

**TEXAS SENATE
HEALTH AND HUMAN
SERVICES COMMITTEE**



**INTERIM REPORT
TO THE
79TH LEGISLATURE**

December 2004

Please direct questions or comments to:

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Senate Committee on Health and Human Services

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December 1, 2004


The Honorable David Dewhurst
Lieutenant Governor of Texas
P.O. Box 12068
Austin, Texas 78711

Dear Governor Dewhurst:

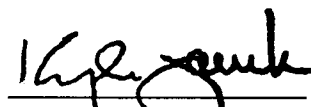
The Senate Committee on Health and Human Services submits this report in response to the interim charges you have assigned to this committee. The committee held seven public hearings to consider invited and public testimony from affected consumers, health and human service providers, and agency personnel regarding all of its charges. This report includes a review of issues and makes recommendations related to Medicaid reform, the implementation of House Bill 2292, indigent health care, ongoing state and federal health care initiatives, information technology in health care administration, facility regulation, and reform of Texas protective services.

The committee has carefully considered all of the testimony received on its charges in order to provide you with these recommendations. We appreciate the leadership and foresight you have displayed in asking this committee to monitor and seek remedies to these key issues, and we trust that the recommendations offered in this report will serve to improve health care and human services in Texas.

Respectfully submitted,

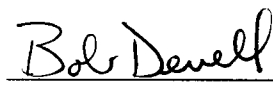


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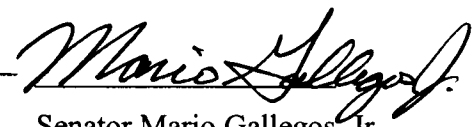
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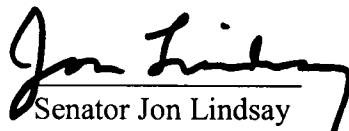
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Senator Mario Gallegos, Jr.



Senator Jon Lindsay



Senator Royce West



Senator Judith Zaffirini

ACKNOWLEDGMENTS

The Senate Health and Human Services Committee would like to thank the following for their contribution to the work of the Committee:

Office of the Governor
Office of the Lt. Governor
Texas Health and Human Services Commission
Texas Department of State Health Services
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Texas Department of Family Protective Services
Texas Department of Insurance
Texas State Board of Medical Examiners
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The Texas Legislative Council
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Texas Senate Staff Services
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This report was made possible by the leadership of the Committee Members, the research assistance provided by the staff of the Texas Senate Research Center and the contribution of key Senate staff, including Steve Roddy, Dave Nelson, and Joe Dyer. The committee would also like to express its appreciation to the numerous other state, industry, provider and consumer representatives for their involvement in this process, especially those who presented testimony to the committee during its public hearings.

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Charge 1: Cost-Containment in Medicaid and CHIP

Study and make recommendations on structural reform, efficiency improvements, and cost savings in the state Medicaid and CHIP programs, with a goal of changing the method and delivery of service to reduce costs while providing the intended services. The Committee should examine and make recommendations to:

- *lower institutional costs;*
- *subsidize private insurance in lieu of Medicaid and CHIP where possible;*
- *use consumer-directed care models;*
- *reimburse health care providers based upon outcomes where feasible;*
- *match currently unmatched local funds with federal funds;*
- *alter Texas' current method of finance and distribution of DSH;*
- *develop possible HIFA waiver options that incorporate premium subsidization;*
- *develop accountability and incentive measures for outcomes within Medicaid managed care and CHIP;*
- *seek flexibility from federal government to allow options and waivers and enhance federal funds;*
- *examine local models for delivery of Medicaid while maintaining best practices; and*
- *expand access to mental health services through expansion of behavioral health organization model.*

Background

Over the last five years, health care costs nationwide and across the public and private sectors have increased dramatically.¹ With the increasing costs of Medicaid and the State Children's Health Insurance Program (CHIP), public health care has become one of the largest categories of

¹ Kaiser Family Foundation, Commission on Medicaid and the Uninsured, *State Budget Constraints: The Impact on Medicaid* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2003).

state expenditures across the country.² The recent increase in the cost of public health care has, in many cases, coincided with state budget shortfalls,³ forcing many states to make difficult choices and adopt aggressive cost containment strategies.⁴

This report will attempt to highlight areas where additional savings may be possible in the Texas Medicaid program and CHIP by weaving together three disparate streams of policy recommendations.⁵ Following a brief explanation of the increasing cost of health care, it will be shown, through a review of common recommendations for reducing cost in Medicaid and CHIP, that Texas has already taken a fairly aggressive stance toward cost containment in these programs. The report will then summarize the findings of the Governor's Medicaid Reform Workgroup.⁶ Finally, several specific areas of reform will be discussed including premium assistance, long-term care reform, outcome-based reimbursement, and method-of-finance manipulations.⁷

² National Association of State Budget Officers, *State Expenditure Report, 2003*. Online. Available: <http://www.nasbo.org/Publications/PDFs/2003ExpendReport.pdf>. Accessed: November 30, 2004.

³ Kaiser Family Foundation, Commission on Medicaid and the Uninsured, *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2003). Online. Available: <http://www.kff.org/medicaid/loader.cfm?url=/commodns/spot/security/getfile.cfm&PageID=22126>. Accessed: November 30, 2004.

⁴ National Governors' Association, Center for Best Practices, *State Actions to Control Health Care Costs* (Washington, D.C., November 2003). Online. Available: <http://www.nga.org/cda/files/1103COSTCONTAIN.pdf>. Accessed: November 30, 2004.

⁵ Since there are several excellent volumes on the subject available, this report will not include a comprehensive review of the benefits, eligibility requirements, and other components of Medicaid and CHIP. The reader is directed to the HHSC "Pink Book": *Texas Medicaid in Perspective, 5th Edition*. Online. Available: <http://www.hhsc.state.tx.us/medicaid/reports/PB5/PinkBookTOC.html>.

⁶ To prevent significant duplication of effort between the Workgroup and the Committee, it is the intent that this report should, as much as possible, avoid repeating the recommendations of the Workgroup and serve as a companion volume. In some areas, repetition will be inevitable and unavoidable.

⁷ In most cases, Medicaid cost containment policies can be applied to CHIP as well. Thus, although this report appears to focus primarily on Medicaid, the recommendations are generally also applicable to CHIP. The two will often be described collectively as public health insurance.

Health Care Cost-Drivers

Health care costs have risen significantly over the past several years due to both the inherent characteristics of the health care industry and prevailing trends. In some labor-intensive industries such as health care, capital cannot be substituted efficiently for labor, leading to higher-than-normal inflation. This characteristic, known as Baumol's law, is cited by some analysts to explain why health care inflation will always be higher than normal inflation.⁸ Other observers blame an upturn in the insurance underwriting cycle for recent increases in cost.⁹ According to a 2002 analysis, the primary factors that contributed to the 13.7% increase in health care premiums (which serve as a useful proxy for all health care costs and likely reflect cost-drivers for Medicaid as well) between 2001 and 2002 were:

- Drugs, medical devices, and other medical advances (22%);
- Rising provider expenses (especially higher prices negotiated by consolidated hospitals) (18%);
- Government mandates and regulation (15%);
- Increased consumer demand (15%);
- Litigation and risk management (7%);
- General Inflation (18%); and
- Other (5%).¹⁰

Other studies and agency evaluations which have focused on Medicaid expenditures have attributed the growth in Medicaid expenditures to increases in caseload, utilization, and cost of services, especially pharmaceuticals.¹¹

⁸ Scott Gottlieb, "One Doctor, One Patient: It's Baumol's Disease, and it Pretty Much Guarantees that Healthcare Will Stay Expensive," *Quarterly Journal of Cost and Quality*, vol. 7, no.1 (Washington, D.C., March 2001).

⁹ National Conference of State Legislatures, Forum for State Health Policy Leadership, *Managing Medicaid Costs: A Legislator's Toolkit*, (Washington, D.C., December 2001), p. 4.

¹⁰ American Association of Health Plans, *The Factors Fueling Health Care Costs*, Prepared by Price Waterhouse Coopers, (Washington, D.C., April 2002). Online. Available: <http://www.aahp.org/InternalLinks/PwCFinalReport.pdf>. Accessed: November 30, 2004.

Existing Cost-Containment Strategies

Not surprisingly, many of the cost-containment strategies recommended by think tanks, policy analysts, and other researchers are specifically developed to address one or more of the main factors driving increased Medicaid costs. Many organizations have created 'laundry lists' of reform recommendations for public health insurance, several of the most prominent follow. The Texas Legislature has already enacted many of these recommendations, making the search for further cost-containment strategies more difficult. The strategies that have been implemented in Texas appear in parentheses.

Kaiser Family Foundation

A 50-state survey by the Kaiser Family Foundation summarized the most common Medicaid cost-containment strategies into the following categories:

- Provider payment rate changes (*decreased provider payment rates*);
- Pharmacy utilization and cost control initiatives (*implemented preferred drug list (PDL) and prior authorization for non-PDL drugs*);
- Benefits changes (*eliminated coverage for most optional populations*);
- Changes to eligibility (*implemented stricter assets test*);
- Co-payment requirements (*increased co-payments for some income groups*);
- Managed care (*extensive use and statewide expansion of managed care*);
- Disease and case management (*directed HHSC to develop statewide disease management strategy*);
- Long-term care and home and community based services (*shifted from nursing homes to Home and Community Based Services (HCBS) through Medicaid waivers*); and

¹¹ National Conference of State Legislatures, Forum for State Health Policy Leadership, *Managing Medicaid Costs: A Legislator's Toolkit*, (Washington, D.C., December 2001). See also -- Texas Senate Finance Subcommittee on Rising Medical Costs, *Interim Report*, (Austin, Tex., January, 2003). See also -- Texas Health and Human Services Commission, *Medicaid, Vendor Drug, and CHIP Caseload and Cost Update*. (Austin, Tex., Spring 2004). Online. Available: <https://www.hhsc.state.tx.us/news/presentations/Spring2004Update.pdf>. Accessed: November 30, 2004.

- Fraud and abuse prevention and prosecution (*created HHSC Office of the Inspector General*).¹²

National Governors' Association

An issue brief from November of 2003 by the National Governors' Association, Center for Best Practices summarized strategies for reducing state public health costs as follows:

- Improving program administration and management (*outsourced claims administration; increased use of managed care*);
- Increasing coordination with private insurance (*implemented Health Insurance Premium Payment programs*);
- Controlling long-term care costs (*expanded STAR+Plus – managed care for long-term care*);
- Improving care management for high cost and chronically ill patients (*expansion of managed care; implementation of statewide disease management initiative*);
- Promoting disease prevention (*implemented Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program*);
- Restructuring benefits and eligibility, provider reimbursement levels, and purchasing arrangements (*eliminated most optional populations; increased co-payments to federal limits; decreased reimbursement levels; created vendor drug program*); and
- Managing prescription drug expenditures (*implemented PDL and prior authorization for non-PDL drugs*).¹³

National Conference of State Legislatures

The National Conference of State Legislatures identifies the following Medicaid cost-containment strategies in its toolkit on managing Medicaid costs:

¹² Kaiser Family Foundation, Commission on Medicaid and the Uninsured, *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005 Results from a 50-State Survey*, (Washington, D.C., October 2004).

¹³ National Governors' Association, Center for Best Practices, *State Actions to Control Health Care Costs*, (Washington, D.C., November 2003).

- Medicaid maximization;
- Low-match to high-match;
- Intergovernmental transfers (*federal match for Disproportionate Share Hospital payments is being drawn down with intergovernmental transfers*);
- Private sector cost sharing (*the Texas Health Insurance Premium Payment program*);
- Reconfiguring the long-term care delivery system (*STAR+Plus; pilot Program of All-Inclusive Care for the Elderly*);
- Pharmacy cost containment strategies (*PDL; prior authorization for non-PDL drugs*);
- Rate adjustment (*reduced reimbursement rates*);
- Managing health care better (*disease management; EPSDT*);
- Expanding managed care (*statewide expansion of managed care*); and
- Selective contracting (*competitive bid processing*).¹⁴

Texas Senate Interim Subcommittee on Rising Medical Costs

The Texas Senate Interim Subcommittee on Rising Medical Costs included the following recommendations for containing rising Medicaid Costs in its report:

- FMAP recalculation (*HHSC is working with the Texas Office of State and Federal Relations and the Texas congressional delegation for re-design*);
- Enhanced FMAP border zone;
- Medicaid simplification (*implemented miscellaneous simplifications*);
- Vendor drug program restricted pharmaceutical formulary (*PDL implemented and prior authorization for non-PDL drugs*);
- Competitive hospital contracting in urban areas;
- Limit services to optional populations (*elderly are the only optional category remaining*); and
- Disease management (*HHSC is developing disease management programs for statewide implementation*).¹⁵

¹⁴ National Conference of State Legislatures, *Medicaid Cost Containment: A Legislator's Toolkit*, (Washington, D.C., March 2002).

Governor's Medicaid Reform Workgroup

In November 2003, Governor Rick Perry formed a Medicaid Reform Workgroup and included individuals representing hospitals, physicians, nurses, pharmacists, health plans, and consumers. The Workgroup issued an informal and open request for Medicaid reform suggestions that resulted in the submission of over 350 recommendations. Facilitated by staff from the Governor's Office of Budget, Planning and Policy, the Workgroup met six times between March and August of 2004 to discuss the recommendations with HHSC agency staff and the Workgroup members voted on whether to recommend changes based on the submitted suggestions.

Since the Workgroup report will be submitted contemporaneously with this report, information regarding the contents of the Workgroup report comes from oral testimony presented by Victoria Ford.¹⁶ As presented to the Committee, the Workgroup report will be composed of eight components: 1) use of data; 2) care coordination; 3) education; 4) finance; 5) long-term care; 6) managed care; 7) program administration; and 8) federal issues.

Use of Data

Currently, the State agencies and contractors involved in the Medicaid program collect a large amount of data that is not used effectively. For example, there is already sufficient data collected to allow HHSC to identify the most expensive clients and verify that they are utilizing services appropriately, but this analysis does not occur. The Workgroup report will include several recommendations toward the better use of available data to ensure that all services are provided appropriately and to direct policy changes to avoid inappropriate disincentives.

¹⁵ Texas Senate Finance Subcommittee on Rising Medical Costs, *Interim Report*, (Austin, Tex., January, 2003).

¹⁶ Texas Senate Health and Human Services Committee, Testimony by Victoria Ford, Moderator, Governor's Medicaid Reform Workgroup, (Austin, Tex., October 19, 2004).

Care Coordination

The different funding streams in the Medicaid program have different federal requirements regarding casework, case management, medical management, or care coordination. These different requirements all work toward the same goal – better coordination of care. Although intended for the same goals, these different requirements sometimes create inefficiencies and duplications of effort. The Workgroup report will include recommendations for streamlining the coordination of care for beneficiaries, especially those in long-term care.

Education

A greater emphasis on education could help to ensure that patients know how to access lower-cost, preventive care and know when to access different types of care. Although there is already some funding being used to produce educational guides for consumers, providers, and insurers, a more focused educational program could result in better outcomes. The Workgroup report will make recommendations for implementing a more effective education and outreach program.

Analyze and Re-arrange Finance Structure

There may be some ways to re-arrange the method of financing for the Medicaid program to maximize the benefit from federal options and to align more appropriately the inherent incentives and disincentives. Although there does not appear to be a simple way to control Medicaid costs through the finance mechanism, there may be some ways to restructure the disproportionate share hospital (DSH) payments and other payment mechanisms to improve efficiency. For instance, there seems to be an inherent incentive in the current finance structure for hospitals to provide inpatient care, even when outpatient care would be cheaper and

medically appropriate. The Workgroup report will include recommendations for re-arranging the finance structure to maximize federal dollars and avoid this sort of disincentive.

Long-Term Care

Since such a large portion of the State's Medicaid expenditures pay for long-term care, the Workgroup report addresses long-term care in its own high-level category. The State's Medicaid long-term care system is generally viewed favorably, although the recommendations from some of the other high-level categories could be effectively brought to bear on long-term care. Specifically, the report will likely recommend increasing the care coordination and education for beneficiaries in the Medicaid long-term care system to increase cost-effectiveness and improve outcomes.

Managed Care

The Workgroup received numerous recommendations regarding Medicaid managed care, especially related to the pending expansion of managed care statewide and the withdrawal of the Primary Care Case Management (PCCM) program from the major urban areas. There was only limited agreement on recommendations related to this issue, so the Workgroup report is not expected to include any significant recommendations regarding managed care.

Program Administration

Although the bulk of Medicaid spending is used for direct payment of providers, internal administrative costs are still high enough relative to other programs that significant cost-savings could result from optimizing program administration. There may be some situations in which HHSC is relying on sub-optimal business processes, technologies, or personnel that could be improved or replaced for greater efficiencies. The Workgroup report will likely recommend

increased use of technology, better business processes, reduced paperwork and hassle, and further use of electronic claims.

Federal Issues

As a joint state-federal program, Texas could stand to gain by changes in federal Medicaid policies. One of the more common federal Medicaid policy changes recommended by Texas policy-makers is a change to the Federal Medical Assistance Percentages (FMAP) that are used to determine the federal match for State Medicaid funds. Currently, the FMAP is determined based on average, per-capita income, which may overestimate the State's relative ability to meet its Medicaid obligation. The Workgroup report is likely to recommend changing the FMAP to use poverty percentage rather than average income. Since this is a federal issue, however, the State has a limited number of options.

Selected Public Health Insurance Reforms

Premium Assistance

There are several options available to the State for helping Medicaid-eligible Texans obtain coverage through private, employer-offered health insurance. In some cases, an employer may pay an employee's health insurance premiums but require the employee to pay part or all of the premium for the employee's family. If some members of the employee's family qualify for Medicaid, the employee's share of the insurance premium could be cheaper than the cost of insuring the family directly through Medicaid. In these cases, it would be cheaper for the State to directly pay the employee's share of the insurance premium through the employer rather than enroll the family in Medicaid.

Commonly referred to as "premium assistance", these sorts of arrangements are explicitly permitted under federal law and are administered through state Health Insurance Premium Payment (HIPP) programs.¹⁷ Similar flexibility is permitted under CHIP. Among other requirements, both the Medicaid and CHIP premium assistance programs require the state to show that covering the eligible individuals will be cost-effective.

Premium assistance programs have become popular, at least in theory, for several reasons. Primary among the justifications given for adopting premium assistance programs are the following:

- Premium assistance may augment the employer-based insurance program, the primary source of health care coverage in the country;
- Premium assistance may allow public health insurance programs to capture the employer premium contribution, thus driving down overall costs to the state;
- Premium assistance may strengthen the attachment of low-wage workers to the workforce, preventing unemployment;
- Premium assistance may provide the opportunity for low-wage workers to be covered by private insurance rather than public health coverage; and
- Premium assistance may allow all members of a family to be covered under the same health plan.¹⁸

There are currently about 6,289 Medicaid-covered children and about 9,442 total Medicaid enrollees in the Texas HIPP program,¹⁹ representing less than 1% of the 2,626,469 total

¹⁷ National Conference of State Legislatures, Forum for State Health Policy Leadership, *Premium Assistance Programs: Potential Help for the Uninsured?*, Technical Assistance Memo, Written by Michelle Herman, (Washington, D.C., 2001).

¹⁸ Kaiser Family Foundation, Commission on Medicaid and the Uninsured, *Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity*, (Washington, D.C., October 2003).

¹⁹ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Guidelines for States Interested in Applying for a HIFA Demonstration*. Online. Available: <http://www.cms.hhs.gov/hifa/hifagde.asp>. Accessed: November 30, 2004.

Medicaid enrollees in September 2004.²⁰ It is expected that individuals qualifying for Medicaid are not likely to receive health insurance through their employers since lower-wage jobs are less likely to include generous benefits. Thus, it is not surprising that the HIPP enrollment is so low. However, it is difficult to determine whether the actual program enrollment has reached optimal levels. In fact, very little research has been done to indicate how many Medicaid beneficiaries might be eligible for the HIPP program.²¹ Since every enrollee in the HIPP program by definition saves the State money, it could be very useful to know how many HIPP-eligible Medicaid beneficiaries there are.

In addition to the Medicaid and CHIP premium assistance programs explicitly allowed under federal statute, states have recently been provided additional flexibility for establishing premium assistance programs in the form of a new variety of Medicaid waiver. The federal Health Insurance Flexibility and Accountability (HIFA) initiative was recently passed by Congress to promote premium assistance programs. Under the provisions of the HIFA program, certain 1115 waiver proposals that incorporate premium assistance components will be reviewed on an expedited basis.²²

Like other Medicaid waiver programs, however, the flexibility for providing services under the HIFA initiative does not generally extend to the mandatory Medicaid populations.²³ Since Texas covers very few optional Medicaid populations and essentially no expansion populations, the

²⁰ Texas Health and Human Services Commission. *Texas Medicaid Enrollment as of Selected Time Periods*. Online. Available: <http://www.hhsc.state.tx.us/research/dssi/McaidMnthlyUpdate.html>. Accessed: November 30, 2004.

²¹ Texas Public Policy Foundation, *Medicaid and the Uninsured*, Research Report, Written by Beau Egert, (Austin, Tex., September 2004), p. 30.

²² States can be granted authority to experiment with different strategies for covering low-income residents under the auspices of 1115 waivers. States receiving approval from CMS for their 1115 waiver program may still receive the federal matching dollars for their waiver program and can be freed from certain standard Medicaid requirements.

²³ Kaiser Family Foundation, Commission on Medicaid and the Uninsured, *Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity*, (Washington, D.C., October 2003).

options for maximizing federal Medicaid dollars through a HIFA waiver are very limited. There is currently an effort underway through HHSC to obtain a HIFA waiver for an CHIP premium assistance program pursuant to House Bill 3038, 77th Legislature, and Senate Bill 240, 78th Legislature.²⁴

Medicaid Long-Term Care Reform

The State pays for a number of different long-term care services through Medicaid, including treatment in a nursing facility, an intermediate care facility for the mentally retarded (ICF/MR), a group home, an assisted living facility, a person's own home, or outside the home when necessary to help the individual live independently and participate in community life.²⁵ In federal fiscal year 2002, Medicaid-funded long-term care services were received by approximately 878,000 Texans and accounted for nearly 30% of total Medicaid spending in Texas.²⁶ As one of the largest components of Medicaid spending across the country, many states have started seeking ways to control the costs of long-term care.²⁷ Among the most promising recent developments in long-term care policy are waiver programs for non-institutional services, consumer-directed programs, and team-delivery models.

²⁴ Texas Health and Human Services Commission, *Health Insurance Flexibility and Accountability (HIFA) Waiver to Implement the CHIP Premium Assistance Provisions of HB 3038, 77th Legislature and SB 240, 78th Legislature*, Draft Concept Paper, (Austin, Tex., November 10, 2003). Online. Available: http://www.hhsc.state.tx.us/chip/cnews/111003_HIFAWaiverCP.html. Accessed: November 30, 2004.

²⁵ Texas Health and Human Services Commission, *Texas Medicaid in Perspective, 5th Edition*, (Austin, Tex., June 2004), p. 4-18.

²⁶ Excluding Disproportionate Share Hospital and administrative payments. Ibid. p. 4-18.

²⁷ Kaiser Family Foundation, Commission on Medicaid and the Uninsured, *Medicaid and Long-Term Care*. (Washington, D.C., May 2004).

Long-Term Care Medicaid Waivers

One of the growing trends in long-term care policy nationally has been deinstitutionalization.²⁸ Pursuant to the 1999 Supreme Court ruling in *Olmstead v. L.C.*²⁹ and the Texas Promoting Independence Plan,³⁰ long-term care policy in Texas has shifted its emphasis away from nursing home care and towards home- and community-based services (HCBS) and community-based alternatives (CBA). In many cases, HCBS and CBA are significantly cheaper than traditional nursing homes.³¹ The administration of these programs can be more complex, however, and they do require Medicaid waivers for implementation since they are outside the scope of traditional Medicaid.³² Maximizing the use of long-term care waiver programs may allow the State to lower Medicaid expenditures while maintaining the same or better quality-of-care.

"Cash and Counseling"

Several states have received federal permission to implement consumer-directed Medicaid waiver programs.³³ The Cash and Counseling Demonstration and Evaluation (CCDE) project, known informally as "cash and counseling," began in 1995 as a public/private collaboration to provide beneficiaries with a cash allowance for spending on approved long-term care services.³⁴ The allowance amount is generally related to either an individual's Medicaid claims history or by "cashing out" the recipient's care plan.

²⁸ Kaiser Family Foundation, Commission on Medicaid and the Uninsured, *Recent Growth in Medicaid Home and Community-Based Service Waivers*. (Washington, D.C., April 2004).

²⁹ *Olmstead v. L.C.*, 527 U.S. 581. 1999.

³⁰ Texas Health and Human Services Committee, *The Revised Texas Promoting Independence Plan*, (Austin, Tex., December 2002).

³¹ Texas Health and Human Services Commission, *Texas Medicaid in Perspective, 5th Edition*, (Austin, Tex., June 2004), p. 4-18.

³² *Ibid.* p. 4-22.

³³ Pamela J. Doty, "The Cash and Counseling Demonstration: An Experiment in Consumer-Directed Personal Assistance Services," *American Rehabilitation*, vol. 24, no. 3, (Summer/Autumn 1998), p. 29.

³⁴ A. E. Benjamin, "New Model for Persons with Disabilities," *Health Affairs* vol. 20, no. 6, (November/December 2001), p. 81.

The "counseling" components of the CCDE generally include financial planning, spending plans, development assistance, and monitoring of consumer health and spending. Although these pilot programs are relatively new, early evaluations have indicated that consumer-directed programs result in better outcomes and lower costs than traditional long-term care.³⁵ Building on the success of the CCDE initiative, the Centers for Medicare and Medicaid Services (CMS) have established the Independence Plus Initiative to encourage additional implementation of consumer-directed long-term care services by making it easier to obtain the necessary waivers.³⁶ Although there is already a consumer-directed component in the Texas Medicaid long-term care system, enrollment is low and the particular type of waiver authority under which the program is implemented is fairly restrictive.³⁷

Team Delivery Model

Some states have implemented demonstration programs through Medicaid waivers that allow them to pursue more intensive and integrated delivery of care for the elderly and disabled. Described by some researchers as "team delivery models", these programs emphasize physician flexibility, integration and flexibility of care through intense case management, care coordination by nurse practitioners, and risk-adjusted (capitated) payment structures.³⁸ Team delivery models have been implemented in Nevada, Massachusetts, and California.³⁹

³⁵ Barbara Phillips et al, "Lessons from the Implementation of Cash and Counseling in Arkansas, Florida, and New Jersey" (Princeton, NJ: Mathematica Policy Research Inc., June 2003).

³⁶ Kaiser Family Foundation, Commission on Medicaid and the Uninsured, *An Overview of the Independence Plus Initiative to Promote Consumer-Direction of Services in Medicaid*, (Washington, D.C., November 2003).

³⁷ Texas Public Policy Foundation, *Medicaid and the Uninsured*, Research Report, Written by Beau Egert, (Austin, Tex., September 2004).

³⁸ *Ibid.*

³⁹ Robert J. Master and Catherine Eng, "Integrating Acute and Long-Term Care for High Cost Populations: An in Depth Look at Two Successful Models and Impediments to their Expansion," *Health Affairs*, vol. 20, no. 6, (November/December 2001) pp. 161-172.

The existing STAR+Plus Medicaid managed care program incorporates many of the characteristics of a team delivery model including integration of acute and long-term care, case management, and risk-adjusted payment structures.⁴⁰ Unlike existing team delivery models, however, STAR+Plus does not generally include the same level of physician flexibility and coordination of care. The team delivery model also shares characteristics with the existing PACE waiver program but, unlike PACE, existing team delivery models utilize a capitated payment structure.⁴¹

Outcome-Based Reimbursement

One of the structural problems that has been identified within the American health care system as a whole is that providers generally get paid more when people are sick rather than when they are in good health.⁴² To combat this misaligned incentive, varied attempts have been made to tie provider reimbursement to health outcomes. If providers (or direct payers) make more money when people are in good health than when they are sick then perhaps they will work harder to prevent patients from getting sick in the first place. One of the main strategies for tying reimbursement to outcomes in Medicaid has been through the use of managed care, especially Medicaid Health Maintenance Organizations (HMOs).

Medicaid Managed Care Expansion

There are two main models for managed care in Texas -- HMOs and Primary Care Case Management (PCCM). Under the PCCM model, each beneficiary has a primary care physician (PCP) and all referrals must come from the PCP. Direct payment is made for services in the

⁴⁰ Texas Health and Human Services Commission, *Texas Medicaid in Perspective, 5th Edition*, (Austin, Tex., June 2004), p. 6-7.

⁴¹ *Ibid.* p. 4-22.

⁴² Bill Frist and Hillary Clinton, "How to Heal Health Care," *Washington Post* (August 25, 2004), p. A-17.

PCCM model and PCPs receive a small, flat per-member, per-month (PMPM) amount for managing the care. Under the HMO model, beneficiaries enroll through a particular HMO and are provided all necessary services by the HMO which is paid a capitated, PMPM rate.⁴³

Under the provisions of House Bill 2292 from the 78th Legislature, HHSC was directed to initiate statewide implementation of the most cost-effective model of managed care.⁴⁴ Based on an analysis by the Lewin Group,⁴⁵ HHSC determined that the HMO model should be deployed in the State's urban areas and the PCCM model should be deployed in all remaining areas of the State not served by Medicaid HMOs. Additionally, the Lewin Group recommended, and HHSC agreed, that each area of the State should only be served by one model. Thus, in those urban areas previously served by both models, PCCM would be withdrawn.

In theory, the HMO model provides incentives for keeping people healthy since it allows the HMOs to keep more money when their enrollees are healthy. However, the HMO model also allows the HMOs to keep more money when their enrollees utilize fewer services, whether the reduction in utilization is due to good health or inappropriately strict management of utilization. Therefore, it is very important for the State and HHSC to ensure that contracts with HMOs are written in such a way that necessary services are provided. Although the PCCM model as it is currently implemented does not tie reimbursement to outcomes, some variations on the model might provide incentives for appropriate care provision and a focus on outcome measures.

⁴³ Texas Health and Human Services Commission. *Texas Medicaid in Perspective, 5th Edition*, (Austin, Tex., June 2004), p. 6-2.

⁴⁴ Texas State House of Representatives. House Bill 2292, 78th Legislature, 2003.

⁴⁵ The Lewin Group, *Actuarial Assessment of Medicaid Managed Care Expansion Options*, Prepared for the Texas Health and Human Services Commission, (January 2004). Online. Available: https://www.hhsc.state.tx.us/pubs/121503_MMC_CostEff_Amend.pdf. Accessed: November 30, 2004.

Behavioral Health Organization Model (NorthSTAR) Expansion

Since 1999, mental health and substance abuse services in Dallas and surrounding counties have been provided through a Medicaid waiver program known as NorthSTAR.⁴⁶ The NorthSTAR model is a fully-integrated, capitated managed care model that blends funding from a variety of sources and provides mental health and substance abuse services to Medicaid beneficiaries and other medically-needy individuals in the greater Dallas area. The original plan was for at least two vendors to hold contracts for the provision of behavioral health services under the NorthSTAR system, each receiving capitated payments and maintaining their own networks of providers. Currently, there is only one vendor in the NorthSTAR system.

As in the case of the Medicaid HMOs, the business arrangement with NorthSTAR is such that they stand to gain financially if they can ensure that individuals receive cheaper, early treatment and avoid costly hospitalizations since they are receiving a fixed PMPM payment from the State. According to the director of an independent assessment of NorthSTAR, the program has been a qualified success, with a higher proportion of eligible patients receiving services than in other cities, but there have been limited indications that better outcomes are being obtained.⁴⁷ Some participants in the NorthSTAR system claim that the results are significantly better under the NorthSTAR model than the traditional Texas mental health system.⁴⁸ Some critics of the State's fragmented mental health system suggest that expanding the NorthSTAR model to other urban areas may be a good idea.

⁴⁶ Lyndon Baines Johnson School of Public Affairs, *NorthSTAR: A Successful Blended-Funding, Integrated Behavioral Health Carve-Out Model*, Policy Research Project Report Series, Prepared for TDMHMR and TCADA, (Austin, Tex., September 2003).

⁴⁷ Pat Wong, Associate Professor, Lyndon Baines Johnson School of Public Affairs, University of Texas, Testimony before Texas Senate Health and Human Services Committee, (Austin, Tex., October 19, 2004).

⁴⁸ Thomas Collins, CEO Green Oaks Hospital (private mental health hospital in NorthSTAR), Testimony before Texas Senate Health and Human Services Committee, (Austin, Tex., October 19, 2004).

Financial Manipulations

There are a number of different finance streams and financial arrangements available through Medicaid. Many common Medicaid reform recommendations involve manipulating the financial arrangement between the state and federal governments in order to maximize the benefit of limited state dollars.

Federal Matching of Unmatched Local Funds

Under current State law, counties and hospital districts are required to provide health care services to any Texans who are medically indigent. Although counties are allowed to define the income level at which an individual is considered to be medically indigent and the range of health care services provided to medically indigent individuals, the State sets a minimum income level (21% of the federal poverty level)⁴⁹ and a minimum benefits package.⁵⁰ Many counties, especially in urban areas, choose to set the medically-indigent income level higher than 21% and to provide a more generous package of benefits.

Currently, local indigent care expenditures are not matched with federal dollars. If common eligibility levels and benefits packages could be defined, the State could apply for a Medicaid waiver to allow inter-governmental transfers from counties and hospital districts for the provision of health care services to the medically indigent population. Although some counties currently set the medically indigent income level higher than 21%, it may be possible to apply for this sort of waiver without requiring these counties to redefine their individual medically indigent income levels.

⁴⁹ Texas Health & Safety Code. § 61.006.

⁵⁰ Texas Health & Safety Code. § 61.028.

Distribution of Disproportionate Share Hospital Payments

Hospitals for which a large proportion of their patients are Medicaid eligible or medically indigent may receive additional Medicaid payments through the Disproportionate Share Hospital (DSH) program. Each state includes a DSH payment reimbursement formula in its state Medicaid plan. The State of Texas distributes DSH funds to hospitals based on the number of Medicaid-reimbursed inpatient bed-days, the percentage of Medicaid-reimbursed inpatient bed-days, or the percentage of inpatient bed-days for low-income patients.⁵¹ This distribution formula may create a bias for hospitals toward inpatient rather than outpatient provision of services, even when outpatient services could be as effective and cheaper for the State.

Recommendations

1. Increase funding for Medicaid fraud and abuse prevention and detection.

Rationale: Medicaid fraud and abuse programs are funded at a 75% match by the federal government. In State fiscal year 2004, the HHSC Office of the Inspector General (OIG) recovered almost \$350 million and achieved cost avoidance of almost \$400 million.⁵² The budget for the HHSC OIG for State fiscal year 2004 was about \$35 million.⁵³ A stronger Medicaid fraud and abuse program would probably pay for itself in terms of lower and avoided costs.

⁵¹ Texas Health and Human Services Commission, *Texas Medicaid in Perspective, 5th Edition*, (Austin, Tex., June 2004), p. 5-9.

⁵² Texas Health and Human Services Commission, Office of the Inspector General, *Semi-Annual Report to the Governor and Legislative Budget Board, Third and Fourth Quarters FY2004*, (Austin, Tex., October 2004).

⁵³ Texas Health and Human Services Commission, *Legislative Appropriations Request, 79th Regular Session*, Agency Submission, Version 1. 3.A. Page 13 of 95.

2. Ensure that limitation on brand name drugs is cost-effective.

Rationale: One of the pharmaceutical cost-containment strategies that has been deployed in Texas is a limit of three different brand name prescription drugs at any one time. Some research has shown that restrictions on pharmaceuticals in public health programs lead to higher cost substitution of other health care services, especially for certain populations.⁵⁴ Certain populations (patients with diabetes, heart disease, or mental illness) should be examined to ensure that the pharmaceutical cost-savings being realized due to lower drug costs are not being offset by higher costs in other areas. If HHSC determines that patients with certain conditions would probably be served at a lower cost by waiving the three brand limit, then HHSC should be permitted to make such waivers.

3. Require Medicaid beneficiaries to participate in a course on the proper use of the health care system including which types of care are appropriate for which types of symptoms.

Rationale: Inappropriate use of the emergency room is especially prevalent among lower-income groups and is among the most expensive types of medical care. Cost-savings should be achieved by ensuring that beneficiaries know how to seek the most appropriate and least expensive type of care.

⁵⁴Stephen B. Soumerai, "Benefits and Risks of Increasing Restrictions on Access to Costly Drugs in Medicaid," *Health Affairs*, vol. 23, no. 1, (January/February 2004) pp. 135-146.

4. Require that Medicaid HMOs and the State's PCCM system have nurse triage lines to direct their enrollees to the lowest-cost source of medically-appropriate care.

Rationale: In addition to directing enrollees to the most appropriate source of care, nurse triage lines should help take some of the pressure off of local ERs. The triage concept could potentially be paired with differential co-payment amounts – an individual could face higher co-payment for services to which they were not directed by a triage nurse. To be implemented successfully, this recommendation might need to be paired with protection from additional liability that could result from inaccurate nurse instructions.

5. Evaluate the logistics and cost-effectiveness of centralized, inter-agency procurement for durable medical equipment (DME).

Rationale: The different agencies that purchase durable medical equipment (ERS, TRS, DSHS, HHSC, etc.) could leverage their joint purchasing power for lower prices. This could probably be done through the Building and Procurement Commission. While some start-up money may be required, the program would almost inevitably lead to lower costs. As a first step, the issue should be studied.

6. Establish standard Medicaid rates for durable medical equipment (DME).

Rationale: Unlike physician services, there are no standard Medicaid rates for DME. Currently rates are set on an ad hoc basis and are based on the lower of (a) reasonable and customary costs; and (b) the amount charged. There are no standard guidelines for establishing or evaluating reasonable and

customary costs. Typically the paid amounts are based primarily on the amount charged rather than on any standardized or regulated rates.

7. Fund a study on interagency purchasing of pharmaceuticals.

Rationale: As in the case of durable medical equipment, there are many agencies (ERS, TRS, DSHS, HHSC, public hospitals, universities, etc.) that purchase pharmaceuticals but all negotiate separately with pharmaceutical companies. Lower prices would probably be possible with pooled purchasing through TBPC or another agency. There has been an Interagency Council On Pharmaceuticals Bulk Purchasing but they lack the expertise to perform a true cost-benefit analysis of this proposal. This analysis would probably need to be done by outside consultants.

8. Add the medically indigent as a Medicaid expansion population.

Rationale: Counties and hospital districts are already required to provide a State-defined, minimum level of health care to individuals with incomes below 21% of the federal poverty level (FPL). Thus, counties are already spending money on this population but without a federal match. In some limited cases, counties receive a State match for spending on indigent health care above a threshold amount, but the bulk of money spent by counties on indigent health care comes entirely from their general revenue. The State portion of the funding would come through intergovernmental transfers from the counties and hospital districts. Counties can continue to negotiate for higher income levels to be included under the state waiver program, but, in the meantime, all Texas counties could benefit from a

federal match for the money they are already spending on minimum services for the required population.

9. Exempt contracting positions from State pay scale.

Rationale: The HHS agencies, especially HHSC, have a poor record with contracting – negotiation, monitoring, enforcement, etc. With the expanded use of Medicaid HMOs, contracting is more important than ever, but HHSC's ability to contract successfully has not changed significantly. Unless HHSC is able to attract and retain contracting professionals, especially lawyers, who can compete with the contracting professionals employed by vendors, the State will continue to lose on contracting.

10. Direct HHSC to pro-actively monitor Medicaid HMO network adequacy and take strong action to enforce network adequacy contract requirements.

Rationale: Currently, there is almost no pro-active monitoring of network adequacy, especially with respect to specialists. This committee has received numerous complaints from physicians and hospitals regarding the specialist networks or lack thereof within Medicaid HMOs. Lax enforcement in the past has allowed the HMOs to avoid taking action to correct these problems.

11. Establish online tracking for Medicaid HMO network adequacy and monitoring of contract requirements.

Rationale: It is extremely difficult for beneficiaries to determine whether or not HMOs are maintaining adequate networks. This information is available

and should be readily accessible to the public. Medicaid HMOs might make a better effort to perform within their contract requirements if performance metrics were posted on the internet for the public and other potential customers to see.

12. Expand community-based alternative (CBA) waiver programs for the elderly and disabled.

Rationale: CBA waiver programs are less expensive than nursing homes because of lower overhead costs and a more generous federal match.

13. Expand Intermediate Care Facilities for the Mentally Retarded (ICF/MR) waiver programs.

Rationale: Like CBA waiver programs, ICF/MR waiver programs are less expensive than institutional treatments, provided by state schools for this population.

14. Develop a "cash and counseling" waiver program for delivery of home and community based services to elderly and disabled Medicaid beneficiaries.

Rationale: In "cash and counseling" demonstration projects in other states, elderly and disabled Medicaid beneficiaries were given cash allowances based on their historical consumption of services, and counseling services to help them spend the money appropriately. Studies of existing programs have indicated greater beneficiary satisfaction, better outcomes, and lower costs. Texas already has limited consumer-directed programs but does not have full "cash and counseling" programs as they are typically described.

15. Direct HHSC to apply for an additional waiver to incorporate Medicare funding directly into the STAR+Plus program.

Rationale: When STAR+Plus was originally established, the legislature intended for the waiver to allow HHSC to incorporate Medicare money directly into the funding stream. At the time, CMS was slow to approve these waivers, so HHSC tried to contract with HMOs that provided both Medicaid HMO and Medicare HMO services to ensure better coordination of care. Recently, CMS has begun approving this sort of waiver more readily, and HHSC should therefore reapply.

16. Develop a "team delivery model" waiver concept paper and apply for a waiver.

Rationale: The "team delivery model" is an approach to long-term care provision emphasizing integration of care and intensity of preventive services. In most existing "team delivery model" projects, the teams are coordinated by physicians or nurse practitioners and are paid a risk-adjusted (capitated) rate. Results from existing programs are relatively positive.

