provider demonstration

This voluntary demonstration began in January 2016 to measure the performance of contracted foster care providers such as Child Placing Agencies, Residential Treatment Centers (RTCs), and emergency shelters. Performance measures include: percentage of siblings kept together in care, percentage of children who receive their Texas Health Steps/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening within 30 days, total number of children who have monthly contact with a relative or fictive kin, and the percentage of children who receive a CANS assessment within 30 days, among others. In May 2016, the first set of performance measure outcomes for each provider participant were reported to DFPS, which allowed the agency to assess baseline data for each performance measure and set targets for the next reporting period. As of May 2016, there are 36 providers participating, covering a total of 64 contracts. These contracts represent 30 CPAs, 14 general residential operations, seven RTCs, nine emergency shelters, and four intense psychiatric treatment programs.[8]

The agency should expand performance-based contracting to all foster care contractors statewide. After collecting baseline data, the agency should begin to tie outcomes to payments through incentives and sanctions and should work with providers to develop performance measures that will capture capacity-building efforts, ensure child safety, and utilize trauma-informed practices. The Legislature should evaluate whether foster care rates for all providers are sufficient and whether they are structured in a way that incentivizes the provision of appropriate care in the least restrictive environment possible.

Continuous Quality Improvement (CQI)

CPS is in the process of integrating CQI into its fundamental practices. This includes ensuring appropriate protocol is followed in conducting case reads for all stages of service, utilizing predictive analytics to identify cases at a higher risk of child maltreatment while in care, and identifying provider contracts in danger of failing, among others.[9]

In addition, CPS has implemented a new Continuous Quality Improvement plan that utilizes Regional Systems Improvement (RSI) specialists that are housed in the regions but report through state office. Starting in January 2016, the RSI teams began working with the CPS regional leadership to advise them on what resources are needed to ensure child safety and how each region is performing. Regional CPS management retains responsibility for using data to effectively manage their resources and ensure that staff are doing quality work, while the RSIs support this work through reviewing, aggregating, and analyzing data at a system level to help regional management identify areas of strength and areas needing improvement. The RSI team also tracks regional efforts so that successful practices can be shared with other regions and incorporated into statewide plans.[10]

While these initiatives are important and should have long-term positive impacts on child safety, the agency must ensure that reported victims of abuse or neglect, particularly those at the highest risk of serious harm, are seen in a timely manner. The agency also must ensure that CPS Investigation Supervisors, Program Directors, Program Administrators, and Regional Directors identify issues with timely visits to children in a proactive manner, and are given the resources and flexibility necessary to comply with existing statutory requirements to see children within specific time frames. The agency should also evaluate repurposing tenured investigation caseworkers for after-hours shifts to ensure timely face-to-face visits occur.

Workforce Retention

To improve caseworker recruitment and retention and to create a more tenured and professional workforce, DFPS has utilized additional funding appropriated by the 84th Legislature, revitalized performance evaluation for all staff, and implemented a new orientation and training program for caseworkers.

Funding

The Legislature appropriated a CPS caseworker compensation package totaling $23.6 million, including:

- *Overtime*: $10.6 million to pay down overtime to 140 hours and maintain balances at 140 hours for CPS caseworkers, Adult Protective Services, Child Care Licensing, Statewide Intake, and Office of Consumer Affairs/Non-Program Administration.
- *Mentoring Stipend*: $5.6 million to provide a $300 mentoring stipend for tenured CPS caseworkers.
- *Merit Pay*: $7.4 million to provide $1,250 in one-time performance based merit to 25% of CPS eligible staff every six months.[11]

The Workforce Development Division

The Workforce Development Division was created to support recruitment, hiring, training, retention, and leadership development. This division seeks to decrease overall turnover by stage of service by appropriately targeting, identifying, and hiring the right candidates; providing appropriate training; ensuring strong supervision; and guiding employees to multiple career path opportunities to inspire confidence, leadership, and mitigate turnover. CPS and the Workforce Development Division have undertaken the following professional development initiatives:[12]

Recruitment: In 2015, the agency delivered new training to Hiring Specialists on new recruitment responsibilities and now use new screening criteria and interview questions to identify optimal candidates for the agency. DFPS now targets criminal justice related professionals, social work professionals, veterans, and workers with more job experience, and requires a new personal statement to describe why an individual wants to work for CPS. Finally, interview questions are now behaviorally-based and centered around a better understanding of the characteristics of quality staff.[13]

Performance Evaluations: The agency has developed enhanced performance evaluations which rolled out for caseworkers in February 2015, and for supervisors in October 2015. In April 2016, DFPS implemented improved evaluations for regional directors, deputy regional directors,

program administrators, administrative assistants and human service technicians. In September 2016, revised program director performance evaluations were implemented. DFPS continues to revise the plan to make them more streamlined and consistent with the format of other HHSC agencies. As part of their business plan, CPS will continue to evaluate the timeliness of completion of performance evaluations and has set a goal to complete new performance evaluations for all staff by December 31, 2016.[14] Also in late 2016, Commissioner Whitman re-interviewed all Regional Directors, which led to four Regional Directors being replaced.[15]

Training and Mentor Program: In Fiscal Year 2015, CPS designed and implemented a new competency-based training model for caseworkers statewide, known as CPS Professional Development (CPD). This program includes revised classroom training, hands-on and field-based specialty-track training, and mentor support. This new model utilizes both training and mentors to allow caseworkers to spend more time in the field, gaining a realistic preview of the job while being matched immediately upon being hired with a tenured mentor. In addition, all CPS supervisors have been trained in "strengths-based supervision," and DFPS is in the process of developing a new competency-based supervision training program for supervisors that will roll out in early 2017. To evaluate the new CPD training and mentor program, DFPS contracted with Dr. Cynthia Osborne and the Child and Family Research Partnership (CFRP) at the Lyndon B. Johnson School of Public Affairs at the University of Texas-Austin to conduct a two-year evaluation of Transformation initiatives aimed at building a high-quality and stable workforce, including the new CPD training program.[16]

While the University of Texas has not completed its evaluation of CPD, they recently issued preliminary findings based on two statewide surveys of caseworkers and supervisors with nearly 12,000 respondents and focus groups made up of caseworkers and supervisors held in all 11 regions. The preliminary outcomes are promising, and the researchers concluded that "CPD is the right approach".[17] Specifically, when compared to their Basic Skills Development (BSD)-trained counterparts, CPD-trained workers feel that that their job responsibilities were clearly defined (85% vs 69%), that they felt prepared for their job when they became case-assignable (76% vs 52%), that they received a comprehensive and accurate portrayal of what their job involves (84% vs 61%), and that they received the training necessary to perform their job duties (83% vs 57%).[18] The majority of supervisors also reported that the CPD model does a better job of building workers' confidence to work independently by teaching new workers their supervisors' expectations and more effectively integrating new workers into their units. Perhaps most importantly, initial reporting shows that CPD-trained caseworkers are far less likely to consider leaving the agency in the near future than their colleagues trained under the BSD model.[19]

High turnover of caseworkers continues to be a problem that has detrimental impacts on those caseworkers who continue to work for CPS and are forced to take on departing workers' cases, and can have a devastating impact on children and families who suffer as a result of delayed investigations and services. This new training model and mentor program has delivered positive results, and demonstrates that improvement in worker retention and job satisfaction is possible. Having supportive supervisors is crucial to retaining a quality workforce. The CPD training model is currently being formatted specifically for supervisor training, and will be rolled out to

supervisors in February 2016. The Legislature and DFPS should continue to support the training for caseworkers and monitor the rollout of the supervisor training.

Although insufficient compensation is not the only contributor to CPS's consistently high level of caseworker turnover, salary is increasingly cited by caseworkers leaving the agency as the primary reason for their departure. Recently, a Senate Finance Committee Workgroup was appointed by Chair Nelson to respond to a request by DFPS for salary increases for the remainder of Fuscal Year 2017. The Workgroup recommended approval of funding to increase front-line caseworker and supervisor salaries significantly in an effort to improve retention and morale.[20]

Prevention

The purpose of the Prevention and Early Intervention (PEI) Division at DFPS is to improve parenting skills, strengthen family relationships, reduce child abuse, enhance school readiness, improve social-emotional and physical health, and strengthen communities in order to reduce the risk of child maltreatment, fatalities, and other childhood adversities. The 84th Legislature focused heavily on strengthening and expanding PEI programs, increasing funding for these programs by 30% ($37 million) over the previous biennium. Funding was provided for:

- Expansion of the Health Outcomes through Prevention and Early Support (HOPES) program from 8 to 24 high risk counties, serving as additional 7,000 families of children ages 0-5;
- Expansion of the Community Youth Development (CYD) program into 3 additional zip codes, serving an additional 17,000 youth;
- Prevention of abusive head trauma;
- Creation of a program to help at-risk military families; and
- Expansion of the alternative response model.[21]

Reports

The 84th Legislature required the PEI Division to submit an extensive report due in December 2016 on the effectiveness of prevention programs, including the number of families served and outcomes such as whether:

- Parents abuse or neglect their children after receiving services;
- Youth are referred to juvenile courts during or after services;
- The length of time in foster care has been reduced; and
- Protective factors among parents have increased.[22]

In addition, Senate Bill 206, DFPS Sunset legislation, required the agency to develop a five-year strategic plan by September 2016. This plan includes community needs assessments, goals, priorities, outcome measures, and strategies on how to leverage other sources of funding. The Legislature should continue monitoring the agency's progress in meeting the goals set out in the five-year plan strategic plan, and should encourage the PEI Division to make data-driven decisions regarding how to target PEI resources in the most efficient and effective manner possible.[23]

Permanency

Increasing permanency for children is dependent on stable placements, which are in turn dependent on sufficient capacity in the community and access to appropriate services and supports. Capacity shortages and access to appropriate services are the drivers of the biggest issues facing DFPS; specifically, an increase in the percent of high needs children in foster care, a capacity crisis in many areas of the state, and the resulting foster care shortfall, which continues to grow. Although Foster Care Redesign (FCR) is the model the agency is moving toward for the state's foster care system, the other initiatives described in the High Acuity Foster Children section of this report including the Integrated Care Pilot, the Treatment Foster Care Pilot, and the STAR Health EPSDT pilot are crucial to ensure that as FCR moves forward, issues impacting permanency in the legacy system are also addressed.

Foster Care Redesign

DFPS has rolled out one FCR catchment area with another following in Region 2 in 2017. The outcomes reported thus far from Our Children Our Kids (OCOK), who is the Foster Care Redesign Single Source Continuum Contractors (SSCC) in Region 3b, are extremely promising. Achievements include:

- No children sleeping in CPS offices;[24]
- Local capacity, especially in rural areas, is growing through targeted recruitment efforts and partnerships with faith-based entities;[25]
- Children are being placed in their home communities at higher rates (83% vs 71% in legacy system);[26]
- 94% of new admissions and 97% of those who transferred from the legacy system have had no more than one move during last two years. The historical baseline is 88%;[27]
- After one year of the OCOK contract, 79% of kids are living in a family setting compared to previous 76% in the area in the previous year; and[28]
- 32 children successfully transitioned out of RTCs in FY 2015 with only 2 youth returning to residential treatment. Two of the 32 children transitioning from RTCs were placed in an adoptive home.[29]

In addition, the flexibility permitted in the FCR contract has allowed OCOK to implement innovative initiatives that have improved child safety, increased capacity, and provided permanency for children in their catchment area. These include:

- Quality Parenting Initiative: This initiative brings caregivers, community partners, child welfare professionals, CASA, Child Advocacy Centers, providers, and CPS employees to the table to talk through expectations and provide support and resources to families and children. This has encouraged relationships between foster parents and biological parents, strengthened permanency, and allowed sibling groups to stay together in the same home.
- Safety Audits: OCOK contracts with Praesidium and requires every CPA to have a safety audit annually to ensure children are safe in care.
- ECAP Placement Matching System: OCOK is now utilizing a software system to match qualified foster families with a child. It provides an inventory of beds and facilitates quick decision-making on placements.
- Provider Information Exchange: Until OCOK became the SSCC in Region 3b, every provider was using their own system of tracking data and providers were unable to

communicate with one another. This system talks with the individual provider systems and allows OCOK to pull data from all providers and manually merge that with IMPACT data.[30]

Foster care redesign is working in Region 3 and should be expanded. CPS should take strengths, weaknesses, and lessons learned from past and current foster care redesign contracts when developing new contracts with a Single Source Continuum Contractor. Specific recommendations that should be implemented regarding foster care redesign are outlined in the High Acuity Foster Children section of this report.

Capacity building

DFPS has developed an occupancy analysis based on the types of bed available by region and the number of children without a placement by region and level of care. Based on this analysis, there is a statewide need for general capacity-building to increase beds overall; keep new to care, younger, basic and moderate children out of CPS offices; and start placing more children and youth close to home. Traditional recruitment, including enhanced faith-based efforts, can help address these needs. Additionally, more specialized, professional levels of foster care providers are needed to serve older youth, larger sibling groups, and children with acute/intense needs. DFPS is working on this through the multiple initiatives discussed earlier in this report and must continue to partner with local partners to recruit foster families and quality providers.[31] DFPS is in the process of using this occupancy analysis to develop a needs assessment due in December that will determine capacity priorities for the state.[32]

Although DFPS has looked at regional capacity versus need by catchment area and shared these findings with providers and CPS regional leadership, the agency should also require the development of regional capacity building plans, as discussed in an earlier section of this report.

IMPACT Modernization

The Legislature added $25.3 million last session to support IMPACT Modernization, but all stages of modernization are currently behind schedule. Many of the efforts to remove burdens on caseworkers made by the Legislature last session are contingent on IMPACT changes which will occur hopefully in 2017. Additionally, partners such as CPAs, SSCC's, and CACs do not have real-time access to IMPACT, which hinders collaboration and the ability to more readily identify case histories and children's needs. The Legislature must continue to oversee the agency's efforts and contracts to ensure IMPACT Modernization is completed during FY 2017.[33]

Conclusion

DFPS has successfully implemented many aspects of Transformation. According to The Stephen Group, two-third of the original 160 recommendations made in the comprehensive review of the agency have been implemented.[34] However, transformation is an ongoing process that seeks to change not only policy and practice, but the entire culture of the organization. The agency must push forward with aspects of transformation that have not yet been implemented or are in progress, and sustain the elements of transformation that have been completed.

The delay of IMPACT Modernization has hindered many Transformation efforts, and the Legislature should continue monitoring to ensure completion of this project. Recruitment,

training, and retention of employees at both the caseworker and supervisor level should be a priority to reduce turnover and develop and sustain a competent, stable workforce. Finally, foster care redesign in Region 3b has produced positive results, and the state should address problematic aspects of the current design and then move forward to expand the model to other regions of the state in a manner that is tailored to the needs and strengths of each catchment area.

Recommendations

1. **The state should continue to monitor implementation of all Transformation initiatives currently in progress, understanding that culture change and better outcomes are long-term goals that will not happen within a year.**
    - CPS initiatives should be looked at in tandem with redesign to ensure that collaboration occurs between pilot programs and redesign, and that pilots introduce elements of the FCR model to providers and caseworkers in the legacy system.
    - DFPS must continue to push forward with key initiatives, but should prioritize roll out of these endeavors to ensure caseworkers are not overburdened.
    - Increased accountability should continue to be a focus of all Transformation efforts. Tying incentives to provider performance in all contracts should be a priority for the agency.
    - The Legislature should continue to monitor IMPACT Modernization to ensure it is completed by the end of Fiscal Year 2017 and includes all components funded during the 84th Legislative Session.

2. **Recruiting the right workers, ensuring that new workers understand their job role, and retaining workers should continue to be a focus of the agency and the Legislature.**
    - The Legislature should evaluate locality based pay increases for areas of the state with high turnover and high cost of living.
    - The agency should evaluate repurposing tenured investigators for after-hour shifts.
    - The new CPD model is working and should be rolled out to supervisors as planned in early 2017.
    - The agency should ensure upper level management including Program Administrators, Program Directors and Regional Directors are well-trained and able to adequately support their staff.

3. **Redesign is working and is the future of the foster care system. However, rate setting and contract design issues must be addressed in the current catchment areas before the model is expanded to new areas of the state.**
    - Moving forward, the agency should transfer case management functions to Single Source Continuum Contractors in Phase 2 of implementation.

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List*, September 13, 2016: http://www.legis.state.tx.us/tlodocs/84R/witlistmtg/pdf/C6102016091309001.PDF

[2] Legislative Budget Board, *Fiscal Size-up 2008-09 Biennium*, May 2008; Legislative Budget Board, *Fiscal Size-up 2010-11 Biennium*, May 2010; Legislative Budget Board, *Fiscal Size-up 2012-13 Biennium*, May 2012; Legislative Budget Board, *Fiscal Size-up 2014-15 Biennium*, May 2014; Legislative Budget Board, *Fiscal Size-up 2016-17 Biennium*, May 2016.
[3] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, September 13, 2016, page 3.
[4] Health and Human Services Commission, *Report to the Transition Legislative Oversight Committee*, August 2016.
[5] *Id*
[6] *Supra* note 4
[7] The Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, September 13, 2016.
[8] Information provided by the Department of Family and Protective Services via email on August 24, 2016.
[9] Department of Family and Protective Services - 2016 Child and Family Services Plan. https://www.dfps.state.tx.us/About_DFPS/Title_IV-B_State_Plan/2015_Progress_Report/V_Program_Support.pdf
[10] Department of Family and Protective Services, *Progress Report to Sunset Advisory Commission: Child Protective Service Transformation*, April 2016.
[11] Legislative Budget Board, *General Appropriations Act for the 2016-2017 Biennium*, May 26, 2015.
[12] *Supra* Note 4
[13] *Supra* Note 11
[14] *Supra* Note 8
[15] Austin American Statesman, *Four CPS leaders lose jobs*, August 30, 2016. http://www.statesman.com/news/news/four-cps-leaders-lose-jobs/nsPHc/
[16] *Supra* Note 8
[17] Dr, Cynthia Osborne, The LBJ School of Public Affairs, Child and Family Research Partnership, *CPS Workforce Evaluation: Overview of Evaluation and Preliminary Findings*, October 18, 2016.
[18] I*d*
[19] *Supra* Note 8
[20] Senate Finance Committee, Workgroup on Child Protective Services, *Letter to Chair Nelson*, November 7, 2016.
[21] Legislative Budget Board, *Fiscal Size-up 2016-17 Biennium*, May 2016.
[22] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, September 13, 2016, page 5.
[23] Department of Family and Protective Services Prevention and Early Intervention, *Five - Year Strategic Plan*, September 2016.
[24] Department of Family and Protective Services, *DFPS Rider 25 Report for Foster Care Redesign*, February 2016.
[25] *Supra* Note 15
[26] ACH Child and Family Services, *Progress Report: Foster Care Redesign in Texas Region 3B*, July 2016.
[27] *Supra* Note 17
[28] *Supra* Note 17
[29] *Supra* Note 15
[30] *Supra* Note 17
[31] Information provided by the Department of Family and Protective Services via email on July 26, 2016.
[32] Information provided by the Department of Family and Protective Services via telephone on September 27, 2016.
[33] Texas General Appropriations Act, Article II, Fiscal Years 2016-2017.
[34] The Stephen Group, *Testimony before the Senate Finance Committee*, October 26, 2016.

Interim Charge 9B- OIG Sunset Implementation

Interim Charge Language: *Monitor the implementation of initiatives at the Office of Inspector General to reduce Medicaid fraud, waste and abuse, and other cost containment strategies, including examining the processes and procedures used by managed care organizations to address Medicaid fraud, waste and abuse.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on September 13, 2016 to discuss Interim Charge 9. Invited testimony was provided by the Inspector General (IG) and the Texas Association of Health Plans.[1,2]

Introduction

In their 2014 review of the OIG, the Sunset Advisory Commission (Sunset) found deep management and due process concerns, particularly in the IG's efforts to detect and deter Medicaid fraud, waste, and abuse. Sunset found the IG's investigative process lacked structure, guidelines, and performance measures to ensure consistent and fair results. The IG also had poor communication and a lack of transparency.[3]

In response to these concerns, the 84th Legislature passed Senate Bill 207 and Senate Bill 200, which collectively strengthened the accountability of the IG; improved the effectiveness of the IG through process improvements, ensured the IG was accurately measuring outcomes, streamlined the credible allegation of fraud (CAF) payment hold appeal process, and amended current law related to the authority and duties of the IG at HHSC.[4] Overall, the IG reports that it has successfully implemented, or is in the process of implementing all of the relevant provisions of SB 200 and SB 207. However, the Sunset Commission is currently conducting a compliance review of the IG's implementation of Sunset statutory and management recommendations which will be published in January 2017. This compliance review will provide a more in depth analysis of implementation efforts.