17. Ensure that all appropriate funding streams are integrated for NorthSTAR.

Rationale: There are numerous patients being treated and services being provided by NorthSTAR that fall within the purview of other agencies (Texas Council of Offenders with Mental Impairments, Texas Department of Criminal Justice, etc.). As NorthSTAR has become more established, other agencies that should be paying for some mental health services have withdrawn their money from the NorthSTAR system. For services that are being provided by NorthSTAR to clients of other agencies, inter-agency

transfers should be taking place to ensure that the appropriate monies are flowing into NorthSTAR.

18. Establish differential Medicaid reimbursement for adoption of new technologies and quality assurance initiatives.

Rationale: During the 78th Legislature, Medicaid payments were reduced by 5% across the board. Although partially restored by the Legislative Budget Board in the interim, it is widely held that providers and hospitals did not fight harder against the reductions based on the understanding that they were temporary. Additionally, even with a full restoration to the reimbursement levels prior to the 78th Legislature, Medicaid reimbursements will still be lower than those from Medicare and private insurance and possibly lower than cost. Therefore, some sort of increase in reimbursement will be necessary to maintain access to participating providers. Instead of just increasing rates by a certain amount across the board, incremental increases should be tied to adoption of new technologies and participation in quality initiatives.

19. Make Medicaid claims data publicly available without identifying information.

Rationale: Medicaid claims history represents a very valuable source of research data for academics and government analysts alike. The more analysts and researchers who are looking at the data, the more likely it will be that important trends will become visible that were not previously known or anticipated. HHSC would strip all identifying data from the claims data and allow public access to the raw data.

20. Augment PCCM payments with outcome-based bonuses.

Rationale: PCPs serving within the PCCM Medicaid model, the standard \$3 PMPM rate could be augmented if certain benchmarks are met in terms of preventive care, screening, immunizations, etc.

21. Change the distribution formula for DSH payments to mitigate the inpatient bias.

Rationale: All elements of the DSH distribution formula are based on inpatient bed-days, causing hospitals to favor inpatient treatment even when outpatient treatment might have been appropriate and less costly for the State. Outpatient treatments could be incorporated into the DSH distribution formulas to mitigate the inpatient bias.

Charge 2: HB 2292 Implementation

Monitor implementation and make recommendations to improve HB 2292. Include reviews of implementation of the preferred drug list and prior authorization and the new call center for determination of program and service eligibility. The Committee will coordinate activities with the Health and Human Services Transition Legislative Oversight Committee.

Background

When the legislature met in 2003, it faced a \$9.9 billion deficit and fiscal climate opposed to tax increases. Cuts in state spending were necessary to fill that hole. Gaining greater efficiencies to enable a larger percentage of dollars to be directed toward service provision, rather than administration, was paramount in order to balance the budget while still maintaining service levels.

The biggest providers of social services in Texas are the Health and Human Service agencies charged with administering critical programs such as Medicaid, Children's Health Insurance Program (CHIP), Food Stamps, and Temporary Assistance to Needy Families (TANF). Texas spent \$19.5 billion in fiscal year 2002 funding these programs, a full 30 percent of state spending. Finding greater efficiencies within the twelve agencies, which employ some 50,000 people,¹ was critical in order to minimize cuts in service levels. House Bill 2292 focused on finding these cost savings by "consolidating organizational structures and functions, eliminating duplicative administrative systems, and streamlining processes and procedures that guide the

¹ Texas Health and Human Services Commission, (n.d.) *Overview of 2292: 78th Legislature, Regular Session, 2003*. Online. Available: http://www.hhsc.state.tx.us/Consolidation/post78/HB2292_Summary.html. Accessed: June 18, 2003.

delivery of services"² and by creating mechanisms to contain rising healthcare costs. Its goals were four fold: improving client services, reducing administrative costs, strengthening accountability, and spending tax dollars more effectively.³

Though the impetus for H.B. 2292 was fiscally driven, the need for structural reform within the health and human service agencies was apparent. Oversight of the agencies by the Health and Human Services Commission was fragmented at best. Each agency had its own board which appointed an executive director. Though in theory overseen by the commissioner of Health and Human Services, ultimately each agency director was accountable to the agency's board first and foremost. Furthermore, duplication of administrative systems permeated the system. Each agency had its own departments of human resources, purchasing, information technology, and legal. Within each agency, each program had its own eligibility determination system, costing taxpayers over \$700 million annually to determine a person's *eligibility* for benefits.⁴ H.B. 2292 sought to address these issues and, in so doing, make the structure more effective and efficient.

Beyond structural reform, H.B. 2292 sought to contain rising health care costs. Between FY 2000 and FY 2003, Medicaid expenditures rose 49%, from \$10.087 billion in FY 2000 to \$15.012 billion in FY 2003.⁵ Especially dramatic were increases in the cost of prescription drugs

² Texas Health and Human Services Commission, (n.d.) *Overview of 2292: 78th Legislature, Regular Session, 2003*. Online. Available: http://www.hhsc.state.tx.us/Consolidation/post78/HB2292_Summary.html . Accessed: June 18, 2003.

³ Texas Health and Human Services Commission, *HHS in Transition, An Overview of the Texas Health and Human Services Reorganization: Requirements and Processes, September 2003*. Online. Available: http://www.hhsc.state.tx.us/news/HB_2292/091203_PH_VideoHandouts.html. Accessed: June 18, 2004.

⁴ Texas Health and Human Services Commission, *Integrated Eligibility Determination: Business Case Analysis* (February 2004).

⁵ Texas Health and Human Services Commission. Written testimony submitted to the Texas House Select Committee on State Health Expenditures (January 29, 2004), (Copy on file with the House Select Committee on State Health Expenditures).

in the Medicaid program, rising 43% from FY 2000 to FY 2004.⁶ H.B. 2292 contained a variety of cost containment measures, including implementation of a Preferred Drug List, enhanced fraud prevention measures, and managed care expansion.

Agency Consolidation

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

In order to eliminate duplication, administrative functions such as information technology, human resources, financial services and purchasing, were consolidated under HHSC, resulting in a cost savings of \$95.6 million in FY 03 and FY 04.⁷ Eligibility determination was also consolidated into HHSC with a net savings of \$79.2 million (FY 03 and FY 04).

⁶ Texas Health and Human Services Commission. Written testimony submitted to the Texas House Appropriations Subcommittee on Health and Human Services (April 27, 2004), (Copy on file with the Texas House Appropriations Subcommittee on Health and Human Services).

⁷ Texas Health and Human Services Commission, *HHS Major Initiatives, Health and Human Services Commission* (May 24, 2004).

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

Consolidation Implementation

Immediately after the passage of H.B. 2292, HHSC began its implementation. The implementation process has four phases: planning, integrating, optimizing, and transforming. The *planning phase* included a functional review "that focused on documenting current agency business functions and analyzing requirements for the future consolidation," formation of a Transformation Program Management Office to guide the implementation process, and creation of a Transition Plan. The Transition Plan was submitted to the Governor and Legislative Budget Board in November 2003.

The *integration phase*, which began after the submission of the Transition Plan, is projected to be completed by August 2005. On December 29, 2003 HHSC announced its commissioner appointments for the four health and human service departments. In January 2004, planning for

the agency councils began. Though the Governor's Office does not have a definite timeframe for the establishment of all the agency councils, the Department of Family and Protective Services Council is already established and has convened. Also in January 2004 consolidation of many of the administrative functions was completed. Finally, the creation of the Office of Inspector General occurred in January 2004. "The Office of Inspector General assumed all the duties of HHSC's Office of Investigation and Enforcement and also all fraud and abuse functions of other health and human services (HHS) agencies."⁸

Seven public hearings to receive input on the proposed agency designs were held around the state in January and February 2004. At these hearings, 344 persons presented oral or written testimony about the consolidation.

The first agency consolidation, that of the Department of Family and Protective Services, occurred on February 2, 2004. The Department of Assistive and Rehabilitative Services soon followed. The Departments of State Health Services and Aging and Disability Services consolidated operations on Sept. 1, 2004.⁹

The *optimization phase* "will be that phase...where the longer-range vision of H.B. 2292 and HHSC begins to be realized. Immediately following the integration [phase]...leaders...will be expected to begin rationalizing and streamlining the business processes for which they are responsible."¹⁰ And lastly, the *transforming phase* will "include continued implementation of changes in health and human services department management activities, continuation of risk

⁸ Texas Health and Human Services Commission, *Overview of the Office of Inspector General*. Online. Available: http://www.hhsc.state.tx.us/OIE/OIE_info.html. Accessed: June 24, 2004.

⁹ Texas Health and Human Services Commission. *HHS Transformation, Frequently Asked Questions*. Online. Available: http://www.hhsc.state.tx.us/Consolidation/Consolidation_FAQ.html. Accessed: June 24, 2004.

¹⁰ Texas Health and Human Services Commission, *H.B. 2292 Transition Plan, November 3, 2003*. (November 3, 2003). Online. Available: http://www.hhsc.state.tx.us/Consolidation/Consolidation_HB_2292/110303_HB2292TP1.html. Accessed: June 16, 2004.

assessments, and conducting a transformation review of the changes to the delivery of health and human services"¹¹ in an effort to become a continuously improving agency.

Through this entire process the Transition Legislative Oversight Committee has exercised and will continue to exercise oversight authority. Created by H.B. 2292, the committee is tasked with "[facilitating] the transfer of powers, duties, functions, programs, and activities between the state's health and human services agencies and the Health and Human Services Commission...with a minimal negative effect on the delivery of those services in this state."¹²

The committee is composed of four legislative members (two from the House and two from the Senate), three public members, and HHSC's executive commissioner. Between September 2003 and June 2004, the committee held five hearings with a sixth scheduled for December 14, 2004. At each, HHSC's commissioners presented updates on their progress and committee members were able to address areas of concern.

Integrated Eligibility Project

The Health and Human Service agencies administer a wide array of assistance programs, each of which requires a process of eligibility determination to receive services. While some, like Medicaid and the Children's Health Insurance Program (CHIP), have mail-in, phone or online applications, most require face-to-face interviews. Every year over \$700 million is spent determining eligibility.¹³ In an effort to reduce this amount, H.B. 2292 directed HHSC to

¹¹ Texas Health and Human Services Commission, *H.B. 2292 Transition Plan, November 3, 2003* (November 3, 2003). Online. Available: http://www.hhsc.state.tx.us/Consolidation/HB_2292/110303_HB2292TP1.html. Accessed: June 16, 2004.

¹² Texas House Bill 2292, 78th Legislature, regular session (2003), pp. 71-74.

¹³ Texas Health and Human Services Commission, *Integrated Eligibility Determination: Business Case Analysis, Streamlined System Will Expand Access to Services, Save Money* (March 2004).

examine ways to streamline the eligibility determination process, including exploring the cost effectiveness of using call centers.

In October 2003, HHSC "formed an Integrated Eligibility Project Team to establish the framework for integrated eligibility in health and human services in Texas...The team was charged with analyzing the cost-effectiveness of a solution that integrated eligibility determination, utilizing call center processes and technologies."¹⁴ The project has proceeded in four phases. The first, the Discovery phase, is complete and consisted of "an in-depth examination of the current eligibility system," focusing on the two programs, Texas Works and Long Term Care, which together comprise about 80% of spending on eligibility determination.¹⁵ The Discovery Report "found that the current system places a huge administrative burden on workers and makes poor use of technology."¹⁶ The report found that it is not uncommon for Texas Works employees to spend 85-95 percent of their time performing eligibility tasks.¹⁷ Furthermore, the current system is time intensive and inconvenient for applicants. Applicants on average interact "with three to four different office employees at each visit and... typically visit the local office on at least two separate occasions, all for the same eligibility determination."¹⁸ Out of this study came three main recommendations: develop an integrated eligibility process, centralize administrative and other work tasks as appropriate, and utilize new technology tools.

¹⁴ Texas Health and Human Services Commission, *Integrated Eligibility Determination: Business Case Analysis*. (February 2004), p. 4.

¹⁵ *Ibid.*

¹⁶ Texas Health and Human Services Commission, *Integrated Eligibility Determination: Business Case Analysis, Streamlined System Will Expand Access to Services, Save Money* (March 2004).

¹⁷ Texas Health and Human Services Commission. *Integrated Eligibility Discovery Report*, (February 2004).

¹⁸ *Ibid.*

The second phase, Evaluating the Business Case, analyzed whether the use of an integrated eligibility determination system (IED) is cost effective and responsive to clients.¹⁹ The product of this phase, the Business Case Analysis, proposed a new model for eligibility determination with projected savings of \$178.6 million in state spending and \$210.2 million in federal spending from FY 2004 to FY 2008.²⁰ Much of the cost savings originate from several key changes in the eligibility determination process. The next section will show how the current process would change in order to realize these savings.

Eligibility Determination Comparison: Differences Between Models

The process described relates to eligibility determination within the Texas Works program, one of the two programs studied in HHSC's Discovery Report.

Information Gathering and Pre-screening: The current model allows for information gathering about programs at the local office, through a phone inquiry (2-1-1²¹ or local office) or online. Prescreening is available through Texas Works programs online through STARS (The State of Texas Assistance and Referral System),²² however, this system does not determine actual eligibility. In the new model, all information gathering and prescreening calls will be routed through 2-1-1, and then referred to IED centers via an Integrated Voice Response (IVR) system. Information about programs and prescreening also will be available online via an enhanced website. Walk-in inquiries will still be accommodated at the local office. These changes will result in cost savings because local offices will have to devote less time to these activities, as it will be consolidated at IED centers and online.

¹⁹ Texas Health and Human Services Commission, *Integrated Eligibility Discovery Report*, (February 2004).

²⁰ Texas Health and Human Services Commission, *Call Center Cost Effectiveness Analysis*, (March 2004), p. 17.

²¹ The 2-1-1 information system connects people with important community services and volunteer opportunities. It provides callers with information about and referrals to human services for every day needs and in times of crisis.

²² Medicaid, Children's Health Insurance Program (CHIP), Temporary Assistance to Needy Families (TANF), Food Stamps, Women, Infants and Children (WIC), and Community Care.

Applying for and Receiving Benefits: The old and new models have similar methodologies for requesting and submitting applications for benefits. In both, a client can request an application for benefits at the HHSC office, via mail, or by downloading it off the web. The current and new models allow for submissions by hand, mail, fax or email. However, in the new model all these activities will be centralized at eligibility determination offices as opposed to local offices. The new model will also allow submission of online applications, which is not currently available.

In the current model, once the application is submitted to the local office, an interview with a case worker is scheduled. During the interview, the application is reviewed by the case worker who then assists with any questions about the application and determines eligibility. If the applicant is eligible, the application is certified and benefits issued. If ineligible, the client is made aware of the appeal process and referred to other resources in the community. This process normally takes between an hour and an hour and a half.

In the new model, applications would be routed to the IED centers for review and eligibility determination. If the application is missing information, the client is prompted for the information and required to provide that information. If clients need assistance filling out applications, they are directed to IED phone representatives or community partners. If upon submission all needed information is present, and the client is eligible for benefits, the person would be notified and would then need to make an appointment at the local benefit issuance center (BIC). Staff at the BIC would collect the needed documentation, certify the case, take a finger image and issue benefits. If the client is deemed ineligible by the eligibility determination specialists, the client would be notified and referred to other resources. This new model saves money in several ways. First, it consolidates all eligibility verification at IEDs, reducing the need for case managers to do this. This will likely result in fewer eligibility verification errors,

saving additional money. Second, the new model reduces the time spent with the case manager answering questions by directing this function to IED phone representatives and community partners, such as non-profits, schools and libraries. Third, the new model reduces the need for case managers at the local office to meet with ineligible clients. Again, IED phone representatives and community partners would provide these services.

Recertification

Recertification of benefits after a specified amount of time (dependent on the program) is required. In the current system, "sixty days prior to benefit expiration the eligibility system generates a notice to the client telling them that their benefits are about to expire. They are asked to reapply. They must fill out the application again and mail, fax or deliver it to an office. Once the application is received, it is reviewed by the caseworker. Texas Works clients are required to schedule an appointment for an office visit to go over the application and review any new documents that may be required to verify changes in eligibility requirements. A case can be pended if appropriate documentation is not brought to the appointment and a client will need to return with the documentation."²³

In the new model, all re-certifications will be completed at the IED center. Clients will receive a recertification packet and will submit it to the IED. Any changes will be entered, and benefit eligibility reevaluated. The client will then be notified of the results. This new process will save money by consolidating the process at one location and eliminating the need for local case managers to be involved, thus freeing their time and energies for other functions.

²³ Laura Stover, Health and Human Services Commission. "Follow up re: Call Centers, PDL's and Prior Authorization". Email correspondence with staff of the Texas Senate Committee on Health and Human Services, (June 12, 2004).

Change Requests

When a client moves, switches phone numbers, or experiences any other change in circumstances that may affect eligibility, the client is required to report that change to a change center or local office within ten days. There are four change centers in Texas that handle all change requests in Houston, San Antonio, Dallas, and Beaumont. Clients in other areas must contact their local office to report changes. Though many of these changes are handled by the office clerk, changes that require a re-determination of eligibility must be processed by the case manager. In the new model, IED centers will handle all change requests around the state and determine any change in eligibility. This will result in savings by consolidating the process at one location and eliminating the need for local case managers to be involved, thus freeing their time and energies for other functions.

Face-to-Face Option

The success of this new model is largely dependent upon clients utilizing the new structure. Under H.B. 2292, clients are guaranteed access to face-to-face interviews upon request. Thus, there is a possibility that clients will choose the old process of face-to-face interviews, and cost savings will be less than projected. Public relations campaigns making clients aware of the new process and its benefits are necessary to attempt to alter current usage patterns. At present, applications by walk-in clients account for upwards of 85% of all new applications, even though applications can be received by mail, phone, and fax.²⁴

²⁴ Texas Health and Human Services Commission, *Integrated Eligibility Discovery Report*, (February 2004), p. 42.

Implementation of the New Model

The approval of this new model initiates the third phase, implementation and system transformation. Total implementation is currently projected to be completed by August 2005. HHSC has yet to determine whether it would be more cost-effective to implement the new system in-house or via outsourcing. HHSC released a draft Request for Proposals to private vendors on June 2, 2004. HHSC's decision will be based on vendors' bids versus the in-house model's projected costs. Vendors are at liberty in the RFP to alter the model in the Business Case or scrap it entirely in place of a better model.

As we wait for a determination about the possible benefits of contracting with a vendor, several initiatives can begin. For example, any model will be dependent on the Texas Integrated Eligibility Redesign System (TIERS). TIERS is a web-based eligibility determination system for case workers delivering food stamps, cash assistance, medical, and community care services. Because TIERS was designed around the current business process, some modifications will be necessary. Currently, TIERS limits case access to the person who owns the file. In any model involving IED centers, case ownership will need to be shared, meaning any phone representatives in IED centers will be able to work on any case.

Additionally, moving to an IED based system will require closing some field offices and a reduction in personnel. Under the Business Case model, 218 agency field offices would be closed with 164 remaining open and an estimated 4,487 current positions would be eliminated with 3,377 remaining. HHSC has yet to determine which offices to close and the level of staffing needed to operate the remaining offices.

Concerns about the Business Case Model

Understandably, many concerns have been raised about the upcoming changes' affects on the delivery of these needed social services. State employee organizations and other advocacy groups argue against the large layoffs saying staff projections in the Business Case are grossly inadequate. The Business Case bases staffing needs on the amount of time it takes a worker to complete a certain task and projected resource demands. The projected resource demands are based on 2003 workloads and do not include anticipated caseload growth.

Some argue the model should not be based on current staffing levels because average caseloads per worker have grown dramatically over the past several years. In 1997, average caseloads in the Texas Works program were between 159-226. In November 2003, average caseloads were between 283-461. Supporters contend that projected resource demands were based on 2003 caseloads because accurate predictive models were not available. Had they taken into consideration caseload growth, projected savings would have only increased savings because the cost per transaction is so much lower in the Business Case model. Additionally, a more efficient process will enable fewer workers to accomplish more. Such has been the case in the Medicaid programs. In 2001 and 2002, regional processing centers opened in San Antonio, Houston, and El Paso to process new applications, re-certifications, and change requests, all of which were previously completed at local offices. This smaller, more simplified version of the Business Case's integrated eligibility centers demonstrates the efficiencies gained in such a system. Staff in regional processing centers can process, on average, 26 applications a day. In comparison, a

tenured worker can work 10 - 12 Children's Medicaid cases daily in traditional face-to-face interviews.²⁵

Another area of different viewpoints is the Business Case assumption that current recipients will be willing to utilize new access points for application and recertification for benefits. Many critics contend that clients will be reluctant to apply for benefits on the phone or via the Internet. They believe many applicants will feel uncomfortable disclosing the kind of sensitive information required during eligibility determination over the phone or via the Internet. They also argue that the complexity of the application process requires face-to-face communication and cannot be accomplished over the phone.²⁶

HHSC conversely reports success with a centralized eligibility determination model in its CHIP and Medicaid programs, which deal with similar populations. The CHIP call center received 87,639 calls, processed 6,843 new applications, and recertified 31,694 renewal applications in July 2004.²⁷ This demonstrates a willingness on the part of this clientele to utilize the call center access point. Whether this clientele will utilize the Internet at projected rates (15% of all applications are projected to be completed over the Internet), remains to be seen. Because of this uncertainty, HHSC maintains that the projected staffing levels are flexible and will adjust to the circumstances.²⁸

²⁵ Aurora LeBrun, Texas Health and Human Services Commission, Office of Eligibility Services, "RE: Regarding the numbers for the local change centers," Email correspondence with staff of the Texas Senate Committee on Health and Human Services, (November 4, 2004).

²⁶ Mariano Castillo, "Social Services Reforms Defended," *San Antonio Express News* (August 27, 2004).

²⁷ Aurora LeBrun, Texas Health and Human Services Commission, Office of Eligibility Services, "Information on CHIP and Medicaid Centers," Email correspondence with staff of the Texas Senate Committee on Health and Human Services (August 6, 2004).

²⁸ Texas Health and Human Services Commission, TIERS Project Staff, personal interview (July 2, 2004).

Differing opinions also surround the model's reliance on community-based organizations and the infrastructure that supports it (i.e. the 2-1-1 information system). Many are concerned this reliance will overwhelm already strained resources on the local level. The model relies on community organizations to assist clients with screening and applying for benefits, applying online or by mail, and faxing/mailing application related materials. Some argue that there has been no effort made to determine whether community organizations want to assume this role or if they have the capacity to do so. Concerns have also been raised that the 2-1-1 system may not have the capacity to accommodate anticipated increases in call volume when 2-1-1 is marketed as the gateway to HHSC programs and more people become aware of its services.

Supporters say it benefits clients to have multiple access points. Because the non-profit community already plays a vital role in delivering social services, it makes sense to engage their relationship to simplify delivery. Those that choose to engage in such a partnership will receive \$6,000 per community volunteer to cover recruitment, training, and additional infrastructure (computers and internet access).²⁹ The Business Case also includes funds for approximately 200 new 2-1-1 agents as well as monies for needed infrastructure upgrades.³⁰

Another concern is HHSC's ability to effectively monitor the performance of a private contractor in the event that the state decides to outsource certain functions to private companies. A recent State Auditor's report found that HHSC overpaid its Children's Health Insurance Program (CHIP) administrator by \$20 million. A November 2003 State Auditor report revealed that HHSC failed to recoup \$13 million in funds due to the State from Medicaid/CHIP contracts. As a result, the Lieutenant Governor asked all Senate committee chairs to "insure greater

²⁹ Texas Health and Human Services Commission, *Integrated Eligibility Determination: Business Case Analysis* (February 2004), p. 43.

³⁰ *Ibid.*, p. 44.

accountability and stricter oversight of...outsourcing" with a renewed emphasis on contract oversight. HHSC has detailed 45 pages of performance requirements, standards, measures and liquidated damages in its request for proposals (RFP) for the integrated eligibility project. The State Auditor is also commencing an audit of the HHS consolidation.

Independence of the Office of the Inspector General

The Office of Inspector General (OIG) was created to perform fraud and abuse investigation and enforcement functions for HHSC.³¹ However, given the intense scrutiny HHSC has been under not only for its integrated eligibility determination plan and contract oversight, but also its oversight of the Department of Family and Protective Services, many have wanted the OIG to act as an independent auditor and reviewer of HHSC. Because the OIG is a division within HHSC, HHSC has budget authority over the OIG, leading some to question the division's independence.

These questions have been intensified in light of the reports released by HHSC in response to the Governor's Executive Orders 33 and 35, ordering the systematic reform of Adult Protective Service (APS) and Child Protective Services (CPS). HHSC utilized OIG to conduct a review of APS and CPS case files for compliance with policy and good practice. A comparison of the reports the OIG submitted to HHSC detailing its case review findings and the subsequent reports HHSC submitted to the Governor reveal that several substantial findings from the OIG's reports were not included in the HHSC reports.

³¹ Texas House Bill 2292, 78th Legislature, regular session (2003), Section 531.008.

Ongoing Pharmaceutical Issues

Expenditures on prescription drugs in the state's Medicaid program rose over 70% between FY 2000 and 2003, from \$1.127 to \$1.921 billion respectively.³² In order to contain costs, H.B. 2292 required the Medicaid and CHIP programs to implement Preferred Drug Lists (PDL) for their Vendor Drug Programs and prior authorization for high cost medical services. In addition, it allowed unused drugs from a nursing home setting to be returned to pharmacies for resale. Together, these three measures were projected to save the State of Texas \$154 million over the biennium.

Preferred Drug List

Preferred Drug Lists contain costs by establishing a list of medications that are deemed to be clinically and/or economically superior to other clinically similar drugs.³³ Medications on a PDL can be prescribed and dispensed without prior authorization which encourages physicians to prescribe drugs on a PDL.

Efforts to create PDLs for Texas Medicaid and CHIP are well under way. HHSC has established a Pharmaceutical and Therapeutics (P&T) Committee to select those drugs to be included.³⁴ In order to be considered, pharmaceutical companies must offer a supplemental rebate or a program benefit proposal. The P&T Committee will have met eight times as of the end of November 2004. It has made recommendations to HHSC on 60 drug classes for the Medicaid PDL. Work

³² Texas Health and Human Services Commission, Written testimony submitted to the Texas House Select Committee on State Health Expenditures (January 29, 2004), (Copy on file with the Texas House Select Committee on State Health Expenditures).

³³ Virginia Department of Medical Assistance Services, *Development of the Preferred Drug List Program by the Virginia Department of Medical Assistance Services*. Online. Available: http://www.ghsinc.com/ghs_com/upload/pdlfaq.rtf. Accessed: October 27, 2004.

³⁴ Drugs are chosen based on their efficacy, safety and cost effectiveness. Included drugs can be prescribed by a physician without prior authorization.

continues on the Children's Health Insurance Program (CHIP) PDL and the remainder of the Medicaid PDL.³⁵

When a drug not on the list is requested, H.B. 2292 requires prior authorization before the prescription can be filled. In response to an inquiry about its progress on creating a process by which prior authorization will be obtained, HHSC responded as follows:

HHSC has created a process and criteria through which doctors and other prescribers can get prior authorization for non-preferred drugs (those drugs reviewed by the P&T Committee, but not placed on the PDL).

The prior authorization criteria have been developed with advisory assistance from the Texas Medicaid Drug Utilization and Review (DUR) Board and the P&T Committee. The initial prior authorization criteria for most drug classes include: therapeutic failure, allergy or contraindication with preferred product(s). HHSC is working with the DUR Board and stakeholders to further refine prior authorization criteria for each drug class.

HHSC contracted with Heritage Information Systems, Inc. to administer prior authorization services. [H.B. 2292] requires the Medicaid program to respond to a prior-authorization request within 24 hours and to provide a 72-hour supply of drugs in cases of emergencies (for example, on a weekend or other times when a doctor can not be reached by the pharmacist). In some cases, HHSC will already have claims data that indicates that the patient has met the prior authorization criteria for the non-preferred drug requested. In those cases, the prescription will be prior authorized when the patient goes to the pharmacy without the necessity of a phone call. In other cases, the prescriber or one of their staff representatives will have to call the Texas Prior Authorization Call

³⁵ Texas Health and Human Services Commission, *HHS Major Initiatives, Health and Human Services Commission* (May 24, 2004).

Center (1-877-PA-TEXAS)³⁶ to obtain approval before a non-preferred drug can be dispensed. Approved requests for prior authorization are valid for one year.

If the call center denies a prior authorization request, the prescriber can mail or fax in a Request for Reconsideration form with supporting clinical documentation. The prescriber and patient will be notified in writing whether the request is approved within 5 business days. If a Request for Reconsideration is denied, the patient will receive written information on the Texas Medicaid appeals process.³⁷

Prior Authorization

H.B. 2292 required HHSC to "evaluate and implement, as appropriate, procedures, policies, and methodologies to require prior authorization for high-cost medical services and procedures."³⁸

Reducing over-utilization of high-cost in-patient hospital services through early intervention, preventive care, and outpatient referrals was the goal. The legislation allowed HHSC to contract for these services. The agency released a request for proposals (RFP) in February 2004.

However, in May 2004, after reviewing the proposals, the agency withdrew the RFP because high implementation costs made the proposals cost-ineffective.

These implementation costs arose from a lack of infrastructure to enable additional vendors to coordinate with the current Medicaid claims administrator, Affiliated Computer Systems (ACS). Because contracting with a new vendor was cost prohibitive, HHSC expanded its contract with ACS to include a prior authorization component. ACS established and will maintain "an extended list of hundreds of procedures and services which require prior authorization." This list

³⁶ Prior authorization has been rolled out monthly for certain drug classes since February 2004. In May 2004, the average call duration was under one minute and over 90% of calls were answered within 90 seconds.

³⁷ Laura Stover, Health and Human Services Commission "Follow up re: Call Centers, PDL's and Prior Authorization." Email correspondence with staff of the Texas Senate Committee on Health and Human Services (June, 12 2004).

³⁸ Texas Government Code, Section 531.075.

will be reviewed regularly by a Benefits Management Workgroup. "This review allows further identification of new technologies and procedures that need to be added to the list of prior authorized services on an ongoing basis."³⁹

Nursing Home Drug Recycling

H.B. 2292 allows nursing facility consultant pharmacists to return to a pharmacy unused drugs sealed in the manufacturer's original unopened tamper-evident packaging that meet a number of conditions. Pharmacies may then restock and redistribute unused drugs. To ensure a cost-effective system, H.B. 2292 specified that only those drugs for which the credit exceeds the cost of the restocking fee by at least 100% could be eligible for credit. HHSC was to provide an electronic system for the issuance of credit for returned drugs. HB 2292 also required that HHSC establish a task force, including representatives of nursing facilities and pharmacists, to develop the reimbursement rules.

The HHSC task force has met and has recommended that HHSC explore alternative ways to prevent waste in long-term care facilities. Task force members believed that pharmacies would not participate in the recycling effort unless the restocking fee was more than twice the current dispensing fee. Taking that into consideration, the program proved cost-ineffective. Task Force members estimated that total savings would amount to little more than \$100,000 annually. As a result, task force members are researching other ways to ensure expensive drugs are not wasted in nursing homes around Texas.

³⁹ Laura Stover, Health and Human Services Commission. "Follow up re: Call Centers, PDLs and Prior Authorization." Email correspondence with staff of the Texas Senate Committee on Health and Human Services (June 12, 2004).

Recommendations

- 1. Bolster current 2-1-1 Information & Referral infrastructure to accommodate anticipated increases in call volume when 2-1-1 is marketed as the gateway to HHSC programs and more people become aware of its services.**

Rationale: In the Business Case model, all information gathering and prescreening calls will be routed through 2-1-1, and then referred to the call centers via an Integrated Voice Response (IVR) system. Many key stakeholders are concerned that demand for 2-1-1 information and referral services will increase substantially when 2-1-1 is marketed as the gateway to HHSC programs and more people become aware of its services. HHSC has budgeted monies to accommodate anticipated increases in demand. However, federal match monies may become available. The Calling for 2-1-1 Act (H.R. 3111/S. 1630) is a bill currently before Congress which would authorize \$200 million in federal funding to help develop 2-1-1 nationwide. If passed, Texas would receive a 50/50 match for expenditures to upgrade the current 2-1-1 system.

- 2. In the event that the state decides to outsource certain functions to private companies, contract negotiations should clearly set forth the private companies' responsibilities, penalties for non-compliance, mechanisms for identifying when contractors are failing to fulfill their obligations, remedies that compel compliance, and remedies available for clients.**

Rationale: Given the Health and Human Service Commission's troubled history with contract oversight, concerns have arisen over the Commission's ability to

effectively monitor the performance of a contractor in the event that the state decides to outsource certain functions to private companies.

Cognizant of this concern, HHSC detailed 45 pages of performance requirements, standards, measures and liquidated damages in its request for proposals (RFP) for the integrated eligibility project. Additionally, the State Auditor is commencing an audit of the consolidation, and will most likely examine the Business Case and the RFP.

3. Ensure the independence of the Office of Inspector General from the Health and Human Services Commission.

Rationale: The Office of Inspector General was created to perform fraud and abuse investigation and enforcement functions for HHSC.⁴⁰ However, given the intense scrutiny HHSC has been under not only for its integrated eligibility determination plan and contract oversight, but also its oversight of the Department of Family and Protective Services, many have wanted the OIG to act as an independent auditor and reviewer of HHSC. Because the OIG is a division within HHSC, the commission has budget authority over the OIG, leading some to question the OIG's independence.

4. Repeal Section 2.14(b)(1) of H.B. 2292, which requires HHSC to establish prior authorization procedures that ensure that: “a prior authorization requirement is not imposed for a drug before the drug has been considered at a meeting of the Pharmaceutical and Therapeutics Committee established under Section 531.074.”

⁴⁰ Texas House Bill 2292, 78th Legislature, Regular Session (2003). Section 531.008.

This will allow HHSC flexibility to require prior authorization for drugs that the P&T Committee has not yet reviewed.

Rationale: Most states require prior authorization until the drug has been reviewed for the PDL. The flexibility to require prior authorization for new drugs will address the issue of manufacturers who create "combo" drugs to circumvent prior authorization requirements. These combination drugs are often made up of individual products the P&T Committee has already recommended be non-preferred and require prior authorization. By requiring that new products be dispensed without prior authorization until the P&T Committee reviews them, Texas loses money in two ways. First, the new product does not have a supplemental rebate yet, and in most cases will be more expensive than the preferred products in the class. Second, the drug manufacturer will actively market the product during this "grace" period to build up market share, which will lead to more prior authorization costs if the P&T Committee recommends and HHSC decides that the product should be non-preferred.

Drug manufacturers will still have an opportunity to get their products on the PDL quickly, as H.B. 2292 Section 2.13(e)(2) requires that HHSC schedule a review for new products at the next quarterly meeting of the P&T Committee.

5. Repeal H.B. 3486, 78th Legislature, Regular Session and the following sections of H.B. 2292: 2.71, 2.102, 2.126, 2.147, 2.148, which require recycling unused nursing home prescription drugs.

Rationale: Revised HHSC savings estimates indicate that recycling unused nursing home prescription drugs will save the state minimal, if any, dollars due to:

1) the U.S. Federal Drug Administration (FDA) limitations on which drugs can be legally recycled and 2) the implementation of Medicare Part D on January 1, 2006, which will assume drug coverage for Medicare-Medicaid dual eligibles, who make up over 90% of the Medicaid nursing home population.

HHSC recommends exploring alternative ways to prevent waste in long-term care facilities and is researching other ways to ensure expensive drugs are not wasted in nursing homes around Texas.

6. Reinstate the School Health Advisory Committee.

Rationale: Reinstatement of the school health advisory council at the Department of State Health Services, which was repealed by H.B. 2292, will help ensure inter-agency coordination in the fight against childhood obesity and its resulting health complications.

7. Reinstate the Indigent Health Care Advisory Committee

Rationale: The Indigent Health Care Advisory Committee previously advised the Department on State Health Services on rules and polices concerning indigent health care, but was repealed by H.B. 2292. Reinstatement of the

advisory committee will provide a clear forum for continued dialogue related to indigent healthcare (see Charge 3).

8. Prevent public disclosure of persons who have defrauded Medicaid until completion of investigations.

Rationale: H.B. 2292 unintentionally closed public access to the names of persons who have defrauded Medicaid. Legislation is needed to clarify that H.B. 2292 intended to prevent only the disclosure of information that could negatively impact a Medicaid fraud investigation.

9. Reinstate continuing education requirements.

Rationale: H.B. 2292 modified licensing renewals to a biennial schedule. However, this inadvertently lowered continuing education requirements in some instances. In order to ensure public safety, legislation is needed to reinstate certain continuing education requirements.

Charge 3: Indigent Health Care

Study and make recommendations on improving Texas's county and local indigent health care system. Consider whether the system should be regionalized to reflect usage and gain efficiencies, so that one or more counties are not paying for regional health care.

Background

The indigent health care system in Texas attempts to provide medical care to the most destitute in the State. The Senate Committee on Health & Human Services was charged with studying whether the system of indigent care as currently organized under the Indigent Health Care and Treatment Act ("Act"), affords medical care in the most cost-effective manner without relying heavily on counties with large safety-net hospitals.

Under the Act, counties have the option of meeting the medical needs of the indigent through county indigent health care programs, hospital districts or public hospitals. Although the Act requires the provision of certain basic medical care, services such as emergency medical services are optional. Additionally, under the current structure residents may face access and availability barriers to receiving care in their resident county. The consequences of inadequate access to medical screenings and preventive care for the indigent and uninsured is non-urgent use of emergency rooms and avoidable hospital stays.¹ This results in higher hospitalization rates and chronic care costs.²

¹ Families USA, *One in Three: Non-Elderly Americans without Health Insurance, 2002 - 2003*, (Washington, D.C., 2004) Prepared by K. Stoll & K. Jones, pp. 20 - 21.

² Texas Institute for Health Policy Research, *The Uninsured in Texas*, (Austin, Tex., 2000), p. 5. Online. Available: http://www.healthpolicyinstitute.org/pdf_files/uninsured_hpb.pdf. Accessed: October 25, 2004.

As rural and suburban county indigent residents are unable to receive the medical care they require because of a lack in infrastructure or medical specialization in their county of residence, they turn to urban safety-net hospitals. Under the Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals are required to provide medical screening to persons appearing at an emergency department requesting treatment. If the patient has an emergency medical condition, "the hospital must provide further medical examination and treatment to stabilize the medical condition".³ Although EMTALA protects the ability of the indigent and uninsured to receive care irrespective of the patient's ability to pay for the services rendered, there is an indication that it has also led to an increase in the number of persons with non-urgent conditions using emergency departments, which has enlarged uncompensated care.⁴

A further complication to the safety-net system is the provision of care to undocumented persons, who may be unable to pay for the medical care received. EMTALA requires hospitals to stabilize patients with emergency medical conditions without regard to citizenship status. The Medicare Modernization Act has provided for \$1 billion dollars over the next four years to help hospitals and providers recoup some of the costs incurred from emergency care regardless of patient citizenship status.⁵ However, a recent Attorney General opinion (GA-0219) added additional concern regarding care to undocumented persons. The Attorney General ruled Texas statute permits, "but does not require a hospital district to provide non-emergency public health

³ U.S. General Accounting Office. *Emergency Care: EMTALA Implementation and Enforcement Issues*. GAO-01-747. (Washington, D.C., 2001). p. 4.

⁴ *Ibid.* pp. 11 - 12.

⁵ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *CMS Implements \$1 Billion Program to Help Hospitals, Others Recoup Unpaid Emergency Room Costs*, (Washington, D.C., 2004). Online. Available: <http://www.cms.hhs.gov/media/press/release.asp?Counter=1123>. Accessed: July 22, 2004.

services to undocumented persons who are otherwise ineligible for those benefits under federal law."⁶

There is general disagreement among rural, suburban and urban counties as to what structure could be developed to best serve the needs of local taxpayers and the indigent. One proposal seeks to regionalize care by structuring the delivery of primary, secondary and tertiary care within a geographical area in a manner that best reflects the infrastructure and medical specialization within a region. Although acknowledging that the current structure of indigent care contains problems, opponents of the regionalization concept would rather not cede local decision-making authority and general revenue tax levy to a regional body that could be dominated by the interests of urban counties. Although groups continue to meet and discuss possible solutions to the shortcomings of the current structure, there does not yet appear to be a consensus among stakeholders.

Indigence and the Uninsured

In 2002, there were an estimated 43.6 million uninsured people in the United States.⁷ This figure is a 14.6 percent increase over uninsured levels in 2001, or approximately 2.4 million additional persons.⁸ More recently, data show that for all or part of 2002 and 2003, approximately 81.8 million people under the age of 65 went without health insurance.⁹ Approximately, 65.3 percent of these individuals went uninsured for six months or more.¹⁰

⁶ Texas Office of the Attorney General, *Opinion Number GA-0219*, (Austin, Tex., 2004).

⁷ Families USA, *One in Three: Non-Elderly Americans without Health Insurance, 2002 - 2003*, (Washington, D.C., 2004) Prepared by K. Stoll & K. Jones, p. 1.

⁸ *Ibid.*

⁹ *Ibid.*

¹⁰ *Ibid.*

Although difficult to quantify, a study released in 2004 estimated that 43.4 percent of the total Texas population or 8,536,000 Texans went uninsured during part or all of the two-year period from 2002 through 2003.¹¹ Of this amount, approximately 73.4 percent or 6,263,000 went uninsured for 6 months or more during the two-year study.¹² Other estimates place the number of uninsured in Texas at 5 million persons, or 23 percent of the state's population.¹³

Nationally, "more than half of individuals in families with incomes between 100 and 200 percent of the federal poverty level were uninsured."¹⁴ However, although the propensity of being uninsured decreases with higher incomes, a quarter of families nationwide with incomes between 300 and 400 percent of the federal poverty level were uninsured at some point during 2002 and 2003.¹⁵ In Texas, the Department of Health estimates that 46.3 percent of the population at 50 percent of the Federal Poverty Level (FPL) are uninsured, or approximately 544,228 individuals.¹⁶ At 200 percent or below the FPL, approximately 32.7 percent of the population or 704,465 people are likely to be uninsured.¹⁷ These Department figures reflect only 105 of a total 141 county-run programs and do not include persons served through non-reporting county programs, hospital districts, and public hospitals.¹⁸

¹¹ Families USA, *One in Three: Non-Elderly Americans without Health Insurance, 2002 - 2003*, (Washington, D.C., 2004) Prepared by K. Stoll & K. Jones, pp. 2-3.

¹² *Ibid.* p. 4.

¹³ George Washington University Medical Center, School of Public Health and Health Services, *An Assessment of the Safety Net in San Antonio, Texas*, (2004), p. 9. Online. Available: <http://www.universityhealthsystem.com/emergency-center/SafetyNet-SA.pdf>. Accessed: October 25, 2004.; See also – Texas Department of Health. Written response to questions posed by members of the Senate Committee on Health and Human Services during the May 25th, 2004 hearing. Received: June 24, 2004.

¹⁴ Families USA, *One in Three: Non-Elderly Americans without Health Insurance, 2002 - 2003*, (Washington, D.C., 2004) Prepared by K. Stoll & K. Jones, pp. 5-6.

¹⁵ *Ibid.*

¹⁶ Texas Department of Health, Written response to questions posed by members of the Senate Committee on Health and Human Services during the May 25th, 2004 hearing. Received: June 24, 2004. Attachment C: Safety-Net Programs.

¹⁷ *Ibid.*

¹⁸ Texas Department of Health, Written response to questions posed by members of the Senate Committee on Health and Human Services during the May 25th, 2004 hearing. Received: June 24, 2004.

Texas' high uninsurance rate is partly attributable to a low rate of private insurance coverage. For instance, approximately 93% of businesses in San Antonio employ fewer than 50 employees and many do not offer health insurance.¹⁹ In addition, employees may not be able to afford health insurance premiums, and, depending on income eligibility criteria, employees may not qualify for government assistance programs.²⁰ The result of Texas' large rate of uninsured is that the state is left "with a large gap to fill with public programs."²¹

The Department of Health estimated that in some instances the uninsured represent more than 50 percent of the client services receiving care through its safety-net programs, including the County Indigent Health Care program.²²

The rate of uninsurance contributes to the non-urgent use of emergency rooms and avoidable hospital stays.²³ For example, approximately 16 percent of emergency visits in the University Health System in San Antonio not resulting in an admission were due to patients with non-emergent conditions.²⁴ Moreover, 17 percent of emergency department encounters were for emergent conditions treatable in a primary care setting.²⁵

¹⁹ George Washington University Medical Center, School of Public Health and Health Services, *An Assessment of the Safety Net in San Antonio, Texas*, (2004), p. 9. Online. Available: <http://www.universityhealthsystem.com/emergency-center/SafetyNet-SA.pdf>. Accessed: October 25, 2004.

²⁰ Families USA, *One in Three: Non-Elderly Americans without Health Insurance, 2002 - 2003*, (Washington, D.C., 2004) Prepared by K. Stoll & K. Jones, p. 12.

²¹ Urban Institute, *Recent Changes in Health Policy for Low-Income People in Texas*, Prepared by J. Wiener & N. Brennan, State Update No. 23, (Washington, D.C., 2002), p. 1.

²² Texas Department of Health, Written response to questions posed by members of the Senate Committee on Health and Human Services during the May 25th, 2004 hearing. Received: June 24, 2004. Attachment C: Safety-Net Programs.

²³ Families USA, *One in Three: Non-Elderly Americans without Health Insurance, 2002 - 2003*, (Washington, D.C., 2004) Prepared by K. Stoll & K. Jones, pp. 20 - 21.

²⁴ George Washington University Medical Center, School of Public Health and Health Services, *An Assessment of the Safety Net in San Antonio, Texas*, (2004), p. 4. Online. Available: <http://www.universityhealthsystem.com/emergency-center/SafetyNet-SA.pdf>. Accessed: October 25, 2004.

²⁵ *Ibid.*

County Indigent Health Care Program

Counties have three options when determining how to provide basic health care to their eligible indigent residents. The options include being part of a hospital district, participating in a public hospital, or operating a county indigent health care program. Statewide there are 136 hospital districts, 141 county indigent health care programs and 26 public hospitals.²⁶ This discussion will focus on the delivery of care through the County Indigent Health Care (CIHC) program as it pertains to Interim Charge 3.

Counties that are not fully served by a hospital district or public hospitals are required by the Act to provide basic health care services to eligible county residents. These services include, but are not limited to, immunizations, medical screenings, annual physicals, inpatient and outpatient hospital services, and up to three prescription drugs per month.²⁷ Counties may provide optional services or supplies they determine to be cost-effective such as ambulatory surgical centers, dental care, psychological counseling, emergency medical services and services provided by federally qualified health centers.²⁸ With approval from the DSHS, counties may credit optional services towards eligibility for state assistance.²⁹

In general, eligibility is contingent on an individual meeting residency and income/resource requirements. The person must reside or intend to reside in the county for purposes other than establishing residency to obtain health care assistance.³⁰ Additionally, the resident cannot reside

²⁶ Texas Department of Health, Written response to questions posed by members of the Senate Committee on Health and Human Services during the May 25th, 2004 hearing. Received: June 24, 2004.

²⁷ Texas Health & Safety Code § 61.028.

²⁸ Texas Health & Safety Code § 61.0285.

²⁹ Texas Health & Safety Code § 61.0285.

³⁰ Texas Health & Safety Code § 61.003.

in the service area of a public hospital or hospital district.³¹ The minimum income eligibility standard for participation in the program is 21 percent of the federal poverty level (FPL); however, this amount can increase to a maximum of 50 percent of the FPL.³² If an aged or disabled individual lives in the household, resources may not exceed \$3,000. All other remaining households are ineligible if resources exceed \$2,000.³³ Furthermore, homesteads are exempted and each household vehicle is exempt up to \$4,650 of fair market value.³⁴

In 2004, the minimum monthly income standard of 21 percent of the FPL translated to:

- \$163 per month for a family of 1
- \$219 per month for a family of 2
- \$274 per month for a family of 3
- \$330 per month for a family of 4

In Fiscal Year 2003, the CIHC Program served/enrolled 28,767 persons from a total 1,052,613 estimated program population.³⁵ These figures reflect only 105 of a total 141 county-run programs and do not include persons served through non-reporting county programs, hospital districts, and public hospitals.³⁶ The population typically qualified to receive services under the

³¹ Texas Health & Safety Code § 61.002.

³² Texas Department of Health, Written response to questions posed by members of the Senate Committee on Health and Human Services during the May 25th, 2004 hearing. Received: June 24, 2004. Attachment C: Safety-Net Programs; see also – Texas Health & Safety Code § 61.006.

³³ Texas Department of Health, *County Indigent Health Care Program Provider Manual*, (Austin, Tex., September 2003), p. 3.

³⁴ *Ibid.*; see also – Texas Health & Safety Code § 61.008.

³⁵ Texas Department of Health, Written response to questions posed by members of the Senate Committee on Health and Human Services during the May 25th, 2004 hearing. Received: June 24, 2004. Attachment C: Safety-Net Programs.

³⁶ Texas Department of Health, Written response to questions posed by members of the Senate Committee on Health and Human Services during the May 25th, 2004 hearing. Received: June 24, 2004.

CIHC program are low-income persons categorically ineligible for Medicaid, such as single adult males, non-pregnant adult females without children, and undocumented aliens.³⁷

The Texas Department of State Health Services administers the County Indigent Health Care Program by assisting counties not served by a hospital district or public hospital to comply with the Act. The Department's function is to define covered services, establish payment rates, and administer the state assistance fund. Additionally, the Department processes Supplemental Security Income Medicaid claims on behalf of participating counties.³⁸

Recently, the Department streamlined its administration of existing safety net programs (including CIHC) by reallocating program resources and reducing operating expenses to less than \$400,000 in Fiscal Year 2004.³⁹ Of a total of \$8,755,026 appropriated in Fiscal Year 2003 to Support of Indigent Health Services, the Department allocated \$7.7 million for client services through the State Assistance Fund.⁴⁰ During the 78th Legislature, a total of \$11.2 million was appropriated for the CIHC program.⁴¹

State Assistance Fund

Counties, by law, are the payor of last resort and are obligated to provide assistance only if other adequate public or private sources of payment are unavailable.⁴² Thus, as providers and

³⁷ *Ibid.* Attachment C: Safety-Net Programs

³⁸ Texas Department of Health, Presentation to the Senate Committee on Health and Human Services, (Austin, Tex., May 25, 2004).

³⁹ *Ibid.*

⁴⁰ *Ibid.*

⁴¹ *Ibid.*

⁴² Texas Health & Safety Code § 61.022.

hospitals treat indigent residents, counties are obligated to reimburse "for individuals not eligible for Medicaid, Medicare, SCHIP or other private insurance."⁴³

Counties operating CIHC programs generally fund their programs through local tax dollars.⁴⁴

The Department reports that in Fiscal Year 2003, counties spent a total \$65,781,114 of general revenue on indigent care through their CIHC programs.⁴⁵ However, 36 of a total 141 counties did not report amounts spent on their indigent care programs to the Department of Health.⁴⁶

Counties spending at least 8 percent of their general revenue tax levy on indigent health care may qualify for available matching funds from the State Assistance Fund.⁴⁷ The State established the Fund as a mechanism to assist counties to defray some of the costs incurred by counties administering CIHC program. The Department bases the allocation of the State Assistance Fund on county spending history, population, residents living below the federal poverty guideline, and any applicable spending cap imposed by the Legislature.⁴⁸ In fiscal year 2003, Fund allocations were constrained to a 35 percent maximum reimbursement limit and to the number of individuals living at or below 50 percent of the federal poverty level.⁴⁹

⁴³ Texas Department of Health, Written response to questions posed by members of the Senate Committee on Health and Human Services during the May 25th, 2004 hearing. Received: June 24, 2004. Attachment C: Safety-Net Programs.

⁴⁴ Texas Department of Health, *County Indigent Health Care Program Provider Manual*. (Austin, Tex., September 2003), p. 2.

⁴⁵ Texas Department of Health, Written response to questions posed by members of the Senate Committee on Health and Human Services during the May 25th, 2004 hearing. Received: June 24, 2004.

⁴⁶ *Ibid.*

⁴⁷ Texas Health & Safety Code § 61.037.

⁴⁸ Texas Administrative Code, Chapter 25, § 14.1.

⁴⁹ Texas Department of Health, Presentation to the Senate Committee on Health and Human Services, (Austin, Tex., May 25, 2004).

Counties qualifying for the state assistance funds receive a 90 percent match for indigent health care services provided over 8 percent of their general revenue tax levy.⁵⁰

Of the counties reporting health care spending in fiscal year 2003, they allocated on average 5.1 percent of their general revenue tax levy to indigent health.⁵¹ The general revenue amounts allocated to indigent health ranged from .19 percent in Kent and Oldham counties to 17.67 percent in Fannin County.⁵² However, it should be noted these figures are based on the Department's most recent figures for county reported general revenue tax levy from 1998 through 2001.

During 2003, the Department distributed \$7.7 million to 20 counties through the State Assistance Fund.⁵³ Amounts distributed ranged from \$1,908 for Kinney County to \$3,290,887 for Hidalgo County.⁵⁴ Of the \$11.2 million appropriated for Support of Indigent Health Services in the 2004 - 2005 Biennium, CIHCP planned to distribute approximately \$5.1 million in 2004 as state assistance.⁵⁵ This represents an approximate 38 percent reduction in appropriation to the Fund due to measures taken by the 78th Legislature to bridge the \$10 billion budget shortfall.⁵⁶ As of May 2004, the Department had distributed approximately \$246,000 to 7 counties.

⁵⁰ Texas Health & Safety Code § 61.038.

⁵¹ Texas Department of Health, Written response to questions posed by members of the Senate Committee on Health and Human Services during the May 25th, 2004 hearing. Received: June 24, 2004.

⁵² *Ibid.*

⁵³ *Ibid.*

⁵⁴ *Ibid.*

⁵⁵ Texas Department of Health, Presentation to the Senate Committee on Health and Human Services, (Austin, Tex., May 25, 2004).

⁵⁶ County Judges and Commissioners Association of Texas, "County Indigent Health Care Programs," *Texas County Progress*, (March 2004), p. 24.

Shortcomings of the Current System

Limited State Authority to Monitor County Compliance

Although the Department monitors county monthly spending reports, the Act does not grant it "enforcement authority to review county programs unless the county is requesting state assistance funds."⁵⁷ Thus, the Department of State Health Services would not be able to examine a county program employing an eligibility criteria different from one outlined in the Act, unless the county was requesting state assistance funds.⁵⁸ Although some argue for a need to increase the Department's enforcement capabilities, some counties resist state interference in county-run programs.⁵⁹

Eligibility restrictions

Due to the County Indigent Health Care Program's restrictive guidelines, "many uninsured or underinsured persons do not qualify, which contributes significantly to the uncompensated care problem."⁶⁰ Most counties use the minimum eligibility standard of net income equal to 21 percent of FPL.⁶¹ At this rate, in 2004 a family of four making over \$330 per month would not qualify for the program. However, the Department indicates it would "be a substantial cost to the State" to expand eligibility to all 1,052,613 persons "in need", based on the current method of

⁵⁷ Texas Department of Health, Written response to questions posed by members of the Senate Committee on Health and Human Services during the May 25th, 2004 hearing. Received: June 24, 2004.

⁵⁸ *Ibid.*

⁵⁹ Texas House of Representatives, House Research Organization. *Indigent Health Care and Treatment Act of 1985: A Burden on Counties?* (Austin, Tex., 2004), p. 18.

⁶⁰ Texas Department of Health, Written response to questions posed by members of the Senate Committee on Health and Human Services during the May 25th, 2004 hearing. Received: June 24, 2004.

⁶¹ *Ibid.*

reimbursing counties.⁶² Additionally, a state imposed increase in baseline eligibility would also create a large unfunded mandate for local county taxpayers.

Maximum County Liability

A county's maximum liability during each fiscal year for all health care services rendered by providers, including hospitals, to each eligible indigent resident is \$30,000. However, health care officials report that the \$30,000 maximum liability does not reflect the actual costs of health care costs associated with tertiary care.⁶³ For instance, between September 2001 through August 2002, Parkland Memorial Hospital in Dallas incurred \$11.5 million in uncompensated costs from 1,265 uninsured out-of-county inpatient admissions (self-pay or charity care).⁶⁴ Of this group, 133 patients exceeded \$30,000 in charges totaling \$5,373,043 in unreimbursed costs.⁶⁵ However, smaller counties argue the \$30,000 cap in expenses offers budget certainty given their constrained fiscal situation.⁶⁶

State Assistance Fund

Under current eligibility criteria and funding levels, 20 counties received a total of \$7.7 million in matching funds from the State Assistance Fund during fiscal year 2003.⁶⁷ These counties accounted for 38 percent of the total county indigent health care spending reported to the Department in fiscal year 2003 or approximately \$25 million dollars.⁶⁸ A total of 81 counties

⁶² *Ibid.*

⁶³ R. Amarasingham, S. Pickens, and R. Anderson, *Regionalization of Medical Services in Texas: Organizing Principles and Funding Strategies*, (2003), p. 10.

⁶⁴ *Ibid.*

⁶⁵ *Ibid.*

⁶⁶ Texas House of Representatives, House Research Organization. *Indigent Health Care and Treatment Act of 1985: A Burden on Counties?* (Austin, Tex., 2004), Page 18.

⁶⁷ Texas Department of Health, Presentation to the Senate Committee on Health and Human Services, (Austin, Tex., May 25, 2004).

⁶⁸ Texas Department of Health, Written response to questions posed by members of the Senate Committee on Health and Human Services during the May 25th, 2004 hearing. Received: June 24, 2004.

spending approximately \$41 million in county indigent health care did not qualify for monies from the State Assistance Fund.⁶⁹

Additionally, if the Department fails to provide assistance to an eligible county, the county is not liable for payments for health care services provided to its eligible county residents after the county reaches the 8 percent expenditure level.⁷⁰

Uncompensated Care

Residents of counties unable to provide tertiary services such as trauma care or other complex medical and surgical interventions rely on larger urban hospitals with these capabilities.⁷¹ As these patients arrive at emergency rooms, EMTALA prevents discrimination against the indigent and uninsured.⁷² This is further reflected in the Act which prohibits counties, public hospitals or hospital districts from reducing or denying medical assistance to eligible residents refusing or unable to contribute financially towards the cost of their care.⁷³ Consequently, because of these factors and the high-uninsured rates in Texas, providers are "likely to see higher demand for care from individuals who cannot pay."⁷⁴

In 2004, the national total medical care expenditures for the uninsured was approximately \$125 billion.⁷⁵ Of this amount, a total \$40.7 billion or 33 percent of the care went unpaid.⁷⁶ Hospitals

⁶⁹ *Ibid.*

⁷⁰ Texas Health & Safety Code § 61.039.

⁷¹ Texas Medical Association, "County Hospitals and Regional Medicare in Texas: Analysis of Out-of-County Costs," *Texas Medicine*, (June 2004). Online. Available: www.texmed.org/ata/nrm/tme/june04_journal_countyhospitals.asp. Accessed: June 16, 2004.

⁷² U.S. General Accounting Office, *Emergency Care: EMTALA Implementation and Enforcement Issues*, GAO-01-747, (Washington, D.C., 2001) p. 4.

⁷³ Texas Health & Safety Code § 61.005.

⁷⁴ Urban Institute, *Health Care Access for Uninsured Adults: A Strong Safety Net is Not the Same as Insurance*, Series B, No. B-42, Prepared by J. Holahan & B. Spillman, (Washington, D.C., 2002), pp. 2 - 3.

⁷⁵ Kaiser Family Foundation, Commission on Medicaid and the Uninsured, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* Prepared by J. Hadley & J. Holahan, (2004), pp. 2 - 3.

accounted for an estimated 60% of uncompensated care in the nation in 2001.⁷⁷ Texas' experience with uncompensated care follows that of the nation as a whole.

The Texas Medical Association reported that, in 2001, 354 general hospitals in Texas provided \$5.2 billion in uncompensated care, with 5 hospitals (Parkland Hospital in Dallas County, R.E. Thomason Hospital in El Paso, Harris County Hospital District, University Hospital in Bexar County, and John Peter Smith Hospital in Tarrant County) accounting for 23% or \$1.2 billion.⁷⁸ Out-of-county care represented approximately 16% of the total uncompensated care provided by these 5 hospitals.⁷⁹ In 2002, these five hospitals had 103,381 clinic or inpatient out-of-county patient encounters costing \$174 million.⁸⁰ However, the hospitals recovered only 62% of their costs, leaving a total \$66 million in unreimbursed costs.⁸¹

Regionalization of Indigent Health Care

Many stakeholders have concluded that "although effective in establishing minimum standards of care for indigent persons, the Act does not acknowledge geographic, economic and demographic differences that complicate the uniform delivery of health care across counties."⁸² One possible change to the current system could occur through a regionalized service delivery system that concentrates "limited or expensive health care services locally within an area while

⁷⁶ *Ibid.*

⁷⁷ *Ibid.*

⁷⁸ Texas Medical Association, "County Hospitals and Regional Medicare in Texas: Analysis of Out-of-County Costs," *Texas Medicine*, (June 2004). Online. Available: www.texmed.org/ata/nrm/tme/june04_journal_countyhospitals.asp. Accessed: June 16, 2004.

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

⁸¹ *Ibid.*

⁸² Texas Medical Association, "County Hospitals and Regional Medicare in Texas: Analysis of Out-of-County Costs," *Texas Medicine*, (June 2004). Online. Available: www.texmed.org/ata/nrm/tme/june04_journal_countyhospitals.asp. Accessed: June 16, 2004.

dispersing primary and secondary care more broadly.⁸³ Such a system would recognize that the complexities of tertiary health care require "economies of scale seldom achieved in rural and suburban counties."⁸⁴ Moreover, a coordinated delivery of services could increase low-income patient access to primary and secondary care by decentralizing the current system, which places a large burden on urban counties.⁸⁵ In building the health care infrastructure of counties surrounding more urbanized areas, proponents argue indigent residents would have less of a need to seek non-emergency care at safety-net hospitals.⁸⁶ Consequently, supporters expect that under a regional system urban hospitals would experience a decrease in the amount of uncompensated care provided to out-of-county residents for non-emergency care.

Although acknowledging that the current structure of indigent care contains problems, opponents of the regionalization concept would rather not cede local decision-making authority and general revenue tax levy to a regional body that could be dominated by the interests of urban counties. Moreover some counties argue the Act, "is an unfunded mandate that unfairly forces counties to spend a large portion of their budgets on a state requirement."⁸⁷ Many stakeholder groups continue to meet and discuss possible solutions to the shortcomings of the current structure; however, there does not yet appear to be a consensus among stakeholders. For the Legislature to address effectively the state's indigent health care delivery system, county representatives must

⁸³ *Ibid.*

⁸⁴ R. Amarasingham, S. Pickens, and R. Anderson, *Regionalization of Medical Services in Texas: Organizing Principles and Funding Strategies*, (2003), p. iv.

⁸⁵ Texas Medical Association, "County Hospitals and Regional Medicare in Texas: Analysis of Out-of-County Costs," *Texas Medicine*, (June 2004). Online. Available: www.texmed.org/ata/nrm/tme/june04_journal_countyhospitals.asp. Accessed: June 16, 2004.

⁸⁶ R. Amarasingham, S. Pickens, and R. Anderson, *Regionalization of Medical Services in Texas: Organizing Principles and Funding Strategies*, (2003), p. 3.

⁸⁷ Texas House of Representatives, House Research Organization, *Indigent Health Care and Treatment Act of 1985: A Burden on Counties?* (Austin, Tex., 2004), p. 1.

come to an agreement on the structure of a regionalized system, funding mechanisms, eligibility and program benefits.

Recommendations

1. Reinstatement of the Indigent Health Care Advisory Committee.

Rationale: The Indigent Health Care Advisory Committee previously advised the Department on State Health Services on rules and policies concerning indigent health care, but was repealed by House Bill 2292, 78 (R). Reinstatement of the advisory committee will provide a clear forum for continued dialogue related to indigent healthcare.

Charge 4: State and Federal Health Care Initiatives

Monitor the implementation and make recommendations to enhance the effectiveness of legislation relating to the Board of Medical Examiners, legislation relating to childhood immunizations, legislation relating to the pilot front end Medicaid fraud reduction systems, federal developments related to TANF reauthorization and related programs, expansion and new construction of Federally Qualified Health Centers, federal developments related to prescription drugs in Medicare and the effect on Medicaid. Also, monitor and report on the use of new federal Medicare funds allocated for Texas.

State Board of Medical Examiners

Background

During the 77th interim, the Special Committee on the Prompt Payment of Health Care Providers was charged with studying the rising social costs stemming from medical malpractice issues. While some resultant legislation focused on capping jury awards for non-economic damages, Senate Bill 104 (78R) focused on problems with physician discipline. Reports began to surface in 2002 which questioned the efficacy of the Texas State Board of Medical Examiners (TSBME) in disciplining physicians, particularly those facing claims of medical malpractice and/or improper behavior with patients.

Disturbing accounts of sexual misconduct going virtually unpunished drew criticism of the TSBME's review process. In the five years leading up to 2002, only two physicians had their licenses permanently revoked following accusations of sexual misconduct, while the remaining

37 doctors disciplined for similar accusations were allowed to continue practicing.¹ Nationwide, sexual misconduct charges typically result in license revocation in 10 percent of all cases while similar action was taken in less than 5 percent of cases in Texas.²

Additional reports were released criticizing the TSBME regarding delays in its investigation process. Cases were cited where disciplinary action was rendered four or five years after the original infraction, and in some instances it took the TSBME 10 years to reprimand doctors guilty of malpractice. One Houston doctor who pleaded no contest to charges of solicitation of capital murder had his license suspension overturned while the TSBME continued their investigation into his situation.³ Other complaints had been left pending indefinitely. Dr. Donald Patrick, Executive Director of the TSBME, identified 40 'tough' cases whose investigations had been suspended and abandoned due to complexities.⁴

As these issues were examined, it became apparent that the problems stemmed largely from a deficiency of two key components: statutory authority and financial resources. Vague language within the Medical Practice Act limited the agency's authority and impeded licensing and malpractice hearings. Additionally, the TSBME contended it was working with limited resources. While the TSBME generated \$22 million a year in licensing fees, it was allotted \$5 million in appropriations.⁵

The goal of SB 104 (78R) was to remedy these problems and equip the Board with the tools it needed to efficiently and effectively discipline doctors. Through SB 104 (78R), the Legislature

¹ Doug J. Swanson "Review of Medical Board Urged After Actions in Doctor Sex Cases." *Dallas Morning News* (Jan. 19, 2002).

² Associated Press, "Medical Board Seen as Lenient on Sex Offenders," *San Antonio Express-News* (Jan. 7, 2002).

³ Leigh Hooper, "Doctor Still at Work After Hiring Hitman," *Houston Chronicle* (Dec. 6, 2002).

⁴ Associated Press, "Medical Board Ignores Cases," *San Antonio Express-News* (May 28, 2002).

⁵ Dallas Morning News Staff, "Radical Surgery," *Dallas Morning News* (Feb. 15, 2003).

raised physicians' registration fees.⁶ Additionally, the TSBME is now authorized to collect an \$80 surcharge for a first registration permit and the renewal of a registration permit, the funds from which are to be appropriated to the TSBME's enforcement program, including the creation of an expert physician panel.⁷

The Legislature increased its oversight of the TSBME by requiring the agency to include with its annual financial report information regarding any investigations that remained pending after one year, including the reasons the investigations had not been completed.⁸ A further report is now required each fiscal year to provide aggregate information regarding the complaints and types of complaints received by the TSBME.⁹

Additional information is also now available to the public through changes to the TSBME's physician profiles rules. The new profiles contain:

- all information regarding convictions for felonies, Class A and/or B misdemeanors involving moral turpitude (previously this information was limited to a 10 year period);
- a description of any charges reported to the TSBME to which the physician pleaded no contest, was subject to deferred adjudication or pretrial diversion, or in which the matter was continued by a court (previously this information was limited to a 10 year period);
- a description of disciplinary actions brought against the physician by the TSBME or any other state's medical board (previously this information was limited to a 10 year period); and
- a description of malpractice claims brought against the physician for which the physician was found liable, a jury awarded monetary damages to the claimant, and

⁶ Texas Senate Bill 104, 78th Legislature, regular session (2003).

⁷ *Ibid.*

⁸ *Ibid.*

⁹ *Ibid.*

the award had been determined to be final and not subject to further appeal. This information must be updated annually.

The TSBME was also instructed to add to its profiles the text of any formal complaints filed by the Board against a provider or Board order relating to the formal complaint filed against a physician; this information was to be updated not later than the 10th working day after the date the formal complaint was filed or the TSBME's order was issued.¹⁰

The complaint and investigation process used by the TSBME was also changed to improve timeliness and prioritization of certain cases. Complaints regarding sexual misconduct, quality of care, and impaired physician issues are now to be given priority. Under SB 104, the TSBME is required to write to the physician who was the subject of the complaint to explain actions taken on dismissed complaints, write to a complainant to explain why his/her complaint was dismissed, and review a physician's National Practitioner Data Bank report following reports of actions limiting the physician's privileges with any entity.¹¹

The Legislature further instructed the TSBME to create an expert physician panel to assist the agency's staff in reviewing complaints regarding medical competency. Experts from this panel now review all quality of care cases in which an initial review by a TSBME board member, staff member with a medical background, or consultant determined that sufficient complaints were made. The experts who review the file report their findings, including a statement of the applicable standard of care and the clinical basis for the experts' findings, in writing to the TSBME.¹²

¹⁰ *Ibid.*

¹¹ *Ibid.*

¹² *Ibid.*

Physicians are now required to register with the TSBME every two years instead of every year and must now include additional information in the renewal application, including an address for electronic mail when available, a primary place (instead of all places) at which the license holder is engaged in the practice of medicine, and a description of any investigations of the license holder being performed by any other states, countries, or by the United States uniformed services. The TSBME is now authorized to exempt from the registration rule retired physicians and those who only perform voluntary charity care. The expiration of registration permits is to be staggered based on a rule the TSBME was instructed to create. Physicians will receive a notice at least 30 days before the expiration of their registration permits and will face penalties ranging from \$75 to cancellation of their licenses for failure to timely renew their permits. The new law specifies that holding a permit does not entitle the permit holder to practice medicine in Texas unless the permit holder has met all relevant continuing medical education requirements and has submitted the necessary information for the physician profile.¹³

SB 104 also clarified the information an insurance company is required to provide to the TSBME. Insurance companies must report to the agency: the settlement of claims relating to the insured party's conduct in providing or failing to provide a medical or health care service and notices of filing of lawsuits, including a copy of the complaint or settlement and a copy of any expert report filed in the suit.¹⁴

SB 104 also addressed concerns regarding the lack of standardization in the disciplinary process. The TSBME was directed by the Legislature to enact by rule a schedule of sanctions to be used when imposing disciplinary action. The TSBME is to consider in making its determination

¹³ *Ibid.*

¹⁴ *Ibid.*

under the newly developed schedule of sanctions whether the person is being disciplined for multiple violations, in which case the agency may impose a more severe penalty than would be used if only one violation was at issue. The agency must also consider whether the person has previously been subject to disciplinary action by the TSBME, in which case the agency should consider a more severe action including revoking the person's license if the person has been subject to repeated disciplinary actions.¹⁵

Changes were also made to the disciplinary procedure used by the TSBME. Informal meetings are now to be scheduled not later than the 180th day after the date the complaint is filed with the TSBME, unless good cause for the delay is shown, and notice to the license holder of the meeting must be provided not later than the 30th day before the meeting is to be held. The TSBME must dismiss a complaint within 180 days if it is found to be baseless or unfounded, and a statement of the reason for the dismissal shall be placed in the records of the complaint. The TSBME must immediately investigate a violation of a disciplinary order by a license holder who is under a disciplinary order and/or a complaint filed against a license holder who is under a disciplinary order. Injunctions to delay the disciplinary process may not be granted if the license holder's continued practice presents a danger to the public, and any injunctions granted may not exceed a term of 120 days.

The TSBME is now specifically authorized:

- to discipline, refuse to admit a person to an examination, or refuse to issue a license to a person who is placed on deferred adjudication, community supervision, or deferred disposition for a felony or misdemeanor involving moral turpitude;

¹⁵ *Ibid.*

- to revoke the license of a person whose license to practice medicine in another state is revoked by the licensing authority of that state.
- include the violation of a federal law connected with the physician's practice of medicine in the definition of unprofessional or dishonorable conduct likely to deceive or defraud the public;
- suspend the license of a licensee who commits:
 - a misdemeanor involving an assaultive offense, so long as the punishment is not limited to a fine;
 - a misdemeanor on conviction of which a defendant is required to register as a sex offender;
 - a misdemeanor involving violation of a protective order or a magistrate's order relating to offenses against the family;
 - and a misdemeanor involving violation of a protective order preventing offense based on bias or prejudice relating to offenses against the family.
- and revoke the license of a physician upon a final conviction for any of the above listed crimes.

The TSBME's authority to temporarily suspend physicians' licenses in certain circumstances was expanded to allow the agency to restrict licenses. Additionally, a disciplinary panel of the TSBME is now authorized to suspend or restrict a license without notice or hearing if the TSBME immediately provides notice of the action to the license holder and a hearing is scheduled for the earliest possible date following 10 days' notice of the hearing to the license holder. If the action is affirmed by the disciplinary panel in its hearing, the TSBME shall schedule an informal compliance meeting as soon as practicable unless such a meeting is waived by the license holder or one has already been held with regard to the issues leading to the

temporary suspension or restriction. If compliance is not shown by the license holder at the informal compliance meeting, the TSBME must file a formal complaint.

The TSBME is now authorized to contact the relevant regulatory authorities if acts or omissions falling within the purview of the other authorities are discovered and to contact prosecuting and/or regulatory authorities if potential violations of the workers' compensation laws are discovered. The Workers' Compensation Commission is likewise authorized to inform the TSBME should it find any acts or omissions relevant to the TSBME in its investigations of physicians. The TSBME is also now instructed to perform a medical competency review of any physician who has had an expert report filed in three separate lawsuits within a five-year period.¹⁶

Through SB 104, the 78th Legislature enacted sweeping change to the TSBME's disciplinary process and authority in an attempt to respond to the many challenges and inadequacies found in Texas' discipline of physicians.

Implementation of SB 104 (78R)

The new surcharge for physician license renewal went into effect on January 1, 2004, and biennial renewal will begin on January 1, 2005. Funds collected from these new and increased fees are being placed in the TSBME's general revenue account and have been used to increase the TSBME's staff, to support office facility changes to accommodate additional staff members, to fund the customer outreach program, and to fund the creation and administrative expenses associated with the new expert physician panel. The new staff positions include: nine new investigator positions, four new compliance officers, and four new attorney positions. Due to the

¹⁶ *Ibid.*

TSBME's increased funding, the agency was able to hire a compliance officer to manage compliance issues relating to drug testing.¹⁷

The TSBME's litigation staff was reorganized in order to more efficiently handle cases and thereby meet the new statutory deadlines for bringing cases to a hearing and filing complaints at the State Office of Administrative Hearings (SOAH).¹⁸ Currently, the staff is assigned either to a division focused on SOAH cases or to a division focused on informal settlement conferences.¹⁹

Through the new expert panel, the TSBME was able to increase its number of available consultants on quality of care cases. This is particularly important given that approximately 70 percent of the cases that come before the agency involve allegations regarding quality of care.²⁰

The panel currently consists of more than 400 physicians in approximately 75 specialties and sub-specialties. A lead panelist initially reviews the case and will refer the case to a second panel member if he/she finds a violation. The second member reviews the file and the preliminary report of the lead panelist. If the second panel member agrees with the lead panel member, the case is referred for further action. If there is disagreement, the case is sent to a third panel member. The panel began reviewing cases in January 2004 and by June 2004 had reviewed 225 cases.²¹

The TSBME has begun the process of updating physician profile information. Due to the staggered registration system, it will be late 2005 before the additional information required is

¹⁷ Lee Anderson, President, Texas State Board of Medical Examiners, *Implementation Report to Senate Committee on Health and Human Services* (June 2, 2004).

¹⁸ *Ibid.*

¹⁹ Michele Shackelford, General Counsel, Texas State Board of Medical Examiners, Testimony to the Texas Senate Committee on Health and Human Services (Austin, Tex., June 8, 2004).

²⁰ Lee Anderson, President, Texas State Board of Medical Examiners. Testimony to the Texas Senate Committee on Health and Human Services (Austin, Tex., June 8, 2004).

²¹ Lee Anderson, President, Texas State Board of Medical Examiners, *Implementation Report to Senate Committee on Health and Human Services* (June 2, 2004).

collected from all Texas licensed physicians. The agency has also decreased the duration a case remains open under investigation. The TSBME estimates that 99 percent of cases filed since November 1, 2003 have been completed within the given timeframes.²²

The TSBME enacted a new rule setting sanction guidelines pursuant to SB 104 (78R). This rule became effective on November 30, 2003. In February 2004, members of the TSBME and District Review Committee members received training regarding the use of this new rule. Additionally, the agency's Hearings Counsel now reviews agreed orders to ensure consistent application of the scheduled sanctions.²³

Between November 1, 2003 and September 28, 2004, the TSBME, using its new authority under SB 104 (78R), imposed 16 temporary suspensions of physicians' licenses.²⁴

Immunizations

HB 1921 Background

Since 1900, the death rate in Texas has decreased over one thousand fold for vaccine-preventable illnesses due to efforts to vaccinate children at young ages.²⁵ With one thousand births a day in Texas, it is imperative that the state continue its efforts to increase vaccination rates to curb the spread of these diseases.²⁶ In order to increase efforts for immunization of all Texas children, in 1994, the Texas Department of Health created an immunization tracking system known as

²² Lee Anderson, President, Texas State Board of Medical Examiners, Testimony to the Texas Senate Committee on Health and Human Services (Austin, Tex., June 8, 2004).

²³ Lee Anderson, President, Texas State Board of Medical Examiners. *Implementation Report to Senate Committee on Health and Human Services* (June 2, 2004).

²⁴ Lee Anderson, President, Texas State Board of Medical Examiners, Testimony to the Texas Senate Committee on Health and Human Services (Austin, Tex., June 8, 2004); see also – Texas State Board of Medical Examiners. Press Releases (June 29, 2004, July 28, 2004, August 16, 2004, September 10, 2004, and September 13, 2004).

²⁵ Texas Department of Health, Testimony to the Texas Senate Committee on Health and Human Services (Austin, Tex., June 8, 2004).

²⁶ *Ibid.*

ImmTrac to be used as a centralized data collection system for the state.²⁷ The system is now administered by the Texas Department of State Health Services (DSHS) and relies on data received from health care providers to create a state-wide database of children who have been vaccinated. The ultimate goal of such a system is to increase the number of immunized children in Texas and thereby decrease the social and financial costs of vaccine-preventable illnesses, hospitalizations, and deaths.²⁸

Health care providers with access to the ImmTrac can review patients' vaccination records to ensure that an individual's immunizations are current. Providers can access information for new patients who may have been treated elsewhere, thus eliminating the potential for both over-immunization and under-immunization. On a broader scale, DSHS can use the entire database to analyze statewide immunization progress and evaluate programs aimed at increasing the number of immunized children.²⁹

The purpose of House Bill 1921 was to further the goal of a 100% immunization rate set forth by the 73rd Legislature by increasing the effectiveness of the ImmTrac program. The main objectives of the bill were to increase participation in the ImmTrac program, establish methods to ensure the privacy of ImmTrac data, and increase the utility of the data.

In order to increase participation, the Legislature simplified the opt-in method.³⁰ DSHS has been working closely with the Bureau of Vital Statistics to implement a program where parents opt into the system by signing a waiver at the time of application for a birth certificate; this program will be operational in January 2005. The information will then be forwarded to DSHS, and those

²⁷ Texas House Bill 1921, Bill Analysis, Engrossed Version, 78th Legislature, regular session (2003).

²⁸ Texas Department of Health, Testimony to the Texas Senate Committee on Health and Human Services (Austin, Tex., June 8, 2004).

²⁹ *Ibid.*

³⁰ Texas House Bill 1921, 78th Legislature., regular session (2003).

children whose parents have consented will be entered into the system. This will place the burden of ensuring that only information regarding those who have consented to be included are entered into the system on DSHS rather than on providers. In order to implement this program, DSHS is establishing methods of cross-referencing files submitted by doctors and consent records to ensure that only willing patients are participating. Starting in January 2005, providers will send all of their vaccination records to DSHS without fear of entering a patient who has not consented to inclusion in the program into the state's records. With this burden removed, providers are more likely to participate in the program.³¹ The Legislature also worked to increase participation by requiring health care payors that receive information from a health care provider regarding immunizations of people younger than 18 years of age to report this information to DSHS and by directing DSHS to provide instruction and education to providers about ImmTrac.³²

Ensuring the privacy, security, and confidentiality of the system has been a priority of the Legislature. HB 1921 strengthened the confidentiality of information in ImmTrac.³³ Multiple reviews of the system have confirmed that the database is in fact compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, security precautions have been implemented that only allow registered doctors with secure codes to access the system's information.³⁴

New programs and initiatives are being developed to optimize the utilization of the ImmTrac system to further the success of the program. In March of 2004, physicians were given the

³¹ Texas Department of Health, Testimony to the Texas Senate Committee on Health and Human Services (Austin, Tex., June 8, 2004).

³² Texas House Bill 1921, 78th Legislature., regular session (2003).

³³ *Ibid.*

³⁴ Texas Department of Health, Testimony to the Texas Senate Committee on Health and Human Services (Austin, Tex., June 8, 2004).

capability of printing off vaccination records for patients with the ability to send reminder notices to parents to update their child's immunization schedule. DSHS staff are currently visiting physicians' offices to educate them about the system and ensure that its abilities are being used to their fullest capacity. In addition, DSHS is developing the Pharmacy Inventory Control System (PICS), which would integrate with ImmTrac and would serve as a statewide inventory of vaccines in order to prevent vaccine shortages. DSHS plans to implement PICS within the next biennium.³⁵

On September 30, 2004, the Disease Prevention and Intervention Section of DSHS submitted its Annual Report on Plans to Increase Immunization Rates in Texas. In 2003, 78.1% of Texas children age 19 months through 35 months were fully vaccinated. This is a 9.5% increase over the previous year but leaves Texas ranked 41st among the 50 states. The City of Houston has one of the lowest coverage levels among urban areas in the United States, at 74.8%³⁶ DSHS noted that information obtained from the national survey is rather dated, given that information released in July 2004 actually contains levels based on children born between February 2000 and May 2002. Any increase in immunizations based on current efforts would therefore not be reflected in the survey until the 2006 survey is released in the summer of 2007. ImmTrac is therefore the best method of obtaining timely information regarding immunization efforts in Texas.³⁷

DSHS reported that areas of potential improvement include: ensuring that children statewide receive the fourth dose of the DTP/DTaP vaccine as nearly 20% of Texas children fail to receive

³⁵ *Ibid.*

³⁶ National Immunization Survey, 2003, as cited in Texas Department of State Health Services. *Annual Report on Plans to Increase Immunization Rates in Texas* (Austin, Tex., Sept. 30, 2004).

³⁷ Texas Department of State Health Services, *Annual Report on Plans to Increase Immunization Rates in Texas* (Austin, Tex., Sept. 30, 2004).

this dose in a timely manner; improve access to health care generally, particularly for medically underserved populations such as the uninsured, underinsured, and those who live in rural areas; and develop and maintain efforts to raise rates within the City of Houston, which has been consistently below the state average on vaccine coverage.³⁸

DSHS reported that best practices nationwide for increasing vaccine coverage levels include: the use of immunization registries, reminder/recall systems, provider and public education, and promoting the concept of every child having a medical home. DSHS has made the following efforts to implement these best practices in Texas: improving ImmTrac enrollment through recruitment activities funded by the Centers for Disease Control and Prevention, a marketing plan, improved customer support, and an incentive program for providers; working with the Texas Medical Foundation, which conducts quality assurance of private sector clinics enrolled in the Texas Vaccines for Children Program statewide, the Children's Health Insurance Program, and managed care contracted health plans to promote reminder/recall systems; and conducting media campaigns targeting the general population, Hispanic, and African-American media markets, working with local health departments, forming the Texas Immunization Stakeholder Working Group, and funding education and outreach services through local seniors and retired volunteers programs to increase public and provider awareness. DSHS is also working with Federally Qualified Health Centers, Community Health Centers, the Women, Infants, and Children (WIC) program, and local health departments in border counties to raise coverage levels in underserved areas. The "Raising Immunizations thru Education" (RITE) pilot project is

³⁸ *Ibid.*

being implemented in the Houston area to offer education in private provider offices regarding immunization practices.³⁹

Medicaid Integrity Pilot⁴⁰

The Texas Health and Human Services Commission (HHSC) is conducting the Medicaid Integrity Pilot (MIP), described in legislation as the Medicaid Front-End Authentication and Fraud Prevention System, to detect and prevent fraud in the Medicaid program. The program is mandated by Section 2.23 of H.B. 2292, 78th Legislature, Regular Session, 2003 and is now codified in Texas Government Code §531.1063. The program includes:

- magnetic identification cards similar to credit cards for all Medicaid clients participating in the pilot; and
- card readers and biometric readers that reside in the offices of participating Medicaid physicians, providers, emergency rooms, and outpatient clinics of hospitals that have volunteered to participate in the pilot.