Background

The following major provisions of SB 207 and SB 200 were effective September 1, 2015 and required no specific action by the IG:

- Allows IG to issue subpoenas without the approval of the executive commissioner;
- Repeals the prohibition on participation in both the Health Insurance Premium Payment Program and Medicaid managed care; and
- Allows IG to conduct a performance audit of any HHS program or project, including audits relating to contracting procedures of HHSC or any HHS agency.

The chart below includes major provisions of SB 207 and SB 200 requiring implementation:[5]

Major Provision	Implementation Due Date	Implementation Status as of 9-1-16
Streamlines provider criminal history background checks by limiting the IG's involvement to providers not already subject to fingerprint-based checks by state licensing boards.	9-1-15 create MOU with state licensing boards.	In progress: All but three boards have signed MOUs.
Requires the IG to establish guidelines for evaluating criminal history record information of existing or potential Medicaid providers after seeking public input.	9-1-16	In progress: IG plans to adopt guidelines through rule by 11-12-16
Allows the IG to share confidential drafts of investigative reports concerning child fatalities with DFPS.	August 2015	Completed: Updated internal affairs policies and procedures
Requires better communication and coordination between the IG and HHSC program staff to avoid duplication of efforts.	Ongoing	Completed: Established trainings and coordination meetings with relevant stakeholders

Requires the IG and HHSC to define in rule their respective roles and purpose of managed care audits and to coordinate all audit activities.	9-1-16	Completed: Rules (TAC 371.37 and 353.6) were effective 7-14-16
Requires the IG to report quarterly to the executive commissioner, governor, and Legislature on the IG's activities and performance, fraud trends identified by the office, and recommendations for policy changes. The IG must publish these reports online.	Ongoing	Completed: Posted quarterly on IG's website
Requires IG to establish criteria for conducting its investigations and sanctioning providers and to complete Medicaid provider preliminary investigations within 45 days and full investigations within 180 days.	3-1-16 Rule adoption	Completed: Rules (TAC 371.1305) were effective 4-22-16
Directs the IG to establish a formal plan for reducing its backlog and improving inefficiencies in its investigative process. Directs the IG to track basic performance measures needed to monitor the efficiency and effectiveness of its investigative processes.	Develop and implement formal plan by 12-31-15	Completed: Plan created/ implemented in 2015.
Requires the IG, by rule, to establish criteria for categorizing its enforcement actions for Medicaid provider investigations to the nature of the violation, including penalties.	3-1-16 Rule adoption	Completed: Rules (TAC 371.1603) were effective 4-22-16
Defines the IG's role in managed care, including strengthened oversight of special investigative units and increased training for the IG and HHSC staff.	October 2016	Completed: Training module complete by October 2016. Rules (TAC371.1311) were effective 4-22-16
Requires the IG to conduct quality assurance reviews and request a peer review of the sampling methodology used in its investigative process, by the Association of Inspectors General or an equivalent organization.	January 2016	Completed: Peer reviewed January 2016
Requires the IG to include, with written notice of a proposed recoupment of overpayment, information relating to the extrapolation methodology used to determine the amount of the overpayment.	January 2016	In Progress: September 2016 extrapolation methodology implemented. Letters to providers about new extrapolation methodology have not been sent.
Changes an informal resolution from a requirement to an option. Requires an informal resolution meeting to be confidential and all information and materials obtained during the meeting to be privileged and confidential.	10-1-15	Completed: Rules (TAC 371.1613) were effective 5-1-16
Extends the deadline to request a hearing on an overpayment from 15 to 30 days and for IG to pay costs.	10-1-15	Completed: Rules (TAC 371.1615) were effective 5-1-16
Clarifies the definition of fraud to exclude unintentional technical, clerical, or administrative errors.	5-1-16	Completed: Rules (TAC 371.1(28)) were effective 5-1-16
Disallows Credible Allegations of Fraud (CAF) holds for services that have received prior authorization but lack additional evidence of fraud.	10-1-15	Completed: Rules (TAC 371.1709) effective 5-1-16

Clarifies good cause exceptions for IG's application of a CAF payment hold.	July 2016	In progress: Legal analysis of authority underway
Streamlines the CAF hold appeal hearing process at SOAH to more quickly mitigate financial risks to the state. Also, clarifies circumstances in which the IG has authority to place payment holds on providers.	July 2016	Completed: HHSC and SOAH signed MOU
Provides pharmacies audited by the IG and not accused of fraud a right to an informal hearing.	3-1-16	Completed: Rules (TAC 354.1891) were effective 3-1-16

IG Initiatives not related to SB 207

In addition to implementing the requirements of SB 207 and SB 200, the IG has created new initiatives to improve the effectiveness and transparency of the office. These new initiatives include outreach to providers, Managed Care Organizations (MCOs) and federal partners; increased stakeholder meetings with hospital and dental providers; a new focus on inspections with the creation of an inspections division; and the creation of the IG Integrity Initiative. The IG Integrity Initiative is a voluntary collaboration between the IG, MCOs, and Medicaid providers with the purpose of preventing fraud, waste, and abuse. The Initiative requires a signed pledge by participants committing to report fraud, waste and abuse to the IG, trained staff on Medicaid integrity practices, a link from their website to the IG's website, and IG informational posters posted in their offices with the number to the fraud hotline, now called the Integrity Line.[6]

Performance Measures

The following chart provides a comparison of performance measures before and after the new IG was installed in early 2015 and Sunset recommendations and other initiatives that were implemented.[7] *(See Appendix A at the end of this report for further explanation of these numbers.)*

Case status	FY 13	FY 14	FY 15	FY 16
Complaints Received (WAFERS)*	1,723	1,612	1,940	1,698
Investigations opened	768	1,405	1,477	Preliminary: 1,549 Full Scale: 106
Investigations closed	415	1,321	2,115	Preliminary: 1,617 Full Scale: 386
Cases Completed (Transferred to RAD or Litigation)	148	327	297	Preliminary: 124 Full Scale: 160
Days to complete preliminary investigations (statute says 45 days)	216	100	109	25
Days to complete full investigations (statute says 180 days)	513	451	231	128
Gross amount of settlement agreement	$8,857,309	$8,247,274	$12,496,650	$5,827,879
Alleged Medicaid provider overpayments**	$603,708,225	$57,361,253	$42,177,869	$31,247,887
Overpayments collected	$12,575,553	$16,004,812	$9,474,316	$10,213,160
Percent of overpayments collected	2%	28%	22%	33%

*Waste, Abuse, and Fraud Electronic Reporting System

** The drastic decrease of Alleged Medicaid provider overpayments from FY 13 to FY 14 is related to the IG's focus in FY 13 on dollars identified instead of focusing on dollars that are substantiated, which is the current approach. This problem was noted in the Sunset review of the HHSC OIG.[8]

MCO Efforts to Reduce Fraud, Waste, and Abuse in Medicaid

The prevention and detection of fraud, waste and abuse requires efforts by both the Medicaid MCOs and the IG. Although MCOs primarily focus on prevention of fraud, waste and abuse, they are statutorily required to engage in fraud detection activities and to work in concert with the IG on these efforts.

Preventative efforts: The overarching strategy of the Medicaid MCOs' is to proactively prevent as much fraud, waste and abuse as possible prior to processing claims in order to maximize profits. Although MCOs do not recover a lot in terms of fraud, part of "managing care" is scrutinizing claims carefully, prior to paying, in order to avoid having to recover any fraudulent, erroneous, or unnecessary services. To that end, MCOs invest heavily in the following processes: prepayment claims review (pre-review of high dollar claims and pre-review of providers with high utilization patterns); prior authorization requirements; and value based purchasing initiatives that pay providers for efficiency and quality. To help avoid provider mistakes that may lead to unnecessary payments, MCOs also conduct provider training on standards and procedures and how to detect fraud, waste and abuse. MCOs also operate their own fraud hotlines.[9]

As the state has transitioned the Medicaid program from a fee for service model to a managed care model, the IG must continue to adapt their policies and practices. One issue that arose at the Senate Health and Human Services Committee hearing was a lack of cost avoidance outcome measures for MCOs.[10] The IG should create these measures in conjunction with the MCOs to understand how effectively the managed care model prevents fraud, waste and abuse, not just the detection and recovery of overpayments.

In addition to monitoring MCO's preventative measures, the IG should also monitor eligibility determination practices at HHSC. The IG should audit and monitor the eligibility determination process in place for Medicaid, the Supplemental Nutrition Assistance Program (SNAP), the Temporary Assistance for Needy Families (TANF) program, and the Women, Infants and Children (WIC) program. Prior to publishing this report, Chairman Schwertner requested an IG audit of the HHSC eligibility system to provide a review of what is currently being done to certify that only those who qualify for these programs are receiving benefits. This will safeguard the integrity of these programs and minimize resources needed to recover fraudulent or erroneous payments on the back end.

Fraud, Waste and Abuse Detection Efforts: MCOs are required to have dedicated Special Investigation Units (SIUs), which meet regularly with the IG to share techniques for identifying fraud, waste and abuse. SIUs are statutorily required to identify, investigate and report possible acts of fraud, waste, and abuse to the IG within 30 days; report to the IG any provider payment suspension initiated by the MCO; and refer cases with an estimated overpayment of $100,000 or more or cases under $100,000 that have a clear indication of fraud to the IG.[11] SIUs also work with MCO Compliance Departments to conduct internal monitoring and auditing of providers; use fraud analytics to identify suspect behavior; use modeling and analysis techniques to compare behaviors of providers to others in their peer groups; and develop claims edits to look for suspicious behavior like using incorrect procedure codes.

Currently, SIUs are undergoing audits by the IG to review the structure and effectiveness of SIUs at each MCO.[12] Based on the initial audits, it is clear that each MCO SIU is structured and staffed differently, with some MCOs having a very small or almost nonexistent SIU office.[13] Depending on the findings of the remaining SIU audits, the IG should work with HHSC to develop minimum standards and more concrete guidelines surrounding the roles and responsibilities of SIUs.

Recoveries

State statute allows MCO SIUs to retain any money the SIU or the MCO's contracted entity recovers.[14] HHSC rules passed to implement this portion of statute allow an MCO to collect any money they recover.[15] Additionally, HHSC adopted rules requiring the IG to

distribute any funds they collect to the MCO minus the cost of the investigation and collection proceedings.[16]

Any fraud, waste or abuse recoveries by MCOs are included in their Financial Statistics Reports (FSRs), as reductions/offsets to medical costs. The FSRs are then used as the baseline to develop capitated rates. MCO recoveries are therefore returned to the state in the form of lower capitated rates. However, monies recovered by the IG are not reflected in the FSR, and should therefore be retained by the IG rather than sent to the MCOs. HHSC's rules should be changed to clarify that MCOs and the IG each retain the fraud, waste and abuse dollars they recover.