The objective of the pilot is to evaluate the effectiveness of biometric and smart card technologies to eliminate Medicaid fraud related to "phantom services" (billing for services not rendered); card swapping; and delivery of services to unauthorized persons.

HHSC has contracted with an independent evaluator to assess the pilot's effectiveness in meeting its objectives. The independent evaluator will also assess the impact of pilot systems on physicians/providers and clients; effectiveness of technical solutions; and clarity and comprehensiveness of pilot communications. Participating providers and other interested stakeholders will be closely involved in the development of conclusions and recommendations.

³⁹ *Ibid.*

⁴⁰ Much of the information in this section comes from website of the Medicaid Integrity Pilot program: http://www.hhsc.state.tx.us/OIE/MIP/032004_Update.html

The Medicaid Integrity Pilot program is being conducted in six counties with four vendors responsible for the development, implementation and operation of the pilot.

- MAXIMUS for Harris and Dallas Counties
- Electronic Data Systems Corporation for Hidalgo and Cameron Counties
- eMedicalFiles, Inc. for Travis County
- Atos Origin (formerly known as Schlumberger) for Tarrant County

Under the Medicaid Integrity Pilot (MIP) program, when a patient arrives at a provider's office, the patient presents a MIP card that is read electronically and contains a digital scan of the patient's thumbprint. The digital thumbprint information is then compared to the patient's actual thumbprint, also taken electronically through the card reader. This protocol is also followed when the patient leaves the provider's office. This process will ensure that HHSC knows that the patient was at the doctor's office at the time the medical services were provided and that the patient was, in fact, enrolled in Medicaid.

Finger images will not be stored or shared with anyone. Each patient's finger image for this pilot will only be kept on the MIP card, will only be used for the purposes of the pilot program, and will not be shared with anyone. The MIP Card is only used for getting medical, dental and emergency medical services. There are no benefits on this card and it cannot be used to pay for prescriptions. If clients forget their MIP cards, medical services are still provided. For the duration of the pilot, providers have been instructed to deliver services as usual, independent of the pilot results.

During the pilot, information will be collected to support the client's presence at the point-of-service, including, date, time, and duration of service. This information will be compared with

traditional billing data received by the state. This process is expected to significantly reduce or eliminate phantom services, upcoding, and delivery of services to unauthorized persons.

The pilot schedule was amended to allow deployment of the provider sites to be implemented throughout the month of March 2004. Pilot vendors were required to have 50 sites installed and operational by March 15, 2004, with the remaining 100 per county implemented by the end of March 2004. The pilot is scheduled to end on December 31, 2004.

TANF Reauthorization

The passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 created Temporary Assistance to Needy Families (TANF), which replaced Assistance to Families with Dependent Children (AFDC). TANF imposed time limits and work requirements on welfare receipt and resulted in dramatic caseload reductions. The number of families receiving TANF benefits declined 59% between 1996 and 2002. PRWORA expired in October 2002, and therefore required reauthorization in order to continue.

In February 2002, President Bush released his vision for the future of TANF, which included expansion of the current work requirements, increasing the number of persons subject to work requirements, and funding for pre-marital counseling to encourage marriage promotion. The United States House of Representatives passed H.R. 4 in February 2003 chiefly with those goals in mind. The Senate has yet to pass a reauthorization bill, largely because of disagreements with the House's version with respect to funding levels and the extent of increases in work requirements. The program has survived through a series of extensions, the latest passed in September 2004, extending the program through March 2005.

Both bills maintain overall spending at \$16.5 billion per year through FY 2008. Both provide the same amount of supplemental grants to states with large populations and low benefits levels and the same funding for marriage and family promotion initiatives. However, they differ on funding levels for child care. While the House increases mandatory funding levels by \$1 billion over five years, the Senate increases it by \$6 billion. Both the House and Senate have fatherhood initiatives, but the House funds at \$20 million annually and the Senate at \$75 million. Both extend Transitional Medicaid Assistance (TMA), but the House requires significant reductions in administrative spending (80% reduction by FY 2008) that the Senate's version does not. The Senate instead allows states the flexibility to implement administrative changes that would likely result in reduced administrative costs. The Senate bill allows states to provide twelve months of continuous eligibility and waive reporting requirements. Additionally, the Senate version gives states the flexibility to provide an additional 12 months of eligibility with federal match (resulting in a possible 24 months of TMA), and waive the requirement that persons must have received Medicaid for three of the past six months.

Both versions encourage integration among safety net programs, but the extent of integration differs. The House allows states to receive a five-year waiver to combine two or more of the following programs: TANF, Food Stamps, Social Services Block Grant (SSBG), Title I of the Workforce Investment Act (WIA), Wagner-Peyser Act, Adult Education and Family Literacy Act, Child Care Development Block Grant (CCDBG), Housing programs (excluding Section 7 & 8), and Titles I-IV of the McKinney-Vento Homeless Act. The Senate version limits the numbers of such waivers to ten and limits the programs eligible to TANF, SSBG, and the CCDBG.

Both bills also increase work and participation requirements. Both chambers have agreed to increasing the percentage of persons under work requirements from 50% to 70%. However, the chambers differ on the number of hours per week a recipient must be engaged in work-related activities to count as participating. The House raised the number of hours of work activities required per week from 30 to 40, and eliminates reduced requirements for persons with children under age six. The Senate bill raised the 30-hour requirement by four hours and does not eliminate the exception for parents with young children.

Another major difference between the bills surrounds the extent to which participation in educational activities should count toward meeting the work requirement. Under the 1996 law, only 30% of the work requirement can be met by completing secondary education (teens) or by participating in vocational education programs. In addition, those participating in vocational education have twelve months before their attendance in such classes ceased to count. The House version limited this time span to four months every two years. However, if a person is working at least 24 hours a week, 16 hours of education could count toward meeting the work requirement.⁴¹ The Senate's version keeps the current law in place but also allows for up to 10% of the caseload to be engaged in educational activities that last longer than 12 months.⁴²

Federally Qualified Health Centers

Background

Federally Qualified Health Centers (FQHCs) provide services to medically underserved populations and communities through a combination of public and private funding. Their

⁴¹ Ron Haskins and Paul Offner, "Achieving Compromise on Welfare Reform Reauthorization," The Brookings Institution (May 2003). Online. Available: <http://www.brookings.edu/es/research/projects/wrb/publications/pb/pb25.htm> Accessed: November 30, 2004.

⁴² Shawn Fremstad and Sharon Parrott, *The Senate Finance Committee's TANF Reauthorization Bill*, Center on Budget and Policy Priorities (May 12, 2004).

mission is to "provide primary and preventive health services to underserved populations, while working within constrained resources."⁴³ FQHCs are largely associated with reducing unnecessary emergency room usage, lowering incidences of chronic disease and disability, and improving health outcomes in the communities they serve, while producing savings on State Medicaid expenditures.⁴⁴

Begun through a 1965 demonstration project, Federally Qualified Health Centers are regulated under section 330 of the Public Health Service Act.⁴⁵ In order to be designated as an FQHC, health centers must comply with program expectations governing their mission, clinical program, governance structure and management and finance practices. These centers must seek to improve the health status of populations with difficulties paying for services, language/cultural barriers, or medically underserved by health professionals/resources.⁴⁶ FQHCs provide basic health care services such as primary care, diagnostic laboratory and disease screening, and immunizations.⁴⁷ Additionally, the centers must provide patients with comprehensive health and social services, such as case management and patient outreach and education.⁴⁸ The health centers are governed by boards composed by a majority of individuals being served by them.⁴⁹ Moreover, the centers' operations must be financially viable and cost-competitive.⁵⁰

⁴³ U.S. Department of Health and Human Services, Bureau of Primary Health Care, *Health Center Program Expectations*, Policy Information Notice: 98-23. p. 2.

⁴⁴ National Conference on State Legislatures, *Community Health Centers: Serving the Nation's Most Vulnerable Populations*, State Health Notes (Washington, D.C., 2004); see also – National Association of Community Health Centers, *A Nation's Health at Risk* (2004), p. 14.

⁴⁵ Kaiser Family Foundation, Commission on Medicaid and the Uninsured *A Profile of Federally Funded Health Centers Serving a Higher Proportion of Uninsured Patients* (2002), p. 2.

⁴⁶ U.S. Department of Health and Human Services, Bureau of Primary Health Care. *Health Center Program Expectations*. Policy Information Notice: 98-23. p. 7.

⁴⁷ *Ibid.*, pp. 13 - 14.

⁴⁸ *Ibid.*, pp. 13 - 14.

⁴⁹ *Ibid.*, p. 21.

⁵⁰ *Ibid.*, p. 28.

Clinics designated as FQHCs receive funding from the US Health Resources and Services Administration (HRSA), local governments, and private foundations, in addition to reimbursements from Medicaid, Medicare, private health plans and patient fees. Clinics designated as FQHC Look-Alikes by the HSRA are eligible for favorable Medicaid and Medicare reimbursement rates but do not receive HRSA grants. Nationally, of the total funding received by community health center funding, state and local governments provide 15 percent, federal grants account for 25 percent, private insurance, patient fees and donations represent 20 percent, and 40 percent is attributable to Medicaid/Medicare reimbursements.⁵¹

The Texas Department of Health reported that, on average, FQHCs in Texas receive \$1,331,179 a year in HRSA grant funding.⁵² Moreover, the annual average Medicaid and Medicare reimbursements for a Texas FQHC is \$920,547 and \$232,218, respectively.⁵³ The average support obtained from other sources is \$1,662,000.⁵⁴ The Texas Association of Community Health Centers estimates that in 2003, FQHCs provided health care services to 527,961 patients in Texas.⁵⁵

⁵¹ National Conference on State Legislatures. *Community Health Centers: Serving the Nation's Most Vulnerable Populations*. State Health Notes (Washington, D.C., 2004).

⁵² Texas Department of Health, Written response to questions posed by members of the Senate Committee on Health and Human Services during the April 20, 2004 hearing, Received: May 17, 2004.

⁵³ *Ibid.*

⁵⁴ *Ibid.*

⁵⁵ Texas Association of Community Health Centers. Email response to questions posed by members of the Senate Committee on Health and Human Services during the May 25, 2004 hearing, Received: June 24, 2004.

Federally Qualified Health Centers, Texas
2003 Health Care Services Spending and Funding Sources

Total Amount Spent:	\$247,661,816	
Type of Funding:	2003 Funding	Percent of Total
Bureau of Primary Health Care	\$ 69,482,032	29%
Medicaid Reimbursement	\$ 66,452,778	27%
Self-Pay Charges	\$ 25,943,613	11%
State/Local Indigent Care Programs	\$ 17,337,917	7%
Medicare Reimbursement	\$ 12,251,310	5%
State Government Grants or Contracts	\$ 11,406,866	5%
Foundation/Private Grants or Contracts	\$ 11,082,460	5%
Other Public Insurance	\$ 7,670,038	3%
Local Government Grants or Contracts	\$ 6,099,357	3%
Other Federal Grants	\$ 4,894,591	2%
Private Insurance	\$ 4,865,333	2%
Other Revenue	\$ 4,293,114	2%
	Total \$ 241,779,409	100%

Source: Texas Association of Community Health Centers

President's Health Care Expansion Initiative for FQHCs

In 2001, President Bush unveiled a \$2.2 billion dollar Health Care Expansion Initiative, which seeks to increase the number of health centers in the nation by 1,200.⁵⁶ The five-year program would double the number of patients served through health centers by 2006 to an estimated 6.1 million patients.⁵⁷ On average, the nation has experienced an average 6 percent decline in the number of state residents categorized as medically underserved⁵⁸ since the start of the health center expansion under the President's Initiative.⁵⁹ Reductions of medically underserved has been slower in Southern states averaging below 5 percent.⁶⁰

⁵⁶ National Conference on State Legislatures, *Community Health Centers: Serving the Nation's Most Vulnerable Populations*. State Health Notes (Washington, D.C., 2004).

⁵⁷ *Ibid*; see also – National Association of Community Health Centers, *A Nation's Health at Risk II* (2004), p. 24.

⁵⁸ Defined by the National Association of Community Health Centers as persons without access to a regular source of primary health care.

⁵⁹ National Association of Community Health Centers. *A Nation's Health at Risk* (2004), p. 10.

⁶⁰ *Ibid*.

The President's Initiative seeks to increase the number of health centers by creating new access points "for the provision of comprehensive primary and preventive health care services" in areas of high need.⁶¹ The initiative also allows for the expansion of current FQHCs through the creation of satellite facilities. Although President Bush has requested an increase in \$219 million for health centers in his fiscal year 2005 budget request, the health center expansion initiative is currently slated to terminate in federal fiscal year 2006.⁶²

Nationally, during fiscal years 2002 and 2003, organizations submitted 1,278 New Access Point and Expanded Medical Capacity applications for grant consideration.⁶³ Of these, the Bureau of Primary Health Care funded 490 applicants increasing the number of persons served nationally by FQHCs by 2.4 million people.⁶⁴

FQHC Incubator Grant Program

Senate Bill 610, 78th (R) Legislature

During the 78th (R) Legislature, the passage of Senate Bill 610 authorized the Texas Department of Health to make grants to establish new or expand existing facilities that can qualify as federally qualified health centers.⁶⁵ The goal of this bill was to increase health care access to medically underserved counties and populations throughout the state. Specifically, most of Texas' 196 rural counties are "classified as medically underserved or have an insufficient number of health care professionals."⁶⁶ Additionally, in urban areas there are fewer providers willing to

⁶¹ U.S. Department of Health and Human Services, Bureau of Primary Health Care, *Requirements of Fiscal Year 2004 Funding Opportunity for Health Center New Access Point Grant Applications*, Program Information Notice, PIN# 2004-02. Online. Available: <http://www.bphc.hrsa.gov/pinpals>. Accessed: October 25, 2004.

⁶² National Association of Community Health Centers, *Summary Report on Status of Select Health Policy Issues*, (2004).

⁶³ *Ibid.*, p. 1.

⁶⁴ *Ibid.*

⁶⁵ Texas Senate Bill 610, 78th Legislature, regular session (2003).

⁶⁶ Texas Senate, Senate Research Center, *Highlights of the 78th Texas Legislature, Regular Session*. Page 137.

treat the poor and uninsured, in conjunction with hospital emergency rooms having difficulties providing adequate care to these populations.⁶⁷

Senate Bill 610 authorizes the Department to make planning, development, capital improvement, and transitional operating support grants.⁶⁸ These grants are used by organizations as they prepare to apply or meet the requirements for federal funding under the President's Initiative. Under the legislation, the Department's grant authorization expires September 1, 2009.⁶⁹ The Legislature appropriated \$10 million for the 2004 - 2005 biennium to implement the FQHC Incubator Program authorized under SB 610.⁷⁰

Implementation of Senate Bill 610, 78th (R) Legislature

The Texas Primary Care Office (TPCO) within the Department of State Health Services is responsible for administering FQHC Incubator Program grants and providing technical assistance to organizations seeking to secure FQHC or FQHC Look-Alike status. Applicants for funding enter into contracts with the Department for one of four types of available grants.

- Planning grants assist organizations to develop components of their FQHC applications, feasibility studies and technical assistance activities.
- Development grants help build organizational and collaborative capacities required of FQHCs, training, some staff support and grant application development.
- Transitional Operating Support grants provide resources to operationalize community-based clinics.
- Capital Improvement grants provide resources to increase the infrastructure of FQHCs and FQHC Look-Alikes.

⁶⁷ *Ibid.*

⁶⁸ Texas Senate Bill 610, 78th Legislature, regular session (2003).

⁶⁹ *Ibid.*

⁷⁰ Texas Department of Health. *Federally Qualified Incubator Grant Program*. April 16, 2004.

In Fiscal Year 2004, the Department awarded \$4.8 million in grants to 40 entities. During the first cycle of grant awards in FY 2005, the Department awarded an additional \$2.8 million in grants to 26 entities. Of the \$10 million appropriated by the Legislature for the FQHC incubator program, the Department has an additional \$2.4 million available in funds for the second cycle of grant awards in FY 2005. The Department has awarded a total \$100,000 in planning grants, \$1,093,865 in development grants, \$4,809,939 in transitional operating support grants, and \$1,623,564 in capital improvement grants.⁷¹

The Department's goal is to assist 17 organizations in receiving new or additional federal funds as an FQHC or FQHC Look-Alike, such as New Access Point grants.⁷² If the Department meets its funding goal, the 17 organizations could receive a total of \$30.6 million over three years in New Access Point grants.⁷³ Additionally, these 17 organizations would obtain \$22,630,043 per year based on average HRSA grant funding to Texas FQHCS, in addition to an average \$21,144,005 per year in Medicaid and Medicare reimbursements.⁷⁴

As of May 2004, Texas has received 15 New Access Point grants under the President's Initiative.⁷⁵ Seven of the grants established new FQHCs and the remaining 8 grants provided new funding to existing centers for clinic expansion.⁷⁶ Additionally, 33 existing FQHCs in

⁷¹ Texas Department of Health, Written response to questions posed by staff of the Senate Committee on Health and Human Services, Received: November 2, 2004.

⁷² Texas Department of Health, Written response to questions posed by member of the Senate Committee on Health and Human Services during the April 20, 2004 Hearing, Received: May 17, 2004.

⁷³ *Ibid.*

⁷⁴ *Ibid.*

⁷⁵ *Ibid.*

⁷⁶ *Ibid.*

Texas have received \$7,926,132 in grant funding under the President's Initiative for expanded services such as mental and/or dental health services.⁷⁷

The Medicare Prescription Drug Act⁷⁸

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), was signed into law by the President on December 8, 2003. The MMA creates a new prescription drug benefit for seniors as Part D of Medicare. Beginning in June 2004, and ending in January 2006, Medicare beneficiaries will have access to Medicare-approved drug discount cards, estimated to produce an overall savings of five to 10 percent. No minimum discount is required under the MMA, and enrollees can sign up for only one drug discount card per year.

Starting in January 2006, Medicare will pay for outpatient prescription drugs through private plans. The MMA authorizes beneficiaries to remain in the traditional fee-for-service program and enroll separately in private prescription drug plans (PDPs), or enroll in integrated Medicare Advantage (MA) plans for all Medicare-covered benefits, including prescription drugs. The voluntary drug benefit under Medicare Part D will be delivered through private risk-bearing entities under contract with the U.S. Department of Health and Human Services (DHHS). However, Medicare will not pay directly for drugs provided to enrollees. Instead, private entities are expected to deliver Part D benefits and will be paid partly on the basis of their expected costs and partly on their actual costs. Under the MMA, Medicare will contract with providers for contingency plans to serve beneficiaries in areas that do not have at least two or more risk-

⁷⁷ *Ibid.*

⁷⁸ This chapter is an excerpt from a research study published by the Texas Senate Research Center. The full report on *Medicare Reform - The Medicare Prescription Drug Act and Older Texans* can be found at <http://www.senate.state.tx.us/SRC/Pub.htm>

bearing plans available. The MMA authorizes government plans to serve areas with insufficient plan choices and provides subsidies to sponsors of retiree plans that provide qualified drug coverage for their Part D eligible enrollees.

Under the standard benefit, beneficiaries in 2006 will:

- Pay the first \$250 in drug costs (deductible);
- Pay 25 percent of total drug costs between \$250 and \$2,250;
- Pay 100 percent of total drug costs between \$2,250 and \$5,100, equivalent to \$3,600 out-of-pocket;
- Pay the greater of \$2 for generics, \$5 for brand drugs, or 5 percent coinsurance after reaching the \$3,600 out-of-pocket limit (\$5,100 catastrophic threshold).

Beneficiaries will pay an estimated \$25-\$40 per month premium for basic drug coverage in 2006 although premiums may vary among plans, in addition to the Medicare Part B premium. Plans are authorized to offer supplemental benefits for an additional premium. Because deductibles, benefit limits, and catastrophic thresholds are indexed to rise with the growth in per capita Part D spending, the benefit gap is projected to increase from \$2,850 in 2006 to \$5,066 in 2013.

Plans are required to cover drugs in each therapeutic class or category, but they are authorized to establish preferred drug lists, create preferred provider pharmacy networks, and offer reduced beneficiary cost-sharing for drugs dispensed by such pharmacies. The MMA also permits plans to offer an actuarially equivalent alternative benefit design provided the alternative plan does not increase the Part D deductible or out-of-pocket limit.

Additional assistance will be available to Medicare beneficiaries who qualify based on low incomes and limited assets. Low-income beneficiaries will have to meet both an income and an asset test to receive assistance for the first time in Medicare. The Congressional Budget Office

(CBO) estimates that 14 million beneficiaries will be eligible for such assistance; however, an estimated 1.8 million beneficiaries are projected to be ineligible based on the assets test requirement.

In 2006, beneficiaries who are eligible for full Medicaid benefits - an estimated 6.3 million dual eligibles (Medicare beneficiaries who also qualify for Medicaid because they are impoverished and/or have extensive health care needs) nationally - will begin to receive drug benefits under Medicare rather than Medicaid. The dual eligibles will pay no premiums, deductibles, or drug costs above the out-of-pocket threshold. Below the threshold, those with incomes under 100 percent of FPL will pay \$1 to \$3 copayments; those above 100 percent of FPL will pay \$2 to \$5 copayments.

Beneficiaries with incomes below 135 percent of FPL and with assets under \$6,000 per individual or \$9,000 per couple - an estimated 5.8 million beneficiaries - will receive a premium subsidy for basic coverage in their region. They will pay \$2 to \$5 copayments with no deductible and no cost-sharing above the out-of-pocket threshold. Those with incomes below 150 of the FPL and assets under \$10,000 per person or \$20,000 per couple - an estimated 1.9 million people - will receive premium subsidies on a sliding scale. These beneficiaries will pay a \$50 deductible, 15 percent coinsurance up to the out-of-pocket threshold, and \$2 to \$5 copayments above the threshold.

Medicaid, which provides supplemental coverage for certain Medicare beneficiaries, will no longer offer drug coverage to dual eligibles; they will have to enroll in Part D plans for prescription drug benefits. The MMA requires states to pay Medicare a portion of the aggregate amount the states would have spent on prescription drugs for dual eligibles, resulting in an \$88.5

billion "clawback" between 2006 and 2013. States are required to use only state dollars, not federal Medicaid matching funds, to assist beneficiaries with cost-sharing or to cover drugs that are not on a Part D plan's formulary. State Pharmaceutical Assistance Programs (SPAP) are authorized to supplement Part D coverage. The MMA also establishes a demonstration for a Medicare competitive government contribution system (Comparative Cost Adjustment Program) scheduled to begin in 2010 that includes traditional Medicare.

Impact on State Expenditures

The elimination of Medicaid-financed prescription drug coverage for dual eligibles will reduce state Medicaid spending by an estimated \$115 billion between federal fiscal year (FFY) 2004 and FFY 2013 according to the CBO. However, this savings amount will be significantly reduced due to the mandatory clawback payments, growth in Medicaid enrollment, and new administrative responsibilities. The CBO projects that net fiscal relief to state Medicaid programs over the next ten years is expected to total \$17.2 billion, nearly 80 percent of which is expected to occur between 2010 and 2013. In the short-term, the CBO estimates suggest that the new law will actually increase state Medicaid spending resulting in state spending exceeding fiscal relief under the MMA by \$1.2 billion.

States will be required to make a payment to the federal government each month equal to the product of:

- a clawback factor, which is set at 90 percent for 2006 and phased down to 75 percent for 2015 and later years;
- the number of dual eligibles enrolled in full Medicaid coverage in that month; and

- a per capita amount approximating the amount a state would have spent each month on Medicaid prescription drugs per full dual eligible in the absence of the Medicare bill.

The per capita amount would be based on a state's per capita Medicaid spending on Part D covered prescription drugs for full dual eligibles in 2003, trended forward through 2006 by the growth in national per capita prescription drug expenditures and in 2007 and later years by per capita growth in Part D spending.

States can reduce the amount of their clawback payment in any given year by reducing the number of optional categories of dual eligibles they cover, but they must still make payments based on the number of beneficiaries in the full dual eligible categories.

Currently states make "buy-in" payments for dual eligibles under Medicare that ensure that dual eligibles remain enrolled in Medicare Part B so that when Medicare and Medicaid cover the same service, such as a physician visit, Medicare pays first. These payments which are set at 25 percent of the costs of the Part B program differ fundamentally from the clawback which has no effect on a Medicaid beneficiary's enrollment in Medicare generally or Medicare Part D in particular and are determined by factors other than the growth in Medicare spending.

The clawback payments will be part of the Medicare Part D baseline for federal budget purposes so that if Medicare Part D expenditures are higher than projected, Congress could increase state clawback payments. State clawback payments are also a dedicated Medicare financing source for purposes of the annual Medicare Funding Warning, which provides for expedited consideration of legislation in the event general revenue funding for Medicare exceeds 45

percent of program outlays. Again, Congress could increase state clawback payments to recover any shortfall.

In addition to the clawback provisions, the MMA added new administrative responsibilities for states relating to Medicare's low-income subsidy program. State Medicaid agencies and Social Security offices are required to accept and evaluate the applications of Medicare beneficiaries seeking assistance under Medicare's Part D low-income subsidy program. States likely will incur new Medicaid administrative expenses associated with staffing and with modifying their computer systems to accommodate these responsibilities. The Federal government will reimburse States for administrative costs at the regular Medicaid matching rate for administrative expenses.

The number of dual eligibles who enroll in the new Medicare Part D benefit will also affect the states' costs. In 2006, state maintenance-of-effort payments are expected to increase by an average of \$1,260 for each dual eligible who enrolls in Medicare Part D coverage. Since these payments are determined in part on the number of dual eligibles who enroll in Part D coverage, some believe that the clawback provision creates a disincentive for states to expand the size of their dual eligible populations with Part D benefits in order to reduce these payments thus leading to a deterioration in coverage.

States with comprehensive Medicaid prescription drug benefits also may fare less well than states with more limited coverage because they will face larger maintenance-of-effort payments to the federal government due to their per capita expenditures on prescription drugs for dual eligibles in 2003, the base year.

Grants to states to educate their enrollees about the new benefit are anticipated. States with qualifying SPAP are authorized to use these funds to establish call center support and counseling for those eligible for the new benefit to help them select and enroll in a drug plan. SPAP may, at state option, provide supplemental drug coverage to Part D enrollees by purchasing extra benefits from a Part D drug plan or providing a supplemental benefit program. SPAP payments on behalf of enrollees count toward the Part D out-of-pocket threshold. The state must also offer an "opt-out" and an opportunity for enrollees to choose an alternate plan if one is available. Thirty-one states currently have statutory authority for a SPAP; eight states, including Texas, have not yet enacted their programs due to budgetary constraints.

Texas' Role in the Administration of the Medicare Modernization Act of 2003

Beginning in June 2004, the Medicare Prescription Drug Discount Card Program will enable Medicare beneficiaries to save on their prescription drugs. Currently, there are 2,392,000 Medicare beneficiaries in Texas, 592,000 who have no prescription drug coverage. CMS estimates that 497,000 beneficiaries in Texas are currently eligible to participate in the Transitional Assistance Program, and that some 323,000 in Texas will actually participate. Based on this assumption, these beneficiaries are expected to save a total of \$388 million in Texas over the duration of the program.

Medicare assumes financial responsibility for drug coverage for the Medicaid full dual eligible population in January 2006, at which time Texas must discontinue Medicaid drug coverage for this population. After December 2005, there will be no federal Medicaid funding for Part D-covered drugs for full dual eligibles. This population will be automatically enrolled in a selected plan if they do not choose a Part D plan. Texas' projected Medicare-eligible population in 2006

is 2,478,000, of whom an estimated 311,562 are currently full dual eligible clients and 153,540 non-full dual eligible clients.

Texas, like other states, will be required to make monthly payments to Medicare. The maintenance of effort (MOE) payments or clawback payments are the monthly payments to the federal government based on an estimate of what the state would have paid for pharmacy benefits. The clawback factor will be 90 percent in 2006 and will be gradually phased down to 75 percent by 2015.

The state's role in the Medicare Part D program is largely administrative; however, there are significant policy implications. Texas will be responsible for converting dual eligible clients from Medicaid to Medicare drug coverage in 2006 and making the required monthly MOE payments. With respect to the Part D low-income subsidy, again effective in 2006, Texas will be responsible for determining eligibility for the low income subsidy for Medicare drug benefit with a 50 percent federal match.

States are required to check low-income subsidy applicants for Medicaid eligibility, which may increase the Texas Medicaid-eligible aged and disabled. If an applicant is determined to be eligible, the state must enroll the individual in the state Medicaid program.

In addition to the potential caseload growth in Medicaid, Texas will face a number of budget issues related to the Medicare Part D benefit. Although the federal government will be responsible for the actual enrollment of beneficiaries, Texas likely will face significant automation costs related to eligibility determination given the complex eligibility criteria and process required under the MMA and staffing costs related to both eligibility determinations and appeals arising from such. The application process for the Medicare low-income subsidy must

work with Texas' Medicaid eligibility system (TIERS). Texas could also incur higher costs related to institutional care if changes in pharmaceutical utilization result in health complications.

Although the prescription drug provisions of the MMA were projected to save the state between \$647 million to \$1.3 billion over 10 years, these savings will be offset by new costs associated with eligibility determination and associated caseload growth. According the Health and Human Services Commission, savings are likely to occur in future years, when the clawback factor declines and the state's MOE payment will be reduced accordingly. Cost and savings estimates were developed by HHSC and included in its 2006-2007 legislative appropriation request.

Recommendations

- 1. Instruct the TSBME to provide an updated report regarding the timeliness of completing their investigations and prosecutions, including a review of cases filed prior to November 1, 2003 as well as those filed on or after November 1, 2003.**

Rationale: In testimony given by the manager of the TSBME's investigations unit on June 8, 2004, the Senate Health and Human Services Committee was informed that there were seven cases still open that were filed during or prior to FY 2003 and 200 cases remained open of those filed between the beginning of FY 2004 (which began on September 1, 2003) and the November 1, 2003 implementation of SB 104's deadlines. Determining the timeliness of responding to these earlier complaints as well as the level of compliance with SB 104's timeliness provision will allow a better review of any potential changes needed to further improve this process.

2. Consider the imposition of a penalty on insurance companies that do not comply with the provisions regarding reporting the filing and settling of lawsuits with the TSBME.

Rationale: The TSBME's staff expressed concern during the June 8, 2004 hearings that its lack of jurisdiction over insurers and therefore its inability to discipline them for failure to report lawsuit filings in a timely manner lead to inadequate reporting.

3. Support continued funding of the FQHC Incubator Grant Program to coincide with the President's Initiative for FQHC Expansion.

Rationale: The Department of State Health Services (DSHS) in its Legislative Appropriations Request is seeking additional funding for the Incubator Grant Program to coincide with the President's Initiative for FQHC Expansion. Currently, funding for the Incubator Grant Program will not go beyond August 2005, while the President's Health Care Expansion Initiative continues for an additional year. The Department's request is for \$10 million in additional grant funds and \$150,000 in funding for technical assistance provided by Department staff to grantees. DSHS estimates this funding level would allow them to assist 17 entities become either Federally Qualified Health Centers or FQHC-Look-Alikes.

Charge 5: Health Care Information Technology

Study and make recommendations on increasing electronic transactions in health care. Review the use and make recommendations on improving technology in health care administration, including expediting pre-authorizations and increasing the efficiency of claims processing so that medical providers are paid once procedures are pre-authorized and performed, and administrative costs lowered, benefiting both the consumer and the managed health care organizations.

Background

This report describes ways that information technology is currently being used and could be used in the future to achieve both lower costs and better outcomes throughout the health care system. Of particular interest is the possibility that the use of electronic transactions for transmitting information between health care providers and health insurance carriers could be increased in order to help contain administrative and overall health care costs. In addition to benefits for the private-sector elements of the health care industry, the adoption and promotion of electronic transactions may contribute to lower costs to the state via efficiencies in the provision of public health care services such as Medicaid and CHIP. Other applications of information technology within the realm of health care administration, such as the use of electronic medical records, computerized order entry, or computer-aided decision support, may also be able to contribute to more effective and efficient delivery of health care services.

Elements of the Health Care System

Each element of the health care system is extremely specialized, causing different information technology solutions to be applicable to each. Although many different taxonomies are possible, a couple of important distinctions will break the health care system down into four primary categories, each of which could be well served by a different set of information technology recommendations.

Clinical Care and Health Care Administration

The health care system can be roughly divided into clinical care and health care administration components. The clinical care component is made up of individuals, processes, and equipment that are used to directly provide health care to patients. Everything else associated with the health care profession, including administrative staff and health insurance comprise the administration component of the health care system. The division between clinical care and administration is somewhat artificial and it is difficult to place some elements of the health care system definitively in one category or the other. Nonetheless, it remains a useful division due to the differential application of technology along this spectrum.

Public and Private

Another useful distinction when analyzing the health care system is between the public and private elements of the health care system. The public elements of health care administration include Medicaid, Medicare, CHIP, and other public programs that pay for the provision of health care. The public elements of clinical care include public clinics, county hospitals, and school nurses. The private sector of health care administration includes private health insurance

providers, doctors' offices, and hospital administration while doctors, nurses, hospitals, specialists, and lab techs are among the players in the private sector of clinical care.

When added to the division between health care administration and clinical care, the distinction between the public and private sectors of the health care system makes it clear just how closely these different elements interrelate. A doctor with his own practice may accept payment from both private insurance carriers and Medicaid while also providing some charity work. Likewise, a hospital will almost inevitably accept payment from both public and private insurers while providing a certain amount of free health care, at the very least through the provision of emergency services.

Clearly, the components of the health care system as described here are very interconnected and the borders between them are somewhat ambiguous. Nonetheless, they are distinct enough that each sector has either specialized information needs or demands a particular class of policies in order to affect change. In addition to varying by sector, the particular information technology solutions that might contribute to increased efficiency or effectiveness in the health care system are heavily affected by state and federal laws.

Legislative Environment

Federal

The primary federal law regulating the ways in which information is gathered and transferred in the health care system is the Health Insurance Portability and Accountability Act of 1996 (HIPAA).¹ The statutory requirements contained in HIPAA that affect health care information

¹ Health Insurance Portability And Accountability Act Of 1996, 104th Congress. Public Law 104-191, Aug. 21, 1996.

fall into three broad categories -- transaction standards, privacy standards, and security standards. With respect to information technology and health care administration, the transaction standards are the most important part of HIPAA because they are designed to standardize the information exchanges that occur between health care providers and health insurance carriers.

HIPAA directed the U.S. Department of Health and Human Services (DHHS) to develop detailed rules governing the different types of transactions that can be sent between providers and carriers. These rules specify exactly which data elements must be present in a health insurance claim and what the responsibilities are for both the provider and the carrier. The HIPAA rules are especially designed to promote the use of electronic claims processing and to standardize the formats used for electronic exchange of claims data. Currently, not all of the rules associated with HIPAA have been finalized. Even those rules that have been finalized are not yet being fully enforced.

State

The primary Texas state law driving changes to the way data is exchanged in the health care system is Senate Bill 418 from the 78th Regular Legislative Session. Also known as the "Prompt-Pay" bill, SB 418 was intended to address providers' concerns that carriers were not paying legitimate insurance claims within a reasonable amount of time and insurers' concerns that claims were not filed properly or in a standard format. Among its implications with respect to information exchange, SB 418 defined the data elements that would comprise a 'clean claim' and required that clean claims filed electronically must be paid within 30 days as opposed to 45 days for non-electronic claims. SB 418 also created the Technical Advisory Committee on Claims Processing (TACCP) which served as an advisory board to the Texas Department of

Insurance (TDI) during the development of rules associated with SB 418 and continues to serve as a forum for issues involving clean claims, prompt payment, and claims processing.

In addition to providing differential billing deadlines for electronic versus non-electronic claims, SB 418 defined verification and pre-authorization procedures to help ensure that providers would be paid for services rendered. Pre-authorization is the process through which a carrier agrees to the medical necessity of a specific procedure for a particular patient. Once a procedure is pre-authorized, the carrier cannot refuse payment based on medical necessity. Some providers are utilizing electronic pre-authorizations although they probably are not yet HIPAA compliant. As providers become HIPAA compliant, the use of electronic pre-authorizations should increase.

To give providers greater assurance that they will receive payment for services and procedures on the pre-authorization list, SB 418 also defined a verification process whereby a provider could request that a carrier verify that it would pay for a procedure. If a carrier provides verification, it is obligated to render payment. Providers contend that the verification procedure is not yet utilized very much due to the complexity of the process.² During the second quarter of 2004, of the 3.5 million claims submitted subject to SB 418, only about 10,000 requests for verification (0.3%) were made.³ Currently, all verifications are done by phone.

Clearly, HIPAA and SB 418 deal with some of the same issues since they are both designed to standardize and promote the use of electronic transactions for processing health insurance claims. In order to avoid conflicting with HIPAA, SB 418 mandates that carriers may not require providers to include more information in electronic transactions than is required by the

² Texas Medical Association. Personal Correspondence from Darren Whitehurst, TMA Public Affairs Director. August 25, 2004.

³ Texas Department of Insurance. Report on the Activities of the Technical Advisory Committee on Claims Processing. September 2004. pp. 15-16.

HIPAA transaction standards. Thus, many providers and carriers are implementing systems allowing them to file and receive claims electronically, despite the fact that the HIPAA rules have not all been finalized.

Applications of Information Technology to the Health Care System

Electronic Transactions

In the context of the health care system, the term 'electronic transactions' generally refers to the exchanges of information between a provider and a carrier including, but not limited to, pre-authorizations, enrollment inquiries, benefits eligibility inquiries, verifications, and claims.

Since electronic claims are easier and faster to process, carriers should be able to make payments more quickly, which would benefit providers. Carriers should also be able to process claims more efficiently, potentially lowering their overhead. Given the potential benefits to both sides, it may seem strange that electronic transactions have not become more widespread in the absence of legislation. Lacking a clear standard, however, the electronic interchange of claims information was unlikely to become universal.

Currently, many providers and carriers use the services of intermediate entities, known as clearinghouses, to transmit their claims and often to convert their claims into the format required by each health plan. Since a provider may have contracts with multiple insurance companies that each have different procedures and requirements with respect to the filing of claims, the provider may find it easier to contract with a single clearinghouse that will receive all of the provider's claims in the format preferred by the provider and then convert each claim into the format required by the particular carrier. With the standardized data interchange formats made possible by HIPAA, at least part of the traditional role of the clearinghouses will be removed. They may

remain a strong presence, however, if providers choose not to gain the expertise internally in order to become HIPAA compliant or if the DHHS continue to delay enforcement of HIPAA requirements.

According to the Texas Association of Health Plans (TAHP), all of the major health plans and about 70% of providers in Texas are currently capable of sending and receiving electronic claims' information. A recent report by the TACCP reports that 72% of claims processed in the first half of 2004 were electronic. The Texas Medicaid Healthcare Partnership (TMHP), the consortium holding the contract for Medicaid claims processing for Texas, receives about 80% of its claims electronically and about 99% of its claims through the Vendor Drug Program electronically. More than 80% of all Medicare claims are filed electronically.

Electronic claim filing is faster and less expensive than paper filing. When a claim is received electronically and is a clean claim, it is generally paid in 10 to 12 days. According to BlueCross/BlueShield of Texas, it costs about \$2.40 to process a paper claim and about \$0.30 to process an electronic claim. Based on the BC/BS processing costs and a statewide, non-electronic claim volume of just over 2 million claims for the first half of 2004 according to the TACCP, conversion of all non-electronic claims to electronic claims would result in annual cost-savings to the industry of more than \$8.5 million.^{4,5} Although all major carriers are able to receive claims electronically and the majority of providers are able to file claims electronically, some providers have been slow in converting to electronic filing.

⁴ Texas Department of Insurance. Report on the Activities of the Technical Advisory Committee on Claims Processing. September 2004. Report. p.15.

⁵ The figure of 2 million claims for the first half of 2004 is based on the volume of claims subject to prompt-pay requirements (i.e. clean claims) reported by HMOs and PPOs to TDI. This number may overstate the number of clean claims because some carriers do not distinguish between clean and deficient claims, preferring to pay all claims within the prompt-pay timelines. This number understates the total number of claims because it does not include claims by indemnity plans or self-funded ERISA plans.

In order to encourage the remaining providers and carriers to utilize electronic transactions before the HIPAA transaction standards are enforced, the Legislature could either continue along its current course by making it even more attractive to file claims electronically or require all claims to be filed electronically. The approach of SB 418 was to require payment of electronic claims in a shorter timeframe (30 days) than non-electronic claims (45 days). This approach could be expanded by increasing the difference in required payment timeframe between electronic and non-electronic claims. Alternatively, carriers could be permitted to pay non-electronic claims at a lower rate than electronic claims or assess a processing fee against non-electronic claims. The most effective method for increasing electronic claims would be to require that all claims be filed electronically by some date sufficiently far in the future. Given a sufficiently long timeline for preparation and waiver provisions to allow small and rural providers to continue filing paper claims, there is no reason to believe that any negative effects are inevitable or even likely.

Electronic Medical Records

One of the most popular theoretical applications of information technology to the health care system is the electronic medical record (EMR). Since computers became a fixture in every office, talk has swirled around the world of health care administration that electronic medical records will bring it into the 21st century. Nonetheless, the potential of the electronic medical record is still far from being realized.

In one form, the use of electronic medical records on a small scale is very widespread. As it has become clear that providers' offices and hospitals can recognize significant savings on administrative overhead by shifting to a system of paperless medical records, many of them have

done so. The real potential of electronic medical records, however, lies in the possibility that an individual's medical record could exist in a single location and be accessible to many providers. Part of the problem with the current system of paper medical records, and even a problem with most proprietary electronic medical record systems currently in place is that the medical record resides in a single office and can only be accessed by providers in other offices after very proactive steps are taken by the patient.

For optimal care, a patient's medical record should be accessible to any provider whenever and wherever care is provided so as to ensure the best health outcomes and greatest continuity of care. Currently, if a patient fails to transfer his or her medical records from one provider to another, the new provider must rely on the patient's memory for potentially important information -- drug allergies, for example. With a system of interoperable, electronic medical records, if an individual arrives in a physician's office or emergency room, the physician would immediately be able to access information about the patient's medical history and would not have to rely solely on the symptoms for a diagnosis.

The full benefit of electronic medical records can only be realized if there is a universal standard for the maintenance and transmission of EMRs. A similar situation motivated the development of transaction standards under HIPAA. Also, like electronic transactions before HIPAA, EMRs are currently being utilized in many circumstances, mostly proprietary, with inefficiencies created by the lack of interoperability between the different systems. Therefore, to promote the use of a common format for EMRs throughout the country, the Bush administration recently unveiled a plan to establish national standards for EMRs within a decade.

Clearly, however, there are some privacy issues surrounding the widespread use of EMRs since a patient's medical history could potentially be transferred to any medical provider. The possibility that medical records could become compromised would increase as the number of people with access to them increases. Although it may be difficult to implement a system of electronic medical records that can be accessed by any physician and yet remain compliant with the privacy and security provisions of HIPAA, the first steps toward realizing that goal are a standardized format and common interchange protocol.

Information Technology in Public Aid Programs

There are several major projects under way to automate the eligibility determination processes and provision of benefits associated with many of the health-related aid programs administered by the state. The Texas Health and Human Services Commission (HHSC) is overseeing the development of the Texas Integrated Eligibility Redesign System (TIERS) to streamline and consolidate the process of determining eligibility and enrolling beneficiaries for numerous state and federal aid programs, including Medicaid and CHIP. This computerized eligibility determination and enrollment system should allow the state to focus more money on direct provision of medical services rather than administrative overhead, thereby making state-funded health care more cost-effective. (A more complete description of the TIERS project is included in the charge 2 report.)

In addition to electronic eligibility determination, the Texas health and human services agencies have been converting many of their benefits programs to utilize electronic benefits transfers (EBT) and electronic identification. Currently, beneficiaries of food stamps and direct cash assistance, federal programs administered by the state, receive their benefits via the Lone Star

Card, which operates like a debit card. For enrollment verification and fraud prevention in the Medicaid program, HHSC has recently begun a pilot program to use biometric identification data embedded on "smart" cards. (A more complete description of the Medicaid fraud-reduction pilot program is included in the charge 4 report.) By reducing administrative overhead and ensuring that only enrolled beneficiaries receive benefits, these two card-based programs shift funding to direct provision of services. Although different in intent, these programs could be merged together along with additional state funded or administered benefit programs for further efficiencies and greater cost-effectiveness.

Other IT Solutions for the Health Care System

Computerized Physician Order Entry

The Institute of Medicine estimates that 98,000 Americans die each year from medical errors, 7,000 of which die from medication errors.⁶ Medication errors are among the most common preventable medical errors and include mistakes about the patient, drug, dosage, and frequency, all often the result of transcription or other communication errors. Computerized physician order entry (CPOE) systems allow doctors or other providers to directly input an order (generally a prescription) into a computer or other electronic device rather than writing it down on paper and having it transcribed. This process reduces the possibility that errors in medication will occur, especially in hospital settings and could powerfully augment new FDA rules requiring standardized barcodes on pharmaceuticals administered in a hospital setting.⁷

⁶ Institute of Medicine. *To Err is Human: Building a Safer Health System*. National Academies Press. Washington D.C. 2000. pp. 26-27.

⁷ Bar Code Label Requirements for Human Drug Products and Biological Products; Final Rule. Federal Register, Vol. 69, No. 38. February 26, 2004. pp. 9120-9171.

Clinical Decision Support

In addition to a high level of medical errors, inadequate provision of care due to slow diffusion of knowledge is another common problem in the health care system. Although the medical community places a strong emphasis on continuing education, some physicians find it challenging to stay abreast of the latest developments in their fields. One study estimated that it takes 17 years for evidence-based practices to be integrated into clinical practice.⁸ Clinical decision support systems are computerized databases of medical information that assist doctors by providing context-sensitive suggestions regarding clinical care. Although some doctors may be hesitant to utilize such systems, research has shown that physicians who receive electronic clinical reminders are more likely to provide treatment based on the latest medical evidence than those who do not receive electronic reminders.⁹

Telemedicine and Telehealth

Although primarily an advance in clinical care rather than health care administration, telemedicine can lower costs, increase patient access, and improve patient outcomes by allowing underserved communities (primarily rural) to take advantage of specialized medical expertise at a greatly reduced cost. Definitions differ somewhat across contexts, but telehealth generally refers to the transmission of public health information through communication networks and includes telemedicine.¹⁰ Telemedicine involves sophisticated communications equipment, including high-resolution video, audio, and imaging technologies, to allow a specialist in one area of the state to assist a general practitioner or nurse in another part of the state.

⁸ Balas, et al (2000)

⁹ AHRQ, Research in Action, 2002

¹⁰ Texas Statewide Health Coordinating Council. "The State of TeleMedicine and TeleHealth in Texas" February 2002. p. 14.

Telemedicine allows patients in all areas of the state, primarily those underserved by specialty physicians, to benefit from specialized medical expertise. Many rural and border communities are unable to recruit specialists and, in the absence of telemedicine, would have access to a lesser breadth of medical care, likely leading to worse patient outcomes. Telemedicine and telehealth help to increase patient access and improve patient outcomes while reducing the often prohibitive costs associated with rural specialty care.

Recommendations

1. Require all health care claims to be electronically filed by 2008.

Rationale: Currently, health plans are allowed to include the requirement that all claim filings must be electronic, but they are not compelled to require it. If they do require electronic filing, plans are also required to allow providers actively to waive out of the requirement. This recommendation would require that all contracts between health insurance carriers and providers or between carriers and hospitals signed after 2007 include a requirement that all claims must be electronically submitted. This new requirement could also include a waiver provision, requiring carriers to allow providers to waive out of the electronic filing requirement.

2. Establish a taskforce to create a road map for Texas health care information technology.

Rationale: The Executive Commissioner of HHSC should be charged with appointing a task force to include representatives from major stakeholder groups and experts in health care policy and information technology. The task force

could be patterned after the Technical Advisory Committee on Claims Processing or the Texas Statewide Health Coordinating Council. The task force will be charged with creating a 10-year road map/blueprint for Texas health care information technology to help promote the adoption of health care IT solutions across the state with the goal of improving patient outcomes and lowering costs. The task force should identify best practices in health care information technology including the use of electronic medical records, computerized physician order entry, decision-support systems, and regional data-sharing interchanges for health care information. The roadmap should describe ways in which adoption of these best practices can most successfully be promoted throughout the state, including legislative action, if necessary.

3. Establish an office of health care information technology and appoint a director of state health care information technology initiatives.

Rationale: The past year has seen a new emphasis on health care IT, especially electronic medical records, at the federal level. A federal office of health care IT, headed by a national director of health care IT, was created earlier this year to promote the adoption of electronic medical records and other IT solutions to improve patient outcomes and lower costs. Grants are available through this new office, other federal government agencies, and several non-profit groups and foundations to promote health care IT. A new state office and director of health care IT could help promote the adoption of health care IT in Texas, serve as a liaison to the federal office

of health care IT, and help cities and communities receive grant monies to establish demonstration and pilot programs in health care IT.

4. Promote the adoption of new technologies by hospitals, physicians, and other health care providers by paying higher Medicaid reimbursement rates for adopters.

Rationale: Many studies have found that there are tens of thousands of deaths due to preventable medical errors in the United States every year. The broadest class of preventable medical errors seems to stem from problems in communication among the many, fragmented elements of the American (and thus, Texas) health care system. New technologies that could be promoted include electronic medical records, computerized physician order entry (e-prescribing), and computerized clinical decision support. Adopters of each new technology could be eligible for a higher Medicaid reimbursement rate (e.g. - 1% higher for all procedures). Application for the higher rates could be made to the HHSC. Verification and auditing of technology adoption claims could be done by the HHSC OIG.

5. Encourage the electronic filing of Medicaid and CHIP claims with higher payment rates.

Rationale: Currently, about 80% of Medicaid claims are filed electronically. Since it is less expensive for the state to process electronic claims, incentives should be deployed to encourage providers to file Medicaid claims electronically. For claims made to private insurance carriers, the shorter payment period contained in the prompt-pay statutes provided an incentive for providers to shift to electronic claims filing. The shorter payment

timeline for electronic claims does not apply to Medicaid claims.

Increasing payment rates by a small amount (e.g. - 1%) for those providers filing electronically could provide the necessary incentive for remaining providers to shift to electronic claim filing.

6. Use federal homeland security funding for the establishment of regional data-sharing interchanges for health care information.

Rationale: One of the health agencies or offices (probably HHSC, but perhaps a new office of health care IT) could be directed to recruit cities and communities to apply for federal homeland security money to be used for the establishment of regional data-sharing interchanges for health care information. When complete, these regional data interchanges could connect all providers and hospitals into a public health network that could be used to track the spread of diseases and identify possible bioterrorism threats. The interchanges could also form the backbone of an electronic medical record sharing system within which all of the health care providers in an area would be able to access patient information, with patient permission.

7. Remove the 30-day grace-period that employers have for paying health insurance premiums for their employees.

Rationale: Part of the reason for promoting electronic transactions is to ensure that providers are paid in a reasonable amount of time for services that they provide. In some cases, even if a provider is initially paid quickly, the health plan will later issue a correction, essentially withdrawing the

payment, if it turns out that the patient was not actually eligible for services at that time. This problem arises because employers are not required to pay health insurance premiums for their employees at the beginning of each month for which they want an employee to be covered. Thus, if an employee is fired or leaves a company, the health plan will not disenroll the employee until the employer has failed to pay the premium for the entire month and will assume that the employer intends to keep each employee enrolled.

The verification process laid out by SB 418 attempted to solve this problem but has not been used very frequently. In cases when it is used, it shifts the risk from the providers onto the health plans and when it is not used, the risk remains with the providers. Promoting electronic transactions to ensure that health care providers are paid in a reasonable amount of time will only remain a partial solution as long as business are able to disenroll employees without warning and health plans are able to recover payments from providers. This recommendation should address this problem at its source without imposing significant additional risk or financial burden on businesses.

8. Explicitly allow (but do not require) hospitals and providers to include language in their contracts with health plans prohibiting batch rejection of claims and assessing penalties.

Rationale: Some health plans have adopted the practice of rejecting large batches of claims contained in single, electronic files due to problems with only

individual claims. This problem appears to be mostly due to the computer systems utilized by particular carriers. The federal Centers for Medicare and Medicaid Services (CMS), which were charged with promulgating rules to explicate and enforce the HIPAA transaction standards, have been somewhat ambiguous in their statements regarding the interaction between processing of HIPAA-compliant clean claims and batch rejections. However, requiring health plans to accept and process all electronic, HIPAA-compliant, clean claims seems to be consistent with both the rules surrounding the HIPAA transaction standards and the legislative intent behind SB 418.

9. Create penalties for the unnecessary and excessive submission of duplicate claims.

Grant TDI authority to make rules to enforce the prohibition of duplicate claims.

Rationale: Currently, providers and hospitals occasionally file multiple, duplicate claims for an individual procedure, imposing an unnecessary administrative cost on health plans. Duplicate claims are defined in statute and prohibited but there are no penalties associated with non-compliance. There are several legitimate reasons why hospitals and providers might file claims that would appear to a health plan to be duplicates, including claims re-submitted at the request of the carrier and corrected claims. These types of claim submissions should remain permitted. The submission of duplicate claims filed under other circumstances should trigger administrative penalties. The legal liability of clearinghouses and third-party billing administrators with respect to duplicate claim

submission will need to be made explicit. Penalties could be restricted to cases in which the carrier is able to provide adequate and timely receipt information.

10. Create an online repository for carrier verification protocols through TDI.

Rationale: Currently, the verification process by which providers can receive a guarantee of payment from carriers is not heavily utilized. Broadly speaking, each carrier has a different verification protocol that providers are required to follow when requesting verification. Some stakeholders attribute the low utilization of the verification process to the obscurity and complexity of the miscellaneous verification protocols. It has been suggested that having a single location for all verification phone numbers and protocols would increase utilization.

11. Require clearinghouses and third-party billing administrators to meet certain already-existing certifications and minimum standards.

Rationale: In an effort to comply with prompt-pay provisions and increase the use of electronic transactions, many providers retain the services of clearinghouses or third-party billing administrators to ensure that claims are in the required electronic format. Currently, clearinghouses and third-party billing administrators are not regulated by the state. Although they are required to abide by the privacy and security standards of HIPAA, their legal status with respect to prompt payment of electronic clean claims is not explicit in state statute.

Submitting an electronic clean claim through a clearinghouse could potentially introduce a delay that might cause the claim to be paid more than 30 days after being submitted. Both providers and carriers seem to agree that these entities should be subject to prompt pay provisions. Unless the legal liability of these entities is made explicit, attempts to increase the use of electronic transactions may not be as effective as they could be.

12. Require workers' compensation insurance carriers to accept electronic claims and comply with prompt-pay deadlines for providers who submit claims electronically.

Rationale: Currently, only about 2% of all workers' comp medical claims are filed electronically. Including workers' comp insurance carriers within the scope of prompt-pay legislation would allow providers to be paid more quickly for services.

Charge 6: Health Care Facility Regulations

Study health facility regulation in Texas and make recommendations that facilitate innovation and patient safety. Concentrate studies on hospitals, including niche hospitals, Federally Qualified Health Centers and long term care facilities, and make recommendations for improving patient choice, facility competition, indigent health care, and for maintaining a competitive, patient-oriented health care industry.

Patient Safety

Concerns regarding medical errors and patient safety came to the forefront of health policy following the Institute of Medicine's 1999 report entitled, "To Err is Human: Building a Safer Health System." Among the report's recommendations was that a nationwide system of error reporting be established.¹

In response to the concerns of the public regarding patient safety and the Institute of Medicine's recommendations, House Bill 1614 (78R) was passed and became law on June 20, 2003. The bill instructed the Texas Department of Health, now part of the Texas Department of State Health Services (hereinafter "the Department"), to enact a patient safety program for hospitals, ambulatory surgery centers, and mental hospitals. As part of the patient safety program, licensed entities must provide an annual report to the Department listing all occurrences of adverse events of the types listed in HB 1614 (78R). The reports are confidential and therefore are only seen by the source hospital and the Department. Included in the list of reportable events are: medication errors resulting in a patient's unanticipated death or major permanent loss of bodily function unrelated to the underlying illness or condition, certain perinatal deaths, suicides by patients

¹ Institute of Medicine, *To Err is Human: Building a Safer Health System* (November 1999).

receiving 24 hour a day care, sexual assaults of patients while at the facilities, wrong side surgical procedures, and foreign bodies accidentally left in patients. Facilities at which the adverse events occur must conduct a root cause analysis to determine the factors leading to the adverse event and to identify improvements to processes or systems to prevent future problems. Facilities must also submit at least one report to the Department regarding a best practice implemented by the facility to prevent medical errors. The Department must issue an annual report summarizing data received from all entities and must make available to the public a summary of effective best practices.²

Facility development of patient safety programs began on June 20, 2003. The annual reports of adverse events and the reporting of best practices began on July 1, 2004. Rules relating to HB 1614 were enacted by the Department in March and April of 2004.³ In order to educate hospital administrators about the new program, the Texas Hospital Association sent letters to all licensed hospitals, posted rules on its website, issued a bulletin to its members, and conducted training at major cities throughout the state in conjunction with the Department.⁴

The Department must evaluate the program and report to the Legislature by December 1, 2006, regarding the ability to detect statewide trends based on the types and numbers of events reported, the degree to which the event summaries were accessed by the public, the effectiveness of the Department's best practices summaries in improving patient care, and the impact of national studies on the effectiveness of state or federal systems of reporting medical errors. The

² Texas House Bill 1614, 78th Legislature, regular session (2003).

³ Texas Department of Health, "Hospital Licensing and Regulation in Texas" (Austin, Tex., April 16, 2004).

⁴ Texas Department of Health, "Patient Safety Initiatives in Texas" (Austin, Tex., April 16, 2004).

Legislature will use this information in making its determination regarding the continuation of this program, as it currently sunsets on September 1, 2007.⁵

Niche Hospitals

Physicians have become increasingly concerned about the limited reimbursement from government and private health care programs and their lack of control over general hospitals' administrative decisions. In response, a new health care delivery model – physician-owned specialty or niche hospitals – has emerged. These new facilities have been created across the United States but are particularly prevalent in Texas.⁶ The concept of a specialized hospital is not a new one. Children's hospitals, eye and ear hospitals, and other specialty hospitals have long been part of the health care system.⁷ These new hospitals have proven controversial due to the physician-ownership aspect and their focus on highly profitable specialties, including cardiac care, orthopedic services, and general surgeries.

Physicians who have chosen to take part in the creation of these new hospitals do so in part to capture a portion of the facility fees paid by third-party payers to hospitals as reimbursement for services rendered therein.⁸ These facility fees often represent the vast majority of reimbursement provided for the delivery of health care.⁹ Additionally, these entrepreneurial physicians state that through their input in the creation and administration of these facilities, they can better respond to patient complaints regarding the treatment received in general hospitals. They also state that

⁵ Texas House Bill 1614, 78th Legislature, regular session (2003); see also – Cindy Bednar, "Reading Between the Rules: The New Medical Error Reporting and Patient Safety Requirements."

⁶ General Accounting Office, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, GAO Rep. No. GAO-03-683R (Apr. 18, 2003).

⁷ Kelly Devers, Moderator, Center for Studying Health System Change. Testimony to Consortium on *Specialty Hospitals: Focused Factories or Cream Skimmers?* (Apr. 15, 2003).

⁸ Jerry A. Bell, Jr. and David W. Hilgers. "Hospital/Physician Relationships: Adversaries by Nature - Partners by Necessity." Written Testimony to the American Bar Association Emerging Issues in Healthcare Law Conference (Feb. 19, 2004).

⁹ *Ibid.*

physicians can better evaluate the design and equipment based on the medical needs of their patients.¹⁰ Proponents of niche hospitals also argue that this model encourages innovation, which can lead to reduced costs and increased quality care.¹¹

Opponents state that operators of niche hospitals are motivated purely by profit and that they take business from community hospitals, thereby interfering with community hospitals' ability to serve the low income population.¹² The loss of profits will force general hospitals to reduce teaching and research programs, as well as other clinical services.¹³ Furthermore, niche hospitals are recruiting physicians away from the general hospitals, thereby reducing the number and type of specialists available for emergency room on-call service.¹⁴ The loss of revenue, coupled with the loss of specialists, could lead to the closing of trauma centers, burn units, and emergency services.¹⁵ Additionally, niche hospitals are increasing the demand on general hospitals' emergency departments by relying on general hospitals when the niche hospital does not have the proper facilities or supplies to respond to emergencies that arise during treatment of patients.¹⁶

Another concern of niche hospital opponents is the problem of scarcity of allied health care personnel, particularly nurses, which is only exacerbated by the growth of niche hospitals

¹⁰ Ed Alexander, President and CEO, Surgical Alliance Corporation, Testimony to Federal Trade Commission and Department of Justice Antitrust Division (Mar. 27, 2003); see also – Cheryl Jackson, "Physicians Build a Hospital of Their Own," *AMNews* (Oct. 16, 2000).

¹¹ Kelly Devers, et al., *Specialty Hospitals: Focused Factories or Cream Skimmers?* Center for Studying Health System Change, Issue Brief No. 62 (Apr. 2003).

¹² R. Jeffrey Layne, *Hospital/Physician Relations at the Fault Line: "Economic Credentialing" and JCAHO Medical Staff & Hospital Standards*, Written Testimony to the American Bar Association Emerging Issues in Healthcare Law (Feb. 20, 2004).

¹³ Cheryl Jackson, "Physicians Build a Hospital of Their Own," *AMNews* (Oct. 16, 2000).

¹⁴ Markian Hawryluk, "Specialty Hospital Growth Put on Hold," *AMNews* (Dec. 15, 2003).

¹⁵ George Lynn, President and CEO, Atlantic Care, Board of Trustees Member, American Hospital Association. Testimony to Federal Trade Commission and Department of Justice Antitrust Division (Mar. 27, 2003).

¹⁶ *Ibid.*

seeking to recruit the best health care professionals away from the general hospitals.¹⁷ With barely enough nurses to staff the existing hospitals, there are genuine quality of care concerns caused by an increasing number of niche facilities, all of which will require full time nursing staffs. These problems are particularly felt by general hospitals in Texas' rural areas, where general hospitals are already facing competition from ambulatory surgery centers and other similar out-patient facilities.¹⁸

Opponents of niche hospitals have also voiced concerns that physicians will send the easiest and most profitable cases to the facility they own,¹⁹ leaving the poorest and sickest patients to the general hospital, furthering economic harm to the general hospitals. The argument is that niche hospitals focus on the best paying services, best paying patients, and healthiest patients to maximize profits.²⁰ Concerns over the potential conflict of interest faced by physicians with ownership interests in niche facilities have led to reviews of existing fraud and abuse laws and, in some communities, to attempts to amend fraud and abuse laws to specifically address specialty hospitals.²¹

The federal government has weighed in on this issue. At the request of Congressmen Bill Thomas and Jerry Kleczka, the United States General Accounting Office (hereinafter "GAO")

¹⁷ Russ Harrington, President and CEO, Baptist Health, Testimony to Federal Trade Commission and Department of Justice Antitrust Division (Apr. 11, 2003); see also – William Petasnick, CEO, Froedtert Hospital, Center for Studying Health System Change, Testimony to Consortium on *Specialty Hospitals: Focused Factories or Cream Skimmers?* (Apr. 15, 2003).

¹⁸ Charles Sexton, CEO, Valley Regional Medical Center, Testimony to the Texas Senate Health and Human Services Committee (Apr. 20, 2004); see also – Patt Dorris, Administrator and CEO, Palo Pinto General Hospital. Testimony to the Texas Senate Health and Human Services Committee (Apr. 20, 2004); see also – Memorandum from David Pearson, VP of Advocacy and Communications, Texas Organization of Rural & Community Hospitals to the Senate Health and Human Services Committee (May 2004).

¹⁹ Mike Norbut, "Battle of the Beds: When Does Enough Hospitals Become Too Many?" *AMNews* (May 5, 2003).

²⁰ Kelly Devers, Moderator, Center for Studying Health System Change, Testimony to Consortium on *Specialty Hospitals: Focused Factories or Cream Skimmers?* (Apr. 15, 2003).

²¹ Anne S. Kimbol, *The Debate Over Specialty Hospitals: How Physician-Hospital Relationships Have Reached a New Fault Line Over these 'Focused Factories.'* (2004).

conducted a study to determine the impact of niche hospitals on community health services,²² the results of which were released through two reports. The first report, released April 18, 2003, is entitled, “Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served.”²³ The GAO found that specialty hospitals account for approximately one percent of Medicare spending on inpatient services and two percent of all short-term, acute care hospitals nationwide.²⁴ Seventy-percent of the facilities identified by the GAO as specialty hospitals had at least partial physician ownership, and one-fifth of the specialty hospitals were entirely, or almost entirely, physician owned.²⁵ Patients at specialty hospitals tended to be less sick – 21 of 25 specialty hospitals for whom the GAO had discharge data had lower proportions of severely ill patients than did the general hospitals in the same areas (17 percent at specialty hospitals as compared to 22 percent at general hospitals).²⁶ The GAO’s second report was issued October 22, 2003.²⁷ The study found that specialty hospitals were less likely to have emergency departments than general hospitals (45 percent to 92 percent).²⁸ Specialty hospital emergency departments treated less than one-tenth the median number of patients treated by general hospital emergency departments; when hospital size was accounted for, the median number was 12 per bed per month at general hospitals and slightly less than three at specialty hospitals.²⁹

²² Markian Hawryluk, "Congress Eyes Boutique Hospital Backers," *AMNews* (May 12, 2003).

²³ General Accounting Office, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, GAO Rep. No. GAO-03-683R (Apr. 18, 2003).

²⁴ *Ibid.*

²⁵ *Ibid.*

²⁶ *Ibid.*

²⁷ General Accounting Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO Rep. No. GAO-04-167 (Oct. 22, 2003).

²⁸ *Ibid.*

²⁹ *Ibid.*

Additionally, specialty hospitals treated a smaller percentage of Medicaid patients when compared to general hospitals.³⁰

Congress responded to the controversy in Section 507 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the Medicare Modernization Act or MMA), which includes “Clarifications to Certain Exceptions to Medicare Limits on Physician Referrals”³¹ or “the moratorium.” Under the moratorium created by the MMA, physicians may not refer patients for designated health services to specialty hospitals in which they have an ownership or investment interest for 18 months starting on the date of the MMA’s enactment.³² As the bill was enacted on December 8, 2003,³³ the moratorium is effective from December 8, 2003, until June 8, 2005, and the reports are due by March 8, 2005. Specifically excluded from the definition are hospitals determined by the Secretary of the United States Department of Health and Human Services to be in operation or under development as of November 18, 2003, so long as the number of physician investors or beds does not increase and the type of services offered does not change after November 18, 2003. Additionally, the MMA calls for additional studies of specialty hospitals, with the results of these studies due to Congress within 15 months of the enactment of the MMA.³⁴ On February 25, 2004, United State Senators Grassley, Baucus, Nickles, and Breaux sent a letter to the United States Department of Health and Human Services' Secretary Tommy Thompson, in which they stated that legislative intent in creating the

³⁰ *Ibid.*

³¹ The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, PL 108-173, §507, 117 Stat. 2006.

³² *Ibid.*

³³ *Ibid.*

³⁴ *Ibid.*

moratorium was to ensure a "much-needed cooling-off period during which we can further understand specialty hospitals" and their impact on the health care community.³⁵

Due to the large number of niche hospitals operating and being developed in Texas, the potential impact on the state's health care system is significant. There are many issues of concern about niche hospitals, including the potential economic harm to community hospitals, the inherent conflict of interest created for physician-owners when referring patients for care, and the possibility of decreased response to emergency situations caused by the lack of acute-care services at niche hospitals. Due to the youth of the niche hospital movement, there is insufficient data available at this time with which to make a responsible and informed decision regarding the appropriate legislative response to these facilities.

Long-Term Care Facilities

The Long-term Care Regulatory (LTCR) program within the Department of Aging and Disability Services is charged with ensuring residents in licensed and/or certified homes "receive appropriate care, are treated with courtesy and respect, enjoy continued civil and legal rights, and that the care complies with Medicare and Medicaid participation requirements."³⁶ The LTCR fulfills its regulatory responsibilities by inspecting and surveying all long-term care facilities and agencies during the licensure process to ensure they are in compliance with all applicable state and federal laws. Staff conduct enforcement actions based on the identification of deficiencies through the licensure process and from complaint allegations. The LTCR monitors provider compliance with corrective action plans aimed at addressing inadequate care, deficient practices, and conditions that jeopardize client health and safety. Additionally, staff investigates all

³⁵ Senator Grassley, et al., Letter to Tommy Thompson, Feb. 25, 2004.

³⁶ Texas Department of Human Services, *Long Term Care Regulatory Annual Report*, (Austin, Tex., November, 2003), p. 1.

allegations of complaints and incidents against facilities (within a period of 24 hours to 45 days) and agencies (within a period of two to 120 working days) based on the severity of the allegation.

During Fiscal Year 2003, the Department imposed administrative penalties on 163 nursing facilities, eight intermediate care facilities for the mentally retarded and adult day care (ICF-MR/RC) facilities, and 19 assisted living facilities.³⁷ The LTCR also referred 23 nursing facilities, 12 ICF-MR/RC facilities, and 10 assisted living or unlicensed facilities to the Office of the Attorney General for civil penalties or injunctive relief.³⁸ In fiscal year 2003, the LTCR denied 47 facilities and 4 home health agencies' licensure renewal, in addition to revoking the licenses of two home health agencies.³⁹ The Department ordered five licensure suspensions and four emergency closures of assisted living facilities due to an immediate threat to the health and safety of residents, in addition to suspending admissions in five nursing facilities.⁴⁰

Quality Monitoring Program

The Legislature passed Senate Bill 1839 during the 77th session with the intent to ensure that long-term care facilities continued to provide the highest quality care to Texans by establishing a quality assurance early warning system for long-term care facilities.⁴¹

The bill mandated that the early warning system detect conditions that could be detrimental to the health, safety, and welfare of residents and that could predict the need for the Department to take action.⁴² As part of this early warning system, SB 1839 required the Department to base

³⁷ Texas Department of Human Services, *Annual Performance Report*, (Austin, Tex., November 2003), p. 4.

³⁸ *Ibid.*

³⁹ Texas Department of Human Services, *Annual Performance Report*, (Austin, Tex., November 2003), p. 6.

⁴⁰ *Ibid.*

⁴¹ Texas Senate Bill 1839, 77th Legislature, Regular Session (2001).

⁴² *Ibid.*

quality-of-care monitors in regional offices in order to perform regular, unannounced monitoring visits to long-term care facilities.⁴³ These monitors assess the overall quality-of-life at a facility by observing the care and services provided to residents, in addition to conducting interviews with the residents, staff and others present at a nursing facility.⁴⁴ The Department has conducted approximately 5,000 nursing facility quality monitoring visits during 2003 - 2004, assessing an estimated 42,000 long-term care facility residents.⁴⁵

Quality of Life Competitive Grant Program

In an effort to improve the quality of life for residents of convalescent or nursing homes, the 77th Legislature established a competitive grant program for projects designed to better the lives of people living in these facilities.⁴⁶ The goal of Senate Bill 159 77th (R), was to generate best practice models that could be adopted by convalescent or nursing homes, thereby improving the quality of life of residents located in these facilities throughout the state.

As envisioned in SB 159, the Quality of Life Competitive Grant Program would pay part of the costs associated with the development of a project designed to improve the quality of life of residents in convalescent or nursing homes. The Department would make grant awards after competitively evaluating proposals. As grantees report on the progress of approved projects, the Department would monitor the appropriateness of grantee expenditures and evaluate the project's success in improving resident quality of life. The bill additionally directed the Department to post summaries of projects worthy of imitation in the industry on its Internet site for best practices.

⁴³ *Ibid.*

⁴⁴ *Ibid.*

⁴⁵ Texas Department on Aging and Disability Services, Invited Testimony, Texas Senate Committee on Health & Human Services (Austin, Tex., April 20, 2004).

⁴⁶ Texas Senate Bill 159, 77th Legislature, regular session (2001).

Although the Legislature provided the statutory structure for the Quality of Life Competitive Grant Program, the funding mechanism identified in statute was not available for program implementation. Senate Bill 159 provided that the Legislature may appropriate monies to fund the grant program from administrative penalties assessed against persons not in compliance with Chapter 242 of the Health & Safety Code: Convalescent and Nursing Home and Related Institution. However, the administrative penalties cited in SB 159 have never been certified for this purpose.⁴⁷

Long-Term Care Quality Reporting System

The Department on Aging and Disability Services maintains a website to assist consumers as they evaluate the quality of long-term care services in a particular area or offered by a provider.⁴⁸ The Long-Term Care Quality Reporting System is the result of an effort begun in 1998 between the Texas Department of Human Services and the stakeholder community to develop a system that responded to the requests and needs of consumers.⁴⁹ The Quality Reporting System currently provides detailed reports and rates on nursing facilities certified to accept Medicare or Medicaid beneficiaries.⁵⁰ The system lists those facilities that are licensed nursing facilities but

⁴⁷ Texas Department of Human Services, Written correspondence with the staff of the Texas Senate Committee on Health and Human Services (Fall 2004).

⁴⁸ Texas Department on Aging and Disability Services, *Long Term Care Quality Reporting System*. Online. Available: http://facilityquality.dhs.state.tx.us/ltcqrs_public/nq1/jsp3/qrsHome1en.jsp?MODE=P&LANGCD=en. Accessed: September 29, 2004.

⁴⁹ Texas Department on Aging and Disability Services, *Provider Frequently Asked Questions*. Online. Available: http://facilityquality.dhs.state.tx.us/ltcqrs_public/nq1/jsp3/qrsProvFAQ1en.jsp?MODE=P&LANGCD=en. Accessed: September 29, 2004.

⁵⁰ Texas Department on Aging and Disability Services, *How QRS Evaluates Free-standing Nursing Homes*. Online. Available: http://facilityquality.dhs.state.tx.us/ltcqrs_public/nq1/jsp3/qrsHowQRSRatesNonhosp1en.jsp?MODE=P&LANGCD=en&TYPSRV=non_hosp&CITY=AUSTIN. Accessed: September 29, 2004.

not certified to serve Medicare or Medicaid beneficiaries. However, QRS does not provide a rate for these licensed-only facilities.⁵¹

Although the QRS should not be the sole basis upon which a consumer selects a particular provider, the information contained in the system does help families identify providers and facilities that may be best suited to meet the individual needs of a family member.⁵² The Department recommends that consumers perform first-hand inspections and evaluations after identifying providers through QRS, in addition to consulting with a doctor knowledgeable of a family's needs and of the various service providers with the abilities to meet those needs.⁵³

With respect to Medicaid or Medicare-certified nursing facilities, QRS provides an overall rating for each entity that incorporates facility quality indicators and direct quality measurements. A facility's overall rating is based on how the particular entity compares to a statewide average for all facilities.

Quality Indicators

The Nursing Home Reform Law of 1987 created a regulatory framework at the federal level recognizing the importance of comprehensive assessment as providing the foundation for the planning and delivery of care to nursing home residents.⁵⁴ In response, the Centers for Medicare and Medicaid Services developed the Resident Assessment Instrument (RAI) to standardize good

⁵¹ *Ibid.*

⁵² Texas Department on Aging and Disability Services, *Long Term Care Quality Reporting System*. Online. Available: http://facilityquality.dhs.state.tx.us/ltcqrs_public/nq1/jsp3/qrsHome1en.jsp?MODE=P&LANGCD=en Accessed: September 29, 2004.

⁵³ *Ibid.*

⁵⁴ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Long-Term Care Resident Assessment Instrument User's Manual, Version 2.0*, (Washington D.C., December, 2002). Revised June 2004. Preface.

clinical practice when assessing, planning and providing care to nursing home residents.⁵⁵ The Minimum Data Set (MDS) System is one component of the RAI, designed to allow long-term care facilities to communicate electronically with their respective state agencies using a standard, nationwide system.⁵⁶ The MDS System incorporates core clinical and functional status elements that provide the basis for comprehensive assessments of long-term care residents participating in Medicare or Medicaid, in addition to monitoring quality of care.⁵⁷

The Department of Human Services, providers and consumer advocates designed the Quality Reporting System to incorporate MDS System outcome measures.⁵⁸ These quality indicators mirror those currently monitored by the CMS, including fecal impaction, dehydration, pressure sores in low risk residents, use of daily physical restraints, falls and new fractures.⁵⁹ Although these assessments are not independently verified by the CMS or the Department, this information provides consumers access to information unrelated to the regulatory process and the Department's judgment about facility quality. As facilities periodically assess their residents, the Department rates the submitted data based on potential quality problems and advantages. The potential advantage score and the potential disadvantage score, "allow consumers to identify the unmet needs of residents in a home. Favorable scores thus suggest that a facility has the capacity

⁵⁵ *Ibid.*

⁵⁶ U.S. Department of Health and Human Services, Health Care Financing Administration, Minimum Data Set National Automation Project, *Long Term Care Facility User's Manual* (Washington, D.C., April 30, 1999). sec. 2, p. 2.

⁵⁷ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Long-Term Care Resident Assessment Instrument User's Manual, Version 2.0*, (Washington, D.C., December, 2002), Revised June 2004. ch. 1, p. 4.

⁵⁸ Texas Department on Aging and Disability Services, *Provider Frequently Asked Questions*. Online. Available: http://facilityquality.dhs.state.tx.us/ltcqrs_public/nq1/jsp3/qrsProvFAQ1en.jsp?MODE=P&LANGCD=en. Accessed: September 29, 2004.

⁵⁹ Texas Department on Aging and Disability Services, *Quality Reporting System: Quality Indicators*. Online. Available: http://facilityquality.dhs.state.tx.us/ltcqrs_public/nq1/jsp3/qrsQI1en.jsp?MODE=P&LANGCD=en. Accessed: September 29, 2004.

to meet the needs of new admissions; unfavorable scores suggest that a facility is strained to meet the needs of the residents it already has."⁶⁰

Quality Measurements

The Quality Reporting System also measures quality by capturing a facility's compliance with applicable state and federal regulations determined through the regulatory work performed by the Department on Aging and Disability Services. As the Department receives complaint allegations concerning nursing homes, it performs an investigation and weighs whether the evidence substantiates the allegation. If the Department finds a violation of state or federal regulations, it typically cites the facility with a nursing home deficiency. Within QRS, consumers have access to an investigation score "based on the nature, severity and scope of the deficiencies cited in each home during the preceding six months."⁶¹ Additionally, QRS provides a survey score which captures the results of the Department's most recent survey of a nursing facility, which average once every twelve months.⁶²

Recommendations

- 1. Direct the Texas Department of State Health Services to study the current state of niche hospitals in Texas, including:**
 - the number of such facilities currently in operation;
 - the number of facilities currently under development;

⁶⁰ Texas Department on Aging and Disability Services, *Provider Frequently Asked Questions*. Online. Available: http://facilityquality.dhs.state.tx.us/ltcqrs_public/nq1/jsp3/qrsProvFAQ1en.jsp?MODE=P&LANGCD=en. Accessed: September 29, 2004.

⁶¹ Texas Department on Aging and Disability Services, *How QRS Evaluates Free-standing Nursing Homes*. Online. Available: http://facilityquality.dhs.state.tx.us/ltcqrs_public/nq1/jsp3/qrsHowQRSRatesNonhosp1en.jsp?MODE=P&LANGCD=en&TYPSRV=non_hosp&CITY=AUSTIN. Accessed: September 29, 2004.

⁶² *Ibid.*

- the location of such facilities particularly with respect to their proximity to general hospitals;
- the financial impact of niche facilities upon general hospitals ;
- the referral patterns of physician-owners as compared to those of physicians with privileges at the niche hospital who are not owners or investors therein; and
- the range of services provided by niche hospitals in Texas, with particular emphasis on the provision of emergency and charity care services.

Rationale: This information will enable the Legislature to have an informed discussion regarding proper legislative action to be taken in this area and to determine, if such action is taken, the appropriate definition of niche hospital to use, in recognition of the fact that not all specialty providers are alike and not all have the same potential to negatively impact health care quality and access in Texas.

2. Establish a Competitive Innovation Grant Program.

Rationale: Grants awarded under the Quality of Life Competitive Grant Program established by Senate Bill 159, 77th Legislature aim to partly pay the costs associated with the development of a project designed to improve the quality of life of residents in convalescent or nursing homes. A Competitive Innovation Grant Program would diffuse knowledge of a particular innovation that promotes a positive outcome for residents of long-term care facilities. Innovation grants would enable facilities that have developed and implemented a quality improvement innovation to highlight and educate others on their innovation. Similar to the Quality of Life Competitive Grant Program, the Department would award innovation

grants after evaluating grant proposals on academic soundness and proven, quantifiable effectiveness. Grantees will be precluded from charging fees for activities associated with the innovation grant.

3. Enhance the ability of the Department to ensure grantee adherence to program goals.

Rationale: The Legislature should take steps to ensure grantee adherence to the Quality of Life Competitive Grant Program and the Competitive Innovation Grant Program. Beyond requiring the Department to monitor the expenditure of grant funds as currently mandated in statute, the Department should be compelled to oversee grantee compliance with program guidelines and the grant contract on a quarterly basis. Additionally, the Department should be authorized to recoup grant monies and assess administrative penalties against grantees using grant monies for unintended purposes. These measures will provide for the proactive monitoring of grantees by the Department in order to assure grant funds are spent improving the quality of life of residents in convalescent and nursing homes.

4. Ensure consumers have access to complete information when evaluating the quality of long-term care services in a particular area or offered by a provider.

Rationale: The Centers for Medicare and Medicaid Services require nursing facilities certified to accept Medicare or Medicaid beneficiaries to complete and

transmit Minimum Data Set for all residents.⁶³ However, unless required by a state, MDS does not apply to licensed-only nursing facilities not participating in Medicare or Medicaid. Moreover, MDS would not apply to individuals residing in non-certified units of nursing homes without a state statute.⁶⁴ The Texas Administrative Code mandates that certified nursing facilities perform a comprehensive assessment of their residents' needs including the MDS reporting requirements and transmit these electronically to the Department.⁶⁵

Consequently, the Legislature should mandate MDS reporting requirements for licensed-only nursing facilities and those facilities with licensed-only distinct parts. The Department reports that without MDS data on all residents in these facilities, it is unable to systematically study or report resident outcomes at these facilities.⁶⁶ Moreover, because the Quality Reporting System incorporates MDS outcomes, the lack of information on non-Medicaid and non-Medicare residents does not provide consumers with a complete picture of quality of care provided to residents. Mandated MDS reporting is necessary to allow consumers to evaluate the quality of long-term care services in a particular area or offered by a provider using the Quality Reporting System. The

⁶³ U.S. Code of Federal Regulations. Title 42, Volume 1, § 482.20.

⁶⁴ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Minimum Data Set Applicability*. Online. Available: <http://www.cms.hhs.gov/medicaid/mds20/mdsapply.asp>. Accessed: August 18, 2004.

⁶⁵ Texas Administrative Code, Chapter 40, § 19.801.

⁶⁶ Texas Department of Human Services, Written correspondence with the staff of the Texas Senate Committee on Health and Human Services (Fall 2004).