Credible Allegation of Fraud (CAF) Holds

Sunset's 2014 review of the OIG found that the previous IG was overusing CAF holds and extending the enforcement process in a manner that was unfair to providers and consumers. The Sunset review found that the previous IG was utilizing CAF holds as a negotiating tactic or bargaining tool, rather than to address a credible allegation that a provider is defrauding the Medicaid program in a manner that puts the state at significant financial risk.[17] Federal statute requires the use of a CAF hold when there is an investigation of fraud pending, but the statute also allows an exception for using a CAF hold for various reasons including: using other remedies that can have faster or more effective remedies; if using a CAF hold would reduce access to services in a community with only one provider or the provider serves a medically underserved area; and when a payment suspension is not in the best interest of the Medicaid program.[18]

Sunset found CAF holds were being overused because of the weak standard of proof definition, which they recommended clarifying to ensure CAF holds are used only when necessary.[19] The new statutory language requires probable cause that fraud exists and proof that continuing to pay a provider presents an ongoing significant financial risk to the state and a threat to the integrity of the Medicaid program.[20] Concerns have been raised as to whether the new language requiring the IG to show an ongoing significant financial risk to the state and a threat to the integrity of the Medicaid program is too restrictive and prevents the IG from using CAF holds altogether. Simply removing this requirement would open the door for the IG to potentially overuse CAF holds again, which is not in the best interest of the state, the providers, or the people served by Medicaid. However, rules should be adopted to clarify statutory language to ensure there are clear situations in which the IG can and should use a CAF hold as required by federal law.

Conclusion

The IG appears to have made significant progress in reforming the agency and implementing most of the key provisions in SB 207 and SB 200. Additionally, performance metrics have improved under Inspector Bowen's leadership. As the IG continues to implement not only the provisions of SB 200 and SB 207, but also initiatives he has developed to improve the agency's functioning, the policies and practices used to detect and prevent fraud, waste and abuse in HHSC programs should be evaluated through the lens of a managed care environment.

Recommendations

1.) **Require the IG, in conjunction with MCOs, to develop outcome measures related to cost avoidance.** As the state phases out of the fee-for-service model of health care delivery to the managed care model, it is necessary for the state to adapt performance measures accordingly. In addition to evaluating SIUs and other efforts to detect fraud, waste and abuse and recover overpayments, the IG should focus on ways to determine the effectiveness of MCOs efforts to prevent fraud, waste and abuse in order to gain a more complete picture of MCO performance.

2.) **Require the IG to audit and monitor the eligibility system in place for safety net programs at HHSC.** For the IG to transition its method of preventing fraud, waste and abuse from the fee-for-service model to the new managed care model, more attention should be paid to prevention efforts and not just back end recoveries related to fraud, waste and abuse. This begins with the state's determination of eligibility for Medicaid, SNAP, TANF and WIC. Chairman Schwertner requested this audit prior to publishing this report to ensure that all individuals receiving these benefits are truly eligible. This will protect the viability of these programs for those who truly need them, and will assist HHSC in preventing fraudulent payments or

services to beneficiary recipients.

3.) **Require the IG, in concert with HHSC and with input from MCOs, to develop more clear guidelines for SIUs.** Although the Committee would recommend against requiring a minimum investment in SIUs by MCOs, the variance in the level of SIU investment and activity indicates that MCOs may need additional guidance on how to structure and utilize these entities.

4.) **Require HHSC to change their rules to allow the IG to recover overpayments they detect.** HHSC created rules that require all funds recovered from an MCO's referral to go to the MCO even if the IG played a role in the recovery. This requirement was made through rule and is not reflective of state statute. Giving all the recovered money, less expenses, to the MCO reduces the incentive for the IG to recover funds when a case is referred from an MCO. To ensure the IG and MCOs are appropriately incentivized, the IG should collect all funds they recover without MCO support and the MCOs should collect all funds they recover independently.

5.) **Require HHSC, in conjunction with the IG, to create rules to define when a provider, "presents an ongoing significant financial risk to the state and a threat to the integrity of Medicaid."** The above language was added in SB 207 as a way to stop the IG from overusing CAF holds for inappropriate reasons.[21] The IG is concerned the language is too restrictive. The intent of the new statutory language was not to prevent the use of CAF holds, which is required by federal law. To address this confusion, HHSC, in conjunction with the IG, should develop rules to further clarify situations in which CAF holds can be used.

- Complaints Received - These numbers represent complaints/referrals that are received through the on-line Waste, Abuse, and Fraud Electronic Reporting System (WAFERS) and sent to the Medicaid Provider Integrity (MPI) or Intake unit. This includes any referrals/complaints received by the 1-800 Integrity Line. Starting in the middle of FY 2013, MPI began scanning referrals/complaints received by fax or U.S. mail into WAFERS. Although fax and mail receipts are minimal, the number in the chart prior for FY 2013 may not include 100% of the referrals received.
- Investigations Opened - Calculated by the date the case was opened in our case management system. An open case can be opened in one fiscal year and still be open in a subsequent fiscal year if it was not completed.
- Investigations Closed - For FY2016, IG is providing the data for MPI and Intake separately since our new reporting system captures the data by user area. Closed means the case was not transferred to any other IG business area for additional work. Although a referral could have been made to a regulatory agency or for education, the Intake or MPI investigation was still closed without any IG administrative enforcement action.
- Cases Complete - This is a count of the number of cases that had a "completed action" other than closure. A "completed action" is a transfer to Research, Analysis and Detection (RAD) or transfer to Litigation. This category was added to show there are other "completed actions" by MPI or Intake beyond a case closure which is captured in category "c" above.
- Days to Complete a Preliminary Investigation - Calculated by first identifying the cases that were opened in each respective FY and then calculating the number of days until the case was closed, transferred to a full scale investigation, transferred to Research, Analysis and Detection (RAD) unit or transferred to Litigations. The 45 day legislative requirement to complete a preliminary investigation was not effective until 09/01/2015. Prior to 09/01/2015 there was a legislative requirement to complete a preliminary investigation within 90 days of receipt of the allegation/referral.
- Days to Complete a Full Scale Investigation - Calculated by first identifying the cases that were made full scale for each respective FY and then calculating the number of days until the case was transferred to Litigation. The 180 day legislative mandate was not effective until 09/01/2015 and no prior legislative requirement was in place.
- Gross Amounts for Settlement Agreements - Represents the total dollar figure of settlement amounts for agreements executed by the IG during each FY. Note: Many settlements are paid over time. As payments on settlements are received, those numbers would also be reflected in the Overpayments Collected amounts for that time period.
- Alleged Medicaid Provider Overpayment - These numbers are based on the preliminary overpayments identified by Medicaid Provider Integrity (MPI) for investigations transferred to IG-Litigation. The actual overpayments could be different when Litigation assesses the evidence in the case and determines a final overpayment amount.
- The numbers represent sums actually received by the IG during the stated period. These amounts will include dollars also reported in one or more fiscal years in the Gross amount of Settlement Agreements category. FY 2013 and 2014 figures contain third party liability and global settlement amounts which were not contained in subsequent fiscal years. Additionally, Litigation is not able to break down the cumulative dollar amounts in FY 2013 and 2014 by source. This was started in FY 2015.

---

[1] Senate Committee on Health and Human Services, Interim Hearing Minutes, September 13, 2016: http://www.legis.state.tx.us/tlodocs/84R/minutes/pdf/C6102016091309001.PDF.

[2] Senate Committee on Health and Human Services, Interim Hearing Witness List, September 13, 2016: http://www.legis.state.tx.us/tlodocs/84R/witlistmtg/pdf/C6102016091309001.PDF.

[3] Texas Sunset Advisory Commission, *Staff Report with Final Results: Health and Human Services Commission and System Issues*, July 2015: https://www.sunset.texas.gov/public/uploads/files/reports/HHSC%20and%20System%20Issues%20Final%20Results.pdf.

[4] Senate Bill 207, 84th Regular Session, 2015 (Hinojosa/ Gonzales, Larry) and Senate Bill 200, 84th Regular Session, 2015 (Nelson/ Price).

[5] Information provided by the Health and Human Services Commission and the Office of Inspector General via email, September 26, 2016.

[6] Texas Office of Inspector General, *Presentation to the Senate Health and Human Services Committee: Stuart W. Bowen, Jr.*, September 13, 2016: http://www.senate.state.tx.us/75r/Senate/commit/c610/h2016/091316-HHSC_OIG_Stuart_Bowen-c9.pdf.
[7] Information provided by the Office of Inspector General via email, September 7, 2016.
[8] *Supra* note 3.
[9] Texas Association of Health Plans, *Reducing Fraud, Waste, and Abuse in Medicaid Managed Care: Senate Health and Human Services Hearing*, September 13, 2016: http://www.senate.state.tx.us/75r/Senate/commit/c610/h2016/091316-TAHP_Jamie_Dudensing-c9.pdf.
[10] Texas Association of Health Plans, *Testimony before the Senate Committee on Health and Human Services*, September 13, 2016.
[11] Texas Government Code §§ 531.113 and 531.1131.
[12] Texas Administrative Code § 353.502.
[13] Texas Office of Inspector General, *Audit of Medicaid and Chip MCO Special Investigative Units: Texas Managed Care Organizations Report Wide Variation in Fraud, Waste, and Abuse Detection and Recovery*, February 5, 2016: https://oig.hhsc.texas.gov/sites/oig/files/reports/IG-MCOSIU-Full-Report-16010.pdf.
[14] Texas Government Code § 531.1131 (c).
[15] Texas Administrative Code § 353.505 (d).
[16] Texas Administrative Code § 353.505 (e).
[17] *Supra* note 3.
[18] 42 C.F.R. §§ 455.23 (a)(1) and 455.23 (e).
[19] *Supra* note 3.
[20] Texas Government Code § 531.102 (g)(3)(c).
[21] Senate Bill 207, 84th Regular Session, 2015 (Hinojosa/ Gonzales, Larry).