Department estimates there are approximately 26 licensed-only facilities, and an uncertain number of facilities with distinct licensed-only parts.⁶⁷

⁶⁷ *Ibid.*

Charge 7: Reform of Texas Protective Services

Study and make recommendations on improving the Protective and Regulatory Services service levels payment system and tiered adoption subsidy program. Study and make recommendations on improving the recruitment and retention of foster care families.

Child Protective Services

Background

In Texas, protecting the unprotected from abuse and neglect is a monumental job. In FY 2003, 162,044 cases of child abuse and/or neglect were reported. Reports of elder abuse, neglect, and exploitation numbered 63,557, and reports of abuse and neglect of disabled adults and children receiving services from the state's mental health agency numbered 10,154.¹ On average, over 16,000 children resided in foster care each month in Texas in FY 2003.²

Department of Family and Protective Services

"The Texas Department of Family and Protective Services (DFPS) was created with the passage of House Bill 2292 by the 78th Texas Legislature, Regular Session. Previously called the Texas Department of Protective and Regulatory Services, DFPS's charges include protecting children, protecting adults who are elderly or have disabilities living at home or in state facilities, and licensing group day-care homes, day-care centers, and registered family homes. The agency is also charged with managing community-based programs that prevent delinquency, abuse, neglect

¹ Texas Department of Family and Protective Services, *Department of Family and Protective Services, Program Detail*, Written testimony submitted to the House Appropriations Committee, Health and Human Services Subcommittee (June 28, 2004). (Copy on file with the House Appropriations Committee).

² Texas Department of Family and Protective Services. (n.d.) *2003 Data Book*.

and exploitation of Texas children, elderly and disabled adults."³ DFPS assumed responsibility for maintaining all programs formerly under PRS, including Adult Protective Services (APS), Child Protective Services (CPS), Child Care Licensing (CCL), and Prevention and Early Intervention Services (PEI).

Agency Under Scrutiny: CPS and APS Program Audits

In the midst of this transition, the agency has come under intense scrutiny for its handling of abuse and neglect investigations by CPS and APS. The media has focused on several child deaths from abuse and neglect in families that CPS had been investigating and monitoring. In April 2004, the Texas Comptroller issued a scathing report on the CPS foster care system entitled "Forgotten Children." In response to this widespread criticism, painting the picture of a completely broken system of child and elder protection, the Governor ordered the systematic reform of the Adult and Child Protective Services programs on April 14, 2004 and on July 2, 2004, respectively. As a result, the Health and Human Services Commission (HHSC), which oversees DFPS, began audits of both programs. The preliminary findings from these reports led the Lieutenant Governor to ask this Committee to thoroughly review DFPS and make recommendations for legislative changes.⁴ This report seeks to respond to that request.

Reforming Child Protective Services

Understanding the Crisis: CPS Program Audits

Between September 1, 2001 and May 31, 2004, 509 children died as a result of abuse or neglect statewide. CPS caseworkers visited 137 of these children at least once before they died and

³ Texas Department of Family and Protective Services. (n.d) *About DFPS*. Online. Available: <http://www.tdprs.state.tx.us/About/About/default.asp>. Accessed: October 26, 2004.

⁴ David Dewhurst, Lieutenant Governor of Texas, Press Release, (Austin, Tex., October 1, 2004). Online. Available: <http://www.senate.state.tx.us/75r/lrgov/pr04/s100104a.htm> Accessed: November 3, 2004.

confirmed abuse and neglect in 57 of these cases.⁵ Such statistics, and the disturbing tales that accompany them, were the catalyst of an executive order from the Governor to HHSC to systematically reform CPS. As part of its reform process, HHSC asked its Office of Inspector General (OIG) to conduct a compliance review of case files. The OIG reviewed 2,200 cases and found compliance with procedures was lacking, resulting in compromised safety outcomes for children. The OIG found that:

- 65% of cases requiring a short-term safety plan, detailing the immediate steps necessary to ensure the child's safety, did not have one or had an insufficient one.
- 48% of cases needing a long-term plan of service to ensure safety lacked or had an inadequate one.
- In 425 investigations (19%), at least one child was left in a state of abuse or neglect without appropriate action by the caseworker.
- In 152 cases (7%), at least one child was left in a life threatening situation.⁶

The federally administered Child and Family Services Review conducted in 2002 produced similar results. The review looked at seven child welfare outcome measures in the areas of safety, permanency, and well-being. Texas was in compliance with only one of the seven safety, permanency and well-being outcomes. Below are examples of its findings:

- In 19% of cases the state did not make diligent efforts to maintain children safely in their homes.
- In 20% of cases the state did not make diligent efforts to reduce risk of harm to children.
- There was a lack of availability of key services and caseworker follow-up to ensure provision of services for children, families and foster parents in 28% of the cases.

⁵ Terri Langford, "CPS Figures Raise Questions," *Dallas Morning News* (September 22 2004).

⁶ Texas Health and Human Services Commission, Office of Inspector General, *Child Protective Services Investigation* (September 2004).

- In 18% of cases, workers did not meet the requirement to meet monthly with children.⁷

Systemic Problems Contributing to CPS' Poor Performance

There are many systemic problems contributing to CPS' poor performance. Consequently, reform efforts must address a variety of issues: the trend of increasing reports of child abuse and neglect, a deficit of resources to address this burgeoning problem, and a poor structure to respond to and address such allegations.

Increasing Reports of Child Abuse and Neglect

The number of reports to CPS of child abuse and neglect have grown significantly. Between FY 1999 and FY 03, the number of reports rose 8.9% from 170,944 (FY 99) to 186,160 (FY 03).⁸

The number of completed investigations rose 31% from 99,929 (FY 99) to 131,130 (FY 03).

The number of investigations in which abuse or neglect was confirmed rose nearly 25% from 26,265 (FY 99) to 32,792 (FY 03).⁹

This rise is in part due to increases in the size and characteristics of the child population. "Texas has the second largest child population, over six million, and one of the most rapidly growing, adding 350,000 children between 2000 and 2003."¹⁰ A growing number of these children are raised in economically disadvantaged families, which have higher incidence of abuse,

⁷ U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, *Child and Family Services Review: Summary of Findings Texas*, (Washington, D.C., June 2002).

⁸ Texas Department of Family and Protective Services. (n.d.). *2003 Data Book*. p. 42-43.

⁹ *Ibid.*, p. 11.

¹⁰ Scott McCown, Executive Director, Center for Public Policy Priorities, Written testimony submitted to the Senate Health and Human Services Committee (October 19, 2004). (Copy on file with the Senate Health and Human Services Committee).

particularly neglect.¹¹ "Over 20% of Texas children are in families living in poverty, while 50% are in economically disadvantaged families."¹²

It is important to note that many reports are unsubstantiated. In Texas, the number of unsubstantiated reports has been increasing steadily - 73,664 (FY 99) or 43% compared to 98,338 (FY 03) or 53%. Nationwide, more than half of reports regarding suspected child abuse are unsubstantiated.¹³ Attempts have been made in some states to decrease the number of unsubstantiated reports by criminalizing the making of knowingly false reports. Under Texas Family Code §261.107, it is a Class A misdemeanor to make a knowingly false report of child abuse and a state jail felony to make such a report if the individual has a previous conviction for false reporting.¹⁴ Despite this provision, false reports are still made, and CPS workers are forced to investigate. Though data does not exist regarding the number of unsubstantiated reports that are knowingly false, anecdotal evidence suggests that false reports consume a substantial amount of CPS investigators' time.¹⁵

Deficit of Resources

Though funding for DFPS has increased by 19% from 2002 to 2005,¹⁶ there are still not enough resources to meet all the needs for child protection in Texas. Total funding for DFPS was increased in the 78th Legislative session despite a \$9.9 billion budget deficit. However, funding for many critical programs was cut or not increased sufficiently to meet increased demand.

¹¹ U.S. Department of Health and Human Services, Administration for Children and Families, *Risk and Protective Factors for Child Abuse and Neglect*. Online. Available: <http://nccanch.acf.hhs.gov/topics/prevention/emerging/riskprotectivefactors.cfm>. Accessed: November 3, 2004.

¹² *Ibid.*

¹³ U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, *Child Maltreatment 2000* (Washington, D.C., 2002).

¹⁴ Texas Family Code §261.107(a) (2004).

¹⁵ Sherry Flume, "RE: A couple of more answers," Email correspondence with staff of Texas Senate Committee on Health and Human Services (November 2, 2004).

¹⁶ Total funding for DFPS increased from \$759.5 million in 2002 to \$904.3 million to 2005.

Prevention and early intervention efforts regarding child abuse and neglect were curtailed due to budget constraints. Funding for at-risk prevention services was cut 20% for the 2004-2005 biennium.¹⁷ Programs eliminated or reduced included Healthy Families, Communities in Schools, Parents as Teachers, and several others.

Moreover, the resources available to provide services are insufficient. Despite rising caseloads, the budget for intensive family preservation services has decreased, from \$17.8 million in FY 99¹⁸ to \$16.1 million in FY 03.¹⁹ Particularly scarce are substance abuse treatment monies and services. The need for substance abuse services is acute. "Over 75% of child abuse cases nationwide involve substance abuse either by a parent or a child."²⁰ However, resources to provide substance abuse treatment are scarce, both in terms of funding and facilities. In FY 03 DFPS only budgeted \$2.9 million, and only \$2.6 million in FY 04, a 10% decrease.²¹

At the same time, staffing rates at CPS have not kept pace with increases in the number of reports and investigations of child abuse and neglect. Though the number of reports has increased 8.9% and the number of investigations by 31% from FY 99 to FY 03, the direct delivery staff has only increased 8.1%, from 4,405 in FY 99 to 4,762 in FY 03.²² Investigative staff have been especially hard hit by ballooning caseloads. "The monthly average caseload in early [FY] 2002 was 47.9 cases per investigation worker. By the close of [FY] 2004, the average

¹⁷ Texas House Bill 1, 78th Legislature, regular session (2003) and Texas House Bill 1, 77th Legislature, regular session (2001).

¹⁸ Texas House Bill 1, 75th Legislature, regular session (1997).

¹⁹ Texas House Bill 1, 78th Legislature, regular session (2003).

²⁰ Polly Ross Huges, "No Unity of Fixing Children's Services," *Houston Chronicle* (November 1, 2004).

²¹ Texas Department of Family and Protective Services, *Legislative Appropriations Request for Fiscal Years 2006 and 2007*, (September 15, 2004).

²² Texas Department of Family and Protective Services. (n.d.). *2003 Data Book*. p. 36.

caseload had risen to 61.4 cases per investigator.²³ The Child Welfare League of America recommends a caseload of no more than 12 to 18, and the national average is 18.²⁴

The volume of work has forced many caseworkers to "ignore policy and use all possible means to close cases."²⁵ The OIG's investigation concluded that "CPS caseworkers are being overwhelmed by the volume of work... This overload condition results in legitimate cases being dropped, children being left in documented states of abuse or neglect..., and numerous subsequent referrals which further compound the overloading problem."²⁶

Frustrated by their inability to do what many believe is an impossible job, many caseworkers resign. Turnover is extremely high, with four out of 10 new workers leaving the agency within two years.²⁷ Remaining caseworkers must absorb the caseload of the resigning worker, which exacerbates the rising caseload problems. Recruiting someone to fill the position is equally difficult, with starting pay averaging \$29,000 a year.²⁸ When the position is finally filled, the inexperienced worker lacks the skill and knowledge to accurately assess child safety and engage families in services to help them care for and protect their children.

Lack of Coordination

CPS' ability to work effectively with law enforcement is crucial to the prosecution of child abuse and neglect. Joint investigations are necessary as the two entities have very different

²³ Texas Health and Human Services Commission, *Implementation Plan, Executive Order 35, Relating to Reforming the Child Protective Services Program* (September 2004), p. 5.

²⁴ Texans Care for Children. *Texas House Budget Score Card* (April 7, 2004). Online. Available: www.texanscareforchildren.org. Accessed: October 5, 2004.

²⁵ Texas Health and Human Services Commission, Office of Inspector General, *Child Protective Services Investigation* (2004, September), p. 2.

²⁶ *Ibid.*

²⁷ Texas Health and Human Services Commission, *Implementation Plan, Executive Order 35, Relating to Reforming the Child Protective Services Program*, (September 2004), p. 6.

²⁸ Texas Comptroller of Public Accounts, *Forgotten Children: A Special Report on the Texas Foster Care System*, (April 2004), p. 147.

investigative goals. Law enforcement and district attorneys have the responsibility of investigating specific types of child abuse reports in order to determine whether a crime has been committed. CPS' role is to investigate all presented reports of child abuse and neglect and take whatever steps are necessary to protect the child from the risk of further harm. CPS acts under civil law, not criminal. Its thrust is not to prosecute or to punish individuals found to be responsible for child abuse, but rather to protect the child by providing help, support and services to children and families within the community.

Historically, CPS and local law enforcement have been required to conduct joint investigations of serious physical or sexual abuse of children. However, prior to the 78th Legislative session, local law enforcement and CPS were not expressly required to respond simultaneously. S.B. 669 (78R) required local law enforcement to accompany CPS caseworkers when responding to Priority I reports of abuse, which concern children who appear to face an immediate risk of abuse or neglect that could result in death or serious harm. Compliance with this law has been spotty and has not resulted in the desired outcome -- joint investigations involving law enforcement and CPS throughout the state.

Lack of Management Accountability

The management of DFPS has come under intense scrutiny in light of the OIG's findings in its case review of compliance with policy and good practice and the Comptroller of Public Accounts investigation of the foster care system. The Bexar County District Court's investigation of the factors leading to the death of two-year-old Diamond Alexander in San Antonio provided further scrutiny. Particularly in the Comptroller and Bexar County reports, management practices have

been criticized and recommendations for reform proposed. This section will examine those criticisms and recommendations.

Agency Culture

It appears based on the investigation conducted by the Bexar County District Court and other anecdotal information provided from stakeholders that CPS has a culture of "withholding information, distorting information, and demonstrating an overriding need to remain in control."²⁹ This attitude has affected both its relationship with the Legislature and its contractors.

CPS reports performance on 136 performance measures to the Legislative Budget Board. Yet, few of the findings in the OIG's investigation of CPS were reflected in these measures. Though the need for additional resources was conveyed in testimony to the Legislature, details of the status of compliance with policy and procedures was not communicated.

The culture of secrecy and control characterizes relations with the advocacy and provider communities as well. Repeatedly the provider and advocacy communities have participated on taskforces regarding issues such as reforming the level of care system, the use of psychotropic drugs in foster care, and countless other issues, only to have their input disregarded.³⁰ Providers, advocates, and even CPS caseworkers also complain that presenting a dissenting opinion regarding a case or policy is met with resistance or even retaliation.³¹ Though such sentiments

²⁹David Reilly and Lynne Wilkerson, *Judicial Review, Cause No. 2003-PA-01637, Report to Honorable Any Mireles, 73rd District Court, Bexar County, Texas* (August 13, 2004).

³⁰Roy Block, President of Texas Foster Family Association. Personal Interview, (August 17 2004).

³¹In letters sent to the Committee from caseworkers, these opinions were expressed; see also – David Reilly and Lynne Wilkerson, *Judicial Review, Cause No. 2003-PA-01637, Report to Honorable Any Mireles, 73rd District Court, Bexar County, Texas* (August 13, 2004).

do not universally characterize CPS management throughout the state, this is a widespread problem.

Poor Oversight of Providers

CPS' relationship with the provider community is affected by its role in licensing and regulation, as well as contract management. "To serve the needs of children in the state's custody, [DFPS] operates a dual public and private foster care system that contracts directly with foster parents as well as with private providers that obtain care for foster children on the state's behalf."³² In 2003, 66.4% of the total licensed foster family beds were provided by private child placing agency (CPA) foster family and group homes, while the remainder contracted directly with DFPS.³³ All foster care providers, whether they contract directly with DFPS or through a private child placing agency must be licensed by DFPS Child Care Licensing Division (CCL), "which enforces minimum standards to ensure the basic health and safety of children in residential care."³⁴

CCL's ability to effectively complete its mission has come under intense scrutiny on several fronts. Examples include:

- Recent media attention has highlighted the fact that CCL allows repeated violations spanning years to continue without licensure revocation.³⁵ This is in part because CCL does not have standards or policies that would automatically trigger action to address repetitive violations.

³² Texas Comptroller of Public Accounts, *Forgotten Children: A Special Report on the Texas Foster Care System*, (April 2004), p. 17.

³³ Texas Alliance of Child and Family Services, Written testimony submitted to the Texas Senate Health and Human Services Committee (April 13, 2004). (Copy on file with the Senate Health and Human Services Committee).

³⁴ Texas Comptroller of Public Accounts, *Forgotten Children: A Special Report on the Texas Foster Care System*, (April 2004), p. 11.

³⁵ Polly Ross Huges, "Foster Children Sent to Agency Despite Violations," *Houston Chronicle* (September 11, 2004).

- Private child placing agencies (CPAs) argue that the minimum standards are arbitrarily and capriciously applied, and no differentiation is made between small and large violations - all are weighted equally regardless of the impact the violation would have on the health and safety of children in care.³⁶
- The Comptroller of Public Accounts' audit found that those homes that directly contract with DFPS are held to lower standards than those that contract through CPAs.³⁷ Youth for Tomorrow agrees, (a non-profit organization that contracts with DFPS assess the amount and intensity of services a child entering care requires) acknowledging that foster homes contracting directly with DFPS are held to lower documentation standards.³⁸

Both providers and DFPS agree that CCL must hold providers of foster care services to higher standards. DFPS incorporated five outcome measures into residential contracts in September 2004. However, providers claim they do not have enough control of these outcomes to provide an accurate measure of performance.

Difficulty Attaining Permanency for Children in Foster Care

If an investigation determines "there is reasonable cause to believe there is an immediate danger to the physical health or safety of the child,"³⁹ CPS may take possession of the child and place that child in substitute care. In 2003, an average of 16,267 children were in foster care each month in Texas.⁴⁰ In each of the past four years, the monthly average of children in paid foster care has increased 7.8%. Recruiting new foster homes to meet this additional need is crucial. The lack of foster homes "impacts the State's ability to achieve stability and permanency for

³⁶ Samuel Sipes, President and CEO of Lutheran Social Services, personal interview (October 21 2004).

³⁷ Texas Comptroller of Public Accounts, *Forgotten Children: A Special Report on the Texas Foster Care System*, (April 2004), p. 19.

³⁸ Ed Liebgott, Youth for Tomorrow, Executive Director, personal interview (Aug 6, 2004).

³⁹ Texas Family Code, § 262.003.

⁴⁰ Texas Department of Family and Protective Services. Written testimony submitted to the Texas Senate Health and Human Services Committee (13 April 2004). (Copy on file with the Senate Health and Human Services Committee).

children."⁴¹ With fewer foster homes, matching the skills and abilities of foster families with the special needs of children becomes increasingly difficult. Poor matches often result in placement disruptions, more moves, and thus less permanency and stability for the child.

The high turnover rate in foster parenting makes this situation even more problematic. Of the 3,518 foster homes administered by CPS in FY 2002, 34% or 1,198 stopped providing foster care services in FY 03. In contrast, only 1017 foster homes started providing foster care services in FY 03. Of those who stopped providing foster care services, 298 adopted the foster child(ren) in their care.⁴² Though this transition from foster to adoptive home is laudable, it exacerbates the foster home turnover problem and necessitates even more aggressive recruitment efforts to ensure increasing numbers of children have safe, supportive foster homes.

DFPS Recruitment Efforts

DFPS has several foster home recruitment programs in place through which it hopes to recruit 1,000 new foster families. "DFPS conducts recruitment on a statewide basis through the support of public service announcements, civic and community group meetings, and distribution of printed materials."⁴³ Interested persons can use the toll free inquiry number or call their local DFPS office to learn more about foster care.

⁴¹ U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, *Child and Family Services Review: Summary of Findings, Texas* (Washington, D.C., June 2002), p. 70.

⁴² Audrey Deckinga, Texas Department of Family and Protective Services, "FW: FAD Flow Through FY 03." Email correspondence with staff of the Texas Senate Committee on Health and Human Services (October 11, 2004).

⁴³ Texas Department of Family and Protective Services, (n.d.) *Foster Care and Adoptions - Overview*, Online. Available: http://www.tdprs.state.tx.us/Adoption_and_Foster_Care/About_Foster_Care/overview.asp. Accessed: November 5, 2004.

Best practices in foster care recruitment repeatedly cite foster parents as the best recruiters of new foster parents.⁴⁴ Currently, DFPS is pursuing foundation funding for an initiative focused around using current foster families and former foster children as speakers at community recruitment presentations.

The newest recruitment program seeks to reach out to communities of faith to find new foster and adoptive homes. The program, entitled Congregations Helping In Love and Devotion (CHILD) was piloted in Bryan, Texas and has quickly spread statewide. The program seeks to recruit and qualify two families per faith community and leverage resources within that community to assist the adopting families with supports such as child care, respite services, meal preparation and transportation, among others. Currently the program is meeting with leaders of congregations to enlist their commitment to making foster care a mission for their faith community. The program has sponsored 17 presentations in congregations and has solicited twenty-five families that are now in the process of becoming licensed foster homes. In order to reach out to more faith communities, DFPS is making a video targeted to communities of faith.

Despite these recruitment efforts, DFPS has not produced needed results. The number of DFPS licensed foster homes (including dual licensed foster/adopt homes) dropped 16.6% from 2002 to 2004, from 3,519 to 2,935 homes. Private child placing agencies (CPA) have done a much better job recruiting new foster families. The number of licensed foster homes administered by CPAs increased 13.2% between 2002 and 2004, from 4,390 to 4,971. Even though CPAs have had greater success recruiting new foster homes, the supply is still woefully short of the need.

Results from the federally administered Child and Family Services Review (CFSR) reflect this

⁴⁴ Lawton and Rhea Chiles Center for Healthy Mothers and Babies, (n.d.) *Florida Foster Care Recruitment and Retention: Perspectives of Stakeholders on the Critical Factors Affecting Recruitment and Retention of Foster Parents*. Online. Available: www.teamfla.org/downloads/FCAPRptFINAL7-31-00.pdf. Accessed: June 17, 2004.

need. The state failed to meet the necessary performance level on the foster care recruitment measure; moreover, it was cited as an area needing improvement.⁴⁵

Given DFPS' poor performance in recruiting new foster families in comparison to that of private CPAs, DFPS should focus its efforts on encouraging CPAs to intensify their current recruitment efforts. Though DFPS' current initiatives are laudable, they are not producing needed results.

Given the current push to recruit foster families in communities of faith, and the fact that the vast majority of CPAs are religiously affiliated, contracting these efforts to CPAs would be a better utilization of precious resources and would likely produce better results.

More accountability on foster care recruitment is necessary. Though recruiting foster parents is critical to achieving needed permanency and stability for foster children, DFPS does not report to the Legislature on its performance in this regard. Many key stakeholders believe that until DFPS is held accountable for foster care recruitment, significant progress will not be made. Though DFPS is held accountable by the federally administered CSFR, which includes foster care recruitment measures, this data is only updated every several years and may not be as strong of an impetus as an annual performance metric.

What cannot be systematically tracked or measured are the families that consider foster parenting but choose not to on account of negative publicity about CPS and foster parenting. Certainly the abundance of negative publicity about CPS operations in the media effects CPS and private child placing agencies' ability to recruit new foster families. As such, improving CPS' overall functioning, thereby improving the image of CPS, is key to improving foster care recruitment.

⁴⁵ U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, *Child and Family Services Review: Summary of Findings, Texas* (June 2002), p. 16.

Efforts to Retain Foster Families

Once recruited, retaining these new foster families becomes the goal. Helping families succeed in foster parenting is an important way to achieve this goal. DFPS offers a wide array of supports to its foster families including monthly reimbursements, child care (if both parents are employed), respite care, Medicaid coverage, training, and case management services.

Community organizations and foster family associations provide foster families with additional supports.

Though this support is critical to help foster families succeed and continue fostering children, an abundance of other factors influence a family's decision to continue foster parenting. Often foster families adopt their foster children and cease foster parenting. Family circumstances, such as a relocation, illness, or having to care for an elderly parent, are also influencing factors. However, sometimes foster parents leave because of negative experiences with CPS or private CPAs.

In an effort to gauge foster parents' experiences with CPS and its caseworkers, CPS has developed a "Post Placement Evaluation Form" for foster parents to complete when a child in their care leaves. The survey will gauge the foster parents' satisfaction with the support received from CPS. Examples of survey questions are included in the following table. This survey will be distributed starting in fall 2004, and the results will be tabulated and released.

Select Questions from CPS' Post Placement Evaluation Form for Foster Parents

Foster parents rate on a scale of 1 to 5 their agreement with the following statements
Child's worker provided school records, shot records, birth certificate, etc. as necessary to meet the needs of the child.
Child's worker gave at least a week's notification of PPT's (staffings), and court hearings.
Child's worker contacted the child or me at least once a month and visited my home quarterly.
My Foster Home worker was helpful and supportive of me when I had a problem or needed information about the children, including permanency plan, siblings, relatives, etc.
My Foster Home worker visited either monthly or on a quarterly basis in my home.

Some homes administered and run by CPS have cited a lack of information about the child's history and service needs upon placement, resulting in families receiving children with higher level service needs than the foster family was trained and certified to handle. This often occurs because CPS places many children in foster care immediately after removal from the biological parents' home. As such, information about the children, including medical histories, school records and the like are often not available. Foster parents feel this puts their families at high levels of risk. For example, foster parents could have a child placed in their care with a history of sexually predatory behavior without any knowledge of that history. CPS acknowledges the risks inherent in such placements, but counters that it tries to place children who may pose a risk with appropriate families (i.e. families without young children) and provides families with training on how to establish a preventative environment that reduces risks. For example, families are encouraged to give high risk children their own rooms. Yet, many private CPAs feel such training is not enough. These agencies will not place children in their foster families' care until psychological evaluations and corresponding needs assessments are completed.

For many children, such evaluations will never occur. Caseworkers assign an initial service level upon placement into foster care. If the child is determined to require basic services, the child does not undergo a needs assessment unless the foster parent or CPS caseworker requests one. Only children determined to require more than basic services must receive professional evaluations of their needs. Because most CPS homes are not certified to care for children with above basic needs, CPS foster parents may not know to or may be reluctant to ask for service level assessments. As a result, children in basic homes may not be receiving the level of services they require. At present only anecdotal evidence of this problem exists. A more systematic research effort would be required to determine the extent of this problem.

Foster Care: Streamlining of Levels of Care and Reimbursement Rates

Providing foster families with the financial resources necessary to provide for children in their care is a crucial element in retaining and recruiting foster families. Foster families receive a daily rate based on the level of service the child requires. Last session, in an effort "to attain greater efficiencies in classifying of foster care children and reduce costs," H.B. 1, Rider 21 ordered DFPS to streamline its foster care levels of care.⁴⁶ The agency converted from six levels of care to four levels of service, with the net effect of reducing overall reimbursement rates.⁴⁷ The majority of those caring for foster children saw rate decreases as a result of the rate change.

A foster home caring for a level two child received \$27.31 a day under the old rate structure, while only \$20 under the new, a 36% decrease. Child placing agencies (CPAs) and residential care facilities received \$53.46 a day for level two and now receive \$36.00, a 33% decrease.⁴⁸ The fact that higher levels of care saw significant rate decreases is particularly relevant given that prior to the rate change, 63% were in level two or higher.⁴⁹ The changes in the Levels of Care system and the corresponding rates were projected to save \$22,231,477 in fiscal years 2004 and 2005.

⁴⁶ Texas House Bill 1, 78th Legislature, regular session, Rider 21 - Foster Care Payments: "The funds appropriated above for Strategy A.1.5, Foster Care Payments, assume \$22,231,477 in savings due to redesign of the Foster Care Levels of Care (LOC) system to one based on services provided. It is the intent of the Legislature that the Department of Protective and Regulatory Services work with the Health and Human Services Commission to create a LOC rate system that merges certain of the current LOCs used in fiscal year 2003 to attain greater efficiencies in classifying of foster care children and reduce costs. The Department of Protective and Regulatory Services shall submit a proposed plan for LOC restructuring to the Governor and the Legislative Budget Board to allow it to have the new rates in effect no later than October 1, 2003."

⁴⁷ While in the past, the service level definitions classified children based on their behavior, the new system classifies them based on service needs. See See Appendix C for definitions of Levels of Care and new definitions of Levels of Service.

⁴⁸ See Appendix D for the rate structure prior to and after September 1, 2003.

⁴⁹ See Appendix E for percentage of children by level of care for FY 04.

Foster care rates are budgeted to be cut an additional 4% for fiscal years 2006 and 2007. In the 78th Legislative Session, the Health and Human Services Commission agreed to keep the fiscal years' 2006-2007 budget the same as that in 2004-2005. Because the number of children in paid foster care is expected to increase by 6.2% in FY 2006 and 6.7% in FY 2007, keeping the rates the same would require additional funding over and above the 2004-2005 allocation. Unless that funding is approved, rates will decrease further.

The net effect of these reductions in reimbursement rates are unknown. However, continued decreases will likely make foster parenting unaffordable for many families and residential treatment centers.

Kinship Care Efforts

Enabling more relative placements is a critical component to alleviating the need for new foster homes. DFPS makes diligent efforts to seek relatives as potential placement resources.⁵⁰ In 2003, 3,850 children for whom DFPS had legal responsibility were placed with relatives, accounting for 17% of the total children in DFPS custody. Many relative placements become licensed foster homes and are reimbursed the same as any other foster home. However, some relatives cannot or do not want to become licensed foster homes and therefore do not receive reimbursement.

Because of financial constraints, some relatives are not able to care for the children. In order to alleviate the financial burden and enable more relative placements, the Legislature passed Senate Bill 58 (78R), which authorized a pilot project in one region of the state to provide relative care givers a \$1,000 one-time payment to purchase essential items, as well as access to other support

⁵⁰ The 2002 Child and Family Services Review indicated that pursuing relative placements was an area of strength for the agency. In 94% of the cases reviewed, diligent efforts were made to seek relatives as potential placement resources.

services, such as child care and counseling. Thus far, this program has helped 27 families care for 70 children.

Past and Current Efforts to Increase Adoptions

The recruitment and retention of foster homes is heavily tied to the recruitment of adoptive homes, as 63% of adoptive parents were foster parents.⁵¹ However, DFPS does have several initiatives specifically designed to recruit and support adoptive families. Discussing these initiatives, as well as federal initiatives in this area, is the focus of this section.

In 2003, 3,766 children were eligible for adoption because parental rights had been terminated.⁵² Moving those children into permanent homes is a high priority given the long-term benefits such stability provides. Recognizing these benefits, the federal government passed legislation in 1997 to substantially increase adoptions out of foster care. The Adoption and Safe Families Act of 1997 (ASFA) authorized adoption incentive payments for increasing the number of children adopted out of foster care with the goal of doubling the number of adoptions in the child welfare system by 2002. States received bonus grants "based on the increased number of children adopted over the previous best performance year." The number of adoptions in Texas increased dramatically after the passage of this legislation. In 1996, 746 adoptions were consummated. In 1998 and 1999, 1,548 and 2,054 adoptions were consummated,⁵³ resulting in over \$4.3 million in

⁵¹ Joyce James, Child Protective Services Assistant Commissioner. Personal Interview with staff of Texas Senate Committee on Health and Human Services, (June 30, 2004).

⁵² Scott McCown, Executive Director of Center for Public Policy Priorities, *Adoption Subsidies and Foster Families*, Written testimony submitted to the Senate Health and Human Services Committee (April 13, 2004). (Copy on file with the Senate Health and Human Services Committee).

⁵³ Texas Alliance of Child and Family Services. (n.d.) *Barriers to Adoption: Texas Child Welfare System, Maximizing Federal Resources*.

incentive grants in FY 1998 and FY 1999. Almost every year since, Texas has set a new record for annual adoptions. This was the case in 2003, with 2,444 adoptions.⁵⁴

In 2003, Congress reauthorized ASFA. The new legislation gives bonus payments to states that outperform their best previous year since 2002 - \$4,000 for each child adopted over the previous best year since, \$4,000 for each child age nine or older that exceeds the number of older child adoptions, and \$4,000 for each special needs child under age nine that exceeds those adoptions.⁵⁵

Recruitment Strategies

In order to continually increase the number of adoptions, DFPS implemented several adoption recruitment programs. The Texas Adoption Resource Exchange (TARE) is a web-based program that allows prospective adoptive families to search for children with certain characteristics, read personal profiles of the children, and watch brief video interviews. Texas also participates in a national program called AdoptUSKids which is similar to TARE. AdoptUSKids is a resource for prospective adoptive families to learn about more than 3,000 children nationwide who are available for adoption.

Partnerships with private adoption agencies have also been key in recruiting new adoptive families, especially for hard to adopt children. Private adoption agencies can pursue adoptive homes. In 2003, 728 of the 2,444 (29.8%) adoptions were completed by private agencies. Private adoption agencies are paid a fee by the state to complete the adoptions. In FY 02 and 03, monies allocated to pay these fees ran out before the end of the fiscal year and halted some pending adoptions. As a result, capacity within the private sector went underutilized and many families

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*

that were recruited to be adoptive homes never received children.⁵⁶ DFPS contends that monies allocated for the 2004-2005 biennium are sufficient to prevent another shortfall. Additionally, in its appropriation request for the 2006-2007 biennium, DFPS requested an additional \$1.1 million for contracted adoption services.

Adoption Subsidies

In order "to reduce barriers to adoption of children with special needs,"⁵⁷ DFPS provides adoption subsidies. The subsidies "consist of reimbursement of certain non-recurring adoption expenses (legal fees and costs of home studies when incurred), monthly financial assistance when needed and Medicaid coverage."⁵⁸ Of the 2,444 children adopted in 2003, 88% received a subsidy (only 285 did not receive a subsidy). That subsidy averaged \$491.46 per month at a total cost to the state of approximately \$92 million.⁵⁹

H.B. 1, Rider 26 ordered DFPS to restructure its subsidy payments based on "the child's service level needs at the time of placement into adoption." In accordance with the legislation, DFPS implemented a tiered adoption subsidy program on September 1, 2003. Prior to September 1, 2003, the maximum monthly subsidy was \$532. Under the tiered adoption subsidy, children in the first tier or those children in the basic service level, have a maximum monthly subsidy of \$400. Children in moderate service levels and above have a maximum subsidy of \$545.⁶⁰

⁵⁶ Texas Alliance of Child and Family Services. (n.d). *Barriers to Adoption: Texas Child Welfare System*.

⁵⁷ Texas Department of Family and Protective Services. *Program Detail*. Written testimony submitted to the Texas House Appropriations Committee Health and Human Services Subcommittee (28 June 2004). (Copy on file with the Texas House Appropriations Committee Health and Human Services Subcommittee).

⁵⁸ *Ibid*.

⁵⁹ Texas Department of Family and Protective Services, *Responses to House Select Committee*, (April 2004).

⁶⁰ Texas Department of Family and Protective Services. Written testimony submitted to the Texas Senate Health and Human Services Committee (April 13, 2004). (Copy on file with the Senate Health and Human Services Committee).

For foster families who want to adopt foster children with moderate needs or above, the current subsidy ceiling may be cost prohibitive. At current rates, a foster family caring for a child with specialized needs receives \$1,350 a month from the State. Even if the family received the maximum adoption subsidy, their reimbursements would drop 60 percent.

Additionally, obtaining an increased adoption subsidy, if after the negotiation of an adoption subsidy a child's service needs change requiring the provision of more services, is much more difficult than obtaining a higher level foster care reimbursement. Foster parents can request a service level assessment, and if the assessment validates a need for a higher level of services, an increased reimbursement will follow. Adoptive parents must negotiate a lengthy appeals process to obtain a higher adoption subsidy. This process often takes 12-18 months because staff resources devoted to such appeals are very limited. Thus, for many considering adopting a higher needs child, the financial risk is too great.

Post-Adoption Services

In addition to adoption subsidies, adoptive families eligible for adoption subsidies have access to a range of post-adoption services. Services such as parent training, counseling, therapy, respite care, therapeutic camps, and residential treatment are provided in order to assist with the adjustment to adoption, treat the effects of abuse, and try to keep adoptive families together.

Availability of these services varies by region and service. Advocates from certain regions argue a need for increased resources. The Legislature approved \$7.47 million for the 2004-2005 biennium and in 2004 all but \$200,000 was spent. DFPS admits the \$200,000 surplus was more due to inability to reallocate the money to needy regions rather than a lack of demand for

services. In DFPS' appropriation request for the 2006-2007 biennium, DFPS requested an additional \$2 million in funding for post-adoption services.⁶¹

Conclusion

There is no doubt that the child welfare system in Texas is broken and the need for reform is acute. These issues detailed in the above narrative are not exhaustive. Many other key issues face the system, some of which are addressed in the Recommendations section. Others are still under investigation.

CPS Recommendations

Streamlining the Increase in Reports of Abuse and Neglect

- 1. Make the reporting of child abuse or neglect by persons who know it is false or lacks factual foundation subject to a state jail felony on the first conviction.**

Rationale: Under Texas Family Code §261.107, it is a Class A misdemeanor to make a knowingly false report of child abuse and a state jail felony to make such a report if the individual has a previous conviction for false reporting. Making such reports a felony on the first conviction will provide a greater deterrent to making false complaints and will ensure that the punishment reflects the harm that such reports can cause.

- 2. Direct CPS to report all cases of suspected false reports to law enforcement.**

Rationale: CPS is currently referring only those cases where it is determined during the CPS investigation that the report was knowingly false. Having law

⁶¹ Texas Department of Family and Protective Services, *FY 2006-2007 Legislative Appropriations Request*, Joint Budget Hearing (September 22, 2004), p. 8.

enforcement conduct false report investigations is more efficient and allows better coordination with prosecutors regarding the type of evidence required in these cases.

3. Require independent corroboration of suspected abuse in cases where the reporter is in a divorce or custody proceeding with the alleged abuser before a full investigation is performed.

Rationale: These cases often result in unsubstantiated reports. Allowing CPS to conduct a small investigation by interviewing child care workers, neighbors, and/or school personnel prior to proceeding with a full investigation will ensure that CPS resources are being focused on cases where a finding of abuse or neglect is likely.

4. Restore and increase funding for early intervention services.

Rationale: The budget for prevention and early intervention services was cut by 20% by the 78th Legislature (from \$63 million to \$50 million). Funding for many programs was eliminated entirely, including Healthy Families, Parents as Teachers, Boys and Girls Clubs, and Big Brother Big Sisters. Studies show these programs to be cost-effective. A Centers for Disease Control and Prevention study found that programs like the Healthy Families program reduce rates of child abuse and neglect among those participating by upwards of 40%.⁶²

⁶² National Conference of State Legislators, *Public Health News: States Using Evidence-Based Methods to Prevent Child Abuse* (May 3, 2004).

5. Create a prevention services taskforce to create a strategic plan for providing prevention services across the state.

Rationale: Prevention services come from a variety of sources and funding streams, federal, state, local and private. Effective utilization of these resources requires coordination and planning, neither of which are occurring on a statewide basis. Establishment of a strategic plan will facilitate this process. The taskforce should determine the feasibility of HHSC and DFPS working with other state agencies and local communities to pool funding for provision of preventive services.

6. Restore and increase funding for family preservation services.

Rationale: Family preservation services are designed "to help families alleviate crises that might lead to out of home placement of children, maintain the safety of children in their own home, support families preparing to reunify or adopt, and assist families in obtaining services and other support necessary to address their multiple needs."⁶³ The budget for intensive family preservation services has decreased, from \$17.8 million in FY 99⁶⁴ to \$16.1 million in FY 03.⁶⁵ Restoring and increasing this funding will enable more families to remain intact, and thereby decrease the need for substitute care.

⁶³ Texas Department of Family and Protective Services. (n.d.) *2004-2005 Legislative Appropriation Request, Strategy Descriptions*. Online. Available: http://www.tdprs.state.tx.us/About/pdf/0204_05_LAR_StrategyDescriptions.pdf. Accessed: November 4, 2004.

⁶⁴ Texas House Bill 1, 75th Legislature, regular session (1997).

⁶⁵ Texas House Bill 1, 78th Legislature, regular session (2003).

7. Increase funding for drug and alcohol abuse treatment.

Rationale: The need for substance abuse services is acute. "Over 75% of child abuse cases nationwide involve substance abuse either by a parent or a child."⁶⁶ However, resources to provide substance abuse treatment are scarce, both in terms of funding and facilities. In FY 03, 169,088 women with children living in poverty in Texas were chemically dependent on an illegal drug. The State was only able to treat 15,273, or 9%.⁶⁷

8. Ensure that parents participating in family-based services, especially those required to meet a reunification service plan, demonstrate that new skills, knowledge, and child care abilities have been learned or acquired.

Rationale: In order for a biological parent to be reunified with his/her children, that parent must complete a service plan. In a recent child death in San Antonio, the parent completed the service plan but did not internalize the information learned in parenting classes. Those involved knew this, but, because she completed the letter of the plan, reunification proceeded, and ultimately the child died.⁶⁸ Advising judges to require the demonstration of new skills and understanding, rather than merely the completion of classes and other programs, will decrease the likelihood of further abuse after reunification.

⁶⁶ Polly Ross Huges, "No Unity of Fixing Children's Services." *Houston Chronicle* (November 1, 2004).

⁶⁷ Liang Liu, "Re: Call from Senate HHS." Email correspondence with staff of the Texas Senate Committee on Health and Human Services (November 3, 2004).

⁶⁸ David Reilly and Lynne Wilkerson, *Judicial Review, Cause No. 2003-PA-01637, Report to Honorable Any Mireles, 73rd District Court, Bexar County, Texas* (August 13, 2004).

Regarding Caseload Reduction

- 9. Bring CPS caseworkers' caseloads down to the national average so that staff can conduct thorough investigations and make good case decisions.**

Rationale: Keeping caseloads at current levels is not sustainable. High caseloads have heavily contributed to poor compliance with policy, premature case closures, and high turnover, all of which have been key factors in the increase in child deaths. Hiring additional caseworkers, in combination with other significant reform efforts, is necessary to ensure provision of effective child protection services in Texas.

- 10. Direct CPS to explore the use of a more generic caseworker approach.**

Rationale: The Bexar County District Court report recommended "CPS cease the practice of assigning multiple workers to one family's case, and examine the benefits to a more generic caseworker approach." The report argued that the practice of assigning multiple caseworkers "creates inefficiencies and quality of service issues," "requiring multiple workers to attend the same hearings, attend and participate in the same case staffings...and the constant need to continually exchange case-related information."⁶⁹ Conversations with CPS caseworkers and supervisors confirm these findings.