Interim Charge 9C- Women's Health

Interim Charge Language: *Monitor the implementation of legislation and riders related to health and human services that were considered by the 84th Legislature, Regular Session and make recommendations for any legislation needed to improve, enhance, and/or complete implementation, including but not limited to the consolidation and expansion of women's health programs at the Health and Human Services Commission.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on September 13, 2016 to discuss Interim Charge 9C. The Health and Human Services Commission (HHSC) provided invited testimony.[1]

Introduction

Programs designed to provide preventative and reproductive health services to low-income Texan women are serving more clients with a larger provider base than ever before. Additionally, the new Healthy Texas Women program provides a streamlined no wrong door system to make enrolling and receiving services easier for clients and providing services easier for providers.

The Legislature should continue to prioritize funding for women's health programs and ensure access to preventative health services for women across the state. Additionally, the Legislature should explore ways to reduce maternal mortality, support healthier pregnancies, and expand the use of highly effective contraceptives such as Long-Acting Reversible Contraceptives (LARCs).

Background

Facing a statewide budget shortfall of $27 billion, the 81st Legislature reduced funding for women's health services by $76 million, including $71 million in family planning services.[2]

Recognizing the importance of restoring these reductions and expanding women's access to preventative healthcare, the 83rd Legislature made an unprecedented investment in services such as family planning, cancer screenings, and other preventative services.[3] Specifically, the Legislature provided more than $240 million over the next biennium for programs that support women's health, including:

- $100 million for the Expanded Primary Health Care Program (EPHC), which allowed an additional 170,000 women with incomes up to 200% of the Federal Poverty Level (FPL) to receive family planning, preventative health services, breast and cervical cancer screenings, and other services such as diagnosis and treatment of STDs and prenatal and dental services[4];
- $71 million for the Texas Women's Health Program, which provides family planning services, preventative health screenings including screening for breast and cervical cancer, HIV screening, and screening and treatment of STDs for women ages 18-44 with incomes up to 185% FPL. This was the reinvented Medicaid Women's Health Program, fully state funded with no abortion providers or affiliates allowed to participate[5]; and

- $45 million for the Department of State Health Services (DSHS) Family Planning Program, which provides family planning services and preventative health screenings for men and women up to 250% FPL.[6] Much of this funding was to replace the loss of Title X funds, which had traditionally been awarded to DSHS, but instead was awarded to a group of private providers.[7]

The investment of the 83rd Legislature more than restored the reductions made in Fiscal Years (FY) 2012-13 and during the FY 2014-15 biennium, more Texas women received women's health services than prior to the budget reductions.[8]

In 2014, the Sunset Advisory Commission directed HHSC to consolidate the Texas Women's Health Program and EPHC into one program under a division at HHSC, and to transfer the Family Planning program from DSHS to the same division at HHSC. The Sunset Commission also directed the agency to work with the Senate Finance Committee and the House Appropriations Committee to determine, based on available funding, the eligibility criteria for the new consolidated program.[9] The consolidation resulted in the following two programs:

- Healthy Texas Women (HTW) was created as a combination of the Women's Health Program and EPHC. This program serves U.S. citizens and legal residents ages 15-44 who are not pregnant, are uninsured, and have a household income under 200% FPL.[10] To support the Healthy Texas Women program, the Legislature appropriated an additional $50 million for the FY 2016-17 biennium[11];
- The Family Planning Program remains unchanged, serving men and women age 64 or younger who are Texas residents and have a household income below 250% FPL.[12]

Both HTW and the Family Planning Program provide pelvic exams, contraceptives, pap smears, STD services, sterilizations, breast and cervical cancer screening and diagnostic services, immunizations, and screening for hypertension, diabetes, and cholesterol. HTW also provides cervical dysplasia treatment and other preventative services, and Family Planning provides prenatal services.[13]

Overall Provider and Client Enrollment

In order to participate in HTW or the Family Planning program, a provider must be an approved Medicaid provider. Services in both programs are provided on a fee-for-service basis and providers are enrolled through an open enrollment process. Women who are covered under Medicaid as pregnant women are auto-enrolled in the Healthy Texas Women program the day after Medicaid coverage ends at 60 days postpartum.[14]

There are more clients and providers in state-funded women's health programs than prior to the FY 2012-13 budget reductions, as shown in the chart below.

Number of Clients[15]*

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Family Planning	212,477	195,709	82,953	48,902	55,869	66,118
Breast and Cervical Cancer Screening	33,835	35,911	37,748	36,718	33,599	34,376
Expanded Primary Health Care					147,083	158,209
Women's Health Program/Texas Women's Health Program	107,567	127,536	126,473	115,440	114,441	105,205
Total	***353,527***	***359,156***	***247,174***	***201,060***	***350,992***	***363,908***

*Note that FY 2016 data is not available due to the timing of this report and the fact that providers have 95 days to submit claims after a service has been provided.

The total number of providers across all women's health programs has more than tripled since FY 2010**.** While there are fewer clinics participating in the Family Planning program than in FY 2010, there are more clinics overall across all women's health programs (581 in FY 2016 versus 539 in FY 2010).[16]

Number of Providers

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Family Planning	77	73	57	41	18	18	18
Breast and Cervical Cancer Screening	43	47	44	43	41	41	38
Expanded Primary Health Care					54	58	58
Women's Health Program/ Texas Women's Health Program	1,647	1,328	1,357	3,853	4,097	4,603	4,713
Total	***1,767***	***1,448***	***1,458***	***3,937***	***4,210***	***4,720***	***4,827***

Outreach

In order to inform women and providers about the availability of the Healthy Texas Women Program and other women's health programs, HHSC has conducted an outreach campaign including television and radio advertisements, social media, and stakeholder factsheets. Additionally, the agency held contractor conferences and launched a completely redesigned website, HealthyTexasWomen.org, on August 31, 2016.

Areas for Further Improvement

Despite the advancements in access to comprehensive women's health services made over the past several years, the Legislature must maintain their investment in women's health, and HHSC must ensure that any access to care issues in underserved areas of the state are proactively identified and immediately addressed. Moving forward, the Legislature should seek to improve access to LARCs, improve birth outcomes, and reduce maternal mortality rates, particularly among minority women.

Long Acting Reversible Contraceptives (LARCs):

LARCs, such as Intrauterine Devices (IUDs), are 20 times more effective than other forms of contraception including birth control pills and patches, and have a low risk of side effects. Clinical experts, including the American College of Obstetricians and Gynecologists (ACOG), have made the promotion of LARC usage a priority due to its effectiveness at reducing unplanned pregnancies, and the ability for LARCs to be inserted immediately after childbirth and used safely while breastfeeding.[17]

In FY 2012, 6.5% of Medicaid enrollees receiving contraception, 6.5% of Texas Women's Health Program enrollees receiving contraception, and 5.1% of Family Planning enrollees receiving contraception were utilizing a LARC. Although these percentages improved slightly by FY 2015, the actual number of women utilizing LARCs in the Women's Health Program and the Family Planning Program actually declined over this period, as shown in the chart below. The choice of contraception is a personal decision for a woman and her family to make, but HHSC should continue to take steps to promote the use of LARCs, ensure they are available to women, and provide sufficient training opportunities for providers on how to insert them.

LARC Utilization[18]

Program	FY 2012	FY 2013	FY 2014	FY 2015
Medicaid	6.5% 31,094	5.9% 28,805	6.7% 31,980	7.5% 37,760
TWHP	6.9% 5,958	7.2% 5,023	9.2% 5,316	10.8% 5,926
Family Planning	5.1% 3,113	7.8% 2,798	13.8% 3,200	13.3% 2,918
EPHC			9.1% 5,680	12.2% 6,856

Rider 53, Article II Special Provisions of the FY 2016-17 budget required DSHS and HHSC to expeditiously implement program policies to increase access to long acting contraceptives and to develop provider education and training to increase access to the most effective forms of contraception.[19] In response to this rider, HHSC has made several policy changes to increase access to LARCs. HHSC has continued to add LARC products as a pharmacy benefit under the Medicaid and Healthy Texas Women programs, which allows providers to prevent significant upfront costs in order to offer LARCs to their patients.

As of January 1, 2016, providers in hospitals may receive an add-on payment for insertion of a LARC outside of the global delivery fee. The lack of this payment was previously a deterrent to providers, who would require the woman to return after her hospital stay for a follow up appointment to have the LARC inserted in order to be adequately reimbursed for LARC insertion. HHSC also now allows Federally-Qualified Health Centers to receive reimbursement for LARC insertion.[20]

In order to increase provider education and training on LARCs, HHSC developed and published the Texas LARC Toolkit on June 24, 2016. This toolkit is being used by women's health providers across the state as a resource for implementing their own LARC policies. Additionally, HHSC provided contractor training on LARCs on August 10, 2016, including an insertion practicum for providers.[21] HHSC should offer these practicums in different regions of the state to increase training opportunities for providers. Additionally, HHSC should explore ways to address prohibitively high pricing of LARCs by manufacturers, which serve as a disincentive for providers to offer these products.

Healthy Birth Outcomes

Texas' infant mortality rate has been below the national average since at least 2005, and in 2014 was 5.9 per 100,000 live births, below the 6 per 100,000 live births Healthy People 2020 target. However, racial disparities in infant mortality have persisted, with an infant mortality rate among black women of 11.9 in 100,000 live births in 2013, more than double the corresponding rates for white and Hispanic women in 2013, which were both slightly higher than 5 in 100,000 live births.[22]

In 2014, 12.33% of babies born in Texas were delivered prematurely. This is down from 13.73% in 2004, but higher than the Health People 2020 target of 11.4%.[23] Preterm birth rates are higher among women enrolled in Medicaid, with 13.1% delivering prematurely in 2014.[24] FY 2015, the state paid over $402 million for newborn prematurity and low birth weight babies enrolled in the Medicaid program. Medicaid costs for the birth of a baby with complications due to prematurity/low birth weight averages $109,220, while a full term birth costs the Medicaid program an average of $572. Care delivered in Neonatal Intensive Care Units (NICUs) is now the costliest episode of care in Medicaid for the non-elderly population.[25]

In order to reduce these costs, improve birth outcomes for babies, and address racial disparities in infant mortality and other birth outcomes, DSHS established the Healthy Texas Babies (HTB) initiative in October 2010. The HTB uses statewide and county level data on infant mortality, morbidity, prematurity, low birth weight, risk behaviors, ethnicity/race, age and socioeconomic status to encourage coordinated infant mortality efforts in communities across the state. The 82nd Legislature appropriated $4.1 million to DSHS for this initiative, and this level of funding was maintained by the 83rd Legislature. The 84th Legislature increased funding for HTB to $5 million for the FY 2016-17 biennium. Utilizing this funding, DSHS has collaborated with healthcare providers and other stakeholders to develop quality improvement initiatives, advance data-driven best practices, and promote education and training for pregnant women and providers. The funding also supports six HTB Community Collaboratives in different regions of the state that implement evidence-based interventions to reduce preterm birth and infant

mortality. Texas A&M University is conducting an analysis of these HTB Collaboratives and will issue a final analysis by the end of FY 2017. DSHS should explore additional ways to evaluate the effectiveness and the return on investment of initiatives to reduce infant mortality and morbidity and should focus resources on the most effective interventions targeted at the highest risk regions and populations in the state.[26]

Maternal Mortality

A recent study found that U.S. maternal mortality rates more than doubled from 2000 to 2014, and that Texas' rate showed modest growth from 2000 to 2010, and then doubled between 2010 and 2012. The report noted that "in the absence of war, natural disaster or economic upheaval, such an increase seems unlikely" and states that "a future study will examine Texas data by detailed cause of death".[27] Prior to the release of this study, the 83rd Legislature established the Maternal Mortality and Morbidity Task Force to study maternal mortality and morbidity in Texas. The task force is required to study and review cases of pregnancy-related deaths and trends in severe maternal morbidity (SMM), determine the feasibility of the task force studying cases of SMM, and make recommendations to help reduce the incidence of pregnancy-related deaths and SMM in this state.[28] In their recent report, the Task Force found that, based on 2011-2012 data:

- black women bear the greatest risk for maternal death;
- cardiac events, overdose by licit or illicit prescription drugs, and hypertensive disorders are the leading causes of maternal death;
- mental health and substance use disorders play a significant role in maternal death;
- hemorrhage and blood transfusion cases largely drive SMM in Texas;
- a majority of maternal deaths occur more than 42 days after delivery; and
- data quality issues related to the death certificate make it difficult to identify a maternal or “obstetric” death.[29]

Finally, the Task Force found that based on 2012 SMM data, new methodologies of calculating SMM revealed a higher prevalence than previously found by past studies.

Based on these findings, the Task Force recommended:

- Increased access to health services during the year after delivery and throughout the interconception period to improve continuity of care;
- Increased provider and community awareness of health inequities;
- Increased screening for and referral to behavioral health services;
- Increased staffing resources in support of the task force.
- Promotion of best practices for improving the quality of maternal death reporting and investigation; and
- Improvement in the quality of death certificate data.

Clearly, improvements in data reporting are necessary to allow the Task Force and other researchers to better understand the disturbing upward trend in maternal mortality, and the root causes of the increase. The Legislature should carefully consider implementation of the recommendations of the Task Force, take steps to improve data utilized for maternal mortality review, and continue to encourage the sharing of best practices across the state to improve both maternal and infant health outcomes.

Conclusion

Through its investment in women's health programs, the Legislature has ensured that Texas is providing preventative healthcare services to more women through a larger provider base than ever before. It is crucial to continue this commitment and maintain the investments that have been made over the past several years. Additionally, the state should explore ways to improve birth outcomes, address alarming increases in maternal mortality, and expand access to LARCs.

Recommendations

1. **Continue to prioritize funding for women's health programs.**
2. **Ensure access to women's health programs across the state.** HHSC should work to proactively identify and quickly remedy any access to care issues that arise in the state-funded women's health programs.
3. **Increase access to Long Acting Reversible Contraceptives.** This should include expanded, statewide training opportunities for the insertion of LARCs, including for mid-level practitioners practicing under the supervision of a physician.
4. **Pursue policies to reduce maternal and infant mortality rates.** This should include careful consideration of the Texas Maternal Morbidity and Mortality Task Force's recommendations, outlined above, and leveraging Healthy Texas Babies funding to better support the Task Force and create a collaborative approach to improve maternal and infant health.

---

[1] http://www.legis.state.tx.us/tlodocs/84R/witlistmtg/pdf/C6102016021809001.PDF
[2] General Appropriations Act, FY 2012-13, Article II.
[3] General Appropriations Act, FY 2014-15, Article II.
[4] Health and Human Services Commission and Department of State Health Services, *Presentation to the Senate Committee on Health and Human Services*, February 20, 2014.
[5] *Id*
[6] *Supra* note 4
[7] *Supra* note 4
[8] *Supra* note 4
[9] Sunset Advisory Commission, *Staff Report with Final Results: Health and Human Services Commission*, July 2015.
[10] Health and Human Services Commission, *Presentation to the Senate Committee on health and Human Services*, September 13, 2016.
[11] *Id*
[12] *Supra* note 10
[13] *Supra* note 10
[14] *Supra* note 10
[15] *Supra* note 10
[16] *Supra* note 10
[17] ACOG site and LARC program
[18] *Supra* note 10
[19] General Appropriations Act, FY 2016-17, Article II Special Provisions, Section 53.
[20] Information provided by Health and Human Services Commission via email, September 26, 2016.
[21] *Id.*
[22] Department of State Health Services, 2015 Healthy Texas Babies Data Book.
[23] Date provided by the Texas Department of State Health Services, Center for Health Statistics, October 13, 2016.
[24] *Id*
[25] *Supra* note 10

[26] Information provided by Department of State Health Services via email on September 9, 2016.
[27] American College of Obstetrics and Gynecology, *Recent Increases in the U.S. Mortality Rate: Disentangling Trends form Measurement Issues*, MS NO: ONG: 16-537, Vol. 128, No 3, September 2016.
[28] Senate Bill 495, 83rd Texas Legislature, Regular Session, 2013 (Huffman).
[29] Maternal Mortality and Morbidity Task Force and the Department of State Health Services, *Joint Biennial Report*, July 2016.

November 9, 2016

The Honorable Charles Schwertner, M.D., Chair
Senate Committee on Health and Human Services
P.O. Box 12068
Austin, Texas 78711

Dear Chair Schwertner:

Thank you for your leadership as Chair of the Senate Health and Human Services Committee. It is our privilege to serve with you, and we appreciate the opportunity to share our perspectives regarding the Committee's Interim Report to the 85th Legislature. Because the report includes many fine recommendations, we are pleased to sign it. We submit this letter to be included in the report, however, as a record of some of our concerns.

Interim Charge 1A

In reference to Interim Charge 1A, relating to human fetal tissue donation, scientists have used fetal tissue for medical research since the 1930s. It was invaluable in the development of vaccines for many deadly diseases, such as polio, measles, mumps, rubella, chicken pox, and rabies.[1] While we share our colleagues' concerns regarding the lack of clear oversight by the state, the committee did not invite a single researcher who has ever, or is currently conducting fetal tissue research, a member of an Institutional Review Board who oversees the research proposal and methodology of a fetal tissue study, or a university partner to offer verbal or written testimony. The recommendations in the report fail to take into account the opinions of the persons most impacted by these suggested changes.

We agree that the statute around fetal tissue research could be clearer, and we support the recommendation that the Department of State Health Services oversee and enforce the process and regulation of fetal tissue research in Texas. We believe that a standard consent form for individuals wishing to donate their fetal tissue would help ensure that all donations are voluntary and made with complete information. We support also the federal prohibition on incentivizing gestation for the purposes of fetal tissue research, and we welcome its codification in Texas statute.

We are concerned, however, about the potential impact of several other recommendations. The

[1] Heather D. Boonstra, *Fetal Tissue Research: A Weapon and a Casualty in the War Against Abortion*, Guttmacher Institute, Feb. 9 2016, https://www.guttmacher.org/about/gpr/2016/fetal-tissue-research-weapon-and-casualty-war-against-abortion (last accessed Nov. 8, 2016).

report proposes banning researchers from reimbursing any fees or expenses generated as a result of the fetal tissue procurement, and it identifies "payments for transportation…preservation, quality control, or storage" as disallowable expenses. Safely handing, packaging, storing, and shipping any sensitive material is costly, and by explicitly prohibiting the reimbursement of these standard costs, the recommendation would require all Texas researchers to find unrealistically philanthropic research partners. What's more, we fear that the ban on reimbursements effectively prohibits Texas researchers from obtaining any fetal material from providers outside of the state of Texas, where reimbursement for such basic costs is standard procedure.

The recommendations to "prohibit the donation of human fetal tissue acquired as a result of elective abortions" and to limit donations from "hospitals, birthing centers, and Ambulatory Surgical Centers that perform 50 or fewer abortions per year" would have significant negative consequences for fetal tissue research in Texas. Currently, no hospitals in Texas are known to participate in fetal tissue donation, and we have received anecdotal evidence suggesting that researchers often need fetal tissue which meets very specific criteria. Limiting both the type of fetal tissue allowed for donation and the medical facilities able to participate in donation could result in researchers being unable to find sufficient material to meet their research needs.

The Senate Health and Human Services Committee did not invite or consult with any experts who have ever or are currently involved with fetal tissue research before issuing its recommendations. Without assurances from those in the field, we fear that the cumulative impact of these proposed regulations is a complete ban on all research using fetal tissue in Texas. Texas has been a national leader in medical science advancement, and we strongly oppose these efforts to undermine significant future discoveries.

Interim Charge 1B

In regard to Interim Charge 1B, the cause of action for wrongful birth, at its core provides families the ability to sue for medical malpractice. This cause of action is available to patients when doctors do not meet the current standard of care by failing to disclose significant information and either misdiagnose or fail to provide all pertinent information to their patients. By withholding the information, the patient is unable to make a fully informed decision about their health care.

What's more, the interim report contends that this cause of action is excessively punitive to physicians. During testimony, however, the committee did not hear from doctors that this indeed is an issue that exploits physicians and encourages them to avoid liability by "promot[ing] abortion." It is our position that, before the legislature takes away a cause of action afforded to any other patient that has faced medical malpractice relating to a doctor's duty to disclose, we have a better understanding from physicians and lawyers regarding the frequency that this cause of action is utilized and the actual consequences of this cause of action to doctors.

In these cases, lawsuits can provide an opportunity for families to find closure and understand the circumstances that led to their doctors failing to fully inform them of the condition their unborn children, including if the omission was accidental or intentional. Such specific insight

typically is not obtainable through the Texas Medical Board complaint process regardless of the disposition since the process is confidential by law, and rarely results in a case being filed with the State Office of Administrative Hearings. It also is important to understand that any monetary resolutions provided through these lawsuits are for the lifelong medical and educational supports the child needs.