The Bexar County also recommended that when a foster child is reunified with his/her parents the case should remain with the same caseworker and only be transferred to a reunification worker in exceptional cases. The

⁶⁹ *Ibid.*

period after reunification is especially dangerous and the rapport and relationship developed by the previous worker is critical to the reunification's success. The facts surrounding Diamond Alexander's death in San Antonio validate this notion.⁷⁰

11. Consider utilizing a supervising caseworker when a child must be placed out of region, instead of having the primary caseworker travel to make home visits.

Rationale: When a child in the State's care must be placed in substitute care out of region the caseworker travels to make monthly visits with the child. As a result, many children are not receiving their monthly visits. If a supervising caseworker from the region of placement was allowed to visit the child and then share that information with the primary caseworker, it would save the state travel costs, reduce caseload burden, and enable monthly visits. Caseworkers have expressed concerns regarding the effect such a policy would have on the relationship between a caseworker and a child. Many fear that children would lose the one stable person in their lives. In light of these concerns, DFPS should explore ways to continue the relationship between the primary caseworker and the child while implementing this policy.

12. Limit the number of court hearings a supervisor must attend.

Rationale: In many areas, CPS supervisors must attend all court hearings, resulting in 20-40% of a supervisor's time being spent in court. In many cases, the supervisor's presence is not necessary and could be better used training

⁷⁰ *Ibid.*

caseworkers or staffing cases. Many local CPS offices have already implemented this recommendation. In Tarrant County, supervisors are only required to attend contested hearings or termination hearings. Under previous policy, supervisors were spending up to three days a week in court. This policy change has reduced this to one day a week.⁷¹

13. Transition all on-going foster home management and recruitment to private child placing agencies.

Rationale: Currently, DFPS operates a dual public and private foster care system that contracts directly with foster parents as well as with private providers that obtain care for foster children on the state's behalf. However, private agencies already serve 75% of the children in care.⁷² Given DFPS' limited resources, inability to hold homes it contracts with directly to the same standards it applies to those contracting with CPAs and poor performance in recruiting new foster homes, transitioning all on-going foster home management and recruitment to CPAs is advised. DFPS should utilize these caseworker positions in other areas of the agency, alleviating the current caseload burden.

14. Transition all on-going adoption services to private child placing agencies.

Rationale: Partnerships with private adoption agencies have been key in achieving record numbers of adoptions. In 2003, 728 of the 2,444 (29.8%) adoptions were completed by private agencies. However, these agencies have far

⁷¹ Susan Ferrari, Tarrant County CPS Program Administrator, personal interview, (Aug 6, 2004).

⁷² Texas Alliance for Child and Family Services, *Recommendations on Restructuring the Texas Child Welfare System*, (July 7, 2004).

more capacity than is currently being utilized. In 2003, the six private agencies in Harris County (Houston) had an average of 80 families approved and waiting for children per month. During this same time period in 2004, the same six private agencies averaged 97 approved and waiting families per month.⁷³ Considering there are 80 child placing agencies that place children for adoption in Texas,⁷⁴ it is likely the number of families approved and waiting to adopt number is in the thousands. The need for more adoptive families is acute. In FY 03, 3,766 children in State custody were eligible for adoption because parental rights had been terminated.⁷⁵ Though CPS has made significant progress in increasing the number of adoptions, its focus needs to be on investigating child abuse, placing children in foster care, and providing services to families. Private and nonprofit agencies are better equipped at finding foster and adoptive families for abused and neglected children. As such, we recommend utilizing DFPS caseworkers currently recruiting adoptive families and facilitating adoptions in other areas of the agency, alleviating the current caseload burden.

⁷³ Conni Barker, "Senate Health Adopt Post-Adopt Aug 04," Email correspondence with the staff of the Texas Senate Committee on Health and Human Services (17 August 2004).

⁷⁴ Texas Department of State Health Services, Bureau of Vital Statistics. *Texas Voluntary Adoption Registries*. Online. Available: <http://www.tdh.state.tx.us/bvs/car/child.htm>. Accessed: November 4, 2004.

⁷⁵ Scott McCown, Executive Director, Center for Public Policy Priorities, *Adoption Subsidies and Foster Families*, Written testimony submitted to the Texas Senate Health and Human Services Committee (13 April 2004). (Copy on file with the Senate Health and Human Services Committee).

15. Transition all case management of foster children in the State's permanent managing conservatorship to private child placing agencies.

Rationale: When a child who has been abused or neglected must be removed from home, CPS must obtain from the court a temporary order for managing conservatorship. Within, the judge must either return the child to the parent and dismiss the suit or appoint a parent, relative, or the State of Texas as managing conservator on a permanent basis. Children under the permanent managing conservatorship of the State remain in foster care until they are of age or are adopted. Those that remain in foster care, even if it is long-term foster care, must maintain contact with CPS caseworkers, including monthly visits. Given these types of cases are stable in that the legal portion has been resolved, allowing child placing agencies to handle all the case management functions of these children, with supervision from CPS, would better utilize current CPS case management resources, alleviating the current caseload burden.

16. Establish a network of faith and community-based organizations to respond to reports of abuse/neglect that CPS classifies as "Priority none."

Rationale: In FY 03, CPS did not investigate 55,030 reports of child abuse and neglect -- 29.6% of all reports. Several other states, including Arizona and Maine, have developed alternative response systems, based on relationships with community-based providers, "to deliver preventative services by connecting professional caregivers with at-risk children and families before situations become so dangerous that state involvement is

required to protect children."⁷⁶ Arizona's Family Builders program decreased the risk for child abuse and neglect among participating families. Only 0.16% of families participating received a subsequent, substantiated report within 6 months of case closure.⁷⁷ In Texas, Net Care, a program structured similarly to Family Builders, began in November 2002 with a grant from the Amon G. Carter Foundation. An evaluation of the program's effectiveness in decreasing risk and preventing further abuse is currently underway. Initial findings are promising and point toward the benefits of establishing similar programs throughout Texas.

17. Reiterate the Legislature's intent to resolve cases involving children brought into foster care within 12 months.

Rationale: The Bexar County District Court report on the CPS system in Bexar County found the court system and the foster care system unnecessarily clogged due to court cases being extended beyond the legislatively mandated 12 months. The Texas Family Code requires the court to make a final determination on the case within 12 months.⁷⁸ The law allows for a one-time extension of six months. However, some judges are dismissing the case and then having it refiled in order to restart the clock and obtain an additional 12 months.⁷⁹ By restating the intent that cases be resolved in 12 months, the Legislature will make it clear that deadlines are meant to

⁷⁶ John Ross, "NETCARE report." Email correspondence with the staff of the Texas Senate Committee on Health and Human Services (November 3, 2004).

⁷⁷ Arizona Department of Economic Security, Office of Prevention and Family Support, *Family Builders Program Annual Report for Fiscal Year 2003* (November 2003).

⁷⁸ Texas Family Code, § 26.401.

⁷⁹ David Reilly and Lynne Wilkerson, *Judicial Review, Cause No. 2003-PA-01637, Report to Honorable Any Mireles, 73rd District Court, Bexar County, Texas* (August 13, 2004).

be firm. Adding language to the statute stressing that six month extensions are for extraordinary circumstances only and should not be used routinely will further emphasize the Legislature's intent to quickly resolve cases involving children brought into foster care. This will ease the clogging of the current court docket and reduce CPS caseworker caseloads.

18. Enhance technology available to caseworkers to increase productivity.

Rationale: CPS is not currently utilizing technology to its fullest extent to alleviate the caseload burden on its caseworkers. For example, there is no automated tracking tool to determine bed capacity and availability within each child placing agency. Though some regions have placement teams that find substitute care placements for children, even they rely on antiquated systems that are not efficient. CPS should invest in an automated tracking system to make this process as effective and efficient as possible.

19. Evaluate CPS job functions to ensure appropriate staff are conducting appropriate functions.

Rationale: Because of the need for more personnel to handle direct-service delivery, it is critical that DFPS make every effort to ensure staff are used appropriately and efficiently.

Alleviating CPS Caseworker Turnover and Enhancing Caseworker Training

20. CPS should hire just-in-time replacements in recognition and in anticipation of high turnover rates.

Rationale: Turnover among CPS caseworkers is extremely high, with four out of 10 new workers leaving the agency within two years.⁸⁰ Remaining caseworkers must absorb the caseload of the resigning workers, only exacerbating the rising caseload problems. One CPS region piloted a program which provided just-in-time replacements of caseworker vacancies by having trained workers ready for hire. This facilitated a dramatic reduction in turnover because caseworkers did not have to carry additional cases during a vacancy period. This program should be instituted state-wide.

21. Improve initial caseworker training and require continuing education training to more tenured workers.

Rationale: New CPS caseworkers receive 6 weeks of job training before being assigned to cases. "Many workers feel unprepared for the demands...when they first enter the field."⁸¹ In order to improve initial caseworker training, a taskforce should recommend changes to the training curriculum and study national best practice curriculums. In addition, "initial training should include more hands-on experiences with tenured caseworkers in

⁸⁰ Texas Health and Human Services Commission, *Implementation Plan, Executive Order 35, Relating to Reforming the Child Protective Services Program* (September 2004), p. 6.

⁸¹ Texas Association for the Protection of Children, *Recommendations for CPS Efficiencies and Best Practices*, Written testimony submitted to the Texas House Select Interim Committee on Child Welfare and Foster Care (August 5, 2004). (Copy on file with the Texas House Select Interim Committee on Child Welfare and Foster Care).

the unit they will be joining...The training should implement...on-the-job skills training and shadowing."⁸² Training on forensic interviewing and investigatory techniques emphasizing the collection of physical evidence should also be included. Continuing education training for more tenured workers should also be required so that workers stay abreast of any new breakthroughs in the field.

Increasing Coordination with Law Enforcement

22. Co-locate CPS investigators with law enforcement detectives.

Rationale: S.B. 669 (78R) required local law enforcement to accompany CPS caseworkers when responding to Priority I reports of abuse, which concern children who appear to face an immediate risk of abuse or neglect that could result in death or serious harm. Compliance with this law has been spotty and has not resulted in the desired outcome of joint investigations involving law enforcement and CPS throughout the state. Locating CPS and law enforcement in the same building will help facilitate the kind of coordination and teamwork required to successfully complete an investigation jointly. Currently, some law enforcement detectives specializing in child physical and sexual abuse and CPS caseworkers are co-located at child advocacy centers. Where this has occurred, it has been extremely successful. Communities without child advocacy centers are encouraged to establish them.

⁸² David Reilly and Lynne Wilkerson, *Judicial Review, Cause No. 2003-PA-01637, Report to Honorable Any Mireles, 73rd District Court, Bexar County, Texas* (August 13, 2004).

23. Require joint investigations involving both CPS and law enforcement on investigations that are criminal in nature.

Rationale: Law enforcement and district attorneys have the responsibility of investigating specific/serious types of child abuse reports, to determine whether a crime has been committed and whether to bring charges against the alleged offender. Criminal acts occur in Priority I and II investigations, but current law only requires coordination with law enforcement on Priority I investigations. Criminal acts should be investigated by law enforcement regardless of whether they are designated as Priority I or II cases. However, it is imperative that CPS establish protocols to differentiate between criminal and non-criminal reports. Conversations with law enforcement consistently reveal that too often non-criminal reports are referred to law enforcement, thus inappropriately utilizing their scarce time and resources.

24. Law enforcement should be the lead agency in joint criminal investigations of child abuse.

Rationale: Effective prosecution of criminal child abuse requires law enforcement to be the lead agency. Current law states that "The department [DFPS] and the appropriate local law enforcement agency shall conduct an investigation." By putting the department (i.e. CPS) first, it gives the impression that CPS should lead the investigation. This is problematic because criminal charges must take precedent and drive the investigation.

25. Establish joint training programs for law enforcement and CPS caseworkers to facilitate joint investigations of criminal cases of child abuse.

Rationale: Law enforcement and CPS need additional training on how to investigate child abuse together. Law enforcement and CPS correctly have different methodologies for conducting child abuse investigations, reflecting their different goals. As such, tension is likely to arise if law enforcement and CPS are not trained in how to conduct a joint investigation. Training will help each organization recognize the purpose and value of the other, while helping to delineate roles and responsibilities. In order to facilitate this process, a "think tank" meeting of law enforcement professionals who conduct child abuse investigations should be held in order to "identify problems and establish standardized guidelines for child abuse investigations."⁸³

26. Put civil arrest warrants (capiuses) pursuant to non-cooperation in CPS investigations on the Department of Public Safety crime information database.

Rationale: If a family disappears and impedes the completion of an investigation, CPS has the authority to file a petition for cooperation in court. If the family ignores that order, the court can order a Writ of Capias (Civil Arrest Warrant). Right now, such orders do not go on to the crime information database - the database police officers access when they pull someone over for a speeding ticket or other violation - to ensure the

⁸³ Carl Coats, Detective for Grapevine Police Department, *Relating to Reforming the Child Protective Services Program*, Written testimony submitted to the Senate Health and Human Services Committee. (October 19, 2004). (Copy on file with the Senate Health and Human Services Committee).

person doesn't have a warrant out for their arrest. By allowing capiuses related to non-cooperation on the crime information database, the likelihood of finding the family, completing the investigation, and possibly preventing a child death increases. Upon identifying a non-cooperative parent, the parent would be required to appear before the court and may be subject to a fine or criminal penalty, per the judge's discretion.

Ensuring Accountability

27. Establish a legislative oversight committee to monitor the reform of DFPS.

Rationale: Ongoing oversight after session is required to facilitate the reform effort and fulfill the Legislature's commitment to ensuring a functioning system of child protection.

28. Require DFPS to report to the Legislature performance on Child and Family Services Review measures for safety, permanency, and well-being every quarter.

Rationale: The Child and Family Services Review (CFSR) is a federal evaluation that examines states' performance on 45 performance/outcome measures. Texas' last evaluation was in 2002 and the next will probably be in 2006. The current performance measures compiled by the Legislative Budget Board are insufficient to hold the agency accountable, as evidenced by the current measures' failure to reflect the current, dire situation. The CFSR measures are more outcome oriented and hold the agency to a higher standard that will facilitate improved service delivery.

- 29. Ensure compliance with policies and procedures by using a quality assurance program with strong staff performance measures and a comprehensive tracking system to ensure accountability at all levels of staff.**

Rationale: The Inspector General's audit found compliance with procedures lacking, resulting in compromised safety outcomes for children. Implementing this recommendation will help ensure future compliance.

Ensuring the Health and Safety of Foster Children

- 30. Establish a priority level that necessitates an immediate response by CPS and law enforcement.**

Rationale: There are situations in which immediate intervention is paramount (i.e. three year old child is left alone at home). Also, there are cases that do not require immediate response, but should be responded to quickly (i.e. within 24 hours). A three tiered classification system would make such classifications easier to differentiate and facilitate more appropriate actions on the part of CPS and law enforcement.

- 31. DFPS should carefully monitor the placement of child sex offenders, sexual predators and children with violent criminal histories.**

Rationale: "CPS does not require that children with histories of sexual abuse, sexual predation or violent criminal records be separated from other children."⁸⁴ Consequently, child-on-child sexual and physical abuse is a problem. Mere separation will not completely resolve this problem, rather constant

⁸⁴ Texas Comptroller of Public Accounts, *Forgotten Children: A Special Report on the Texas Foster Care System*, (April 2004), p. 189.

supervision is key. The OIG's review of therapeutic camps, where many children with such histories reside, revealed that the best camps use a combination of separation and constant supervision to ensure child-on-child abuse is minimized.⁸⁵

32. CPS caseworkers should consider foster children's educational needs and the education services available from each foster care facility when making placement decisions.

Rationale: "Educational research has repeatedly established that foster children tend to do poorly in school. Many eventually drop out—twice as often as their peers, according to the Casey Family Programs' National Center for Resource Family Support."⁸⁶ Consequently, DFPS must do all it can to ensure children receive the best education possible. However, based on a 2002 study by the U.S. Administration for Children and Families -- the Child and Family Services Review -- Texas "does not meet federal standards for educational services. For example, it found that in 16 percent of the cases studied, [DFPS]...had not met children's educational needs. Two major problem areas cited in the review were poor assessment of foster children's educational needs and lack of follow-up by caseworkers to determine if recommended educational services...were actually being provided."⁸⁷

⁸⁵ Texas Health and Human Services Commission, Office of Inspector General, *Child Protective Services Investigation* (September 2004).

⁸⁶ Texas Comptroller of Public Accounts, *Forgotten Children: A Special Report on the Texas Foster Care System*, (April 2004), p. 239.

⁸⁷ *Ibid.* p. 240.

33. HHSC should implement a Medicaid catastrophic case management program for medically fragile foster children in DFPS care.

Rationale: "Catastrophic case management is a series of techniques designed to provide patients with quality care while avoiding lengthy hospital stays...In 2001, the Texas Legislature required catastrophic case management on complex Medicaid patients. The state's Medicaid office implemented it only in their Primary Care Case Management Program. Foster care children are in fee-for-service Medicaid and receive no catastrophic case management. If catastrophic case management were used for medically fragile children in foster care, the children would be better served, their foster families could depend upon expert care and assistance in managing their children's conditions, while the state would benefit from oversight stressing cost-effectiveness."⁸⁸

34. HHSC should design an assessment system that ensures that children with developmental disabilities are properly identified.

Rationale: DFPS calculates that 1,017 children, or four percent of the children in foster care, have mental retardation. Some worry that this number may be underestimated and that more should be done to ensure detection.⁸⁹ Youth for Tomorrow (YFT) screens children for developmental disabilities when they enter care; however, some believe that because they are not specialists in developmental disabilities, their screenings are inadequate.

⁸⁸ *Ibid.* p. 189.

⁸⁹ *Ibid.* p. 213.

DFPS should work with YFT to create an assessment system that ensures children with developmental disabilities are properly identified.

35. HHSC should appoint a task force on foster care children with developmental disabilities to obtain input from experts on the development of a more comprehensive and “seamless” service system for such children.

Rationale: The task force should review agency efforts regarding foster children with developmental disabilities and make recommendations for improvements. It should include representatives of HHSC, other relevant state agencies, child placement agencies, mental retardation providers, foster families, youths and young adults who have received services from DPRS and foster care facilities, as well as mental retardation/developmental disability experts, disability advocates, medical professionals and family members of children with disabilities.

36. Foster care caseworkers, foster parents and parents (if they have not lost or surrendered their parental rights) should be required to sign authorizations for psychotropic medications to be given to foster children.

Rationale: The overuse of psychotropic⁹⁰ medications among the foster care population is a serious problem that has been detailed by numerous studies. In its investigation of CPS, the OIG evaluated therapeutic camps. In the review of all three currently operating camps, executive directors indicated that "the average child comes to the camp on four to five

⁹⁰ Webster's Dictionary defines psychotropic as "Affecting the mind or mood or other mental processes."

psychotropic drugs."⁹¹ DFPS established an advisory committee on Psychotropic Medications in March 2004 to research the issues related to the use of psychotropic medications and recommend protocols to govern their use. One of their recommendations was to "develop clear provisions regarding informed consent."⁹² As this recommendation is congruent with DFPS' own findings, this recommendation should be implemented immediately.

37. DFPS should develop “Medical Passports” for foster children.

Rationale: "Federal law states that a foster child's health care record is to be reviewed, updated and given to the foster care provider at the time of placement. A recent health care study of children in foster care in Texas by the federal Office of Inspector General (OIG) reported that the foster care providers of 46 percent of the children studied never received medical histories for the children in their care."⁹³ Not having medical records makes it difficult for providers to effectively care for foster children. However, CPS says they do their best to ensure medical histories are provided, but often they are not available and/or do not exist.

Implementing medical passports will ensure whatever records are available are made available to providers. "The passport would accompany the child on every doctor and therapist visit and would provide

⁹¹ Texas Health and Human Services Commission, Office of Inspector General, *Child Protective Services Investigation* (September 2004).

⁹² Texas Department of Family and Protective Services, *The Use of Psychotropic Medications for Children and Youth in the Texas Foster Care System* (September 2004).

⁹³ Texas Comptroller of Public Accounts, *Forgotten Children: A Special Report on the Texas Foster Care System* (2004, April), p. 206.

information on their complete medication, medical and therapy history.

This passport would stay with the child during their entire time in foster care, even if they change placements, physicians, therapists, etc."⁹⁴

38. DFPS should develop a page on its website providing the names and photographs of missing foster children.

Rationale: "In Texas, according to [DFPS], 142 children in the agency's conservatorship were missing from care at the end of November 2003." DFPS requires providers to report children as missing to law enforcement within 24 hours. Placing the names and photographs of missing foster children on the website will assist law enforcement in finding the child.

39. DFPS should upgrade licensing standards to include requirements that foster care providers notify the agency and law enforcement immediately of missing children and notify the intake center of incidents involving runaways, missing children, arrests of children and all potential licensing violations.

Rationale: Though the current requirement necessitates reporting within 24 hours, the National Center for Missing and Exploited Children recommends calling law enforcement as soon as a child is noticed as missing, as the first few hours can be critical in finding a missing child.⁹⁵ Additionally, the agency should be aware of all incidents occurring at substitute care facilities and licensing standards should reflect that imperative.

⁹⁴ *Ibid.*

⁹⁵ Texas Comptroller of Public Accounts, *Forgotten Children: A Special Report on the Texas Foster Care System* (April 2004), p. 228.

40. DFPS should work with other states to develop agreements to check central registries of abuse and neglect in states where applicants have lived previously.

Rationale: DFPS checks Texas' abuse and neglect central registry when performing a background check on foster parents and staff providing direct care for children to detect any history of having abused or neglected a vulnerable person. However, such a check would not reveal any history in other states. Checking other states' registries will ensure a complete and thorough background check.

41. DFPS should assure the places of prior foster care employment are available in its database to facilities as part of the background check for prospective foster caregivers.

Rationale: "The Child Care Licensing database on facilities tracks information on background checks, which must be conducted every two years. This information provides a track record of foster care employment to some extent, but [DFPS] does not provide this information to facilities automatically; facilities must request it. Few do. Individuals sometimes attempt to work at other foster care facilities when they are fired and may not provide an accurate employment history to prospective employers."⁹⁶

⁹⁶ *Ibid.*

- 42. Direct CPS and TEA to share information regarding TEA unique identifying numbers used to track children in the public school system for use in finding children whose families have disappeared in order to avoid CPS investigation or cooperation.**

Rationale: Texas Education Agency (TEA) has a unique number identifying each child enrolled in school. CPS is currently not utilizing this number to track down families that are hiding from CPS in order to avoid cooperation with an investigation..

Improving Regulation of Providers

- 43. Enable Child Care Licensing to rigidly enforce minimum standards for the health and safety of children and establish meaningful civil and administrative penalties for violation of Child Care Licensing standards.**

Rationale: All foster care providers, whether they contract directly with DFPS or through a private child placing agency must be licensed by DFPS Child Care Licensing Division (CCL), "which enforces minimum standards to ensure the basic health and safety of children in residential care."⁹⁷ CCL's ability to effectively complete its mission has come under intense scrutiny. Recent media attention has highlighted the fact that CCL allows repeated violations spanning years to continue without licensure revocation. This is in part because CCL does not have standards or policies that would automatically trigger action to address repetitive violations. At the same time, CCL tends to be overly zealous with minor violations that do not

⁹⁷ Texas Comptroller of Public Accounts, *Forgotten Children: A Special Report on the Texas Foster Care System* (April 2004), p. 11.

impact the health and safety of children. Private child placing agencies argue the minimum standards are arbitrarily and capriciously applied, and no differentiation is made between small and large violations - all are weighted equally regardless of the impact the violation would have on the health and safety of children in care.⁹⁸

44. DFPS should develop a quality assurance system that performs sample audits of reports, investigations and inspections to ensure their completeness and validity.

Rationale: The Comptroller's audit of the documentation of the reports, investigations and inspections completed by CCL revealed repeated omissions of relevant information that decision makers should have to assess a facilities' records.⁹⁹ By instituting a quality assurance system, such deficiencies could be identified and rectified.

Improving Contract Management

45. DFPS should revise the outcome measures used in its residential care contracts to reflect outcomes in the control of contractors that reflect quality service delivery.

Rationale: DFPS incorporated six outcome measures into residential contracts in September 2004. DFPS now evaluates providers based on whether 1) the child is safe in care, 2) the child is placed with siblings, 3) the child moves toward permanency, 4) the child improves functioning, and 5) the child is placed within region of conservatorship. Providers argue they do not have enough control of these outcomes to make them a good basis of

⁹⁸ Samuel Sipes, President and CEO of Lutheran Social Services, personal interview (October 21, 2004).

⁹⁹ Texas Comptroller of Public Accounts, *Forgotten Children: A Special Report on the Texas Foster Care System* (April 2004), p. 160.

performance measurement. For example, the outcome measuring the percent of children placed in region of conservatorship is determined by DFPS and the court system. The Comptroller's evaluation of these measures agreed and also argued that methodology of measurement is flawed. "The indicator proposed for measuring the outcome 'children are safe' is misleading. The sole proposed indicator is the percent of children in placement with no validated abuse/neglect by caregivers; in fiscal 2003, [DFPS] had 98 validated allegations of abuse or neglect by caregivers, which means that 99 percent of children in foster care would be considered safe." However, "the indicator... ignores the fact that licensing standard violations can directly affect the safety of children."¹⁰⁰

46. Revise payment methods to create financial incentives for reducing length of stay and institutionalization of children in foster care .

Rationale: "The present...rate system gives providers no incentive to request a lower service level, which would reduce their payments. In effect, it creates a perverse incentive either to deliver more services than needed or to prolong treatment longer than necessary."¹⁰¹ However, it is important to ensure incentives do not result in children being taken out of foster or institutional care before they can return home safely.

¹⁰⁰ Texas Comptroller of Public Accounts, *Forgotten Children: A Special Report on the Texas Foster Care System* (April 2004), p. 33.

¹⁰¹ *Ibid.*, p. 34.

47. DFPS should cap funds for administration and require recovery of funds expended above the cap.

Rationale: Caps would ensure that dollars are directed into service delivery and administrative costs are minimized.

48. DFPS should consider enabling providers to go online to view their reimbursement accounts or provide detailed data so that providers can reconcile their accounts.

Rationale: "This would enable providers to identify and correct problems quickly."¹⁰²

49. The State Auditor's Office should conduct a management review of HHSC and DFPS to improve contract administration and management systems.

Rationale: In light of the recommendations in this report to increase contracting with providers for foster care, adoptive, and case management services, and in light of the poor contract management indicated in the Comptroller's report, ensuring DFPS contract administration and management systems are adequate is vital.

¹⁰² *Ibid.*, p. 180.

Increasing Collaboration with Faith-based and Community-based Organizations

- 50. CPS should repair its damaged relationship with the community. CPS needs to develop a culture of openness that invites opposing viewpoints, is open to different perspectives, and recognizes that the consequences of errors are far too great for the agency to be trying to deal with the problems alone.**

Rationale: CPS has a reputation of being secretive, unresponsive, unwilling to share information, overly controlling, punitive, retaliatory, and not always acting in good faith.

- 51. DFPS should partner with volunteer and advocacy organizations to develop a Texas Foster Grandmas and Grandpas program.**

Rationale: The goal of this program would be to provide emotional support and encourage the development of children's social, behavioral, language and academic skills by harnessing the power of senior volunteers.

Enhancing Permanency for Children in Foster Care

- 52. Keep foster care rates at FY 2004/2005 levels.**

Rationale: Foster care reimbursements rates were significantly decreased for many foster families beginning in September 2003. Rates will be cut again unless the Legislature approves more funding. This would be especially traumatic for private child placing agencies that serve 75% of the children in care.¹⁰³ Currently, reimbursement rates only cover between 80-83% of

¹⁰³ Texas Alliance of Child and Family Services, *Recommendations on Restructuring the Texas Child Welfare System* (July 7, 2004).

allowable costs.¹⁰⁴ Further rate cuts could be even more financially devastating. Recognizing the large negative impact further cuts could have on foster families, DFPS requested \$11.6 million in General Revenue funds to keep the rates at current levels in their FY 2006-2007 Legislative Appropriation Request (exceptional item 1).

53. Establish Legislative Budget Board performance measures for foster family recruitment and retention.

Rationale: The need for additional foster homes is apparent. The number of foster homes decreased from FY 02 to FY 03 while the number of children in care increased. The 2002 Child and Family Services Review (CFSR) cited this as an area needing improvement. Though DFPS has recruitment efforts in place, many key stakeholders believe DFPS is not devoting enough attention to this issue and will not do so until the Legislature holds DFPS accountable. Incorporation of performance measures for foster family recruitment and retention within the Legislative Budget Board's annual performance assessments would provide the ongoing monitoring and accountability necessary to make this an agency priority.

54. Pilot a program in one region of the state that requires all children entering CPS' care via a CPS foster home to have a service level assessment. CPS shall compare the service level needs of this cohort to a similar group not in the pilot and

¹⁰⁴ Texas Alliance of Child and Family Services, *Texas Department of Family and Protective Services, FY 2006-2007 Legislative Appropriations Request Testimony* (March 20, 2004).

determine whether the difference in the service level distribution is statistically significant.

Rationale: Many children in CPS care never receive an assessment of their service level needs and thus may not be receiving the level of care they require. Caseworkers assign an initial service level upon placement into foster care. If the child is determined to require basic services, the child does not undergo a needs assessment unless the foster parent or CPS caseworker requests one. Only children determined to require more than basic services must receive professional evaluations of their needs. Because most CPS homes are not certified to care for children with above basic needs, CPS foster parents may not know to or may be reluctant to ask for service level assessments. As a result, children in basic homes may not be receiving the level of services they require. Because only anecdotal evidence of this problem exists, a more systematic research effort is necessary to determine the extent to which this is occurring. A pilot project implemented in one region of the state requiring all children that come into CPS care to receive a service level assessment and a subsequent evaluation of the pilot's results is necessary.

55. Expand the pilot program created in Senate Bill 58, 78R , to include all regions of the state, thus enabling more placements with relatives.

Rationale: Enabling more relative placements is a critical component to alleviating the need for new foster homes. Many relative placements become licensed foster homes and are reimbursed the same as any other foster home.

However, some relatives cannot or do not want to become licensed foster homes and therefore do not receive reimbursement. Because of financial constraints, some relatives are not able to care for the children. In order to alleviate the financial burden and enable more relative placements, the Legislature passed Senate Bill 58 (78R), which authorized a pilot project in one region of the state to provide relative care givers a \$1,000 one-time payment to purchase essential items, as well as access to other support services, such as child care and counseling. Expanding this pilot program will enable more relative placements, which will help alleviate the need for new foster homes and provide significant cost savings to the state, as such a kinship placement forgoes a regular foster placement and the costs associated with it.

56. Remove financial barriers to adoption of special needs children (those in the moderate, specialized and intense level of care categories) by increasing the monthly adoption subsidy ceiling from \$545 to \$700 for those in the moderate service level and from \$545 to \$900 for those in the specialized and intense service levels.

Rationale: In order to reduce barriers to adoption of children with special needs DFPS provides adoption subsidies. Adoption subsidies include monthly financial assistance when needed. The 78th Legislature ordered DFPS to implement a tiered adoption subsidy program. Prior the change, the maximum monthly subsidy was \$532. Under the tiered adoption subsidy, children in the first tier or those children in the basic service level, have a maximum monthly subsidy of \$400. Those children in moderate service

levels and above have a maximum subsidy of \$545. However, for foster families who want to adopt foster children with moderate needs or above, the current subsidy ceiling may be cost prohibitive. At current rates, a foster family caring for a child with specialized needs receives \$1350 a month from the State. Even if the family received the maximum adoption subsidy, their reimbursements would drop 60 percent.

By raising the adoption subsidy from \$545 to \$700 for those in the moderate service level and from \$545 to \$900 for those in the specialized and intense service levels, DFPS believes the financial barrier to adoption will be removed for many families considering adoption. DFPS estimates the program would have a start up cost of \$1 million, but would ultimately save money if more than 57 children currently in foster care were adopted.

57. Expedite the appeals process for adoption subsidies.

Rationale: If after the negotiation of an adoption subsidy a child's service needs change, requiring the provision of more services, obtaining an increased adoption subsidy can be very difficult. Adoptive parents must negotiate a lengthy appeals process to obtain a higher adoption subsidy. This process often takes 12 to 18 months because staff resources devoted to such appeals are very limited. Thus, for many considering adopting a higher needs child, the financial risk is often too great. Expediting the appeal process will lesson this risk and may encourage more families, especially foster families, to adopt special needs children.

Improving Interaction with the Courts

- 58. Ensure that every order appointing DFPS as Temporary Managing Conservator contains child support and medical support orders. Child support collected should go directly to DFPS without the Office of the Attorney General keeping any portion.**

Rationale: Though the State may need to remove a child from the care of his/her parents because of child abuse or neglect, this does not abdicate the parents' responsibility to financially support the child.

- 59. Develop uniform standards for Ad Litem appointed to represent the interest of children or parents in action brought on behalf of the State.**

Rationale: The Bexar County District Court investigation of CPS found that Ad Litem are not sufficiently held accountable. Often they do not meet their obligations for advocacy and for visits with child clients. By establishing formal standards and requirements, the courts will be able to hold Ad Litem accountable to providing quality representation to their clients.

Adult Protective Services

Understanding the Crisis

In response to shocking stories of elder abuse and neglect in which Adult Protective Services (APS) failed to intervene, Governor Rick Perry ordered the Health and Human Services Commission (HHSC) to systematically reform APS in April 2004.¹⁰⁵ In accordance with this order, HHSC began an intensive review of the program, starting in El Paso. The review began there because El Paso County Probate Judge Max Higgs had sent Governor Perry reports on cases where APS failed to remove people from horrid living conditions.¹⁰⁶ Judge Higgs' reports showed that APS was slow to respond to referrals, extremely reluctant to seek guardianship services for clients, and left people in deplorable conditions which workers labeled "life style choices."¹⁰⁷

The Health and Human Services Commission (HHSC) released a preliminary report on May 19, 2004 detailing findings from its review of 200 APS cases from El Paso. According to the report, "serious deficiencies exist in virtually all aspects of the APS program."¹⁰⁸ This report focused on 1,200 cases involving 200 people in El Paso. The review team found that 35% of investigations did not fully address all allegations of abuse, neglect, or exploitation, 35% of the cases reviewed contained service plans that did not address a threat or risk to the client's health or safety in the client's environment, and that capacity was not assessed in 71% of cases where mental illness was identified or strongly indicated. The review team noted that policy, the handbook provided

¹⁰⁵ Mitch Mitchell, "Local Protective Services for Elderly Under Scrutiny." *Fort Worth Star-Telegram* (May 18, 2004).

¹⁰⁶ Associated Press, "Judges Say State Failing Elderly," *Houston Chronicle* (May 18, 2004).

¹⁰⁷ Mitch Mitchell, "Local Protective Services for Elderly Under Scrutiny." *Fort Worth Star-Telegram* (May 18, 2004).

¹⁰⁸ Texas Health and Human Services Commission, *Preliminary Report: Implementation of Executive Order RP33 April 14, 2004 Relating to Reforming the Adult Protective Services Program* (May 19, 2004).

to caseworkers, and practice were not aligned, and that policy strongly favored an individual's ability to refuse services without appropriate guidance on intervention to prevent abuse, neglect, or exploitation. Furthermore, compliance with documentation requirements was found to be poor, as was staff training and compliance with procedures.¹⁰⁹

HHSC's Office of the Inspector General (OIG) released its full report on the APS investigation on October 7, 2004. The OIG report stated that APS policies were adequate but were not being followed. The report cited management concern with closing cases as the main reason for failure to comply with policies and procedures. It additionally stated that the crisis was heightened by the failure to report outcome-based measures to senior management, the failure to hold people accountable for job performance, and management's practice of minimizing APS failures all lead to the current crisis in the system. The OIG focused on management structure, compliance with policies, increased accountability, and improved quality assurance measures as major areas in need of reform.¹¹⁰

Systemic Problems Contributing to APS' Poor Performance

The HHSC and OIG reports indicate broad systemic problems at APS, all of which have combined to weaken the agency and undermine the safety net that exists for vulnerable elderly and disabled adults.

¹⁰⁹ *Ibid.*

¹¹⁰ Texas Health and Human Services Commission, Office of the Inspector General, *Adult Protective Services Investigation Report* (Oct. 7, 2004).

Lack of Management Accountability

Key problems at APS stem from management actions and a lack of accountability. HHSC found that APS lacks clear goals and a delineation of process steps for case management.¹¹¹ HHSC also noted a lack of performance standards.¹¹² The OIG report furthered criticism of management and accountability. It stated, "The only apparent mandate from management is to close cases quickly."¹¹³ Management was described as dysfunctional and was criticized for creating a strong bias towards self-determination and away from intervention in almost all circumstances. The investigation revealed that caseworkers were not receiving regular evaluations and received little feedback on job performance. This lack of accountability continued up the career ladder, as the performance measures used by APS were inadequate and outcome measures were not reported to senior management. APS personnel indicated to the OIG that the Quality Assurance Program was changed because the old program reflected poorly on current performance levels, furthering an atmosphere that minimized accountability.¹¹⁴

Management further failed seniors by ordering APS workers to close cases quickly in order to increase agency funding and threatening caseworkers with disciplinary action for keeping investigations open for more than 30 days.¹¹⁵ Living in horrible conditions was labeled a "lifestyle choice," which was used to justify closing cases when clients stated they were not interested in receiving services.¹¹⁶ The resulting problems - the failure to address the needs of elderly and disabled clients - are reflected in figures from the OIG report, which found that

¹¹¹ Texas Health and Human Services Commission, *Implementation of Executive Order RP33 April 14, 2004 Relating to Reforming the Adult Protective Services Program* (July 12, 2004).

¹¹² *Ibid.*

¹¹³ Texas Health and Human Services Commission, Office of the Inspector General, *Adult Protective Services Investigation Report* (Oct. 7, 2004).

¹¹⁴ *Ibid.*

¹¹⁵ Lee Hancock, "Elderly Neglect Cases padded, Employee Says," *Dallas Morning News* (Jun. 18, 2004).

¹¹⁶ Lee Hancock, "A State of Neglect," *Dallas Morning News* (Jun. 13, 2004).

subsequent investigations were opened on individuals involving substantially the same issues as the original investigation 50 percent of the time.¹¹⁷ The average number of prior investigations with substantially similar issues was 2.47.¹¹⁸

Deficit of Resources

Inadequate Assessment Tool

APS has been hampered by poor tools to assess client needs, particularly with respect to the capacity tool. The mental capacity tool used by APS was woefully inadequate. If a person could correctly answer questions about what to do if a fire broke out, if they needed or were asked for money, or if they ran out of medicine, they were declared competent regardless of evidence to the contrary.¹¹⁹ The tool did not identify or document potential harms or risks, medical issues, environmental issues, or personal relationships; the sole focus was mental capacity.¹²⁰ The OIG report stated that even when the capacity test was administered, it was not properly documented.¹²¹ Additionally, HHSC noted that problems with the APS intake system lead to cases not being assigned or prioritized properly.¹²² These insufficient tools hindered caseworkers from achieving positive outcomes even for those cases that could be successfully completed with the 30 day deadline caseworkers were told to meet.

¹¹⁷ Texas Health and Human Services Commission, Office of the Inspector General, *Adult Protective Services Investigation Report* (Oct. 7, 2004).

¹¹⁸ *Ibid.*

¹¹⁹ Lee Hancock, "A State of Neglect," *Dallas Morning News* (Jun. 13, 2004).

¹²⁰ Texas Health and Human Services Commission, *Preliminary Report: Implementation of Executive Order RP33 April 14, 2004 Relating to Reforming the Adult Protective Services Program* (May 19, 2004).

¹²¹ Texas Health and Human Services Commission, Office of the Inspector General, *Adult Protective Services Investigation Report* (Oct. 7, 2004).

¹²² Texas Health and Human Services Commission, *Preliminary Report: Implementation of Executive Order RP33 April 14, 2004 Relating to Reforming the Adult Protective Services Program* (May 19, 2004).

High Caseloads

Resource deficits have led to high caseloads and decreased the effectiveness of APS workers. Precise calculations of caseloads can not be determined in part because of the problem of premature closing of cases and partially due to reports that caseloads are being artificially inflated. APS workers have reported that they were encouraged by management to validate all referrals in order to increase caseloads and thereby increase funding, as well as to move cases from the investigations phase to service delivery prematurely.¹²³ Despite these problems, there is evidence that APS caseworkers are overloaded. Accreditation agencies recommend a caseload of 12 to 18 cases per worker, but last year APS had an average of 48 cases per worker.¹²⁴ State figures show a average monthly caseload of 40.6.¹²⁵ Even accounting for caseload inflation, Texas APS workers are clearly handling higher than recommended caseloads. Staff turnover adds to this problem, as the remaining workers absorb the cases of those who have left the agency.¹²⁶ Additionally, workers are hampered by a lack of support staff, and supervisors find themselves performing administrative tasks rather than focusing solely on their supervisory duties.¹²⁷

Lack of Guardianship Services

APS's problems are exacerbated by the lack of available guardianship services. There are 23 county-run and non-profit volunteer programs providing guardianship services in 73 counties; Texas has 254 counties. Even in those counties where there are programs, there is generally a

¹²³ Mitch Mitchell, "Workers: Agency's Reports Falsified," *Fort Worth Star-Telegram* (July 1, 2004).

¹²⁴ American-Statesman Staff, "Report: Investigators Overworked," *Austin American-Statesman* (Jul. 26, 2004).

¹²⁵ Peggy Fikac, "Proposal on Way to Hire More Adult Caseworkers." *San Antonio Express-News* (Aug. 4, 2004).

¹²⁶ Erica Molina, "A Day in the Life of an APS Worker," *El Paso Times* (Aug. 9, 2004).

¹²⁷ Texas Health and Human Services Commission, *Preliminary Report: Implementation of Executive Order RP33 April 14, 2004 Relating to Reforming the Adult Protective Services Program* (May 19, 2004).

greater demand than supply of guardianship services.¹²⁸ This leaves clients without necessary support and further exacerbates the underlying risk of abuse, neglect, and exploitation. Without reform of this system, APS' most vulnerable clients will remain unprotected and at risk of future harm.