We disagree that this cause of action communicates to families of children with disabilities that they "would have been better off had that child been aborted." Instead, we recognize that this is an option families can utilize to combat medical malpractice. We do, however, agree that no birth is "wrong," and respectfully suggest an alternative recommendation to change the term of art that is "wrongful birth" to a term that acknowledges all lives involved, while empowering families to pursue remedies when medical malpractice takes place.

Interim Charge 4

Medicaid in the Texas Budget

We agree that Medicaid, and health and human services more broadly, comprise a considerable portion of the state's budget. Without distinguishing, however, between All Funds expenditures, which includes federal funds, and state expenditures (i.e., General Revenue, General Revenue-Dedicated, and other funds), the figures provided in the report do not paint the entire picture. Similar to public education, funding for health and human services accounts for nearly half of the state's budget. Unlike public education, however, the federal government provides a significant portion of our funding for health and human services.

For the 2016-17 biennium, the ***state*** spending for all of Article II, which includes programs such as child protective services as well as Medicaid, is $34 billion, as compared to $48.4 billion in state spending for public education (Article III).[2] In terms of federal spending, Texas' budget includes $43.2 billion for Article II, as compared to $10.2 billion for public education.[3] In sum, total or All Funds spending is $77.2 billion for Article II, and $58.6 billion for public education.[4]

Notably, Medicaid is by far the single largest ***source*** of federal funds in every state's budget. This bears true in Texas. For the 2016-17 biennium, $61.2 billion in All Funds was appropriated for Medicaid, which includes $36 billion in federal funds and $25.2 billion in state (GR/GR-D) funds.[5] Moreover, 50 percent of all hospital funding via Texas Medicaid is now funded with a local match; or in other words, no support from the state.

We agree that the costs for the state's Medicaid program continue to grow. That cost growth in Texas' Medicaid program, however, is due to increased enrollment among already eligible

[2] Legislative Budget Board, *Fiscal Size-Up FY 2016-17*, May 2016, http://www.lbb.state.tx.us/Documents/Publications/Fiscal_SizeUp/Fiscal_SizeUp.pdf (last accessed Nov. 8, 2016).
[3] *Id.*
[4] *Id.*
[5] *Id.*

populations (e.g., children and adults with disabilities). In fact, the cost per beneficiary in Medicaid has been stable and is lower than Medicare or private insurance. Experts attribute the enrollment growth in Medicaid to the high poverty level in our state and the relatively high proportion of low-wage jobs that don't provide health insurance in our state's economy.

Medicaid Reform

We disagree with many of the premises offered in this section of the committee's report. First, the report characterizes the Affordable Care Act (ACA) as an "abysmal failure." Inevitably, we encounter some operational issues as we implement major programmatic endeavors like Medicare 50 years ago, Social Security 80 years ago, or Medicaid managed care in Texas this past decade. As history shows, we have been able to overcome these issues when we work together. We would argue the ACA is no different.

Over the past three years, the federal and state insurance marketplaces and expanded Medicaid programs – all resulting from the ACA – have reduced the national uninsured rate to 9.1 percent in 2015, a historic low.[6] In Texas, 1.1 million citizens have gained coverage, and the state's uninsured rate has dropped three years in a row to 17.1 percent for 2015 – a remarkable figure given that from 1999 to 2013, the rate fluctuated from 21 to 25 percent.

This is progress, but Texas still holds the dubious distinction of having the highest number and percentage of uninsured. According to the latest figures, 4.6 million Texans do not have affordable health insurance options. About one million of these Texans could be helped if the state expanded Medicaid. They include those who do not receive health insurance through their employers and make too little to qualify for the discounted health plans provided through the marketplace.

Many of these insured work in the food and service industries while others can only work part-time because of disability or diseases like multiple sclerosis, cancer, or mental illness. In fact, as this report notes, various findings from DSHS and HHSC show that one-third of potentially preventable hospital admissions have a co-occurring mental health or substance use disorder, and the top three diagnoses for potentially preventable readmissions are bipolar disorders, schizophrenia, and major depression. These findings underscore the need for ongoing care and comprehensive coverage in a medical home for Texas adults, and a coverage gap solution is the most effective tool available for Texas to achieve this goal.

Unfortunately, this report does not include a recommendation to provide coverage for these one million Texans.

This is shortsighted. Health care and the economy go hand-in-hand – a healthy workforce is a more productive workforce. Two noteworthy statistics:

---

[6] Jessica C. Barnett and Marina Vornovitsky, *Health Insurance Coverage in the United States: 2015*, U.S. Census Bureau, Sept. 13, 2016, http://www.census.gov/library/publications/2016/demo/p60-257.html (last accessed Nov. 8, 2016).

- According to the Centers for Disease Control and Prevention, productivity losses related to personal and family health problems cost U.S. employers $1,685 per employee per year, or $225.8 billion annually.[7]

- The number one cause of homelessness and personal bankruptcies is health care costs.[8] Both issues have a profound impact on the economic vitality of families and communities.

These costs can be avoided if we invested up front in making sure that people have the opportunity to be healthy. While a person can take care of her health proactively through diet and exercise, unexpected events occur. Nobody can predict a car accident, and disease can strike quickly and unexpectedly. In those cases, access to affordable, quality health care is critical.

The state's Medicaid program provides health care coverage to millions of low-income Texans who are children, pregnant women, elderly, and Texans with disabilities. The program is a joint federal-state program with about 60 percent of the costs paid for by the federal government and the remainder picked up by the state. The Texas Legislature currently controls two key components of the program; it establishes who may be eligible for enrollment and sets the rates at which health care providers are paid for their services.

Unfortunately, Texas legislators steadfastly refuse to acknowledge the health and economic benefits that Medicaid expansion would bring Texans, often stating that Medicaid is "broken" so we should not cover more people under the program. The facts simply do not give credence to the idea that Medicaid is broken. Numerous other states that have expanded Medicaid are showing positive health improvements, and Texas children have had a long track record of improved health from being on Medicaid. The latter has happened even under the most difficult of circumstances, as the legislature has cut doctor and other provider reimbursement rates over the years.

States that have expanded Medicaid have shown positive impacts on state budgets, a bolstering of their state economies, a strengthening of their rural hospitals, and lower rates of uninsured people. Every chamber of commerce, economist, and serious research group that has considered this issue has strongly recommended to state leaders that we expand Medicaid or come up with an alternative, private market-based solution like Arkansas, Indiana, and other conservative states have. This would allow us to accept the return of billions of our federal tax dollars to support people in need of health care while providing an economic boost, with relatively minimal state investment. In fact, if the state had expanded Medicaid, HHSC estimated Texas would receive roughly $100 billion dollars back for the state's $20 billion dollar investment.

---

[7] *Worker Productivity Measures*, Centers for Disease Control and Prevention, http://www.cdc.gov/workplacehealthpromotion/model/evaluation/productivity.html (last accessed Nov. 8, 2016).
[8] National Coalition for the Homeless, http://www.nationalhomeless.org/factsheets/health.html (last accessed Nov. 8, 2016); Dan Mangan, *Medical Bills Are the Biggest Cause of US Bankruptcies: Study*, CNBC, http://www.cnbc.com/id/100840148 (last accessed Nov. 8, 2016).

As we continue to discuss how we can improve access to affordable, quality care for Texans, and at a minimum, maintain the existing health care safety net, the legislature must include closing the coverage gap either through Medicaid expansion or alternative private marketplace solutions.

1115 Transformation Waiver Renewal

The situation is even more acute now, as the 1115 Transformation Waiver, a mechanism that has preserved payments to hospitals for uninsured care and provided incentive payments for improved health outcomes, is set to expire next year. That means that billions of dollars that the federal government sent to hospitals and local communities to alleviate the burden of uncompensated care costs will no longer come to Texas. If the waiver expires without a plan in place, Texas communities would lose $1.3 billion in federal funding in 2018 alone, according to estimates by the Center for Public Policy Priorities.[9]

As stated in the committee report, CMS has made it clear that they will not continue these high uncompensated care payments that cover care in the most expensive setting when we can provide access to care for uninsured Texans in a much cheaper way. To be clear, these guidelines stipulated by CMS for Uncompensated Care (UC) pools were first laid out for all states in April 2015; they were not new guidelines announced in CMS' May 2016 extension letter to Texas.

HMA's Uncompensated Care Study

The committee report echoes some questionable assumptions from the HMA study. Here are what we believe to be the most glaring methodological flaws:

1. assumes only 60 percent take-up in Medicaid expansion population despite receiving expert advice to contrary; and
2. projects reduced revenues from a shift of those in the 100-138 percent FPL range who currently have insurance through the federal marketplace from the marketplace to Medicaid.

In addition, the HMA study states that $3.1 to $3.5 billion of unreimbursed care in 2015 is due to the Medicaid shortfall. However, this doesn't acknowledge that under the guidelines, CMS would not approve payment of any of this shortfall through the uncompensated care pool in Texas' 1115 waiver. Nonetheless, this shortfall amount is included in the $8.7 billion figure, along with bad debt and charity care.

With regard to the first issue, despite citing the Urban Institute study as its model, HMA assumes only 60 percent of eligible Texas uninsured adults would sign up for Medicaid expansion. As

[9] Anne Dunkelberg, *Looking Ahead to 2018: Can Texas Avoid the Loss of $1.3 billion in Health Care Waiver Funds?*, Center for Public Policy Priorities, July 14, 2016, http://forabettertexas.org/images/HW_2016_07_WaiverLossCovGap.pdf (last accessed Nov. 8, 2016).

compared to HMA's figure of 668,000, the Urban Institute projects 1.17 million uninsured Texas adults would enroll.

The Urban Institute reports that it advised HMA against this assumption even though it was requested by HHSC, noting that the very lowest take-up rate it has found in states that have expanded Medicaid is 70 percent, and at the high end, 88 percent. For example, Kentucky has enrolled 25 more than Census-based estimates in their Medicaid expansion. Similarly, Louisiana has enrolled over 306,000 adults since July, surpassing their Census-based estimates. Louisiana officials have stated that using enrollment data from SNAP and children's Medicaid gave them a much more accurate, higher projection for the number of low-income adults that may enroll, and they expect to exceed 400,000 by next July, their one-year anniversary.

Indeed, Texas take-up rate has been about 85 percent for children in Medicaid and CHIP, and HHSC assumed 75 percent in its Medicaid expansion models previously provided to the legislature. In sum, HMA's low enrollment projection isn't supported by the available data from states that have expanded Medicaid, or even historical data and trends in Texas.

With regard to the second issue, the assumptions behind HMA's modeling of net-reduced revenues for hospitals under Medicaid expansion are not specified in any detail, but HMA does assume that the state would not increase Medicaid reimbursement rates for hospitals.

Next, we highlight differences in the three conclusions reached with regard to Medicaid rate increases (see page 73).

The committee report asserts that states may not direct that increased Medicaid Managed Care premiums be used to increase hospital payments. This is inconsistent with final Medicaid Managed Care regulations that will allow states to direct payments as needed for either access to care or quality of care. It also does not seem to fully recognize impending implementation of Actuarial Soundness and Medical Loss Ratio standard in Medicaid Managed Care under the same regulations.

Next, the committee report assumes an all-or-nothing approach with regard to hospital Medicaid rates; according to the HMA study, fully funding hospital rates would require a 36 percent rate increase at a cost of $3.1 billion. It is conceivable, however, that the legislature could increase hospital rates by 10 or 15 percent or to be comparable to Medicare rates rather than the full 36 percent. This would, in turn, alleviate concerns regarding a potential violation of Texas' constitutional spending limits, which presumably refer to requirements to pass a balanced budget and the cap on growth rate of appropriations of non-constitutionally-dedicated state tax revenues.

The third bullet point makes an assumption that "rate increases would be paid by reducing UC and DSH payments, large public hospitals that care for a disproportionate share of the uninsured would experience huge losses in revenue that would threaten their survival." We are unable to decipher the rationale for this assumption. As stated previously, CMS would not permit rate increases to be paid through the uncompensated care pool.

Further, discussions regarding a Texas-style, 1115-based expansion contemplate using a combination of local funds and a broad-based provider tax to not only expand, but increase Medicaid hospital rates to the Medicare level, thus replacing the $3.1 to $3.5 billion "Medicaid shortfall" dollars that would otherwise be lost starting in 2018.

Finally, it is important to note that the scope of the HMA study is limited to hospitals. It does not take into account the direct financial impact that Medicaid expansion would have on other health care providers, or the direct and indirect economic impacts of expansion on the state's economy.

Committee's Recommendations

Although we agree with the general recommendations that the state should aggressively seek a longer-term renewal of the 1115 waiver and reduce costs associated with Medicaid, we would emphasize the importance of improving access to care and health outcomes as the primary goals of any 1115 waiver renewal and any Medicaid reform efforts.

With regard to the recommendation that Texas should seek a Medicaid block grant, the committee report does not provide any details as to what eligibility standards would be reduced, or explain what funding levels would be sought. As mentioned earlier, Texas Medicaid currently serves children, pregnant women, elderly with incomes below the poverty line, and those who are fully disabled and below the poverty line. Which one or more of these groups would no longer be eligible to receive benefits under a proposed block grant? Additionally, as stated in the committee report, about 92 percent of Texas Medicaid services are provided through managed care, and as a result of the state's decision to aggressively expand Medicaid managed care, the state has realized billions of dollars in cost savings. What other means would be utilized through a block grant to achieve further cost savings? Finally, as acknowledged in the committee report, a block grant would require Congressional approval; given the gridlock that has stymied Congressional action in recent years, we suggest the Texas Legislature's efforts would be better spent working on more practical proposals.

In conclusion, we reiterate our strong support for renewal of the 1115 Transformation Waiver as well as finding a solution to closing our coverage gap, thereby enabling nearly one million Texans to access affordable, quality health care and providing much needed support to our state's health care safety net.

Interim Charge 8

In regard to Interim Charge 8, relating to the Refugee Resettlement Program, we are concerned that the report's description of the program is mischaracterized, and that the recommendations for this charge are misguided and would reinsert the state into an oversight role that it surrendered voluntarily by withdrawing from the program.

The report overstates perceived security gaps in the current refugee vetting process. It is true that the current presidential administration removed the need for United Nations High Commissioner for Refugees' (UNHCR) referral so that the United States would be able to accomplish its goal of

placing 10,000 refugees. It is important to understand that this UNHCR referral stage serves only to determine a person's refugee status and does not determine the security risk posed by the refugee. Prospective refugees continue to be screened by the United States' National Counterterrorism Center, Federal Bureau of Investigation, Department of Homeland Security (DHS), and Department of State. DHS conducts an enhanced review of Syrian cases, and a single red flag ends the screening process for a person, preventing the person from acquiring entry into the United States. Refugees are fingerprinted and sent for in-person interviews in processing stations located in Jordan and Turkey. Pending applications continually are vetted against databases of security risks throughout the process. Within one year, refugees are required to apply for a green card, triggering another set of security checks. Despite the removal of the UNHCR referral, the high-level security checks process has not been weakened.

What's more, the report is mistaken in characterizing the Obama administration's refugee goals as purely humanitarian. In addition to upholding our country's highest values of compassion, generosity, and leadership, welcoming refugees has been a central part of long-standing U.S. national security policy. Maintaining a leading role in resolving the refugee crisis and the conflict of Syria is consistent with that policy. Taking state-level measures to impede refugee resettlement damages the national security and credibility of the country.

The report's first recommendation regarding requiring the HHSC to consider creating a state license for local refugee resettlement agencies is impractical and borders on interference in a federal grant process. Since the state voluntarily withdrew from the Refugee Resettlement Program, the state relinquished its ability to provide any oversight relating to resettlement processes. If the state were participating in the program and the HHSC was the designated coordinator for the state, licensure for resettlement agencies might make sense. In the current situation, however, it is contradictory for the state to absolve itself from the process and subsequently add an unnecessary layer of state government bureaucracy to refugee service agencies that does not appear to provide additional security measures. We fear that a new oversight operation would attempt to shut down local refugee resettlement agencies through overregulation in an attempt to bypass the state's inability to unilaterally halt federal resettlement. Such actions could only result in costly litigation and further unnecessary politicization of the plight of refugees and would not enhance the security of Texans.

With regard to the last recommendation for Interim Charge 8, directing HHSC to work with local communities who are disproportionately impacted by the refugee program to submit an annual fiscal impact report to ORR, the recommendation implies that refugees use our resources without contributing or giving back to our communities. This is not true. Most refugees get jobs and pay taxes very quickly upon arrival and contribute state, local, and federal taxes once employed. If HHSC is going to assist local communities in such a study, then it must be balanced to include the true fiscal impact including contributions as well as use of services.

The U.S. refugee resettlement system emphasizes early self-sufficiency through employment, and most refugees are employed within their first six months of arriving to the country. In fact, refugee men are employed at a higher rate than their U.S.-born peers, with 66.67 percent of refugee men employed during the 2009-2011 period, compared to 60 percent of U.S.-born men.

More than half of refugee women were employed during the same period—the same rate as U.S.-born women. The high employment of refugees increases their tax payments and other economic contributions, while decreasing their dependency on public assistance and services over the long run.[10]

Although many refugees initially depend on public benefits,[11] most quickly become self-sufficient. Benefits usage declines with length of residence, and after ten years, most of this gap closes. During the 2009-2011 period, less than 25 percent of refugee households with at least a decade of U.S. experience received food stamps, compared to 11 percent for the U.S. born; and only three percent of refugee households received cash welfare benefits, compared to two percent for the U.S. born.[12] Refugees' incomes rise over time, almost reaching parity with their U.S.-born counterparts. Many arrive to the U.S. with limited resources or penniless, but over time, they find jobs, advance economically, and become self-sufficient. The median household income for recent refugees—those arriving within the past 5 years—was just 42 percent of the median for U.S.-born population in the 2009-2011 period. For those who had arrived 10-20 years earlier, their median income was 87 percent of that for the U.S.-born. Rising income and falling public benefit dependency demonstrate the increasing self-sufficiency of refugees and their increasingly positive fiscal contributions over time.[13]

Nationwide, research has shown that refugees are contributors to local economies; for every dollar spent helping refugees start a new life in the U.S., there is significant economic return to communities. For example, a report in Tennessee found that refugees contributed almost twice as much in tax revenues as they consumed in state-funded services in the past two decades.[14] And in a recent study in Columbus, Ohio, resettlement agencies spent about $6 million a year, but from that investment, the central Ohio community reaps an annual economic impact of $1.6 billion, including nearly $36 million in spending and supports over 13,000 jobs.[15] A study in Cleveland, Ohio showed resettlement agencies spending $4.8 million on refugee services in one year, while refugees brought in $48 million to the Cleveland economy and created 650 jobs.[16]

---

[10] Randy Capps, et al., *The Integration Outcomes of U.S. Refugees: Successes and Challenges*, Migration Policy Institute, June 2015, http://www.migrationpolicy.org/research/integration-outcomes-us-refugees-successes-and-challenges (last accessed Nov. 8, 2016).

[11] The affiliates are responsible for assuring that a core group of services are provided during the first 30-90 days after a refugee's arrival, including food, housing, clothing, employment services, follow-up medical care, and other necessary services. There are approximately 350 affiliates throughout the United States.

[12] *Supra* note 9.

[13] *Supra* note 9.

[14] Krista Lee, *A Study on the Federal Cost Shifting to the State of Tennessee as a Result of the Federal Refugee Resettlement Program for the Period 1990 through 2012*, Tennessee General Assembly, Nov. 12, 2013, http://www.hias.org/sites/default/files/tn_report_federalcostshifting_refugeeresettlement.pdf (last accessed Nov. 8, 2016).

[15] Chmura Economics & Analytics, *Economic Impact of Refugees in the Cleveland Area*, Oct. 2013, http://www.hias.org/sites/default/files/clevelandrefugeeeconomic-impact.pdf (last accessed Nov. 8, 2016).

[16] Lynnette Cook, Impact of Refugees in Central Ohio 2015 Report, http://www.wrapsnet.org/Portals/1/IMPACT%20OF%20REFUGEES%20ON%20CENTRAL%20OHIO_2015SP.pdf (last accessed Nov. 8, 2016).

Clearly there is some economic gain from the resettlement of refugees, and reporting only the costs would be misleading in regards to the total economic impact these refugee resettlement programs have on a community. Since this committee is concerned with "protecting the financial stability of the state and local communities from unfunded mandates by the federal government," it would seem that considering economic growth related to these mandates would be just as important. Therefore, we have concerns that directing HHSC to assist communities with calculating the full costs of refugee resettlement to local governments is not enough; the committee should also direct HHSC to assist with calculating the full gains to local economies as well.

Thank you for your dedication to these important issues. We look forward to our continued productive relationship during the 85th Legislative Session. We remain committed to ensuring that every Texan has access to quality health and human services.

Very truly yours,

José Rodríguez
Senate District 29

Carlos Uresti
Senate District 19

Judith Zaffirini
Senate District 21