Inadequate Training

Poor training has further hurt APS. A former APS supervisor stated in a hearing before Judge Higgs that workers were sent in the field untrained.¹²⁹ There is a general lack of specific policies and procedures with respect to training and a failure to require continuing education of seasoned workers.¹³⁰ Additionally, testing is not used to evaluate staff learning.¹³¹ This led to inexperienced and untrained workers attempting to respond to the often complex issues seen in the field and further reduced the likelihood that clients' needs would be adequately addressed. Caseworkers also reported to the OIG that they did not have sufficient time to take advantage of the training that APS was offering. This failure to adequately train caseworkers contributed to the failure of staff to use civil processes to intervene where appropriate and to refer potential criminal cases to law enforcement.¹³²

Structural Deficiencies

The failure to separate investigations from service delivery has caused additional problems. As reported by HHSC and the OIG, APS did not have clear delineation of its roles as investigator

¹²⁸ Mitch Mitchell, "State to Look into Area Elder Care," *Fort Worth State-Telegram* (May 24, 2004).

¹²⁹ Lee Hancock, "A State of Neglect," *Dallas Morning News* (Jun. 13, 2004).

¹³⁰ Texas Health and Human Services Commission, *Preliminary Report: Implementation of Executive Order RP33 April 14, 2004 Relating to Reforming the Adult Protective Services Program* (May 19, 2004).

¹³¹ *Ibid.*

¹³² Texas Health and Human Services Commission, Office of the Inspector General, *Adult Protective Services Investigation Report* (Oct. 7, 2004).

and service provider.¹³³ The review team used by the OIG found that the majority of cases referred to APS do not require investigation and therefore a clear focus on service delivery would be the best use of current caseworkers. A separate investigations team would allow APS staff to gain greater expertise in a specific area, either investigations or service delivery, and create a more efficient process.¹³⁴

Conclusion

There is no doubt that the adult protection system in Texas is broken and the need for reform is acute. These issues detailed in the above narrative are not exhaustive. Many other key issues face the system, some of which are addressed in the Recommendations section. Others are still under investigation.

APS Recommendations

Ensure Accountability

1. Establish a legislative oversight committee to monitor reform measures.

Rationale: Ongoing oversight is required to facilitate the reform effort and fulfill the Legislature's commitment to ensuring a functioning Adult Protective Services system.

¹³³ *Ibid*; see also – Texas Health and Human Services Commission, *Preliminary Report: Implementation of Executive Order RP33 April 14, 2004 Relating to Reforming the Adult Protective Services Program* (May 19, 2004).

¹³⁴ Texas Health and Human Services Commission, Office of the Inspector General, *Adult Protective Services Investigation Report* (Oct. 7, 2004).

- 2. Require DFPS to report to the Legislature performance on APS outcomes measures for each APS function and findings of comprehensive quality assurance performance reviews on a quarterly basis.**

Rationale: This will ensure that the Legislature is aware of problems as they arise and can react accordingly.

- 3. The APS Quality Assurance Program should be revised to establish a minimum level of performance and maintain meaningful outcome measures. Failures to meet performance targets should result in disciplinary actions.**

Rationale: A strong quality assurance program will enable APS and DFPS to determine the effectiveness of reform. Additionally, this creates accountability within the system and creates disincentives to closing cases prematurely, as such action will result in employee discipline.

- 4. Ensure all staff members receive a performance evaluation on an annual basis and take corrective action against management if this does not occur.**

Rationale: The lack of employee evaluation has limited caseworker development and has allowed poor performers to continue without review or corrective action. This recommendation will ensure that workers are aware of their performance levels and of needed improvements. It will also create a process by which caseworkers who are working hard and doing their jobs well will be acknowledged.

Reduce Caseloads

5. Hire additional caseworkers in order to reduce caseload.

Rationale: As in CPS, APS caseworkers are hindered in their ability to meet clients' needs by large caseloads. Reducing caseloads will create a more responsive system and ensure better outcomes.

6. Provide caseworkers with technology to enable them to more efficiently complete casework.

Rationale: Caseworkers need to be able to enter notes into the APS database from the field in order to reduce the need for duplicative efforts in documentation. Additionally, ensuring that all caseworkers have digital cameras will allow better documentation and better coordination with medical personnel on individual cases.

Ensure a Well-Trained Workforce and Retain Experienced Staff

7. Strengthen training requirements for new staff and ensure that all staff members receive standardized training before working in the field. Develop and implement a mandatory continuing education program, including a comprehensive training program for supervisors.

Rationale: Only with adequate training will APS workers be able to recognize the needs of their clients and ensure positive outcomes. Under the current system, workers are entering the field without adequate training and seasoned workers lack training on new innovations and best practices. Additionally, workers are promoted to supervisory positions with

inadequate training on their new duties. Establishing standardized training programs will create a better informed and more efficient APS workforce.

8. Create staff specialist positions based on particular types of abuse, such as self-neglect and financial exploitation.

Rationale: APS clients enter the system with numerous complex problems. Some types of abuse, such as financial exploitation, require specialized knowledge of the law and of corrective actions. Creating specialized positions would allow caseworkers to develop the needed expertise to address these complicated issues and allow general caseworkers to focus on the less intricate cases where they can be the most effective.

9. Train all staff on Texas Family Code, Chapter 48 procedures.

Rationale: Chapter 48 is the law regarding obtaining an emergency order from the court when a person lacks mental capacity. The recent audit by the OIG revealed that many APS workers were not aware of this option or were not aware of the necessary process. Requiring training on Chapter 48 would ensure that this option is available in practice as well as in theory to protect our most vulnerable citizens

Reforming Intake

10. Establish a formal review process for intake of reports to ensure that cases are appropriately prioritized and are screened for any special issues or requirements.

Rationale: Currently there is no formal review of reports or referrals from intake. Intake information is often incomplete or inaccurate when it is given to

caseworkers, thus creating inefficiencies. Furthermore, proper prioritization of cases will ensure that those in most need of aid are seen first.

11. Establish a procedure for intake of reports at local APS offices.

Rationale: Currently, people who present to local offices to make reports are referred to the 1-800 number. This is inefficient and creates the potential for loss of reports if people do not follow up with the 1-800 number. Additionally, there is a delay in this system which could hurt those most in need of help. Allowing intake at local offices will reduce these delays and show the public that APS is responsive to its concerns.

Reforming Investigations

12. Assign cases to staff based on level of difficulty.

Rationale: Certain cases present more difficult and complicated issues than others. More seasoned workers should be assigned these more difficult cases to provide for the best possible outcome. Allowing more junior workers to focus on the less complicated cases gives them the opportunity to gain experience without unnecessary stress or jeopardizing the welfare of more difficult clients.

13. Develop and implement a risk assessment tool.

Rationale: A risk assessment tool is necessary to ensure that cases are properly prioritized and assigned to staff based on their level of difficulty. It would

also allow supervisors to track the cases with higher risk more carefully to ensure that all available and necessary services are provided.

14. Ensure allegations are fully investigated before closing.

Rationale: Currently there is no adequate system of case review prior to closing. This has allowed cases to be closed prematurely. Additional oversight is needed in the form of case reviews prior to closing to ensure that the investigations and service delivery phases are completed before cases are closed.

15. Establish standards for case closures and transfers between departments.

Rationale: Such standards would allow APS caseworkers and supervisors to ensure that cases are appropriately moved from the investigations phase to the service delivery phase and finally to guardianship if needed. This will further protect our citizens against premature case closings.

16. Change the funding mechanism to eliminate incentives to close cases before they have been fully investigated and all needed services have been provided.

Rationale: In its audit, the OIG found that relationship between number of cases closed and funding was creating a perverse incentive to close cases prematurely. This clearly does not serve our vulnerable citizens nor is it an effective use of taxpayers' money. A new mechanism is needed to ensure that incentives reward positive outcomes and not merely the closing of cases.

17. Ensure that all criminal allegations of abuse or neglect are reported to law enforcement upon suspicion of criminal activity.

Rationale: APS investigators currently must report possible criminal activity to law enforcement after completing an investigation. However, early police involvement helps ensure appropriate evidence is collected and secured to effectively prosecute cases. Referring cases to law enforcement upon suspicion of criminal activity will help ensure that those who would victimize vulnerable Texans are brought to justice.

18. Create a process by which APS will provide feedback on case status to those who reported the potential abuse or those who referred the case to APS when these parties request information.

Rationale: Currently feedback is not being provided. This leaves those who report or refer cases to APS to worry about whether the case has been adequately managed. Providing feedback will help solidify positive relationships with the community and help encourage people to report and refer cases to APS.

19. Establish an APS investigator position that is distinct from a caseworker position to provide service delivery.

Rationale: With the exception of emergency or life-threatening situations, the investigations stage of a case should be completed before service delivery begins. The investigator would examine the situation and provide sufficient information for the caseworker to determine what services are

required. Creating separate positions ensures that each aspect of a case receives proper attention.

- 20. Within the Investigations Unit, establish positions for Administrative and Criminal Investigators. Criminal Investigators would have the responsibilities of Administrative Investigators but would also file criminal charges where appropriate.**

Rationale: This system would ensure greater consistency in reporting potential criminal violations to law enforcement. Additionally, Criminal Investigators would receive additional training regarding criminal investigations and be able to work collaboratively with law enforcement personnel to provide necessary evidence of criminal wrongdoing.

- 21. Establish multi-disciplinary teams to review difficult cases and develop service plans. Teams should include APS personnel, law enforcement personnel, representatives of community-based providers, healthcare providers, and other key stakeholders.**

Rationale: APS clients often have complicated issues that require multi-disciplinary services to ensure a positive outcome. Multi-disciplinary teams would bring together those with sufficient knowledge and expertise to determine precisely what problems the client faces and what services are available in the community.

Determining Mental Capacity

- 22. Allow APS to use licensed psychologists, as well as medical doctors and psychiatrists, to determine mental capacity.**

Rationale: The OIG report stated that APS workers have been seeing clients after hours to avoid the requirement of using a medical doctor or psychiatrist to determine mental capacity because these professionals are generally unavailable to do the necessary screening. Licensed psychologists have the necessary training to perform these screenings and would be less expensive and more readily available to APS.

Guardianship Services

- 23. Clarify who is guardian of last resort.**

Rationale: Currently there is no guardian of last resort in Texas. Therefore, if an elderly or disabled adult requires a guardian and no appropriate family or community member is available to fill this role, there is no person or entity the courts can select to fulfill this duty. Statutory clarification is needed in the form of a guardian of last resort.

- 24. Establish a statewide guardianship program.**

Rationale: The Guardianship Advisory Board estimates that 46,000 Texans need guardianship services but do not have access to them. Creating a statewide guardianship program would ensure that our citizens have access to these services when needed.

25. Contract all guardianship services to community service providers.

Rationale: Experts in this field argue that APS should contract for all of its guardianship services as community organizations could do a better job for a lower price. This would also eliminate the conflict of interest inherent in APS being both the investigator of abuse and guardian in cases where allegations are made against guardians.

26. Expand APS' authority to share information with community organizations and local governments for the specific purpose of addressing an elderly or disabled adult's medical, housing, or social service needs. Regulate the use of the information.

Rationale: APS has been scrutinized for not serving clients that need services but refuse them. APS did not make referrals because state law limits APS' ability to share this information with those outside the investigative process without the express consent of the client. This limitation prevents APS from obtaining timely and meaningful assistance from community organizations for vulnerable persons whose conditions do not rise to a level that requires immediate intervention.

Charge 8: State Contracting Practices

On July 27, 2004, the Lieutenant Governor called on all Senate committee chairs to evaluate state agency contracting practices and to develop recommendations to ensure greater accountability and stricter oversight of state dollars spent on outsourcing. Specific to Health and Human Services (HHS) agencies, recent State Auditor's Office (SAO) audit findings have called into question the ability of these agencies to safeguard state monies because of systemic deficiencies throughout the contracting process. The SAO has concluded that contracting deficiencies exist throughout the contract life cycle at HHS agencies including planning, procurement, rate and price establishment, contract formation, and monitoring. As the state continues to outsource functions previously performed by governmental entities in order to benefit from the economic advantages of the private sector, agencies must be equipped with a contract management infrastructure that assures taxpayer money is spent as intended by the Legislature.

Reorganized under House Bill 2292, 78 (R), the Health and Human Services agencies consist of the Department of Aging and Disability Services, the Department of Family and Protective Services, the Department of State Health Services, the Department of Assistive and Rehabilitative Services, and the Health and Human Services Commission. These agencies maintain approximately 936,689 contracts for client services, information technology, consulting, professional services, and other services worth an estimated \$14,845,203,907 as of State fiscal year 2004.

The Senate Committee on Health and Human Services, in cooperation with the Senate Finance Subcommittee on State Contracting, is exploring recommendations to improve agency

accountability over state contracts. The Chair of the Subcommittee on State Contracting provided a progress report during the October 19, 2004 Senate Committee on Health and Human Services hearing. The Subcommittee's preliminary findings are that:

- conflicts of interest exist in the contracting process;
- training on contract management and negotiation is lacking throughout HHS agencies;
- HHS agencies maintain insufficient records on the decision-making process related to contracts and poorly organize contracting information;
- there is a lack of standardization in contracting terminology;
- contracting may improve if administrative agencies are authorized to exclude companies with poor performance records from participating in state procurements for a specific period;
- an approved contractor list may provide additional guidance for agencies; and
- contract management should be a career path within state agencies.

The Subcommittee has developed a set of options for consideration in coordination with the State Auditor's Office, the Comptroller of Public Accounts, and the Building and Procurement Commission. At the time of publication, the full Subcommittee had not held a hearing to debate the merit of these recommendations.

The Senate Committee on Health and Human Services will continue to evaluate recommendations to improve HHS contracting practices during the 79th Legislative Session.

Appendices

Appendix A: Additional Resources for Medicare Reform

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- Center for Medicare Advocacy, *Federal Regulations Issued: CMS Proposes Complicated Process For Medicare Drug Plan*, August 19, 2004.
- Center for Medicare Advocacy, *Impact of the Medicare Act of 2003 on State Pharmaceutical Programs*, December 17, 2003.
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- U.S. Congress, Congressional Budget Office Testimony, Statement of Douglas Holtz-Eakin, Director, *Estimating the Cost of the Medicare Modernization Act*, before the Committee on Ways and Means, U.S. House of Representatives, March 24, 2004.

Appendix B: Additional Resources for Health Care IT

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Appendix C: Definitions of Levels of Care and Service

Service Levels in Foster Care Prior to FY 2004*

Level of Care	Description
1	Adequate functioning in all areas; transient difficulties, "everyday" worries and occasional misbehavior.
2	Occasional problems in functioning in any area; some acting-out behavior in response to life stresses; minimally disturbing to others.
3	Frequent or repetitive minor problems; may engage in non-violent antisocial acts; capable of meaningful interpersonal relationships.
4	Substantial problems; may present moderate risk of causing harm to self or others; frequent episodes of aggressive or other antisocial behavior.
5	Severe problems, may exhibit persistent or unpredictable aggression; markedly withdrawn; moderate to severe risk of causing harm to self or others.
6	Very severe impairments; consistently unwilling/unable to cooperate in own care; aggressive or self-destructive behavior; severe risk of causing serious harm to self or others.

* Department of Family and Protective Services, Senate Committee on Health and Human Services, April 13, 2004

Current Services Levels in Foster Care*

Level of Care	Service Level	Description
1 & 2	Basic	Supportive setting, preferable a family, with routine guidance and supervision; structured activities.
3 & 4	Moderate	Structured supportive setting, preferable a family; structured daily routines and activities; structured therapeutic intervention; access to therapeutic habilitative or medical support.
4 & 5	Specialized	Treatment setting, preferable a family, in which caregivers have specialized training; close monitoring and increased limit setting; therapeutic activities; regularly scheduled professional therapeutic, habilitative or medical support.
6	Intense	Highly structured setting, preferably a family; frequent one to one monitoring; constant attention and limit setting; professional therapeutic, habilitative or medical support including frequent intervention.

* Department of Family and Protective Services, Senate Committee on Health and Human Services, April 13, 2004

Appendix D: Rate Structure Before and After Sept. 1, 2003

FY 03 Level of Care Rate Reimbursements*

Level of Care (LOC)	FY 03 Rate	Level of Care (LOC)	FY 03 Rate
LOC 1		LOC 3	
PRS Homes - Age 0-11	\$17.12	PRS Homes	\$36.33
CPA Pass Through - Age 0-11	\$17.12	CPA Pass Through	\$30.57
PRS Homes Age 12+	\$17.50	CPA	\$67.10
CPA Pass Through - Age 12+	\$17.50	Residential	\$81.88
CPA	\$27.86	LOC 4	
Residential	\$27.86	PRS Homes	\$36.33
LOC 2		CPA Pass Through	\$40.66
PRS Homes	\$36.33	CPA	\$88.42
CPA Pass Through	\$27.31	Residential	\$91.22
CPA	\$53.46	LOC 5	
Residential	\$53.46	Residential	\$121.55
		LOC 6	\$206.60
		Emergency Shelter	\$99.47

* Department of Family and Protective Services, Senate Committee on Health and Human Services, April 13, 2004

FY 2004 Level of Care Rate Reimbursements*

Service Level Rate Structure	FY 2004 Rates
Basic CPA	\$36.00
Basic Foster Family	\$20.00
Basic Facility	\$36.00
Moderate CPA	\$65.50
Moderate Foster Family	\$35.00
Moderate Facility	\$80.00
Specialized CPA	\$87.25
Specialized Foster Family	\$45.00
Specialized Facility	\$115.00
Intense Facility	\$202.00
Emergency Shelter	\$94.00

*Department of Family and Protective Services, Senate Committee on Health and Human Services, April 13, 2004

Appendix E: Percentage of Children by Level of Care

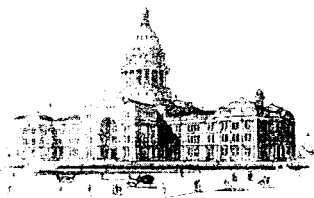
Percentage of Children by Level of Care as of FY 2004

Level of Care	Percentage of Children*	Consolidated Levels of Care	Percentage of Children**
Level 1	37.1	Basic	49.2
Level 2	9.5	Moderate	28.6
Level 3	22.9	Specialized	16.1
Level 4	18.1	Intensive	1.5
Level 5	5.7	Unleveled	4.6
Level 6	1.4		
Emergency Shelters	5.3		

* Texas Board of Protective and Regulatory Services, Board Meeting Minutes, June 16, 2003.

** Department of Family and Protective Services, June 2004.

Appendix F: Responses from Committee Members



The Senate of The State of Texas

DEC 09 2004
C/HR 9
ACTION:
SUBJECT: CPS
COMMITTEE: Legislative
GROUP: Informations, Chair
LEGISLATIVE: Health and Human Services
Infrastructure Development
and Security
Natural Resources

JON LINDSAY
District 7

December 8, 2004

The Honorable Jane Nelson, Chair
Committee on Health & Human Services
Room 1E.3
Capitol Building
Austin, Texas 78701

Dear Madam Chair,

Thank you for all of the work undertaken by you and your staff on the interim report of the Committee to the 79th Legislature. I appreciate the vast amount of time, research and energy expended in order to report and make recommendations on the many complex subject areas assigned to the Committee.

Due to the lateness of the CPS study (Charge #7) being assigned to the Committee, I understand that demanding time constraints may have made a complete vetting of the report impossible. Although I agree with most of the recommendations, I have concerns with a few, which I would like to share with you. I look forward to working with you, as well as the other members of the Committee, to develop the recommendations into the best possible legislation in order to protect those future victims of abuse in the CPS system.

Recommendations on Charge 7 (beginning on page 165):

#1 - Make the report of child abuse or neglect by persons who know it is false or lacks factual foundation subject to a state jail felony on the first conviction.

The portion of this recommendation that states "or lacks factual foundation" is of concern as a reporter of alleged abuse may not know whether the situation lacks factual foundation until it is investigated. "On the first conviction" also seems problematic to some of the child advocates to whom I spoke. Certainly, the Committee does not want to discourage credible reporting of abuse; if this recommendation is not structured properly in statute, this may be the ultimate outcome.

#3 - Require independent corroboration of suspected abuse in cases where the reporter is in a divorce or custody proceeding with the alleged abuser before a full investigation is performed.

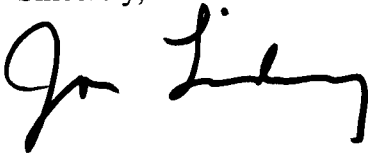
Independent corroboration by another person without an investigation is likely impossible in sexual abuse cases, and may be very difficult depending on the circumstances of certain physical abuse cases. As one advocate said, "child abuse is often a silent crime." The recommendation does not define "full investigation" versus perhaps some initial checking with neighbors or school personnel. Generally, child advocates may have a problem with this recommendation despite its good intent, especially when you consider cases of sexual abuse where others besides the child and the perpetrator would not know what occurred without a full investigation, including a medical exam.

#24 - Law enforcement should be the lead agency in joint criminal investigations of child abuse.

This recommendation sounds good as we all want to see perpetrators of child abuse prosecuted by the criminal justice system, however the practical effect may be problematic. CPS is often the first agency to act in reported cases of abuse, for example, by removing the child from the home. A criminal case may or may not be pursued depending on the evidence. CPS must be able to take the lead and act in cases where a child's life may be in danger whether or not a criminal case can be made in the situation.

I appreciate your consideration of these points and look forward to working with you and the members of the Committee to craft the best possible piece of legislation in order to better protect the youngest victims in our society. As Harris County Judge, I worked closely with the county CPS Board of Directors, and was intimately involved in launching one of the first and finest child advocacy centers in the nation. I hope to lend my experience and expertise, and that of my staff, as we move forward on this issue.

Sincerely,

A handwritten signature in black ink, appearing to read "Jon Lindsay". The signature is fluid and cursive, with a large initial "J" and "L".

JON LINDSAY
State Senator

JSL/ld

cc: Lieutenant Governor David Dewhurst
Members, Senate Committee on Health & Human Services

Sent by Telefax to 512/463-9889

Signed Original Mailed



zv

Committees

Finance, Vice Chair

Education

Health and Human Services

Judith Zaffirini

State Senator, District 21

President Pro Tempore, 1997

Committees

International Relations and Trade

Legislative Budget Board

December 10, 2004

Senator Jane Nelson, Chair
Senate Health and Human Services Committee
Texas Legislature
Austin, Texas 78711

Dear Chair Nelson:

Thank you for your leadership as Chair of the Senate Health and Human Services Committee. It is my privilege to serve with you, and I appreciate the opportunity to share my perspective regarding the Interim Report to the 79th Legislature. Although I signed the report because it includes many fine recommendations that could improve the quality of health and human services for many Texans, I submit this letter to record my abiding concerns about some of the recommendations.

I believe strongly that the legislature's top priority should be to provide the funding necessary to support existing health and human services programs and professionals. Any proposal for additional requirements, such as lowering the caseload for the Department of Family and Protective Services (DFPS) caseworkers, must be accompanied by the necessary funding.

The attachment to this letter reflects many of my concerns, two of which are set forth here.

Recommendations Regarding Charge 7 (beginning on page 165):

#3 - Require independent corroboration of suspected abuse in cases where the reporter is in a divorce or custody proceeding with the alleged abuser before a full investigation is performed.

A requirement of independent corroboration of suspected abuse threatens to endanger the children DFPS exists to protect. In child abuse, which goes on behind closed doors, independent corroboration before an investigation takes place may be impossible. The issues in Recommendation 3 should be studied further before the recommendation is adopted.

Capitol Office: P.O. Box 12068 • Austin, Texas 78711 • 512/463-0121 • Fax 512/475-3738 • Dial 711 For Relay Calls

South District Office: P.O. Box 627 • Laredo, Texas 78042-0627 • 956/722-2293 • Fax 956/722-8586

North District Office: 12702 Coeppertwein Road #214 • San Antonio, Texas 78233 • 210/657-0095 • Fax 210/657-0262

Letter to Senator Nelson
December 10, 2004
Page Two

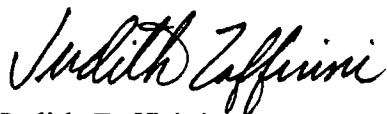
#15 - Transition all case management of foster children in the state's permanent managing conservatorship to private child placing agencies.

When a child comes into the permanent conservatorship of the state, the work has just begun. To ensure timely adoption, the state must be aggressive. To turn the child over to a private agency that is paid as long as the child is not adopted is not enough. Moreover, a CPS supervisor cannot just monitor the contract; a CPS caseworker has to monitor the progress of each child. The life of foster children is already challenging. Some private foster agencies move children around from home to home, use medicine inappropriately, and fail these children in ways that the report documents. Accordingly, how can the report propose giving the private agencies greater control without a CPS worker being responsible for the child? The recommendation should be amended to require study before any implementation of the recommendation.

Thank you for your dedication to these important issues. Count on my continued leadership to help ensure that every Texan has access to quality health and human services. I look forward to continuing working with you and other members of the committee during the forthcoming legislative session.

May God bless you.

Very truly yours,



Judith Zaffirini

JZ/cc

Attachment: Concerns about Texas Senate Health and Human Services
Committee Interim Report to the 79th Legislature

**Concerns about Texas Senate Health and Human Services Committee
Interim Report to the 79th Legislature**

Recommendations Regarding Charge 1 (beginning on page 1):

Background Section:

It should be noted that two primary justifications for people not to participate in premium assistance, where the state pays the premium on employer coverage, are that only 14.3 percent of Americans below 100 percent FPL have employer-sponsored health insurance (Source: Employee Benefits Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2003 U.S. Census Current Population Survey," December 2003), and premium assistance is not a better deal for the taxpayer if the private premium is larger than the Medicaid cost, which it typically is.

#1: Increase funding for Medicaid fraud and abuse prevention and detection.

Any increased funding for Medicaid fraud and abuse prevention and detection should include a provision protecting against overzealous investigation. Also, it is unclear what the Committee means by the program will "probably" pay for itself.

#2: Ensure that limitations of brand name drugs are cost-effective.

The discussion has conflated two different policies. Texas Medicaid has for years had a 3-Rx (all Rx not brand name) limit for adults except those in Medicaid Managed Care. In the 78th Regular Session, the legislature added a directive to look at imposing a 4-Brand name Rx limit only for adults in Medicaid Managed Care, but this was to be implemented only if deemed cost-effective and HHSC thus far has opted to fully implement the preferred drug list system and see if it yields the needed efficiencies before looking at the 4-brand concept.

#3: Require Medicaid beneficiaries to participate in a course on the proper use of the health care system including which types of care are appropriate for which types of symptoms.

An investment must be made to fund the course. No one will provide the training for free.

#4: Require that Medicaid HMOs and the State's PCCM system have nurse triage lines to direct their enrollees to the lowest-cost source of medically appropriate care.

Standards for these lines should be established. Their performance should be studied and compared for effectiveness in reducing ER visits so that best practices can be spread to/required of all providers.

#6: Establish standard Medicaid rates for durable medical equipment.

DME procurement efficiencies must be designed in a way that protects ease and speed of access for clients. This is especially a concern for clients in rural Texas.

#8: Add the medically indigent as a Medicaid expansion population.

Note, CIHC covers able-bodied adults without children. These cannot be covered by Medicaid except with 1115 waiver. Texas could, however, cover parents with dependent children under Medicaid up to any desired income limit without a waiver of any kind. This could still provide very substantial relief to local governments. This step could be taken first, while the much more difficult process of pursuing an 1115 waiver could be pursued as a longer-term objective.

#9: Exempt contracting positions from State pay scale.

This seems contrary to using contracts with private industry to save money and contrary to open government. Paying private contractors more for the same work is a disincentive to public service by state employment.

#s 12, 13, 14: These recommendations all support community based alternatives to institutionalization of the elderly and disabled.

The focus of these recommendations should be to greatly expand the options to allow consumers to direct which models and how much counseling they need in managing their care. The focus should not on funding one kind of service instead of another. The key is to allow the consumer as much flexibility as possible. Basing the level of need on historical consumption of services will, in many cases, be inappropriate. For some, the need for Consumer Directed Services comes from the consumer's inability to get the provider agencies to provide the appropriate level of supports and services. If that is the case, basing future services on those levels only continues the provision of inadequate services.

Secondly, changes in the condition of persons with disabilities can create the need for either more or fewer services. The extent of services needed should be determined individually and should be based on the individual's current, not past, functional needs. Further, the report should mention how community services can greatly improve the quality of life for people with disabilities, and why de-institutionalization and expansion of community services are considered best practices in service delivery and are the direction selected by most states for years. The report should also note that most persons with disabilities want to receive services in their communities and not in institutions, as evidenced by the thousands on the community waiver waiting lists. Finally, the recommendations should address the importance of the Promoting Independence Plan and how the currently lack of access to the appropriate waivers are negatively affecting implementation of that plan.

#18: Establish differential Medicaid Reimbursement for adoption of new technologies and quality assurance initiatives.

HHSC should be granted authority to devote from 12 to 18 months to ensure that the correct processes for collecting data and implementing this initiative are studied and used. It is unclear what new technologies are indicated in this recommendation.

Recommendations Regarding Charge 2 (beginning on page 29):

Background Section:

On page 29 the report states, "Texas spent \$19.5 billion in FY 02 funding these programs, a full 30% of state spending." This implies that these dollars are purely administrative, which they are not. The \$19.5 billion probably reflects the combined federal/state dollars spent on benefits and may include the combined federal/state dollars spent on administration. In reality, administrative costs as a percentage of the total value of benefits are only approximately 3 percent. Because it is unclear what the \$19.5 billion includes this statement should be revised to separate benefits dollars from administration costs, and to distinguish between state and federal expenditures.

On page 31 the last paragraph states that \$79.2 million from eligibility determination have been saved this biennium. It is unclear where these savings come from, since the IE initiative has not yet been implemented, and HHSC insists they have not commenced lay-offs. Is it from attrition in eligibility workers at local offices? From consolidation of state office eligibility staff? It remains unclear.

On page 36-44, in order to ensure an accurate analysis of the IE model, the following statements should be corrected, as follows:

- I. Page 37: Suggests that the “IED centers” (assuming this means call centers) will be responsible for “review and eligibility determination” of initial applications. This contradicts what HHSC has emphasized, that no determinations would occur at the privately staffed call centers, but that all would occur at the remaining state-staffed local offices.
- II. The report also states that staff at the BIC will “collect required documentation,” just after it says that all verification will occur at the IEDs. What documentation is referenced?
- III. The report should ask for clarification of the division of labor and work flow in the business case, since these are the critical points driving the assumptions about cost-savings and staff reductions.

On page 38, when discussing how the model will save money, it states that “Texas Works clients are required to schedule an appointment for an office interview” at recertification. This is an incorrect statement. Two-thirds of children on Medicaid (of 1.7 million total) recertify by mail with no office visit.

Page 42 cites success of the centralized ED model for *CHIP and Medicaid*. It is incorrect to say that these centers take Medicaid applications. The centers take CHIP applications and, if an applicant is really eligible for Medicaid, then that application is sent to a DHS worker. No Medicaid applications are processed over the phone. Even with the CHIP applications, the vast majority of their work is via mail, so it is not a good test case for a phone-in model. Further, the CHIP call centers have an abysmal track record of tracking the applicants they referred to Medicaid, even with co-located HHSC workers at the call centers.

HHSC says the model will be flexible to accommodate clients not being able to use the Internet (and presumably needing personal assistance, in general). Thus, it should be noted that funding for the new model will have to be flexible as well.

Page 42 of the report fails to include two of the most important concerns raised by CBOs regarding the use of volunteers as “community partners.” They question whether volunteers are well-suited to this kind of work, and do not think volunteers will be available in the areas where they will most be needed.

#22: Bolster current 2-1-1 Information and Referral infrastructure to accommodate anticipated increases in call volume when 2-1-1 is marketed as the gateway to DHS programs and more people become aware of its services.

This recommendation should include a provision that states: “Provide the relevant committees of the legislature and the AG’s office with an opportunity to review and modify these contract provisions before a contract is signed.” Also, the recommendation should include that the state auditor review the business case as part of its review of the consolidation. HHSC should not award a contract until this review is complete in order to incorporate SAO’s findings and make needed modifications.

#24: Ensure the independence of the OIG from HHSC.

An Independent HHS OIG should not alter the oversight of the SAO.

Also, this recommendation should be stated in a straightforward manner as follows: “Make the OIG an independent office that is separate from the HHSC.”

#25: Repeal Section 2.14(b)(1) of HB 2292, which requires HHSC to establish prior authorization procedures that ensure that: "a prior authorization requirement is not imposed for a drug before the drug has been considered at a meeting of the Pharmaceutical and Therapeutics Committee established under Section 531.074. This will allow HHSC flexibility to require prior authorization for drugs that the P&T Committee has not yet reviewed."

If the intent is to allow prior authorization to be imposed on new drugs on the market, this section should be amended, not repealed. This will create a distinction for new-on-the-market-drugs.

Recommendations Regarding Charge 3 (beginning on page 54):

#31: Reinstate the Indigent Health Care Advisory Committee.

This is redundant of Rec. 28. The report therefore offers no recommendation specifically addressing how to improve the indigent health care system. The Health and Human Services Committee was charged with making recommendations for the improvement of Texas's county and local indigent health care system and has failed.

Recommendations Regarding Charge 4 (beginning on page 70):

Background Section:

Although there was considerable information in two places about FQHCs, the sections did not mention the obligation of the FQHCs to provide mental health care. Further, the legislature should support HHSC in asking Congress to assume 100 percent of the state's cost of administering eligibility for the new Medicare benefit subsidy.

Also, the state must ensure that all functionalities and policy structure of the Medicaid Integrity Project (e.g. exemptions for nursing home or ICF-MR or mentally ill clients and decisions about how to handle finger imaging for children age 15 and younger) be fully tested in the pilot areas before any state-wide roll-out is allowed, and that statewide rollout not be attempted until the project function can be combined with live online eligibility verification on the same card.

#3: Support continued funding of the Federally Qualified Health Center (FQHC) Incubator Grant Program to coincide with the President's Initiative for FQHC expansion.

This recommendation merits support, but continued funding of an incubator program should not come at the expense of the primary health care program, unless all de-funded primary health care sites can be assisted in creating or expanding an FQHC.

Recommendations Regarding Charge 7 (beginning on page 165):

CPS Background Section:

Page 143 includes a statement that reports of abuse and neglect of adults and children with disabilities who receive services from the state's mental health agency numbered 10,154 (data from testimony provided 6/28/04, not the fiscal year). This is somewhat misleading because those "facility investigations" are actually under the APS division of DFPS.

The following should be added to the report: Children with developmental disabilities often are not considered adoptable because of their high cost of care. Adoption subsidies for these children should be increased to the current foster care rate, and their Medicaid coverage should continue. Until this happens these children will be moved from family to family or, worse, be placed in long term care facilities until they age out of CPS and are forced into adult long term care facilities.

#1: Make the report of child abuse or neglect by persons who know it is false or lacks factual foundations subject to a state jail felony on the first conviction.

On the one hand, case after case in which a child dies or is seriously abused occurs because CPS took no action even if it knew about the child. The report calls this “the major problem.” Then, statistically, we see that there are many more allegations than confirmations of abuse. The report calls this a separate problem - “unsubstantiated reports,” - and concludes that these are “false” reports, which leads to recommendations 1, 2, and 3. The unsubstantiated reports are not “false” reports, they are instead the very cases identified as the major problem - cases where investigations are inadequate and lead to a subsequent tragedy of a child dying or being seriously injured. “Unsubstantiated reports” have not been increasing steadily; rather, CPS’s capacity to substantiate reports has been decreasing because of overwhelming caseloads. There is no authority cited on page 147 for the proposition that unsubstantiated reports are fraudulent. False reports are rare. Moreover, to prove a “knowing” false report beyond a reasonable doubt is next to impossible even in those rare cases. Accordingly, this recommendation requires substantive support.

#2: Direct CPS to report all cases of suspected false reports to law enforcement.

This recommendation also requires substantive support because it is conditioned upon the unsupported assumption that unsubstantiated reports are false reports. The issue of allegedly false reporting in the CPS system must be studied carefully before these recommendations are adopted.

#3: Require independent corroboration of suspected abuse in cases where the reporter is in divorce or custody proceeding with the alleged abuser before a full investigation is performed.

Recommendation 3 may endanger children. There is a reason families get into divorce and custody proceedings, they are dysfunctional. Cases of domestic violence or other abuse may well end up in divorce or custody court. While an investigator can take pending proceedings into account on the issue of credibility, when allegations of abuse are made, there still must be an investigation. Moreover, what is "independent corroboration"? In child abuse, which goes on behind closed doors, independent corroboration before an investigation may be impossible to find. The issues in Rec. 3 should be studied carefully before the recommendation is adopted.

#9: Bring CPS workers' caseloads down to the national average so that staff can conduct thorough investigations and make good case decisions.

This is a great recommendation, but there is no detail as to how caseloads will be lowered. CPS must get funding to tackle this issue. Further, caseworker salaries must be raised.

#11: Consider utilizing supervising caseworkers when a child must be placed out of region, instead of having the primary caseworker travel to make home visits.

This recommendation is appropriate if the distant placement is absolutely necessary. The focus of CPS reform, however, should be on placing the child in his or her home community as SB 22 addresses.

#15: Transition all case management of foster children in the state's permanent managing conservatorship to private child placing agencies.

When a child comes into the permanent conservatorship of the state, the work has just begun. To ensure timely adoption, the state must be aggressive. Just to turn the child over to a private agency that is paid as long as the child is not adopted is not enough.

Moreover, a CPS supervisor cannot just monitor the contract; a CPS caseworker has to monitor the progress of each child. The lives of many foster children are already difficult. Private foster agencies move children around from home to home, use medicine inappropriately, and fail these children in many, many ways that the report documents. Yet the report proposes to give the private agencies greater control without a CPS worker being responsible for the child.

The recommendation that case management should be privatized should be amended to require extensive study before any adoption is considered.

#17: Reiterate the Legislature's intent to resolve cases involving children brought into foster care within 12 months.

This seems like a good idea, but there is no justification for imposing an arbitrary deadline on courts. There are no explanations or data showing that courts are extending the 12-month guideline for arbitrary or unfounded reasons. This rule could result in harm to children if a clogged docket forces rushed decisions. The root of the problem, the clogged docket, must be addressed before requiring adherence to deadlines.

#23: Require joint investigations involving both CPS and law enforcement on investigations that are criminal in nature.

This recommendation is unclear. All investigations are criminal in nature, so it remains unclear at what point law enforcement will get involved.

#29: Ensure compliance with policies and procedures by using a quality assurance program with strong staff performance measures and a comprehensive tracking system to ensure accountability at all levels of staff.

This recommendation is fine, but it is unfair to hold caseworkers accountable for more and more policies when their caseload is overwhelming. Requiring an inhuman amount of work only encourages the high turnover that makes caseload and quality of case management worse.

#36: Foster care caseworkers, foster parents, and parents (if they have not lost or surrendered their parental rights) should be required to sign authorizations for psychotropic medications to be given to foster children.

Recommendation 36 is unclear. Do all three have to sign the form? Certainly all three should not have to consent. There is likely to be disagreement. The Committee should wait to look at what HHSC recommends in its December report on this issue to decide how to address this matter.

APS Background Section:

The issue of when guardianship is advisable needs to be studied in order for proper guidelines to be promulgated. Funding for ongoing services, those beyond emergency services, must be allocated, and APS needs to connect with DADS and DSHS to get those services to clients.

#66: Strengthen training requirements for new staff and ensure that all staff members receive standardized training before working in the field. Develop and implement a mandatory continuing education program, including a comprehensive training program for supervisors.

Any training should be competency based training. Any assessment tools the staff are trained to use should be developed with input from stakeholders and sensitivity to a client's right to choice.

#84: Contract all guardianship services to community service providers.

Any contract must include training and education guidelines. Any contract must also include accountability guidelines.

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MARIO GALLEGOS, JR.

December 16, 2004

The Honorable Jane Nelson, Chair
Senate Committee on Health and Human Services
P.O. Box 12068
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Dear Chairwoman Nelson:

I would like to thank you for all the hard work you and your staff have committed to the extremely important issues contained within this Interim Report to the 79th Legislature. This interim has been one that contained several health and human services issues that I hope the Governor will deem emergency issues when we begin the upcoming legislative session.

While I am pleased to offer my signature and support for the body of work that this committee has produced, there are some broad themes I see throughout the report that concern me. In my estimation, the function of interim reports is to supply the Legislature with the best recommendations possible as a result of meticulous study.

I found however, as I read through the report, that I was worried as to how we might be funding for all of these good ideas. For example, there are a number of recommendations under Charge Five, relating to Health Care Information Technology, that propose raising rates and payments.

There are also several recommendations throughout the report that propose changes of a broad or general nature, such as the creation of an online repository for carrier verification protocols or the creation of a "cash and counseling" waiver program. I would be interested to see the legislative equivalent of those recommendations before I offer unequivocal support.

With respect to our state's protective services agencies, there seem to be two opposing themes regarding the administration of our protective service programs. While it appears we are moving toward the further generalization of our caseworkers with respect to child protective services, we are recommending the exact opposite in our adult protective services. I understand that different populations might require varied approaches to the administration of services, however I am hesitant to endorse opposite positions when it comes to caseworker duties.

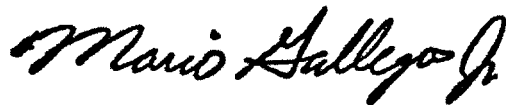


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Further, it appears that we are creating a high standard with respect to reporting abuse, as well as increasing the punishment for people who submit false reports, or reports that lack factual foundation. While I understand the intent behind these measures, we do not want the unintended consequences of these actions to be an increased hesitancy among individuals wanting to report suspected abuse – yielding a decrease in the number of reports overall.

I applaud you on your work with so many expansive charges this interim. Your efforts are even more laudable given the abbreviated nature of our interim. I look forward to the upcoming legislative session where we can begin the vetting process of these recommendations that will translate many of these good ideas into quality pieces of legislation.

Sincerely,

A handwritten signature in black ink that reads "Mario Gallegos, Jr." in a cursive script.

Mario Gallegos, Jr.